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London Strategic Health Authority

2012-13 Annual Report

NHS London Annual Report 2012/13

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LOOKING AFTER LONDON

NHS London

NHS London provided strategic leadership for all of the NHS health services in the capital. We had overall responsibility for the performance of 31 primary care trusts operating in five clusters, 16 acute trusts, three mental health trusts and the London Ambulance Service.

We also had a role to play in helping trusts achieve foundation status where they can work more autonomously. A further 18 Trusts in London are self-governing as Foundation Trusts, regulated by Monitor.

We made sure that NHS services in London spent taxpayers' money properly and provided high quality services. We also looked at ways they could improve performance and make services more accessible to diverse communities in London. We also worked to develop the skills of the NHS workforce.

As well as enhancing health services in London, we wanted to help Londoners look after their own health. We also built strong partnerships with other organisations such as local government to ensure services across the city were joined up and working well together.

Our vision and values

NHS London had a vision of world-class health and healthcare for Londoners. This vision was built on eight key challenges for London's healthcare, which were to:

- Improve Londoners' health
- Meet Londoners' rising expectations
- Overcome inequalities in care
- Reduce the over-reliance on hospitals
- Meet the need for specialised care
- Keep London at the cutting edge of medicine
- Make more effective use of the workforce and buildings
- Make the best use of taxpayers' money

We used this vision to address the changes needed to implement the new system while continuing to improve and maintain performance across London's NHS.

Our work was guided by a set of values. They were not just words, they were a critical element of our organisational strategy and steered how we approached our work and the decisions we made for the future. They underpinned what we did and why we did it. We aimed to be:

- Innovative: we lead the way to improve health by championing creative solutions

- Collaborative: we succeed by working with our partners
- Proactive: we think ahead to identify and seize opportunities
- Outcome focused: we focus on the solutions that deliver greatest health benefit to all Londoners
- Inspiring: we believe passionately in what we do and strive for excellence
- Respectful: we treat each other with respect and professionalism.

We wanted a working environment where everyone felt valued, accepted and listened to.

Directors' statement

NHS London directors have each confirmed that, to the best of their knowledge, there is no relevant audit information of which the auditors are unaware and that they have taken all necessary steps to ensure they are aware of all relevant audit information and to establish that the auditors are aware of that information.

Chairman's statement

This is the last Annual Report for NHS London, as it will be for 160 other statutory bodies which will cease to exist in April 2013 as a consequence of the Health and Social Care Act 2012.

Times change, and the structures which manage the NHS must evolve according to the needs of patients, as determined by the Government's reform programme. In the course of its 7 year existence, I believe that NHS London has achieved much for Londoners: it has co-ordinated the transformation of stroke and trauma services; it has set in train a similar process for vascular surgery and has initiated a transformation of cancer services; it has created *MyHealthLondon* enabling Londoners unrivalled access to information which enables them to compare the performance of GP practices; and in *Healthcare for London* it created a lasting blueprint for the way in which patients could be better served and at lower cost.

Many have contributed to these achievements, but I would like to highlight the contribution of Non-Executive Directors. Non-Executives have been part of the governance of health services for nearly 30 years in Strategic Health Authorities and their predecessors, and locally in PCTs. As such, they have not only ensured transparency and propriety within their organisations, but also provided a link to local populations, not least through the links they have cultivated with local authorities. They have also brought a breadth of experience from the commercial and business world as well as from voluntary and academic sectors to influence management and decision making. Some of our present cadre of Non-Executives will take up new roles as lay members of Governing Bodies of Clinical Commissioning Groups – but I here pay tribute to all those who have served the NHS in London in Non-Executive capacities, and wish them well for the future. I should also draw attention to the excellent leadership given to NHS London from my two predecessors - George Greener and Sir Richard Sykes.

London holds a unique place not only within the UK, but also internationally, which was fully demonstrated during 2012 with the Jubilee celebrations and the Olympic and Paralympic Games. With an increasingly diverse and comparatively young population, the needs of London's citizens are different and in some ways more demanding than in other English regions.

In terms of education and training, competition remains intense to secure places in London's medical schools, not only for trainee doctors, but for the full range of health professionals. Those training in London will go on to pursue careers not only throughout the UK, but across the world, benefiting from the thorough and internationally recognised grounding which our medical schools and higher education institutions afford.

In addition, London holds a pre-eminent place in international medical research. Its three Academic Health Science Centres, the creation of which are further achievements of NHS London, provide a framework not only for the delivery of world-class services to Londoners, but also for the cutting-edge research upon the results of which our children and grandchildren will rely.

In my personal view, the maintenance of this degree of excellence in our capital city will be one of the most significant challenges facing the new management of the NHS. Not only will the Strategic Health Authority be no more, but existing structures for co-operation between Primary Care Trusts and London Hospitals will disappear, together with the integrated organisation of medical and allied professional training. The risk of fragmentation is real. The new organisations have been working together over the last 6 months to try and fill this void. The new London system will need to ensure that the voices of patients are given the necessary airtime in discussion of strategic change.

Finally, I record my thanks to those who have supported me in my tenure as the last chair of this remarkable organisation: to Dame Ruth Carnall and her Executive Team; to the Non-Executive Directors of the Health Authority; and to all the staff of NHS London.

Professor Mike Spyer

Chief executive's foreword

2012/13 sees the end of NHS London as the significant changes introduced by the Government in 2010 are finally brought to a conclusion. It has been a very challenging year for everyone, but there are many positive things to report. Before going into a little detail on this year's highlights I should like to take the opportunity to record some of the significant points of the last seven years.

I am very proud of the improvements that have been achieved by the NHS in London. Staff in NHS London should all be congratulated for their contribution to these improvements. I am grateful to them all.

At its formation in 2006, the financial position of the whole London NHS system was in deficit, key performance measures were not being met and service reconfigurations had stalled. Perhaps most importantly, there was no coherent strategy for London that would address well-recognised but always controversial changes that needed to happen to provide medium and long-term improvements in the quality of care, patient experience and efficiency.

While never easy, by building effective London-wide relationships and taking difficult decisions, London's financial and operational performance has moved from being among the worst in the country to among the best. These relationships gave us solid ground to stand upon when confronted with other challenges, including difficult winters, swine flu, the Olympic and Paralympic Games and the changing priorities of the five Secretaries of State for Health whom we have served during these years. In addition, we are now making progress on implementing some of the long-standing changes that need to happen to address quality of care, access and inequalities affecting the capital. The history of attempts to tackle the problems of London's health care system date back to 1892. There have been many subsequent attempts, but they have had little sustained impact.

Lord Ara Darzi's comprehensive review, *Healthcare for London*, was an attempt to change that history and has been a platform for all of our work. It provided the case for change and an evidence base upon which a wide ranging strategic programme of improvements has been built. Where these proposals have been followed through they have achieved stunning results recognised internationally. His work and approach also demonstrated the importance and power of effective clinical leadership. It has been a huge privilege to work with hundreds of committed clinicians from London and elsewhere.

Having visited many Clinical Commissioning Groups (CCGs) in London I am confident that they will take forward their own version of this strategy, both at local and regional level. The changes we have made provide a model for others to use. Change is always controversial and I hope that the leaders of the new system will join together to provide the support that is needed at local level.

Review of 2012/13

This year has been dominated by establishing the new structures in London; 32 CCGs, 33 Health and Wellbeing Boards, three Commissioning Support Units, three Local Education Training Boards, NHS England, the NHS Trust Development Authority, Public Health England, Health Education England, NHS Property Services Ltd, the Health and Social Care Information Centre, and the London Health Board.

The NHS in London has worked hard to ensure that the transition on 1 April 2013 to the fully-functioning new structures goes as smoothly as possible, with the leaders of the new receiving organisations working closely together on mitigating risks as far as possible in the new system. But this has been perhaps the most complex change programme ever in the NHS.

The 2012 Olympic and Paralympic Games was a once in a lifetime opportunity to showcase our city and saw the most logistically complex and highest profile peace-time event ever staged in the UK, with public sector providers, including NHS staff, working around the clock to ensure services were maintained and additional demand was met. I would like to thank all those involved for their hard work in making the Games a remarkable success. The challenge now is to ensure that the Olympic legacy lives on and sustainable improvements are made in the health and wellbeing of all Londoners.

A new set of clinical standards for emergency and maternity care have been developed and agreed by the London Clinical Council and the London Clinical Senate. When fully implemented, these standards will deliver a far more effective service for patients, seven days a week and save up to 500 lives a year. As part of our drive for transparent data, a full audit of how every single hospital performs against these standards has been published on the *MyHealthLondon* website. This is just a start and deserves to be built on as a tool for service development and patient information.

The introduction of the Unsustainable Provider Regime for South London Healthcare Trust to tackle its long-standing debt problems saw the first appointment of a Trust Special Administrator (TSA). Working to a constrained timetable, the TSA and his team consulted with the public and staff and delivered a set of plans to the Secretary of State earlier this year, which were then accepted in the main. The next step is to implement these recommendations over the next three years and bring to an end the financial issues that have dogged all parts of the NHS system in this area of the capital for more than a decade.

I am pleased that the Shaping a Healthier Future consultation on hospital services in North West London has been concluded. Changes of this nature are hugely controversial and rightly attract political and media interest as well as significant public concern. However, as with South East London, ignoring quality and financial issues in the short term stores up larger problems for the future and I am hopeful that this ambitious programme will move to implementation soon. I should like to record my appreciation of the outstanding leadership provided by NHS North West London and the CCGs in that part of London.

Finally, I know that there is still much more to do to improve healthcare in London. We have only just begun to see the changes proposed by Lord Darzi come to fruition – more needs to be done on cancer, mental health and integrated care for people with long-term conditions. I hope that the relationships we have put in place in the NHS in London, with Academic Health Science Networks, with the Mayor of London and Local Government as well as with other stakeholders, will help support further transformational change.

On a personal note I would just like to say what a privilege it has been for me to lead the NHS in London over the past six years and pay tribute to my team in NHS London – the most supportive and capable group of people I have ever worked with. I should also like to thank Professor Mike Spyer, my chair, and the Non-Executive Directors for providing such great leadership in very challenging times.

Dame Ruth Carnall

Urgent care

Across the year over 4.4 million people attended an A&E department in London. London delivered the 95 % threshold of patients being seen and treated, admitted or discharged within four hours at A&E across each of the first three quarters.

During the winter NHS London worked in partnership with the six PCT clusters on a risk assessment and assurance process to ensure that the capital's health system had robust plans to address the key risks and additional pressure that it would face during the winter period. However, as with previous winters, maintaining the 95% threshold was a challenge over winter 2012/13. At the end of March London performance was below the 95% threshold at 94.62%. NHS England is working with CCGs to understand the causes of under performance and to deliver improvement.

Planned care

NHS London saw strong performance across 2012/13 in delivering planned care within the 18-week timeframe set out in the NHS constitution. Between April 2012 and January 2013 over 400,000 people were admitted for treatment and over 1.7 million treated in an outpatient setting. During that time over 90% of patients admitted for treatment and over 95% of patients treated in an outpatient setting received treatment within 18-weeks of referral from their GP.

London continued to meet national cancer treatment standards for the more than 55,000 patients receiving treatment for cancer each year.

London worked hard to reduce incidences where patients were placed in wards with patients of the opposite sex. Since mandatory reporting of 'sleeping breaches' started in December 2010, considerable work has been undertaken with the PCT cluster leads and acute trusts to reduce mixed sex accommodation breaches from 2,769 to 257 in January 2013. NHS London worked to ensure that the learning was handed over to the new system so that breaches are further reduced.

Staying healthy

Access to dental services is important for the population of London. Just under 10% more people accessed an NHS dentist in the two years to October 2012 compared to the same figure in October 2011. London was committed to ensuring that there is good access to NHS dentistry in the capital.

Health Care Acquired Infections (HCAIs) reduced in London during 2012/13, with cases of Clostridium difficile (C.diff) in hospitals dropping to 785 for the year to January 2013 compared to 1008 recorded for the same period in 2011/12. There have been 73 reported cases of MRSA in London hospitals to the end of January 2013, against 97 in the same period the previous year.

Public Health remains a priority for the NHS in London. NHS London maintained steady improvement in performance across London in the five prevention priorities – childhood immunisations, smoking cessation, screening, vascular health checks and sexual health. This is detailed further in the Public Health section of the report.

General Practice Outcome Standards

Over the last two years NHS London developed a set of General Practice Outcome Standards (GPOS). These are a set of clinically developed and owned standards that look at the quality of General Practice across London to support improvement in care received by patients. This was a clinically led programme; the standards were developed with clinicians across London and with the invaluable support of the primary care and medical teams at NHS London. The standards have been shared across the NHS in London and made public through the *MyHealthLondon* website which gives the public access to the data.

This is the first time that a set of standards have been developed and agreed regionally. The cutting edge nature of this work, and the way in which the information is made public through *MyHealthLondon*, was recognised nationally with NHS London winning a prestigious award at the Health Service Journal HSJ awards for ”Enhancing Care with Data and Information”.

SAFETY & QUALITY CARE FOR PATIENTS

Local Supervising Authority

Local Supervising Authorities (LSAs) are organisations that hold statutory roles and responsibilities for supporting and monitoring the quality of midwifery practice at a local level. This is done through the mechanism of statutory supervision of midwives and is delivered in line with the standards set by the Nursing and Midwifery Council (NMC). The LSA has a pivotal role in clinical governance and a responsibility to ensure there is a local framework to provide equitable, effective statutory supervision for all midwives. The primary responsibility of the LSA is to safeguard and protect the public. In England, LSAs sat within the Strategic Health Authorities (SHAs).

The London LSA was reviewed by the NMC as part of their two to three-year cycle of LSA reviews. The review identified that the London LSA had met 53 out of the 54 standards for the statutory supervision of midwives. The London LSA has yet to meet the NMC recommended ratio of one supervisor of midwives to every 15 midwives working in the capital. This is being addressed in a number of ways and it is anticipated that the ratio will be achieved by the end of 2013. The London LSA has successfully recruited and trained 10 lay audit reviewers to assist in undertaking statutory annual maternity service audits. The NMC stipulate that lay auditors should be involved in this important statutory function.

As midwifery establishments increase so does the need for more Supervisors of Midwives. The London LSA has worked collaboratively with employers to secure additional time for supervisory activities; this included being the first LSA in the UK to appoint a full time Supervisor of Midwives within a Trust with high ratios. This model has been particularly successful and is being considered by other Trusts.

In September 2012 the London LSA launched a leadership programme for Contact Supervisors of Midwives, with a representative from every Maternity Service in London attending. This culminated in a presentation of the projects that the Supervisors have been working on in their sectors, with a view to each recommendation being rolled out across the London LSA.

A pilot scheme was run by the London LSA that replaced the current system of faxing patient discharge information with the use of secure email – the Secure Transfer of Women (STOW) project. The pilot proved so successful that the use of email to transfer discharge information between trusts is now being rolled out across London.

The London LSA audit tool for auditing Maternity Services has been acknowledged by the NMC as an exemplar and is to be rolled out across England for use within other LSAs.

Maternity Care

NHS London continued its work in supporting and funding initiatives to raise the standard of care and the experience for women, babies and their families in the capital. There were 22 acute trusts in London that provided maternity services in 2012 across 32 sites. Services are also provided within a community setting and within the woman's home. There were 131,821 births between April 2011 and March 2012.

Since the increase in the number of co-located and/or standalone midwifery-led units/birth centres, London maternity services were in a better position to offer women greater choice of place of birth. December 2012 saw the opening of an additional stand-alone birth centre in Barking, which will give more choice to women resident in North East London. The number of co-located birth centres has also increased and more women are choosing to use these facilities to give birth.

As part of the London Health Programmes for quality and safety within acute trusts clinicians, with the support of commissioners, have developed minimum clinical commissioning standards and interdependency frameworks for maternity services.

Maternity Services in London have seen the vacancy rate for midwives decrease year on year since 2008. NHS London continued to support the 'return to practice' programme, with over 130 midwives undertaking such programmes within the past four years. NHS London was the first SHA to commission a foundation degree programme for maternity support workers. This programme – now in its fourth year – aims to free-up midwifery time without compromising standards of care, to enable midwives to offer one to one care to women in labour and early access to a midwife in pregnancy (i.e. prior to their twelfth completed week of pregnancy).

Maternity Provider Networks have been established within each of the current five London sectors, their development was overseen by the NHS London Maternity Provider Network Board. The aim of the networks is to ensure a collaborative and standardised approach to the commissioning and provision of maternity services within the capital and enable a smoother and more seamless pathway for women and their babies.

Health Visiting and Family Nurse Partnership Programme

Health Visitors (HVs) play a vital role in promoting health, preventing illness and safeguarding children. They provide invaluable support to families and have a lasting and positive impact. Increasing evidence shows that health and wellbeing in pregnancy and childhood has an impact upon health in later life and HVs provide key support to children during the first five years of life and to their families. In recognition of this key role, the government launched a 'Call to Action' in February 2011 to increase the number of Health Visitors by 4,200 and implement a new service offer and vision in England by 2015. Alongside the HV programme, by 2015 the structured

Family Nurse Partnership Programme aims to double the number of vulnerable families being supported.

The Chief Nurse's Directorate continued to lead this programme, in collaboration with the Performance and People and Organisational Development Directorates. As this is a nationally-led programme, all the NHS London directorates were involved with it and had direct relationships with the Department of Health teams. The HV FNP Programme Management Board, with representation from all PCT clusters, continued to report to the Delivery Group of the NHS London Board. Progress is being made in London in relation to increasing the number of HV students in training and in the recruiting of newly qualified HVs. Notable achievements for the London programme included:

- Successful delivery of centralised recruitment for student placements through the London Deanery
- 259 training commissions filled for 2012/13

To support the transformation of HV services to deliver the new service vision, a number of bespoke projects have also been delivered, including:

- A specific leadership programme for HVs and School Nurses – with two cohorts successfully launched
- The selection of further Early Implementer Sites, giving London six sites to date
- Delivery of a Practice Teacher development programme, including an e-learning package that incorporates a 'Building Community Capacity' module
- Support to five HV services to improve on mobile-working capacity and capability using technology
- The launch of the HV Community of Practice/Clinical Network for the profession

Energise for Excellence and High Impact Actions for Nursing and Midwifery (E4E/HIA)

NHS London led the 'Energise for Excellence' (EfE) programme regionally, which was launched by the Chief Nursing Officer in early 2010 as a quality framework for nursing, midwifery and health visiting. The programme aims to support the delivery of safe and effective care to all by providing nurses and midwives with an array of tools, approaches and measures that can be used to drive both quality improvement and cost reduction.

Organisations in London focused on delivering improvements in nationally identified high-impact actions that are associated with the essentials of patient care; for example, in pressure area care, hygiene and infection control. These high-impact actions are simple to implement, and lead to a significant improvement in patient care. Throughout 2012 NHS London monitored the numbers of pressure ulcers, falls and urinary catheter infections across London and disseminated this to all trusts and community health providers. Organisations were able to benchmark their

performance, focus on key areas that require improvement and also share best practice initiatives across London.

To assist in the sharing of best practice and promotion of online resources, NHS London hosted quarterly London Quality Matters meetings, which were well attended by senior nurses in practice. This afforded the opportunity for trusts to share lessons from local initiatives. The EfE lead disseminated information from the monthly national leads meeting, and encouraged sign-up to national Calls for Action and participation in webinars and other activities organised by regional leads across the country. As part of this programme, NHS London organised and hosted a national conference on 'Dignity in Care' in October 2012. The feedback from this event was very positive and the momentum and energy from the conference and associated webinar events was used to follow-up on actions from attendees.

Allied Health Professionals

The Allied Health Professionals (AHP) team delivered several key projects during the year. A launch was held at the Kings Fund to introduce the Allied Health Quality, Innovation, Productivity and Prevention (QIPP) Toolkits. The role of the 12 allied health professions in the delivery of quality cost effective health care was clearly demonstrated by the content of these toolkits. The Toolkits were introduced by Jim Easton and their use in the NHS was seen as very helpful. The toolkits focus on Stroke, Cancer, Musculo-skeletal disorders, Use of Oral Nutritional supplements and Diabetes. The National Clinical Directors for these areas were involved and their expertise was combined with endorsements from the 12 Allied Health Professions Professional Bodies.

The Toolkits aim to help providers and commissioners remain aware of how clinicians can help improve health gains for patients at the same time as reducing costs. A further Toolkit on the area of Continuous Personal and Professional Development for Allied Health staff was produced. Both Toolkits are available on the NHS Networks site and can be viewed nationally on www.networks.nhs.uk.

AHPs continue to pursue work to improve rehabilitation services across a number of clinical areas, such as major trauma and stroke. It is essential that such services are constantly improving so that people return to work and home activities with the skills and confidence to help them meet their own goals.

Safeguarding children

Focused activity to ensure children are safeguarded continued throughout 2012/13. A dedicated team monitored and audited safeguarding children arrangements during transition and CCG authorisation to ensure that safeguarding children expertise was retained at all levels of the NHS. A majority of practitioners with safeguarding children responsibilities have completed leadership training and new professional networks for Mental Health Safeguarding Children Named Nurses, Named Doctors and Named GPs were established and supported by NHS London.

Collaborative-working with multi-agency partners remained a priority. NHS London maintained full representation on the London Safeguarding Children Board and participated as a member of several sub-groups to provide NHS expertise, advice and information on NHS reforms and practice issues. The NHS was fully engaged with the local implementation plans for Multi-Agency Safeguarding Hubs (MASH) for safeguarding children, many of which are in the process of 'going live'. NHS London also worked with colleagues from the Department of Education and NHS England to scope how the systems approach to Serious Case Reviews could align more closely with NHS-established Serious Incident monitoring processes.

To enable and promote the 'early help' to families, the safeguarding children workstream was connected to the NHS London Health Visiting and Family Nurse Partnership programme and stronger links have been established with the safeguarding adults team.

Safeguarding Adults at Risk

The abuse uncovered at Winterbourne View was a stark reminder of what can happen if the NHS does not work in partnership with regulators, commissioners, providers, family carers and those using services. It demonstrated what happens when commissioners and providers ignore their responsibility and ensure that they successfully apply general duties of good care to service users who are vulnerable adults, and to mitigate risks linked to specific vulnerabilities.

NHS London continued to support the development of safeguarding adults at risk practice in London, and participated in the monitoring of its success, including the rolling out of performance frameworks to measure the effectiveness of local systems.

To make change happen, close working relationships were forged nationally, at pan-London and local level with the Association of Directors of Adult Social Services (ADASS), the Home Office, Department of Health, PCT clusters, Clinical Commissioning Groups, Local Authorities, NHS Trusts and patient groups.

All NHS providers and commissioners in London were supported to review their organisational safeguarding practices, using a national agreed self assessment and assurance framework and improvement actions were set with their Local Safeguarding Boards where performance was deemed as less effective.

For the first time, organisations also assessed their response to Prevent. Prevent, part of the national Anti-Terrorism Strategy 'Contest', identified 17 London Local Authority areas where there was a high risk to vulnerable adults being radicalised to extremist views.

For the third consecutive year, NHS London implemented a Learning Disability Health Self Assessment across 31 PCTs in London. In response to Winterbourne View, additional assurance was sought about the quality of commissioned services and commissioners were asked to give confidence to people with learning disabilities and family carers about the quality and safety of universal and specialist services.

NHS London supported the facilitation of 30 engagement events across London in which local health services came together with people with learning disabilities and their family carers to rate service providers' performance against targets and to set joint actions for the next year. NHS London met with local commissioners, family carers and people with learning disabilities to jointly agree final scoring and improvement plans. There was positive engagement from GPs and CCGs with the process in preparation for taking on their commissioning role.

NHS London worked with NHS England and CCGs to take on their responsibilities on safeguarding adults, including implementing the lessons learned from Winterbourne View, as outlined in the NHS England Mandate and Concordat.

Continuing healthcare

NHS Continuing Healthcare is a package of care that is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing health care needs. Eligibility for NHS Continuing Healthcare is not dependent on a particular disease, diagnosis or condition, or on who provides the care or where that care is provided. If an individual's assessment of care needs shows that their primary need is a health need, rather than a need for social or 'personal' care, then they are eligible for NHS continuing healthcare.

Across London, approximately 8,400 new patients were found eligible in 2011/12, and in total, approximately 16,000 people in the capital received a fully-funded NHS continuing healthcare package at a cost of over £358 million. Indications for 2012/13 are that numbers are rising.

As the alternative to Continuing Healthcare is social care, where individuals are financially assessed regarding their ability to pay for social care, disputes often arise about eligibility decisions. NHS London had a statutory duty to set up independent review panels (IRPs) to settle disputes about continuing healthcare decisions. PCTs were strongly encouraged by NHS London to settle disputes locally whenever possible, and this resulted in a large reduction in the number of IRP requests over the past few years. This indicated that local processes have improved and PCTs are now investing more time with individuals, explaining decisions and listening to their concerns. NHS London worked with families, clinicians and the NHS Ombudsman to improve the process, as well as collaborated with the other SHAs in England to increase consistency – these improvements have made a clear difference to the quality and robustness of the independent review process. If a person is not satisfied with the recommendation of the IRP, the next stage of complaint is to the Parliamentary and Health Service Ombudsman. There have been no such investigations for over three years.

In 2012, the Health Minister announced that from April 2014, all people eligible for Continuing Healthcare will have a right to ask for a Personal Health Budget. Therefore, PCTs needed to develop systems and processes to be able to offer Personal Health Budgets. NHS London worked with PCTs to roll out some of the learning from the Personal Health Budget pilot sites.

The function of the Continuing Healthcare team will be transferred into NHS England. The roles and responsibilities will be very similar and will be defined in the new Continuing Healthcare Standing Rules.

Dignity in care for older people

Improving dignity and compassion in the care of vulnerable, older people remains a major priority for all providers of healthcare and links to the national dementia agenda, patient safety and work on long-term conditions. Following the launch of the *Delivering Dignity* report by the Commission on Dignity and Care for Older People, key recommendations have been widely presented to national and London professional, patient and public groups in partnership with the NHS Confederation, Age UK, and the Royal College of Nursing, as well as local provider meetings. NHS London participated in workshops with national leaders in the care of older people which resulted in support for *Improving hospital care for older people; a call to action* launched at the House of Lords on 3 December 2012.

The project to identify factors influencing dignity in care through observations at ward level progressed to acute, mental health and community hospital wards and influenced the inclusion of peer review into the Delivering Dignity report as a means of real time learning and feedback to staff on the behaviours and attitudes that have an impact on the respect and compassion afforded to both patients and colleagues.

In October 2012, NHS London hosted a Delivering Dignity conference. It attracted 120 frontline nurses, highlighted work from a range of settings, was highly acclaimed by attendees and has resulted in sharing practice and innovations for providers. A series of dignity webinars presented by staff from London, in partnership with the NHS Institute for Innovation, also served to provide a national audience for debate and our Twitter debate on dignity similarly attracted participation in significant numbers.

NHS London recruited a partner to develop web-based 'situational judgement testing' for applicants to nurse training in adult, mental health and children's nursing and these were piloted. The test is intended to ensure that student nurses will have the values and attitudes most likely to provide kind and compassionate care. The pilot was completed in March 2013 and outputs and potential further work was transferred to the Local Education and Training Boards (LETBs).

Work to identify and address issues relating to the culture in which staff work which are known to influence the dignity afforded patients, has been supported through two projects underway in London. The first, in partnership with the Foundation of Nursing studies, called *Caring Cultures,* involved the recruitment of two Trusts to a two-year programme of onsite leadership support at ward-level working with ward teams to instil team working for the benefit of improved patient and staff experiences. The second project was a pilot of the *Cultural Barometer* in two London acute Trusts, sponsored by NHS London. The Cultural Barometer is a staff questionnaire that gathers individual employee opinion about how they are treated at work. It has been cited in the new Chief Nursing Officer's vision and strategy for nurses, midwives and care givers *Compassion in Practice* for national rollout.

Dignity in care and older people's work streams continue within the patient experience domain of NHS England.

Patient Safety Action Team

The Patient Safety Action Team (PSAT) helped to ensure the appropriate management of around 350 serious incidents each month across London; ran a successful programme of Sharing the Learning events; identified and shared pan-London patient safety themes and provided advice and leadership to a number of trusts to help improve standards and governance processes.

Over 2012/13, four 'Sharing the Learning' workshops were held, with wide-ranging attendance from staff from trusts across London. The topics were: Falls Prevention, Pressure Ulcers, Maternity Incidents and Patient Safety Processes. A series of Improvement Science workshops was also held that provided frontline and managerial staff with some simple tools to support them to improve the care of patients.

Several detailed reports on serious incident themes have been produced and shared with commissioners and trusts enabling all organisations to learn from others, including an in-depth analysis of maternity incidents across London.

London Harm Free Care Campaign

In 2012 the London programme focussed on two strands:

- Reduction of the four main avoidable harms in Mental Health Trusts (violence and aggression, falls, self-harm and medication errors)
- Reduction of harms in Care Homes – organised and led by the PCT clusters

The Harm Free Care in Mental Health pilot programme involved most of the mental health trusts in London, each of which put in place improvement projects to reduce the incidence of harm.

Preparatory work was undertaken for the Care Homes strand in North West, South West and North East London and City PCT clusters.

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of the harm from pressure ulcers, falls, urinary infection in patients with catheters and treatment for Venous Thrombo-embolism. It is called the NHS Safety Thermometer because it takes only a minimum set of data to signal where individuals, teams and organisations might need to focus more detailed measurement, training and improvement. In London, the majority of trusts submitted data using this tool and planned improvement work to achieve reductions in these 'harms'.

Mental Health Homicide Independent Investigations

Health service guidance introduced in 1994 by the DH (HSG (94) 27) outlined the requirement for an independent investigation to be undertaken when a person convicted of a homicide has been under the care of specialist mental health services in the six months prior to the incident and subject to care programme approach (CPA). The responsibility for commissioning independent investigations sat with the SHA.

Over the last 12 months (2012/13) NHS London published the 2009 mental health homicide independent investigations on its website. All cases from 2011 where court proceedings have concluded were commissioned with investigations by one of the specialist companies to conclude by the end of March 2013. Progress was closely monitored to ensure that the timescales were met.

The new process, based on the Embedding The Learning project, continued to be used. So far, 32 professionals from the mental health trusts across London have been panel members on independent investigations. The panel members have found this a positive experience which has broadened their understanding of investigation processes and provided the opportunity to take learning back to their own organisations.

Friends and Family Test

NHS London led the implementation of the Friends and Family Test (FFT) by providers of NHS-funded care in acute and A&E settings from April 2013. It provided real-time patient feedback at ward level so that staff could respond to ensure continuous improvements in patient care. NHS London worked with PCT clusters and CCG colleagues to influence national guidance and supported implementation of a single question for discharged patients that asks if they would recommend the ward or department in which they have received care to friends and family. A London steering group reported to the National Programme Board on progress. A national staff and public campaign was launched in February 2013, ahead of publishing results by ward, speciality, hospital site and trust. All providers have robust plans for the introduction of the test. CCGs will monitor compliance with national guidance, including the monthly reporting of data which will be published on the NHS Choices website from May 2013. NHS England will seek assurance from CCGs of the use of the feedback to initiate improvement in patient experience.

Medical revalidation

The Responsible Officer legislation regarding GMC revalidation of doctors came into practice in December 2012. Revalidation is designed to ensure doctors remain up-to-date and fit to practise. Responsible Officers and the Designated Bodies for whom

they work must ensure that they have effective clinical governance systems in place, including appraisal systems for doctors that reflect learning from patient and colleague feedback and adverse incidents and contribute to quality improvement and patient safety.

The London Revalidation Support Team was part of the NHS London Medical Directorate. The Team interacted with over 140 Responsible Officers (ROs) and 200 Designated Bodies across London involving all sections of healthcare, including those outside the NHS. During 2012/13 NHS London ran regular Responsible Officer Network events to share learning and enable benchmarking of ROs' judgments on doctors' performance. NHS London was grateful for the support we have received from the GMC, the English Revalidation Support Team, the National Clinical Assessment Service and London Deanery.

The performance of individual Designated Bodies was recorded through a series of national Organisational Readiness Self-Assessments (ORSAs) and the compliance of London healthcare organisations with this process rose to over 90 per cent, and the content also improved so that the large majority of Designated Bodies now meet the requirements stipulated.

NHS London appointed and trained a group of 23 RO appraisers, and supervised a standardised GMC-compliant approach to the appraisal of ROs across London. The NHS London Medical Director began to make revalidation recommendations on ROs to the GMC.

In terms of governance, the RO Network was led by a Network Board that reported through a Programme Board to the Quality and Clinical Governance Committee of NHS London. Plans have been made to bring together the central London Revalidation Support Team with revalidation teams in the three London geographical patch teams in the London regional part of NHS England from April 2013.

Case Study: Dementia Strategic Clinical Network Programme

Situated within the Medical Directorate, the Dementia Strategic Clinical Network Programme set up by NHS London used a clinical leadership model to drive improvements in dementia care in line with the National Dementia Strategy (2009) and the Prime Minister's Dementia Challenge (2012). The Programme has been running since March 2011, with a multidisciplinary team of clinical leaders from primary and secondary care working to deliver improvements across the system.

The Programme focused on a number of key enablers and priorities identified in the National Dementia Strategy:

- **Developing strategic clinical networks** – since inception, the Programme developed an overall network of over 500 London clinicians, commissioners, Local Authority and voluntary sector colleagues across all areas of care.

- **Strengthening commissioning, integration and primary care leadership for dementia** – the Programme has worked collaboratively with the Joint Improvement Partnership (which works on behalf of the Adult Directors of Social Services) to facilitate the Integrated Health and Social Care Commissioners Network and support its workstreams. The Programme has also run a bespoke leadership and development programme in dementia for 27 London GPs with a strong interest in commissioning and strategic leadership. Additional commissioning support tools and resources have also been developed, such as the London Dementia Needs Assessment and pan-London template CQUINs.

- **Supporting workforce development and training** – Train the Trainer programmes were run for both acute and community care which has developed the capacity of London organisations to run dementia training in-house. Across the 27 Acute Trusts that care for older people, 99 Trainers have been trained, while 80 have been trained from London's specialist and non-specialist community services. Tailored interactive training resources for both settings have also been developed in collaboration with clinicians for London's clinical trainers to use.

- **Supporting improvements to dementia care in hospitals** – the Programme has facilitated quarterly meetings and supported workstreams of the Acute Hospital Dementia Clinical Network. This included facilitating the delivery of the national initiative around "Dementia-Friendly Hospitals" by bringing clinicians together to develop ideas for action planning templates and providing a mechanism for sharing resources.

- **Driving reductions in inappropriate prescribing of antipsychotics to people with dementia** – the Programme has developed and run the London Primary Care Antipsychotic Audit and Reductions Exercise and provided expert pharmacy change leadership advice and guidance to Medicines Management teams to encourage reductions. As a result, the exercise has already stopped 85 prescriptions of antipsychotics to people with dementia and reduced a further 60 prescriptions across seven London boroughs. The Programme has also encouraged mental health trusts to reduce inappropriate prescribing through a pan-London CQUIN.

SERVICE TRANSFORMATION

Transforming service delivery to deliver improved care and financial sustainability

Strategic planning and service change implementation

NHS London continued to provide expertise and support to two planned major service reconfigurations in north west and south west London, while overseeing the delivery of service change in north east and north central London.

We supported north west London commissioners in developing the *Shaping a Healthier Future* (SaHF) strategy, seeing it through a successful public consultation phase which saw the preferred option, with enhanced proposals for Charing Cross and Ealing Hospitals, approved by the Joint Committee of PCTs on 19 February 2013. The overall strategy, based around improved clinical quality standards for acute and out-of-hospital services, will be delivered through improved community care and the consolidation of A&E services – from 9 to 5 major hospital sites. Out-of-hospital strategies are already starting to be implemented, while changes to major hospital sites will be gradually phased in between the next three to five years.

We also provided support and assurance to the *Better Services, Better Value* (BSBV) strategy in south west London, including the revision of the programme in light of the halted transaction for the acquisition of Epsom General Hospital (part of the Epsom and St Helier Trust) by Surrey-based Ashford and St Peter's Foundation Trust. At the time of writing, local GPs, nurses and health professionals have asked people in south west London and Epsom to shape the future of their local health services by taking part in the BSBV programme.

Good progress was made on the implementation of the *Barnet, Enfield and Haringey Clinical Strategy* (BEH) in North Central London. The planned move of emergency care and consultant-led obstetric and neonatal services from Chase Farm to Barnet Hospital and North Middlesex University Hospital is on track. The £80m business case for building work to accommodate the increased workload in maternity and unplanned care at North Middlesex was approved by HM Treasury and is underway. The full business case for £34m investments at Barnet and Chase Farm Hospitals was approved in November 2012 to help deliver additional capacity at Barnet Hospital and an urgent care centre and other refurbishments at Chase Farm Hospital.

NHS London continued to support the implementation of the *Health for North East London* (H4NEL) strategy. Barking, Havering and Redbridge University Hospitals Trust have consolidated maternity services on to the Queen's site and re-distributed some of these services across north east London. These new arrangements were in place from the end of March following an NHS London assurance gateway review to assess the readiness of the system to make these changes. Changes to A&E services will only be implemented when it is safe to do so, with a precise date still to be determined and only after extra capacity is built at the Queen's site. It is expected that implementation will be completed in 2015.

With effect from 7 March 2013 NHS England took over responsibility for service transformation and, through the support and transfer of NHS London staff, started to support this challenging work during a smooth handover period.

Transforming Primary Care

During 2012/13, NHS London worked with the clinical commissioners of the future to seize a fresh opportunity to transform primary care. NHS London worked with the Kings Fund and Imperial College London to describe the quality of general practice services in London.

"While there are some excellent general practices in London, the quality of care that Londoners receive is not as consistently good as it could be. There is huge potential to make better use of information and data to understand and address variations in performance. I hope this report will encourage GPs to engage in a discussion about how to lead a transformation in general practice to ensure all Londoners enjoy the best possible healthcare."

Anna Dixon, Director of Policy at The King's Fund

“The King’s Fund report recognised the excellent service offered by GPs across the capital but calls upon us to consider the transformation of general practice, taking into account the changing population and varied, increasing demands. This comes at a pivotal time as Clinical Commissioning Groups plan for the future; using it as a basis to identify strategic change priorities to develop general practice services in each area, thereby improving the services local people receive.”

Dr Tom Coffey, Assistant Medical Director at NHS London

The Kings Fund GP Quality Report argued that major changes are needed to the organisation and delivery of primary care to meet these challenges including:

- •GPs should work more closely with hospitals, community services and social care to improve the co-ordination of care, especially for patients with long term conditions.

- •GPs and commissioners must make better use of data to understand and act on local variations in performance, and exploit the potential of IT to improve the quality of services for patients.

- •GP practices could move more quickly towards different models of service provision e.g. federations or networks – this will enable smaller practices to retain their local focus, but provide a wider range of services.

NHS London had a successful track record in developing quality improvement tools for general practice:

- GP Outcome Standards
- *MyHealthLondon*,
- Once for London Commissioning

London's framework for primary care transformation was published in the latter part of 2012/13. The framework supports CCGs in setting a more radical and ambitious vision for general practice locally with a direction of travel towards greater collaboration on core general practice services to deliver scale benefits.

In 2012, London launched the UK's first GP Innovation Challenge Fund – it aims to identify and demonstrate future models of general practice delivery and understand better how to get others to adopt the things that work. Of 200 bids to the fund, nine projects were funded in year one, including:

- Introducing a flow station and GP assistant roles to increase GP continuity of care for people with complex co-morbidities
- Introducing a tele-monitoring service with health coaches/assistants designed to support patients to stay well – a proactive care model
- Introducing a new digital first access system incorporating web consultations, online prescribing templates, email diagnostics, telephone triage and much more.

Each project is supported by a growing innovation community for general practice including patient representatives and partners such as the Design Council, NAPC, Londonwide LMCs, the Royal College of General Practitioners, Participle, ThinkPublic, AHSCs and others.

Transforming primary care in London will continue to be delivered by NHS Engalnd through an ambitious combination of performance management, quality improvement, effective commissioning, transparency, transformation, redesign and innovation.

Integrated Care

During 2012/13, NHS London supported coalitions of health and social care leaders to develop integrated care systems serving large populations within London to provide seamless care to patients through a programme of shared learning and problem solving.

The four inner north west London boroughs of Westminster, Hammersmith and Fulham, Kensington and Chelsea, and Hounslow worked together, supported by NHS London, to deliver seamless health and social care for elderly patients and those with diabetes, through an integrated care pilot established in 2010. During 2012/13, NHS London provided funding from the Regional Innovation Fund to enable the commissioners of the future, including CCGs, local government and NHS England, to come together to review the progress of the pilot and to develop

ambitious proposals for an integrated care system that will provide integrated health and social care focussed on the 20 per cent of patients and users in the four boroughs that are at highest risk of emergency admissions and that currently require almost three quarters of the health and social care resources available. CCG leads, local government and GP providers discussed proposals to pool budgets for health and social care and to establish networks of GPs and other providers to receive budgets based on a per capita allocation that will enable them to provide all the care required for patients and users.

NHS London also supported a community of practice that brought together leaders of developing care systems across the capital. A narrative describing the potential of integrated care delivered at scale and pace resulted in recognition across London of the potential for multiple, local integrated care initiatives to be brought together to form coherent integrated care systems providing all the services a population needs in a joined up fashion. Integrated care systems in outer north west, north central, north east and south east London continue to develop, supported by the allocation of Regional Innovation Fund (RIF) monies for North Central London; Outer North East London; Waltham Forest, East London and the City and Croydon, to support the continued development of integrated care locally as well as a London-wide initiative to support integration for children and young people.

Continued engagement with NHS and social care stakeholders has led to an increased and ongoing interest in developing integrated care systems, at scale and pace across London.

NHS 111

NHS 111 is a free-to-call, 24/7 telephone service to make it easier for the public to access local health services when they urgently need medical help or advice but it's not a life threatening emergency. NHS 111 provides a single point of access for patients into NHS urgent care services so patients will be able to access the right services at the right time to meet their needs.

NHS 111 is part of a wider development of improving and integrating urgent care clinical pathways. To deliver this ambition a London 111 service specification was agreed that

- Incorporated care planning for patients at the end of life (Coordinate My Care) into the NHS 111 system.
- Built capacity in the system to support mental health patients who are in crisis.
- Electronically transmitted referral data to GP out-of-hours services; urgent care centres and community nursing services using the London Directory of Services (DoS).

- Enabled immediate booking of appointments with caller's own GP for urgent unplanned care.

NHS 111 was rolled out across London through 11 pilot sites run by four suppliers. The pilots allowed London to test different NHS 111 approaches in order to identify the most effective model to support callers seeking urgent care and for the health economy as a whole, while taking into account London's complex provider landscape and demographic challenges. This has included the transition of staff and call volumes from NHS Direct to local NHS 111 providers.

A key aspect to mobilising NHS 111 in 2012/13 has been encouraging CCGs to commission NHS 111 services that reflect local health challenges and health systems, whilst incorporating both national and London service specifications. The pilots tested different approaches to NHS 111 to identify the most effective model for potential callers, healthcare professionals and the wider health economy.

NHS London has facilitated clinical engagement through the development of a pan-London clinical governance group, which enabled a consistent approach to clinical governance by ensuring clinical representation from across London. Additionally, the London team commissioned Patient Opinion to better understand patient experience of the NHS 111 service.

NHS London worked closely with the Department of Health to assure and support each NHS 111 service launch including marketing and communications activity to ensure consistent NHS 111 messages across London.

Throughout 2011/12 the London Directory of Services was created to sit as a powerful navigation tool in the NHS 111 service to give NHS 111 advisors a way of guiding patients to the most appropriate service. Over 7,000 live services have been profiled covering service information for primary, community, acute and mental health services along with voluntary and integrated health and social care services. Each entry will be kept updated by individual providers and includes service descriptions, opening times, referral methods and the skill set of providers. This tool also provided clinicians and CCGs with opportunities to review service utilisation, service gaps and develop responsive care pathways that span urgent care across primary, community and secondary services

NHS England will continue building an evidence base to understand live site progress and impact through regular monitoring, collating system level data across the NHS 111 patient journeys and developing a NHS 111 dashboard

Londoners are most likely to die in a place they have not chosen. In 2011/12 over 60% of patients diagnosed as terminally ill died in an acute hospital bed, yet up to 74% of patients stated their preferred place of death was their home or a nursing home (DH 2003). London primary and community services for the terminally ill are too often variable and work in silos. To improve this position, London CCGs and PCT clusters agreed to align the rollout of NHS 111 services with the rollout of a single London electronic end of life register, bringing together two large-scale change

programmes: NHS 111 with Coordinate my Care (CMC) to provide an integrated approach in caring for patients at the end of their life.

NHS London commissioned the Royal Marsden Hospital to build the CMC platform and train clinicians in discussing the care plan service with patients and their families. CMC is a place where patients can outline their wishes and preferences for their place of treatment and death. Nearly 5,000 doctors and nurses from community care, primary care, NHS 111, LAS, acute hospitals, hospices and nursing homes have now been trained. CMC provides a 24/7 safety net for patients and families at time of distress and urgent health need. Patients on CMC are immediately flagged should they call 111 or 999. Awareness and training on CMC ensures that plans are honoured, even when the instinct is to elevate to an unwanted level of care.

The benefits of this integrated system have started to emerge. By ensuring all providers have access to the same source of patient information, no matter where they work, the CMC and NHS 111 teams have started to break down barriers between interconnecting services, such as those between community, acute and primary care and London Ambulance Services. CMC saw an increase in the numbers of patients achieving their wish to die in their preferred place of death with death in hospital rates in for CMC patients reduced from 61% (London average) to 19 % (Sutton &Merton) indicating the potential to reduce unnecessary interventions and admissions at the end stage, improving patient and families experience and reducing unnecessary acute costs.

Following the successful establishment of NHS 111 service across London, the NHS 111 programme will transition into NHS England where the focus will be to support London's CCGs to refine and evaluate their local NHS 111 service and plan for the procurement of a final NHS 111 service model for London.

Transforming cancer services across London

In 2009, there were 13,600 deaths from cancer in London with significant variation in the death rate across different boroughs (130 – 220 deaths/100,000). In North East London, 3,481 patients with cancer first presented via A&E between 2006 – 2008 equating to 28 per cent of all patients with cancer. The case for transforming cancer services remains compelling. During 2012/13, the London Cancer Programme established the two Integrated Cancer Systems as a platform for delivering the transformation of cancer services and laid the foundations for improvements in the consistency of care for cancer patients.

Detailed modelling has been completed to establish the current demand for cancer services, the nature of the services provided and the cost of providing these services. This indicated that by 2016, cancer services are expected to cost £2.6bn in London, with the opportunity to deliver improvements in patient outcomes and the sustainability of cancer services if the cancer model of care is implemented.

To achieve the transformation of cancer services, two Integrated Cancer Systems (ICSs) have been established covering all London cancer providers:-

- *London Cancer* represents 12 secondary care providers in North East and Central London
- *London Cancer Alliance* represents 17 secondary care providers in North West and South London

Both ICSs are supported and held to account by Joint Development Groups that bring together commissioners and providers and agree priorities for service improvement. Significant progress has been made in the following areas:

- Shared governance across all organisations
- Engagement with general practice
- Development of clinically-led pathway groups to review and implement best practice and standardised guidelines for care

Commissioning arrangements have been developed to bring together the commissioning of local cancer services by CCGs and specialised commissioning. The Cancer Commissioning Board has agreed best practice commissioning pathways for breast, lung, colorectal and brain/CNS cancer. These are being implemented from April 2013. CCGs' commissioning will be supported by two Cancer Commissioning Teams (CCTs) that work within the relevant Commissioning Support Units. The two CCTs replace the previous five Cancer Networks.

A multi-year programme to transform cancer services is underway focused on delivering the *Model of Care* for London's Cancer Services published in 2010. This transformation programme will be delivered through the Integrated Cancer Systems (ICSs) networks of provider organisations that will continue to share best practice and drive improvements in care, supported by strengthened commissioning arrangements.

Innovation

NHS London encouraged and promoted innovation, diffusion and adoption of best practice in the NHS across London and supported the development of a culture that enhances innovation.

NHS London supported the portfolio of projects funded by the Regional Innovation Fund (RIF) in order to maximise both their individual impact and the learning for the NHS in London about innovation and diffusion.

The two most successful projects from the RIF were from the Royal Brompton and Harefield NHS Trust and South London and Maudsley NHS Foundation Trust with Sidekick Studios.

The Royal Brompton and Harefield NHS Trust's "Supporting Complex Hospital Discharge" worked to reduce discharge delays along the care pathway and supported local centres to provide safe care as a transition to home. The project significantly reduced costs per patient and halved the time children on long-term

ventilation now spend in hospital. It also improved the patient and parent experience. This successful RIF project has now received national funding.

“Buddy: Recovery in Mental Health”, the South London and Maudsley NHS Foundation Trust’s project working with Sidekick Studios saw the development and roll out of a digital service for patients with long-term mental health issues. It allowed users to record and reflect on their moods and use this information to aid recovery. By the integration of Buddy into mainstream service provision, service users have been more empowered through self-management and demand has reduced. This innovative RIF project was shortlisted for an HSJ award.

In 2012/13 the RIF funded innovative projects with a focus on integrated care, detailed in the section on integrated care including further information on funding, aims and outcomes.

NHS London collaborated with the DH and London Health Programmes on a Small Business Research Initiative (SBRI) competition to support the development of powerful technologies to impact on personal behaviour change. The technological solution was to help change behaviour in order to reduce the impact of obesity and alcohol related diseases.

NHS London was awarded £2m to run the project in two phases. Phase one showed the technical feasibility of the proposed concept. The development contracts placed were for a maximum of six months and eight projects were selected with a total sum of funding available of up to £770K. Phase two contracts are intended to develop and evaluate prototypes or demonstrators from the more promising technologies in phase one, and it is anticipated that the total sum of funding will be £1.2m across three to five projects. This will take place from April 2013.

NHS London encouraged and promoted innovation, diffusion and adoption of best practice in the NHS across London and supported the development of a culture that enhances innovation. Academic Health Science Networks will be managing the delivery of SBRIs in the future.

PUBLIC HEALTH

London 2012

The London Organising Committee of the Olympic Games (LOCOG), in partnership with the Department of Health (DH) and the NHS, were responsible for delivering four health-related Olympic Games bid commitments.

- Free comprehensive healthcare to Olympic and Paralympic Games Family members throughout their stay for the Games
- Emergency treatment from the NHS for visitors to the UK to watch the Games
- Ambulance cover at sporting venues by the London Ambulance Service (LAS)
- Appropriate contingency for health resilience at Games-time in compliance with DH guidance and in agreement between DH and the Home Office Olympic Security Directorate as part of the contribution to the Olympic Security and Safety Programme.

While the Olympic Games was singled out as a major event with a high resource need, no additional changes to a tried and tested chain of command was required to coordinate the effective deployment of emergency medical services.

The NHS committed to the Games by agreeing to paid leave for as many staff as were needed to serve the Games venues. In addition, the Government promised to ensure a lasting legacy from the Games.

NHS London's 2012 Programme was accountable for the design and leadership of the NHS in London's response to the 2012 Games. This included providing assurance that the local population would continue to receive business as usual health services during the Games, supporting LOCOG medical services at sporting venues and Games Family (athletes and VIPs) and creating a lasting legacy for health services and improvement of the health of the population.

NHS London and DH assessed the supply and demand for health services across regions hosting events during the 2012 Olympics to inform NHS planning and ensure that the services could be commissioned to meet the demands.

Business planning focused on ensuring that the LAS, designated hospitals and other NHS organisations in London had the ability and capacity to deliver the bid commitments and protect business as usual services. All were expected to meet all the national performance targets and to ensure that the quality of healthcare services they provided did not deteriorate because of the additional demand or constraints associated with the 2012 Games.

Health services activity was not markedly increased and thankfully there were no major incidents or emergencies that might have affected services for patients. Coverage of the NHS by the media was largely positive.

As we worked with TfL, local authorities and the Foreign and Commonwealth Office, multi-agency relationships became stronger and there is now a better understanding across local and pan-London partnerships about what health can offer in the planning and response to major events in the capital and major incidents and emergency situations. This will be particularly valuable with the move of Directors of Public Health to local authorities as part of the NHS transition process.

One of the 2012 Programme's aims was to use the Games as a springboard to generate lasting health benefits for Londoners. While the initial focus of this 'health legacy' work was originally based around increasing physical activity levels, it became evident that much of the work undertaken to plan the NHS in London's provision for the Games would improve the NHS itself.

The NHS, as an institution, and Great Ormond Street Hospital (GOSH) in particular, was celebrated in the opening ceremony with participation from over 1,000 NHS staff.

The investment in the Olympics and Paralympics was a catalyst for transforming East London, not least the conversion of the Olympic polyclinic used during London 2012 to become the Sir Ludwig Guttmann Health Centre, serving the new residents of the Olympic Village and the existing local community.

Using the inspiration of the Games to get people active, extensive engagement with partners drove health improvement across London. This catalysed hundreds of initiatives aimed at increasing exercise and activity levels in the general population, the NHS workforce and people with chronic health conditions.

NHS London held meetings with the medical team from Rio de Janeiro, Brazil to transfer learning and support their planning as the next host city for the Olympic and Paralympic Games. It also met with counterparts from healthcare in Switzerland to support their research of the 2012 health legacy strategy, and NHS Greater Glasgow and Clyde to share learning and support them in their planning for the Commonwealth Games taking place in Glasgow between 23 July and 3 August 2014.

The 2012 programme contributed to the 2012 WHO Observer Programme for international delegates. NHS London was also asked by the International Olympic Committee to submit a case study on the origins and evolution of the Go London! strategy for the benefit of future Games host cities attempting similar strategies.

The detailed planning and preparation for the Games in London ensured the health system continued to function effectively throughout the summer.

All of the hard work has left a legacy of improvements that will last well beyond the Games: there are now productive working relationships with key organisations like TfL around access and movements; Local Authorities around event planning; better equipment and more thoroughly tested plans for responding to incidents involving dangerous chemicals and explosions; we also have more robust systems to enable business continuity and support major events in London.

In addition, there were hundreds of health initiatives across London up to and during the 2012 Games. Achievements from the health improvement legacy programme have been documented in editions of the Go London! directory. Benefits and good practice from the Go London! strategy will be mainstreamed to support the delivery of a lasting legacy while the health legacy function is formally transitioned to Public Health England.

Emergency preparedness

The emergency preparedness function at NHS London continued to support NHS London and other NHS organisations in London in handling and planning for incidents in the capital.

There was a concentrated piece of work during the winter with regards to seasonal flu and the uptake of vaccine. London saw an overall increase in vaccine uptake in both staff and the public and NHS London has looked at the learning from this to influence planning for next winter.

A large part of the work for the Emergency Preparedness Team was the preparation for, and support to, the successful 2012 Olympic Games. The Emergency Preparedness team worked closely with the 2012 team and all NHS and partner organisations across London to ensure that London's NHS preparedness and potential response was robust. NHS London underwent a concentrated series of testing and exercising and supported the games time coordination centre effectively during the games.

The annual emergency preparedness audit took place before the games and the results demonstrated a notable improvement in local planning and collaboration with other resilience partners across the Capital, embedding some excellent relationships and practises going forward.

Training continued to be a priority and NHS London commissioned a number of additional 'Strategic Leadership in a Crisis' courses for London NHS executive leads. During 2012 NHS London funded a program in conjunction with the London Ambulance Service to provide standardised training for all acute hospitals in response to a chemical biological or radioactive substance (CBRN). This will facilitate a much more robust response to any self-presenting casualties that are contaminated from an accidental or the deliberate release of a CBRN substance.

NHS London was heavily involved in the design work for the future of NHS emergency preparedness, resilience and response structures post-transition. 2012 saw a large amount of work taking place to realise the emergency preparedness, resilience and response structure for London. There have been a number of incidents during this year and these have provided NHS London and local NHS organisations with a great deal of learning which is being incorporated into planning for the coming year. Work will continue to embed the new systems across London through NHS England.

Public Health prevention

London has some of the worst health outcomes in the country with significant inequalities across the capital. The 2009 NHS London prevention strategy identified five priorities, selected on the basis that a targeted approach would achieve the greatest health impact – NHS London continued to focus on these through to the end of 2012/13.

NHS Healthcheck programme

As part of the first year of implementation to offer health checks to 20 per cent of the eligible population, London exceeded its planned target with 20.6% of the eligible population offered a check The data from quarter four 2012/13 showed that London offered health checks to 429,027 of its population and was also the highest performer among the SHAs in England.

Childhood immunisation

NHS London made significant progress in improving the coverage of childhood immunisations across London over the period 2008/09 to Q4 2012/13 and the rate of improvement was significantly higher than the England average. In 2012/13 thirteen PCTs achieved the 95 per cent uptake level for the age two five-in-one vaccination. The age five 2nd dose MMR vaccination uptake was at 80.8%, up from 80.67% in Q2 and from 55.60% in Q1 2008/09.

Smoking cessation

London made significant progress in smoking cessation and since 2008/09 the number of four-week quits has increased year on year. PCT delivery against plans improved; and the number of four-week quits across London was 3 per cent below plan compared with 4.3 per cent below plan for the same period in 2011/12.

NHS Stop Smoking services were also more successful – 49 per cent of smokers setting a quit date managed to quit successfully compared with 46 per cent in quarter two 2011/12.

Sexual Health

The under age conception rate in London has continued to fall. In September 2011 (the most up to date published data), the rate of under-18 conception was 28.6 per 1,000 girls aged 15-17 for London compared to the England rate of 29.4 per 1,000, and the rate of reduction within 2010 was greater in London at 16 per cent compared to a 13 per cent reduction in England.

NHS London was the second best performing SHA for Chlamydia screening coverage and Chlamydia diagnosis rate in 2011/12.

Breast cancer screening

The latest available data for quarter four 2011/12 showed that coverage for eligible women aged between 53-70 years increased to 69.42 per cent for London compared with 69.04 per cent for the same period in 2010/11. However, this remains just below the national minimum standard for coverage of at least 70 per cent.

LONDON'S WORKFORCE

Equipping the NHS in London with a well trained and skilled workforce was crucial to providing world class healthcare to patients and the development and support of staff across the NHS remained a key priority.

A major focus for 2012/13 was the implementation of workforce reforms as set out in *Liberating the NHS: Developing the Healthcare Workforce, From Design to Delivery (2012).* From 1 April 2013, Health Education England (HEE) is the national body responsible for putting education, training and service development at the heart of service delivery.

For London, this work will be delivered by three Local Education and Training Boards (LETBs) that take over the commissioning of healthcare education and training from 1 April 2013 for the South, North West, and North Central and East London. NHS London's work to support the establishment of the LETBs in London centred on working closely with our stakeholders to improve the quality of education and training outcomes so they meet the needs of service providers, patients and the public.

In parallel to the establishment of the new workforce system, NHS London continued to integrate medical and non-medical commissioning via a single commissioning system, contributing to world-class training programmes in London and improved quality and safety of education and training.

Alongside this we supported the development of clinical leaders across London, as well as the new landscape of effective authorised commissioners in London, working in partnership with local authorities, PCT clusters and other organisations to develop Clinical Commissioning Groups (CCGs), Commissioning Support Units and Health and Wellbeing Boards.

"This year has marked the beginning of an exciting new chapter for the development of the NHS workforce in London. Over the last 12 months we have worked hard with stakeholders and LETBs building on the solid foundations we previously laid, creating a workforce that ultimately supports the needs of patients. I am proud of the legacy we are handing over to the LETBs."

Julie Screaton, Acting Director of People and Organisational Development

Education Commissioning and Workforce Planning

The Education Commissioning System continued to focus on quality, operations and planning to deliver its goal of ensuring that London has the skilled workforce required to deliver care at the highest standards. The additional responsibility of supporting and ensuring safe transition to the new receiving organisations was a key focus for all staff.

Successful completion of the mobilisation phase of the first tender for non-medical education saw nine providers begin to deliver education to a much higher quality standard and to an enhanced set of performance indicators. This year quality and

outcome based education commissioning for the adult nursing commissions utilised nursing practice analysis, which defined ideal competencies for newly qualified nurses.

Over 1530 clinicians, service managers and representatives from Higher Education Institutions from across London were engaged with during 2012 to discuss future education planning, recruitment and education issues. This engagement supported the production of detailed education plans and commissioning recommendations for eight non-medical professions in London. Key stakeholders were also engaged in the development of a pathway-based workforce planning pilot, delivered through North Central East London LETB.

The current programme of active commissioning of post graduate medical and dental education has grown and now covers 22 secondary care specialities, Dental Foundation Year 2 and a GP pilot. From August 2012, Lead Providers (LPs) took responsibility for Stage 2 commissioned bundles. Proposals for the LP Stage 3 commissioning processes were developed with the LETBs and will cover most of the remaining specialties. At the time of writing, discussions were on-going on the nature and timing of the commissioning of the GP training posts.

The Government has made a commitment to increase numbers of Health Visitors (HVs) by an extra 4,200 (over 50%) by April 2015 to enable local teams to improve public health (PH) outcomes and provide personalised care, with HVs having the time to provide parents with critical health and development advice and connect families to the array of health and wider community resources to help them to give their children the best start in life. London has to achieve a growth of over 800 in its HV workforce to achieve a total of 1,842 HV posts by the end of March 2015, with a training commissioning target of 374 for 2012/2013 and 2013/14. This represents a significant increase over previous commissioning levels.

Although the NHS in London had been very successful in attracting sufficient numbers of high calibre HV candidates to meet the training target in 2012/13, the pace of change in developing HV services has meant that service providers have only limited capacity to support the increased number of students and NHS London did not meet its training target for 2012/13. In 2011/12 and 2012/13 NHS London developed a financial incentives scheme to support increases in the number of placements available, pay for Practice Teacher training and support more flexible use of Practice Teachers. In 2013/14 the LETBs will continue to work with providers to explore how they can grow placement capacity still further, and they are also developing plans for reducing retirement and net turnover rates, persuading bank staff to convert to contract status, reduce training course attrition and looking into recruiting trained HVs from outside the UK.

The Medical Professional Development department contributed to provide a range of educational resources and support services offering a coherent, responsive and integrated function to support providers in managing their educational and workforce challenges.

This year the General Medical Council (GMC) undertook its tri-annual audit of medical education in London, including the role of the London Deanery. Feedback

indicated that the GMC had no serious concerns and noted considerable areas of good practice.

“During a period of significant change, when it is easy for progress to slow down, the teams have managed to keep progressing their support for education and training in a more focused manner, which has engaged more people than ever before in helping to train staff to deliver care to patients.”

John Pope, Managing Director, LCMDE

Leadership Development – Leading for Health

Delivery of the leadership development programmes built on the successes of last year’s portfolio and continued to attract a wide range of participation across London, particularly newly emerging organisations and their aspiring leaders.

A central theme of the 2012/13 portfolio was a deliberate shift towards clinical leadership development on a multi-disciplinary basis. Clinical Leadership Fellowship, Clinicians in Commissioning and Barking, Havering and Redbridge University Hospitals Clinical Fellowships encapsulated the move towards inter-professional development.

The Clinical Leadership Fellowship programme was reviewed and refreshed to provide a new focus on primary and community care staff and the changes in commissioning. Two Clinical Fellowship Schemes were launched at Barking, Havering and Redbridge University Hospitals NHS Trust where a number of recently qualified consultants and midwives joined a range of clinical staff to undertake service improvement projects underpinned by a bespoke leadership development programme.

Clinicians in Commissioning were piloted for a six-month period. It was open to all non-medical clinical disciplines in primary, community, or secondary settings with the aim of developing the confidence and leadership potential of clinicians to influence the commissioning process.

Both the bespoke diversity and coaching programmes have gone from strength to strength.

In a league of strong competition, Leading for Health won the Healthcare Performance Award for best coaching and personal development strategy in the UK. The coaching register boasted 107 coaches who have provided coaching to 361 people in the NHS over the year. Central to the success of the Mentoring for Diversity programme was the introduction of a formalised mentoring relationship with a senior healthcare leader who supported the development of individuals through a series of workshops.

The Talent Management programme has been running for three years. Over this last year more than 5,500 staff in 20 trusts were engaged enabling better targeting of

development programmes and developing further insight of critical talent and succession pipelines. This was a significant increase from previous years.

At the heart of the talent process is an effective conversation between the staff member and line manager. NHS London was pleased that the training of 500 managers supported these wider career discussions to be held.

Board development was supported through a course of Action Learning Sets and topical Master Classes to executive and non-executive Board members as well as funding for bespoke development programmes for Foundation Trusts and the newly forming LETB Boards.

Development of Clinical Commissioning Groups continued in close collaboration with the Strategy and Commissioning Development team. Support took the form of a programme of mock site visits in preparation for authorisation, and governance and commissioning planning as well as delivering action learning sets and individual coaching.

Building on a strong history of leadership development delivered in the last six years, the Leading for Health partnership has been authorised as a Local Delivery Partner of the NHS Leadership Academy going forward into 2013 and is licensed to operate as an NHS Leadership Academy partner.

“I am very pleased that London will continue its history of investment in leadership development and will have a leadership development partnership that develops, commissions, implements and evaluates interventions on behalf of local partners and the NHS Leadership Academy.”

Aurea Jones, Director of Workforce Transformation

External Workforce Management

Working through Industrial Action in Partnership, NHS London worked with unions through the London NHS Partnership to provide a unique forum for employers and unions to work together to ensure that patients would not be adversely affected by periods of industrial action. Working together in this way during challenging times showed the commitment that the Partnership has enabled, and was an example that can be taken forward through the transition into the new system.

The first Partnership Conference was held in February 2011 and its success has made it a regular event. Each conference has provided a unique opportunity to bring together management and Trade Unions and promote effective partnership working.

Streamlining Staff Movements was established by NHS London to look at the experience of staff when moving from one organisation to another and more recently joined forces with Skills for Health and their UK-wide Skills Passport for Health Programme. The Programme optimised areas for improvement and increased workforce productivity, such as duplication of training and HR administration, compliance staff and patient safety. The Programme took NHS organisations on a

journey to standardise, streamline and automate activities and share best practices from across London and in some cases nationally.

LETB development

The health care reforms signalled the need to restructure workforce planning and development, and education and training to put employers and professionals in the driving seat. NHS London worked with and supported London's emerging LETBs to ensure the safe transition of education and training responsibilities to the new system landscape by April 2013. LETB core functions are to:

- Bring together all healthcare and public health employers providing NHS funded services with education providers, the professions, local government and the research sector, to develop a skills and development strategy for the local health workforce that meets employer requirements and responds to the plans of commissioners
- Consult with key stakeholders including patients and local communities to ensure the strategy is responsive to their needs
- Aggregate workforce data and plans for the local health economy to improve local workforce planning
- Account for education and training funding allocated by HEE
- Commission education and training to deliver the local strategy and national priorities set out in the Education Operating Framework
- Ensure value for money throughout commissioning and for running costs

Support for the emerging LETBs in their development throughout 2012/13 included establishing the pathfinder status of the LETBs, developing the high level operating models for each LETB, agreeing the LETB structures and interim Shared Service structure, and producing the investment plan:

- All 3 London LETBs appointed permanent Chairs and Managing Directors
- All 3 LETB Boards held their inaugural meetings
- The interim Shared Service structure was agreed and the appointment of staff undertaken
- For their authorisation, NHS London provided support to the LETBs to enable all 3 London LETBs to submit their pre-evidence and final evidence submission and manage HEE assurance visits to the three London LETBs and Shared Service in late January 2013
- Shadow governance arrangements were in operation throughout 2012/13, with LETBs engaged in the 2013/14 annual planning and commissioning round.
- By 1 April 2013 all three London LETBs successfully achieved authorisation.

TRANSITION

The system transition programme was established to deliver and support the necessary system changes in London. This included supporting the establishment of the new London arrangements as well as people transition and the handover and closure of existing organisations.

People Transition

The people transition workstream supported the migration of functions and people into the new NHS system in London, working at a national, regional and local level. NHS London worked hard to shape transition policies for the organisational changes required by April 2013 and all policies and approaches were communicated to staff via an extranet designed to keep everyone up to date. In London, the function analysis completed during last year was built upon by using it as an assurance tool to allow teams to target support to staff not originally allocated to new organisations or whose destination was unclear. NHS London worked closely with union colleagues during the process of matching staff to posts in the new organisations as time scales were short, with a focus on getting outcomes communicated to staff as soon as possible. Significant effort went into closure activities of the existing organisations, such as payroll and staff data, in a way that reduced risk to the organisations and put the receivers in the best possible position to manage the employees effectively from April 2013.

Handover & Closure

In addition to the transition of functions and people, a pan-London handover and closure programme was established across NHS London, PCTs and London's hosted bodies. The programme received assurance from the Department of Health following the Major Projects Authority (MPA) review which assessed the readiness of NHS London.

The Interim Operating Model

To ensure stability and resilience for the current system and a smooth transition to the new health system, Interim Operating Model arrangements were put in place incrementally from 1 October 2012. This enabled the new receiving organisations to take over in-year core delivery and management responsibility from NHS London and the PCT clusters, as well as planning for 2013/14. Governance arrangements were put in place to support the transition of responsibility to the new system and maintain cohesion.

PROVIDER DEVELOPMENT

Changing the provider landscape in London: Foundation Trust solutions for the remaining NHS trusts

The Government's vision is for all NHS Trusts to become Foundation Trusts by April 2014. For some Trusts, this means applying for and proceeding through the FT pipeline, achieving the standards required around quality of services, governance and finance every step of the way until gaining Monitor authorisation. For others, achieving FT status may mean joining forces with an existing Foundation Trust, either through a merger or an acquisition. Each of these routes presents its own challenges, and NHS London played an active part in helping Trusts determine which path to take and providing quality assurance through their journey.

Foundation Trust pipeline

NHS London continued to make progress against this key objective, with the Strategy, Commissioning and Provider Development team taking a leading role in supporting organisations as they went forward towards FT status.

Three organisations were presented to DH for consideration and, of those, Kingston Hospital NHS Trust gained authorisation on 1st May 2013.

Other organisations within the pipeline continued to make progress on their respective journeys, with a number of Trusts either approved to enter the FT Pipeline *(NMUH, RNOH, St George's, SWL & St George's)* or allowed to move from the FT Development phase to the FT Assurance phase of the Single Operating Model *(WLMHT, HRCH, Whittington).*

NHS London also played a key role in the further development and roll-out of the national Single Operating Model, focussing on oversight of NHS Trusts in support of the FT pipeline. NHS Trusts are required to become self-governing, autonomous organisations when they mount an FT application and they need to keep on demonstrating the robustness of their Boards once authorised. The oversight approach therefore aimed to develop Board members' skills and experience, which are rigorously tested as part of the Trust's application for FT status.

With effect from October 2012 the NHS Trust Development Authority took over direct responsibility of the FT pipeline and, through the support and transfer of key NHS London staff, continued to support aspirant London FTs during this transitional period.

Creating synergy through Trust mergers and acquisitions

Organisations that unite to provide services across wider areas can hope to release efficiencies and achieve greater sustainability. Barts Health was created on 1 April 2012 as part of the transformation programme to improve the quality of healthcare in

east London and to support the financial sustainability of health services at a time of growing financial pressure in the health economy.

The new trust brought together the three hospitals of Whipps Cross University Hospital NHS Trust in Leytonstone, Newham University Hospital NHS Trust in Plaistow and Barts and The London NHS Trust, including Barts Hospital in the City, The Royal London Hospital in Whitechapel, The London Chest Hospital in Bethnal Green and services at the Mile End Hospital. This makes it the largest trust in the country with a turnover of £1.1bn.

In the past year, NHS London provided support to Barnet and Chase Farm through developing a Strategic Outline Case with the Royal Free London NHS Foundation Trust, with a view to a potential future acquisition of Barnet and Chase Farm Hospital as a going concern by the Royal Free. The current target acquisition date is January 2014.

NHS London also provided support to North West London Hospitals and Ealing Hospital, who are pursuing a merger to address the clinical and financial sustainability challenges of both Trusts.

West Middlesex University Hospital is unable to reach FT status on its own and, on behalf of NHS London, undertook a process to identify a potential partner for merger or acquisition. A range of organisations expressed interest in partnering with the Trust and bids were subsequently received and evaluated. The Trust Board will consider the evaluation and make a recommendation to the NHS Trust Development Authority on a preferred partner.

In south west London, the demerger of Epsom and St Helier NHS Trust and the acquisition of Epsom General Hospital by neighbouring Surrey's Ashford & St Peter's NHS Foundation Trust was halted by the NHS London Board on 25 October 2012. This decision was based on a detailed analysis of the Trust's finances which estimated that Epsom General Hospital's deficit would be greater by the end of the financial year 2012/13 than originally envisaged in the Strategic Outline Case. This level of deficit was considered too great by Ashford & St Peter's, as it would have meant that a 'merged' Ashford & St Peter's/Epsom Trust would not have been able to break even within five years, as required by Monitor. Epsom General Hospital had to be brought into the Better Services, Better Value (BSBV) service change programme alongside St Helier and other acute Trusts in south west London. The public consultation launch of BSBV was therefore delayed to allow Surrey commissioners to integrate the programme fully.

Changing the provider landscape in London: Social enterprise

NHS London continued to support the remaining staff-led social enterprise pipeline under the Department of Health's Right to Request and Right to Provide policy which

seeks to empower front-line staff to run the services they deliver, with the aim of encouraging innovation and improvements in the quality of services being provided using a different model of ownership. These organisations provide a range of primary care, public health, social care, counseling and therapy services. In November 2012, Accelerate CIC, previously the wound and lymphoedema service provided by Tower Hamlets primary care trust community services, was voted the most successful at the national Social Enterprise of the Year Awards 2012.

Case-study: South London Healthcare NHS Trust – Unsustainable Provider Regime

The Secretary of State decided to enact the Regime for Unsustainable NHS Providers (UPR) for the first time at South London Healthcare NHS Trust (SLHT) with effect from 16 July 2012. The Trust Board was suspended from this date and a Trust Special Administrator (TSA) was appointed to be the accountable officer for the Trust, and to develop recommendations for the Secretary of State, ensuring that all patients have access to high-quality, sustainable services.

The challenges faced by the NHS in south east London are long-standing and there have been previous attempts by the NHS to address them, including the *Service Redesign and Sustainability Project* in 2004/05; *A Picture of Health*, which was consulted on in 2008; and the merger of three NHS Trusts to form SLHT in 2009.

Some of these attempts have been unsuccessful in the face of opposition. For example, planning for the implementation of *A Picture of Health* was halted whilst the decisions were subject to the Independent Reconfiguration Panels' review, and halted again in 2010 for review against the Government's four new tests for service reconfiguration which were later demonstrated as met. When changes have been undertaken, too often changes are undertaken at too slow a pace or done only by making compromises that have not fully eradicated the challenges and have therefore led to the need for further change.

When consulting on whether to enact the UPR at the Trust, the Secretary of State received written responses from SLHT, NHS London and the views of the Trust's main commissioners: South East London PCT cluster and Bexley, Bromley and Greenwich CCGs.

NHS London supported the enactment of the UPR at SLHT as presenting the intervention capable of resolving the Trust's fundamental problems. NHS London's view was that it would be essential that the Secretary of State's directions to the TSA would need to take a broad strategic view involving the whole of the south east London health economy and that applying the UPR – with its broad remit and the timetable the TSA would work to – would be the best opportunity to deliver the necessary changes at pace to secure access to high-quality, financially viable health services for the people of this part of London.

The TSA's draft report set out "In general the responses welcomed the proposed enactment of the UPR and all explicitly suggested that the TSA would have to look for solutions outside of the Trust, looking across the NHS in south east London. These responses were taken into consideration in the establishment of the work programme."

Subsequently, between 16 July and 29 October 2012, the TSA rapidly assessed the issues facing the organisation, engaged with a range of relevant stakeholders including staff and commissioners, and developed a draft report including recommendations for consultation.

NHS London's role did not involve quality assurance of the TSA's work as it normally would for proposals for service reconfiguration and organisational transactions. Rather, NHS London's Board met in public on 10 December 2012 to consider its response to the TSA's consultation on the draft report and recommendations, as a significant stakeholder in health and healthcare in London. The Board recognised that much of the TSA's work had built upon work already supported by NHS London, and that in engaging and harnessing the insight of clinicians and stakeholders, a compelling set of interdependent recommendations had been put forward.

In its response, NHS London supported all of the recommendations and offered additional advice and guidance which we believed would strengthen the proposals and help to ensure a safe and successful implementation of them. In doing so, NHS London recognised that these recommendations would only provide the holistic solution for the NHS in south east London if delivered in their entirety.

NHS London was also clear that any changes should enable services to meet the clinical standards and interdependencies that have been developed and agreed by clinicians through the London Quality and Safety Programme during 2011/12 and 2012/13.

COMMISSIONING DEVELOPMENT

During 2012/13 the Commissioning Development programme focused on the development and authorisation of London's emerging CCGs, the development and assurance of London's CSUs, and supporting London's Health and Wellbeing programme. A number of key successes were achieved throughout the year, with Commissioning Development supporting the safe and effective transition to the new commissioning system, and aiding the design of NHS England's London structure.

All London CCGs successfully took on 100% of delegated responsibility for 'eligible' commissioning activities, totalling approximately £10 billion. Delegation of the PCT commissioning budgets enabled the emerging CCGs to develop their skills as commissioning leaders and allowed them to build a track record as part of their submissions for authorisation. NHS London assured the process for delegation in each London PCT cluster and a 'stock take' of delegation was undertaken by NHS London with the PCT clusters to ensure that risks to operational and financial performance were being appropriately managed.

The London team of NHS England played a significant role in the formal authorisation of CCGs, including leading on the design of the national pre-assessment process, identifying domain assessors and site visit panellists, in conjunction with the national team managing the programme of authorisation within London, and reviewing further authorisation evidence submitted by CCGs after their site visits. All CCG authorisation applications were submitted with accompanying SHA context statements. Working closely with the People and Organisational Development directorate, continued development support was delivered to help London CCGs prepare pre- and post-authorisation. The focus of Phase 1 of the development programme was on core leadership and organisational development, with Phase 2 involving mock site visits to give CCGs practical support in preparation for their formal authorisation site visits by NHS England. Dame Ruth Carnall, Chief Executive of NHS London, chaired a majority of mock site visits and offered one to one coaching for CCG chairs on their presentations, which was well taken up. Themes of draft 'red button' criteria and development needs identified during the authorisation visits were systematically captured and analysed and fed into the specification for Phase 3 of CCG Development Support (delivered between December 2012 and March 2013), to ensure a coordinated approach to commissioning development across London. This 'post-authorisation' support phase delivered:

- bespoke governing body development for each CCG
- real time support with planning and contracting to support the planning and contracting round
- coaching sessions for CCG Chairs, Chief Officers and Chief Finance Officers and
- action learning sets for these groups, plus nurses, secondary care doctors and lay members.

A CCG Reference Group with representation from CCG Chairs, Chief Officers and Chief Financial Officers from across London was put in place. Part of their role as representatives of London's CCGs is to assist in the design of the support programme. The group will help to identify common development needs and facilitate the sharing of best practice. The Reference Group will also develop proposals for Phase 4 of the Development Support programme for 2013/14.

NHS London worked with the CCGs and the three Commissioning /support Units (CSUs) to ensure that the new organisations not only have support from their CCG customers but that they are set up effectively. In the latter six months of the year, this was led by the Business Development Unit of the Department of Health. London's three CSUs have all been rated in the lower risk group nationally following an assessment of full business plans of all 23 CSUs in August 2012. The new organisations recruited their staff and are operational, and had an active role in supporting CCGs in delivering the contracting round for 2013/14.

The commissioning development team have been active in supporting the NHS England London team and other organisations to create system architecture in London that enables and supports the ongoing development of the future commissioning system. This has included supporting the development of the new London Health Board working with partners such as the GLA, London Councils and the Mayor's office.

NHS London invested further resources in 2012/13 in the development of Health and Wellbeing Boards (HWBs) which resulted in significant progress in these areas, with good working between CCGs and HWBs and a number of collaborative commissioning initiatives.

NHS London also invested £50k towards the establishment and running of the London Clinical Commissioning Council which is a member organisation for CCGs. This proved to be instrumental in engaging with issues which are larger than local or are pan London.

Case Study: Development Support Programme –– Mock Site Visits

In 2010, NHS London committed to support pathfinders, now Clinical Commissioning Groups (CCGs), in their journey towards achieving authorisation as statutory organisations. The support was very well received by CCGs, particularly in developing wider understanding of their new responsibilities, writing their constitutions and implementing new ways of working with their stakeholders to face the challenges that lie ahead.

Practical support was delivered to help CCGs across London to prepare for the authorisation process. Dame Ruth chaired 20 of the 31 mock site visits, which were designed to prepare CCGs for NHS England's authorisation site visits. Briefing reports and key lines of enquiry (KLOEs) were developed, which informed the mock site visit panels of each CCG's background and unique challenges.

Designed to be developmental, the panels provided a constructive level of challenge to the CCG governing bodies, based on their existing evidence for authorisation. Each CCG received written feedback and a bespoke development plan, including actions to prepare them for their actual site visit.

Following the mock site visits, CCG chairs were given the opportunity to receive additional support from Dame Ruth in advance of their formal authorisation site visit. Positive feedback was received from the CCGs, many of whom regarded the mock site visits as an authentic and valuable way of preparing for the authorisation process.

The programme delivered the following 'post-authorisation' support:

- bespoke governing body development for each CCG
- support with planning and contracting
- coaching sessions for CCG Chairs, Chief Officers and Chief Finance Officers
- action learning sets for executives as well as nurses, secondary care doctors and lay members.

A pan-London CCG Reference Group, comprising representation from CCG Chairs, Chief Officers and Chief Financial Officers has been established. Part of their role as representatives of London's CCGs will be to assist in the future design of the support programme, help to identify common development needs and facilitate the sharing of best practice.

The CCG Reference Group will also develop proposals for the Development Support programme for 2013/14, which will be implemented by NHS England.

FINANCE

Maintaining financial grip through transition to ensure a strong financial legacy

It was important for the transition into the new system that NHS London maintained close control of the financial picture across London to ensure the best possible start for the new system. The Finance & Investment directorate continued to develop monitoring and performance management mechanisms in line with the requirement to maintain financial control and delivery across the patch during the transition to the new system.

London NHS organisations ended 2012/13 with a financial pan-London surplus of £259.2 million, which represented 1.6 % of London's total resource allocation. The majority of NHS trusts had stable financial positions, although there were still some organisations with deeply entrenched financial issues. NHS trusts' delivery of Cost Improvement Plans (CIPs) remained broadly similar to 2011/12 with savings performance being an average of 4.5 %. During 2012/13 financial support and analysis of the 5 year financial plans continued with organisations that moved further along the FT pipeline in London. Working with our colleagues in the Provider Development team, a number of NHS Trusts made significant progress on their journey to FT status and start 2013/14 in the latter stages of the FT pipeline. Going forward, the NHS Trust Development Agency (TDA) is responsible for the oversight, support and performance management of these trusts.

The underlying PCT financial positions improved significantly in 2012/13. PCT savings performance under the QIPP programme remained broadly similar to 2011/12 at an average of 3% of revenue resource limit. A small number of PCTs continued to face significant financial challenges and these challenges will be inherited by the associated Clinical Commissioning Groups (CCGs). The Finance and Investment team worked to assure that CCGs are financially viable, have the capability and capacity to manage commissioning budgets and can maintain adequate financial control in 2013/14 and beyond. This involved a delegation assurance process and a full authorisation process. To be fully authorised CCGs needed to have a clear and credible finance plan. The team worked with CCGs to assure financial plans, particularly looking at the robustness of the QIPP plans that had been developed. This work was developed further in operational plans for 2013/14 which had been the primary focus of the Finance and Investment team in the latter part of financial year. The directorate also supported work on the three London Commissioning Support Unit (CSU) business cases. NHS England is now responsible for the oversight, support and performance management of CCGs.

During 2012/13 NHS London published the findings of the NHS Croydon report into the historic financial issues of that organisation up to 2010/11. The findings of the report were accepted by the successor South West London cluster of PCTs (SWL PCT cluster) and an action plan putting forward to address the recommendations of the report was accepted by NHS London and implemented by SWL PCT cluster. Thereafter NHS London created a checklist covering controls on governance and finance which were completed and implemented by all London PCT clusters and

NHS London to reduce the risk of a repeat of the issues which arose in NHS Croydon. The completed checklists and actions plans were assured by NHS London.

The London trust productivity support programme launched by NHS London in 2012/13 was a series of initiatives to support London's providers, with a particular focus on the £1.2bn opportunity for the acute trusts that are yet to achieve FT status. The programme focused on the development of internal capabilities and structured support for teams to deliver productivity improvements across their organisations. The initial programmes to identify opportunities and share best practice to facilitate local initiatives delivered potential opportunities for trusts in pathology, medicines use and back office support. Diagnostic imaging and nursing studies are currently helping trusts identify specific opportunities for efficiency improvements in those areas. The broader programme to support value improvement projects in the trusts is based on the three principles of more efficient and effective organisations:

- alignment of culture and values;
- robust process improvement methodology, such as Lean, and;
- systematic and evidence based management, such as service line management and patient level costing.

This programme supported over 60 value improvement projects in participating trusts across London, which should both deliver value improvements to support short term business plans and also improve capabilities for longer term operational efficiency, effectiveness and economy. The programme has been transferred to the NHS Trust Development Authority so that this work can be continued.

The implementation of the Health and Social Care Act 2012 also required the transfer of contracts safely and effectively to the new contracting authorities by April 2013. The Finance & Investment directorate assured three phases of work to assure a smooth transfer of healthcare service contracts:

- Stocktake of existing agreements held by commissioners and risk assessment of each one
- Stabilisation by addressing identified risks with actions to safeguard transition
- Formal transfer of contracts and contracting responsibilities to the new commissioning bodies.

Furthermore, all non-clinical contracts across the PCT clusters and NHS London were also renegotiated, transferred to the appropriate successor bodies or terminated. NHS London assured these processes for PCT clusters whilst completing the transfer of its own contracts and financial obligations.

Lastly, in order to ensure the safe and effective close down and transfer of balances of PCT clusters and NHS London, the directorate led on a programme of pan London assurance working closely with the Department of Health. This work included cleansing of Balance Sheets to minimise receivables and payables at transfer.

NHS London financial performance

As one of ten SHAs in the country, NHS London had the following statutory financial duties for our own financial performance to:

- Contain expenditure within the approved revenue resource limit;
- Contain expenditure within the approved capital resource limit;
- Remain within our cash limit.

NHS London met all of these financial duties in 2012/13, and these are explained in more detail below. The full financial accounts for NHS London and the annual governance is published in the Annual Report & Accounts in June 2013.

Revenue resource limit

This is the allocation of money given to NHS London to operate in a particular year. NHS London had a final revenue resource limit of £1,875.1 million for the year ended 31 March 2013. This revenue resource limit included all hosted organisations. NHS London recorded a small deficit on core SHA activities (including the London Programme for IT) of £0.2 m. The Medium Term Financial Strategy and NHS London Reserves were £87.3 million. Further additional surpluses of 10.0 million on Multi Professional Education & Training (MPET), and £0.4 million on other hosted organisations (being the Cancer Action Team, the National Specialised Commissioning Team and the National Ambulance Radio Programme) resulted in a total surplus of £97.4 million against the final resource limit of £1875.1 million.

Capital resource limit (CRL)

The CRL for NHS London was £460k against which NHS London spent £458k during 2012/13.

Cash limit

The final cash limit on expenditure was £11,990.4million, of which NHS London used £1,781.9million. NHS London ended the year with £ 45k in its bank accounts. The cash limit above is different from the resource limit due to a number of resource only and cash only allocations.

Off-Payroll Engagements

NHS London was asked by Her Majesty's Revenue & Customs (HMRC) to conduct an exercise to consider the historic and current use of consultants from 1 April 2010 to determine whether any of the consultants should be treated as employees as

determined by HMRC guidelines. A full exercise was undertaken and duly reported to HMRC. Following the review by HMRC of the data submitted, HMRC advised NHS London that no further action would be taken with regard to the consultants concerned.

The Department of Health (DH) contacted all NHS organisations in August 2012 to advise new requirements in respect of off-payroll engagements, in particular engagements of more than six months and at a daily rate of more than £220 where there was a need to include contractual provisions which allowed the NHS organisation to seek assurance on income tax and national insurance payments. The majority of such engagements in NHS London were through recruitment agencies where the contract was between the agency and the consultant. A number of agencies were contacted to discuss the new DH requirements. The general response was that all contracts between the agency and the consultant were drafted to take account of HMRC's IR35 requirements and that the high numbers of consultants engaged in the NHS and local authorities made it impractical to amend existing contracts. However, it was noted that consideration would be given to including a tax assurance clause when drafting future contracts.

Directors' Remuneration

NHS London is required to disclose, as part of Greenbury regulations, the remuneration of its directors. This disclosure forms part of the annual report as opposed to the annual accounts. It should be noted that the remuneration only relates to the period when these individuals were employed as directors. As such, care needs to be taken when comparing year-on-year remuneration to ensure that the periods of employment are the same.

Pension scheme

Directors' pension costs are detailed in the Remuneration Report in annex 2, pages 73-76. Note 7.5 to the Annual Accounts provides information on pension costs, actuarial/accounting valuation and scheme provisions.

International financial reporting standards (IFRS)

The accounts were prepared adopting IFRS standards to the extent that they are meaningful and appropriate to the NHS.

CORPORATE RESPONSIBILITY

Equality and Diversity

As a public body, NHS London had a duty under the Equality Act 2010 to demonstrate compliance with the principles of the Act and acknowledge the following responsibilities in discharging its equality duties:

- Providing leadership for NHS organisations in London to support the local implementation of national policy and programmes, ensuring equality and diversity issues are given appropriate consideration;
- Developing and implementing robust assurance processes to enable NHS London to support and monitor the compliance with the equality duty of NHS organisations;
- Ensuring NHS London itself achieves and maintains compliance in discharging its functions as a public body and in its role as an employer.

The population and demographic makeup of London results in a richness of cultures but brings with it a number of challenges. London has the most diverse population in Europe with 33% of the population recorded as being from a Black or Minority Ethnic (BME) background. There are a number of localities and wards in London that are ranked amongst the most deprived in the country.

Within this context, NHS London delivered and published its equality objectives in 2012. Across London 95% of NHS organisations signed up to implement the Equality Delivery System (EDS) by the end of March 2013. Progress was made with all NHS organisations making improvements against the EDS outcomes and work will continue in all of the new organisations on implementing the EDS.

Managing our Estate

A significant part of the year was devoted to ensuring that the NHS in London was fully prepared for the transition into the new health system from 1st April 2013, that timely decisions relating to the destination of the primary and community care property were informed by robust and consistent data collection and analysis across London and that associated staff and equipment associated with the change had new homes to go to.

NHS London and the 31 PCTs in London closed on 31st March 2013 to make way for the new health system. These organisations owned the property they needed to deliver their functions either as freeholds or under a lease, licence or some other property agreement, equating to approximately 650 clinical and administrative properties across London that have now been transferred to either qualifying providers of clinical services that wanted the properties and met other transfer criteria or to NHS Property Services Ltd, a new property company wholly owned by the Secretary of State for Health and set up at the beginning of 2012.

NHS London oversaw this process and colleagues in both commissioning and provider organisations determined which property should transfer to where, based on the Department of Health guidance that was issued last year.

Collection, validation and presentation of detailed property data, carrying out property enquiries and uploading the information for the DH to process nationally required very significant dedicated resource consistently throughout 2012/13.

A subset of this transition-related work was to identify the current and future requirements for the NHS London and PCT administrative estate in order to ensure that we passed over sufficient estate to allow the new organisations to perform their administrative duties whilst minimising the cost to the system caused by carrying void space in buildings. This was achieved by developing a London wide administrative estate strategy based on a small number of core guiding principles set out in the DH guidance, such as not renewing leases that came to the end of their term, actioning any break clauses on leased buildings and making best economic use of administrative space.

Whilst this was going on, NHS London continued to process through to approval high volumes of capital investment business cases with major decisions for approval of schemes at North Middlesex Hospital, Barnet and Chase Farm Hospitals, St Bernard's and the Royal National Orthopaedic Hospital as well as supporting the Trust Special Administrator in South East London and major service reconfiguration processes in North West and South West London.

The NHS estate remains a key ingredient for the delivery of new service strategies and whatever the structure and whoever the owner of the estate is, there will be an ongoing requirement to ensure that the estate delivers environments for patients that are of a high quality, safe and fit for the delivery of 21st century healthcare. The newly configured system will continue to play an important part in supporting the NHS in London to manage and meet these expectations.

"We have come to the end of a very busy year for the Capital and Estates team with little let up in the high volume of investment business cases submitted for approval and a very challenging transition agenda to lead, resource, guide and support across London. With a tidy legacy delivered at closure the team is looking forward to providing continuing leadership and support within the reformed NHS. "

Peter Brazel, Head of Strategic Investment, NHS London

Supporting a sustainable NHS in London and preparing for climate change

The drive to deliver a sustainable healthcare system supported by an equally sustainable infrastructure is underpinned by the carbon reduction strategy of the NHS Sustainable Development Unit's (SDU), NHS England: 'Saving Carbon, Improving Health' and Route Map for Sustainable Health. The SDU have set a carbon reduction target of 10% for the NHS over the period 2007 to 2015 and the NHS in London has already achieved a 12.1% reduction in their carbon footprint for building related emissions. This compares with an overall reduction of 1.9% across the NHS nationally over the same period. (Source: NHS Sustainable Development Unit)

A sustainable healthcare system is essential to allow the NHS to continue to provide effective and quality services for our local populations whilst not compromising the future provision of those services. It contributes to the overall health of the population when combined with, for example, healthy lifestyles, reduction of pollution and mitigating the effect of climate change amongst a host of other things.

NHS London worked closely with both the NHS Sustainable Development Unit and all the NHS organisations within the London region whilst facilitating networking groups and producing and disseminating information to the NHS via the Carbon Reduction Steering Group, the Carbon Reduction Leads Network and the London Environmental Network. Strong support from the NHS in London means that these groups have continued to flourish and provided an opportunity for networking with like minded people to ensure we continue to progress in this area. Joint working with the Local Authority's London Environmental Coordinators' Forum has provided the opportunities for partnership working with other public sector bodies.

We continued to encourage the NHS in London to produce and operate board approved Sustainable Development Management Plans (SDMP) and associated action plans that addressed all aspects of sustainable development within their organisations. In May 2012, 82% of NHS organisations in London had board approved SDMPs. The requirement for SDMPs will transfer to the new system and so all new organisations will be working to produce these with encouragement and guidance from the NHS Sustainable Development Unit.

A key part of any organisation's SDMP should address the risks around the impact of climate change and include a plan to mitigate those risks. NHS London helped the NHS in London to understand the potential impacts of increased winter rainfall and hotter dryer summers on the delivery of services. We facilitated joint working in this subject area with the Greater London Authority (GLA). NHS London has also been investigating the impact of surface water flooding on key sites within London in conjunction with the GLA and the outcomes will be reported back through the networks in the near future.

London continued to lead the way nationally in reducing carbon emissions from NHS buildings through excellent management and strategic investment. As the NHS moved through significant change, NHS London ensured that the key elements were in place to provide a route forward to a sustainable future and made available to the new NHS landscape.

"Once again the NHS in London has performed magnificently in continuing to reduce our carbon footprint and raise the profile of the sustainability agenda. This effort has helped take forward both the climate change mitigation and adaptation agendas to a point that we can hand over significant progress to the new NHS system in 2013. I am grateful for the continued hard work of colleagues in Foundation Trusts, NHS Trusts and Primary Care Trusts in this area and I am confident this good work will continue into the coming years."

Simon Greenfield, Strategic Estates Advisor and Carbon Reduction Lead

Patient engagement

NHS London continued to work to actively engage with patients in all areas of the organisation and to promote wider patient and public engagement with the NHS in London. Patient engagement (sometimes referred to as patient involvement) is crucial to ensure that patients' opinions are listened to and included in the strategic decisions we make to delivering healthcare in London.

During 2012/13 NHS London supported the wider development of patient engagement in setting up the new NHS system. This included supporting the development of London's local emerging Healthwatch by funding the Healthwatch Development Programme. In addition, during 2012 NHS London ran a series of Patient and Public Engagement masterclasses for London's emerging Clinical Commissioning Groups to support their authorisation.

One of NHS London's main roles was to support PCT clusters and providers with expert advice and guidance on patient engagement. We did this by sharing best practice engagement tools to ensure consistency and monitor compliance with the statutory guidance. NHS London worked with providers of acute NHS funded care to ensure that the Friends and Family test was implemented in A&E and Inpatient wards by April 2013. To this end, in partnership with the Department of Health, we developed publicity materials for use by local organisations and provided operational advice and support to those at the front line. Representatives from NHS London also attended the SHA patient and public engagement (PPE) leads meetings held at the DH on a bi-monthly basis. We shared the information from these meetings with our PPE and communication colleagues around London.

The public and patient advisory group

One way we engaged with, and involved, patients at NHS London was through the Patient and Public Advisory Group (PPAG). The group consisted of twenty-one LINks (Local Involvement Networks) members of the public who were originally recruited for the *Healthcare for London* programme in 2008. The group transferred from Commissioning Support for London (CSL) to NHS London in January 2011 and the last meeting of the NHS London PPAG was held in November 2012.

During 2012 NHS London engaged with our PPAG through a regular newsletter, keeping them informed and updated on the progress of the NHS transition as well as national developments in patient and public engagement in healthcare. A few of the topics that PPAG have been engaged with in the past year were: CCG development, London's Public Health transition; London Health Programme's work on the paediatric emergency services project and the Quality and Safety Programme.

There were also a number of individual members of the group who remained as patient representatives on NHS London programme advisory boards and other pan London health forums. NHS London would like to take the opportunity in this final

annual report to thank all the members of the PPAG for their work and dedication over the past four years.

Freedom of information

NHS London received 319 Freedom of Information requests this year, a decrease compared to the very high numbers received in the previous year. These requests were primarily made by members of the public but also included private businesses, educational intuitions, the press and MPs.

Complaints

The NHS London Complaints Policy was applicable to the handling of any enquiry or complaint about the attitude or actions of staff within NHS London, which may also have included decisions made by NHS London staff during the course of their work.

NHS London was committed to dealing with complaints fairly and impartially, aiming to resolve these quickly whilst allowing for thorough investigation. Our target was to send a letter of acknowledgement within 2 working days and provide a full written response to all complaints within 20 working days.

Under the current NHS Complaints Regulations, NHS London did not have any remit to deal with complaints about the care and treatment provided by NHS Trusts, Primary Care Trusts or any other provider of NHS services. In such cases, complainants were encouraged to directly contact the NHS body concerned.

Any complaint about NHS London was investigated in line with the requirement of the NHS Complaints Regulations. In 2012/13 NHS London received 28 complaints about NHS London. A brief summary of these complaints is detailed below:

> Three complaints related to proposals to reconfigure services in South East and North West London. Responses were sent, within the target time, reassuring complainants as to the objectives of service transformation.
>
> One complaint was regarding NHS London's decision to commission an independent investigation into the death of a patient, and the SHA's management of the incident.
>
> 15 complaints were received via the Parliamentary & Health Service Ombudsman against NHS London, regarding outcomes of continuing care funding applications and eligibility for NHS Continuing Healthcare Funding. NHS London provided all relevant documentation to investigators where requested, and within the specified deadlines.
>
> Two complaints were regarding eligibility for NHS Continuing Healthcare Funding. NHS London responded within the target time.

There was also correspondence with an individual regarding a complaint about disability discrimination and access to healthcare provision. NHS London responded within the target time.

NHS London continued to respond to complaints up until the 28th March and directed complainants to the new receiving organisations and their complaints processes.

INFORMATION MANAGEMENT AND TECHNOLOGY

London Programme for IT: Delivering RIO

RiO is networked software for mental health and community services organisations being implemented within the NHS National Programme in England. Programme delivery has continued successfully throughout 2012. Deployments of RiO Release 1 have progressed throughout the year with 7 mental health organisations and 24 community health organisations having deployed the product in London. Six deployments were scheduled in 2013.

In March 2012 RiO Release 1.1 was implemented which introduced new innovative functionality including RiO2RiO which allows the sharing of information between RiO organisations within the same care setting. In addition to this, three configuration releases a year continued to be implemented which introduced changes to RiO to help keep the product aligned to organisations needs.

The next software release, RiO Release 2 completed its first stage of module testing and was in system and integration testing at the time of writing. The release is planned for deployment to the First of Type organisations for each care setting before full roll out commences. The London Programme for IT (LPfIT) continued to support community and mental health organisations in London throughout their deployments and in live service.

London Programme for IT: Delivering Cerner

Programme delivery of Cerner software continued throughout 2012. The Royal Free London completed a configuration upgrade, St Georges completed an orders communications deployment, South London QMS and Barts Health upgraded their systems and are now also spine enabled. These deployments have enabled significant benefits to each trust. NHS London continued to support Croydon, Imperial and Kingston for go-lives in 2013/14. Work started to look at options for exit and transition in line with the contract expiry in October 2015 and the procurement of replacement systems progressed well.

London Health and Social Care Information Sharing Programme

The secure email project worked with over 50 organisations across London to help replace the fax with secure email to enable secure transfer of documents. This

project was ‘Highly Commended’ at the Heath Service Journal (HSJ) Efficiency Awards in September 2012. The Adapter Project built on this work by enabling key social care suppliers to be compliant with national messaging standards. The main workflows addressed were admission and discharge notifications, referrals, integrated care and support plans and continuing care. The admission and discharge work is likely to provide the basis for the national standard in that area in 2013. This programme continued to support other external projects including summary care record, offender health, end of life, the Child Protection Information System, MASH (Multi Agency Safeguarding Hub) and the development of NHSmail2.

Electronic Prescription Service

NHS London supported the roll out of the Electronic Prescription Service (EPS), Release 1 delivery is now complete and Release 2 is underway. EPS will enable prescribers, such as GPs and practice nurses, to send prescriptions electronically to a dispenser of the patient’s choice. This is making the prescribing and dispensing process safer and more convenient for patients and NHS staff.

LPfIT staff transferred to the new Health and Social Care Information Centre following the closure of NHS London ensuring the ongoing delivery of the portfolio of projects including RiO, Cerner and information sharing projects. The programme will continue to focus on the ongoing delivery of systems to trusts in London as well as supporting the safe transition and exit from the LSP contract in 2015.

ANNEX 1: NHS LONDON BOARD

Non - executive directors

Professor Mike Spyer - Chair for NHS London

Professor Mike Spyer has retired from his post as vice-provost (Enterprise) at UCL. He was previously vice-provost (Biomedical) and dean of UCL's Medical School. He is a neuroscientist with extensive research accomplishments in the field of the central nervous control of the heart, circulation and ventilation.

His research has been supported by the Wellcome Trust, the British Heart Foundation and the Biotechnology and Biological Sciences Research Council (BBSRC). Professor Spyer has sat on numerous national and international scientific grant committees and was awarded an Honorary Doctorate of Medicine by the University of Lisbon in 1991. He was made a founder fellow of the Academy of Medical Sciences in 1998 and an honorary fellow of the Royal College of Physicians in 2002. He is on the board of the Anthony Nolan Trust.

Mike was a member of the NHS London Remuneration Committee.

Mike Bell

Mike Bell is the director of a research and consultancy company, MBARC Ltd, which works with central and local government on issues relating to social and financial exclusion and specialises in working with marginalised communities.

Prior to establishing his company he was the chief executive of a national charity supporting community-based advice and legal services across the UK. He has also previously worked with the NHS in a number of roles. Mike has been the chair of the London Mental Health & Employment Partnership, on the board of the London Mental Health Programme and vice-chair of the London Health Observatory.

In January 2013, Mike resigned as Vice-Chair of NHS London to become the Interim Chair of Croydon Health Services NHS Trust. Mike was then appointed as Associate Director at NHS London to continue to assist with the hand over and closure of the NHS London. Mike is now the substantive Chair of Croydon Health Services NHS Trust.

Mike was a member of the NHS London Remuneration Committee.

Rachel English

Rachel is an economist and chartered accountant. She is the founder of Helios Social Enterprise, and a non-executive director of Kuwait Energy plc, Petropavlovsk plc, the Global Carbon and Capture Institute (GCCSI) and a member of the audit committee at the Department of International Development (DFID).

Previously, Rachel held senior positions in leading energy companies, including BG Group and Shell, with responsibilities spanning corporate strategy, mergers and acquisitions, business planning, project finance and business development, and was the chief financial officer of a UK-listed company. She began her career at Coopers & Lybrand (PwC).

Rachel is a graduate of Oxford University and a fellow of the Institute of Chartered Accountants in England and Wales.

Rachel was the Chair of the NHS London Remuneration Committee and a member of the NHS London Audit Committee.

Rima Makarem

Rima Makarem was a non-executive director and chair of audit and governance for NHS Haringey from 2007 before being appointed to a similar role at NHS London in 2010. She previously worked for GlaxoSmithKline, where she was latterly director of competitive excellence, managing special corporate projects for the chief executive officer and operating board. Prior to this, she was a management consultant, advising FTSE 100 companies on financial, strategic and operational issues.

Rima is also a director on the board of the Anchor Trust and a member of the Medical Research Council audit and finance committee. She runs her own business conducting interim management and consultancy in the pharmaceutical and healthcare industries.

Rima holds a PhD in Biochemistry and an MBA from INSEAD.

Rima was the chair of the NHS London Audit Committee.

Ian Harrison

Ian Harrison was a non-executive director of Barts and the London NHS Trust, where he also chaired the audit committee, from April 2008 until November 2010, when he was seconded to NHS London.

He retired on 31st March 2013 from his position as managing director of the Association for Financial Markets in Europe, having joined in 1999 from Courtaulds, the international chemicals group, where he was group financial controller and company secretary. In his earlier career he worked as a management consultant, a lecturer at a leading US business school, a corporate planner, chief executive of a transport company, and in a range of senior financial positions with Unilever.

Ian was educated at St Paul's School, Heidelberg University and Balliol College, Oxford where he read mathematics. Amongst his other activities, he is vice-chairman of the Hampstead, Wells & Campden Trust, a trustee of the Scoliosis Association UK (SAUK), and a governor of Westminster School.

Ian was a member of the NHS London Audit and Remuneration Committees.

Michael Parker

Michael Parker was the UK representative of the International Assembly of the Association of Chartered Certified Accountants (ACCA). He served as a non-executive director and vice chair of Guy's and St. Thomas's NHS Trust before being appointed as chair of King's College Hospital NHS Foundation Trust in 2002 and served as a director of its subsidiary companies until November 2011.

He is the president of the Sickle Cell Society and patron of the Big Issue, Malawi. Michael is also a member of the health panel and chairman of the corporate governance and risk management committee for the Association of Chartered Certified Accountants. Michael is an external advisor to the Royal College of Nursing audit committees as well as a non-executive director of the Food Standards Agency.

Michael was a member of NHS London's Remuneration Committee until he resigned in April 2012 as a Non Executive Director of NHS London when he became Chairman of Croydon Health Services NHS Trust.

George Wood

George Wood retired from the Financial Services Division of the Ford Motor Company after 33 years, where he held various senior positions with the organisation, including: Director of Marketing and Credit policy; Managing Director of Ford Credit Brazil; and later, Vice President of the South America region.

More recently he was Director of the UK Customer Service Centre. George joined Barking, Havering and Redbridge University NHS Trust as a Non-Executive Director in August 2010 and was asked to become Interim Chairman in November 2011 until October 2012, when he joined NHS London as a Non-Executive Director

George was a member of the NHS London Audit and Remuneration committees.

Associate member

Jane Ramsey

Jane Ramsey was a member of the board of UCLH from December 2006 and was chair of Lambeth PCT for five years prior to joining that.

She has undertaken a range of non-executive roles including as a lay member of the Royal Pharmaceutical Society of Great Britain and chair of a local housing association. Before that she was vice-chair of Lambeth, Southwark & Lewisham Health Authority and a senior lawyer in local government in London, latterly as director of law and public services at Islington Council.

Jane was an Associate member of NHS London until she left in August 2012 when she became chair of Cambridge Hospitals Foundation Trust.

Executive directors

Dame Ruth Carnall DBE - Chief Executive

Ruth Carnall was appointed chief executive of NHS London in March 2007. From September 2006 she worked as NHS London's interim chief executive.

Between 2004 and 2006 she was a freelance consultant working for government departments including the Prime Minister's Delivery Unit and the Home Office as well as for the health service. Prior to 2004, Ruth worked in the NHS for over 25 years. During this time, she undertook senior leadership positions at local, regional and national levels. In 1992 Ruth became chief executive at Hastings and Rother NHS Trust.

She was chief executive of the West Kent Health Authority for six years before taking the position of regional director, South East and then director of Health and Social Care for the South. From April 2003 to September 2004 Ruth served as director of the Departmental Change Programme at the Department of Health.

She was awarded the CBE in 2004 and appointed a Dame Commander of the British Empire in 2011 for services to the NHS.

Paul Baumann - Director of Finance and Investment

Paul Baumann is a fellow of the Chartered Institute of Management Accountants and joined NHS London in May 2007 following 22 years of experience of international financial management and strategic leadership at Unilever.

He was NHS London’s first director of Finance and Performance and more recently held the post of director of Finance and Investment. In this role he has overseen a significant financial recovery programme for London’s PCTs and trusts and has focused on the development of strategies to deliver long term viability and sustainability across the London health economy.

Paul was appointed to NHS England as its first national Director of Finance.

David Slegg – Director of Finance and Investment

David was appointed Director of Finance and Investment for NHS London in October 2012. David has been a Director of Finance for over 20 years and brings Board experience at both provider and commissioner levels.

He was Director of Finance in Ashford and St Peters Trust for 10 years and subsequently joined NHS Ealing as Director of Finance in 2002 until his appointment as Director of Finance for NHS North West London PCT cluster in 2010.

In April 2013, David joined NHS England London Regional Office as Director of Finance.

Trish Morris Thompson - Chief Nurse

Trish Morris-Thompson trained at Whipps Cross Hospital in east London, and qualified as a registered general nurse in 1982, then as a registered midwife in 1986.

Trish has a BA (Hons) in Health Studies and Applied Social Sciences (1991), an MBA from Hull University (1993) and in 2007 was awarded a visiting professorship by the Faculty of Health and Social Care at London South Bank University. Trish has extensive experience in healthcare gained through her work in London, the East and West Midlands, and South Australia. Prior to taking up her role at NHS London, Trish was Executive Director of Nursing for the former North East London Strategic Health Authority.

Trish was awarded the Florence Nightingale Burdette Scholarship in 2011/12 and a RCN Clinical Fellowship in 2012. She is board director for Women of the Year, trustee on Florence Nightingale Foundation and founder patron of Britain's Nurses.

Caroline Alexander, Chief Nurse, London Region NHS England

Caroline graduated as a nurse in 1987 from Edinburgh University (BSc/RGN) and has an MSc in Nursing Studies from Southbank University (2001). From 1987 to 1993 she specialised in nursing older people in Edinburgh and then London at Guy's Hospital. She then worked for the Foundation of Nursing Studies for three years supporting nurses to use research in practice.

In 1998 Caroline returned to the NHS and worked in Tower Hamlets until February 2011 in a range of roles – from nurse adviser for older people, head of services for older people to the role of Director of Quality Development for NHS Tower Hamlets. In February 2011 when the PCTs formed into PCT clusters, Caroline took on the role of Director of Quality and Clinical Governance of the newly formed NHS East London and City PCT cluster. The role was extended to outer North East London in February 2012. In October 2012 Caroline took on the role of Chief Nurse, NHS London and Chief Nurse (designate) of the NHS England London Region.

Caroline was a 2008 Florence Nightingale Leadership Scholar and is a visiting professor at Bucks New University.

Dr Simon Tanner – Regional Director of Public Health

Dr Simon Tanner was appointed by the chief medical officer to the post of Regional Director of Public Health London and health adviser to the GLA in June 2007.

Previously he was Regional Director of Public Health, South Central from July 2006. Prior to that Simon was the Director of Public Health and Medical Director at the former Hampshire and Isle of Wight SHA and before that, director of Public Health with the North and Mid Hampshire Health Authority until it was dissolved in March 2002.

Simon qualified as a doctor in 1981 and spent eight years as a principal in general practice before training in public health medicine. During his time as Regional Director of Public Health in London he has concentrated on public health priorities for London, networking with external stakeholders and building a public health framework across London.

Dr Anne Rainsberry - Director of People and Organisational Development and Deputy Chief Executive

Dr Anne Rainsberry has worked in health for over 20 years both in general management and in human resources roles.

Anne first became an HR director in the NHS in 1995 holding a number of board level positions in London. Anne joined the Department of Health in 2001, working firstly as director of workforce development in the South East Regional Office and latterly the Department of Health and Social Care Sector, with responsibility for leading the delivery of workforce modernisation in the NHS and Social Care across the south east and subsequently the south of England.

In 2004, she was appointed as Director of Human Resources for the Department of Health with responsibility for the department and its agencies and leading HR policy for its 26 arms length bodies.

In 2005 she was awarded Doctorate of Business Administration with distinction and in 2006 was appointed as Director of People and Organisational Development and Deputy Chief Executive. Anne is now the London Regional Director for NHS England.

Associate directors

Sara Coles - Director of Performance

Sara Coles has worked at NHS London since October 2008. For the three years prior to joining NHS London she worked at the Department of Health in two national roles as Director, 18 weeks Intensive Support Programme and Director, National Cancer Waits Project.

She has nearly 20 years experience in the NHS, predominantly in acute hospital operational management roles, with her latest experience in deputy chief executive and director of operations posts. In January 2013, Sara was seconded to become the Interim Chief Operating Officer at Croydon Health Services NHS Trust to provide additional support to improve performance at the Trust.

Sara remained Director of Performance at NHS London alongside this additional role.

Hannah Farrar – Director of Strategy and Commissioning Development

Hannah Farrar joined NHS London in June 2006 initially as Deputy Director of Strategy & Commissioning. In September 2008, Hannah took up the position of Director of the Strategy and System Management directorate, now the Strategy Commissioning and Provider Development directorate.

Previously Hannah has worked for the Department of Health, joining the Civil Service fast-stream programme, she worked in a number of roles, focusing on change and system reform.

In 2005 Hannah moved to Monitor as a senior policy advisor, where she was the author of the first three-year strategic plan for the regulator of NHS foundation trusts.

Stephen Webb - Director of Communications and Public Affairs

Stephen Webb has over 14 years of experience in media relations and communications in complex government and public sector roles. Stephen joined NHS London as communications director in April 2008 and has played a lead role in building the capacity and capability of NHS communications in London.

He was previously director of group communications for Transport for London (TfL), with responsibility for a broad range of the organisation's key strategic communications work, including government and stakeholder relations and internal communications.

Stephen joined TfL in 2001 after working in media relations for a number of government departments. He was deputy head of the TfL media team that won the 2006 CIPR award for Crisis Communications following the July 2005 London bombings, and has lectured in the UK and abroad on crisis communications.

Dr Andy Mitchell - Medical Director

Dr Mitchell joined NHS London in 2009. He has worked in the Armed Services and remains a civilian adviser to the Defence Medical Services. As Joint Service Clinical Director he was responsible for world wide intensive care retrieval of sick children.

In 1997 he established the Central South Coast Paediatric Intensive Care network and chaired the network through seven years of development. In 2006 he began working as associate medical director at Great Ormond Street, where he facilitated the London children's pathway group as part of the NHS Next Steps review.

He was a member of the London Clinical Advisory Group, and co-directed the Healthcare for London children's project. He continues in part time general paediatric practice.

John Goulston - Regional director of Provider Development and director of LPfIT

John Goulston was regional Director of Provider Development, and from September 2011 Director of London Programme for IT at NHS London. As Director of Provider Development, John oversaw the foundation trust pipeline for London's 26 NHS trusts, leading on the NHS London assurance process for reviewing both trust's FT applications and the development of mergers and acquisitions where agreed in principle by trusts.

From March 2008 to January 2011, John was Chief Executive at Barking, Havering & Redbridge University Trust following a secondment as Acting Chief Executive. Over the period 2002 to 2007, John was Director of Finance, Deputy Chief Executive, and Acting Chief Executive at Barts and The London NHS Trust. This role included leading on the approval of the Full Business Case, contract agreement and the first year of construction for the £1bn PFI redevelopment of Barts and the Royal London Hospitals. John was also Director of Finance at the Royal Free Hampstead NHS Trust from 1995 to 2002. Overall John has 20 years of experience as a director of finance and chief executive with NHS providers. John also has six years' experience working for Coopers & Lybrand, first in the audit and then in the healthcare consultancy practice.

John left NHS London in April 2012 to join Croydon Health Services NHS Trust.

ANNEX 2: DIRECTORS' REMUNERATION

The remuneration committee was made up of at least three independent non-executive directors in accordance with the terms of reference. At the time of NHS London's closure, the committee was chaired by Rachel English, and Professor Mike Spyer, Ian Harrison and George Wood were the other members.

Remuneration of very senior managers was applied in accordance with the Very Senior Manager Pay Framework (VSM PF). This was issued by DH on a yearly basis. We also had two very senior managers on consultant terms and conditions (paid in accordance with the Medical & Dental terms and conditions).

All very senior managers were required to undergo an appraisal and complete a standard appraisal form which assessed their performance against specific targets relevant to that performance year. A locally developed weighting system was then used to score individuals against the various targets and an overall rating for each individual was then obtained. This ensured a consistent and robust system. Comparison with external organisations was not directly made. The VSM PF outlined different pay bandings that were applicable to different specialisms. These were set parameters of pay and not subject to performance conditions. Senior Managers were also entitled to a yearly bonus payment which was subject to performance conditions. Details of bonus payment arrangements for each year were provided by DH.

Relevant policies and letters in relation to duration of contracts, notice periods and termination payments were issued by DH. Terms for notice periods and termination payments were mainly stipulated within the VSM contract, AfC terms and conditions and Medical & Dental terms and conditions. The duration of posts were determined locally dependant on the particular needs of the post and budget constraints.

NHS London had 11 very senior managers (VSMs), nine on VSM contracts and two on consultant contracts. All were on permanent contracts. VSMs were entitled to six months written notice from NHS London and could terminate their employment with three months notice, except in the case of summary or immediate dismissal. Payment in lieu of notice, as a lump sum payment, could have been made at the discretion of NHS London and with the approval of its remuneration committee. NHS London could at any time have terminated a VSM's employment by giving notice unless the reason for termination of employment was summary/immediate dismissal. If part of the notice had been worked, pay in lieu of notice, as a lump sum payment, could be paid for the unexpired element of the notice period.

Annual Awards were issued in accordance with the VSM PF for individuals who meet the eligibility criteria determined yearly by DH. NHS London agreed not to make any recommendations for awards for the 2012/13 performance year.

		2012-13				2011-12			
Name	**Title**	**Salary (bands of £5,000)**	**Other Remuneration - Compensation for Loss of Office or Early Retirement* (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (Rounded to the nearest £000)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (Rounded to the nearest £000)**
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mike Spyer	**Chair**	**60-65**				**60-65**			
Michael Bell	**Vice Chair (left 31 December 2012)**	**5-10**				**5-10**			
Rima Makarem	**Non-Executive Director**	**10-15**				**10-15**			
Rachel English	**Non-Executive Director**	**5-10**				**5-10**			
Ian Harrison	**Non-Executive Director**	**5-10**				**5-10**			
Michael Parker	**Non-Executive Director (left 30 April 2012)**	**0-5**				**0-5**			
George Wood	**Associate Member (appointed 1 December 2012) Non-Executive Director (appointed 20 December 2012)**	**0-5**				**N/A**			
Jane Ramsey	**Associate Member (left 30 June 2012)**	**0-5**				**5-10**			
Ruth Carnall	**Chief Executive**	**260-265**				**260-265**			
Paul Baumann (note 1)	**Director of Finance and Investment (left 30 September 2012)**	**100-105**				**200-205**			
David Slegg	**Director of Finance and Investment (appointed 1 October 2012 and seconded from Ealing Primary Care Trust at nil cost)**	**nil**				**N/A**			
Dr Anne Rainsberry	**Deputy Chief Executive and Director of People and Organisational Development**	**165-170**				**165-170**		**5-10**	
Dr Simon Tanner	**Director of Public Health**	**145-150**	**50-55**	**15-20**		**145-150**		**15-20**	
Prof Trish Morris-Thompson	**Chief Nurse (seconded to Care Quality Commission 16 October 2012, but remained Joint Director of Chief Nurse)**	**150-155**	**130-135***			**150-155**			
Caroline Alexander	**Chief Nurse (appointed Joint Director 16 October 2012 and seconded from NHS North East London & The City at nil cost)**	**nil**				**N/A**			

		2012-13				2011-12			
Name	**Title**	**Salary (bands of £5,000)**	**Other Remuneration - Compensation for Loss of Office or Early Retirement* (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (Rounded to the nearest £000)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (Rounded to the nearest £000)**
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
John Goulston (note 2)	**London Programme for IT Director (Seconded from BHRT, left 30 April 2012)**	**15-20**				**105-110**			
Teresa Moss (note 3)	**Director of National Specialised Commissioning (left 31 October 2012)**	**75-80**	**130-135**			**130-135**			
Joanna Sheehan	**Acting Director of National Specialised Commissioning (appointed 18 July 2012), Director of National Specialised Commissioning (appointed 1 November 2012)**	**70-75**				**N/A**			
Alwen Williams	**Director of National Trust Development Association (appointed 31 October 2012 and seconded from NHS North East London & The City at nil cost)**	**nil**				**N/A**			
Hannah Farrar	**Director of Strategy and Commissioning Development (appointed 1 April 2012)**	**140-145**	**115-120**			**N/A**			

Notes
1. 2012/13 Salary was for 6 months in post
2. 2012/13 Salary was for 1 month in post; 2011/12 salary was for 7 months in post
3. 2012/13 Salary was for 7 months in post

Name	Title	Real increase (decrease) in pension at age 60 (bands of £2,500)	Real increase (decrease) in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase (decrease) in Cash Equivalent Transfer Value
		£000	£000	£000	£000	£000	£000	£000
Ruth Carnall	Chief Executive	(2.5)-(5.0)	(13.0)-(13.5)	105-110	325-330	0	2,223	(2,338)
Paul Baumann	Director of Finance and Investment (left 30 September2012)	0-2.5	3-3.5	10-15	40-45	260	206	22
David Slegg	Director of Finance and Investment (appointed 1 October 2012 and seconded from Ealing Primary Care Trust at nil cost)	2.5-3	8-8.5	65-70	195-200	1,439	1,216	80
Dr Anne Rainsberry	Deputy Chief Executive and Director of People and Organisational Development	0-(2.5)	(2.0)-(2.5)	55-60	165-170	940	880	14
Dr Simon Tanner	Director of Public Health	0-(2.5)	0-(2.5)	55-60	170-175	1,187	1,106	24
Prof Trish Morris-Thompson	Chief Nurse (seconded to Care Quality Commission 16 October 2012, but remained Joint Director of Chief Nurse)	0-(2.5)	0-(2.5)	50-55	160-165	994	933	13
Caroline Alexander	Chief Nurse (appointed Joint Director 16 October 2012 and seconded from NHS North East London & The City at nil cost)	0-2.5	3-3.5	20-25	65-70	379	314	23
John Goulston	London Programme for IT Director (Seconded from BHRT, left 30 April 2012)	0-(2.5)	0-(2.5)	50-55	161-165	1,080	1,006	2
Teresa Moss	Director of National Specialised Commissioning (left 31 October 2012)	0-(2.5)	0-(2.5)	45-50	135-140	962	901	4
Joanna Sheehan	Acting Director of National Specialised Commissioning (appointed 18 July 2012), Director of National Specialised Commissioning (appointed 1 November 2012)	0-2.5	0-(2.5)	27-30	65-70	576	514	25
Alwen Williams	Director of National Trust Development Association (appointed 31 October 2012 and seconded from NHS North East London & The City at nil cost)	0-(2.5)	0-(2.5)	60-65	180-185	1,254	1,179	6
Hannah Farrar	Director of Strategy and Commissioning Development (appointed 1 April 2012)	0-2.5	4-4.5	5-10	25-30	103	81	18

Median Pay Disclosures

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, who was the Chief Executive, in the financial year 2012/13 was £260-265k (2011/12 £260-265k). This was 5.66 times (2011/12 5.45 times) the median remuneration of the workforce, which was £46,374 (2011/12 £48,162).

No employees received remuneration in excess of the highest-paid director (2011/12 none). Remuneration ranged from £11,469 to £261,538 (2011/12 £15,314 to £261,538).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

ANNEX 3: GLOSSARY OF ACRONYMS

A&E	Accident & Emergency
AC	Approved Clinician
AfC	Agenda for Change
AHP	Allied Health Professional
AHSC	Academic Health Science Centre
AHSP	Academic Health Science Partnership
ALS	Action Learning Sets
BAME	Black, Asian and Minority Ethnic
BMA	British Medical Association
BME	Black or Minority Ethnic
BMJ	British Medical Journal
BSBV	Better Services, Better Value – SW London reconfiguration programme
BT	British Telecom
C.diff	Clostridium difficile
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CIC	Capital Investment Committee
CIP	Cost Improvement Plan
CMC	Coordinate My Care
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPPD	Continuing Personal and Professional Development
CQC	Care Quality Commission
CQUIN	Commission for Quality and Innovation
CRL	Capital Resource Limit
CSL	Commissioning Support for London
CSS	Commissioning Support Service
CTB	Challenged Trust Board
DH	Department of Health
E4E	Energise for Excellence
ECS	Education Commissioning System
EDS	Equality Delivery System
EHIC	European Health Insurance Card
EIS	Early Implementer Sites
ERIC	Estates Return Information Collection
FNP	Family Nurse Partnership
FT	Foundation Trust
GLA	Greater London Authority
GMC	General Medical Council
GP	General Practitioner
GUM	Genito-Urinary Medicine
HASU	Hyper-Acute Stroke Unit
HCAI	Healthcare Associated Infections
HCS	Healthcare Scientist
HEE	Health Education England
HES	Hospital Episode Statistics
HIA	High Impact Actions
HIEC	Health Innovation and Education Cluster
HPA	Health Protection Agency
HSG	Health Service Guidance

HSJ	Health Service Journal
HV	Health Visitor
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
IFRS	International Financial Reporting Standards
IRP	Independent Review Panel
IT	Information Technology
iTAPP	Innovation Technology Adoption Procurement Programme
JCNC	Joint Consultative Negotiating Committee
LARC	Long Acting Reversible Contraception
LCMDE	London Commissioner for Mental and Dental Education
LETB	Local Education and Training Board
LETC	Local Education and Training Committee
LGV	LymphoGranuloma Venereum
LHIB	London Health Improvement Board
LINk	Local Advisory Network
LMC	Local Medical Committee
LOCOG	London Organising Committee of the Olympic Games
LOD	Leadership and Organisational Development
LOS	Length Of Stay
LSA	Local Supervising Authority
LSP	Local Service Provider
M&A	Merger and Acquisitions
MDG	Multi-Disciplinary Group
MHA	Mental Health Act
MMR	Mumps, Measles and Rubella
MRSA	Multidrug-Resistant Staphylococcus Aureus
MS	Multiple Sclerosis
NCAT	National Cancer Action Team
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCL	North Central London
NELC	North East London and City
NHS	National Health Service
NHS CB	NHS Commissioning Board
NMC	Nursing and Midwifery Council
NWL	North West London
OD	Organisational Development
ONEL	Outer North East London
ORSA	Organisational Readiness Self-Assessment
PCT	Primary Care Trust
PDSA	Plan, Do, Study, Act cycle
PHE	Public Health England
PMO	Programme Management Office
POCT	Point Of Care Testing
PPAG	Patient and Public Advisory Group
PPE	Patient and Public Engagement
PSAT	Patient Safety Action Team
PSSO	Provider Shared Service Organisation
QIPP	Quality, Innovation, Productivity & Prevention
RIF	Regional Innovation Fund
S12	Section 12
SaFE	Sustainable and Financially Effective
SaHF	Shaping a Healthier Future – NW London reconfiguration programme

SAHPLE	Allied Health Strategic Leads for England group
SDMP	Sustainable Development Management Plans
SEL	South East London
SES	Single Equality Scheme
SHA	Strategic Health Authority
SI	Serious Incident
SOM	Single Operating Model
SRO	Senior Responsible Officer
STeLI	Simulation and Technology-enhanced Learning Initiative
STI	Sexually Transmitted Infection
STOW	Secure Transfer Of Women
SWL	South West London
TFA	Tripartite Formal Agreement
VSM PF	Very Senior Manager Pay Framework

Department of Health

NHS

London Strategic Health Authority

2012-13 Accounts

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London Strategic Health Authority

2012-13 Accounts

LONDON STRATEGIC HEALTH AUTHORITY

ANNUAL ACCOUNTS

2012/13

NATIONAL HEALTH SERVICE

ANNUAL ACCOUNTS 2012/2013

The Accounts of the London Strategic Health Authority

FOREWORD

These accounts have been prepared by the Authority under section 98(2) of the National Health Service Act 1977 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statutory background

London Strategic Health Authority is a public body and part of the National Health Service. It is a statutory body governed by Acts of Parliament and came into existence on the 1st July 2006 under Statutory Instrument 2006 No 1408. As a statutory body, the Strategic Health Authority has specific powers to act as regulator, to contract in its own name, act as a corporate trustee, to fund projects jointly planned with and to make payment and grants to local authorities, voluntary organisations and other bodies.

Going Concern

Management have considered the changes proposed by the Government in the Health and Social Care Act and, as services will continue to be provided by other public sector entities, have concluded that it is appropriate for the accounts to be prepared on a going concern basis. Note 1.18 (Accounting Policies) and note 22 (Events After The Reporting Period) provide further information.

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE LONDON STRATEGIC HEALTH AUTHORITY 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of Signing Officer for the final accounts of the London Strategic Health Authority 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 Strategic Health Authority;
- the expenditure and income of the Authority 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 Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed.....

Richard Douglas
Signing Officer

Date: 6 June 2013

Independent auditor's report to the Department of Health's Accounting Officer in respect of the London Strategic Health Authority

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

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

- the table of salaries and allowances of senior managers and related narrative notes on pages 74 & 75;
- the table of pension benefits of senior managers on page 76; and
- the pay multiples narrative notes on page 77

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

Respective responsibilities of the signing officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Authority's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Authority; 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.

Independent auditor's report to the Department of Health's Accounting Officer in respect of the London Strategic Health Authority (continued)

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been 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 annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

• in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;

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

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

We have nothing to report in these respects.

Independent auditor's report to the Department of Health's Accounting Officer in r of the London Strategic Health Authority (continued)

Other matters on which we are required to conclude

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

We have undertaken our audit in accordance with the Code of Audit Practice and, having regard to the guidance issued by the Audit Commission in October 2011, have considered the results of the following:

- our review of the Annual Governance Statement;
- the work of other relevant regulatory bodies or inspectorates to the extent the results of the work have an impact on our responsibilities; and
- our locally determined risk-based work on managing the transition.

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 London Strategic Health Authority in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Susan M. Exton
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Grant Thornton
Grant Thornton House
Melton Street
Euston Square
London NW1 2EP

6 June 2013

London Strategic Health Authority

Governance Statement

2012/13

1 Scope of responsibility

The Board was accountable for internal control and governance of the London Strategic Health Authority (NHS London). The Accountable Officer, the Chief Executive, had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives. The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide a reasonable and not an absolute assurance of effectiveness.

The system of internal control was based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control was in place in NHS London for the whole of the year ended 31 March 2013.

The Accountable Officer also had responsibility for safeguarding public funds and the organisation's assets, for which the Accountable Officer was personally responsible as set out in the Accountable Officer Memorandum.

Under the Health and Social Care Act 2012, NHS London (in common with the other nine Strategic Health Authorities) ceased to exist on 31st March 2013, and its functions, assets and liabilities were transferred to a range of new statutory organisations. The management of this programme of transition and closedown was one of the major tasks of NHS London over the past twelve months.

In line with national plans from October 2012 new organisations started to take on management responsibility for work relating to their future functions, covering both in-year delivery and planning for 2013/14. The NHS London Board agreed revised governance arrangements for this in September 2012, designed to:

- Minimise the risk of a "big bang" transition of functions and staff on 1 April 2013;
- Provide resilience for delivery; and
- Provide receiving organisations with the opportunity to build teams in parallel with taking on responsibility for functions, with support from senders.

Governance Statement (continued)

1 Scope of responsibility (continued)

Statutory accountability of course, remained with the demising organisations (referred to as Senders in this report) until 1st April 2013, which continued to hold the new receiving organisations (referred to as Receivers in this report) to account for delivery during 2012/13.

In order to manage these arrangements, the following executive committees were established (some building on existing structures):

- **London Future System Group:** This provided a forum for receivers in London to manage dependencies and risks as part of start-up. It also provided a single forum for the sending system to work with London receivers on functional take-on.
- **Strategy Group:** This oversaw programmes that remained with the sending system to deliver in 2012/13.
- **Delivery Group:** This oversaw in-year operational and financial performance (as before).
- **Handover & Closure Programme Board:** This managed the delivery of handover to the receiving system and safe closedown of NHS London and Primary Care Trust (PCT) clusters, reporting to the new Handover and Closure Committee of the Board.

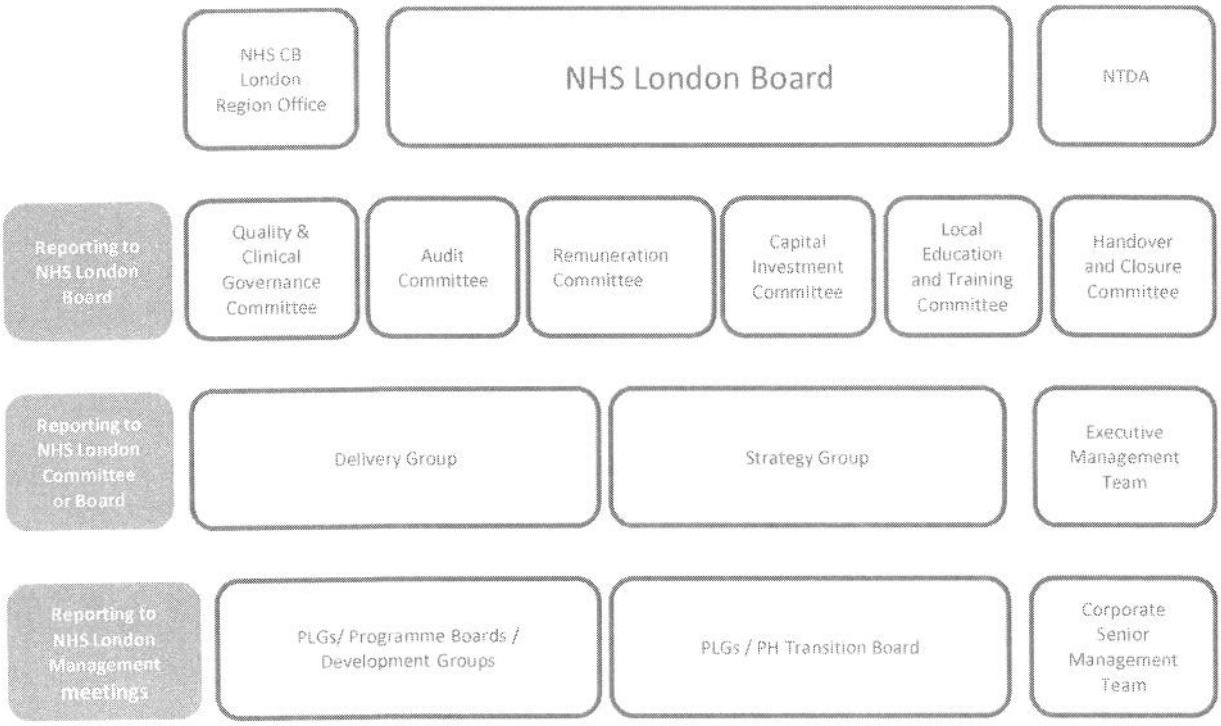
The Handover and Closure Committee was established in order to oversee and provide assurance on the way NHS London and PCTs were closed down and their functions and assets transferred under Transfer Schemes to receiving organisations. The Committee was supported by both the Handover and Closure Programme Board (which brought together the Transition Programme Directors for PCT clusters and Handover and Closure Leads for NHS London) and by quarterly meetings of PCT cluster Audit Chairs under the chairmanship of the NHS London Audit Chair.

Processes to ensure effective working with partner organisations were put in place, including regular meetings with PCT cluster Chairs and Trust Chief Executives and Chairs in the NHS London area. In addition, meetings were held with London Councils, the Mayor of London and the London Assembly.

Governance Statement (continued)

2 The governance framework of NHS London

The NHS London Board and governance architecture for 2012/13 is detailed below (acronyms are explained as an appendix to the Annual Report):



The Board met quarterly in public, as well as meeting in private to discuss confidential items. In addition, the Board had regular focus sessions to discuss a broad range of strategic issues. At the beginning of 2012/13 the Board agreed a new committee to manage the handover of Local Education and Training. The Local Education and Training Committee (LETC) met quarterly. It had Executive and Non-Executive membership as well as significant participation from the Chairs and executive managers from the pathfinder Local Education and Training Boards (LETBs) to facilitate the transition of the education and training system in London. It was chaired by the Chair of NHS London.

A new Handover and Closure Committee was established in October 2012 and chaired by the Audit Chair of NHS London and met every two months to assure the Board that progress against objectives set out within NHS London's handover and closure and workstreams were being monitored adequately, managed correctly, and that risks and opportunities were managed and reported to the Board in a timely manner. The committee was also responsible for assuring the Board that similar arrangements were in place and working effectively for each of London's PCT clusters and reported to the Board on arrangements for legacy requirements. A particular focus was ensuring that all statutory functions of NHS London and PCTs were discharged during the year, and effectively and safely transferred to the relevant receiving organisations. NHS London commissioned legal advice on behalf of all 10 SHAs to ensure that there were no irregularities or omissions. In addition, a legacy document and a quality and safety handover document were produced to encapsulate the aggregated knowledge and information held about services across London. These documents were supported by detailed handover meetings with Receivers and an extensive library of knowledge.

Governance Statement (continued)

2 The governance framework of NHS London (continued)

The PCT cluster Audit Chairs met every quarter to provide advice to the NHS London Handover and Closure Committee, PCT cluster Chairs and to PCT cluster boards on risk management and transition arrangements to provide assurance to Audit Chairs across London. Their meetings were chaired by the Audit Chair of NHS London.

The Quality and Clinical Governance Committee met every two months. The committee had Executive Management Team (EMT), Corporate Senior Management Team (CSMT) and Non-Executive Director (NED) participation and reported to the Audit Committee and directly to the Board on a quarterly basis. The Committee considered quality of service and clinical governance issues via a series of regular and ad hoc reports that responded to specific issues as well as considering the risks associated with those areas. The Audit Committee delegated to the Quality and Clinical Governance Committee the oversight of clinical risks. This latter committee was chaired by the Chair of NHS London.

The Audit Committee was scheduled to meet five times a year, including a meeting to review the annual accounts and annual report. During the final quarter of 2012/13 additional meetings were scheduled monthly to provide extra assurance during transition. It had only Non-Executive membership and reviewed reports from the Executive Directors, internal and external auditors and counter-fraud specialists. The Committee reviewed all identified risks at each meeting, as well as pan-London and internal finance reports. In addition, the Committee commissioned papers on areas of interest to Members on an ad hoc basis.

The Remuneration Committee was chaired by a Non-Executive Director and met frequently during 2012/13 to help manage transition arrangements. It reviewed all matters relating to the employment, training and development policies of NHS London to ensure a good quality and sustainable workforce. This included all remuneration packages of senior staff and elements to be included in them as well as any termination payments to NHS London, PCT and Trust Chief Executives and Directors.

The Capital Investment Committee was scheduled to meet monthly, with extraordinary meetings arranged as required. The Committee was chaired by a Non-Executive Director and reviewed issues relating to capital investment strategy, mergers and acquisitions and Trusts' progression to Foundation Trust (FT) status. It also reviewed and assessed business cases at all stages (strategic outline case, outline business case, full business case and post control reports). All Non-Executive Directors (NEDs) were ex officio members of this committee in view of the importance and the need for timeliness of these deliberations. Since October 2012 the Chair and the Director for Development for London of the NHS Trust Development Agency (NTDA) were also invited to attend relevant meetings to facilitate transition.

Governance Statement (continued)

2 The governance framework of NHS London (continued)

All committee minutes were provided to the quarterly Board meetings and the Chair of each committee updated the Board on key issues. The Board meetings were held in public and regularly answered questions from members of the press and public.

The attendance at the Board was good in 2012/13 with 93% of Non-Executive Directors (NEDs) and 79% of Executive Directors (EDs) attending during the year. The attendance at Committees has also been good with 82% of NEDs and 79% of EDs attending during the year. As 2012/13 was the last year of NHS London's operations, the Board prioritised the management of transition and did not formally undertake a review of its own effectiveness. However the Board and Committees have been effective and complied with all the relevant aspects of the UK Corporate Governance Code.

In 2012/13 our corporate management groups have continued to meet monthly, with our Strategy Group alongside our Delivery Group. Our Executive Management Team (EMT) continued to meet quarterly to consider internal business supported by our Corporate Senior Management Team (CSMT) who met at least monthly. The Strategy Group oversaw the management of programmes that remained with the NHS London to deliver in 2012/13. The Delivery Group continued to oversee in-year delivery of the annual operating plan for London including performance and finance targets. These groups included our EMT and PCT cluster Chief Executives. The Professional Leadership Groups (PLGs) continued to focus on key areas of work and report into the Delivery Group each month.

3 The risk and control framework

A Corporate Risk Assurance Framework (CRAF) was in place throughout 2012/13 and covered all of the strategic and operational objectives of NHS London. Following on from training in 2011/12, additional representatives from all directorates undertook formal Management of Risk (MoR) training in 2012 which resulted in NHS London having 25 qualified MoR practitioners. The learning from this qualification training was disseminated throughout NHS London to ensure that risk management was further embedded and risks were consistently and concisely described. The training programme was commended by the Audit Committee as having significantly strengthened NHS London's capability for Risk Management.

The Corporate Senior Management Team (CSMT) was tasked with compiling and reviewing individual risks and the overall structure of the CRAF. Comments from the directorates, CSMT, Executive Management Team (EMT) and the Audit Committee were taken into consideration during each review cycle to ensure the CRAF was maintained as a living document and tool.

Governance Statement (continued)

3 The risk and control framework (continued)

The CRAF for NHS London also encompassed key pan-London risks which we managed jointly with PCT clusters. During transition NHS London developed a London-wide Risk Assurance Framework to help inform PCT and NHS London risk management which was reviewed regularly by the PCT cluster Audit Chairs. PCT cluster Chief Executives were all members of the Strategy and the Delivery Groups, as well as the Handover and Closure Committee and Programme Board. NHS London played a co-ordinating role in ensuring PCT cluster governance structures were fit for purpose, particularly in the approach to the delegation of financial responsibilities to Clinical Commissioning Groups (CCGs) which were originally constituted as committees of PCTs. In addition, the NHS London Chair met every six weeks with the PCT cluster Chairs to monitor progress and ensure risk mitigations were effective.

The CRAF was reviewed quarterly by the CSMT, EMT and the Audit Committee with all pre-mitigation red risks being reviewed by the full Board on a quarterly basis. The reviews considered the controls and actions to mitigate the risks as well as the assurance the Board could take that the controls and actions were being appropriately managed.

The CRAF covered all of NHS London's priorities, core business and statutory obligations and identified the principal risks which could prevent these priorities and objectives from being achieved. The risks were also linked to the part of the organisation to which they related and the NHS London business plan objectives. To facilitate transition, NHS London reviewed its strategic priorities in Autumn 2011 together with the PCT cluster Chief Executives. This resulted in a revised and shared set of priorities across all the PCT clusters and NHS London for the period until the end of March 2013.

The CRAF was developed so that risks were identified as risks to Performance, Transition or Strategic Priorities, Core Business or Statutory Obligations. The first three categories had overarching risks followed by specific risks which mapped onto the detailed priorities in each category. The CRAF therefore covered all key aspects of NHS London and ensured these risks were identified and managed. Risks were identified as being either London-wide or NHS London only, and were further categorised between financial, clinical or reputational risks.

The CRAF assessed each risk within a clearly defined framework in terms of its likelihood and impact and risks were assessed as red, amber or green, prior to mitigation. The key mitigating controls and actions that were in place to support the achievement of the objective were identified and this resulted in a revised post-mitigation assessment of the risk, likelihood and impact. Assurance mechanisms, on which the Board placed reliance to ensure that the systems and controls were effective, were also detailed. Both the mitigating controls and the assurance mechanisms were split between existing and planned so that CSMT, EMT, Audit Committee and the Board could assess progress. Furthermore, the CRAF highlighted any movements in impact and likelihood from one quarter to the next so that the Board was able to monitor the trends for particular risks which were rated as red. The Board received these reports at public meetings.

Governance Statement (continued)

3 The risk and control framework (continued)

Public stakeholder involvement:

The NHS London CRAF included risks relevant to public stakeholders. This register was published every quarter prior to the NHS London Board and members of the public were free to attend and ask questions. At a local level across London, there were also various PCT-sponsored public and patient forums in existence to cover both general and specific health-related issues.

4 Risk Assessment

At each of its meetings the Audit Committee undertook a full review of the CRAF, including its format, the identified risks and their definitions and the risk management processes. It also reviewed transition governance arrangements as well as reviewing the controls, number and nature of tender waivers.

The Audit Committee regularly reviewed finances, both of NHS London and within the local health economy. In addition it reviewed key issues on an ad hoc basis, including reviewing the processes of system handover and closure.

The most recent risks reviewed by the Board related to the 2012/13 Quarter Four risks and were taken to the March 2013 Board meeting. Any material changes to the risks identified in this Statement were noted. Risks for functions that transferred to new organisations are being managed by those organisations from April 2013 and were formally transferred to them by the Chief Executive on the 28th March 2013 following a final review by the Audit Committee.

A summary of each of the red risks, post mitigation for functions transferred to each organisation is detailed below.

<u>Risks for functions transferring to NHS England (London region):</u>

19 risks were identified as relating to functions transferring in full or part to NHS England (London region); 11 were rated as red pre-mitigation (reduced from 16 at the end of 2011/12), of which 3 remained red post-mitigation:

London Maternity Services:

- There was a risk that women may be exposed to unsafe services/systems/ processes which could cause them harm, and/or experience poor quality care if NHS London fails to implement a comprehensive approach to planning the capacity of maternity services and capability of the workforce.

  This risk was mitigated by NHS London coordinating access for midwifery Return to Practice programmes; commissioning the foundation degree programme for Maternity Support Workers (MSW); and increasing undergraduate training places.

Governance Statement (continued)

4 Risk Assessment (continued)

Each Serious Incident (SI) was reviewed by the the Maternity Services Advisor and a Patient Safety Manager; working with trusts including executive members of the Board; Root Cause Analysis training. Each current London sector has a maternity provider network established. The London Health Programmes formulated standards for the maternity acute care pathway; the maternity capacity planning proposal was approved by the Quality and Safety Programme Board.

Differential Standards in Primary Care:

- There was a risk that CCGs will not be able to produce primary care strategies that set a robust vision for primary care services and agree them with NHS England. CCGs may not have the capability and capacity required to prioritise and deliver improvements in standards of primary care. The consequence of this could be continued unacceptable variation in primary care performance and an inability to deliver out-of-hospital strategies that support major reconfigurations and the achievement of QIPP savings. This could result in greater inequity, and reduced standards of primary care. A further consequence could be that the QIPP financial challenge may not be delivered.

  This risk was mitigated by the NHS London primary care transformation programme launched in January 2012. A delivery plan set out a programme of work to March 2013 to build on the NHS Change model adopted by NHS England. Reports on the quality of primary care at London- and CCG-level and the development of a transformation framework were completed in December 2012. Seed funding was awarded to support GP practices in innovating for primary care improvement. Support tools have been published: 'Once for London' commissioning guides, the general practice outcome standards web tool, good performance management guidance and a contract compliance monitoring tool. The myhealthlondon website will drive improvements in general practice by facilitating patient choice and feedback.

Safeguarding and Promoting the Welfare of Children and Young People:

- There was a risk that the quality and standards of care for children in London may be impacted by i) any breach of compliance with the policy for safeguarding children and young people, ii) dilution and/or loss of expertise leadership within NHS London and the wider workforce (i.e. loss of substantive designated/named professionals), iii) merging of children and adult roles, and iv) weaknesses in information sharing systems and processes. The consequences of this were preventable harm to children, damage to the reputation and loss of public confidence in the NHS in London. There is also a risk that the reputation of NHS London could be damaged in relation to the implications arising out of the Jimmy Saville allegations regarding his management role at Broadmoor Hospital.

Governance Statement (continued)

4 Risk Assessment (continued)

This risk was mitigated by all Ofsted/CQC Safeguarding Children (SgC)/Looked After Children (LAC) inspections and reports being reviewed by Chief Nurse and Performance Directorates and followed up; audit of Serious Case Reviews (SCR) reported to NHS London and action plans monitored; an SCR Database tracks and reported emerging themes; NHS London was a member of the multi-agency London SgC Board which produced regular reports. There was support for Designated/Named Professionals (D/NP) for SgC. There were formal clinical and professional networks for all professional groups. A Lead Paediatrician for SgC worked with the Medical Director and SgC Advisor to improve the engagement of doctors and CCGs. All Commissioning / Operational plans were reviewed. Handover and Closure meetings with PCT cluster Directors of Nursing were held. Full engagement with the roll-out of Multi-Agency-Safeguarding-Children hubs (MASH). A national investigation into all trusts involved (including Broadmoor Hospital) was undertaken.

A CCG 'aide memoir' was drafted which incorporated the guidance from the NHS England regarding commissioning of Safeguarding Children and widely circulated. A Safeguarding programme was devised for integration into the CCG development programme. David Nicholson's letter was sent out to Chairs and Chief Executives with the instruction that they must review their processes and procedures for Safeguarding Children and Safeguarding Vulnerable Adults.

Risks for functions transferring to the National Trust Development Authority (NTDA):

5 risks were identified as relating to functions transferring in full or part to the NTDA; 2 were rated as red pre-mitigation, both of which remained red post-mitigation:

Achievement of Foundation Trust (FT) status:

- There was a risk that NHS trusts may not meet their FT trajectory as set out in their Tripartite Formal Agreement (TFA) signed off by DH due to a lack of progress in respect of organisational and service reconfiguration, financial challenges, organisational capacity/capability issues and agreement of stakeholders. There is a related risk of NHS trusts not satisfying CQC requirements. The consequence of this could be the application of the trust administration regime and further delay in the creation of a sustainable provider landscape that can deliver high-quality clinical services in an affordable way.The financial impact of the 2013/14 NHS England/NTDA Planning Guidance was considered as to whether this has a detrimental effect on the short-to medium-term viability of the individual organisations.

  This risk was mitigated by NHS London and DH/Monitor FT guidance including robust internal approval processes for FT applications and a Gateway Review to provide assurance on the quality and safety of a trust's services; the Tripartite Formal Agreements between trusts and NHS London/DH detailing the key work and timetable for achieving NHS FT status are signed off by DH, and trusts are performance-managed on these; NHS London delivers development and support programmes for NHS trusts aiming for FT status as standalone organisations and; Performance management of trusts was undertaken.

Governance Statement (continued)

4 Risk Assessment (continued)

Revised TFAs were required for some trusts. An Accountability Agreement was agreed with each trust to underpin the delivery of the TFA including a SHA/DH escalation process; Pan-London Productivity Improvement Programme, the roll-out of the Board Governance Assurance Framework (BGAF) and the monitoring of the Action Plan; actions on organisational or service change over and above the productivity improvements; implementation of acute medicine and surgery 7/7 senior medical coverage; monthly reviews of finance, performance and quality indicators; the adoption of the Single Operating Model Part 1 - FT Assurance and Part 2 - Oversight productivity support programme for trusts and; a number of trusts are focusing on integrated care to support their FT process. Mitigation was also via transition governance arrangements, liaison with receiving organisations, and discussions at Professional Leadership Groups (PLGs). As the NTDA became increasingly operational since 1st Oct 2012, it took on this risk. Following the release of the 2013/14 NHS England/NTDA planning guidance, organisations considered the financial implications to ascertain any risks and identified associated mitigations as appropriate.

Mergers and Acquisitions (M&A) programme:

- There was a risk that trusts may fail to deliver a transaction to the agreed timescale and within budget and a failure post-merger to realise the financial and clinical benefits identified as part of the pre-merger due diligence and development of merger business cases (including integration plans). The consequence of these risks could be a delay to the FT pipeline and non-delivery of respective TFAs (designed to promote financially and clinically viable organisations).

  This risk was mitigated by the application of the NHS London's Transactions Manual and DH transactions guidance; the NHS TDA's appointment of Senior Responsible Officer (SRO) and Transaction Directors to lead M&A transactions; close working between M&A and FT Assurance workstreams to sustain an organisation's "flight path" towards clinical and financial sustainability post-transaction as appropriate; Accountability Agreements agreed with each Trust to underpin the delivery of the TFA and; clarification of the interface between potential organisation change and potential service change in agreed Tripartite Formal Agreements (TFAs).

<u>Risks for functions transferring to the Health and Social Care Information Centre (HSCIC):</u>

3 risks were identified as relating to functions transferring to the HSCIC; 1 was rated as red pre-mitigation and remained red post-mitigation:

Governance Statement (continued)

4 Risk Assessment (continued)

Capability and Capacity within London Programme for Information Tecnnology (LPfIT) to deliver the Programme:

- There was a risk arising from the general capacity, capability and availability of skills within LPfIT to deliver the systems and services required to fulfil the Project Agreement, in part due to LPfIT being unable to recruit permanently to established posts due to transition policies. Failure to resolve this risk may result in the non-delivery or late delivery of Programme milestones. The impact of this could be financial penalty and failure to maximise the full benefits of the Cerner and RiO products for Trusts.

  This risk was mitigated as 'potential resource contentions' were escalated to the Joint Executive Board (JEB). JEB has SPfIT (Southern Programme for IT) attendance to deal with any threats or exploit any opportunities to deployments across both Programmes. The Local Service Provider (LSP) Delivery Director was on the HSCIC board and increased visibility of LPfIT risks and issues. There was agreement with HSCIC to short term extensions to agency/contractor staff and seconded-in staff.

Risks for functions transferring to the Department of Health, Health Education England and Local Authorities:

1 risk was identified as relating to a function transferring to the Department of Health but this was rated as amber pre-mitigation. There were no red risks for functions transferring to Health Education England or Local Authorities.

Equality Impact Assessments

Equality Impact Assessments (EQIAs)/Equality Analyses were undertaken to demonstrate that NHS London was open and transparent about the decisions that it made on service changes, improvements and policy decisions in relation to any of the protected characteristics, including with our staff. These ensured that any negative consequences were eliminated or minimised and opportunities for promoting equality and equity were maximised. Conducting EQIAs/Equality Analyses ensured that NHS London was able to demonstrate compliance with the three overarching principles of the Equality Act Public Sector Equality Duty (PSED).

All current policies and service development, both new and existing, were monitored and regularly reviewed for relevance and impact. Managers were encouraged to build EQIAs/Equality Analyses into existing business planning cycles, processes and service reviews to help embed equalities into mainstream business practices.

Control measures were in place to ensure compliance with all the organisation's obligations under equality, diversity and human rights legislation.

Governance Statement (continued)

4 Risk Assessment (continued)

Employer obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures were in place to ensure all employer obligations contained within the Scheme regulations are complied with. This included ensuring that deductions from salary, employer's contributions and payments into the Scheme were in accordance with the Scheme rules and that member Pension Scheme records were accurately updated in accordance with the timescales detailed in the Regulations.

Data Security

There were no identified lapses of data security during 2012/13 and up to the point the annual accounts were finalised.

Information governance

The Information Governance Management Framework was supported by an Information Policy. The framework set out the methodology for management of NHS London's information risks as part of the corporate risk management process. As a result, NHS London operated within the NHS Information Governance compliance framework.

NHS London made limited use of person and patient identifiable information given our role, and our information governance control framework protected that information accordingly. NHS London continues to review all risks on an ongoing basis and develop action plans to mitigate risk.

Operational handover and closure

The final Handover and Closure Programme Board meeting was held on 11th March 2013 where its closure was formally acknowledged. The minutes and final summary report was distributed to members. An update summarising the closure position and legacy organisation was then taken to Audit Committee on 27th March 2013.

Transition risks were subject to the same process and review cycle as the Corporate Risk Assurance Framework. In the latter stages of the programme, risk owners nominated an appropriate recipient for the risk should it not be closed with the closure of the SHA. The final Transition Risk Assurance Framework was agreed at Audit Committee on 27th March 2013.

Governance Statement (continued)

4 Risk Assessment (continued)

NHS London and PCT Clusters each completed programme closure documentation in line with guidance from DH. These provided a summary of the system transition programme (underpinned by detailed appendices) and outlined outstanding issues to be addressed by the Regional Legacy Management Team Hub (London) or appropriate receivers.

The NHS London System Transition Closeout Report was noted by the NHS London Board at the final meeting on 21st March 2013.

5 Review of effectiveness of risk management and internal control

The Accountable Officer had responsibility for reviewing the effectiveness of risk management and the system of internal control. Her review was informed in a number of ways. The Head of Internal Audit provided an opinion for 2012/13 which was that significant assurance could be given that there was a generally sound system of internal control. That opinion was based on the overall arrangements for gaining assurance through the Corporate Risk Assurance Framework and on the controls reviewed as part of Internal Audit's work. For all individual internal audits during the year for which an overall opinion was provided, the opinion given was substantial assurance.

Executive managers within the organisation, who had responsibility for the development and maintenance of the system of internal control, provided assurance in this respect. The CRAF provided evidence that the effectiveness of controls that managed the risks to the organisation achieving its principal objectives had been reviewed.

The Accountable Officer's review was also informed by External Audit who have undertaken work in the following areas:

- Governance – transition planning & management and delivery of current responsibilities.

  Their conclusion was that NHS London overall had put in place effective arrangements to deliver the transition, whilst maintaining the appropriate level of focus and degree of scrutiny over its operational activities. The Legacy Document provides a comprehensive and well-written record of structure, objectives and achievements.

- Finance – financial monitoring.

  An unqualified opinion will be issued on the financial statements for 2012/13 in the audit report.

Governance Statement (continued)

5 Review of effectiveness of risk management and internal control (continued)

- Recommendations of the Audit Commission's 2011/12 report on 'Managing the Transition'.

  Their conclusion was that the recommendations raised had been satisfactorily implemented.

A further source of assurance was derived from the ongoing discussions of strategies, performance, policies and processes across London. The PCT cluster Chief Executives were members of the Delivery and Strategy Groups and the Handover and Closure Committee. These meetings were supplemented by the regular six-weekly meetings between the Chair of NHS London, Non-Executive Directors and the PCT cluster Chairs.

The Accountable Officer was advised on the implications of the result of her review of the effectiveness of the system of internal control by the Board, Audit Committee, Capital Investment Committee, Remuneration Committee, Quality and Clinical Governance Committee, Local Education and Training Committee and the Handover and Closure Committee.

The process that was applied in maintaining and reviewing the effectiveness of the system of internal control included regular reviews of the CRAF by the Board, the Audit Committee and Executive Management Team. The overall process was managed by the Director of Finance and Investment and the Corporate Senior Management Team, who instituted a number of improvements in 2012/13 in line with best practice and feedback from the Audit Committee and the Handover and Closure Committee.

6 Governance Framework for Accounts Scrutiny and Sign Off Process

The Department of Health (DH) advised all SHA Chief Executives that the statutory duty for finalising the final accounts of the SHAs transferred from them on 1 April 2013 to the Secretary of State for Health and that the formal accountability for those accounts falls to the Permanent Secretary at the DH.

The Acting Permanent Secretary, and Principal Accounting Officer for the DH has been instructed to sign the Accounts on behalf of the Permanent Secretary. To enable him to discharge this duty effectively, he has required the SHA Chief Executive to sign a Certificate of Assurance confirming that the SHA:

- 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 SHA;
- Took reasonable steps for the prevention and detection of fraud and other irregularities;
- Achieved value for money from the resources available to the SHA;
- 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.

Governance Statement (continued)

6 Governance Framework for Accounts Scrutiny and Sign Off Process (continued)

- Has prepared the annual statutory accounts in the format directed by the Secretary of State to give a true and fair view of the state of affairs at the end of the financial year, and the net operating cost, recognised gains & losses and cash flows for the year. As required the accounts should:
  - 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; and
  - State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Acting Permanent Secretary has also required the SHA Director of Finance to sign a Certificate of Financial Assurance covering the preparation of the annual statutory accounts as stated in the last bullet point above.

The Acting Permanent Secretary has further required the SHA Chief Executive and the SHA Director of Finance to sign a Signature Brief covering the context in which the accounts have been prepared and any significant issues arising.

NHS London has been able to confirm that all of above requirements have been met. The SHA Deputy Chief Executive, on behalf of the Chief Executive, signed the Certificate of Assurance referred to above on 24 May 2013. The SHA Director of Finance signed the Certificate of Financial Assurance referred to above on 24 May 2013. The SHA Deputy Chief Executive, on behalf of the Chief Executive, and the SHA Director of Finance signed the Signature Brief on 24 May 2013

7 Significant Issues

Undoubtedly the most significant issue for NHS London in its final year was the management of its own closure and the handover of its functions to a wide range of successor bodies, while at the same time ensuring operational and financial performance was maintained in a climate in which all NHS bodies were subject to continued pressure to increase efficiency. So far as the risks can be controlled, the Accountable Officer was confident that we put in place robust programme management arrangements under the Handover and Closure Committee and Programme Board.

The Accountable Officer's review confirms that NHS London has a generally sound system of internal controls and robust governance that supports the achievement of its policies, aims and objectives.

Signed on behalf of the Accountable Officer:

Richard Douglas, Signing Officer

Department of Health

Signature:

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	**77,412**	65,740
Other costs	5.1	**1,718,309**	1,675,570
Income	4	**(18,075)**	(16,984)
Net operating costs before interest		**1,777,646**	1,724,326
Finance costs	9	**45**	57
Net operating costs for the financial year		**1,777,691**	1,724,383
Of which:			
Administration Costs			
Gross employee benefits	7.1	**53,819**	48,755
Other costs	5.1	**48,707**	41,799
Income	4	**(5,565)**	(2,161)
Net administration costs before interest		**96,961**	**88,393**
Finance costs	9	**-**	57
Net administration costs for the financial year		**96,961**	**88,450**
Programme Expenditure			
Gross employee benefits	7.1	**23,593**	16,985
Other costs	5.1	**1,669,602**	1,633,771
Income	4	**(12,510)**	(14,823)
Net programme expenditure before interest		**1,680,685**	1,635,933
Finance costs	9	**45**	-
Net programme expenditure for the financial year		**1,680,730**	1,635,933

Other Comprehensive Net Expenditure	2012/13 £000	2011/12 £000
Impairments and reversals	-	-
Movement in other reserves	-	-
Total comprehensive net expenditure for the year	**1,777,691**	**1,724,383**

The notes on pages 24 to 50 form part of this account.

Statement of financial position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	10	**1,136**	1,427
Intangible assets	11	**285**	225
Total non-current assets		**1,421**	1,652
Current assets:			
Trade and other receivables	13	**14,260**	10,817
Cash and cash equivalents	14	**45**	-
Total current assets		**14,305**	10,817
Total assets		**15,726**	12,469
Current liabilities			
Trade and other payables	15	**(60,563)**	(61,933)
Provisions	17	**(2,759)**	(2,389)
Total current liabilities		**(63,322)**	(64,322)
Non-current assets plus/less net current assets/liabilities		**(47,596)**	(51,853)
Non-current liabilities			
Provisions	17	-	-
Total non-current liabilities		**0**	-
Total Liabilities Employed:		**(47,596)**	(51,853)
Financed by taxpayers' equity:			
General fund		(47,596)	(51,901)
Revaluation reserve		-	48
Other reserves		-	-
Total taxpayers' equity:		**(47,596)**	(51,853)

The notes on pages 24 to 50 form part of this account.

The financial statements on pages 20 to 50 were approved by the Board on 5 June 2013 and signed on its behalf by

Richard Douglas

Signing Officer

Date: **6 June 2013**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
For the year ended 31 March 2013

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2012	(51,901)	48	**(51,853)**
Changes in taxpayers' equity for 2012/13			
Net operating cost plus (gain)/loss on transfers by absorption	(1,777,691)		**(1,777,691)**
Impairments and reversals		-	-
Movements in other reserves	-		-
Transfers between reserves	48	(48)	-
Total recognised income and expense for 2012/13	(1,777,643)	(48)	**(1,777,691)**
Net Parliamentary funding	1,781,948	-	**1,781,948**
Balance at 31 March 2013	**(47,596)**	**-**	**(47,596)**
Changes in taxpayers' equity for 2011/12			
Balance at 1 April 2011	**(23,317)**	**48**	(23,269)
Adjustment for accounting policy changes (donations and grants)	-	-	-
Other adjustments	-	-	-
Restated balance at 1 April 2011	(23,317)	48	**(23,269)**
Net operating cost for the year	(1,724,383)		(1,724,383)
Movements in other reserves	-		-
Transfers between reserves	-	-	-
Total recognised income and expense for 2011/12	**(1,724,383)**	-	**(1,724,383)**
Net Parliamentary funding	**1,695,799**		1,695,799
Balance at 31 March 2012	**(51,901)**	**48**	**(51,853)**

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012/13 £000	2011/12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(1,777,646)**	(1,724,326)
Depreciation and Amortisation		**689**	532
(Increase)/Decrease in Trade and Other Receivables		**(3,443)**	16,642
(Increase)/Decrease in Other Current Assets		**-**	-
Increase/(Decrease) in Trade and Other Payables		**(1,370)**	12,447
(Increase)/Decrease in Other Current Liabilities		**-**	-
Provisions Utilised	17	**(1,553)**	(1,311)
Increase/(Decrease) in Provisions		**1,878**	606
Net Cash Inflow/(Outflow) from Operating Activities		**(1,781,445)**	(1,695,410)
Cash flows from investing activities			
(Payments) for Property, Plant and Equipment	10.1	**(327)**	(195)
(Payments) for Intangible Assets	11.1	**(131)**	(205)
Net Cash Inflow/(Outflow) from Investing Activities		**(458)**	(400)
Net cash inflow/(outflow) before financing		**(1,781,903)**	(1,695,810)
Cash flows from financing activities			
Net Parliamentary Funding	3.4	1,781,948	1,695,799
Net Cash Inflow/(Outflow) from Financing Activities		**1,781,948**	1,695,799
Net increase/(decrease) in cash and cash equivalents		**45**	**(11)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**-**	**11**
Cash and Cash Equivalents (and Bank Overdraft) at year end		**45**	-

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of SHAs shall meet the accounting requirements of the SHA Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 SHAs 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 SHA 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 SHA for the purpose of giving a true and fair view has been selected. The particular policies adopted by the SHA are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

The SHA 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 SHA exercises in-year budgetary control over the other entity.

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

1.1 Accounting Conventions

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

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 SHA'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.

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.

- Due to current economic conditions indexation has not been applied to property, plant and equipment.
- Restructuring provisions relate to a restructuring of the SHA.
- Legal provisions have been calculated based on expert advice from solicitors which includes probability, estimated settlement and timing of cash flows.

1. Accounting policies (continued)

1.2 Revenue and Funding

The main source of funding for the SHA is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the SHA. 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 SHA. 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 Taxation

The SHA 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.

1.4 Administration and Programme Costs

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

For SHAs, 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.

1.5 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 SHA;
- 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.

1. Accounting policies (continued)

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.6 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the SHA'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 SHA; 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 amortised historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.7 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 SHA expects to obtain economic benefits or service potential from the asset. This is specific to the SHA 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 SHA checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

1. Accounting policies (continued)

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

1.8 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 SHA's cash management.

1.9 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 SHAs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.10 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 SHAs.

The NHSLA operates a risk pooling scheme under which the SHA pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The total value of clinical negligence provisions carried by the NHSLA on behalf of the SHA is disclosed at Note 17.

1.11 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1. Accounting policies (continued)

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 SHA commits itself to the retirement, regardless of the method of payment.

1.12 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.

1.13 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 SHA, 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 SHA. 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.

1.14 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 SHA 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 SHA's net operating cost.

1. Accounting policies (continued)

The SHA as lessee (continued)

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. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

1.15 Provisions

Provisions are recognised when the SHA has a present legal or constructive obligation as a result of a past event, it is probable that the SHA will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 1.8% in real terms (2.35% for employee early departure obligations).

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 SHA 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 SHA 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.

1.16 Financial Instruments

Financial assets

Financial assets are recognised when the SHA 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.

The SHA does not have any financial assets available for sale or held at fair value through profit and loss, nor does it have any held to maturity investments.

1. Accounting policies (continued)

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

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

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

Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the SHA 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.

The SHA does not have any financial liabilities held at fair value through profit and loss.

1. Accounting policies (continued)

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

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

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

1.18 Going Concern

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013,the London Strategic Health Authority (SHA) was dissolved on 1st April 2013. The SHA's functions, assets and liabilities transferred to other public sector entities as outlined in Note 22 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. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operations.

As a result, the Board of the London Strategic Health Authority have prepared these financial statements on a going concern basis.

2 Operating segments

The following information segments the results of the Authority by:

- NHS London Activities
- Multi Professional Education and Training Activities
- National Specialist Commissioning Group

	NHS London Administration		Multi Professional Education and Training Activities		National Specialist Commissioning Group		Total	
	2012/13 £000	2011/12 £000	**2012/13 £000**	2011/12 £000	**2012/13 £000**	2011/12 £000	**2012/13 £000**	2011/12 £000
Net operating expenditure	**75,627**	55,841	**1,159,271**	1,152,917	**542,793**	515,625	**1,777,691**	1,724,383
Surplus/(deficit)	**87,448**	219,169	**10,004**	34,065	**(15)**	2,438	**97,437**	255,672

NHS London also host the National Cancer Action Team and the National Ambulance Radio Programme, whose operating costs are included in the NHS London Administration costs, but are not considered material enough for separate disclosure.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012/13 £000	2011/12 £000
The SHA's performance for the year ended 2012/13 is as follows:		
Total Net Operating Cost for the Financial Year	**1,777,691**	1,724,383
Revenue Resource Limit	**1,875,128**	1,980,055
Under/(Over)spend Against Revenue Resource Limit (RRL)	**97,437**	255,672

3.2 Capital Resource Limit

	2012/13 £000	2011/12 £000
The SHA is required to keep within its Capital Resource Limit.		
Total Gross Capital Expenditure	**458**	400
Charge Against the Capital Resource Limit (CRL)	**458**	**400**
Capital Resource Limit (CRL)	**460**	550
(Over)/Underspend Against CRL	**2**	**150**

3.3 Cash Limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**1,781,948**	1,695,799
Cash Limit	**1,990,367**	1,792,338
Underspend Against Cash Limit	**208,419**	**96,539**

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

	2012-13 £000	2011-12 £000
Total cash received from DH (Gross)	1,781,948	1,695,799
Parliamentary funding credited to General Fund	**1,781,948**	**1,695,799**

4 Operating Revenue

	2012/13 Total £000	2012/13 Admin £000	2012/13 Programme £000	2011/12 £000
Fees & Charges	**15,227**	2,753	12,474	13,804
Recoveries in respect of employee benefits	**2,848**	2,812	36	1,687
Other	**-**	-	-	1,493
Total operating revenue	**18,075**	5,565	12,510	16,984
Investment Revenue	**-**	-	-	-
Total Operating and Investment Revenue	**18,075**	**5,565**	**12,510**	16,984

5.1 Operating costs (excluding employee benefits)

	2012/13 Total £000	2012/13 Admin £000	2012/13 Programme £000	2011/12 £000
Chair and Non-executive directors remuneration	**90**	90	-	102
Consultancy Services	**15,443**	11,131	4,312	11,671
Establishment expenses	**13,153**	10,678	2,475	10,632
Transport and moveable plant	**47**	47	-	42
Premises	**14,732**	11,832	2,900	10,151
Depreciation	**618**	618	-	493
Capital - Amortisation	**71**	71	-	39
Impairments and Reversals of Receivables	**26**	26	-	-
Auditors remuneration - audit fee - External Audit	**137**	137	-	213
Auditors remuneration - other fees	**6**	6	-	0
MPET	**1,112,780**	303	1,112,477	1,113,776
Other (see note)	**17,473**	13,768	3,705	12,841
Commissioning of Healthcare (London SHA)	**376,241**	-	376,241	359,995
High Cost Drugs (London SHA)	**167,492**	-	167,492	155,615
Total Operating Costs excl. Employee benefits	**1,718,309**	48,707	1,669,602	1,675,570

Note: Other above include support costs for the London Ambulance Service £3.5m, mobilisation costs for the Academic Health & Socialcare Network £1.5m, development costs for the London Health Improvement Board £2.2m, legal claims £1.0m, transition costs £1.4m, Trust Special Administrator costs £0.5m, End of Life Care costs £1.1m and National Cancer Intelligence Network costs £1.8m.

5.2 Gross Employee Benefits - excluding capitalised costs and income in respect of staff costs

	2012/13 Total £000	2012/13 Admin £000	2012/13 Programme £000	2011/12 £000
Employee Benefits (excluding officer board members)	**75,468**	51,875	23,593	63,811
SHA Officer Board members	**1,944**	1,944	-	1,929
Total Employee Benefits	**77,412**	53,819	23,593	65,740
TOTAL OPERATING COSTS	**1,795,721**	102,526	1,693,195	1,741,310

5.3 Running costs and public health expenditure

	2012/13 £000	2011/12 £000
Of the above: running costs	**90,445**	85,339
Total operating costs excl employee benefits: Public Health	**3,226**	1,372
Employee Benefits: Public Health	**2,016**	1,672
Total Public Health expenditure	**5,242**	3,044

5.3 Running costs and public health expenditure (continued)

Running Costs 2012/13	SHA & MPET	Public Health
Running costs (£000s)	90,445	3,242
Weighted population (number in units)	8,114,957	8,114,957
Running costs per head of population (£ per head)	**11.15**	**0.40**

Running Costs 2011/12	SHA & MPET	Public Health
	£000	£000
Running costs (£000s)	85,339	3,044
Weighted population (number in units)	7,892,474	7,892,474
Running costs per head of population (£ per head)	**10.81**	**0.39**

6. Operating Leases

NHS London's headquarters at Southside, Victoria in London are leased. The site comprised three leases for the mezannine, second and fourth floors of the Southside building. NHS London also holds leases for areas on the 16, 18th and 19th floors of Portland House, Victoria in London and Community House on Barking Rd, London. All the leases were transferred to NHS Property Services Limited on 1 April 2013 in accordance with Department of Health guidance.

6.1 SHA as lessee	Buildings £000	Other £000	2012/13 Total £000	2011/12 £000
Payments recognised as an expense				
Minimum lease payments	2,731		2,731	3,314
Contingent rents	0		-	-
Sub-lease payments	-		-	-
Total	2,731	-	2,731	3,314
Payable:				
No later than one year	2,706	-	2,706	3,114
Between one and five years	6,376	-	6,376	6,685
After five years	-	-	-	-
Total	9,082	-	9,082	9,799

7. Employee benefits and staff numbers

7.1 Employee benefits

	Total			Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits 2012/13 - gross expenditure									
Salaries and wages	**65,576**	43,340	22,236	**29,695**	29,053	642	**35,881**	14,287	21,594
Social security costs	**3,173**	3,173	-	**3,173**	3,173	-	**-**	-	-
Employer Contributions to NHS BSA - Pensions Division	**3,651**	3,651	-	**3,651**	3,651	-	**-**	-	-
Termination benefits	**5,012**	3,655	1,357	**3,692**	3,655	37	**1,320**	0	1,320
Total employee benefits	**77,412**	**53,819**	**23,593**	**40,211**	**39,532**	**679**	**37,201**	**14,287**	**22,914**
Less recoveries in respect of employee benefits (table below)	**(2,848)**	(2,812)	(36)	**(2,450)**	(2,450)	-	**(398)**	(362)	(36)
Total - Net Employee Benefits including capitalised costs	**74,564**	51,007	23,557	**37,761**	37,082	679	**36,803**	13,925	22,878
Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net Employee Benefits excluding capitalised costs	**77,412**	53,819	23,593	**40,211**	39,532	679	**37,201**	14,287	22,914

Employee Benefits 2012/13 - income	Total			Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Salaries and wages	**2,848**	2,812	36	**2,450**	2,450	0	**398**	362	36
Other Employment Benefits	**-**	-	-	**-**	-	-	**-**	-	-
Total excluding capitalised costs	**2,848**	**2,812**	**36**	**2,450**	**2,450**	**0**	**398**	**362**	**36**

7.1 Employee Benefits (continued)

Employee Benefits Prior Year

Employee Benefits Gross expenditure 2011/12	Total £000	Permanently employed £000	Other £000
Salaries and wages	**54,978**	30,897	24,081
Social security costs	**4,102**	3,014	1,088
Employer Contributions to NHS BSA - Pensions Division	**3,600**	3,600	-
Other pension costs	**1,716**	-	1,716
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**1,344**	561	783
Total employee benefits	**65,740**	38,072	27,668
Less recoveries in respect of employee benefits	**(1,687)**	(1,687)	-
Total - Net Employee Benefits including capitalised costs	**64,053**	36,385	27,668
Employee costs capitalised	**-**	-	-
Net Employee Benefits excluding capitalised costs	**65,740**	38,072	27,668

7.2 Staff Numbers

	2012/13			2011/12		
Average Staff Numbers	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Other	943	476	467	989	539	450
TOTAL	943	476	467	989	539	450
Of the above - staff engaged on capital projects	-	-	-	-	-	-

7.3 Staff Sickness absence and ill health retirements

	2012/13 Number	2011/12 Number
Total Days Lost	**2,806**	1,661
Total Staff Years	**540**	503
Average working Days Lost	**5.20**	3.30

[Note: this should be included in the SHA's annual report. Inclusion in accounts is optional]

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

7.4 Exit Packages agreed during 2012/13

	2012/13			2011/12		
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	**17**	-	**17**	15	-	**15**
£10,001-£25,000	**13**	-	**13**	20	-	**20**
£25,001-£50,000	**7**	-	**7**	2	-	**2**
£50,001-£100,000	**2**	-	**2**	3	-	**3**
£100,001 - £150,000	**5**	-	**5**	2	-	**2**
£150,001 - £200,000	**5**	-	**5**	0	-	**0**
>£200,000	**9**	-	**9**	2	-	**2**
Total number of exit packages by type (total cost)	**58**	**-**	**58**	**44**	**-**	**44**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	5,011	-	**5,011**	1,370	-	1,370

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the SHA has agreed early retirements, the additional costs are met by the SHA 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.

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	**20,513**	**347,260**	16,089	302,333
Total Non-NHS Trade Invoices Paid Within Target	**19,058**	**328,789**	15,436	293,307
Percentage of NHS Trade Invoices Paid Within Target	**92.9%**	**94.7%**	95.9%	97.0%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**9,357**	**1,472,529**	8,980	1,405,675
Total NHS Trade Invoices Paid Within Target	**8,599**	**1,380,790**	8,231	1,343,031
Percentage of NHS Trade Invoices Paid Within Target	**91.9%**	**93.8%**	91.7%	95.5%

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

9. Finance Costs

	2012/13 Total £000	2012/13 Admin £000	2012/13 Programme £000	2011/12 Total £000
Interest				
Other finance costs	-	-	-	-
Provisions - unwinding of discount	**45**	-	**45**	57
Total	**45**	-	**45**	57

10.1 Property, plant and equipment

2012/13	Information technology	Furniture & fittings	Total
	£000	£000	£000
Cost or valuation:			
At 1 April 2012	1,794	2,144	**3,938**
Additions Purchased	275	52	**327**
Disposals other than for sale	-	-	**-**
At 31 March 2013	**2,069**	**2,196**	**4,265**
Depreciation			
At 1 April 2012	1,390	1,121	**2,511**
Disposals other than for sale	-	-	**-**
Charged During the Year	167	451	**618**
At 31 March 2013	**1,557**	**1,572**	**3,129**
Net Book Value at 31 March 2013	512	624	1,136
Asset financing:			
Owned	512	624	**1,136**
Held on finance lease	-	-	**-**
Total at 31 March 2013	**512**	**624**	**1,136**

The assets shown above were transferred on 1 April 2013 to various receiving organisations in accordance with the requirements of the Department of Health.

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology	Furniture & fittings	Total
	£000	£000	£000
At 1 April 2012	-	48	**48**
Movements	-	(48)	**(48)**
At 31 March 2013	**-**	**-**	**-**

10.2 Property, plant and equipment

2011/12	Information technology	Furniture & fittings	**Total**
	£000	£000	**£000**
Cost or valuation:			
At 1 April 2011	1,599	2,144	**3,743**
Additions - purchased	195	-	**195**
Disposals other than by sale	-	-	**-**
At 31 March 2012	**1,794**	**2,144**	**3,938**
Depreciation			
At 1 April 2011	1,116	902	**2,018**
Disposals other than for sale	-	-	**-**
Charged During the Year	274	219	**493**
At 31 March 2012	**1,390**	**1,121**	**2,511**
Net book value	**404**	**1,023**	**1,427**
Asset financing:			
Owned	404	1,023	**1,427**
Held on finance lease	-	-	**-**
Total at 31 March 2012	**404**	**1,023**	**1,427**

11.1 Intangible non-current assets

2012/13	Software purchased £000	Total £000
At 1 April 2012	**499**	**499**
Additions - purchased	131	131
Disposals other than for sale	-	-
At 31 March 2013	**630**	**630**
Amortisation		
At 1 April 2012	**274**	**274**
Disposals other than for sale	-	-
Charged during the Year	71	71
At 31 March 2013	**345**	**345**
Net Book Value at 31 March 2013	**285**	**285**

The assets shown above were transferred on 1 April 2013 to various receiving organisations in accordance with the requirements of the Department of Health.

11.2 Intangible non-current assets

2011/12	Software purchased £000	Total £000
Cost or valuation:		
At 1 April 2011	294	**294**
Additions - purchased	205	**205**
Disposals other than by sale	-	**-**
At 31 March 2012	**499**	**499**
Amortisation		
At 1 April 2011	235	**235**
Disposals other than by sale	-	**-**
Charged during the year	39	**39**
At 31 March 2012	**274**	**274**
Net book value at 31 March 2012	**225**	**225**

12 Intra-Government and other balances

2012/13	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other Central Government Bodies	2,991	-	2,412	-
Balances with NHS bodies outside the Departmental Group	-	-	15	-
Balances with NHS Trusts and Foundation Trusts	3,306	-	32,085	-
Balances with bodies external to government	7,963	-	26,051	-
At 31 March 2013	**14,260**	**-**	**60,563**	**-**
2011/12				
Balances with other Central Government Bodies	1,448	-	9,274	-
Balances with NHS Trusts and Foundation Trusts	4,110	-	25,632	-
Balances with bodies external to government	5,259	-	27,027	-
At 31 March 2012	**10,817**	**-**	**61,933**	**-**

13.1 Trade and other receivables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS Receivables - Revenue	**4,675**	5,243
NHS Prepayments and Accrued Income	**1,622**	315
Non NHS Trade Receivables - Revenue	**1,107**	1,780
Non-NHS Prepayments and Accrued Income	**3,754**	906
Provision for Impairments of Receivables	**(26)**	-
VAT	**3,080**	2,504
Other receivables	**48**	69
Total	**14,260**	10,817

13.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**179**	12
By three to six months	**19**	818
By more than six months	**0**	39
Total	**198**	869

13.3 Provision for impairment of receivables

	31 March 2013 £000	31 March 2012 £000
Balance at 1 April 2012	**-**	-
Amount written off during the year	**-**	-
Amount recovered during the year	**-**	-
(Increase)/decrease in receivables impaired	**(26)**	-
Balance at 31 March 2013	**(26)**	-

14 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	-	11
Net change in year	45	(11)
Closing balance	45	-
Made up of		
Cash with Government Banking Service	45	-
Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position and statement of cash flows	45	-

15 Trade and other payables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS Payables - Revenue	15,520	30,499
NHS Accruals and Deferred Income	18,992	3,428
Non-NHS Trade Payables - Revenue	9,983	6,114
Non-NHS Accruals and Deferred Income	11,377	20,424
Social Security Costs	18	410
VAT	-	-
Tax	712	539
Other	3,961	519
Total	60,563	61,933

16 Deferred income

	Current	
	31 March 2013 £000	31 March 2012 £000
Opening balance at 1 April 2012	1,322	-
Deferred income addition	-	1,322
Transfer of deferred income	(1,322)	-
Deferred Income at 31 March 2013	0	1,322

17 Provisions

	Total	Legal Claims	Restructuring	Other
	£000	£000	£000	£000
Balance at 1 April 2012	**2,389**	1,538	318	533
Arising During the Year	**2,372**	1,610	517	245
Utilised During the Year	**(1,553)**	(1,207)	(10)	(336)
Reversed Unused	**(494)**	(179)	(315)	-
Unwinding of Discount	**45**	28	6	11
Balance at 31 March 2013	**2,759**	**1,790**	**516**	**453**
Expected Timing of Cash Flows:				
No Later than One Year	**2,759**	1,790	516.00	453.00
Later than One Year and not later than Five Years	**-**	-	-	-
Later than Five Years	**-**	-	-	-
	2,759	**1,790**	**516**	**453**

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

As at 31 March 2013	£144,939
As at 31 March 2012	£143,000

18 Contingencies	**31 March 2013**	31 March 2012
	£000	**£000**
Contingent liabilities		
Litigation	**3,981**	-
Amounts Recoverable Against Contingent Liabilities	**-**	-
Net Value of Contingent Liabilities	**3,981**	**-**

The contingent liabilities relate to possible medical litigation cases (£3,947k) and trainee doctor litigation cases (£34k).

19 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 SHA 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 SHA's expected purchase and usage requirements and the SHA is therefore exposed to little credit, liquidity or market list.

Currency risk

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

Interest rate risk

SHAs are not permitted to borrow. The SHA therefore has low exposure to interest-rate fluctuations.

Credit Risk

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

Liquidity Risk

The SHA 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 SHA is not, therefore, exposed to significant liquidity risks.

19.1 Financial Assets	Receivables	Total
	£000	£000
Receivables - NHS	4,675	**4,675**
Receivables - non-NHS	1,081	**1,081**
Cash at bank and in hand	45	**45**
Other financial assets	48	**48**
Total at 31 March 2013	**5,849**	**5,849**
Receivables - NHS	5,243	5,243
Receivables - non-NHS	1,780	1,780
Cash at bank and in hand	-	-
Total at 31 March 2012	7,023	7,023

19.2 Financial Liabilities	Payables	Total
	£000	£000
NHS payables	15,520	**15,520**
Non-NHS payables	13,937	**13,937**
Total at 31 March 2013	**29,457**	**29,457**
NHS payables	30,499	30,499
Non-NHS payables	14,785	14,785
Total at 31 March 2012	45,284	45,284

20 Related party transactions

Details of transactions with counterparties related to the individuals below are as follows:

		Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£000	£000	£000	£000
Michael Spyer Non-Executive Director	Interim Chair at Croydon PCT.	2,603	-	7	74
Michael Bell Non-Executive Director	Interim Chair at Croydon Healthcare NHS Trust.	8,544	-	56	-
Trish Morris-Thompson Executive Director	Honorary contract (clinical) at Kingston NHS Trust.	8,306	-	22	-
	Prof Matt Thompson (husband) is Professor of Vascular Surgery at St George's Hospital	47,005	-	116	42
	Prof Matt Thompson (husband) is Trauma and Cardiovascular Clinical Director of London Health Programme.	3,513	-	55	96
Sara Coles Associate Member	Interim Chief Operating Officer at Croydon Healthcare NHS Trust.	8,544	-	56	-
	Peter Coles (husband) was Senior Responsible Officer, Epsom and St Helier Hospitals through Peter Coles Consulting Ltd.	124	-	-	-
	Peter Coles (husband) was Senior Responsible Officer, North West London Hospitals through Peter Coles Consulting Ltd.	124	-	-	-
	Peter Coles (husband) currently works as Delivery Director at North Central and North East London PCT cluster.	20,703	75	517	504
Jane Ramsey Associate Member	Non-Executive Director of University College London Hospitals.	69,597	2	1,594	26
	Non-Executive Director, Audit Committee at Department of Health.	377	9	45	565
Peter Brazel - Head of Strategic Investment	Unpaid advisor - Parkhill Audit and Consultancy Services CIC	283	0	7	0
Azara Mukhtar - Deputy Director of Finance & Investment	Interim Director of Finance & Information at Croydon Health Services NHS Trust	8,544	-	56	-

20 Related party transactions (continued)

The Department of Health is regarded as a related party. During 2012/13 the SHA 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:

NHS Foundation Trusts	Expenditure £000	Income £000	Payables £000	Receivables £000
Birmingham And Solihull Mental Health NHS Foundation Trust	6,772	-	1,864	-
Birmingham Childrens Hospital NHS Foundation Trust	17,761	-	459	-
Cambridge Univ Hosp NHS Foundation Trust	29,737	-	1,755	-
Camden And Islington NHS Foundation Trust	19,916	1	26	-
Central And North West London MH NHS Foundation Trust	12,250	5	96	-
Central Manchester University Hospitals NHS Foundation Trust	26,714	-	1,382	-
Chelsea And Westminster Hospital NHS Foundation Trust	25,826	1	73	26
East London NHS Foundation Trust	7,243	-	6	-
Great Ormond Street Hospital for Children NHS Foundation Trust	54,708	-	3,065	757
Guys And St Thomas NHS Foundation Trust	90,405	750	837	159
Hampshire Hospitals NHS Foundation Trust	9,419	-	-	66
Homerton University Hospital NHS Foundation Trust	11,977	-	46	-
Kings College Hospital NHS Foundation Trust	82,782	-	1,255	26
Newcastle Upon Tyne Hospitals NHS Foundation Trust	26,928	-	43	-
North East London NHS Foundation Trust	5,087	4	38	3
Northumberland, Tyne And Wear NHS Foundation Trust	7,118	-	1,335	-
Papworth Hospital NHS Foundation Trust	18,362	-	-	-
Royal Brompton And Harefield NHS Foundation Trust	23,697	-	10	26
Royal Free London NHS Foundation Trust	77,694	1	2,581	88
Royal Orthopaedic Hospital NHS Foundation Trust	6,102	-	-	-
Salford Royal NHS Foundation Trust	40,107	-	2,740	-
South London And Maudsley NHS Foundation Trust	12,782	-	5	-
Southern Health NHS Foundation Trust	6,379	-	-	-
Tavistock And Portman NHS Foundation Trust	14,172	-	18	-
The Hillingdon Hospital NHS Foundation Trust	6,979	-	86	-
The Royal Marsden Hospital NHS Foundation Trust	7,401	1	44	26
University College London NHS Foundation Trust	69,597	2	1,594	26
University Hospital Birmingham NHS Foundation Trust	24,379	-	717	-
University Hospital Of South Manchester NHS Foundation Trust	16,065	-	-	40

English NHS Trusts	Expenditure £000	Income £000	Payables £000	Receivables £000
Barking, Havering And Redbridge University Hospitals NHS Trust	13,701	-	26	-
Barnet And Chase Farm Hospitals NHS Trust	11,703	29	8	-
Barts Health NHS Trust	95,285	1	702	126
Croydon Health Services NHS Trust	8,544	-	56	-
Ealing Hospital NHS Trust	8,187	-	-	24
Epsom And St Helier University Hospitals NHS Trust	14,655	1	5	9
Imperial College Healthcare NHS Trust	70,120	-	534	37
Kingston Hospital NHS Trust	8,306	-	22	-
Leeds Teaching Hospitals NHS Trust	37,678	-	2,171	-
North Middlesex University Hospital NHS Trust	6,767	3	5	-
North West London Hospitals NHS Trust	27,289	-	682	-
Oxford University Hospitals NHS Trust	12,340	-	155	-
South London Healthcare NHS Trust	14,882	1	295	-
South West London And St Georges Mental Health NHS Trust	13,374	-	28	-
St Georges Healthcare NHS Trust	47,005	-	116	42
The Lewisham Healthcare NHS Trust	12,117	1	18	1
The Royal National Orthopaedic Hospital NHS Trust	7,520	-	174	147
University Hospitals Of Leicester NHS Trust	8,076	-	2,291	555
West London Mental Health NHS Trust	8,363	-	198	-
West Middlesex University NHS Trust	7,882	-	56	-
Whittington Hospital NHS Trust	17,418	-	65	-

20 Related party transactions (continued)

Other Bodies	Expenditure £000	Income £000	Payables £000	Receivables £000
NHS Business Services Authority (incl NHS Supply Chain)	104,458	-	175	65

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

22 Events after the end of the reporting period

The Department of Health has made arrangements for the transfer of balances (assets/liabilities/contractual commitments) from The London Strategic Health Authority to successor bodies at their recognised carrying value such that there will be no profit or loss arising from this transfer. The London Strategic Health Authority 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 The London Strategic Health Authority will be transferred to successor bodies that form part of the NHS controlled by the Department of Health.

The key functions transferring to successor bodies from 1 April 2013 include the commissioning of highly specialised clinical services, the provision of ambulance radio communications across England and Wales, the development of cancer services strategy, the provision of education and training of healthcare professionals, the provision of employment services and leadership training, and oversight of Primary Care Trusts and Provider Trusts in the London region.