Department of Health

NHS

Richmond and Twickenham Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

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Richmond and Twickenham Primary Care Trust

2012-13 Annual Report

NHS

South West London

NHS Richmond
Annual Report 2012/13

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Section 1
Welcome

1. Welcome

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

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

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

This year has seen the formal handover from PCTs to the new commissioning bodies, Clinical Commissioning Groups (CCGs). The CCGs will take on most commissioning functions from PCTs and manage the majority of the NHS budget. This means that GPs will be leading the planning and organising of local health services. We are pleased to report that Richmond CCG became a fully authorised clinical commissioning group in February 2013.

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

2. Welcome from Richmond Borough Team

We would like to add our welcome to that of the Chair and Chief Executive of NHS South West London.

Despite the challenges imposed on us as a result of the Health and Social Care Act 2012 and gearing up to take on commissioning as a Clinical Commissioning Group we as a team have risen to the challenges with the success of authorisation. We are pleased and proud of the many achievements we have delivered in Richmond during 2012-13.

NHS Richmond exists to support the local community and, while our structure is changing, this commitment is not. We will continue to deliver the best possible health services for people in Richmond both now and in the future. Richmond is a CCG that is able to call upon many natural community advantages such as a relatively well educated, involved and affluent population whose health is generally very good. As a CCG we have inherited a strong legacy of performance from the PCT but our ambition must be to take this already good position and make Richmond one of the best CCGs in England as measured by improvements in health outcomes for all of our residents and service quality of our commissioned services.

Alongside managing an unprecedented period of change, a great deal of work has taken place in Richmond and across South West London during the last year to develop and improve health and healthcare services. A range of prevention, intervention and early detection programmes are offered to help people improve and maintain their health, including:

- Addressing inequalities – especially among older residents with long-term health conditions
- Stop smoking programmes
- Alcohol and substance abuse programmes
- Cancer screening for bowel, breast and cervical cancers
- Tackling childhood obesity
- Increasing paediatric immunisation uptake
- Programmes to promote sexual health, including chlamydia screening
- NHS Health Check
- Caring for Carers

Notable achievements in 2012 included:

- The successful opening of state-of-the art Whitton Health and Social Care Centre which provides local residents with access to an integrated range of GP, social services, mental health and other primary care services under one roof.
- The provision by Hounslow and Richmond Community Healthcare NHS Trust of clinical specialist physiotherapy triage for all orthopaedic and rheumatology referrals through the Richmond Clinical Assessment Service. This launched in May 2012 and, where appropriate, specialist treatment will be provided in a community setting.
- The NHS new 111 service that will provide local residents with 24-7 access to urgent care, including out-of-hours GP visits.

In 2013-14 we will continue in our commitment to provide local residents with local care as a Clinical Commissioing Group, our main aims for the year are:

- Work with our member practices to invest in and deliver Improvements in access for patients to primary care services
- Help our patients with long term conditions to remain independent and well cared for locally without the need for unplanned hosptial care
- Finish rolling out the improvements in our primary mental health care services that commenced during the last year
- Continue to put in place improved assessment and services for people with learning difficulties

- To ensure we have the right processes and feedback opportunities in place to ensure that we work in partnership with our patients, local population, and other partners to commission and maintain access to quality services for our registered population
- Continue to foster strong collaborative working arrangements with the London Borough of Richmond, the voluntary sector, hospitals, neighbouring CCGs and others as we recognise that to commission great services for our patients we need to work closely together

In most areas related to public health we are pleased to report that we met or exceeded our performance targets in 2012-13. .

One of our priorities in 2013-14 is to continue to commission better healthcare services at better value in order to meet the health needs and priorities of local Richmond residents that were identified in our Joint Strategic Needs Assessment:

- Give children a good start
- Integrate health and social care to increase independence and manage patients with long-term conditions out-of-hospital
- Adopt a systematic approach to prevention and self-care
- Look out for hidden risks and harms and be ready to address them when they have been identified

Greater detail on this year's achievements and our future priorities are provided in later sections of this year's report.

We would like to take this opportunity to thank Richmond's Strategic Partners for the progress they have made in improving services for local people and addressing the financial challenges we have faced. In particular our thanks goes to the London Borough Richmond-upon-Thames and our NHS partners, including Richmond's GPs and Hounslow and Richmond Community Healthcare NHS Trust.

We are aware that the successful advancements and enhancements we have achieved during the year would not have been possible without the dedication of our staff, good working relationships with our partners and the views, feedback and comments of the local community. On behalf of the Board we would like to thank each of you for helping to contribute to a local NHS of which we can all be very proud. We are sad that this is the final report as a PCT but look forward to the future as a Clinical Commissioning Group. We have the skills, confidence and capability needed to shoulder our health and financial responsibilities and serve the people of Richmond from April 2013

Dominic Wright Borough Managing Director

2.1. How the NHS in Richmond has changed

In April 2012 the local emerging Clinical Commissioning Group (CCG) in Richmond took delegated authority for the delivery of health services in line with the Health and Social Care bill. The CCG developed during the course of the year and were successfully authorised by the NHS Commissioning Board to become a statutory body on 1 April 2013.

The individual PCTs remained as statutory organisations, but NHS South West London continued to operate as one management team, sharing resources, roles and functions.

As part of this arrangement, all five PCT Boards met together as the Joint Boards of South West London Primary Care Trusts, which included NHS Richmond Board.

Section 3
Who we are and what we do

3. Who we are and what we do

NHS Richmond is responsible for improving the health of the people of Richmond, through the planning and funding of health services. We do this with a wide range of partners including local NHS Trusts, GPs and other primary care providers, our staff, London Borough of Richmond upon Thames, voluntary organisations and groups representing patients and the public.

Health services in Richmond have been through a year of transition. Richmond PCT has spent the year devolving commissioning responsibility to Richmond CCG, who became fully authorised in February 2013 and from 1 April 2013 will take on the role of commissioning local health services.

Richmond CCG is made up of 30 GP practices serving over 199,000 people across the borough. Working alongside health practitioners from nursing, pharmacy and secondary care and will formally take responsibility for commissioning hospital, community and mental health services for local people from April 2013, overseeing a budget of approximately £220 million. It has been operating in shadow form since April 2012.

Richmond CCG covers the London Borough of Richmond upon Thames (LBRuT) area and is working to redress inequalities and ensure that high quality healthcare services are commissioned on behalf of the local population to improve patient outcomes and experiences in the most cost effective ways.

The borough of Richmond is relatively diverse when compared with England and Wales with a population of approximately 191,000. Overall, Richmond is healthy and safe with low levels of crime, lots of green spaces, good schools and high levels of volunteering.

While Richmond benefits on the whole from good health and wellbeing, there are still a significant proportion of the population who make lifestyle choices that put their health at risk, i.e. who smoke, drink alcohol to excess, engage in risky sexual behaviour, misuse substances, eat unhealthy foods and don't engage in physical activity. Childhood immunisation coverage is below herd immunity and recently measles cases were rising. A high proportion (51%) aged 75 and over live alone compared with 35% London-wide.

3.1. How we spent your money

You will find a complete breakdown of how your money is spent in the section 'How we spent your money'.

Financial Summary

NHS Richmond achieved its statutory financial targets for 2012/13 and continued to demonstrate strong financial management and effective use of resources throughout the year.

- **Income and Expenditure Target**

  The PCT has a statutory duty to break even on income and expenditure. In 2012/13 the PCT was however required to make a surplus of £6,023k. With the agreement of NHS London this was increased reflecting financial pressures across South West London and the PCT achieved a surplus of £9,058k against a revenue resource limit of £300 million.

- **Capital Resource Limit**

  The PCT achieved a £563k underspend against a Capital Resource Limit of £6,941k.

- **Cash Target**

  The cash limit for the PCT was £292,764k and this was achieved.

Developments in 2012/13

- **Healthcare Investments**

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

Better Payment Practice Code

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

Value for Money

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

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

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

External Auditors

The Trusts accounts are externally audited by Grant Thornton to provide assurance to the PCT stakeholders. An opinion is given as to whether the accounts represent a true and fair

view, ensure that governance arrangements are adequate and that adequate arrangements are in place to provide economy, efficiency and effectiveness in use of resources.

The full auditors' opinion regarding the Trust Accounts is included in this Annual Report and concludes that the financial statements provide a true and fair view of the Trust's position.

The total fees paid to the external auditors, Grant Thornton, during 2012/13 was £80k.

Summary Financial Statements

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

Carl Vincent
Director of Provider Finance & Transition
Department of Health

4 June 2013

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF RICHMOND & TWICKENHAM PRIMARY CARE TRUST

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

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

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

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

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

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

Opinion

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

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

Annual Accounts - Summary Financial Statements –Table 1

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	**4,669**	3,791
Other costs	5.1	**296,477**	283,063
Income	4	**(10,612)**	(7,941)
Net operating costs before interest		**290,534**	278,913
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**419**	0
Net operating costs for the financial year		**290,953**	278,913
Transfers by absorption -(gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**290,953**	**278,913**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**4,612**	3,759
Other costs	5.1	**7,773**	5,744
Income	4	**(1,287)**	(415)
Net administration costs before interest		**11,098**	**9,088**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**419**	0
Net administration costs for the financial year		**11,517**	**9,088**
Programme Expenditure			
Gross employee benefits	7.1	**57**	32
Other costs	5.1	**288,704**	277,319
Income	4	**(9,325)**	(7,526)
Net programme expenditure before interest		**279,436**	**269,825**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net programme expenditure for the financial year		**279,436**	**269,825**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**712**	749
Net (gain) on revaluation of property, plant & equipment	**(590)**	(112)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**291,075**	**279,550**

Summary Financial Statements – Table 2

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**28,446**	23,399
Intangible assets	13	**12**	9
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**110**	0
Total non-current assets		**28,568**	23,408
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**1,655**	1,875
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**2,586**	1
Total current assets		**4,241**	1,876
Non-current assets held for sale	24	**0**	0
Total current assets		**4,241**	1,876
Total assets		**32,809**	25,284
Current liabilities			
Trade and other payables	25	**(18,247)**	(21,196)
Other liabilities	26,28	**0**	0
Provisions	32	**(1,890)**	(1,100)
Borrowings	27	**(7)**	0
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(20,144)**	(22,296)
Non-current assets plus/less net current assets/liabilities		**12,665**	2,988
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(4,052)	(919)
Borrowings	27	(4,855)	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(8,907)**	(919)
Total Assets Employed:		**3,758**	2,069
Financed by taxpayers' equity:			
General fund		(3,034)	(4,845)
Revaluation reserve		6,792	6,914
Other reserves		0	0
Total taxpayers' equity:		**3,758**	2,069

Summary Financial Statements – Table 3

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(4,845)**	**6,914**	**0**	**2,069**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(290,953)			**(290,953)**
Net gain on revaluation of property, plant, equipment		590		**590**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(712)		**(712)**
Movements in other reserves			0	**0**
Transfers between reserves*	0	0		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(290,953)**	**(122)**	**0**	**(291,075)**
Net Parliamentary funding	292,764			**292,764**
Balance at 31 March 2013	**(3,034)**	**6,792**	**0**	**3,758**

Balance at 1 April 2011	**-7786**	**7551**	**0**	**(235)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(278,913)			(278,913)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		112		112
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		(749)		(749)
Movements in other reserves			0	0
Transfers between reserves*	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(278,913)	(637)	0	(279,550)
Net Parliamentary funding	281,854			281,854
Balance at 31 March 2012	**(4,845)**	**6,914**	**0**	**2,069**

Summary Financial Statements – Table 4

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(290,534)**	(278,913)
Depreciation and Amortisation		**972**	996
Impairments and Reversals		**234**	0
Other Gains / (Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**0**	0
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**0**	0
(Increase)/Decrease in Trade and Other Receivables		**110**	871
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(2,608)**	(4,335)
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(58)**	(554)
Increase/(Decrease) in Provisions		**3,981**	610
Net Cash Inflow/(Outflow) from Operating Activities		**(287,903)**	**(281,325)**
Cash flows from investing activities			
Interest Received		**0**	0
(Payments) for Property, Plant and Equipment		**(1,842)**	(519)
(Payments) for Intangible Assets		**(7)**	(20)
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**(8)**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	4
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(1,857)**	**(535)**
Net cash inflow/(outflow) before financing		**(289,760)**	**(281,860)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(419)**	0
Net Parliamentary Funding		**292,764**	281,854
Capital Receipts Surrendered		**0**	0
Capital grants and other capital receipts		**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**292,345**	**281,854**
Net increase/(decrease) in cash and cash equivalents		**(289,760)**	**(281,860)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**0**	**0**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**(289,760)**	**(281,860)**

Audit Committee

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

The Director of Finance of the PCT, the head of the PCT's Counter Fraud team, representatives of the PCT's Internal Audit function (RSM Tenon and Parkhill) and representatives of the external auditors (Grant Thornton) also attend the Audit Committee.

Staff Sickness Absence

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

	2012-13 Number	2011-12 Number
Total Days Lost	437	269
Total Staff Years	42	51
Average Working Days Lost	10.40	5.28

Remuneration Committee

The Remuneration Committee comprises one non-executive director from each PCT in the Cluster, from whom a Chair is appointed; the Chief Executive also attends in an advisory capacity.

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

Remuneration Policy

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

The main components of the Chief Executive's, Executive Directors' and senior officers' remuneration are set out below.

Basic Salary

The remuneration of the PCT's Chief Executive and Directors is set annually by the Very Senior Managers Pay Framework. The Framework is available to the general public on the Department of Health website and was last updated in July 2007. The reward package set by the Very Senior Management Pay Framework is as follows:

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

Incentive Arrangements

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

As part of the VSM pay arrangements the Chief Executive and Directors are eligible to be considered for a performance related bonus scheme.

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

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

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

Level of Awards

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

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

The overall performance of Non Executive Directors and the Chief Executive is appraised by the Chair. This appraisal is reviewed by the Directors of NHS London. The performance of PCT Executive Directors is appraised by the Chief Executive and the performance of the PCT Chair is managed by the Chair of NHS London.

NHS Pension Entitlement

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

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

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

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

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

Service Contracts

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

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

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

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

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

None of the service contracts for Directors or Senior Managers make any provision for compensation outside of the national pay and remuneration guidelines or NHS Pension Scheme Regulations.

Termination arrangements

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

Non Executive Directors

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

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

Non Executive Directors do not receive pensionable remuneration and therefore are not eligible to join the NHS Pension Scheme.

The Non Executive appointments became effective on the following dates:

Non Executive Director	Role	Contract Date	Leave date
Sian Bates	Chair	01/04/2011	31/03/2013
Paul Gallagher	Audit Committee Chair	01/04/2011	31/03/2013
John Simpson	Non Executive Director	01/04/2011	31/03/2013
Charles Humphry	Non Executive Director	01/04/2011	31/03/2013
Stephen Hickey	Partner Non Executive Director	01/04/2011	31/03/2013
Godfrey Allen	Partner Non Executive Director	01/04/2011	31/03/2013

Godfrey Allen ceased to be a voting member of the Board upon his appointment as a Non Executive Director of Corydon University Hospitals NHS Trust in January 2013. He remained an Associate Non Executive Director until 31 March 2013.

Expenses and Benefits in kind – Unaudited

Benefits in kind relate to travel allowances payable in accordance with Agenda for Change NHS Terms & Conditions and reimbursement for telephone expenses.

All expense claims are approved by either the Chair or the Chief Executive.

Directors' and Senior Managers' salaries and allowances							
		2012/13			2011/12		
NAME AND TITLE		Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (to the nearest £100)	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (to the nearest £100)
	Note	£000	£000	£	£000	£000	£
Chair and Non Executive							
Sian Bates (Chair)	1	-	5-10	-	-	5-10	-
Paul Gallagher (Audit Committee Chair)	2	-	0-5	-	-	0-5	-
John Simpson (Non Executive)		-	10-15	-	-	10-15	-
Charles Humphry (Non Executive)		-	10-15	-	-	5-10	-
Stephen Hickey (Partner Non Executive)	3	-	-	-	-	-	-
Godfrey Allen (Partner Non Executive)	3	-	-	-	-	-	-
Executive Directors							
Ann Radmore (Chief Executive - to 06/01/13)	4	15-20	-	-	15-20	-	-
Christina Craig (Interim Chief Executive - from 07/01/13)	5	0-5	-	-	-	-	-
Jill Robinson (Director of Finance)	6	15-20	-	-	10-15	-	-
Dr Dagmar Zeuner (Director of Public Health)		95-100	-	-	95-100	-	-
Dr Marilyn Plant (Chair of the Professional Executive Committee)		45-50	-	-	45-50	-	-
Sarah Timms (Director of Nursing - from 29/06/11 to 15/12/11)		N/A	-	-	0-5	-	-
Debbie Stubberfield (Director of Nursing - from 01/02/12)	7	10-15	-	-	0-5	-	-
Senior Managers							
Dominic Wright (Borough Managing Director)		95-100	-	-	90-95	-	-
Bill Gillespie (Director of Strategy and Performance - to 19/02/12)		N/A	-	-	15-20	-	-
Dominic Conlin (Managing Director ACU - to 31/12/11)		N/A	-	-	10-15	-	-
Dr Jonathan Hildebrand (Cluster Director of Public Health)	8	5-10	-	-	0-5	-	-
Dr David Finch (Joint Medical Director)	9	5-10	-	-	5-10	-	-
Dr Howard Freeman (Joint Medical Director)	10	5-10	-	-	5-10	-	-
Charlotte Gawne (Director of Communications)	11	10-15	-	-	10-15	-	-
Jacqui Harvey (Director of Transition)	12	20-25	-	-	20-25	-	-
Jocelyn Fisher (Director of Human Resources, OD and Workforce)	13	15-20	-	-	20-25	-	-
Paula Swann (Director of Financial Management)	14	0-5	-	-	5-10	-	-
Neil Ferrelly (Director of Strategic Financial Planning - to 14/08/11)		N/A	-	-	0-5	-	-
Hardev Virdee (Director of Strategic Financial Planning - from 02/01/12 to 30/06/12)	15	0-5	-	-	0-5	-	-
Neil Roberts (Director of Primary Care Contracting)	16	10-15	-	-	10-15	-	-

Notes

1.	Sian Bates was also Chair of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £40,000 - £45,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
2.	Paul Gallagher was also Audit Committee Chair of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £10,000 - £15,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
3.	Stephen Hickey and Godfrey Allen were also non-executive directors of Wandsworth PCT. Their remuneration is shown in the Annual Report of Wandsworth PCT.
4.	Ann Radmore was also Chief Executive of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. She was appointed Chief Executive of London Ambulance Service NHS Trust with effect from 7 January 2013, but remained Accountable Officer for all five PCTs. The full value of her salary and allowances was in the range £120,000 - £125,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
5.	Christina Craig was also Interim Chief Executive of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £25,000 - £30,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
6.	Jill Robinson was also Director of Finance of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £125,000 - £130,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
7.	Debbie Stubberfield was also Director of Nursing of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £95,000 - £100,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
8.	Dr Jonathan Hildebrand also supported Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £130,000 - £135,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
9.	Dr David Finch was also the Joint Medical Director of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £65,000 - £70,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
10.	Dr Howard Freeman was also the Joint Medical Director of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £65,000 - £70,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
11.	Charlotte Gawne was also Director of Communications of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £85,000 - £90,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
12.	Jacqui Harvey was also Director of Transition of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The payments disclosed represent fees paid to AML Management Ltd and Verdedus in respect of her services. The total cost of her services was in the range £165,000 - £170,000 and has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
13.	Jocelyn Fisher was also Director of Human Resources, OD and Workforce of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The payments disclosed include fees paid to Employee Relations Solutions Limited in respect of her services for the period 1 April to 13 May 2012. The total of her remuneration and service fees was in the range £120,000 - £125,000 and has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
14.	Paula Swann was also Director of Financial Management of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £15,000 - £20,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
15.	Hardev Virdee was also Director of Strategic Financial Planning of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £25,000 - £30,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
16.	Neil Roberts was also Director of Primary Care Contracting of Croydon, Kingston, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £85,000 - £90,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

Directors' and Senior Managers' pension benefits								
NAME AND TITLE	Note	Real increase in pension at age 60 (bands of £2,500)	Real Increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 at 31 March 2012 (bands of £5,000)	Cash equivalent transfer value at 31 March 2012	Cash equivalent transfer value at 31 March 2011	Real increase in cash equiv transfer value funded by employer
		£000	£000	£000	£000	£000	£000	£000
Executive Directors								
Ann Radmore (Chief Executive)	5	0-2.5	0-2.5	5-10	20-25	141	126	5
Christina Craig (Interim Chief Executive)	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jill Robinson (Director of Finance)	7	0-2.5	0	0-5	0	14	10	2
Dr Dagmar Zeuner (Director of Public Health)		0-(2.5)	0-(2.5)	25-30	80-85	544	505	8
Dr Marilyn Plant (Chair of the Professional Executive Committee)	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debbie Stubberfield (Director of Nursing)	9	0-(2.5)	0-(2.5)	5-10	15-20	112	N/A	N/A
Senior Managers								
Dominic Wright (Borough Managing Director)		2.5-5	7.5-10	30-35	95-100	572	475	42
Dr Jonathan Hildebrand (Cluster Director of Public Health)	10	0-2.5	0-2.5	0-5	0-5	29	26	1
Dr David Finch (Joint Medical Director)	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr Howard Freeman (Joint Medical Director)	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Charlotte Gawne (Director of Communications)	11	0-2.5	2.5-5	0-5	5-10	29	26	1
Jacqui Harvey (Director of Transition)	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jocelyn Fisher (Director of Human Resources, OD and Workforce)	12	0-2.5	0	0-5	0	3	0	2
Hardev Virdee (Director of Strategic Financial Planning)	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Neil Roberts (Director of Primary Care Contracting)	14	0-2.5	0-2.5	0-5	10-15	94	86	2

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

Section 4
Health and wellbeing in Richmond

4. Health and wellbeing in Richmond

4.1. Population

According to the Office for National Statistics, the resident population of Richmond was about 187,000 in 2011. This population:

- Is split 49% male, 51% female
- Includes about 37,000 people (20%) aged under 16 (same proportion as London, but higher than England (19%))
- Includes about 125,000 (67%) aged between 16 and 64 years (lower than London's 69% but higher than England overall (65%))
- with an estimated 29% from BAME backgrounds (lower than London's 45% but higher than England overall (20%))
- The population increase experienced throughout the last decade (approx 1,500 year on year) is expected to continue.

The number of people registered with a general practice in NHS Richmond is 202,000 according to figures from Primary Care Support Services (December 2012). This is higher than the resident population. Some of this difference can be explained by patients moving from the borough but not registering with a new GP, or moving out of the country without informing their GP. A relatively small proportion of patients live in neighbouring boroughs including Hounslow, Kingston and Wandsworth, but are registered with a Richmond general practice.

Some key differences between the resident population of Richmond and the country as a whole include:

- A greater proportion aged up to 9 years
- A lower proportion aged 10 to 29 years
- A greater proportion of working age, aged 30 to 59
- A lower proportion aged 60 to 89 years
- A similar proportion aged 90 years and over

4.2. Life expectancy

Life expectancy in Richmond is among the highest in England. Life expectancy for a male born and resident in Richmond is 81 years, and for a female 86 years.

4.3. Inequalities

There is a five year disparity in life expectancy between the best and the worst in Richmond. Greater focus on tackling coronary disease, chronic obstructive pulmonary disease and cancers would help close this gap.

Six small areas in the borough have above levels of deprivation (according to the 2010 Index of Multiple deprivation) and the most disadvantaged areas are within the wards of Castlenau, Ham, Hampton North and Heathfield, but no area in Richmond falls within the most deprived 20% of the country overall. More is being done to support those living in these communities.
The levels of educational achievement vary considerably across the borough and we need to address this

to improve future health and wellbeing in the borough.

4.4. Shadow Health and Wellbeing Board – health improvement priorities

Richmond's Health and Wellbeing Board (HWB) brings together local leaders from the health and social care system. The role of the HWB is to understand the community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, local people should experience more joined up services from the NHS and the borough council in the future. A shadow HWB currently meets each month until its transition to a full Board in April 2013

The HWB has agreed their first Joint Health and Wellbeing Strategy will focus on integration of services where from a patient perspective the care system is not joined up; and where improvements can only be made in partnership rather than issues that are the remit of a single agency.

- Child to adult services transition
- Mental and physical health services
- Health and social care services
- Hospital and community services

The JHWS is intended as a framework for improving health and wellbeing by developing better responses to local needs. The audience for the strategy is primarily commissioners (the local authority and emerging Clinical Commissioning Group (CCG) as members of the HWB) and providers of health and social care services. The strategy contains a number of tools to support effective commissioning and planning to meet health and social care needs, be effective and efficient in the use of limited resources and build on local assets in a more integrated way.

A Health and Wellbeing Board Digest is produced quarterly to provide an update on the Board's discussions, links to more information and resources and highlights areas for action. See http://www.richmond.gov.uk/health_and_wellbeing_partnership.htm

4.5. Addressing inequalities

Older residents in Richmond upon Thames bring specific challenges. Some 25,000 (14%) people are aged 65 and over in the borough, this is lower than the proportion of older people in England (16%). Over half the residents aged 65 and over have a condition that limits their day-to-day activities (13,000 people). The number of those with physical long-term conditions, as well as with mental health conditions including dementia, is expected to increase as the population increases.

Emergency admissions are relatively low overall but around 15% (2011/12) of those admissions are for potentially preventable conditions.

In 2008 some 61% of deaths occurred in hospitals but since the implementation of the End of Life Care Strategy there has been a decrease to 55% in 2010 (NHS Richmond, Public Health).

4.6. Smoking

An estimated 29,000 adults in the borough smoke and each year 173 deaths (one in seven) are directly attributable to smoking.
Richmond and Kingston CCGs have commissioned a new provider. Kick It, to offer free stop smoking services. Kick IT offers free stop smoking clinics with trained advisors in convenient locations throughout the borough. There are clinics in several locations across Richmond and also in the nearby Borough of Kingston. The service provides smokers with the opportunity to speak confidentially to trained advisors and learn specialist techniques to deal with nicotine cravings.

4.7.Hazardous drinking

Alcohol remains a significant public health issue for Richmond. An estimated 21% of the Richmond population aged 16 and over are considered to be hazardous drinkers (weekly units: males >21, females >14), this is higher than London (20%) or England (20%). The borough also has a higher proportion of drinkers consuming 2.5 times the hazardous drinking level (defined as 'harmful'); 8% in Richmond, and 7% in London or England. Binge drinkers (daily units: males 8+, females 6+) are more prevalent in England (20%) than in Richmond (18%) or London (14%).

Rates of alcohol related hospital admissions continue to increase; in 2011/12 there were 3,100 alcohol related hospital admissions (40% higher than in 2008/09). This compares with a similar increase in London (41%) and a lower increase across England (29%) over the same period. Most hospital admissions in 2010/11, for alcohol attributable conditions continue to be males (60%), but females are closing the gap.

4.8.Mental health

Approximately 7% of the registered population of Richmond aged 18+ are on the mental health register; this is slightly lower than the average for London (8%).

4.9.Improving Health

Alcohol

Richmond reviewed and re-commissioned the Local Enhanced Service (LES) for alcohol in 2012/13. The revised LES for alcohol involved practices adopting a more targeted approach in screening the general population – focusing on those groups more likely to be using alcohol at increasing and high risk levels.

The new LES also extended the brief interventions offered in primary care and provided additional training for all practices taking part. Of the 31 practices in Richmond 20 signed up to provide these extended brief interventions.

Brief interventions for alcohol use will continue to be an important element in the early identification and prevention of high risk and dependent drinking.
A new Substance Misuse Strategy for Richmond, which will include alcohol, is currently in development and will be going out for wider consultation in 2013/14.

Cancer screening

This is a key part of the PCT's work towards preventing ill health. There are three national cancer screening programmes that are offered to residents: the NHS bowel cancer screening programme; the NHS breast cancer screening programme and the NHS cervical screening programme.

Bowel screening has been offered to men and women aged 60 to 69, every two years, since the programme was launched in 2007. From January 2011, men and women aged 70 to 74 were invited to take part. Since the bowel screening programme was launched – it is unique in that a testing kit is sent to the patient's home to complete - NHS Richmond has achieved the highest uptake in London. The uptake for 2011/12 was 52%.

Breast screening is offered to all women aged 50 to 70, every three years. Women aged 47 to 50 and 70 to 73 are also now being phased into the screening programme and this process should be complete in 2016. The screening service is provided by St George's Hospital, with mammography taking place at Teddington Memorial Hospital. The coverage of breast cancer screening continues to increase and is currently at 72% of eligible women.

Cervical screening, involving a cervical smear test, is provided in GP practices and at family planning clinics. Women aged 25 to 49 are offered screening every three years and women aged 50 to 64 are offered screening every five years. In 2011/12, coverage was at 79% of eligible women. Over 99% of the screening results from Kingston Hospital are consistently available within two weeks.

Healthy weight

Approximately 1500 primary school aged children are obese, with prevalence increasing from 6.5% in reception to 13% in year 6. In this age group in 1984, obesity was about 0.9% nationally.

The latest National Child Measurement Programme (NCMP) results from the 2011/12 school year show that 93% of Richmond school children were weighed and measured. Of those 17.6% of children in reception and 26.6% of children in Year 6 were classified as either overweight or obese (17.6% and 24.6% respectively in 2010/11).

While these are the lowest levels within south west London it still equates to 792 children out of 3,703 who are overweight or obese so there is still considerable work to do within the borough to reduce the prevalence further.

Over the last year we have worked with a range of local partners to deliver our healthy weight action plan. This has included the delivery of a range of intitatives:

- Promoting and supporting breastfeeding
- Healthy Start
- Healthy food in nurseries and schools
- Cooking lessons in schools
- The Change4Life convenience store
- Sports and physical activity in and out of the school curriculum
- Health walks
- Active travel to schools
- Training for health care professionals.

Olympic legacy

Working in collaboration with partners from education, business and enterprise, sport, physical activity and health, culture and tourism, and community and volunteering we have sought to develop an action plan that will help us to secure a legacy from the Olympics. The action plan sets out a number of key areas where we can build on and extend opportunities for physical activity. In particular, hosting a key part of the Olympic road cycling route, has led to a strong focus on cycling and the development of two cycling programmes: Strictly Cycling and Sky Rides.

Strictly Cycling has been developed in partnership with the Twickenham Cycling Club and British Cycling. This programme includes delivery of a secondary schools coaching programme both during curriculum and after school leading to an inter schools competition. In addition, an after school community session is delivered throughout the summer. The culmination of this activity is an event called Bikefest which consists of a grass track racing competition and a number of different opportunities to both try and learn more about cycling opportunities. All these events will be rolled out again in 2013.

Sky Rides have been delivered in partnership with British cycling and include Sky Ride Local, Breeze (women's cycling groups) and Social Cycling Groups. These sessions involve a series of small, informal group cycle rides led by trained ride leaders, who guide participants along the route, and provide tips and advice on cycle safety and skills. There are 90 trained ride leaders actively leading cycle rides in the borough, and 13 validated local sky rides. According to London borough data provided by British Cycling –

- **69%** of Sky Ride Local participants go on to cycle regularly once a month
- **90%** of those who rode once a month went on to ride each week
- **39 %** of frequent riders said that Sky Ride Local has influenced them to use their bike to commute to work
- **90%** of participants rated Sky Ride Local Rides as 'excellent'

Healthy lifestyle

Despite favourable comparison to London and England, large numbers of people in Richmond still lead unhealthy lifestyles. For example, although many people are doing some physical activity only 14% of Richmond residents achieve the recommendations of 150 minutes of activity a week, one in five adults smoke, alcohol-related hospital admissions are on the increase and nearly one in six adults overweight and obese.

In 2012, a new service - LiveWell – was commissioned to provide residents with the support they need to make healthy lifestyle changes. LiveWell offers residents looking to make a lifestyle change the opportunity to access one-to-one support which is tailored to their needs. LiveWell also provides a gateway for residents to access a wealth of other healthy lifestyle services, a few of which include: Richmond's exercise referral scheme, the weight 2 lose programme, smoking cessation support and local group walks. We also continue to work with a wide range of partners to provide other healthy lifestyle opportunities, including working with local fast food outlets to improve their healthy food offer as part of the healthy catering commitment and supporting the delivery of the local Sky Ride programme to encourage cycling.

Immunisation

Across England the national child immunisation programme has been extremely successful, reducing the occurrence of many diseases that cause unnecessary disease and death. Currently, the following vaccinations are given as part of the routine childhood – children under 5 years of age - immunisation programme delivered in Richmond: diphtheria, polio, tetanus, meningococcal group C, haemophilus influenzae type b (Hib), pneumococcal, measles, mumps and rubella.

These vaccinations are provided through GP practices community clinics or school nursing service and local residents can access more information on immunisation from their GP, practice nurse, health visitor or school nurse and from the www.immunisation.nhs.uk website.

Although levels of immunisation in Richmond remain below the 95% threshold required for herd immunity – the proportion of people that need to be vaccinated in order to protect everyone in the community - compared with coverage in 2011/12, performance regarding all childhood immunisations is steadily improving. Furthermore, coverage in Richmond is either in line with or better than the average performance in London.

We are committed to ensuring that these improvements in performance continue and are making good progress against the actions set out in our immunisation action plan to ensure that we do so. This has ensured that we are now at a stage where:

- the use of an automatic data upload tool has been completely integrated into practice and is providing timely immunisation data on a weekly basis;
- the standardised data collection template has been developed, tested and is being transitioned into practice;
- GP practices receive routinely receive feedback on their immunisation performance; and
- early years workers can share information on immunisation with vulnerable families using a locally developed leaflet and having completed immunisation.

Human Papilloma Virus

This is an immunisation programme for 12 -13 , in England, against the Human Papilloma Virus (HPV), which leads to cervical cancer: one of the most common cancers in women. In Richmond, the programme is delivered by school nurses in the school setting. In the 2011/12 school year 78.8% of girls received all three doses of the immunization, more than the London average of 75%. For the 2012/13 school year we are seeking to ensure that 90% of eligible girls benefit from participating in the programme.

Sexual health

Through the development of the Genitourinary Medicine Clinical Activity Dataset (GUMCAD) in 2010, local data is now available on sexually transmitted infections (STIs) by borough of residence for the first time, enabling commissioners to gain a better picture of the local rates of infection. Prevention, early diagnosis and treatment of infection are crucial in reducing poorer health outcomes and onward transmission of the infection to others.

During 2011, Richmond had the fourth lowest rate of acute STIs per 100,000 population in London and overall local STI rates were lower than the London and England averages. Chlamydia remains the most common bacterial STI in the UK, with those aged under 25 being at greatest risk. The National Chlamydia Screening Programme data indicates that between the 1st April 2011 and the 31st March 2012, 4379 young people aged 15 to 24 years were screened in Richmond (in both the community and GUM settings) and 5.9% tested positive for Chlamydia.

HIV

Richmond has a relatively low prevalence of HIV compared to the rest of London but a large proportion of people continue to be diagnosed late. Late diagnosis (CD4<350/mm3 within three months of diagnosis) makes treatment more difficult and health outcomes poorer. Richmond continues to invest in Pan London and South London approaches to HIV prevention in 2012/2013 as part of its effort to reduce late diagnosis of HIV. During 2011 there were 261 people living with HIV (2.23 per 100,000) in Richmond. Richmond is currently developing an HIV needs assessment to better understand unmet needs within this population.

Teenage pregnancies

Teenage pregnancy rates in Richmond remain very low compared to London and England. Data from the Office of National Statistics (ONS) and the Teenage Pregnancy Unit indicate that in 2011 Richmond upon Thames had the fourth lowest under 18 conception rate in London at 19.8 per 1,000, this is significantly lower than the London and England averages.

During 2011 under 18 abortions contributed to 5% of all abortions in Richmond. The Department of Health reported that the under 18 abortion rate was 11 per 1000 women in Richmond, this is lower than London (19 per 1000) and England (15 per 1000) averages and is the third lowest under 18 abortion rate in London.

Contraception

Providing access to the full range of contraception methods is crucial in reducing unintended pregnancy and abortion, particularly repeat abortions. Richmond's Contraception and Sexual Health Services saw 3,349 people in 2011/12, giving them advice and providing contraception.

Richmond continues to work towards identifying opportunities in providing robust and accessible services. In February 2013 a new young people-friendly clinic opened in Whitton. The Steering Committee on Sexual Health, which includes key partners to ensure that there is a multi-agency approach to improving sexual health in the borough, is now looking to develop a Sexual Health Services review that will inform a local Sexual Health Strategy.

Smoking

While Richmond has a lower than average level of smoking prevalence compared to other London boroughs, seven of the 13 GP practices in the borough which report a higher smoking prevalence than the London average, are in areas of relative deprivation. The areas may also have a higher rate of Chronic Obstructive Pulmonary Disease (COPD) than the London average.

The Government's main aims for tobacco control as set out in the Tobacco

Control Plan for 2011/12 were to reduce smoking prevalence:

- Among adults from 21.2% to 18.5%
- Among young people from 15% to 12%
- During pregnancy from 14% to 11%.

The plan targets groups in which smoking prevalence can be reduced fastest, including the manual workforce and areas of disadvantage.

An advisory group to champion the tobacco control agenda and smokefree campaign continues to meet every three months and membership includes the London Borough of Richmond, NHS Richmond, the voluntary sector, fire brigade, police and the Chamber of Commerce. This group has extended in the last year to ensure the services deliver an effective tobacco control programme and to reduce the prevalence of people smoking in the borough.

The local stop smoking service has recently been re-commissioned and a joint service across Richmond and Kingston has been procured. This new service is provided by Kick-It and began seeing clients in October 2012.

The stop smoking service continues to offer free evening group motivational sessions as well as staff sessions in local businesses. One-to-one sessions in GP practices, pharmacies, youth centres and other venues are also available as part of the service. Specialist targeted advice is also provided for those in Kingston Hospital, West Middlesex Hospital and clients of the local NHS Mental Health Trust.

Our annual target for 2012/13 is to achieve 596 four week quitters, over the last couple of years the service has performed well, meeting key annual targets.

Health checks

The NHS Health Check is a national programme for vascular risk assessment and management for people aged 40 to 74. In our borough nearly a quarter (23.51%) of deaths are attributable to coronary heart disease (CHD), stroke or diabetes.

In Richmond there may be approximately 2,000 undiagnosed cases of Type 2 diabetes which could be identified through the NHS Health Check programme. Although the percentage of deaths attributable to CHD in Richmond is considerably lower than in England and Wales (13.76% versus 16.36% respectively), there are marked inequalities. For example mortality from CHD in East Sheen is a third of that in West Twickenham. The programme therefore offers an opportunity to target these known health inequalities in the borough.

The NHS Health Checks programme aims to:

- Reduce the prevalence of CHD
- Narrow health inequalities.

The implementation of the NHS Health Checks in Richmond was designed specifically to target high risk and medium risk patients, those with learning disabilities or with a severe mental health illness. Lifestyle services such as the Health Trainer Service, Weight Management and Walking Away Programme for pre-diabetes were also commissioned.

A pharmacy pilot programme in areas of high need and deprivation ran during 2009/10 and more than 1,000 checks were completed in seven months. The evaluation of the pilot informed the full-roll out in 2010/11. The full roll-out programme began in November 2010 and was delivered through a mixed model: 25 general practices, 10 pharmacies and community outreach in areas of high need and deprivation and where practices were not participating in the programme. Some 2,600 checks were completed in five months and more than 120 people were referred to various life style services.

During 2011/12, 27 General Practices, nine pharmacies and an outreach provider took part and more than 5,700 checks were completed. 185 people were diagnosed with one of the cardiovascular diseases i.e.

Hypertension, Diabetes, CHD and Chronic Kidney Disease, and more than 300 people were referred to life style services.

During 2012/13, 29 out of 31 General Practices participated and more than 4000 checks (8%) and more than 10,000 (20%) invites were sent out. The national targets were met in month eleven. The targets were lower as compared to 2011/12 as the eligible cohort was calculated accurately according to the DH guidance. Since 2009, more than 20% of the Richmond's population have had a health check completed and more than 50% have been invited.

Year	Programme	Models	Budget	Completed checks	Invitations
2009-10	Pharmacy Pilot	Pharmacies & Outreach	£300,000	1,017	13,000 (approx)
2010-11	Full Roll-out	GPs , Pharmacies & Outreach	£300,000	2,600	4,000 (approx)
2011-12	Full Roll-out	GPs , Pharmacies & Outreach	£312,000	5,707	13,000
2012-13	Full Roll-out	GPs , Pharmacies & Outreach	£317,000	4000	11,000

Section 5
Commissioning healthcare

5. Commissioning healthcare

5.1. Local health needs

Overall, Richmond is healthy and safe with:

- Increasing life expectancy, low premature mortality
- Low levels of crime and accidents
- Green spaces, good schools and high levels of volunteering.

However, there are some significant areas of identified need which include:

Health inequalities

- Life expectancy gap of about 5 years between the best and worst quintile (mainly due to coronary heart disease, chronic obstructive pulmonary disease and cancers)
- Six small areas (LSOAs) with around 11,000 (6%) residents including some of the estimated 4,350 children living in poverty have levels of deprivation that are above average for England (IMD 2010).
- There is wide variation between schools in the numbers of children eligible for free school meals and a gap in educational attainment.
- There is some emerging evidence of wealth related health inequalities, especially for children.

Hidden risks and harm

- About 12% of older people are carers and 1% of all carers known to the council are under 18 years.
- A high proportion (51%) aged 75 and over live alone compared to 35% London-wide.
- Higher than average percentage of people die in winter months (excess winter deaths) compared to the England average (79 additional deaths per year).
- Alcohol-related hospital admissions are increasing (especially in older age groups), as well as increasing mortality from liver cirrhosis.
- Childhood immunisation coverage is below herd immunity and recently measles cases were rising.

- Neighbouring Hounslow has one of the highest tuberculosis rates in London at 66 per 100,000 population (Richmond 9/100,000).

- Prevalence of diagnosed HIV is 41st out of 151 PCTs in England but 50% of cases are diagnosed late.

Prevention opportunities

- Despite favourable comparison in London and nationally, numbers of people with unhealthy lifestyles are still big.

- Over 25,000 adults smoke, and 210 deaths per year (1:5) are attributable to smoking

- Over 2000 children are obese, with prevalence increasing from 6% in reception to 12% in year 6. In the 1980s childhood obesity was about 2%.

- There are large numbers of people with undiagnosed long-term conditions.

- Young people's risky behaviour often indicates various overlapping family needs, ie sexual health, mental health and substance misuse. Chlamydia screening uptake in high-risk groups is low.

Increasing numbers of (older) people with multiple long–term conditions

- The number of people with physical long-term conditions and with mental health conditions including dementia, is expected to increase in line with population increase**.**

- Proportion of people with more than one long-term condition (i.e. co-morbidities) is expected to increase by an estimated 30% over the next ten years.

- Whilst overall emergency admissions are relatively low, around 16% (~ £5 million) of emergency admissions are for potentially preventable conditions.

- In 2009/10 the emergency admission rate for hip fractures was significantly higher compared to London and England averages.

- In 2008, 61% of deaths occurred in hospitals. Since the implementation of the End of Life Care Strategy there has been a decrease of 6% in hospital deaths.

- Number of care homes (20) is high relative to other boroughs. 7% (£1.7 million) of spend on emergency admissions is attributable to care homes. 30% of emergency hospital admissions from care homes are short stay (0 or 1 days) suggesting there is potential to reduce these. Quality and safety issues identified in care homes.

The five year strategy

In order to address these challenges and focus on a healthier future for its population, Richmond CCG will deliver a comprehensive model of out-of hospital-care, with strong primary care services (both general and specialist), robust community care and integrated social services provision through community hubs and the wider local estate. There will be a focus on ensuring clear, evidence based pathways to acute services, where patients are offered a choice of provider where appropriate in order to drive market quality, and a series of specialist provision from single providers/sites where this improves outcomes and drives down risk and cost.

5.1. Richmond's health priorities for 2012/13

Any Qualified Provider

In 2012/13, Richmond has been establishing the AQP model for the delivery of some local services, in line with the Department of Health Operational Guidance on Extending Patient Choice of Provider. This enables patients to exercise choice in the delivery of their care, empower patients and enable innovation. Importantly, extending choice of provider provides a vehicle to improve access, address gaps and inequalities and improve quality of services where patients have identified variable quality in the past.

From 1st October 2012, after a DH led London procurement, and in collaboration with MSK lead GPs and Richmond and Wandsworth LINks, Richmond and Wandsworth PCTs jointly rolled out choice of provider to patients for physical therapy (physiotherapy), specifically for neck and back pain. South West London residents had previously taken part in a survey to choose which services could be offered out for choice of provider and care closer to home. As a result of this work, 11 providers qualified to offer MSK services in Richmond.

To date patient feedback on the service has been very good; patients are enjoying having a choice of provider, care closer to home and shorter waiting times. The next service to be commissioned under AQP is Community Podiatry Services, which will launch in April 2013.

111

Richmond carried out a joint procurement with Kingston CCG in the summer of 2012 and commissioned Harmoni to deliver the service for a 2 year pilot. The two CCGs were commended on their clinical governance submission in November 2012 and proceeded to soft launch the service in January 2013. The service publically launched in February 2013.

The CCG is committed to using 111 to offer patients alternatives to attending A&E or dialling 999. The 111 clinical governance group has developed a plan for ensuring a broad range of services are available on the 111 Directory of Services, to allow for the effective diversion of patients to alternative services to A&E. This plan includes the inclusion of extensive mental health, social care and voluntary services on the DoS by October 2013. The CCG is also committed to streamlining the pathway between 111 and GP out-of-hours services, as well as identifying appropriate services for direct booking of appointments.

Richmond Clinical Assessment Service

The Richmond Clinical Assessment Service (RCAS) is now in its fourth year of operation and continues with its success. A team of local clinical assessors triages and peer reviews referrals from GPs to secondary care. This helps to ensure that all information needed is included in the referral letter, that appropriate treatments have been tried in primary care and that the referral has been made to the most appropriate clinic choice.

The local RCAS commissioning lead evaluated the first 18 months of the service and it has been shown to improve quality and deliver savings. In 2013 another review of the service will take place to evaluate current treatment pathways and look for opportunities to develop additional community services. In 2013 RCAS will be improving data reporting to GPs, developing additional GP educational sessions and supporting the development of a community Directory of Services.

Richmond Wellbeing Service

The new Richmond Wellbeing Service has been fully operational since July 2012. The service, provided by East London Foundation NHS Trust operates from Richmond Royal, with satellite clinics in a number of GP practices and community settings across the borough. The service is open to residents in Richmond,

registered with a Richmond GP practice and accepts GP and self referrals, providing a single point of access for primary enhanced support and psychological therapies. Additionally, the service is working closely with specialist mental health services as well as other community based services.

The patient waiting times for psychological therapies have significantly decreased since the introduction of the new service, with patients waiting no longer than two weeks for an assessment and patients receiving therapy promptly after assessment.

Dementia

We have recognised the importance of local specialist dementia knowledge and will continue to support our local GP, Dr Stavroula Lees, in her role as NHS London Dementia Fellow in helping us to achieve the earliest diagnosis and best outcomes for our patients. We held training sessions for GPs as part of our work to raise their awareness of local services which was also linked to a local audit and programme to reduce anti-psychotic primary care prescribing for dementia. As part of our aim to improve access to information and services we commissioned a Guide to Dementia services and this together with a leaflet about local memory services have been made widely available locally. We have also demonstrated reduction of antipsychotic prescribing for behavioural symptoms. More work is ongoing. We have introduced memory clinic and dementia care navigator and evaluated work by HTT

Whitton

The new Whitton Health and Social Care Centre opened in May 2012 and had its official opening in October 2012. The centre houses multiple services under one roof, including:

- Two GP practices
- An NHS dentist
- Physiotherapy and podiatry services
- The Richmond Wellbeing Service
- Integrated health and social care teams
- Well baby clinics
- Health visiting clinics
- School nursing clinics
- Sexual health clinics
- Abdominal aortic aneurysm screening clinics

A range of other public health and voluntary services also run out of the building, which is a state of the art facility for the delivery of services in the Whitton area.

Teddington Walk-in Centre

The GP-led health centre at Teddington Memorial Hospital was closed in December 2011 and the walk-in centre service was subsequently redesigned to feature integrated GP and nursing provision. During the summer of 2012, a full evaluation of the service was undertaken. This included an analysis of the operational service model, as well as patient and staff feedback on the service. Patient feedback on the service offered was excellent, as was staff feedback on how the new model was working. As a result, the service was re-commissioned in December 2012.

QIPP

QIPP is a national NHS programme aimed at making efficiency savings while delivering Quality, Innovation, Productivity and Prevention outcomes. NHS Richmond successfully met its QIPP challenge in 2011/12 and 2012/13. In 2012/13 we had a particularly challenging QIPP of £8.46m.

Areas of particular strength where over-performance was indicated in 2012/13 include the preventable admissions from the community scheme (phase 2), end of life care (EoLC) phase 2 scheme and the MSK pathway. The preventable admissions from the community phase 2 scheme is commissioned to respond to urgent referrals within two hours and as a result of this intervention patients often avoid an elective admission within five days. The EoLC scheme requires community services to add patients deemed to be in the last 12 months of life to Coordinate My Care, the EoLC register. This has been shown to prevent unnecessary hospital admissions through improved case management. The MSK pathway has supported a reduction in secondary care referrals, increased primary care provision and diversion to MSK pathway in the community. The MSK pathway was developed using referral data via RCAS and commissioned as a result of the high referral rates and costs to secondary care trauma and orthopaedics.

5.2.Richmond's health priorities for 2012/13

Children and young people

Commissioning plans will be developed to ensure that children (0-5) and those in transition to school have appropriate access to services. Ensuring that the needs of children with physical and other disabilities are met is a key outcome.

We will develop and implement a new 5 year strategy for Emotional Well-being and Mental Health in children and young people. As a part of this work we will develop a new specification for specialist (Tier3) CAMHS services across Richmond which may impact on service provision at tier 4 including specialist placements. We will implement a revised ADHD pathway for children and young people.

We will conduct and implement the findings of a needs assessment and review of learning disabilities services for children and move to an integrated model of delivery across health and social care for disabled children's services which will aim to close gaps I service provision. We will commission a challenging behaviour service for children and their families based on assessed need and develop a new specification for an integrated multi professional team to assess and manage neurodevelopment, ADHD, ASD, epilepsy, behaviour and disability

There will be a focus on early intervention and prevention and the co-ordination of services to have a systematic approach to risky behaviour. Richmond CCG will support the development of targeted services to help families in need.

Adults and older people

There will be a progressing of a feasibility study to determine what health and social care arrangements will look like in Richmond. This will be progressed with the relevant commissioning organisations in Richmond and in partnership with Hounslow.

Richmond will prioritise its pathways for the frail elderly and people with long term conditions to ensure opportunities to improve quality are maximised. This will include the implementation of risk stratification in general practices and implementation of the community ward.

Richmond will integrate the existing Intermediate Care Team (ICT) and Reablement functions into one service that can meet the rehabilitation needs of patients providing:

- Rapid response with the most appropriate care and professional input
- Better outcomes through a more flexible patient journey and service time
- Service availability 7 days per week responding to crises and the needs of local hospitals.
- All elements of facilitating discharge in one service

Richmond will develop a telehealth/telecare strategy for Richmond that is integrated into the Model of Care and community rehabilitation service described above.

Richmond will commission Learning Disability services to ensure clients are able to remain independent and functioning within the community.

There will be a formal procurement of new model of delivery for continuing healthcare placements in Richmond.

Mental health

We will seek to manage expectation and increase the use of group cognitive behavioural therapy (CBT) to manage demand for mental healthcare in primary care**.**

We will review demand for older people's liaison services, in conjunction with neighbouring CCGs, with a view to improving timely access to appropriate MH services.

There will be formal reviews of the following service provision with the intention to address service variation where appropriate: Adult community mental health teams (CMHTs), dementia care, including the memory service, and rehabilitation.

We will introduce pilot provision of high and medium support community rehabilitation in the borough.

In line with the community ward model proposed for the elderly and frail, we will implement a case management approach in mental health to ensure early intervention and prevention, where appropriate, of acute admissions.

We will develop community based dementia services which are integrated into the virtual community ward and community rehabilitation service as part of our overall approach for the management of long term conditions.

Planned care

We will prioritise the repatriation of follow up appointments for various services to primary care where appropriate in order to reduce inappropriate follow-ups from secondary care providers.

Pain management service provision will be reviewed and primary care clinics in the community will be piloted. A review will also be undertaken to look at the opportunities to provide more minor surgery in primary care.

A priority will also be a review of the gynaecology care pathway to ensure a more consistent and integrated care pathway for patients closer to home. This will include a review of the pathway with Chelsea and Westminster gynaecology clinic at Teddington Memorial Hospital and other secondary care pathways.

Urgent care

Richmond will prioritise the development and roll-out of 111 in order to streamline urgent care pathways and direct patients to appropriate services as alternatives to A&E. In line with this, Richmond will work closely with neighbouring CCGs on the redesign of local A&E departments, with the development of urgent care centres as a priority.

Richmond has committed to reviewing its GP out-of-hours pathway with 111 to streamline care and ensure patients get the right treatment, first time.

End of life care

The continued establishment of the use of the Co-ordinate My Care register as core practice within providers will be a priority for the CCG going forward to ensure the best possible treatment for patients at the end of life.

5.3. How we will deliver our plans

Richmond Clinical Commissioning Group (CCG), in collaboration with the patients, carers, people and communities we serve, aspires to deliver better care and a healthier future for the borough of Richmond.

Clinical leadership

The CCG will harness the knowledge and experience of its member practices to ensure the implementation of commissioning plans is clinically driven. The CCG will use its GP Membership Group, Clinical Advisory Group and Governing Body to ensure that clinicians are key to decision-making at all levels.

Patient and public engagement

For Richmond CCG patient and public engagement is about putting patients, carers and the public at the centre of the commissioning process. The CCG has a duty to inform, engage and consult with the public to ensure accountability and build the trust and confidence of its local population. Successful patient and public engagement will mean that:

Richmond CCG will:

- Involve patients, carers and the public in all stages of its decision making and explain how decisions are made
- Use patient and carer experience to improve the quality of services and patient care
- Support patients to make informed and timely decisions about their own health
- Work together with partners to share and use patient insight to improve patient experience across the borough of Richmond.

Working in partnership with London Borough of Richmond upon Thames

Richmond CCG will take a collaborative approach to commissioning health and social care services in the future. Richmond recognises that it is a small borough and that the commissioning resources of both public sector bodies will be limited over coming years, which may affect capacity and speed of action in relation to commissioning plans. By developing a collaborative commissioning structure, the overall commissioning

resource and skills will be magnified and it will be possible to ensure a greater focus and strength in local commissioning plans and deliver

Richmond believes there is such significant overlap in the commissioning outcomes that both public bodies seek to achieve that collaborative commissioning will provide a clear voice and purpose and will ensure that duplication of resource is reduced and the public pound is invested to deliver greater efficiency. Richmond believes that the approach taken by both Richmond CCG and the local authority to transfer and develop the Public Health function is evidence that significant new strategy and approaches will be generated through collaborative commissioning.

5.4. Quality, Innovation, Productivity and Prevention (QIPP)

QIPP is a national NHS programme aimed at making efficiency savings while delivering Quality, Innovation, Productivity and Prevention outcomes. NHS Richmond has successfully met its QIPP challenge in 2012/13. In 2012/13 we had a particularly challenging QIPP of £8.46m.
Areas of particular strength where over-performance was indicated in 2012/13 include the preventable admissions from the community scheme (phase 2), end of life care (EoLC) phase 2 scheme and the MSK pathway. The preventable admissions from the community phase 2 scheme is commissioned to respond to urgent referrals within two hours and as a result of this intervention patients often avoid an elective admission within five days. The End of Life Care (EoLC) scheme requires community services to add patients deemed to be in the last 12 months of life to Coordinate My Care, the EoLC register. This has been shown to prevent unnecessary hospital admissions through improved case management. The MSK pathway has supported a reduction in secondary care referrals, increased primary care provision and diversion to MSK pathway in the community. The MSK pathway was developed using referral data via RCAS and commissioned as a result of the high referral rates and costs to secondary care trauma and orthopaedics.

Section 6
Improving performance

6. Improving performance

NHS South West London has been working with the shadow clinical commissioning group, to measure the performance of all health services provision for Richmond residents. The measurement is used to identify areas where performance is strong. We work with the service providers to learn lessons that can be implemented across the borough to enhance service delivery and the quality of care which all patients receive. Similarly, services that are struggling to deliver the required outcomes are identified and support is provided to improve quality and outcomes.

Performance indicators are an important way for us to measure the quality and productivity of the services we commission, and benchmark ourselves against similar organisations.

Here is a snapshot of how we have performed in Richmond in 2012/13 against the NHS Operating Framework indicator groups.

Targets achieved

NHS Operating Framework resources indicators

We have achieved the targets for hospital acquired c.difficile infections. We also are expecting to meet the target for all cancer two week waiting times.

NHS Operating Framework public health indicators

Richmond has achieved childhood obesity targets in Reception Year, however more work is being done to improve obesity levels in Year 6 children. All mortality indicators have been met with low mortality rates for cancer and cardiovascular disease in Richmond. Plans are in place to increase immunisation rates in the borough to make them one of the best in the country. We are developing a local campaign to raise further awareness amongst new mothers around immunisations. We are also working with local schools and parents to increase the uptake of the HPV immunisation for girls aged 12-13 years.

NHS Operating Framework quality and public health indicators

All of the headline quality indicators were achieved in Richmond last year. These demonstrate strong performance across the borough for waiting times for referral to treatment and beginning treatment for suspected cancers early.

The borough performed strongly in stroke and cancer services, with patients suffering from suspected stroke and transient ischaemic attacks (TIAs) treated in the appropriate unit quickly and effectively.

18 Weeks Referral to Treatment (RTT)
We met the standard for 18 Weeks RTT performance for admitted and non-admitted patient care.

Stroke Care

We met both of the stroke Key Performance Indicators in 2012/13. These relate to patients who spend at least 90 per cent of their stay on a dedicated stroke unit, and to patients who are at risk of Transient Ischaemic Attack who are treated within 24 hours.

Cancer Waits
Cancer patients were treated quickly, with performance targets for access to surgery, drugs and radiotherapy all achieved.

Mental Health
Richmond achieved the required performance standards for Crisis Resolution, Early Intervention and Care Programme Approach (CPA) follow-up. The Improving Access to Psychological Therapies (IAPT) service was re-tendered. There is still more work to be done to achieve the required performance levels in the IAPT proportion of people moving to recovery.

Mortality
In line with previous years, NHS Richmond achieved its target for all-cause mortality rates for males and females, and for rates for cardiovascular disease and cancer mortality for those under the age of 75 were also met.

Areas where targets were not achieved – future targets

Breastfeeding at six to eight weeks
The rate of breastfeeding initiation in Richmond is one of the highest in London and England. Breast feeding prevalence and coverage rates were not met in 2012/13, but this was predominantly due to data extraction issues, rather than a drop in breastfeeding itself. The target set for NHS Richmond was set artificially high in 2012-13 making it difficult to achieve. Richmond has addressed this for 2013-14 to ensure performance improves year-on-year.

Substance misuse
As with the previous year, the baseline Problem Drug User (PDU) denominator has not reflected the actual number of problem drug users. As a result, targets have not been realistic. However, the new Drug Strategy and Public Health Outcomes Framework has signalled a shift away from a focus on the numbers of problem drug users entering effective treatment, towards an indicator which instead focuses on outcomes such as the numbers successfully completing treatment. In the past Richmond has performed well for the number of problem drug users successfully completing treatment.

Teenage conceptions
The target for this indicator was not achieved, however it should be noted that the overall rate and number of conceptions in under 18 year olds in Richmond is low compared to London and England. Due to the low numbers of conceptions each year, rates can fluctuate considerably, affected by small increases or decreases in the overall numbers.

Number of self-reported four week smoking quitters (awaiting final data)
The target for four week smoking quitters was not met in 2012/13. The shadow Richmond CCG and Kingston CCG have commissioned a new provider, Kick It, to provide their stop smoking service. We expect to see a marked improvement in the number of four week quitters the next year.

Section 7
Working in partnership

7. Working in partnership

The *Better Services, Better Value* review was a major focus for public and patient involvement in south west London. NHS South West London (NHS SWL) worked with LINks/shadow Healthwatch and local authority partners across all the NHS SWL boroughs, including Richmond. With these stakeholders and partners NHS SWL arranged large-scale meetings, community outreach sessions, e-bulletins, online surveys and other social media engagement to outline and explain the case for changing health services, the emerging new models of care, and the process for deciding on options for consultation. The feedback from these varied approaches to consultation has influenced the clinical reports and the approach to options appraisal.

7.1. Involving local people

Local people, services users and carers have had the opportunity to be involved in a range of strategy and service projects over the year including our Commissioning Strategy Plan, Learning Disability Needs Assessment, Adult mental health rehabilitation consultation and the local roll out of NHS 111. Further information on local patient and public involvement activities are included in Richmond's annual report on the Duty to Involve in Consultations.

We have continued to develop our Community Involvement Group (CIG) as a valuable source of input from key voluntary sector and community organisations about local patient and public involvement in commissioning. During the year both the CIG and Richmond LINk have supported Richmond shadow Clinical Commissioning Group (CCG) to develop its communication and engagement strategy. The strategy sets out mechanisms to embed a culture of engagement across Richmond CCG and to develop the role of clinicians and member practices in engaging with and empowering patients and carers. To reflect the CIG's new role in supporting Richmond CCG the group is now chaired by the CCG's governing body lay member for patient and public involvement and governing body GP leads for engagement are now members.

Under the banner of Richmond's Health & Wellbeing Board we are working with health and social care partners including Richmond Council, Richmond LINk and Richmond CVS to develop a shared approach to involving seldom heard groups.

We have continued to work in partnership with Richmond Council, Richmond Local involvement Network (LINk), and our local voluntary sector to ensure that during this period of change for health and social care we keep local people informed about what this will mean for us in Richmond upon Thames. Richmond LINk is represented on the Richmond CCG governing body, Community Involvement Group and a number of commissioning project groups.

7.3. Richmond LINk

We continued to work with Richmond Council, Richmond Local Involvement Network (LINk), and our local voluntary sector. The aim at all times has been to ensure that, during this period of change for health and social care, we keep local people informed about what this will mean for all of us in Richmond upon Thames.

Richmond LINk is represented on the Richmond CCG governing body, Community Involvement Group and on a number of commissioning project groups. It has also continued to work with the borough health team

and emerging GP leads representing the views of patients and carers about commissioned services, as well as commenting on - and being involved in - the development and commissioning of new services, including community and mental health care.

Its representatives have also been involved in some of the BSBV Clinical Working Groups and the NHS SWL Patient and Public Advisory Group, and continues to monitor services at the local acute hospitals

Richmond LINk is a Local Healthwatch Pathfinder and is a member of the shadow Richmond Health and Wellbeing Board. Local Healthwatch takes over from Richmond LINk in April 2013.

7.5. Health, Housing and Adult Services Overview and Scrutiny Committee

The Health, Housing and Adult Services Overview and Scrutiny Committee met six times through 2012 to 2013. The committee is attended by at least one of the following members of the Richmond Borough Team: Dr Dagmar Zeuner, Director of Public Health; Dominic Wright, Managing Director and Dr Marilyn Plant, PEC Chair. A verbal update on health transition is provided at each meeting, as well details of discussions relating to identified health issues.

One of the priorities for this year was participating in a South West London Joint Health Overview and Scrutiny Committee of Better Services Better Value. Other priorities included: Public Health transition; homelessness strategy; Joint Strategic Needs Assessment; updates on the 'Shaping a Healthier Future' consultation; HRCH Foundation Trust Consultation; immunisations and mental health services which at the most recent committee meeting it was noted that budgeting for Mental Health Services in Richmond was above national average and in future services would become more community-based with a greater emphasis on primary healthcare.

7.6. Carers

During the year we have continued to work with Richmond Council, local carer-focused organisations and carers to promote and increase the take up of NHS Carers Breaks funding direct to carers to support their health and wellbeing. Carers benefitted from a direct payment which they have used to support and improve their own health and wellbeing from taking a holiday, attending a course, going to the gym through to buying a family dog.

7.7. Patient Advice and Liaison Service (PALS) and complaints

During 2012/13, the NHS Richmond Complaints and PALS teams handled a total of 736 enquiries and 27 formal complaints (to 31 January 2013). The number of complaints increased by 58 per cent compared with the previous year. The majority of complaints were responded to within 25 days. The PALS team resolved many of the enquiries and concerns in a timely manner.

The complaints procedure in Richmond reflects the six principles of remedy as outlined in The Parliamentary and Health Service Ombudsman report, October 2007.
These principles are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

The three main areas that the complaints related to were:

- Commissioning including mental health commissioning
- Independent contractors (e.g. GPs and dentists)

- Public Health

Although many of the complaints received related to specific patient concerns, a number led to improvements that would benefit the wider local population. For example, improving communication and information available to patients; and informing commissioners about gaps in service provision.

The PALS team always listen carefully to the concerns being raised and provide advice or make recommendations, where possible, as to the best way forward for the patient or member of the public.

The three main areas of PALS contacts related to:

- GP practice
- Requesting information
- Dental practice/treatment

Although some people contact PALS initially to make a complaint about primary care or commissioned services, after discussing their options they are usually happy for the PALS team to take immediate action for a prompt resolution.

It is not always possible to resolve a concern to the patient's satisfaction; however, the PALS team can give information about support services and voluntary organisations that may be able to help. Alternatively, sometimes people just want to let someone know about their concerns and do not want further action to be taken.

7.8. Better Services Better Value

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

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

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

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

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

Section 8
Making it happen

8. Making it happen

8.1. Equality, equity and diversity

We have continued to work closely with the shadow Clinical Commissioning Groups (CCGs) and our public health colleagues to ensure that our health service commissioning takes account of the diverse needs of local people. Our goal is to remove the obstacles that some groups face when accessing health services - obstacles that can adversely affect the health of those groups.

During 2012/13 the shadow Richmond CCG continued to work on making equality central to everything we do. A range of equality impact assessments were carried out to help us understand the needs of our population. We have used focus groups to talk to local people from different backgrounds about what help and support they need to help them improve their health and wellbeing.

8.1. Supporting Strategic decision-making

The Joint Strategic Needs Assessment (JSNA) for Richmond 2011/12 was produced in partnership with the local Boroughs. It is commissioning tool which forms a part of evidence based planning. It provides information about local health needs and areas of inequalities. The JSNA supports the London Borough of Richmond upon Thames and the shadow Richmond CCG to work together to address local needs and highlights issues such as age, disability, deprivation, ethnicity, gender, religion and sexual orientation, as they affect specific population groups.

Information from the JSNA is used to develop our Commissioning Strategy Plan. This ensures that equality and diversity are taken into consideration when planning for the future. The shadow Richmond CCG will to strive to build assurances that health care providers are meeting statutory equality duties.

8.2. Making a difference for patients and staff

The Equality Act 2010 provides a legal framework to drive improvements and advance equality and human rights. The Department of Health's Equality Delivery System tool relates to patients and staff, we have used it to support us to deliver our equality performance to identify future priorities and actions.

During 2012/13 we reviewed the ways in which we are meeting the needs of our patients and local people. To help us improve our performance, we have worked with stakeholders including, local authority, voluntary and community sectors, Local Involvement Networks (LINks), carers and older people. We have also worked with organisations that support black and Asian minority.

We have set Equality objectives with the aim to improve transparency and focus our activities in meeting the general equality duty. These have been published and an action plan for 2012/13 has been developed with our stakeholder group.

8.3.Engaging with diverse communities

We have used a variety of ways to involve and consult staff, patients and the public so as to better engage with the diverse communities in the borough of Richmond. During 2012/13 we have worked with health and social care partners including Richmond Council, Richmond LINk and Richmond CVS to develop a shared approach to involving seldom heard groups. We have been involved in a number of community events to raise public awareness of the services and ensure that all patients have the opportunity for their voices to be heard.

8.4. Patient advice and liaison service

PALS, together with the Complaints Service, deals with queries, concerns and formal complaints relating to services commissioned by NHS Richmond. Equality monitoring is undertaken as part of the evaluation of these services. The annual report collates the findings and includes comparative equalities monitoring data for age, gender and ethnicity and highlights problem areas requiring action.

In the last year we have been committed to reaching out to patients and the public.
During 2012/13, the NHS Richmond Complaints and PALS teams handled a total of 736 enquiries and 27 formal complaints (to 31 January 2013). The number of complaints increased by 58% compared with the previous year and the majority were responded to within 25 days. The PALS team was able to resolve many of the enquiries and concerns in a timely manner.

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- Putting things right
- Seeking continuous improvement

The three main areas that the complaints related to were:
- Commissioning including mental health commissioning
- Independent contractors (eg GPs and dentists)
- Public Health

Although many of the complaints received related to specific patient concerns, a number led to improvements that would benefit the wider local population. For example, improving communication and information available to patients; and informing commissioners about gaps in service provision.

The PALS team always listen carefully to the concerns being raised and provide advice or make recommendations, where possible, as to the best way forward for the patient or member of the public.

The three main areas of PALS contacts related to:
- GP practice
- Requesting information
- Dental practice/treatment

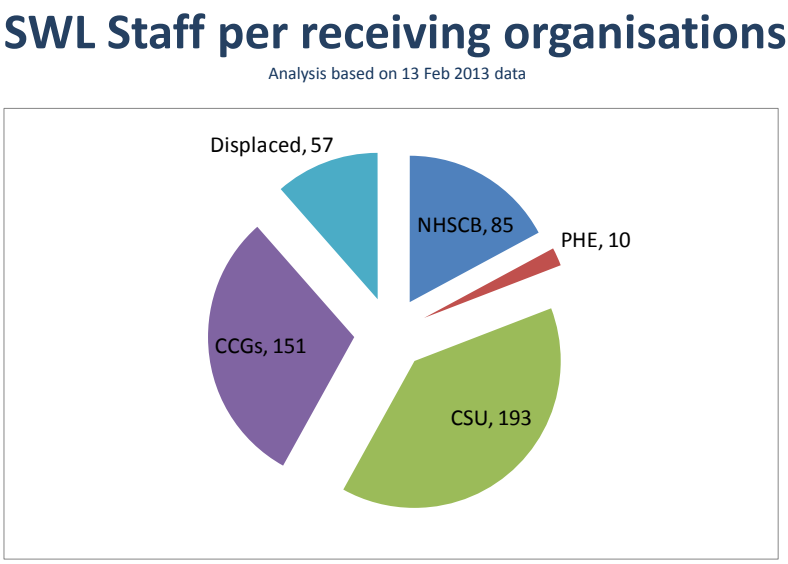
Although some people contact PALS initially wanting to make a complaint about primary care or commissioned services, after discussing their options they may be happy for the PALS team to take immediate action for prompt resolution.

It is not always possible to resolve a concern to the patient's satisfaction; however, the PALS team can give information about support services and voluntary organisations that may be able to help. Alternatively, sometimes people just want to let someone know about their concerns and do not want further action to be taken.

8.5. Our staff

Transition to new organisations

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



Staff development

NHS South West London was committed during transition to helping all staff improve their working lives and develop professionally through our education and development programmes.
Our Development Passport programme helped staff plan for their futures and equipped them for transition into the new NHS organisations. We worked with Croft Management Centre to produce a Development Passport with a two-tiered approach to training; Level One for bands 6 and below, and Level Two for bands 7 and above.
From September 2011 up to the end of January 2013 more that 1400 delegates attended sessions delivered over 150 separate training days. 83 delegates achieved an Award, Certificate or Diploma in Management and Leadership qualifications drawing on a range of 21 different topics around personal, commercial and leadership effectiveness.
In addition to the passport programme staff also had access to support services that assisted them to update and develop their personal curriculum vitae and interview skills. Staff also had access to an employee assistance programme which is a free confidential 24 hour access to advice and counselling online or on the telephone.

Workplace health

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

Staff profile

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

8.6. Communicating with staff

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

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

Senior management was very involved in face-to-face briefings and discussions with staff and the transition team was central to ensuring that staff had the most up-to-date information available at the time. As staff moved into the new organisations in their shadow form, cluster Team Briefings were replaced by a weekly Transition Update newsletter supported by face-to-face briefings led by the cluster Chief Executive and directors. Staff whose functions were moving to the South London Commissioning Support Unit or NHS Commissioning Board were also invited to briefings run by the new organisations.

8.7.Protecting your information: Information governance

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

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

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

Reported Information Governance Incidents

- There were no serious incidents (categorised as 3-5) reported by NHS Richmond during 2012-13
- There were three minor incidents (categorised as 1-2) summarised in the table below

Summary of other personal data related incidents in 2012/13

category	nature of incident	NHS SWL total	Cluster directorates	Richmond
I	loss/theft of inadequately protected electronic equipment, devices or paper documents form secured NHS premises	1		
II	loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1		
III	insecure disposal of inadequately protected electronic equipment, devices or paper documents	1		
IV	unauthorised disclosure	17	5	3
V	other	2	1	
	total	**22**	**6**	**3**

8.8.Safeguarding

Safeguarding Adults and Children is a high priority for NHS Richmond (Richmond Shadow Clinical Commissioning Group from 1st September 2012) and we are committed to working with Richmond Safeguarding Adult Partnership Board (SAPB) , Richmond Local Safeguarding Children's Board (LSCB), our providers of services and partner agencies to continuously improve safeguarding services to protect adults and children who live within the London Borough of Richmond upon Thames (LBRUT) and when needed those adults and children who live outside of the Borough.
Unlike children's safeguarding at present there is no legislative framework in place for safeguarding adults however following a review of the national document *'No Secrets'* it is thought that this will change in the

near future. Richmond SAPB and Richmond LSCB through these multi agency boards have strategic responsibility for overseeing the local safeguarding arrangements, which includes responding to allegations of abuse and prevention strategies.
NHS Richmond adheres to the statutory requirements directed by the:

- The Children Act (2004) Section 11 which places a statutory responsibility to safeguard children upon all NHS organisations.
- Section 13, also requires NHS Trusts to cooperate and engage fully with partner agencies as competent members of their Local Safeguarding Children's Board (LSCB).
- Section 14 (1) of the Children Act (2004) stipulates that all agencies must ensure the effectiveness of what is done by each representative member or body.

NHS Richmond is committed to:

- Working within the "London multi-agency policy and procedures to safeguard adults from abuse".
- Cooperate and engage fully with partner agencies as competent members of the Richmond SAPB and any future legislative frameworks.

NHS Richmond has contributed financially to the costs of the LSCB and the SAPB and has a Section 75 agreement regarding the Deprivation of Liberty Safeguards (DoLS), to provide Best Interests Assessors.

NHS Richmond complies with safer recruitment guidance.

The safeguarding team reports on safeguarding adult and children to the Integrated Quality, Finance and Performance Committee on a monthly basis and bi monthly to Richmond Governing Body.

The Safeguarding Children and the Safeguarding Adult Policies were ratified by Richmond Governing Body in late 2012 and have been revised to reflect the DH (2012) guidance for future authorised clinical commissioning groups (CCGs) from April 1st 2013.

The DH (2012) stated that CCGs would be required to meet safeguarding duties, these Safeguarding Commissioning policies focus on the assurance frameworks and contractual arrangements with health providers which ensure that safeguarding procedures, recruitment, training and responsibilities are in place and operating appropriately.
There are Designate and Named safeguarding professionals who lead on issues related to safeguarding children and a newly appointed Lead for Safeguarding Adults(interim until 31st March) who working with the Chief Nurse and Named Nurse will enhance the newly formed RCCG's work in protecting adults at risk including those with learning disabilities. This team of designate and named professionals provide advice and support to colleagues both internally and across primary care services and work closely with local health and social care organisations. They also have representation on the SAPB, LSCB and their sub groups.
The Chief Nurse is the Designate Nurse and Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) Lead for Adult Safeguarding and is part of the Supervisory Body; she works alongside partner colleagues to approve the assessments that support a DoLS being implemented.
With the handover functions from the Primary Care Trust Cluster arrangement from the 1st April, NHS Richmond's Chief Nurse will be the RCCG Governing Body member and the Safeguarding Executive Lead. A 'stand alone' Designate Nurse will be in position to reflect these organisational changes.
Richmond Shadow CCG has also identified a GP Governing Body member as a Quality Lead and as part of this role she will be 'champion' for vulnerable adults and children. Two GP members have also been recruited as GP leads for children.
This year the Named Nurse has enhanced the work being undertaken with victims of domestic and sexual abuse through her attendance at monthly MARAC (Multi Agency Risk Assessment Conference) and MAPP(Multi Agency Public Protection meetings. Information can now be shared with GPs to help increase the safety of victims.
The safeguarding team have helped to shape the safeguarding assurance tools that commissioners have in place with providers and are involved in the monitoring and performance of the safeguarding elements of contracts.
The Designate Doctor and the Designate Looked After Children Nurse are recruited and work as part of Hounslow and Richmond Community NHS Trust.

The Government has a *Prevent* strategy as part of its overall approach to countering terrorism which is now included as part of the Safeguarding remit. The aim of the strategy is to prevent vulnerable people being involved in supporting violent extremism. PREVENT training has been rolled out to staff who work in

NHS SWL Richmond Borough Team and to senior staff in Hounslow and Richmond Healthcare Trust in early 2012. A representative from NHS Richmond has attended the multi-agency London Steering Group.

This year the safeguarding team has worked with partners to support the serious case review (SCR) process with regard to one child and two adults. A SCR should always be undertaken when and adult or child dies (including suicide), and abuse or neglect is known or suspected to be a factor.

The purpose of a SCR is to:

- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of adults and children
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- improve intra- and inter-agency working and better safeguard and promote the welfare of adults and children

The safeguarding team will continue to work with the commissioners of health providers involved in these SCRs, Richmond SAPB and Richmond LSCB to gain assurance that identified actions to improve services have been implemented.

Richmond CCG will ensure that in 2013/14 safeguarding adults and children continue to be given a high profile as the transitional NHS and Social Care organisational structural changes, highlighted in the Health and Social care Bills become substantive from 1st April 2013.

8.10. Sustainability

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

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

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

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

8.11. Informatics

During the year the South West London Cluster started the process of merging with the South East London Cluster to form the South London Commissioning Support Unit. As part of the setup of the new

organisation, an active investment programme in Informatics started in mid-2012 building on previous projects to evolve the Business Intelligence and ICT capability.

Our vision for Informatics is to:

- Provide clinical commissioners with the IT and information they need to commission services, which will improve outcomes for patients.
- Improve the sophistication of business information over time, in order to support the Commissioning Intelligence Model (CIM).
- Exploit the benefits of scale, to both provide information in a cost effective way and also provide commissioners with a broader range of information and informatics tools.

Our investment programme has already started delivering the following benefits:

Advanced Business Intelligence: a single platform supporting reports and self-service analysis tools for CCGs with a rich visual interface, a large selection of inbuilt charts, conditional formatting and intuitive ways of presenting data.

Single Service Desk: development of a single service desk for all customers, focusing on stronger customer relationships, harmonised and streamlined procedures and better response to major incidents.

Supporting remote working: investment in our Citrix Remote Working system to improve capacity, reliability and increasing the applications and services available remotely.

Improving sharing of information: extending the use of SharePoint across the CSU and our customers, increasing the capacity and size of the shared portal, using it to deliver websites, intranets and business intelligence for CCGs.

Better equipment, newer versions of software: we will shortly start rolling out a new desktop image to all end users, so we are on the same versions of office and Windows, as well as replacing older PCs and equipment for CCGs, GPs and internal staff.

Planning investment in ICT for primary care: we have planned the full roll out of EMIS Web / Vision 360, Summary Care Record and EPS R2 for 2013/14, so that all CCGs are meeting national standards (subject to funding agreed by the NHS Commissioning Board).

8.12. Risk Assessment

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

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

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

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

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

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

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

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

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

Key risks during 2012/13 have included:

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

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

1.2 The Risk and Control Framework

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

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

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

1.3 Executive Management Team and Board Committee Scrutiny of Risks

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

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

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

1.3.4 Other mechanisms to support risk management (of both manifest and potential risks) include the system in place for reporting and investigation of serious incidents (SIs), including a Serious Incident Monitoring Panel to monitor completion of SI investigations and implementation of action plans across the Cluster. Significant issues which are identified are escalated to Senior Management Team and Joint Boards.

1.4 Managing risks around delegation to CCGs under shadow working arrangements

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

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

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

1.5 Review of the Effectiveness of Risk Management and Internal Control

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

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

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

The Internal Audit report acknowledges that as part of internal control mechanism, “the Transition Programme, Incident Reports, Borough Complaints, Health and Safety Working Group issues, compliance items and other areas of Cluster interest have been considered and discussed”.

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

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

1.6 Final Board Assurance Framework Report to Joint Boards in March 2013
A final Joint Boards risk report was represented in March 2013 show a comparative picture of risk at the beginning and end of 2012/13, using visual ‘heat maps’. The formal transfer of risk ownership, where relevant, was also presented and clearly audited.

8.13. Risk Management

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

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

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

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

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

8.14. Register of Joint Boards member interest 2012/13

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

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

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

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

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

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

Department of Health

NHS

Richmond and Twickenham Primary Care Trust

2012-13 Accounts

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Richmond and Twickenham Primary Care Trust

2012-13 Accounts

ANNUAL ACCOUNTS 2012-13

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

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Richmond and Twickenham Primary Care Trust to discharge the following responsibilities for the Department of

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

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

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

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

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

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

nb: sign and date in any colour ink except black

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

Signed..... C Vincent .....

Date..... 4/6/13

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

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

i. to assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the
ii. had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
iii. kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of
iv. took reasonable steps for the prevention and detection of fraud and other irregularities;
achieved value for money from the resources available to the PCT;
v. applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them and
vi. had effective and sound financial management systems in place.

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

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

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

Signed: 

Date: 4/6/2013

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iv. achieved value for money from the resources available to the PCT;
v. applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them and
vi. had effective and sound financial management systems in place.

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

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

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

Signed:

Date: 4/6/13.

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

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

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

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

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

Respective responsibilities of the signing officer and auditor

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

Scope of the audit of the financial statements

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

apparent material misstatements or inconsistencies we consider the implications for our report.

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

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

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

· our review of the annual governance statement; and

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

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

Certificate

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

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

Gatwick

7 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	4,669	3,791
Other costs	5.1	296,477	283,063
Income	4	(10,612)	(7,941)
Net operating costs before interest		290,534	278,913
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	419	0
Net operating costs for the financial year		290,953	278,913
Transfers by absorption -(gains)		0	
Transfers by absorption - losses		0	
Net (gain)/loss on transfers by absorption		0	
Net Operating Costs for the Financial Year including absorption transfers		290,953	278,913
Of which:			
Administration Costs			
Gross employee benefits	7.1	4,612	3,759
Other costs	5.1	7,773	5,744
Income	4	(1,287)	(415)
Net administration costs before interest		11,098	9,088
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	419	0
Net administration costs for the financial year		11,517	9,088
Programme Expenditure			
Gross employee benefits	7.1	57	32
Other costs	5.1	288,704	277,319
Income	4	(9,325)	(7,526)
Net programme expenditure before interest		279,436	269,825
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	0	0
Net programme expenditure for the financial year		279,436	269,825

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	712	749
Net (gain) on revaluation of property, plant & equipment	(590)	(112)
Net (gain) on revaluation of intangibles	0	0
Net (gain) on revaluation of financial assets	0	0
Net (gain)/loss on other reserves	0	0
Net (gain)/loss on available for sale financial assets	0	0
Net (gain) /loss on Assets Held for Sale	0	
Release of Reserves to Statement of Comprehensive Net Expenditure	0	
Net actuarial (gain)/loss on pension schemes	0	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year*	291,075	279,550

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 5 to 44 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**28,446**	23,399
Intangible assets	13	**12**	9
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**110**	0
Total non-current assets		**28,568**	23,408
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**1,655**	1,875
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**2,586**	1
Total current assets		**4,241**	1,876
Non-current assets held for sale	24	**0**	0
Total current assets		**4,241**	1,876
Total assets		**32,809**	25,284
Current liabilities			
Trade and other payables	25	**(18,247)**	(21,196)
Other liabilities	26,28	**0**	0
Provisions	32	**(1,890)**	(1,100)
Borrowings	27	**(7)**	0
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(20,144)**	(22,296)
Non-current assets plus/less net current assets/liabilities		**12,665**	2,988
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(4,052)	(919)
Borrowings	27	(4,855)	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(8,907)**	(919)
Total Assets Employed:		**3,758**	2,069
Financed by taxpayers' equity:			
General fund		(3,034)	(4,845)
Revaluation reserve		6,792	6,914
Other reserves		0	0
Total taxpayers' equity:		**3,758**	2,069

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

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

Carl Vincent, Director of Provider Finance and Transition

Signed; .....

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(4,845)**	**6,914**	**0**	**2,069**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(290,953)			**(290,953)**
Net gain on revaluation of property, plant, equipment		590		**590**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(712)		**(712)**
Movements in other reserves			0	**0**
Transfers between reserves*	0	0		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(290,953)**	**(122)**	**0**	**(291,075)**
Net Parliamentary funding	292,764			**292,764**
Balance at 31 March 2013	**(3,034)**	**6,792**	**0**	**3,758**

Balance at 1 April 2011	**-7786**	**7551**	**0**	**(235)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(278,913)			(278,913)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		112		112
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		(749)		(749)
Movements in other reserves			0	0
Transfers between reserves*	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(278,913)	(637)	0	(279,550)
Net Parliamentary funding	281,854			281,854
Balance at 31 March 2012	**(4,845)**	**6,914**	**0**	**2,069**

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		(290,534)	(278,913)
Depreciation and Amortisation		972	996
Impairments and Reversals		234	0
Other Gains / (Losses) on foreign exchange		0	0
Donated Assets received credited to revenue but non-cash		0	0
Government Granted Assets received credited to revenue but non-cash		0	0
Interest Paid		0	0
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		0	0
(Increase)/Decrease in Trade and Other Receivables		110	871
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		(2,608)	(4,335)
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(58)	(554)
Increase/(Decrease) in Provisions		3,981	610
Net Cash Inflow/(Outflow) from Operating Activities		(287,903)	(281,325)
Cash flows from investing activities			
Interest Received		0	0
(Payments) for Property, Plant and Equipment		(1,842)	(519)
(Payments) for Intangible Assets		(7)	(20)
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		(8)	0
Proceeds of disposal of assets held for sale (PPE)		0	0
Proceeds of disposal of assets held for sale (Intangible)		0	0
Proceeds from Disposal of Other Financial Assets		0	4
Proceeds from the disposal of Financial Assets (LIFT)		0	0
Loans Made in Respect of LIFT		0	0
Loans Repaid in Respect of LIFT		0	0
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		(1,857)	(535)
Net cash inflow/(outflow) before financing		(289,760)	(281,860)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(419)	0
Net Parliamentary Funding		292,764	281,854
Capital Receipts Surrendered		0	0
Capital grants and other capital receipts		0	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		0	0
Net Cash Inflow/(Outflow) from Financing Activities		292,345	281,854
Net increase/(decrease) in cash and cash equivalents		2,585	(6)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Perioc		1	7
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		0	0
Cash and Cash Equivalents (and Bank Overdraft) at year enc		2,586	1

1. Accounting policies

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

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

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Richmond and Twickenham PCT was dissolved on 1 st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 42 Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - in the case of Richmond & Twickenham PCT this was to Hounslow and Richmond Community Healthcare NHS Trust at the end of 2010-11. Therefore, FReM guidance on 2012-13 transfers does not apply.

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

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

Key sources of estimation uncertainty

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

The prescribing costs for March were unknown at the time of the draft accounts, an average daily cost for the previous 11 months has been used to estimate the March value.

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

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

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

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Care Trust Designation

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

1.4 Pooled budgets

The PCT no longer has a Pooled Budget arrangement with the London Borough of Richmond. Pooled budget management arrangements were transferred to Hounslow & Richmond Community NHS Trust (HRCH) with effect from 1 April 2011. Therefore, PCT expenditure is reflected through its purchase of healthcare from HRCH and is classified as such in these Accounts.

1.5 Taxation

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

1.6 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure). From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programm
For PCTs, the Department has defined "admin and programme" in terms of running costs.
The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements.

1. Accounting policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.8 Intangible Assets

Recognition

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

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

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

Measurement

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

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

1.9 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.10 Donated assets

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

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

1.13 Inventories

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

1.14 Cash and cash equivalents

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

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

1.15 Losses and Special Payments

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

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

1.16 Clinical Negligence Costs

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

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

1. Accounting policies (continued)

1.17 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.18 Research and Development

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

1.19 Other expenses

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

1.20 Grant making

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

1.21 EU Emissions Trading Scheme

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

1. Accounting policies (continued)

1.22 Contingencies

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

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

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

1.23 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.24 Foreign exchange

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

1.25 Provisions

Provisions are recognised when the PCT has a present legal or constructive obligation as a result of a past event, it is probable tha the PCT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of -1.85% for years 0 to 5 inclusive, -1.0% for years 6 to 10 inclusive and 2.2% for over 10 years. in real terms. The rate applicable for all provisions arising from continuing obligations arising from previous employment service is 2.35% in real terms.

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

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

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

1. Accounting policies (continued)

1.26 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Loans and receivables

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

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

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

1.27 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

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

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

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

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

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

1. Accounting policies (continued)

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

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

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

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

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

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

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

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

1. Accounting policies (continued)

1.28 Going Concern

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

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

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

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IAS 19 (Revised 2011) Employee Benefits
IAS 32 Financial Instruments: Presentation
IFRS 7 Financial Instruments: Disclosures

2 Operating segments

In 2012-13 and 2011-12 the PCT only recognised one type of expenditure which as an operating segment would be classified commissioning. Previously, the PCT reported seperate operating segments of provider and commissioner. From the 1st April 2012 the provider arm transferred out of the PCT to become Hounslow and Richmond Community Healthcare.

3. Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 2012-13 is as follows:	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	**290,953**	278,913
Revenue Resource Limit	**300,011**	286,655
Under/(Over)spend Against Revenue Resource Limit (RRL)	9,058	7,742

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	**6,941**	600
Charge to Capital Resource Limit	**6,378**	507
(Over)/Underspend Against CRL	**563**	**93**

3.3 Provider full cost recovery duty

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

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**292,764**	281,854
Cash Limit	**292,764**	284,620
Under/(Over)spend Against Cash Limit	**0**	**2,766**

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

	2012-13 £000
Total cash received from DH (Gross)	264,315
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**264,315**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	4,576
Plus: drugs reimbursement (central charge to cash limits)	23,873
Parliamentary funding credited to General Fund	**292,764**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	0	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	1,365		1,365	1,478
Dental Charge income from Trust-Led GDS & PDS	0		0	0
Prescription Charge income	1,226		1,226	1,210
Strategic Health Authorities	1,567	0	1,567	1,499
NHS Trusts	8	0	8	0
NHS Foundation Trusts	0	0	0	0
Primary Care Trusts Contributions to DATs	0		0	0
Primary Care Trusts - Other	1,714	0	1,714	296
Primary Care Trusts - Lead Commissioning	0	0	0	0
English RAB Special Health Authorities	0	0	0	0
NDPBs and Others (CGA)	0	0	0	0
Department of Health - SMPTB	0	0	0	0
Department of Health - Other	0	0	0	0
Recoveries in respect of employee benefits	0	0	0	0
Local Authorities	281	0	281	204
Patient Transport Services	0		0	0
Education, Training and Research	0	0	0	0
Non-NHS: Private Patients	0		0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	0		0	0
NHS Injury Costs Recovery	0		0	0
Other Non-NHS Patient Care Services	0	0	0	0
Charitable and Other Contributions to Expenditure	0		0	0
Receipt of donated assets	0		0	0
Receipt of Government granted assets	0		0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	4,393	1,287	3,106	3,215
Other revenue	58	0	58	39
Total miscellaneous revenue	**10,612**	**1,287**	**9,325**	**7,941**

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	**14,866**		14,866	11,040
Non-Healthcare	**3,749**	3,722	27	2,750
Total	**18,615**	**3,722**	**14,893**	**13,790**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**153,941**	0	153,941	155,334
Goods and services (other, excl Trusts, FT and PCT))	**510**	0	510	576
Total	**154,451**	**0**	**154,451**	**155,910**
Goods and Services from Foundation Trusts	**26,169**	0	26,169	25,151
Purchase of Healthcare from Non-NHS bodies	**27,931**		27,931	19,833
Social Care from Independent Providers	**0**		0	0
Expenditure on Drugs Action Teams	**848**		848	826
Non-GMS Services from GPs	**3,234**	494	2,740	2,842
Contractor Led GDS & PDS (excluding employee benefits)	**6,046**		6,046	6,095
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**422**		422	418
Chair, Non-executive Directors & PEC remuneration	**25**	25	0	0
Executive committee members costs	**57**	57	0	28
Consultancy Services	**172**	172	0	68
Prescribing Costs	**20,026**		20,026	21,186
G/PMS, APMS and PCTMS (excluding employee benefits)	**24,349**	0	24,349	24,001
Pharmaceutical Services	**0**		0	0
Local Pharmaceutical Services Pilots	**151**		151	125
New Pharmacy Contract	**5,999**		5,999	6,199
General Ophthalmic Services	**914**		914	970
Supplies and Services - Clinical	**36**	0	36	25
Supplies and Services - General	**0**	0	0	1
Establishment	**1,153**	893	260	2,014
Transport	**0**	0	0	0
Premises	**4,008**	1,882	2,126	2,360
Impairments & Reversals of Property, plant and equipment	**234**	0	234	0
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**968**	519	449	985
Amortisation	**4**	0	4	11
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**(135)**	(135)	0	(3)
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**80**	80	0	120
Other Auditors Remuneration	**0**	0	0	30
Clinical Negligence Costs	**0**	0	0	0
Education and Training	**24**	22	2	49
Grants for capital purposes	**0**	0	0	0
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Other	**696**	42	654	29
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**296,477**	**7,773**	**288,704**	**283,063**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	0
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**210**	210	0	196
Other Employee Benefits	**4,459**	4,402	57	3,595
Total Employee Benefits charged to SOCNE	**4,669**	**4,612**	**57**	**3,791**
Total Operating Costs	**301,146**	**12,385**	**288,761**	**286,854**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,717**	10,301	1,416
Weighted population (number in units)*	**150,898**	150,898	150,898
Running costs per head of population (£ per head)	**77.65**	**68.26**	**9.38**
PCT Running Costs 2011-12			
Running costs (£000s)	**9,221**	8,029	1,192
Weighted population (number in units)	**150,898**	150,898	150,898
Running costs per head of population (£ per head)	**61.11**	**53.21**	**7.90**

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	24,349	24,001
Prescribing costs	20,026	21,186
Contractor led GDS & PDS	6,046	6,093
Trust led GDS & PDS	425	429
General Ophthalmic Services	913	970
Department of Health Initiative Funding	0	0
Pharmaceutical services	0	0
Local Pharmaceutical Services Pilots	151	125
New Pharmacy Contract	5,999	6,199
Non-GMS Services from GPs	2,525	2,556
Other	0	0
Total Primary Healthcare purchased	**60,434**	61,559
Purchase of Secondary Healthcare		
Learning Difficulties	3,808	3,656
Mental Illness	27,232	26,813
Maternity	10,214	10,706
General and Acute	133,531	123,639
Accident and emergency	4,782	5,203
Community Health Services	43,418	37,217
Other Contractual	748	5,843
Total Secondary Healthcare Purchased	**223,733**	213,077
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**284,167**	**274,636**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	26,169	25,149

6. Operating Leases

The PCT's main operating lease relates to the rental of its HQ at Thames House, Teddington. This lease expires in February 2019, although there is a break clause effective in February 2014, which was enforced in January 2013. Currently, the annual rent stands at £415,800 and the PCT is responsible for all revenue running costs, such as business rates; utilities and day to day maintenance. Under the terms of the lease, the PCT will be responsible for the cost of any premises reinstatement works required by the landlord at the time the lease is surrendered.

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**416**	415
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**416**	**415**
Payable:					
No later than one year	**0**	**347**	**0**	**347**	415
Between one and five years	**0**	**0**	**0**	**0**	1,663
After five years	**0**	**0**	**0**	**0**	762
Total	**0**	**347**	**0**	**347**	**2,840**
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

The PCT had operating leases income totalling £4.4m in 2012/13, the majority being received from Hounslow & Richmond Community NHS Trust (HRCH). The PCT does not have a formal lease arrangement with HRCH, but it does hold a Memorandum of Occupation with the Trust. Under this arrangement, HRCH has licence to accommodate offices and clinics and make use of PCT assets. HRCH pays the PCT a rental of £3.2m in consideration of the Memorandum of Occupation.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**4,393**	3,215
Contingent rents	**0**	0
Total	**4393**	3,215
Receivable:		
No later than one year	**0**	3,215
Between one and five years	**0**	0
After five years	**0**	0
Total	**0**	3,215

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13								
				Permanently employed			Other	
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure								
Salaries and wages	3,967	3,917	50	2,383	2,353	30	1,584	1,564	20
Social security costs	216	213	3	213	210	3	3	3	0
Employer Contributions to NHS BSA - Pensions Division	317	313	4	315	311	4	2	2	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	169	169	0	169	169	0	0	0	0
Total employee benefits	4,669	4,612	57	3,080	3,043	37	1,589	1,569	20
Less recoveries in respect of employee benefits (table below)	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	4,669	4,612	57	3,080	3,043	37	1,589	1,569	20
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net Employee Benefits excluding capitalised costs	4,669	4,612	57	3,080	3,043	37	1,589	1,569	20
Recognised as:									
Commissioning employee benefits	4,669			3,080			1,589		
Provider employee benefits	0			0			0		
Net Employee Benefits excluding capitalised costs	4,669			3,080			1,589		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	3,163	2,546	617
Social security costs	256	253	3
Employer Contributions to NHS BSA - Pensions Division	372	368	4
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total gross employee benefits	3,791	3,167	624
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	3,791	3,167	624
Employee costs capitalised	0	0	0
Net Employee Benefits excluding capitalised costs	3,791	3,167	624
Recognised as:			
Commissioning employee benefits	3,791		
Provider employee benefits	0		
Net Employee Benefits excluding capitalised costs	3,791		

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

7.2 Staff Numbers

	2012-13 Total Number	Permanently Number	Other Number	2011-12 Total Number	Permanently Number	Other Number
Average Staff Numbers						
Medical and dental	2	2	0	2	2	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	52	32	20	50	40	10
Healthcare assistants and other support staff	0	0	0	0	0	0
Nursing, midwifery and health visiting staff	3	3	0	3	3	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	6	6	0	6	6	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	62	42	21	61	51	10
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

This information is reported in the Annual Report of the PCT

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	2	1	3	0	0	0
£10,001-£25,000	0	0	0	0	0	0
£25,001-£50,000	1	0	1	0	0	0
£50,001-£100,000	0	0	0	0	0	0
£100,001 - £150,000	1	0	1	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	4	1	5	0	0	0
	£s	£s	£s	£s	£s	£s
Total resource cost	167,237	2,718	169,955	0	0	0

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

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

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

7.5 Pension costs

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

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

a) Accounting Valuation

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

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.
Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.
On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Full Actuarial Funding Valuation

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**8,185**	**34,032**	10,083	37,436
Total Non-NHS Trade Invoices Paid Within Target	**6,871**	**27,286**	7,155	27,649
Percentage of NHS Trade Invoices Paid Within Target	83.95%	80.18%	70.96%	73.86%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,823**	**206,615**	3,253	202,968
Total NHS Trade Invoices Paid Within Target	**2,811**	**191,127**	2,053	194,706
Percentage of NHS Trade Invoices Paid Within Target	73.53%	92.50%	63.11%	95.93%

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

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

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

9. Investment Income

The PCT received no investment income in 2012-13 (2011-12 £nil).

10. Other Gains and Losses

There are no other gains and losses to report for 2012-13 (2011-12 £nil)

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under PFI contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	419	419	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	419	419	0	0
Other finance costs	0	0	0	0
Provisions - unwinding of discount	0		0	0
Total	419	419	0	0

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	5,852	17,259	0	454	1,125	42	2,272	503	27,507
Additions of Assets Under Construction				0					0
Additions Purchased	0	340	0		122	0	1,044	(5)	1,501
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	750	4,120	0		0	0	0	0	4,870
Reclassifications	0	454	0	(454)	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	358	232	0	0	0	0	0	0	590
Impairments/negative indexation	0	(712)	0	0	0	0	0	0	(712)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	6,960	21,693	0	0	1,247	42	3,316	498	33,756
Depreciation									
At 1 April 2012	0	1,773	0	0	673	42	1,440	180	4,108
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	195	0	0	8	0	0	31	234
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	474	0		79	0	353	62	968
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	2,442	0	0	760	42	1,793	273	5,310
Net Book Value at 31 March 2013	6,960	19,251	0	0	487	0	1,523	225	28,446
Purchased	6,960	19,251	0	0	487	0	1,523	225	28,446
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	6,960	19,251	0	0	487	0	1,523	225	28,446
Asset financing:									
Owned	6,210	15,131	0	0	487	0	1,523	225	23,576
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	750	4,120	0	0	0	0	0	0	4,870
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	6,960	19,251	0	0	487	0	1,523	225	28,446

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	2,369	4,317	0	0	207	0	0	21	6,914
Movements (relating to net downward movement in valuations)	0	0	0	0	0	0	0	0	0
At 31 March 2013	2,369	4,317	0	0	207	0	0	21	6,914

Additions to Assets Under Construction in 2012-13

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

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**5,740**	**18,008**	**0**	**454**	**1,083**	**42**	**1,951**	**379**	**27,657**
Additions - purchased	0	0	0	0	42	0	321	124	**487**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	112	0	0	0	0	0	0	0	**112**
Impairments	0	(749)	0	0	0	0	0	0	**(749)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**5,852**	**17,259**	**0**	**454**	**1,125**	**42**	**2,272**	**503**	**27,507**
Depreciation									
At 1 April 2011	**0**	**1,149**	**0**		**602**	**42**	**1,194**	**136**	**3,123**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	624	0		71	0	246	44	**985**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**0**	**1,773**	**0**	**0**	**673**	**42**	**1,440**	**180**	**4,108**
Net Book Value at 31 March 2012	**5,852**	**15,486**	**0**	**454**	**452**	**0**	**832**	**323**	**23,399**
Purchased	5,852	14,276	0	454	452	0	832	323	**22,189**
Donated	0	1,210	0	0	0	0	0	0	**1,210**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**5,852**	**15,486**	**0**	**454**	**452**	**0**	**832**	**323**	**23,399**
Asset financing:									
Owned	5,852	15,486	0	454	452	0	832	323	**23,399**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**5,852**	**15,486**	**0**	**454**	**452**	**0**	**832**	**323**	**23,399**

12.3 Property, plant and equipment

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

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

Asset lives:

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	1	2
Property, Plant and Equipment		
Buildings exc Dwellings	23	43
Dwellings	0	0
Plant & Machinery	1	9
Transport Equipment	0	0
Information Technology	1	3
Furniture and Fittings	2	9

Open Market Value of Assets at balance sheet date

At 31 March 2013 the PCT held no assets that were valued at Open Market Value.

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**20**	**0**	**0**	**0**	**20**
Additions - purchased	0	7	0	0	0	7
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0
At 31 March 2013	**0**	**27**	**0**	**0**	**0**	**27**
Amortisation						
At 1 April 2012	**0**	**11**	**0**	**0**	**0**	**11**
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	4	0	0	0	4
In-year transfers to NHS bodies	0	0	0	0	0	0
At 31 March 2013	**0**	**15**	**0**	**0**	**0**	**15**
Net Book Value at 31 March 2013	**0**	**12**	**0**	**0**	**0**	**12**
Net Book Value at 31 March 2013 comprises						
Purchased	0	12	0	0	0	12
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2013	**0**	**12**	**0**	**0**	**0**	**12**

Revaluation reserve balance for intangible non-current assets

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

13.2 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2011	**0**	**0**	**0**	**0**	**0**	**0**
Additions - purchased	0	20	0	0	0	**20**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**20**	**0**	**0**	**0**	**20**
Amortisation						
At 1 April 2011	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	11	0	0	0	**11**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
Less cumulative dep written down on revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**11**	**0**	**0**	**0**	**11**
Net Book Value at 31 March 2012	**0**	**9**	**0**	**0**	**0**	**9**
Net Book Value at 31 March 2012 comprises						
Purchased	0	9	0	0	0	**9**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	**0**	**9**	**0**	**0**	**0**	**9**

13.3 Intangible non-current assets

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

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCNE				
Loss or damage resulting from normal operations	39	0	39	0
Over-specification of assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Total charged to Departmental Expenditure Limit	39	0	39	0
Unforeseen obsolescence	0		0	0
Loss as a result of catastrophe	0		0	0
Other	0		0	0
Changes in market price	195		195	0
Total charged to Annually Managed Expenditure	195		195	0
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve				
Loss or damage resulting from normal operations	0			749
Over Specification of Assets	0			0
Abandonment of assets in the course of construction	0			0
Unforeseen obsolescence	0			0
Loss as a result of catastrophe	0			0
Other	0			0
Changes in market price	712			0
Total impairments for PPE charged to reserves	712			749
Total impairments of Property, Plant and Equipment	946	0	234	749
Intangible assets impairments and reversals charged to SoCNE				
Loss or damage resulting from normal operations	0	0	0	0
Over-specification of assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen obsolescence	0		0	0
Loss as a result of catastrophe	0		0	0
Other	0		0	0
Changes in market price	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Intangible Assets impairments and reversals charged to the Revaluation Reserve				
Loss or damage resulting from normal operations	0			0
Over-specification of assets	0			0
Abandonment of assets in the course of construction	0			0
Unforeseen obsolescence	0			0
Loss as a result of catastrophe	0			0
Other	0			0
Changes in market price	0			0
Total impairments for Intangible Assets charged to Reserves	0			0
Total impairments of Intangibles	0	0	0	0
Financial Assets charged to SoCNE				
Loss or damage resulting from normal operations	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Loss as a result of catastrophe	0		0	0
Other	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Financial Assets impairments and reversals charged to the Revaluation Reserve				
Loss or damage resulting from normal operations	0			0
Loss as a result of catastrophe	0			0
Other	0			0
TOTAL impairments for Financial Assets charged to reserves	0			0
Total impairments of Financial Assets	0	0	0	0
Non-current assets held for sale - impairments and reversals charged to SoCNE.				
Loss or damage resulting from normal operations	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen obsolescence	0		0	0
Loss as a result of catastrophe	0		0	0
Other	0		0	0
Changes in market price	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Total impairments of non-current assets held for sale	0	0	0	0
Inventories - impairments and reversals charged to SoCNE				
Loss or Damage Resulting from Normal Operations	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen Obsolescence	0		0	0
Loss as a Result of a Catastrophe	0		0	0
Other (Free text note required)*	0		0	0
Changes in Market Price	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Total impairments of Inventories	0	0	0	0
Investment Property impairments charged to SoCNE				
Loss or Damage Resulting from Normal Operations	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen Obsolescence	0		0	0
Loss as a Result of a Catastrophe	0		0	0
Other (Free text note required)*	0		0	0
Changes in Market Price	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Total Investment Property impairments charged to SoCNE	0	0	0	0
Investment Property impairments and reversals charged to the Revaluation Reserve				
Loss or Damage Resulting from Normal Operations	0			0
Over Specification of Assets	0			0
Abandonment of Assets in the Course of Construction	0			0
Unforeseen Obsolescence	0			0
Loss as a Result of a Catastrophe	0			0
Other (Free text note required)*	0			0
Changes in Market Price	0			0
TOTAL impairments for Investment Property charged to Reserves	0			0
Total Investment Property impairments	0	0	0	0
Total impairments charged to Revaluation Reserve	712			749
Total impairments charged to SoCNE - DEL	39	0	39	0
Total impairments charged to SoCNE - AME	195		195	0
Overall Total impairments	946	0	234	749
Of which:				
Impairment on revaluation to "modern equivalent asset" basis	0	0	0	0
Donated and Gov Granted Assets, included above -				
PPE - Donated and Government Granted Asset Impairments: amount charged to SoCNI DEL*	0	0	0	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged SoCNE -AME*	0	0	0	0

15 Investment property

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

16 Commitments

16.1 Capital commitments

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

16.2 Other financial commitments

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

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	759	0	790	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	371	0	4,045	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	525	0	13,412	0
At 31 March 2013	**1,655**	**0**	**18,247**	**0**
prior period:				
Balances with other Central Government Bodies	596	0	1,115	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	929	0	5,379	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	355	0	14,702	0
At 31 March 2012	**1,880**	**0**	**21,196**	**0**

18 Inventories

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

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	1,130	1,198	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	0	327	0	0
Non-NHS receivables - revenue	315	578	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	167	0	0	0
Provision for the impairment of receivables	(82)	(342)	0	0
VAT	125	114	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0	110	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total	1,655	1,875	110	0
Total current and non current	1,765	1,875		
Included above:				
Prepaid pensions contributions	0	0		

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

19.2 Receivables past their due date but not impaired

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

19.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	(342)	(345)
Amount written off during the year	125	3
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	135	0
Balance at 31 March 2013	(82)	(342)

20 NHS LIFT investments

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

21.1 Other financial assets - Current

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

21.2 Other Financial Assets - Non Current

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

21.3 Other Financial Assets - Capital Analysis

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

22 Other current assets

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

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**1**	0
Net change in year	**2,585**	0
Closing balance	**2,586**	0
Made up of		
Cash with Government Banking Service	**2,586**	1
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**2,586**	1
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**2,586**	1
Patients' money held by the PCT, not included above	0	0

24 Non-current assets held for sale

The PCT did not have any Non Current Assets held for sale in 2011/12 and 2012/13.

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0		
NHS payables - revenue	**4,056**	6,494	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**779**	0	**0**	0
Family Health Services (FHS) payables	**4,812**	5,105		
Non-NHS payables - revenue	**4,539**	4,864	**0**	0
Non-NHS payables - capital	**6**	347	**0**	0
Non_NHS accruals and deferred income	**3,941**	4,386	**0**	0
Social security costs	**66**	0		
VAT	**0**	0	0	0
Tax	**48**	0		
Payments received on account	**0**	0	**0**	0
Other	0	0	0	0
Total	**18,247**	21,196	**0**	0
Total payables (current and non-current)	**18,247**	**21,196**		

26 Other liabilities

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

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

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**7**	0	**4,855**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**7**	**0**	**4,855**	**0**
Total other liabilities (current and non-current)	**4,862**	**0**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	**Other £000s**	**Total £000s**
0 - 1 Years	0	7	**7**
1 - 2 Years	0	7	**7**
2 - 5 Years	0	87	**87**
Over 5 Years	0	4,761	**4,761**
TOTAL	**0**	**4,862**	**4,862**

28 Other financial liabilities

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

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at1 April 2012	**1,338**	1,338	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**0**	0	**0**	0
Current deferred Income at 31 March 2013	**1,338**	1,338	**0**	0
Total other liabilities (current and non-current)	**1,338**	**1,338**		

30 Finance lease obligations

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

31 Finance lease receivables as lessor

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

32 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**2,019**	5	16	10	0	1,039	0	0	949	0
Arising During the Year	**5,049**	0	0	0	0	4,238	0	0	780	31
Utilised During the Year	**(58)**	(3)	(8)	(9)	0	0	0	0	(38)	0
Reversed Unused	**(1,068)**	0	0	(1)	0	(1,039)	0	0	(28)	0
Unwinding of Discount	**0**	0	0	0	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**5,942**	**2**	**8**	**0**	**0**	**4,238**	**0**	**0**	**1,663**	**31**
Expected Timing of Cash Flows:										
No Later than One Year	**1,890**	**2**	**8**	**0**	**0**	**1,030**	**0**	**0**	**819**	**31**
Later than One Year and not later than Five Years	**3,362**	**0**	**0**	**0**	**0**	**3,208**	**0**	**0**	**154**	**0**
Later than Five Years	**690**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**690**	**0**

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

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

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

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

33 Contingencies

The PCT had no Contingent Liabilities. (Nil 2011-12).

34 PFI and LIFT - additional information

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

The LIFT Co entered into a land retained agreement with the PCT: LIFT Co built a new Whitton Health and Social CareCentre, and leased this asset to the PCT for 25 years from the agreement date. In addition to the lease of the asset, and intrinsically linked to it, LIFT Co was also contracted to provide facilities management and other services over the 25 years of the lease, services in excess of a normal commercial rental agreement.

Financial close of the scheme and the signing of the agreement was in March 2011 and completion and opening of the Centre in May 2012. In April 2013 the asset was transferred to NHS Property Services. At the end of the 25 year term the NHS has the option, but not the obligation, to repurchase Whitton Health and Social Care Centre from LIFT Co at a value assessed by a professional valuer and adjusted for changes in the asset's fair value as forecast at the scheme's inception.

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

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

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

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

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

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

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	31 March 2013 £000	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	0	0
Service element of on SOFP LIFT charged to operating expenses in year	86	0
Total	86	0

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	94	0
Later than One Year, No Later than Five Years	406	0
Later than Five Years	2,840	0
Total	3,340	0

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

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

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	31 March 2013 £000	31 March 2012 £000
No Later than One Year	462	0
Later than One Year, No Later than Five Years	1,950	0
Later than Five Years	11,041	0
Subtotal	13,453	0
Less: Interest Element	(8,591)	0
Total	4,862	0

35 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI			
Depreciation charges	72	0	72
Interest Expense	419	0	419
Impairment charge - AME	195		195
Impairment charge - DEL	0	0	0
Other Expenditure	0	0	0
Revenue Receivable from subleasing	0	0	0
Total IFRS Expenditure (IFRIC12)	686	0	686
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	0	0	0
Net IFRS change (IFRIC12)	686	0	686
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC1:			
Capital expenditure 2012-13	5,324		
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0		

36 Financial Instruments

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

Currency risk

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

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

Credit Risk

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

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		1,130		**1,130**
Receivables - non-NHS		525		**525**
Cash at bank and in hand		2,586		**2,586**
Other financial assets	0	110	0	**110**
Total at 31 March 2013	**0**	**4,351**	**0**	**4,351**
Embedded derivatives	0			0
Receivables - NHS		1,198		1,198
Receivables - non-NHS		677		677
Cash at bank and in hand		1		1
Other financial assets	0	0	0	0
Total at 31 March 2012	0	1,876	0	1,876

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		4,056	**4,056**
Non-NHS payables		14,191	**14,191**
Other borrowings		0	**0**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**18,247**	**18,247**
Embedded derivatives	0		0
NHS payables		6,494	6,494
Non-NHS payables		14,702	14,702
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	21,196	21,196

37 Related party transactions

During the year the GP PEC Members undertook material transactions with the PCT via their GP Practices. Details are given below. No members of the key management team had material transactions with the PCT other than to receive their contractual remuneration.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
2012-13	**£000**	**£000**	**£000**	**£000**
Jezierski Practice (Dr Darren Tymens)	893			23
Glebe Road Surgery (Dr Marilyn Plant)	980			
Total	**1,873**	**0**	**0**	**23**
2011-12	**£000**	**£000**	**£000**	**£000**
Jezierski Practice (Dr Darren Tymens)	1,057		75	23
Glebe Road Surgery (Dr Marilyn Plant)	1,251		76	
Total	**2,308**	**0**	**151**	**23**

Any payments due to related parties are on an unsecured basis.

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

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

Major Healthcare providers

	Expenditure		Income	
	2012-13 £000	2011-12 £000	2012-13 £000	2011-12 £000
Ashford & St Peters	2,011	2,010	0	0
Chelsea & Westminster Foundation Trust	4,478	4,727	0	0
Croydon PCT	14,375	9,960	12	16
Epsom & St Helier	2,259	2,296	0	0
Guy's & St.Thomas Foundation Trust	2,895	2,746	0	0
Hammersmith Hospitals/ Imperial College	16,619	18,918	0	0
Hounslow PCT	490	30	9	305
Hounslow & Richmond Community Healthcare	23,622	24,514	3,626	2,932
Kingston Hospital	39,300	39,785	0	26
Kingston PCT	0	125	270	499
London Ambulance Service	4,531	4,554	0	0
Royal Brompton & Harefield	2,903	3,250	0	0
Royal Marsden Foundation Trust	4,703	5,173	0	0
St Georges Healthcare	19,833	19,187	2	13
SW London & St Georges	17,385	19,088	79	77
Wandsworth PCT	4,101	2,996	407	391
West Middlesex University Hospital	27,486	26,970	0	10

38 Losses and special payments

The PCT had no losses and special payments in 2012-13 or 2011-12

39 Third party assets

The PCT does not hold any Third Party assets. (Nil 2011-12).

40 Pooled budget

The PCT no longer has a Pooled Budget arrangement with the London Borough of Richmond. Pooled budget management arrangements were transferred to Hounslow & Richmond Community NHS Trust (HRCH) with effect from 1 April 2011. Therefore, PCT expenditure is reflected through its purchase of healthcare from HRCH and is classified as such in these Accounts.

41 Cashflows relating to exceptional items

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

42 Events after the end of the reporting period

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

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

Richmond Clinical Commissioning Group
NHS England
London Borough of Richmond
Public Health England
Department of Health
NHS Property Services Ltd

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

Richmond Primary Care Trust
Annual Governance Statement 2012 - 2013

NHS Richmond

Organisation Code:

Governance Statement

1 Scope of responsibility

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

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

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

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

· NHS SWL Joint Boards
· NHS SWL Finance Committee
· NHS SWL Audit Committee

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

2 The Governance Framework of the Organisation

2.1 Governance Framework

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

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

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

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

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

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

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

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

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

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

2.2 NHS SWL Joint Boards' Committee Structure

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

In terms of remit, the Committees cover:

Statutory Committees

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

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

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

(iv) **PEC/Clinical Commissioning** (CCC) – the former to exercise functions specified in the Directions 2007 and the latter to be directly accountable to the appointing PCT for delegated commissioning functions to enable each

PCT to achieve its statutory commissioning functions in a locally applicable way, with GP leadership. The CCCs supported the delivery and development of local GP consortia and their initiatives through making recommendations to its appointing Board, and undertaking delegated functions. Where PECs and CCCs met together, the combined membership ensured the statutory functions of the PEC were fulfilled.

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

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

Non Statutory Committees

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

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

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

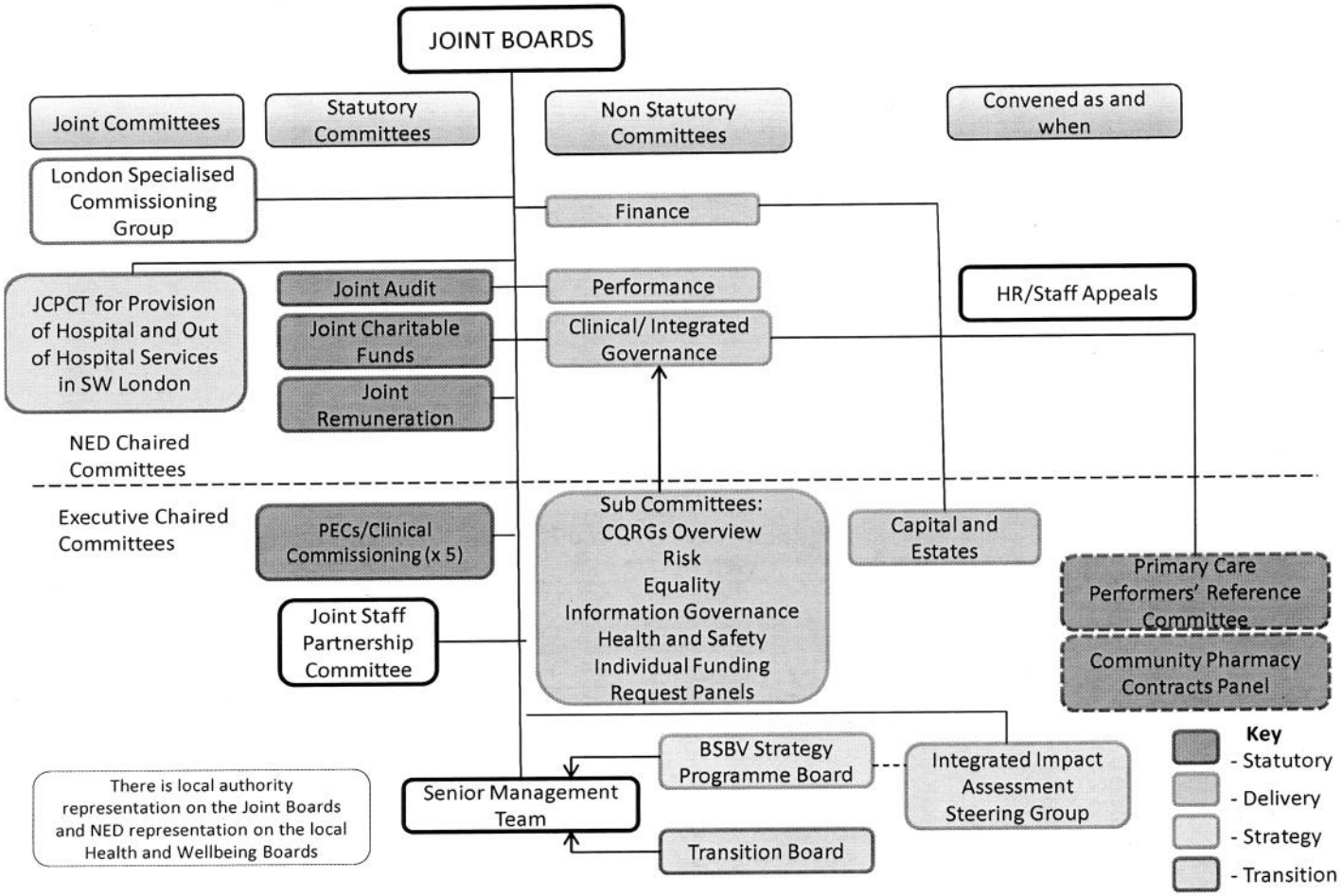
(ix) **(Joint Committees ((ix) Pan London; (x) South West and South East Clusters)**

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

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

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

JOINT BOARDS' COMMITTEE STRUCTURE



2.3 NHS SWL Joint Boards' Performance

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

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

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

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

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

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

2.3.6 In addition to the public meetings, the effectiveness of the Joint Boards' members (both collectively and individually) has been enhanced with a programme of more informal Board seminars/ workshops. These give members the opportunity to gain insight, clarify priorities and expectations, formulate strategy and ensure accountability in a more informal, reflective setting.

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

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

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

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

- Board Assurance Framework and Key Risks Exception Report
- Finance Reports
- Annual Accounts
- Performance Reports
- QIPP Plans
- SWL PCTs Operating Plan
- Commissioning Strategic Plan
- Quality and Patient Safety Reporting
- Transition

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

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

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

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

- A&E Waiting time: Whilst there has been an improvement against the 4 hour wait, this has continued to be an area for constant monitoring and the lessons learnt from the winter of 2011/12 were used to strengthen the plans for winter 2012/13. Achieving compliance with 95% standard for Type-1 performance at Croydon University Hospital has been a particular focus for 2012/13.

Performance during February and March across London has been challenging for all Trusts as a result of a multitude of factors including: higher than predicted levels of acuity and emergency admissions, intermittent loss of beds due to beds due to Norovirus, and poor discharge profile. All Trusts have recovery plans to improve performance and the YTD positions shows that they are still on track to achieve the 95% Standard for All Type performance and Type-1 performance, with the exception of Croydon University Hospital.

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

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

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

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

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

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

2.4 Highlights of Boards Committee Reports

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
Joint Audit Committee	Met 11 times	Yes	A key role of the Joint Audit Committee throughout the year is to scrutinise and review management performance against a range of pre-determined governance and control standards embedded within NHS South West London's corporate and financial governance framework. Largely, this is done through three reporting streams: i. Reports from SW London Cluster and PCT senior managers ii. Internal Audit reports against agreed annual plan iii. External Audit advice and direction on issues relating to PCT annual accounts and reports The Audit Committee reviews actions arising from these reports and directs officers to ensure compliance with best financial management practices and accounting standards across the Cluster. The Audit Committee also receives counter fraud reports detailing new and ongoing cases, plus counter fraud initiatives to proactively avoid losses and fraud and to develop and embed an anti fraud culture across all areas of the Cluster. Traditionally, the Audit Committee would receive reports on audited Annual Accounts from the independent external auditors and approve those Accounts to the Joint Boards of NHS South West London for adoption. However, given organisational restructuring under the Health & Social Care Act, for 2012-13 this function will be performed by a newly appointed Department of Health Audit Sub Committee. The governance arrangements around the

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
			closedown for 2012/13 – covering Annual Accounts, Annual Governance Statements and Annual Reports – was received, and the delegation to the DH Audit Sub Committee approved, by Joint Boards in March 2013.
Remuneration and Terms of Service	Met 9 times	Yes	
Richmond Clinical Commissioning Committee	Met 6 times	Yes	• Children and Young People's Services – Work Plan for 2011-12 • The London Pathfinder Toolkit • SWL Programme for Delegating Responsibility to Pathfinder Consortia including Revised Terms of Reference • Richmond GP Pathfinder Draft Constitution • Patient and Public Involvement in Clinical Commissioning • Update on Mental Health Commissioning: Older Peoples Inpatient Service; Procurement Process for Primary Mental Health Services; Adult and Older Peoples Inpatient Review • London Ambulance Service Commissioning Intentions • Programme of Transition

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

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
Finance	Met 12 times (Monthly)	Yes	Standing Items: • Finance report for Position To Date and Forecast Outturn; • QIPP reports • Approve single tender actions and ad hoc business cases Major decisions made by the FC in 2012/13 are as follows: • Approve all business cases from the 2% non-recurrent fund • To agree an increase in the Cluster Control Total from £25.2m to £30.2m. • To approve the transfer of funds to NHSC of £9m from 2% non-recurrent reserve.
Performance	Met 5 times (Bi-monthly)	Yes	• A&E and ambulance turnaround times at Croydon Hospital • 18 week waiting times at St George's, • HCAIs at Epsom & St Helier • Childhood Immunisations • A&E winter pressures • Ensuring focus on performance is maintained during the final stages of transition
Joint Committee (across South West and South East Cluster of PCTs: the South London Commissioning Support Services (SLCSS) Development Committee	Set up 1.3.12 Met twice	Yes	Recommending terms of reference for approval to Joint Boards; and detailed review and scrutiny of South London Commissioning Support Services Final Business Case, also with recommendations for approval to Joint Boards

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
London Specialised Commissioning Group Joint Committee	Met 6 times April '12 July'12 October'12 December'12 January'13 March'13	Yes	• Monitoring quality and performance through the Finance and Information report and governance measures and achievement of 12/13 corporate objectives via the Board Assurance Framework at each meeting. Annual reporting from Patient and Public Engagement Group and the London SCG Annual Report • Endorsement of the recommendations proposed by the Steering Group of the London and South East Burns Network for progressing with Phase 2 of the project • Consideration and approval of a Cystic Fibrosis Commissioning Policy for London • Considered and agreed the tender for HIV services in London as part of the national QIPP • Approved a preferred Network configuration for Children's Neuroscience Networks • Consideration of the final report on Respiratory Engagement from the review of Children's Congenital Heart Services • Endorsed the recommendations of the Review of Specialised Burns Services in London and South East England • Endorsed the proposals for a future consultation process for HIV Service Model Change • Considered and agreed preferred model of care for Children and Young People with Cancer following the NCAT review • Noted the London SCG's transition and closedown programme and agreed the process for financial closedown

2.5 An Account of Corporate Governance

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

2.5.1 Information Governance:

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

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

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

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

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

3. Risk

3.1 Risk Assessment

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

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

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

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

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

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

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

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

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

Key risks during 2012-13 have included:

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

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

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

3.2 Lapses of data security including reported to Information Commissioner:

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

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2012-2013		**Richmond**
Category	**Nature of incident**	
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	
IV	Unauthorised disclosure (73% involved failure to use NHS.net to e-mail identifiable data)	3
V	Other	
TOTAL		**3**

3.3 The Risk and Control Framework

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

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

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

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

3.4 Executive Management Team and Board Committee Scrutiny of Risks

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

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

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

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

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

3.5 Managing risks around delegation to CCGs under shadow working arrangements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.6 Review of the Effectiveness of Risk Management and Internal Control

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

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

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

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

3.6.2 However, internal audit have identified specific areas where high risk recommendations required action to ensure that the Primary Care Trust's strategic objectives were met and the systems of internal control remained

sufficiently robust to mitigate critical financial, operational and governance risks.

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

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

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

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

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

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

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

4. Significant Issues

4.1 Continuing Care

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

secured a new common continuing care service from South London Commissioning Support Unit. This provides greater consistency of approach to applications, quality monitoring, patient safety assurance and increased staffing resilience across all South West London areas. Continuing care placements that had not been subject to a formal review within the prescribed timelines set out in national guidelines, are now being completed, although this exercise will not be completed until the late spring/early summer of 2013.

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

Department of Health Designated Signing Officer

Carl Vincent – Director of Provider Finance and Finance Transition

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