Department of Health

NHS

Croydon Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

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Croydon Primary Care Trust

2012-13 Annual Report

NHS

South West London

NHS Croydon
Annual Report 2012/13

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1. Welcome

Welcome to NHS Croydon'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 Croydon's excellent work in 2012-13 and to celebrate their work since NHS Croydon 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 Croydon CCG received authorisation in February, and took on its statutory responsibilities in April 2013

Over the past 11 years, NHS Croydon 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 Croydon'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 Croydon 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. Who we are and what we do

In April 2011 NHS Croydon came together with the other four PCTs in South West London (NHS Kingston, NHS Richmond, NHS Sutton and Merton, and NHS Wandsworth) to form NHS South West London.

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

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

In Croydon, the Croydon Clinical Commissioning Group (CCG) formed when the two Croydon Pathfinders came together at the end of December 2011. Croydon CCG's vision is one of sustainability, better use of resources through service redesign, and improving quality through innovation.

This annual report for 2011-12 sets out what we have achieved over the last year to deliver the NHS Croydon vision of ***longer, healthier lives for all the people in Croydon.***

2.1. How the NHS in Croydon has changed

In April 2012 the local emerging Clinical Commissioning Group (CCG) in Croydon 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 was successfully authorised by the NHS Commissioning Board to become a statutory body on 1 April 2013.

Clinical Commissioning Development in 2012-13

From 1 April 2013 all established Clinical Commissioning Groups will become statutory bodies responsible for around 66% of the healthcare budget. They will plan and commission care on behalf of the patients within their area, including hospital, community and mental health services.

Throughout 2012-13 NHS Croydon Clinical Commissioning Group has made good progress in towards authorisation, receiving its authorisation in March 2013.

Governing Body

In Croydon a full Governing Body has now been appointed through a mixture of elections and appointments.

NHS Croydon CCG Governing Body

- Dr Anthony Brzezicki — Chair (GP) — Elected
- Dr Agnelo Fernandes — Assistant Clinical Chair (GP) — Elected
- Dr Dev Malhotra — GP Governing Body Member — Elected
- Vacant — GP Governing Body Member — To Be Elected
- Vacant — GP Governing Body Member — To Be Elected
- Paula Swann — Accountable Officer — Appointed
- Mike Sexton — Chief Finance Officer — Appointed
- Stephen Warren — Director of Commissioning — Appointed
- Fouzia Harrington — Director of Quality and Governance — Appointed
- Dr Jonathan Norman — Secondary Care Consultant — Appointed
- Amy Page — Chief Nurse — Appointed
- David Hughes — Lay Member - Finance — Appointed
- Helen Pernelet — Lay Member – Governance &PPI; Vice Chair — Appointed

Non-voting members

- Dr Mike Robinson — Director of Public Health
- Hannah Miller — Director Adult Social Services and Deputy Chief Executive Croydon Council

Since September 2012 the monthly Governing Body meetings have been held in public with members of the public and press attending and having the opportunity to ask questions.

Clinical Leadership Group

The Clinical Leadership Group (CLG) was elected and established in 2012. Its purpose is to provide clinical and corporate support to the Governing Body, through leading on agreed areas, engaging with member practices and providing clinical leadership in service redesign and commissioning improvement programmes.

Each member of the CLG has an agreed portfolio of work and is supported by one of the GP Governing Body members.

Clinical Leadership Group

- Dr Bobby Abbot — Elected
- Dr Karthiga Gengatharan — Elected
- Dr Kamran Khan — Elected
- Dr Brian Okumu — Elected
- Dr Rajeev Sagar — Elected
- Dr Farhhan Sami — Elected
- Dipti Gandhi — Co-opted

Alongside the Clinical Leadership Group are a number of other GPs involved in specific workstreams such as end of life, reablement and cancer.

Networks

To facilitate practice engagement with clinical commissioning and ensure two way communication between the Governing Body, Clinical Leadership Group and the practices, practices have been working in small groups (Networks). These 6 Networks evolved from the networks set up when Croydon had two Clinical Commissioning Groups.

As the CCG moved towards authorisation, the Networks were reviewed and realigned so that they are geographically based, grouping together practices with similar demographics to enable more effective clinical commissioning.

Each network is led by a Clinical Lead from the Clinical Leadership Group, supported by a Network Coordinator (Manager). The Networks will be further supported by named leads for finance, business intelligence, public health and medicines management. Commissioning support will be provided as required and there will also be business and administrative support available.

Networks will develop localised commissioning and QIPP plans, and will be supported, as described above, to deliver these. They will aim to deliver both strategic and network objectives, supporting financial recovery and sustainability.

Authorisation

Applications for CCG Authorisation took place in four waves from July 2012 onwards. NHS Croydon CCG opted for wave 4.

A 360 degree stakeholder survey was carried out by Ipsos Mori where all member practices of the CCG and up to 40 other stakeholders including provider colleagues, local authority representatives and community groups were asked to complete a survey about their engagement with the CCG.

As part of the authorisation process the CCG had to submit evidence by 1st November 2012 that demonstrated how they met 119 criteria across 6 domains, set out by the NHS Commissioning Board. The 6 domains were:

- a strong clinical and multi-professional focus which brings real added value
- meaningful engagement with patients, carers and their communities
- clear and credible plans which continue to deliver the QIPP challenge within financial resources, in line with national requirements and local joint health and wellbeing strategies
- proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial controls, as well as effectively commission all the services for which they are responsible
- collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as appropriate external commissioning support
- great leaders who individually and collectively can make a real difference.

This evidence was reviewed by a number of assessors and the gaps were then addressed at the site visit on 20th December 2012. The site visit was carried out by a panel of assessors from the NHS Commissioning Board, local authority, other CCGs, and each member of the panel had a specific area of expertise for example finance or commissioning. They met with key members of the CCG to explore specific areas further, and provide the opportunity to meet additional criteria.

Following moderation of the final report from the site visit and a conditions panel NHS Croydon CCG was authorised in March 2013 with two directions and seven conditions. The two directions relate to the challenging financial position the CCG faces, as do four of the conditions. One condition relates to a South West London risk sharing agreement not being in place yet and two relate to SI and early warning systems not yet fully in place. We will work hard to meet these conditions as quickly as possible.

Constitution

Every clinical commissioning group must have a constitution. NHS Croydon CCG developed its constitution, including discussions with the Local Medical Committee and member practices. The constitution was finalised in October 2012 and sent out to all practices, asking them to sign up in November 2012. All 61 member practices have signed up to the constitution.

Governance

Under the Constitution the Governing Body has established:

- an integrated Governance and Audit Committee, chaired by one of the Governing Body lay members, which will oversee governance, audit, quality, PPI and patient safety
- a Finance Sub Committee of the Integrated Governance and Audit Committee
- a Remuneration Committee

All members of the Governing Body and Clinical Leadership Group have to declare any interests and a register is kept.

The Chief Nurse has delegated responsibility for ensuring the CCG carries out its safeguarding statutory duties effectively and will act as the representative on the safeguarding boards.

Engagement

The CCG has continued to hold 2-monthly meetings open to all practices, with regular attendance of over 40 GPs, practice managers and other practice staff.
Networks have continued to meet and are being realigned so that they cover geographical areas.

Each Network will have a clinical lead from the Clinical Leadership Group, a Network Coordinator and will have named representatives from Finance, Public Health, Medicines Management and Business Intelligence.

Delegated budgets
For the last 6 months of 2012-13 the CCGhad full authority for managing the delegated Croydon budget.

Development of future structures and commissioning support
Croydon CCG developed its model for commissioning support with most areas of support bought from the South London Commissioning Support Unit. The integrated commissioning unit with the local authority is still in development and so initially these staff will be employed by the CCG.

Delivery of QIPP schemes, service redesign and innovation
Throughout the year the CCG has been involved in developing and implementing QIPP schemes, service redesign projects and promoting innovation, contributing towards achieving the financial position. Each member of the Governing Body and the Clinical Leadership Group has a defined portfolio of work that they lead on, in conjunction with the management team and staff at NHS Croydon.

Some of the successes from this work in 2012-13 include:

- Croydon Referral Support Service (CReSS) – procured and rolled out to all practices
- Patient Navigation – HSJ Efficiency Awards 2012 winner of 'Efficiency in Commissioning Support Services' category
- Ophthalmic triage set up
- ENT Intermediate Service re-procured through Any Willing Provider
- Gynaecology Intermediate Service re-procured through Any Qualified Provider
- Dermatology Intermediate Service re-procured through Any Qualified Provider
- Risk stratification rolled out across Croydon
- Mental Health
- Urgent Care
- Telehealth
- Better Services Better Value - Croydon clinicians have continued to be involved in this.

2.2 How we spent your money

OPERATING AND FINANCIAL REVIEW

Introduction

The PCT commissioned healthcare services to meet the needs and improve the health of the population of the London Borough of Croydon. This healthcare was purchased from a wide variety of NHS and non-NHS providers across London.

The main providers were Croydon University Healthcare Services NHS Trust and South London and the Maudsley Mental Health Trust. Community services are directly managed by Croydon Community Health Services, a division of Croydon University Healthcare NHS Trust. In addition, the PCT paid for services from primary care practitioners such as GPs, dentists, pharmacists and opticians.

In April 2011 the PCT came together with the four other PCTs in South West London (Wandsworth, Kingston, Richmond & Twickenham and Sutton & Merton) to form NHS South West London, which operated through a central management team sharing resources, roles and functions.

Croydon PCT remained an independent statutory organisation until the abolition of PCTs on 31 March 2013. NHS South West London (SWL) was hosted by Wandsworth PCT, with the costs incurred by the shared service recharged to participating PCTs.

The material financial misstatements referred to in the 2011/12 Annual Report have impacted heavily on the PCT in the 2012/13 financial year: this was the second year of significant financial recovery, dependent on strong QIPP (Quality, Innovation, Productivity and Prevention) achievement in-year, plus support from SWL Risk Sharing, with the requirement to deliver a break-even position for this year. The recovery obligation continues beyond 2012/13 as the newly-established NHS Croydon Clinical Commissioning Group inherit the PCT's financial shortfall and develop their own 3-year improvement plan.

These Financial Statements including comparators have been prepared under International Financial Reporting Standards (IFRS).

Objectives

The PCT's main financial objectives were:

- to maintain financial stability through not exceeding its resource targets and
- to use the PCT's resources wisely to meet the health needs of Croydon and to ensure value for money and fair and effective use of resources. It does this by setting a budget at the start of the year, in accordance with the PCT's financial strategy and updating this as necessary as new funding becomes available.

Performance against this budget was monitored throughout the year, allowing prompt action to be taken to alleviate any particular financial pressures that arose.

The PCT's Revenue Resource Limit was adjusted in-year to reflect some £9.0m support provided from the SWL Risk Sharing arrangement; this, together with stringent cost-control and the achievement of some £21.2m against QIPP targets, enabled the PCT to deliver a modest surplus against its break-even objective for the year.

In line with other NHS bodies, Croydon PCT is required to prepare its accounts on a resource accounting basis. Expenditure net of income is measured against Resource Limits set by the Department of Health. There are two resource limits – revenue for on-going operations and capital for new investment. PCTs are required to keep their expenditure within these limits. The PCT's revenue resource limit is set annually by Department of Health and performance against the limit is reported below.

Performance for the year ended 31 March 2013 is detailed below:

Operational Financial Balance:

	2012/13 £000	2011/12 £000
Total net operating cost for the financial year	623,875	611,825
Adjustments for expenditure relating to a prior accounting period	0	27,754
Net operating costs chargeable against the resource limit	623,875	639,579
Revenue Resource Limit	623,938	640,417
Operational under/(over) spend	**(63)**	**838**

Capital Resource Limit:

	2012/13 £000	2011/12 £000
Gross capital expenditure	706	1,092
Less: Net book value of assets disposed of	0	0
Less: Donations	0	0
Charge against the capital resource limit	**706**	1,092
Capital resource limit	1,030	2,250
Under spend against the capital resource limit	**324**	**1,158**

FIXED ASSETS

During the year the PCT invested £706k in fixed assets. The expenditure was used to refurbish and upgrade existing properties and to purchase equipment.

All NHS property assets are valued in accordance with the latest RICS guidance and the requirements of IFRS. Under normal conditions, the property assets are based on depreciated replacement cost which is based on a modern equivalent asset basis. This review was carried out by the District Valuer and was updated at 31 March 2013. The result of the valuation was to enhance the PCT's property assets by a net £51k.

AUDIT FEES

The PCT's independent external auditors are Grant Thornton. Audit fees paid in respect of the statutory audit for 2012-13 amounted to £132,120 (incl.VAT). This figure is net of a refund of £10,440 in respect of the distribution of Audit Commission reserves to NHS organisations.

WHERE DID THE MONEY GO?

Expenditure of £623.875m was spent in 2012/13 on the commissioning of the following health care services:

	2012/13 £000	2011/12 £000
Primary care	121,605	124,332
Learning difficulties	5,395	5,611

Mental illness	53,098	54,499
Maternity	23,292	21,655
General and acute	311,529	290,167
Accident and emergency	12,801	11,330
Community health services	32,801	34,277
Other healthcare	63,354	69,954
Total	**623,875**	**611,825**

The PCT's main providers of healthcare were Croydon University Healthcare Services NHS Trust and South London and the Maudsley Mental Health NHS Trust.

As a key component of the financial recovery plan, the PCT's focus for investment in the year was reinvestment, to deliver savings as well as quality improvements, in expanded community based outpatient services and other QIPP supporting investments. Strict financial controls were imposed to limit increases in expenditure, or minimise the impact of increased activity, for example in acute settings.

Value for Money

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

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

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

RUNNING COSTS

The PCT for 2012/13 has measured its running costs according to the definitions provided by the Department of Health in 'Definition of Running Costs in Primary Care Trusts - 6 April 2010.

Commissioning only (excl. Public Health)	**2012/13**	**2011/12**
Running costs (£'000)	14,101	14,191
Weighted population (number of units)	343,127	343,127
Running cost per head of weighted population (£)	**41.10**	**41.36**

Public Health	2012/13	2011/12
Running costs (£'000)	2,937	2,180
Weighted population (number of units)	343,127	343,127
Running cost per head of weighted population (£)	8.56	6.35

Staff Sickness

During 2012-13, a total of 1,737 days were lost to staff sickness, at an average of 10.22 days per whole time equivalent employee (2011-12 6.46 days).

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, 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. The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. (Further details can be found at Note 7.5 of the Annual Accounts).

LOSSES & COMPENSATION

There was 63 cases of losses and special payments approved during 2012-13 of totalling £6,679 which related to aged debts deemed to be uncollectable. The relatively high number of cases was the outcome of a pre-PCT closure balance sheet cleansing exercise, carried out in line with Department of Health guidelines.

BETTER PAYMENT PRACTICE CODE PERFORMANCE

The NHS requires Primary Care Trusts to pay their NHS and non-NHS trade creditors in accordance with the Better Payment Practice Code and Government Accounting Regulations. This code requires the PCT to pay all invoices within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier. The PCT's payment policy is consistent with the Better Payment Practice Code and Government Accounting Regulations and its measurement of compliance is:

Non-NHS	**2012/13**		**2011/12**	
	Number	**£000**	**Number**	**£000**
Total bills paid in year	14,658	82,775	14,710	80,812
Total bills paid within target	12,959	67,396	12,910	65,913
Percentage of bills paid within target	**88.41%**	**81.42%**	**87.76%**	**81.56%**

NHS	**2012/13**		**2011/12**	
	Number	**£000**	**Number**	**£000**
Total bills paid in year	8,645	1,511,035	7,377	1,297,357
Total bills paid within target	6,756	1,410,228	5,892	1,250,192
Percentage of bills paid within target	**78.15%**	**93.33%**	**81.09%**	**96.36%**

Audit Committee Members

As part of the governance arrangements for NHS South West London, a Governance Framework was developed to enable five statutory PCTs to function in a cluster operating arrangement; this received NHS

London and legal assurance of compliance with primary and secondary legislation governing PCTs, and also with the Cluster Implementation Guidance published by the Department of Health.
In line with the arrangements, a Joint Audit Committee was established that 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.
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, Parkhill) and representatives of the external auditors (Grant Thornton and Price Waterhouse Coopers) also attend the Audit Committee.
With the impending abolition of Primary Care Trusts on 31 March 2013, the Department of Health sought nominations for membership of a (local) Audit Sub Committee which would oversee legacy governance arrangements and the sign-off of 2012-13 Accounts between 1 April and 30 June 2013. For south west London, the appointed non-executive directors were Paul Gallagher (Chair), Toni Letts, John Simpson and Vidya Verma OBE. All four were members of the Joint Audit Committee for NHS South West London.

Remuneration Committee Members

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.

Principles for Remedy

Sutton and Merton PCT has complied with Treasury guidance for Principles for Remedy as per Appendix 4.14 of the Managing Public Money guidance. There are six principles that represent best practice and these are directly applicable to Sutton and Merton PCT's procedures.

RELATED PARTY TRANSACTIONS

Croydon Primary Care Trust was, until its abolition on 31 March 2013, a body corporate established by order of the Secretary of State for Health. During the year there were no payments made to General Practitioner Partnerships defined as related parties; the 2011/12 figures, where one or more partners sat on the PCT's Professional Executive Committee, are stated below.

	2012/13		2011/12	
	Payments to related party **£**	Amounts owed to related party **£**	Payments to related party £	Amounts owed to related party £
DR K. TARRANT	**-**	-	2,294,924	-
DR P. BOFFA	**-**	-	2,487,180	-
DR T. BRZEZICKI	**-**	-	3,438,584	-
DR A. FERNANDES	**-**	**-**	3,042,432	23,890
DR K. SHAH			-	-

The PCT, as a commissioner of healthcare services, had a number of significant transactions with related parties, especially Croydon Health Services NHS Trust and Epsom & St.Helier University Hospitals NHS Trust, as well as the Department of Health, other central government departments and the London Borough of Croydon.

The London Specialised Commissioning Group, hosted by Croydon PCT, had material transactions with a large number of PCTs, NHS Trusts and NHS Foundation Trusts across greater London and the south of England.

Head of Internal Audit Opinion

During 2012-13, the Joint Boards for NHS South West London were accountable for internal control and the management of risk to a reasonable level. The Chief Executive Officer of NHS South West London has responsibility for maintaining a sound system of internal control that supports the achievement of the PCT's policies, aims and objectives, and for reviewing its effectiveness.

The Head of internal audit opinion provides the Joint Boards with **significant assurance** over matters relating to corporate governance arrangements and financial management and control. However, only **limited assurance** was given in relation to the PCT's Continuing Care assessment arrangements due to the large number of backlog cases due to be assessed.

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

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

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

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

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

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

SUMMARY FINANCIAL STATEMENTS

Introduction

The following statements have been prepared to provide a summary of the PCT's full audited annual accounts for the year ended 31 March 2013. These accounts have been prepared in accordance with directions issued under the PCT Manual of Accounts for 2012-13 as directed by the Secretary of State and approved by HM Treasury. 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 PCTs 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 trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the PCT are described in the full Annual Accounts document. They have been applied consistently in dealing with items considered material in relation to the accounts. The PCT is within the government resource accounting boundary and therefore has only consolidated interests in other entities where the other entity is also within the resource accounting boundary and the PCT exercise in-year budgetary control over the other entity.

These summary financial statements do not contain sufficient information to allow as full an understanding of the results of the of the Trust and state of affairs of the Trust and of its policies and arrangements concerning directors' remuneration as would be provided by the full annual accounts and reports. A copy of the full accounts for the year ended 31 March 2013, is available on request, at no charge, from the Director of Finance, Croydon Primary Care Trust, 11th Floor, Leon House Croydon CR0 9XT.

So far as the directors are aware, there is no relevant information of which the PCT's auditors are unaware; and the directors have taken all steps that ought to have been taken as directors in order to make themselves aware of any relevant audit information and to establish that the PCT's auditors are aware of that information.

Signed:

Carl Vincent
Director of Provider Finance and Transition
Department of Health

4 June 2013

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH's ACCOUNTING OFFICER IN RESPECT OF CROYDON PCT

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 Croydon 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 Croydon Primary Care Trust for the year ended 31 March 2013.

Grant Thornton UK LLP
Grant Thornton House
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NW1 2EP

Section 2

Who we are and what we do

Summary Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2013

	2012/13 £'000	2011/12 £'000
Commissioning		
Employee benefits	14,141	14,563
Other costs	1,680,298	1,493,339
Revenue	(1,070,564)	(896,110)
PCT net operating costs before interest	**623,875**	**611,792**
Other losses	0	0
Investment revenue	0	0
Finance costs	0	33
Net operating costs for the financial year	**623,875**	**611,825**

Statement of Financial Position as at 31 March 2013

	2012/13 £'000	2011/12 £'000
Non-current assets		
Property, plant and equipment	19,254	19,877
Intangible assets	105	141
Other financial assets	2	2
Trade and other receivables	0	0
Total non-current assets	**19,361**	**20,020**
Current assets		
Trade and other receivables	8,283	21,196
Cash and cash equivalents	958	69
	9,221	21,265
Non-current assets classified as held for sale	0	0
Total current assets	**9,221**	**21,265**
Total assets	**28,582**	**41,285**
Current liabilities		
Trade and other payables	(64,732)	(77,347)
Provisions	(5,581)	(1,549)

Borrowings	(0)	(0)
Total current liabilities	**(70,318)**	**(78,896)**
Non-current assets less net current liabilities	**(41,731)**	**(37,611)**
Non-current liabilities		
Provisions	(1,938)	(1,655)
Borrowings	(0)	(0)
Total non-current liabilities	**(1,938)**	**(1,655)**
Total assets employed	**(43,669)**	**(39,266)**
Financed by Taxpayers' equity		
General fund	(49,377)	(45,018)
Revaluation reserve	5,708	5,752
Donated asset reserve	0	0
Total Taxpayers' equity	**(43,669)**	**(39,266)**

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	(45,018)	5,752	0	**(39,266)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(623,875)	0		**(623,875)**
Gain on revaluation of estate	0	109		**109**
Impairments and reversals		(51)		**(51)**
Transfers between reserves	102	(101)		**0**
Total recognised income and expense for 2012-13	(623,773)	(44)	0	**(612,249)**
Net Parliamentary funding	619,414	0	0	**619,414**
Balance at 31 March 2013	**(49,377)**	**5,708**	**0**	**(43,669)**
Balance at 1 April 2011				
Opening balance adjustments	(16,780)	6,176	(36)	**(10,640)**
Restated balance at 1 April 2011	(27,754)	-	36	**(27,718)**
	(44,534)	6,176	0	**(38,358)**

Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(611,825)			**(611,825)**
Impairments and reversals	0	(424)	0	**(424)**
Total recognised income and expense for 2011-12	(611,825)	(424)	0	**(612,249)**
Net Parliamentary funding	611,341	0	0	**611,341**
Balance at 31 March 2012	**(45,018)**	**5,752**	**0**	**(39,266)**

The **General Fund** reflects the cumulative surplus made by the PCT. The balance from the Statement of Comprehensive Net Expenditure (SoCNE) is transferred into this fund each year. The PCT's Parliamentary funding is also accounted for in this reserve. This balance cannot be released back to the SoCNE. The PCT Manual of Accounts from 2011/12 no longer permits the use of a **donated asset reserve** by NHS bodies. The balance on this reserve has been taken to the general fund. Where assets have been funded by donation, there will no longer be any offset of the reserves against depreciation and loss on disposal transactions, and the full expense will be taken through the SoCNE.

The **Revaluation Reserve** reflects movements in the value of property, plant and equipment and intangible assets as set out in the accounting policy. The revaluation reserve balance relating to each asset is released to the general fund on disposal of that asset.

Summary Cash Flow Statement for the Year Ended 31 March 2013

	2012-13	2011-12
	£000	£000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(623,875)**	**(611,792)**
Depreciation and Amortisation	**1,294**	**1,522**
Impairments and Reversals	**129**	**161**
(Increase)/Decrease in Inventories	**-**	**-**
(Increase)/Decrease in Trade and Other Receivables	**12,933**	**(484)**
Increase/(Decrease) in Trade and Other Payables	**12,444**	**16**
Provisions Utilised	**(79)**	**(989)**
Increase/(Decrease) in Provisions	**4,394**	**849**
Net Cash Inflow/(Outflow) from Operating Activities	**(617,648)**	**(610,717)**
Cash flows from investing activities		
(Payments) for Property, Plant and Equipment	**(854)**	**(555)**
(Payments) for Intangible Assets	**(23)**	**-**
Net Cash Inflow/(Outflow) from Investing Activities	**(877)**	**(555)**
Net cash inflow/(outflow) before financing	**(618,525)**	**(611,272)**
Cash flows from financing activities		
Net Parliamentary Funding	619,414	611,341
Net Cash Inflow/(Outflow) from Financing Activities	**619,414**	**611,341**
Net increase/(decrease) in cash and cash equivalents	**889**	**69**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	69	
Cash and Cash Equivalents (and Bank Overdraft) at year end	958	69

Independent auditors' statement to the Directors of the Board of Croydon Primary Care Trust ('the PCT')

This report is made by the Board on the recommendation of the Remuneration Committee in accordance with Regulation 11, Schedule 8 of SI 2008/410 of the Companies Act 2006. The first part of the report provides details of remuneration policy; the second part provides details of the remuneration and pensions of the PCT's senior managers for the year ended 31 March 2013.

The report is in respect of the senior managers of the PCT, who are defined as *'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body'*. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.

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.

Pay Multiples
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2012/13 was £152,500 (annualised salary, 2011/12 £147,500). This was 3.3 times (2011/12, 3.3 times) the median remuneration of the workforce, which was £46,248 (2011/12, £44,508).

In 2012/13 (as in 2011/12) no employee received remuneration in excess of the highest paid director.

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

Following the introduction of Cluster management arrangements in South West London at the end of February 2011, the cost of certain Executive Directors is shared across five Primary Care Trusts. For such posts only the proportion of the salary paid by Croydon PCT is taken into consideration when calculating the remuneration of the highest paid director.

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 Kate Woollcombe	Acting Director of Public Health	01/03/2012	14/10/2012
Dr Michael Robinson	Director of Public Health	15/10/20102	31/03/2013
Dr Shade Alu	Interim Chair of the Professional Executive Committee	01/04/2011	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
Fouzia Harrington	Acting Borough Managing Director	24/10/2011	31/05/2012
Paula Swann	Borough Managing Director	01/06/2012	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	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	31/03/2013
Neil Roberts	Director of Primary Care Contracting	28/02/2011	31/03/2013

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

Termination Arrangements

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

Non Executive Directors

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

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

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

The Non Executive appointments became effective on the following dates:

Non Executive Director	Role	Contract Date	Leave date
Sian Bates	Chair	01/04/2011	31/03/2013
Paul Gallagher	Audit Committee Chair	01/04/2011	31/03/2013
Toni Letts	Non Executive Director	01/04/2011	31/03/2013
Tony Newman	Non Executive Director	01/04/2011	30/04/2012
Joy Tweed	Partner Non Executive Director	01/04/2011	31/03/2013
John Thompson	Partner Non Executive Director	01/04/2011	31/03/2013

John Thompson 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

Croydon Primary Care Trust

Directors' and Senior Managers' salaries and allowances

NAME AND TITLE	Note	2012/13 Salary (bands of £5,000) £000	2012/13 Other remuneration (bands of £5,000) £000	2012/13 Benefits in kind (to the nearest £100) £	2011/12 Salary (bands of £5,000) £000	2011/12 Other remuneration (bands of £5,000) £000	2011/12 Benefits in kind (to the nearest £100) £
Chair and Non Executive Directors							
Sian Bates (Chair)	1	-	10-15	-	-	10-15	-
Paul Gallagher (Audit Committee Chair)	2	-	0-5	-	-	0-5	-
Toni Letts (Non Executive)		-	15-20	-	-	10-15	-
Tony Newman (Non Executive - to 30/04/12)		-	0-5	-	-	5-10	-
Joy Tweed (Partner Non Executive)	3	-	-	-	-	-	-
John Thompson (Partner Non Executive)	3	-	-	-	-	-	-
Executive Directors							
Ann Radmore (Chief Executive - to 06/01/13)	4	30-35	-	-	35-40	-	-
Christina Craig (Interim Chief Executive - from 07/01/13)	5	5-10	-	-	-	-	-
Jill Robinson (Director of Finance)	6	30-35	-	-	25-30	-	-
Dr Peter Brambleby (Director of Public Health - to 29/02/12)		N/A	-	-	145-150	-	-
Dr Kate Woollcombe (Director of Public Health - from 01/03/12 to 14/10/12)		45-50	-	-	5-10	-	-
Dr Michael Robinson (Director of Public Health - from 15/10/12)		70-75	-	-	-	-	-
Dr Shade Alu (Interim Chair of the Professional Executive Committee)		10-15	-	-	10-15	-	-
Sarah Timms (Director of Nursing - from 29/06/11 to 15/12/11)		N/A	-	-	5-10	-	-
Debbie Stubberfield (Director of Nursing - from 01/02/12)	7	20-25	-	-	0-5	-	-

Senior Managers							
Amanda Philpott (Borough Managing Director - to 25/10/11)		N/A	-	-	62-80	-	-
Fouzia Harrington (Acting Borough Managing Director - from 24/10/11 to 31/05/12)		10-15	-	-	30-35	-	-
Paula Swann (Borough Managing Director - from 01/06/12)		85-90	-	-	-	-	-
Bill Gillespie (Director of Strategy and Performance - to 19/02/12)		N/A	-	-	30-35	-	-
Dominic Conlin (Managing Director ACU - to 31/12/11)		N/A	-	-	20-25	-	-
Dr Jonathan Hildebrand (Cluster Director of Public Health)	8	10-15	-	-	5-10	-	-
Dr David Finch (Joint Medical Director)	9	15-20	-	-	15-20	-	-
Dr Howard Freeman (Joint Medical Director)	10	15-20	-	-	15-20	-	-
Charlotte Gawne (Director of Communications)	11	20-25	-	-	20-25	-	-
Jacqui Harvey (Director of Transition)	12	40-45	-	-	40-45	-	-
Jocelyn Fisher (Director of Human Resources, OD and Workforce)	13	30-35	-	-	40-45	-	-
Paula Swann (Director of Financial Management)	14	0-5	-	-	10-15	-	-
Neil Ferrelly (Director of Strategic Financial Planning - to 14/08/11)		NA	-	-	5-10	-	-
Hardev Virdee (Director of Strategic Financial Planning - from 02/01/12 to 30/06/12)	15	5-10	-	-	5-10	-	-
Neil Roberts (Director of Primary Care Contracting)	16	20-25	-	-	20-25	-	-

Notes	
1.	Sian Bates was also Chair of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £40,000 - £45,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
2.	Paul Gallagher was also Audit Committee Chair of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £10,000 - £15,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
3.	Joy Tweed and John Thompson were also non-executive directors of Sutton & Merton PCT. Their remuneration is shown in the Annual Report of Sutton & Merton PCT.
4.	Ann Radmore was also Chief Executive of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. She was appointed Chief Executive of London Ambulance Service NHS Trust with effect from 7 January 2013, but remained Accountable Officer for all five PCTs. The full value of her salary and allowances was in the range £120,000 - £125,000 for the period to 6 January 2013. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
5.	Christina Craig was also Acting Chief Executive of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £25,000 - £30,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
6.	Jill Robinson was also Director of Finance of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £125,000 - £130,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
7.	Debbie Stubberfield was also Director of Nursing of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £95,000 - £100,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
8.	Dr Jonathan Hildebrand also supported Kingston, Richmond & Twickenham, 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 Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £65,000 - £70,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
10.	Dr Howard Freeman was also the Joint Medical Director of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £65,000 - £70,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
11.	Charlotte Gawne was also Director of Communications of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £85,000 - £90,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

12.	Jacqui Harvey was also Director of Transition of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The payments disclosed represent fees paid to AML Management Ltd and Verdedus in respect of her services. The total cost of her services was in the range £165,000 - £170,000 and has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
13.	Jocelyn Fisher was also Director of Human Resources, OD and Workforce of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The payments disclosed include fees paid to Employee Relations Solutions Limited in respect of her services for the period 1 April to 13 May 2012. The total of her remuneration and service fees was in the range £120,000 - £125,000 and has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
14.	Paula Swann was also Director of Financial Management of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £15,000 - £20,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
15.	Hardev Virdee was also Director of Strategic Financial Planning of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £25,000 - £30,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
16.	Neil Roberts was also Director of Primary Care Contracting of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £85,000 - £90,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

Croydon Primary Care Trust								
Directors' and Senior Managers' pension benefits								
NAME AND TITLE		Real increase in pension at age 60 (bands of £2,500)	Real Increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of	Lump sum at age 60 at 31 March 2013 (bands of £5,000)	Cash equivalent transfer value at 31 March 2013	Cash equivalent transfer value at 31 March 2012	Real increase in cash equiv transfer value funded by employer
	Note	£000	£000	£000	£000	£000	£000	£000
Executive Directors								
Ann Radmore(Chief Executive)	5	0-2.5	0-2.5	10-15	40-45	280	251	9
Christina Craig (Acting 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	27	20	4
Dr Kate Woollcombe (Director of Public Health - from 01/03/12 to 14/10/12)		0-2.5	7.5-10	35-40	105-110	840	718	49
Dr Michael Robinson (Director of Public Health)		N/A	N/A	60-65	140-145	994	N/A	N/A
Dr Shade Alu (Interim 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)	10-15	30-35	223	N/A	N/A
Senior Managers								
Paula Swann (Borough Managing Director)		0-2.5	0-2.5	35-40	50-55	575	N/A	N/A
Dr Jonathan Hildebrand (Cluster Director of Public Health)	10	0-2.5	0-2.5	0-5	5-10	57	52	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	0-2.5	0-5	10-15	57	51	2
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	N/A	6	0	3
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	5-10	25-30	186	170	4

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 2011/12.
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 Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £55,000 - £60,000; the full value of her lump sum at age 60 was in the range £170,000 - £175,000; and the full CETV of her pension benefits was £1,122,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
6. Christina Craig and Jacqui Harvey were not directly employed by the NHS in 2012/13 and their pension entitlements are managed by their employer.
7. Jill Robinson was also Director of Finance of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £5,000 - £10,000; the full value of her lump sum at age 60 was £0; and the full CETV of her pension benefits was £108,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
8. Dr Shade Alu, 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 Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £40,000 - £45,000; the full value of her lump sum at age 60 was in the range £120,000 - £125,000; and the full CETV of her pension benefits was £894,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
10. Dr Jonathan Hildebrand also supported Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of his accrued pension at age 60 was in the range £40,000 - £45,000; the full value of his lump sum at age 60 was in the range £120,000 - £125,000; and the full CETV of his pension benefits was £765,000. His pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

11.	Charlotte Gawne was also Director of Communications of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £15,000 - £20,000; the full value of her lump sum at age 60 was in the range £45,000 - £50,000; and the full CETV of her pension benefits was £230,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
12.	Jocelyn Fisher was also Director of Human Resources, OD and Workforce of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £0 - £5,000; the full value of her lump sum at age 60 was £0; and the full CETV of her pension benefits was £24,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
13.	No information was available for Hardev Virdee, who is on secondment from Hounslow PCT.
14.	Neil Roberts was also Director of Primary Care Contracting of Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of his accrued pension at age 60 was in the range £35,000 - £40,000; the full value of his lump sum at age 60 was in the range £105,000 - £110,000; and the full CETV of his pension benefits was £745,000. His pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

Section 3
About our borough

3. About our borough

With a population of 362,000 (2011 estimates), Croydon isthe second largest borough in London. It is also one of the fastest growing, estimated to grow to 382,100 by 2031. Most of this growth is expected to be in the under 15 and 25-40 age groups.

Croydon has a particularly large proportion of young people and both the very young and very old are forecast to rise. The number of births is expected to rise by around 10% in the next five years, and the number of people aged over 85 is also forecast to increase, by two thirds by 2029.

Croydon is a diverse borough, home to a thriving migrant population. The number of immigrants registered with GPs (which underrepresents the true picture) rose from 5,977 in 2009 to 6,560 in 2011. Immigrants from India and Pakistan account for over 34% of all immigrants (up from 24% in 2007).

Around four in 10 people in Croydon (42%) are from ethnic minority communities and the total black and ethnic minority population is forecast to grow to more than 50% of the total population by around 2025. Along with the four main minority languages of Tamil, Urdu, Gujerati and Polish, over 100 languages are spoken as a first language by patients registered in the borough.

Although Croydon is a relatively prosperous borough, with some parts of it in the least deprived 15% in the country, there are pockets of deprivation, with most of the poorer areas in the north of the borough, and some significant pockets of deprivation in the east, in areas such as Coulsdon and New Addington. More than 21,500 children – one in four or 27% - in Croydon live in poverty.

Along with that comes higher incidence of the ill heatlh that comes with deprivation. Life expectancy is 9.5 years less for men, and 5.2 years less for women in the most deprived areas of Croydon – a statistic that has not changed since 1995.

3.1. Croydon Health and Wellbeing Board

The Health and Social Care Act 2012 requires local authorities to establish a health and wellbeing board as a council committee by 1 April 2013. As a first step towards the establishment of the full statutory board, NHS Croydon has worked with the council to establish and take part in a shadow health and wellbeing board which has been in place for two years.

Croydon's health and well-being board was the focus of one of nine case studies in a national publication jointly produced by the Local Government Association and the Department of Health *New partnerships, new opportunities: a resource to assist in setting up and running health and wellbeing boards.*

The shadow board has overseen the development of Croydon's annual joint strategic needs assessment (JSNA). As well as providing a comprehensive overview of health and wellbeing in the borough, this year's JSNA has in depth analysis of children's emotional health and wellbeing, depression in adults and services for people with schizophrenia.

Based on the JSNA, the shadow board developed Croydon's first joint health and wellbeing strategy which was agreed by partners in December 2012. Board members have agreed to work together to transform

health and social care services, to prevent illness and injury and to promote personal responsibility, self-management and shared decision making. They have also committed themselves to tackling the causes of ill health – the social determinants of health such as poor housing, worklessness and educational attainment.

The strategy has three overarching goals and six areas for improvement:

- Goal 1: increased healthy life expectancy and reduced differences in life expectancy between communities
- Goal 2: increased resilience and independence
- Goal 3: a positive experience of care

The improvement areas are:

i. giving our children a good start in life
ii. preventing illness and injury and helping people recover
iii. preventing premature death and long term health conditions
iv. supporting people to be resilient and independent
v. providing integrated, safe, high quality services
vi. improving people's experience of care

3.2. Croydon's Health Priorities 2012/13

Joint Strategic Needs Assessment (JSNA) Prioritisation process

The Croydon Joint Strategic Needs Assessment (JSNA) Steering Group is a multi-agency partnership that drives the completion of an annual needs assessment in Croydon. JSNAs are statutory requirements of PCTs and local authorities, although there is considerable flexibility about how and what is produced by way of a needs assessment. The approach taken in Croydon has been to combine a broad overview of health and wellbeing in the borough with a smaller number of in-depth needs assessments.

A prioritisation process developed in 2011 to guide the selection of key topic areas for in-depth needs assessments was trialled for the 2011-12 JSNA. Despite the trial not being entirely successful, the lessons learned from it have helped the Steering Group refine and simplify the prioritisation process for the 201213 round.

As in 2011-12, a wide range of stakeholders was invited to submit proposals for deep dive needs assessments for 2012-13 and a small panel of volunteers was convened to consider and score these proposals. For the 2012-13 round the scoring panel included representatives from general practice, local authority commissioning, pharmacy, shadow Healthwatch public health, the Mental Health forum and several representatives from the community and voluntary sector

Improvements made to the prioritisation process for 2012-13 included a significantly simplified proposal form and the provision of additional information to support the scoring criteria (e.g. data relating to the prevalence of the issue in Croydon, the evidence for reducing or addressing the issue, and the financial considerations associated with addressing the issue)

Eleven proposals were received in total. Two sets of two proposals were very similar so each set was merged into a single proposal, and another, that proposed the whole of mental health be considered, was rejected as it was considered to be too broad for a 'deep dive' needs assessment. This left eight proposals for the panel to score. As for the 2011-12 round, each proposal was scored according to the following criteria:

- Scale of the issue (numbers of people affected in Croydon)
- Impact of the issue (qualitative effect of the issue on sufferers, their families and carers)
- Links with deprivation
- Impact on protected groups (under the Equalities legislation)
- Potential to make financial savings by addressing the issue
- Evidence that the issue can be tackled and reduced effectively

- Number and range of stakeholders for whom the issue is a priority
- Evidence that Croydon does not currently perform well regarding the issues

By following this approach an objective prioritisation of the top scoring proposals for 2012-13 has been agreed which has been taken to the Health and Wellbeing Board for consideration.

The topics which have been agreed for 2012 to 2013 were:

- Emotional health and wellbeing of children,
- Depression in adults, and
- Services for people with schizophrenia

3.3.Health and Wellbeing

The health of people in Croydon is mixed. Life expectancy for men in Croydon is higher than the England average and about the same as the national average for women. However, life expectancy is 9.5 years lower for men and 5.8 years lower for women in the most deprived areas of Croydon compared with the least deprived areas.

Deprivation in Croydon is lower than average. However almost three in ten children (29.3%) children live in poverty, higher than the national average. Croydon is becoming relatively more deprived as a borough. Homelessness and the number of households in temporary accommodation has been worsening.

Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have also fallen.

About 23.3% of Year 6 children in Croydon are classified as obese. This is higher than the average for England. The estimated level of adult physical activity is worse than the England average. The estimated level of adult 'healthy eating' is better than the England average.

The level of teenage pregnancy is worse than the England average but has seen a significant improvement over the last three years. The rate of sexually transmitted infections is worse than the England average.

Immunisation rates in Croydon are significantly lower than the national average.

Levels of GCSE attainment, alcohol-specific hospital stays among those under 18, breast feeding initiation, road injuries and deaths and smoking in pregnancy are all better than the England average.

3.4. Improving health

Teenage Pregnancy

Teenage pregnancy is a complex issue and a key contributing factor to inequality and social exclusion. It is pleasing to report, therefore, that excellent progress continues to be made in reducing teenage pregnancy rates in Croydon: Croydon saw its conception rate drop from a rate of 41.8 conceptions per 1000, 15-17 year old women during 2010 to 32.8 per 1000 during 2011. This equates to just 234 conceptions during 2011, which shows a drop of 28 conceptions from 2010 figures. As a consequence Croydon has seen its under-18 conception rate drop by 44.5% from the 1998 baseline, and shown a drop of 22% from 2010 rates.

For under 16 year olds, in 2011, the rate of under-16 conceptions was 6.1 per 1000 girls aged 13-15 – 9.0% lower than the rate of 6.7 per 1,000 in 2010. The total number of conceptions for under-16s was 5,661, down by 9.5% from 6,256 in 2010. The proportion of under-16 conceptions leading to abortion was 60.5%, down from 62.8% in 2010.

Many interventions have taken place during the year to maintain Croydon's reduction in its local under-18 conception rate. Examples include pregnancy prevention programmes for vulnerable young people;

practitioner seminars and training courses on young people's sexual health. During the year over 1,000 young people attended sexual health drop-ins offered in local colleges and other non-clinical settings and many more attended reproductive health or sexual health clinics . Around 5,000 young people received some form of formal or informal sex and relationship education in local colleges and at other outreach events

Despite Croydon's recent success, reducing teenage pregnancy remains a high priority and there is strong commitment at all levels to ensure the local strategy continues to deliver further improvements.

Changing the world – one baby at a time

The family nurse programme offers an intensive home visiting programme to first-time mothers aged under 19; visiting throughout pregnancy and until their babies reach two years of age. Specially trained family nurses build supportive relationships with families and guide first-time teenage parents so that they adopt healthier lifestyles for themselves, provide good care for their babies, and make plans for their futures.

The programme has been running in the USA for over thirty years and since 2007 in England. Studies have shown families on the programme have healthier pregnancies, children have improved health and development and families are more able to achieve a better life for themselves.

The Family Nurse Partnership team in Croydon is in its third year and currently supports 106 families. Because it is part of a national programme, the team keeps a record of how things are going. Already the programme is showing positive results, such as higher numbers of mothers breastfeeding and fewer low birth-weight babies, compared to similar aged mums not on the programme. Most of the children are reaching their developmental milestones and often beyond.

Childhood obesity

We have taken a community wide, multi-agency, approach to childhood obesity and work to promote active lifestyles and healthy eating in various settings including:

- Maternity and Health Visiting – promotion of breastfeeding and Healthy Start nutritional advice
- Early Years – Children Centre settings
- Primary and Secondary Schools through the Healthy Schools programme & School Sports Partnership
- Feedback to parents of children's weight status through the National Child Measurement Programme
- Workplaces – promoting healthy eating and active lifestyles though the Government's Responsibility Deal
- Providing healthy lifestyle information at the Healthy Living Hub in Croydon's central library

In addition, Croydon's Public Health team is commissioning a new service to promote a child's healthy weight and provide treatment for children who are overweight to start in Autumn 2013.

Healthy Start is a great way to give families the very best nutritional start in life by making healthy eating more affordable and providing essential vitamins needed by pregnant women, new mothers and babies and children up to four years of age. Good nutrition, supported by breastfeeding is key to a child's healthy development.

Provided by the Department of Health, Healthy Start vouchers can be spent on milk, fruit, vegetables and infant formula milk at local shops and supermarkets, and Healthy Start coupons can be exchanged for free vitamins. Entitlement for Healthy Start is based on family income, and benefits received, but pregnant women under 18 years of age, regardless of income can apply. In Croydon, midwives, health visitors and GPs are encouraging more pregnant women and families to apply for the scheme and to use the coupons to obtain their free vitamins.

Healthy weight/ lifestyle service

A quarter of all adults in Croydon are obese, and by the age of 45, six people in 10 are overweight or obese. People from more deprived areas are more likely to be overweight or obese, and some black and minority ethnic groups are more at risk of becoming so. This significantly increases the risk of developing cancer, heart disease and Type 2 diabetes. Increasingly, children in their teens are presenting with type 2 diabetes as a result of being obese.

During the year a range of initiatives, such as measuring children at Reception and Year 6, healthy eating after-school cooking club have aimed to tackle this. The Croydon Healthy Living Hub, located in the Central Library by the Town Hall, offered advice and tips on healthy eating and physical activity.

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Immunisations

To improve uptake of childhood immunisations Croydon has joined a London-wide birthday card scheme called 'Celebrate and Protect'. Birthday cards are sent out from the family's GP at three ages: shortly following birth and at the baby's first and fourth birthdays, as a way of reminding parents to make an appointment to have their baby or child immunised.

Breastfeeding

A range of local breastfeeding initiatives with different approaches have been set up to encourage and support continued breastfeeding, with peer support programmes in New Addington, Fieldway and Waddon as well as Baby Cafés® in five locations across the borough.

Baby Cafés® in Croydon
These drop-ins offer a bridge between a clinic and a café where support with, and information about breastfeeding is available in a relaxed and informal setting reaching out to mums from all parts of the community. These cafés allow breastfeeding women to meet and help each other, share experiences and have the opportunity to discuss all aspects of breastfeeding, parenting, working and family life .An added bonus is that pregnant women and new mothers can get to see babies of all ages and can observe how life with a new born baby differs very much from the life of a three month old. Baby Cafés® can also provide information and encouragement to anyone who is supporting a breastfeeding mother. A baby café in Croydon is open each day of the week (Monday to Friday) and held in a children's centre.

An essential part of increasing breastfeeding in Croydon is the commitment of Croydon Health Services to achieving UNICEF Baby Friendly Accreditation. This year both Croydon University Hospital and community services have achieved Stage 1. This staged approach of assessment ensures a high standard of care with infant feeding for pregnant women and new mothers and babies with the aim that Croydon mothers receive effective information, support and encouragement needed to start and continue breastfeeding.

Smoking

Almost a quarter of adults in Croydon smoke tobacco, and among the poorest communities this is nearer to a third. In Croydon in the 12 months to 2009-2010 (latest figures) 1560 hospital admissions were attributable to smoking. That is 16% higher than the London average, and 10% higher than the England average.

The evidence that stop smoking services improve the health of the public is probably stronger than for any other intervention around lifestyle choice. Stop smoking services are cost effective and really work; every pound invested in supporting people to stop smoking is recouped by the health service and the wider economy several times over.

The NHS in Croydon provides two free services for people who live or work in the borough, Croydon Health Services Stop Smoking Service and Solutions 4 Health. They provide expert health and advice, along with access to free or discounted nicotine replacement products and help with other stop smoking medications. They provide clinics in a range of settings and can offer services through local pharmacies and many GP practices.

QUIPP

Throughout the year the CCG has been involved in developing and implementing QIPP schemes, service redesign projects and promoting innovation, contributing towards achieving the financial position. Each member of the Governing Body and the Clinical Leadership Group has a defined portfolio of work that they lead on, in conjunction with the management team and staff at NHS Croydon.

Some of the successes from this work in 2012-13 include:

- Croydon Referral Support Service (CReSS) – procured and rolled out to all practices
- Patient Navigation – HSJ Efficiency Awards 2012 winner of 'Efficiency in Commissioning Support Services' category
- Ophthalmic triage set up
- ENT Intermediate Service re-procured through Any Willing Provider
- Gynaecology Intermediate Service re-procured through Any Qualified Provider
- Dermatology Intermediate Service re-procured through Any Qualified Provider
- Risk stratification rolled out across Croydon

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 Croydon Board.

Section 4
Improving performance

4. Improving performance

The majority of Information Performance Measures monitored in 2012/13 are meeting or exceeding their targets, with a small number that are underperforming. Work is ongoing between the new shadow South London Commissioning Support Unit, SWL Cluster Primary Care Contracting and Croydon CCG teams to understand the reasons for any underperformance and the mitigating actions that can be put in place to improve performance in 2013/14/.

For 2012/13 the indicators shown below in Figure One are the responsibility of Clinical commissioning Group. The majority of indicators are expected to meet or exceeding their target by the end of the year while 9 will nearly reach target and 10 will fall below target.

	Period	Year End				
		Forecast 2012/13		*Target*	Last Year 2011/12	
CCG Responsibility						
PHQ03: Cancer first treatment 62 days wait: GP urgent referral	Monthly	82.80%	A	*85.00%*	87.60%	G
PHQ04: Cancer first treatment 62 days wait: Screening referral	Monthly	87.80%	A	*90.00%*	91.90%	G
PHQ06: Cancer first definitive treatment within 31 days of diagnosis	Monthly	98.70%	G	*96.00%*	99.00%	G
PHQ07: Cancer subsequent treatment within 31 days: surgery	Monthly	98.40%	G	*94.00%*	96.50%	G
PHQ08: Cancer subsequent treatment within 31 days: drug	Monthly	99.70%	G	*98.00%*	99.80%	G
PHQ09: Cancer subsequent treatment within 31 days: radiotherapy	Monthly	96.70%	G	*94.00%*	97.30%	G
PHQ10: Early intervention in psychosis - new cases	Quarterly	89	G	*57*	59	G
PHQ11: Crisis resolution home treatment episodes - cumulative from	Quarterly	987	G	*756*	759	G
PHQ12: Care Programme Approach followup within seven days	Quarterly	92.90%	A	*95.00%*	95.10%	G
PHQ13: IAPTS proportion of relevant population	Quarterly	2.90%	R	*3.60%*	3.10%	G
PHQ13: IAPTS proportion of people moving to recovery	Quarterly	38.10%	R	*50.00%*		
PHQ19: RTT admitted patients compliant percent	Monthly	90.70%	G	*90.00%*	90.30%	G
PHQ20: RTT non admitted patients compliant percent	Monthly	97.20%	G	*95.00%*	97.50%	G

	Period	Year End					
		Forecast 2012/13		Target	Last Year 2011/12		
PHQ21: RTT incomplete pathway patients compliant percent	Monthly	90.70%	A	*92.00%*			
PHQ22: Diagnostic tests waiting 6 weeks or more	Monthly	1.06%	A	*1.00%*			
PHQ24: All cancer two week waits	Monthly	96.00%	G	*93.00%*	97.30%	G	
PHQ25: Breast symptoms (cancer not initially suspected)	Monthly	95.80%	G	*93.00%*	98.30%	G	
PHQ27: MRSA	Monthly	5	G	*9*	8	G	
PHQ28: C-Difficile	Monthly	59	G	*65*	62	G	
PHS06: Non-elective FFCEs	Monthly	35,925	R	*34,123*	34,521	R	
PHS07: GP written referrals to hospital	Monthly	74,427	G	*75,588*	70,613	A	
PHS08: Other referrals for a first outpatient appointment	Monthly	48,807	G	*49,989*	50,821	G	
PHS09: First outpatient attendances following GP referral	Monthly	56,352	A	*55,347*	54,493	G	
PHS10: All first outpatient attendances	Monthly	112,368	A	*111,403*	110,710	G	
PHS11: Elective FFCEs	Monthly	45,688	A	*44,652*	45,480	R	
PHS14: Diagnostic tests, endoscopy	Monthly	10,379	R	*9,776*			
PHS15: Diagnostic tests, non-endoscopy	Monthly	114,615	R	*108,304*			
PHS16: Numbers waiting on incomplete RTT	Monthly	18,973	G	*19,002*	20,662	G	
PHF08: GP Referrals to first OP appointments booked using Choose and Book	Monthly	23.80%	R	*90.00%*	20.00%	R	
SQU06: Percent of stoke patients with 90% of time on stroke unit	Quarterly	95.50%	G	*80.00%*	92.30%	G	
SQU06: Percent of TIA cases assessed and treated within 24 hours	Quarterly	81.10%	G	*60.00%*	92.00%	G	
SQU12: Percentage of women seeing professional within 13 weeks of pregnancy	Quarterly	92.00%	G	*90.00%*	96.40%	G	
SQU19: Breastfeeding at 6-8 weeks prevalence	Quarterly	68.70%	R	*75.00%*	67.30%	R	
SQU19: Breastfeeding at 6-8 weeks coverage	Quarterly	99.70%	G	*98.00%*	99.50%	G	
NHS COMMISSIONING BOARD							
PHS17: Health visitor numbers	Monthly	44.56	G	*39.26*	39.27	G	
SQU09: Access to dental services	Monthly	187,390	A	*193,407*	188,006	A	
SQU22: Cervical screening results within two weeks	Monthly	97.90%	A	*98.00%*	94.60%	A	
PUBLIC HEALTH							
PHQ30: Smoking Quitters	Quarterly			*2,188*	2,176		
PHQ31: Eligible population offered an NHS health check	Quarterly	13.40%	R	*20.00%*	18.50%	G	
PHQ31: Eligible population receiving an NHS health check	Quarterly	3.20%	R	*8.80%*	1.60%	G	
VSB08: Under 18 conception rate per 1,000 female 15-17 population	Quarterly	29.8	G	*40.5*	41.7	R	

Section 5
Working in partnership

5. Working in partnership

5.1. Key partnerships

Following parliamentary approval of the Health and Social Care Act 2012, NHS Croydon has worked with Croydon Council to establish a Health and Wellbeing Board. This was set up in shadow form in 1 April 2011. In addition to the agreed programme of work for the shadow board, a development programme has been agreed with support from the Local Government Association's Healthy Communities Peer Challenge team and NHS London's Health and Wellbeing Board support programme.

5.2. Public health transfer

The Health and Social Care Act 2012 transfers public health functions to the local authority

In March 2012 Croydon Council and Croydon PCT initiated a transition project to manage the transfer of public health functions. The project's principal objective was to ensure that on 1 April 2013 the staff, resources, operating model and information would be in place to enable Croydon Council to fulfil its new public health responsibilities.

A public health grant was provided by the Department of Health to give the council the funding needed to discharge its new public heath responsibilities These funds were intended to be used to:

- improve significantly the health and wellbeing of the local population
- carry out health protection functions delegated from the Secretary of State
- reduce health inequalities across the life course, including within hard to reach groups
- ensure the provision of population healthcare advice.

Public Health Croydon will continue to work closely with Croydon Clinical Commissioning Group to ensure that commissioners have excellent public health advice and support. The council and CCG have made a commitment to work together to deliver Croydon's new joint health and wellbeing strategy.

5.3. PALS and complaints

NHS Croydon has operated a combined Patient Advice and Liaison Service (PALS) and Complaints service for about 5 years. Combining these two services allows us to provide an efficient and modern approach to dealing with concerns or formal complaints made by local people. The combined service also complements the PALS approach recommended in the ombudsman's guidelines.

The trained team professionally assesses the individual needs of the caller and advises them on the choices and support open to them.

The PALS and Complaints service worked in four ways to provide:

- a walk-in service

- an appointment service
- a home visiting service
- a local resolution service/

On average it managed three “walk-in” cases and two fixed appointments each week. In addition it conducts at least two home visits and three local resolution meetings between complainants and service providers each month.

The team used its knowledge of local services to resolve things as quickly as possible to the caller’s satisfaction. However, if the caller wishes to make a complaint for formal investigation with a written response from the Chief Executive, the team will explain the process and deal with the matter as set out in our Complaints Policy.

In England there is now a unified two-stage complaints policy governing the complaints process across Health & Social Care:

- Local resolution
- Independent Review by the Ombudsman

NHS Croydon’s complaints procedure was built on the Ombudsman’s “six principles for remedy” which means our complaints-handling process focuses on the customer:

1. Getting it right
   - Quickly acknowledging and putting right cases of maladministration or poor service that have led to injustice or hardship.

2. Being customer focused:
   - Apologising for and explaining the maladministration or poor service
   - Understanding and managing people’s expectations and needs
   - Dealing with people professionally and sensitively
   - Providing remedies that take account of people’s individual circumstances.

3. Being open and accountable
   - Being clear about how public bodies decide remedies
   - Operating a proper system of accountability and delegation in providing remedies
   - Keeping a clear record of what public bodies have decided on remedies and why.

4. Acting fairly and proportionately
   - Offering remedies that are fair and proportionate to the complainant’s injustice or hardship
   - Providing remedies to others who have suffered injustice or hardship as a result of the same maladministration or poor service, where appropriate
   - Treating people without bias, unlawful discrimination or prejudice.

5. Putting things right
   - If possible, returning the complainant and, where appropriate, others who have suffered similar injustice or hardship, to the position they would have been in if the maladministration or poor service had not occurred If that is not possible, compensating the complainant and such others appropriately
   - Considering fully and seriously all forms of remedy, including: an apology; an explanation; remedial action; or financial compensation.

6. Seeking continuous improvement
   - Using the lessons learned from complaints to ensure that maladministration or poor service is not repeated
   - Recording and using information on the outcome of complaints to improve services.

In 2012-13 NHS Croydon received 73 telephone messages, letters and cards of appreciation. Wherever possible, these compliments were shared with the staff concerned. NHS Croydon received 101 formal complaints that required investigation. Of these:

- 30 related to the work of Croydon community health services or other connected providers

- 60 related to the work of primary care contractors e.g. GPs and dental services

- 11 related to commissioning work that NHS Croydon conducted and mainly concerned funding for treatment for exceptional circumstances and quality of clinical service provided.

All complaints were formally acknowledged within three working days and responded to in line with timeframes negotiated with the complainant. No complaints managed by NHS Croydon that have been referred to the Parliamentary and Health Service Ombudsman have been upheld.

It also received 1,123 PALS contacts over the year via telephone, email, letter, facsimile and face-to-face drop in meetings that raised a variety of concerns about health services provided locally. Of these:

- 393 (35%) came in by email and were general PALS enquiries about finance, freedom of information, GP, dental and primary care concerns.
- 254 (23%) were about GP concerns
- 66 (6%) were about dentists
- 18 (2%) were about pharmacists .

The remaining contacts were walk in and face to face contacts. The most common concerns raised were regarding access to GP appointments and individual funding requests. Other concerns included the failure to diagnose or to carry out a GP home visits and difficulty in obtaining a GP referral were also features.

5.4. Safeguarding

The Safeguarding Team sits within Croydon CCG. Until April 2013, it provided services which focussed exclusively on the needs of children and young people under the age of 18 years. From Spring 2013, it took on responsibility for providing a service for vulnerable adults.

There are currently approximately 89,000 children under the age of 18 years living in the borough.

There are currently approximately 750 Looked After children and just under 300 children subject to child protection plans within Croydon.

The Safeguarding Team is formed of doctors and nurses who have expert knowledge, skills and experience in the care of vulnerable children and young people. They believe that all children deserve the opportunity to achieve their full potential from both a physical and emotional perspective. The Safeguarding Team is committed to achieving this by ensuring that the welfare of the child is paramount.

The team works closely with partners across the health economy and the local authority. This includes the Croydon Safeguarding Children Board and the Safeguarding Adults Board. We do not work in isolation - a key component of our work is collaborating and liaising with other agencies. Information sharing is important and there are times when there is a need to share information with police, social services, and the voluntary sector in order to protect the vulnerable.

If you need advice about a safeguarding issue please contact the safeguarding team on 020 8274 6148

If you have urgent concerns relating to a child or adult or you wish to speak with a social worker, please contact:

Croydon Children's Services on 020 8726 6400 (24 Hours)
Croydon Vulnerable Adult Services on 020 8726 6500 (24 hours)

5.5. 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.

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

Section 6
Making it happen

6. Making it happen

6.1. Patient and Public Involvement

A valuable channel for NHS Croydon to engage with patients is through its Local Involvement Network (LINk) which, in accordance with the government's Health and Social Care Bill, evolved into Croydon Shadow HealthWatch during 2011-12.

For information on PPI for the BSBV review, see the BSBV section above.

6.2. Equality and Diversity and Engaging Hard to Reach Groups

After adopting the Equality Delivery System (EDS) in 2011, in 2012 NHS Croydon built upon achievements made during 2011/12.

The EDS aims to achieve positive cultural change in the NHS by creating an environment where services for patients and workplaces for staff are more equitable, diverse and that fairly represent the wider community. It also enhances collaboration with local stakeholders and interest groups by enabling the analysis of service commissioning, provision and performance which leads to clearer identification of equality objectives and ensures compliance with statutory equality obligations.

The EDS enabled NHS Croydon to meet the aims of the Equality Act 2010 which is a legal requirement of all public organisations to take the necessary actions to achieve:

- Elimination of unlawful discrimination.
- Advancement of equality of opportunity.
- Fostering of good relations between individuals and communities.

NHS Croydon published its Public Sector Equality Duty report (along with the other PCTs in South West London) on 31 January 2013. At the same time NHS Croydon published a schedule outlining progress made in achieving the Equality Objectives that were published on 5 April 2012.

Achievements during 2012/13 include:

- **Partnerships**
  The Healthy Weight, Healthy Lives project is a key example from the Healthy Croydon Partnership (now the Croydon Shadow Health and Wellbeing Board) demonstrating how clinical commissioners are working with a range of partners to address the wider determinants of health and reduce health inequalities.
- **Procurement and Commissioning**
  A full review of all current provider contracts is taking place in line with the annual NHS Contracts review process and the need to transfer contracts from one legal entity to another (PCT to CCG). The EDS will become part of the new organisation's strategic annual commissioning cycle and will be considered as part of all future Commissioning Intentions.
- **Mental Health**

Most of the protected groups are referenced in the relevant service contracts and service specifications, including eligibility criteria. Some services are designed specifically for protected groups such as the Foxley Lane Women's Service, the Community Peri-natal Team, the BME Community Development Service, the Gender Re-assignment Service and a number of services for older people.

- **Learning Disability**
  Supporting mainstream health service to ensure the delivery of good quality general health care to people with learning disabilities is embedded into practice. This has been achieved as a result of resourcing specialist staff (Learning Disability nurses/Allied Health Professionals) with the explicit role to liaise with, train and support the primary care and acute sector to better meet the healthcare needs of people with learning disabilities. We also have in place specialist professionals who have close liaison with GP practices.
- **Equality impact assessments (EIAs)**
  Equality impact assessment forms part of our commissioning cycle and is considered during the redesign of a service or policy to ensure that the needs of our community groups are being met. Impact assessments were completed for 24 new QIPP schemes in line with our EDS objectives.

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Adoption of the EDS was an essential requirement in order for Croydon Clinical Commissioning Group (CCG) to become authorised.

Croydon CCG will continue to work closely with local partners and Croydon HealthWatch to ensure that equality and diversity requirements are embedded across its business activities in accordance with the Equality Act 2010.

6.3. Emergency preparedness

2012/2013 was a busy year for Emergency Preparedness. Within South West London we saw the Olympic Cycle races pass through our boroughs having a significant impact on Kingston and Richmond. Resilience for this was achieved through prior planning with multi-agency partners and the processes outlined in the NHS South West London Emergency Management Plan. The Emergency Management plan was reviewed regularly in the lead up to the Olympics. These reviews were done in accordance with the Civil Contingencies Act 2004, NHS Emergency Planning Guidance 2005 and the London Olympic Resilience Planning Assumptions (LORPA).

NHS South West London provided a 24/7 emergency response capability with a rota of Directors on call. The on-call Director provided overall direction for all five Borough Teams during an incident with the support of the Senior Manager on call within each Borough Team. This process was regularly tested and a weekly pager test carried out on the Director on call. These arrangements have now ceased as we move through transition. Currently, there is an on call rota for Clinical Commissioning Groups (CCGs) in South West London to deal with EPRR issues and one for the Commissioning Support Unit who will deal with Surge Capacity management on behalf of the CCGs.

As a Category One responder under the Civil Contingencies Act 2004, Emergency Preparedness was a statutory requirement for Kingston Primary Care Trust (PCT) until April 2013. The PCT retained a dedicated Emergency Planning Manager who reported to the Director of Public Health and who was a member of the South West London Regional Resilience Forum. Other NHS organisations within South West London engaged with us by way of the South West London Emergency Preparedness Network and the Chief Executives Emergency Planning Network. Further connections within localised areas were covered by the Emergency Planning Managers for each of the Borough Teams attending the local Borough Resilience Forums. The PCT maintained a number of plans, all of which are based on the borough Risk Register, including:

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

The priorities for 2013 were:

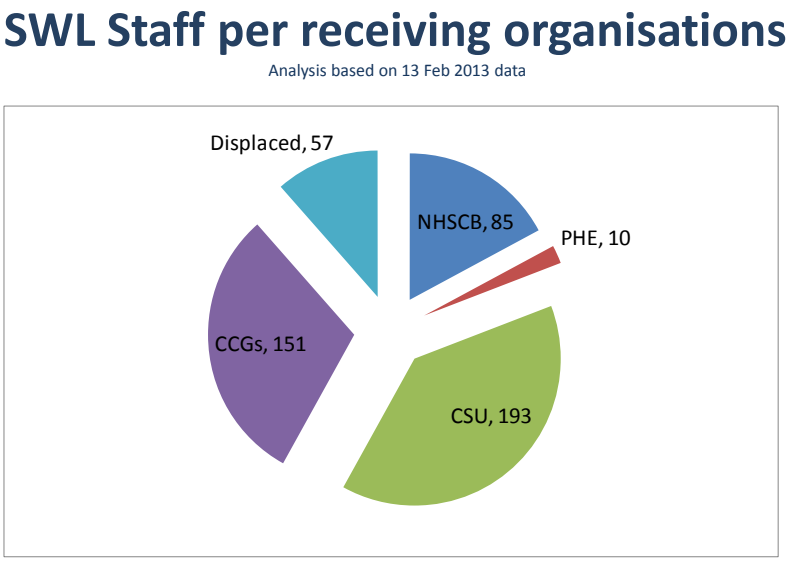
- to continue the emergency preparedness training and exercising

programme
- to maintain emergency preparedness in the period of transition up to April 2013

6.4. 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

Breakdown of staff at 31 March 2013 by headcount (743), BME and gender

		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**

6.5. 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.

6.6. Information governance

Croydon PCT 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.

Serious incidents in relation to Information Governance

NHS organisations are required to include in their annual report details of serious incidents involving data loss or breach of confidentiality. During 2012/13 there was one serious incident serious incident (categorised as 3-5) reported by NHS Croydon.

Describe the nature of the Incident
Inappropriate use of primary care data extracts for Secondary use without relevant patient consent.
Action taken: Immediate suspension of all data extracts flows anonymisation of data sets, physical deletion of identifiable data.
During 2012/13 there was one minor incidents categorised as 1-2.(see summary in the table below).

Summary of other personal data related incidents in 2012/13

category	nature of incident	NHS SWL total	Cluster directorates	Croydon
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,	1		

	devices or paper documents			
IV	unauthorised disclosure	17	5	
V	other	2	1	1
	total	**22**	**6**	**1**

6.7. 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

6.8.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).

6.9. Risk Assessment

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

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

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

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

Core objectives focussed on ‘delivery for today’

- Transition objectives associated with ‘building for the future.’

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

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

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

- Identification and assessment of risks relating to the Cluster’s corporate objectives
- Newly identified risks relating to delivery and transition under the shadow operating arrangements

- BAF risks identified by individual Clinical Commissioning Groups (CCGs) under shadow operating arrangements. These have been monitored by the CCG Governing Bodies and also visible on the NHS South West London BAF to maintain an oversight of risks associated with delegated responsibilities.

Key risks during 2012/13 have included:

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

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

1.2 The Risk and Control Framework

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

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

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

1.3 Executive Management Team and Board Committee Scrutiny of Risks

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

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

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

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

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

1.4 Managing risks around delegation to CCGs under shadow working arrangements

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

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

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

1.5 Review of the Effectiveness of Risk Management and Internal Control

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

- The audit reviewed any changes to previous arrangements, ensuring there was clear process for escalation of issues to the Boards, throughout the period of transition towards the full establishment of 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.

6.10. 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.

6.11. 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) Cancer Commissioning Local Advisory Group – Commissioning for Cancer London Alliance Member Croydon PBC Ltd Queenhill Medical Practice is a shareholder

Name	Position	Interests
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

Croydon Primary Care Trust

2012-13 Accounts

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Croydon Primary Care Trust

2012-13 Accounts

CROYDON PRIMARY CARE TRUST

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

i. to assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:
ii. had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
iii. kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the PCT;
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 Treasury;
ii. make judgements and estimates which are reasonable and prudent;
iii. state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

Signed: 

Date: 4/6/2013

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

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

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

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

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

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

Signed: 

Date: 4/6/13.

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

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

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

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

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

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

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

nb: sign and date in any colour ink except black

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

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

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

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER OF CROYDON PRIMARY CARE TRUST

We have audited the financial statements of Croydon PCT 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 accountable officer of Croydon 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 Trust's accountable 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 Croydon PCT 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 the transition to new commissioning arrangements.

As a result, we have concluded that there is the following matter to report:

In 2012/13, Croydon Primary Care Trust continued to operate with a significant underlying financial deficit. Although the Primary Care Trust met its statutory financial performance targets, the underspend of £0.063 million against the Revenue Resource Limit was only achieved with unplanned financial support of £9 million from other Primary Care Trusts within the South West London Cluster.

Certificate

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

S. M. Exton

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

Grant Thornton House
Melton Street
London
NW1 2EP

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	14,126	14,563
Other costs	5.1	1,680,313	1,493,339
Income	4	(1,070,564)	(896,110)
Net operating costs before interest		623,875	611,792
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	0	33
Net operating costs for the financial year		623,875	611,825
Transfers by absorption -(gains)		0	0
Transfers by absorption - losses		0	0
Net (gain)/loss on transfers by absorption		0	0
Net Operating Costs for the Financial Year including absorption transfers		623,875	611,825
Of which:			
Administration Costs			
Gross employee benefits	7.1	12,721	13,074
Other costs	5.1	6,103	12,307
Income	4	(1,167)	(8,935)
Net administration costs before interest		17,657	16,446
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	0	33
Net administration costs for the financial year		17,657	16,479
Programme Expenditure			
Gross employee benefits	7.1	1,405	1,489
Other costs	5.1	1,674,210	1,481,032
Income	4	(1,069,397)	(887,175)
Net programme expenditure before interest		606,218	595,346
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	0	0
Net programme expenditure for the financial year		606,218	595,346

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	51	424
Net (gain) on revaluation of property, plant & equipment	(109)	0
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	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	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*	623,817	612,249

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	**19,254**	19,877
Intangible assets	13	**105**	141
investment property	15	**0**	0
Other financial assets	21	**2**	2
Trade and other receivables	19	**0**	0
Total non-current assets		**19,361**	20,020
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**8,263**	21,196
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**958**	69
Total current assets		**9,221**	21,265
Non-current assets held for sale	24	**0**	0
Total current assets		**9,221**	21,265
Total assets		**28,582**	41,285
Current liabilities			
Trade and other payables	25	**(64,732)**	(77,347)
Other liabilities	26,28	**0**	0
Provisions	32	**(5,581)**	(1,549)
Borrowings	27	**0**	0
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(70,313)**	(78,896)
Non-current assets plus/less net current assets/liabilities		**(41,731)**	(37,611)
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(1,938)	(1,655)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(1,938)**	(1,655)
Total Assets Employed:		**(43,669)**	(39,266)
Financed by taxpayers' equity:			
General fund		(49,377)	(45,018)
Revaluation reserve		5,708	5,752
Other reserves		0	0
Total taxpayers' equity:		**(43,669)**	(39,266)

The notes on pages 5 to 42 form part of this account.

The financial statements on pages 1 to 5 were approved by the Department of Health Audit Sub Committee and signed on its behalf by:-

C Vincent Date: 4/6/13

Carl Vincent
DH Director, Provider Finance and Finance Transition

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	**(45,018)**	**5,752**	**0**	**(39,266)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(623,875)	0	0	**(623,875)**
Net gain on revaluation of property, plant, equipment	0	109	0	**109**
Net gain on revaluation of intangible assets	0	0	0	**0**
Net gain on revaluation of financial assets	0	0	0	**0**
Net gain on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	(51)	0	**(51)**
Movements in other reserves			0	**0**
Transfers between reserves*	102	(102)	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0	0	**0**
Net actuarial gain/(loss) on pensions	0	0	0	**0**
Total recognised income and expense for 2012-13	**(623,773)**	**(44)**	**0**	**(623,817)**
Net Parliamentary funding	619,414	0	0	**619,414**
Balance at 31 March 2013	**(49,377)**	**5,708**	**0**	**(43,669)**

Balance at 1 April 2011	**-16,780**	**6,176**	**-36**	**(10,640)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(639,579)			(639,579)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	0	0	0
Net Gain / (loss) on Revaluation of Intangible Assets	0	0	0	0
Net Gain / (loss) on Revaluation of Financial Assets	0	0	0	0
Net Gain / (loss) on Assets Held for Sale	0	0	0	0
Impairments and Reversals	0	(424)	0	(424)
Movements in other reserves	0	0	36	36
Transfers between reserves*	0	0	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	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	(639,579)	(424)	36	(639,967)
Net Parliamentary funding	611,341	0	0	611,341
Balance at 31 March 2012	**(45,018)**	**5,752**	**0**	**(39,266)**

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		(623,875)	(611,792)
Depreciation and Amortisation		1,294	1,522
Impairments and Reversals		129	161
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		12,933	(484)
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		(12,444)	16
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(79)	(989)
Increase/(Decrease) in Provisions		4,394	849
Net Cash Inflow/(Outflow) from Operating Activities		(617,648)	(610,717)
Cash flows from investing activities			
Interest Received		0	0
(Payments) for Property, Plant and Equipment		(854)	(555)
(Payments) for Intangible Assets		(23)	0
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		0	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	0
Proceeds from the disposal of Financial Assets (LIFT)		0	0
Loans Made in Respect of LIFT		0	0
Loans Repaid in Respect of LIFT		0	0
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		(877)	(555)
Net cash inflow/(outflow) before financing		(618,525)	(611,272)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		0	0
Net Parliamentary Funding		619,414	611,341
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		619,414	611,341
Net increase/(decrease) in cash and cash equivalents		889	69
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		69	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		958	69

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

The PCT is within the Government Resource Accounting Boundary and therefore has only consolidated interests in other entities where the other entity is also within the resource accounting boundary and the PCT exercises in-year budgetary control over the other entity.
In accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.1 Accounting Conventions

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

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

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.

The curent lease arrangements held by Croydon Primary Care Trust have been reviewed and the judgement has been taken that these are all operating leases.
For the purposes of segmental reporting, the segments reported on are (i) the hosted London Specialised Commissioning Group transactions and (ii) Croydon Primary Care Trust transactions for the Croydon registered population. This is consistent with management reporting arrangements during the financial year.

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 2013 have been estimated in light of the 11 months expenditure to date, the 2012/13 monthly expenditure profile, and informed by local intelligence from the PCT's Head of Prescribing.

The estimated value of partially completed in-patient spells is provided by our providers of acute hospital services as at balance date, and reviewed by the PCT. It should be noted that the PCT contracts for, and routinely receives data on, completed spells of care i.e. where the patient has been discharged. The majority of the estimate relates to partially completed in-patient spells at Croydon Healthcare Services NHS Trust.

1. Accounting Policies (continued)

Key sources of estimation uncertainty (continued)

The estimated liability arising from retrospective continuing care claims is based on the number of claims received, response rate to the follow-up questionnaires, average number of years claimed for, average age of claim (to estimate interest due), estimated weekly cost of care in a local nursing home, transaction costs of reviewing claims and management judgement on the probability of success of the claims lodged. The deadline for claims relating to periods of continuing care up to 31 March 2011 was 30 September 2012. The deadline for claims relating to periods of care between 1 April 2011 to 31 March 2012 was 31 March 2013.

The current estimate of old clinical negligence liabilities not transferred to the NHS Litigation Authority is based on the agreed annual liability, current actuarial projections of life expectancy, and the discount rates to be applied to future cashflows for general provisions, as advised by HM Treasury.

The building and land assets' values have been estimated by the District Value as at 31 March 2013. The estimation undertaken by the District Valuer is in accordance with best practice guidelines from both the Department of Health and the Royal Institute of Chartered Surveyors.

The estimate of premises severance costs for Leon House and Windsor House, including dilapidation costs and onerous lease clauses, has been informed by the District Valuer and the terms of the leases.

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

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

1.4 Pooled Budgets

The PCT has not entered into a pooled budget arrangement with any other body.

1.5 Taxation

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

1.6 Administration and Programme Costs

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

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

1. Accounting policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components, each 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

As at 31 march 2013, the PCT did not hold any assets donated by a third party

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.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been

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 PCT does not value, small value, inventory items. These are written off as Revenue expenditure at the point of purch

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. In previous years, untaken annual leave that is carried forward to the following year has been accounted for as a Provision for a Future Liability. However, as this is the final year of the PCT as a corporate body, the facility to carry forward annual leave beyond 31 March 2013 was withdrawn.

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

The Primary Care Trust has not carried out any Research & Development activities.

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

The Primary care Trust does not participate in the EU Emissions Trading Scheme.

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

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

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

A restructuring provision is recognised when the PCT has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising 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.

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

The PCT does not hold any loans or receivables that are subject to market prices.

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

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

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

1.27 Private Finance Initiative (PFI) and NHS LIFT transactions

The Primary Care Trust has not entered into any PFI or NHS LIFT schemes as at 31 March 3013.

1.28 Accounting Standards (issued but not yet adopted)

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

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

2 Operating Segments

Croydon Primary Care Trust hosts the London Specialised Commissioning Group. The London Specialised Commissioning Group (SCG) works on behalf of the capital's 31 primary care trusts to understand the health needs of Londoners and agree the types of specialised services that will meet those needs. It then commissions safe, reliable and cost-effective services and evaluates their effect.

The London Specialised Commissioning Group is treated as a separate segment for the purposes of segmental reporting. All other services commissioned by Croydon Primary Care Trust are treated as one segment (NHS Croydon).

NHS Croydon makes financial contributions to the cost of the services commissioned by the SCG on the same basis as other primary care trusts in London.

The London SCG makes payments to NHS Croydon in respect of administrative services received.

	Croydon PCT		London SCG		Total	
	2012-13 £000	2011-12 £000	**2012-13 £000**	2011-12 £000	**2012-13 £000**	2011-12 £000
Income & Expenditure						
Total Operating Costs	598,710	583,564	1,095,729	924,338	1,694,439	1,507,902
Finance costs	-	33	-	-	0	33
Revenue	(13,155)	(13,736)	(1,057,409)	(882,374)	(1,070,564)	(896,110)
Segment surplus/(deficit)	585,555	569,861	38,320	41,964	623,875	611,825
Int Common costs	34,542	25,104	(34,542)	(25,104)	0	0
Net operating costs	620,097	594,965	3,778	16,860	623,875	611,825
Revenue Resource Limit	620,160	595,803	3,778	16,860	623,938	612,663
Segment surplus/(deficit)	63	838	-	-	63	838
Net Assets:						
Segment net assets	(3,383)	(14,404)	(40,286)	(24,862)	(43,669)	(39,266)

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	0	611,825
Net operating cost plus (gain)/loss on transfers by absorption	623,875	0
Adjusted for prior period adjustments in respect of errors	0	0
Revenue Resource Limit	623,938	612,663
Under/(Over)spend Against Revenue Resource Limit (RRL)	63	838

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	1,030	2,250
Charge to Capital Resource Limit	706	1,092
(Over)/Underspend Against CRL	324	1,158

3.3 Provider Full Cost Recovery Duty

The PCT has not hosted Provider Services since March 2011 and, as such, is not subject to achieving Provider full cost recovery.

3.4 Under/(Over)spend against Cash Limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	619,416	611,341
Cash Limit	619,416	633,272
Under/(Over)spend Against Cash Limit	0	21,931

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

	2012-13 £000
Total cash received from DH (Gross)	555,180
Less: Trade Income from DH	(2)
Less/(Plus): movement in DH working balances	0
Sub total: net advances	555,178
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	15,841
Plus: drugs reimbursement (central charge to cash limits)	48,395
Parliamentary funding credited to General Fund	619,414

4 Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Fees and Charges	0	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	3,093	0	3,093	3,523
Dental Charge income from Trust-Led GDS & PDS	29	0	29	0
Prescription Charge income	2,481	0	2,481	2,340
Strategic Health Authorities	2,979	0	2,979	666
NHS Trusts	1,167	1,167	0	260
NHS Foundation Trusts	62	0	62	182
Primary Care Trusts Contributions to DATs	0	0	0	0
Primary Care Trusts - Other	1,054,276	0	1,054,276	872,169
Primary Care Trusts - Lead Commissioning	1,979	0	1,979	6,057
English RAB Special Health Authorities	0	0	0	0
NDPBs and Others (CGA)	14	0	14	0
Department of Health - SMPTB	2	0	2	0
Department of Health - Other	0	0	0	12
Recoveries in respect of employee benefits	0	0	0	1,302
Local Authorities	3,466	0	3,466	1,009
Patient Transport Services	0	0	0	0
Education, Training and Research	0	0	0	2,151
Non-NHS: Private Patients	0	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	0	0	0	0
NHS Injury Costs Recovery	0	0	0	0
Other Non-NHS Patient Care Services	821	0	821	0
Charitable and Other Contributions to Expenditure	0	0	0	0
Receipt of donated assets	0	0	0	0
Receipt of Government granted assets	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	195	0	195	1,252
Other revenue	0	0	0	5,187
Total miscellaneous revenue	**1,070,564**	**1,167**	**1,069,397**	**896,110**

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	9,620		9,620	13,001
Non-Healthcare	9,878	0	9,878	6,697
Total	19,498	0	19,498	19,698
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	766,217	0	766,217	826,110
Goods and services (other, excl Trusts, FT and PCT))	0	0	0	2,008
Total	766,217	0	766,217	828,118
Goods and Services from Foundation Trusts	685,388	0	685,388	442,930
Purchase of Healthcare from Non-NHS bodies	76,863		76,863	63,587
Social Care from Independent Providers	0		0	0
Expenditure on Drugs Action Teams	890		890	2,453
Non-GMS Services from GPs	2,690	0	2,690	0
Contractor Led GDS & PDS (excluding employee benefits)	19,750		19,750	20,022
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	0		0	0
Chair, Non-executive Directors & PEC remuneration	444	444	0	29
Executive Committee members costs	52	52	0	127
Consultancy Services	1,079	1,079	0	388
Prescribing Costs	38,110		38,110	44,466
G/PMS, APMS and PCTMS (excluding employee benefits)	44,957	0	44,957	45,214
Pharmaceutical Services	146		146	0
Local Pharmaceutical Services Pilots	0		0	0
New Pharmacy Contract	11,512		11,512	12,044
General Ophthalmic Services	2,840		2,840	2,675
Supplies and Services - Clinical	191	0	191	713
Supplies and Services - General	2,600	2,600	0	13
Establishment	1,202	264	938	878
Transport	10	0	10	8
Premises	3,108	1,530	1,578	4,752
Impairments & Reversals of Property, plant and equipment	129	0	129	161
Impairments and Reversals of non-current assets held for sale	0	0	0	0
Depreciation	1,235	0	1,235	1,407
Amortisation	59	0	59	115
Impairment & Reversals Intangible non-current assets	0	0	0	0
Impairment and Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	1,120	0	1,120	82
Inventory write offs	0	0	0	0
Research and Development Expenditure	0	0	0	0
Audit Fees	132	132	0	223
Other Auditors Remuneration	0	0	0	31
Clinical Negligence Costs	0	0	0	18
Education and Training	91	2	89	2,206
Grants for capital purposes	0	0	0	41
Grants for revenue purposes	0	0	0	0
Impairments and reversals for investment properties	0	0	0	0
Other	0	0	0	940
Total Operating costs charged to Statement of Comprehensive Net Expenditure	1,680,313	6,103	1,674,210	1,493,339
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	5,904	4,770	1,134	128
Trust led PDS and PCT DS	0	0	0	738
PCT Officer Board Members	196	196	0	1,293
Other Employee Benefits	8,026	1,280	6,746	12,404
Total Employee Benefits charged to SOCNE	14,126	6,246	7,880	14,563
Total Operating Costs	1,694,439	12,349	1,682,090	1,507,902
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	0	0	0	41
Grants to Local Authorities to Fund Capital Projects	0	0	0	0
Grants to Private Sector to Fund Capital Projects	0	0	0	0
Grants to Fund Capital Projects - Dental	0	0	0	0
Grants to Fund Capital Projects - Other	0	0	0	0
Total Capital Grants	0	0	0	41
Grants to fund revenue expenditure				
To Local Authorities	0	0	0	0
To Private Sector	0	0	0	0
To Other	0	0	0	0
Total Revenue Grants	0	0	0	0
Total Grants	0	0	0	41

5.1 Analysis of Operating Costs (continued)

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,182**	9,483	1,699
Weighted population (number in units)*	**343,127**	343,127	343,127
Running costs per head of population (£ per head)	**32.59**	**27.64**	**4.95**
PCT Running Costs 2011-12			
Running costs (£000s)	**16,371**	14,191	2,180
Weighted population (number in units)	**343,127**	343,127	343,127
Running costs per head of population (£ per head)	**47.71**	**41.36**	**6.35**

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

5.2 Analysis of Operating Expenditure by Expenditure Classification	2012-13 £000	2011-12 £000	
Purchase of Primary Health Care			
GMS / PMS/ APMS / PCTMS	43,388	45,214	
Prescribing costs	38,110	44,481	0
Contractor led GDS & PDS	16,526	16,499	
Trust led GDS & PDS	0	0	
General Ophthalmic Services	2,655	2,675	
Department of Health Initiative Funding	0	0	
Pharmaceutical services	9,369	9,401	
Local Pharmaceutical Services Pilots	0	0	
New Pharmacy Contract	0	0	
Non-GMS Services from GPs	0	0	
Other	8,179	6,062	
Total Primary Healthcare purchased	**118,227**	124,332	
Purchase of Secondary Healthcare			
Learning Difficulties	5,395	5,611	
Mental Illness	53,098	54,499	
Maternity	23,292	21,655	
General and Acute	311,529	290,167	
Accident and emergency	12,801	11,330	
Community Health Services	32,801	34,277	
Other Contractual	34,129	31,300	
Total Secondary Healthcare Purchased	**473,045**	448,839	
Grant Funding			
Grants for capital purposes	0	41	
Grants for revenue purposes	0	0	
Total Healthcare Purchased by PCT	**591,272**	**573,212**	
PCT self-provided secondary healthcare included above	0	0	
Social Care from Independent Providers	0	0	
Healthcare from NHS FTs included above	104,452	94,777	

6. Operating Leases

The Primary Care trust rentspremises from private landlords. The leases are for terms varying from one to sixteen years. The rent payable is subject to review every 3-5 years and is liable for value addted tax (currenlty 20%) which is not recoverable. No leases contain terms of renewal, purchase options or restrictions.

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	0	1,579	0	1,579	1,355
Contingent rents	0	0	0	0	224
Sub-lease payments	0	0	0	0	0
Total	0	1,579	0	1,579	1,579
Payable:					
No later than one year	0	1,156	0	1,156	1,579
Between one and five years	0	2,194	0	2,194	4,943
After five years	0	2,648	0	2,648	3,633
Total	0	5,998	0	5,998	10,155
Total future sublease payments expected to be received				0	0

6.2 PCT as Lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	195	0
Contingent rents	0	1,252
Total	195	1,252
Receivable:		
No later than one year	0	1,254
Between one and five years	0	418
After five years	0	0
Total	0	1,672

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	11,777	10,565	1,212	9,104	8,273	831	2,673	2,292	381
Social security costs	879	795	84	874	794	80	5	1	4
Employer Contributions to NHS BSA - Pensions Division	1,131	1,022	109	1,123	1,020	103	8	2	6
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	339	339	0	339	339	0	0	0	0
Total employee benefits	14,126	12,721	1,405	11,440	10,426	1,014	2,686	2,295	391
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	14,126	12,721	1,405	11,440	10,426	1,014	2,686	2,295	391
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	14,126	12,721	1,405	11,440	10,426	1,014	2,686	2,295	391
Recognised as:									
Commissioning employee benefits	14,126			11,440			2,686		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	14,126			11,440			2,686		

Employee Benefits - Revenue
There was no revenue generated in the PCT in respect of Employee Benefits.

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	12,454	10,305	2,149
Social security costs	975	967	8
Employer Contributions to NHS BSA - Pensions Division	1,294	1,284	10
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	14,723	12,556	2,167
Less recoveries in respect of employee benefits	(1,302)	(1,302)	0
Total - Net Employee Benefits including capitalised costs	13,421	11,254	2,167
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	14,723	12,556	2,167
Recognised as:			
Commissioning employee benefits	14,723		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	14,723		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	6	6	0	10	10	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	185	140	45	214	144	70
Healthcare assistants and other support staff	0	0	0	0	0	0
Nursing, midwifery and health visiting staff	12	11	1	14	13	1
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	12	12	0	17	16	1
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	215	169	46	255	183	72
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sicknes

This information will be reported in the PCT's Annual Report

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	4	1	5	1	1	2
£10,001-£25,000	6	3	9	1	0	1
£25,001-£50,000	1	2	3	1	0	1
£50,001-£100,000	2	1	3	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	2	0	2
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	13	7	20	5	1	6
	£	£	£	£	£	£
Total resource cost	292,078	191,657	483,735	431,000	1,000	432,000

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.

7.5 Pension Costs

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

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

a) Full actuarial (funding) valuation

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

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

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

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

b) Accounting valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**14,658**	**82,775**	14,710	80,812
Total Non-NHS Trade Invoices Paid Within Target	**12,959**	**67,396**	12,910	65,913
Percentage of NHS Trade Invoices Paid Within Target	88.41%	81.42%	87.76%	81.56%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**8,645**	**1,511,035**	7,377	1,297,357
Total NHS Trade Invoices Paid Within Target	**6,756**	**1,410,228**	5,982	1,250,192
Percentage of NHS Trade Invoices Paid Within Target	78.15%	93.33%	81.09%	96.36%

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

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

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

9. Investment Income

The PCT did not generate any investment income in 2012-13.

10. Other Gains and Losses

The PCT did not incur any exceptional losses in 2012-13, nor did it create any exceptional gains in year.

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under PFI contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	0	0	0	0
Other finance costs	0	0	0	0
Provisions - unwinding of discount	0	0	0	33
Total	0	0	0	33

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	6,338	11,927	0	0	1,117	0	4,349	1,124	24,855
Additions of Assets Under Construction	0	0	0	0	0	0	0	0	0
Additions Purchased	0	41	0	0	(1)	0	429	214	683
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	(1,331)	0	0	0	0	0	0	(1,331)
Upward revaluation/positive indexation	109	0	0	0	0	0	0	0	109
Impairments/negative indexation	0	(51)	0	0	0	0	0	0	(51)
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	6,447	10,586	0	0	1,116	0	4,778	1,338	24,265
Depreciation									
At 1 April 2012	0	1,331	0	0	401	0	2,905	341	4,978
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	(1,331)	0	0	0	0	0	0	(1,331)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	129	0	0	0	0	0	0	129
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	547	0	0	137	0	454	97	1,235
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	676	0	0	538	0	3,359	438	5,011
Net Book Value at 31 March 2013	6,447	9,910	0	0	578	0	1,419	900	19,254
Purchased	6,447	9,910	0	0	578	0	1,419	900	19,254
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	6,447	9,910	0	0	578	0	1,419	900	19,254
Asset financing:									
Owned	6,447	9,910	0	0	578	0	1,419	900	19,254
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	6,447	9,910	0	0	578	0	1,419	900	19,254

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	3,094	2,598	26	0	5	1	0	28	5,752
Movements (specify)	(102)	84	(26)	0	0	0	0	0	(44)
At 31 March 2013	2,992	2,682	0	0	5	1	0	28	5,708

Note: There were no additions to Assets Under Construction in 2012-13

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	**6,338**	**11,969**	**0**	**678**	**1,047**	**0**	**3,735**	**420**	**24,187**
Additions - purchased	0	382	0	(4)	70	0	614	30	**1,092**
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	(674)	0	0	0	674	**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	0	0	0	0	0	0	0	0	**0**
Impairments	0	(424)	0	0	0	0	0	0	**(424)**
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	**6,338**	**11,927**	**0**	**0**	**1,117**	**0**	**4,349**	**1,124**	**24,855**
Depreciation									
At 1 April 2011	**0**	**627**	**0**	**0**	**270**	**0**	**2,265**	**248**	**3,410**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	161	0	0	0	0	0	0	**161**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	543	0	0	131	0	640	93	**1,407**
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**	**1,331**	**0**	**0**	**401**	**0**	**2,905**	**341**	**4,978**
Net Book Value at 31 March 2012	**6,338**	**10,596**	**0**	**0**	**716**	**0**	**1,444**	**783**	**19,877**
Purchased	6,338	10,596	0	0	716	0	1,444	783	**19,877**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**6,338**	**10,596**	**0**	**0**	**716**	**0**	**1,444**	**783**	**19,877**
Asset financing:									
Owned	6,338	10,596	0	0	716	0	1,444	783	**19,877**
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	**6,338**	**10,596**	**0**	**0**	**716**	**0**	**1,444**	**783**	**19,877**

12.3 Property, Plant and Equipment

The PCT does not hold any donated assets

The PCT's land & buildings estate was valued as at 31 December 2012 by the District Valuer's Office, Wimbledon.

The District Valuer is an independent valuer who has no related party , or pecuniary interest in the PCT.

Assets are valued under the Modern Equivalent Asset concept. Any impairments caused by fluctuations in market conditions are charged through the PCT's Revaluation Reserve, but only where a reserve in respect of that specific asset exists. If no reserve exists, revaluation impairments are carried through the PCT's income and expenditure accounts as a direct charge to operating costs.

The PCT's estate was valued in December 2012 by the District Valuer. The impact of this exercise was a downward valuation of £180k, of which £129k was charged against the PCT's Operating Costs, whilst £51k was passed through the PCT's accumulated Revaluation Reserve.

Asset lives:

Economic Lives of Non-Current Assets

	Minimum Years	Maximum Years
Intangible Assets		
Software Licences	5	5
Property, Plant and Equipment		
Buildings exc Dwellings	9	77
Dwellings	5	10
Plant & Machinery	5	5
Transport Equipment	5	5
Information Technology	5	10
Furniture and Fittings		

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	644	0	0	0	644
Additions - purchased	0	23	0	0	0	23
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	667	0	0	0	667
Amortisation						
At 1 April 2012	0	503	0	0	0	503
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	59	0	0	0	59
In-year transfers to NHS bodies	0	0	0	0	0	0
At 31 March 2013	0	562	0	0	0	562
Net Book Value at 31 March 2013	0	105	0	0	0	105
Net Book Value at 31 March 2013 comprises						
Purchased	0	105	0	0	0	105
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2013	0	105	0	0	0	105

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	644	0	0	0	644
Additions - purchased	0	0	0	0	0	0
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	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	644	0	0	0	644
Amortisation						
At 1 April 2011	0	388	0	0	0	388
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	115	0	0	0	115
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	503	0	0	0	503
Net Book Value at 31 March 2012	0	141	0	0	0	141
Net Book Value at 31 March 2012 comprises						
Purchased	0	141	0	0	0	141
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2012	0	141	0	0	0	141

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	129	0	129
Total charged to Annually Managed Expenditure	**129**	**0**	**129**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0	0	0
Over Specification of Assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	51	0	51
Total impairments for PPE charged to reserves	**51**	0	51
Total Impairments of Property, Plant and Equipment	**180**	**0**	**180**
Intangible assets impairments and reversals charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	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	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	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 impairments for Intangible Assets charged to Reserves	**0**	0	0
Total Impairments of Intangibles	**0**	**0**	**0**

	Total	Admin	Programme
Financial Assets Impairments and reversals charged to the Revaluation Reserve	£000	£000	£000
Loss or damage resulting from normal operations	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
TOTAL impairments for Financial Assets charged to reserves	0	0	0
Total Impairments of Financial Assets	0	0	0
Non-current assets held for sale - impairments and reversals charged to SoCNE.			
Loss or damage resulting from normal operations	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen obsolescence	0	0	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
Inventories - impairments and reversals charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen Obsolescence	0	0	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
Investment Property impairments charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen Obsolescence	0	0	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
Investment Property impairments and reversals charged to the Revaluation Reserve			
Loss or Damage Resulting from Normal Operations	0	0	0
Over Specification of Assets	0	0	0
Abandonment of Assets in the Course of Construction	0	0	0
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 impairments for Investment Property charged to Reserves	0	0	0
Total Investment Property Impairments	0	0	0
Total Impairments charged to Revaluation Reserve	51	0	51
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	129	0	129
Overall Total Impairments	180	0	180
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	0	0	0

15 Investment property

The PCT does not hold any investment properties within its land and buildings asset portfolio.

16 Commitments

16.1 Capital commitments

The PCT has no Capital commitments over and above those reported as Capital creditors and accruals in Note 25 to these Accounts.

16.2 Other financial commitments

The PCT has not entered into any non-cancellable contracts.

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	4,922	0	10,574	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	2,325	0	21,853	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,016	0	32,305	0
At 31 March 2013	**8,263**	**0**	**64,732**	**0**
prior period:				
Balances with other Central Government Bodies	12,199	0	5,823	0
Balances with Local Authorities	614	0	749	0
Balances with NHS Trusts and Foundation Trusts	5,761	0	40,289	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,622	0	30,486	0
At 31 March 2012	**21,196**	**0**	**77,347**	**0**

18 Inventories

The PCT does not value, small value, inventory items. These are written off as Revenue expenditure at the point of purchase.

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	7,247	17,960	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	0	0	0	0
Non-NHS receivables - revenue	1,916	1,882	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	0	1,037	0	41
Provision for the impairment of receivables	(1,120)	0	0	0
VAT	220	38	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	279	0	4
Total	8,263	21,196	0	45
Total current and non current	8,263	21,241		
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

	31 March 2013 £000	31 March 2012 £000
By up to three months	0	3,650
By three to six months	0	5,266
By more than six months	0	4,484
Total	0	13,400

19.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	0	82
Amount written off during the year	0	(82)
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(1,120)	0
Balance at 31 March 2013	(1,120)	0

The Impairment of receivables relate to provision for doubtful debts. The provisions include amounts for General practitioners Service charges outstanding. The Services charges was not agreed with the General Practitioners prior to levy and are in dispute. The remainder relate to settlement agreement with Croydon Health Services Trust and immaterial other write off's that has been put top the audit committee

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**0**	**2**	**2**
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**	**2**	**2**
Balance at 1 April 2011	12	2	14
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**	**2**	**2**

21.1 Other financial assets - Current

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

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**2**	0
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**2**	0

21.3 Other Financial Assets - Capital Analysis

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

22 Other current assets

	31 March 2013 £000	31 March 2012 £000
EU Emissions Trading Scheme Allowance (see Note 1.21)	**0**	0
Other Assets	**0**	0
Total	**0**	0

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**69**	0
Net change in year	**889**	69
Closing balance	**958**	69
Made up of		
Cash with Government Banking Service	**958**	63
Commercial banks	**0**	6
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**958**	69
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**958**	69
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

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

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

At 31 March 2012	0
At 31 March 2013	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**32,112**	46,060	**0**	0
NHS payables - capital	**0**	52	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Family Health Services (FHS) payables	**10,732**	17,329	0	0
Non-NHS payables - revenue	**811**	2,470	**0**	0
Non-NHS payables - capital	**365**	485	**0**	0
Non-NHS accruals and deferred income	**20,434**	10,003	**0**	0
Social security costs	**119**	(20)	**0**	0
VAT	**0**	0	**0**	0
Tax	**159**	(4)	**0**	0
Payments received on account	**0**	0	**0**	0
Other	0	972	0	0
Total	**64,732**	77,347	**0**	0
Total payables (current and non-current)	**64,732**	**77,347**		

26 Other liabilities

As at 31 march 2013, the PCT had no additional liabilities to those reported in Note 25 to these Accounts.

27 Borrowings

The PCT had no borrowings as at 31 March 2013.

28 Other financial liabilities

The PCT has no financial liabilities other than those reported in Note 25 to these Accounts.

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	**401**	0	**0**	0
Deferred income addition	**0**	401	**0**	0
Transfer of deferred income	**(401)**	0	**0**	0
Current deferred Income at 31 March 2013	**0**	401	**0**	0
Total other liabilities (current and non-current)	**0**	**401**		

30 Finance lease obligations

As at 31 March 2013, the PCT had no finance lease obligations (2011-12 Nil)

31 Finance lease receivables as lessor

As at 31 March 2013, the PCT did not act as a lessor under the terms of a finance lease.

32 Provisions

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**3,204**	0	1,140	257	0	0	1,366	441
Arising During the Year	**5,100**	0	120	4,438	0	0	542	0
Utilised During the Year	**(79)**	0	(59)	(2)	0	0	(2)	(16)
Reversed Unused	**(706)**	0	0	0	0	0	(425)	(281)
Unwinding of Discount	**0**	0	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0	0	0
Balance at 31 March 2013	**7,519**	**0**	**1,201**	**4,693**	**0**	**0**	**1,481**	**144**
Expected Timing of Cash Flows:								
No Later than One Year	**5,581**	**0**	**59**	**4,693**	**0**	**0**	**685**	**144**
Later than One Year and not later than Five Years	**679**	**0**	**250**	**0**	**0**	**0**	**429**	**0**
Later than Five Years	**1,259**	**0**	**892**	**0**	**0**	**0**	**367**	**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

Certainty of future cash flows:-
Pensions to Former Staff - Quarterly payments are made to the NHS Pensions Authority as reimbursement for pension payments made to former employees. Therefore, the certainty over future cash
Other - This Provision balance includes that of a structured medical negligence settlement and is based on the estimated life expectancy of the claimant. Subject to that, certainty over future cash flows
Continuing Care - Future cash flows are not certain, as they will depend on the success of claimants in individual cases. However, it is anticipated that future payments will be significant in total.

The PCT does not anticipate making any recoveries against these provisions.

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Continuing Care	**205**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**205**	0
Contingent Assets		
Contingent Assets	**0**	5,880
Net Value of Contingent Assets	**0**	5,880

These Accounts report a Provision for Future Liabilities of £4,693k in respect of Continuing Care claims, £4,438k of which has been recognised in 2012-13 to account for retrospective claims (see Note

34 PFI and LIFT - additional information

As at 31 March 2013, the PCT had not entered into any PFI or LIFT arrangements.

35 Impact of IFRS treatment - 2012-13

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

36 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

PCTs are not permitted to borrow in the open market. Only borrowings in relation to PFI and NHS LIFT schemes are permitted. 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	0	**0**
Receivables - NHS	0	7,247	0	**7,247**
Receivables - non-NHS	0	1,016	0	**1,016**
Cash at bank and in hand	0	958	0	**958**
Other financial assets	2	0	0	**2**
Total at 31 March 2013	**2**	**9,221**	**0**	**9,223**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	17,643	0	17,643
Receivables - non-NHS	0	2,199	0	2,199
Cash at bank and in hand	0	69	0	69
Other financial assets	2	0	0	2
Total at 31 March 2012	2	19,911	0	19,913

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	32,112	**32,112**
Non-NHS payables	0	32,620	**32,620**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**64,732**	**64,732**
Embedded derivatives	0	0	0
NHS payables	0	45,795	45,795
Non-NHS payables	0	21,232	21,232
Other borrowings	0	0	0
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	0	67,027	67,027

37 Related Party Transactions

Croydon Primary Care Trust is a body corporate established by order of the Secretary of State for Health.

During the year two Board Members or members of the key management staff or parties related to them had undertaken material transactions with the Primary Care Trust as set out below:

	2012/13		2011/12	
	Payments to related party	Amounts owed to related party	Payments to related party	Amounts owed to related party
			£	£
DR K. TARRANT	0	0	2,294,924	-
DR P. BOFFA	0	0	2,487,180	-
DR T. BRZEZICKI	0	0	3,438,584	-
DR A. FERNANDES	0	0	3,042,432	23,890
DR K. SHAH	0	0	-	-
DR J. CHAN	0	0	2,326,429	14,115
DR B. ABBOT	0	0	867,829	-
DR N. FORD	0	0	1,134,821	7,754
DR J. KHAN	0	0	764,126	-
DR F. SAMI	0	0	1,175,600	-
DR H. ANSARI	0	0	502,946	-
K. NORTHWOOD	0	0	1,910,697	44,905

The members of the PEC ceased to influence the Board decisions and thus no GP related parties are reported for 2012/13

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

	2012/13		2011/12	
	Expenditure with related party	Revenue from related party	Expenditure with related party	Revenue from related party
	£000	£000	£000	£000
Barking And Dagenham PCT	7	14,895	61	10,954
Barnet PCT		34,866	-	25,422
Barnet, Enfield And Haringey Mental Health NHS Trust	39,332		40,638	-
Barts And The London NHS Trust	54,334		59,554	76
Bexley NHS Care Trust PCT	1	15,470	5	10,647
Brent Teaching PCT	4	42,893	-	28,744
Bromley PCT	71	20,119	307	13,858
Camden PCT		35,684	171	31,451
Central And North West London MH NHS Foundation Trust	30,133		31,076	-
Chelsea And Westminster Hospital NHS Foundation Trust	68,003	21	61,602	202
City And Hackney Teaching PCT	38	46,950	83	43,923
Croydon Health Services NHS Trust	209,367	1,167	202,059	1,032
Ealing PCT	3	48,664	68	35,782
East London NHS Foundation Trust	41,807		36,810	-
Enfield PCT		33,906	47	25,360
Epsom and St Helier University Hospitals NHS Trust	31,129		22,200	-
Great Ormond Street Hospital for Children NHS Trust	63,467		51,891	-
Greenwich Teaching PCT	9	30,654	23	20,698
Guy's and St Thomas NHS Foundation Trust	118,550		102,912	-
Hammersmith And Fulham PCT	15	29,646	12	25,460
Haringey Teaching PCT		45,909	16	37,673

37 Related Party Transactions (continued)

	2012/13		2011/12	
	Expenditure with related	Revenue from related party	Expenditure with related	Revenue from related party
	£000	£000	£000	£000
Harrow PCT		21,444	-	15,241
Havering PCT		14,650	-	10,832
Hillingdon PCT	2	22,606	3	17,137
Homerton University Hospital NHS Foundation Trust	21,996		16,218	-
Hounslow PCT	5	31,076	3	23,228
Imperial College Healthcare NHS Trust	107,800		49,602	115
Islington PCT		38,035	19	32,973
Kensington And Chelsea PCT		26,743	237	22,288
Kings College Hospital NHS Foundation Trust	84,276	41	66,474	32
Kingston PCT		11,330	35	9,143
Lambeth PCT	136	57,197	311	49,154
Lewisham PCT		38,228	40	28,094
London Ambulance Service NHS Trust	11,924		11,622	-
Mid Essex Hospital Services NHS Trust	12,628		15,203	-
Newham PCT		36,314	-	34,296
North Middlesex University Hospital NHS Trust	12,230		10,462	-
North West London Hospitals NHS Trust	23,311		23,230	-
Redbridge PCT	3	18,668	2	15,116
Richmond And Twickenham PCT		13,704	16	10,742
Royal Brompton and Harefield NHS Foundation Trust	13,414		14,961	-
Royal Free Hampstead NHS Trust	96,289		46,997	-
South East Essex PCT		6,379	270	52,931
South London and Maudsley NHS Foundation Trust	52,154		46,542	-
South London Healthcare NHS Trust	15,505		14,172	-
South West London and St Georges Mental Health NHS Trust	16,017		16,342	-
Southwark PCT		43,556	-	36,668
St Georges Healthcare NHS trust	70,047		61,544	-
Sutton & Merton PCT	488	30,737	2,466	27,419
The Royal Marsden Hospital NHS Foundation Trust	29,608		24,778	-
Tower Hamlets PCT	4	28,439	-	30,129
University College London NHS Foundation Trust	21,356		19,227	-
Waltham Forest PCT	2	26,723	2	24,219
Wandsworth PCT	8,451	32,666	6,674	30,703
West Kent PCT	9,292	11,130	9,155	63,381
West London Mental Health NHS Trust	86,150		101,167	-
Westminster PCT		35,053	-	28,821

In addition, the Primary Care Trust has had a significant number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with the London Borough of Croydon

	2012/13		2011/12	
	Expenditure with related party	Revenue from related party	Expenditure with related party	Revenue from related party
	£000	£000	£000	£000
London Borough of Croydon	10,614	1,002	12,869	956

38 Losses and Special Payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	6,679	63
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	6,679	63
Total special payments	0	0
Total losses and special payments	6,679	63

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	5,250	1
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	5,250	1
Total special payments	0	0
Total losses and special payments	5,250	1

Details of cases individually over £250,000
There were no high value cases in excess of £250,000

39 Third Party Assets

The PCT does not hold any assets on behalf of third parties.

40 Pooled Budget Arrangements

Croydon PCT does not have any Pooled Budget arrangements with other parties.

41 Cashflows relating to exceptional items

During 2012-13, the PCT had no cash flows relating to extraordibary items.

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 however, these accounts have been prepared on the going concern basis, as the PCTs statutory duties and responsibilities will be undertaken by a successor NHS organisation from 1 April 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.

Croydon Primary Care Trust
Annual Governance Statement 2012 - 2013

NHS Croydon

Organisation Code:

Governance Statement

1 Scope of responsibility

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

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

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

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

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

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

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

2 The Governance Framework of the Organisation

2.1 Governance Framework

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

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

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

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

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

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

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

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

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

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

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

2.2 NHS SWL Joint Boards' Committee Structure

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

In terms of remit, the Committees cover:

Statutory Committees

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

(ii) **Joint Charitable Funds** – This committee is not applicable to NHS Croydon. Charitable Funds as trusteeship in Croydon was transferred to Croydon Healthcare Services in 2010- 11.

(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 .

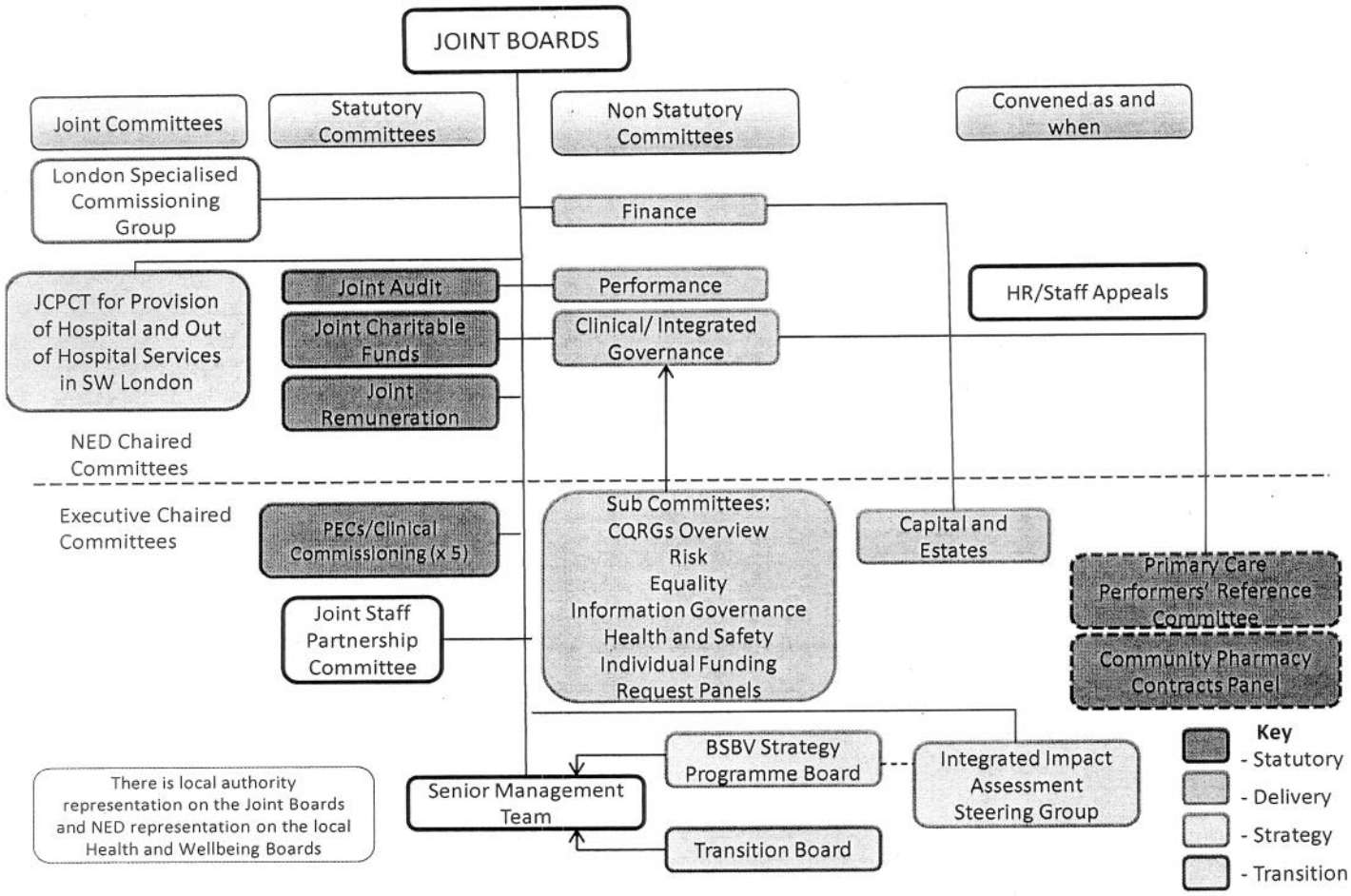
(ix) **(Joint Committees ((ix) Pan London; (x) South West and South East Clusters)**

(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 continue 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 Trust's as a result of a multitude of factors including: higher than predicted levels of acuity and emergency admissions, intermittent loss of beds due to beds due to Noro-virus, 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 Borough's 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	
Croydon Clinical Commissioning Group Governing Body	Met 10 times	Yes	• Authorisation • Strategic Planning for 2013/14 • Financial Recovery • Quality, Innovation, Productivity and Prevention Performance (QIPP) • Risk

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

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
Finance	Met 12 times (Monthly)	Yes	Standing Items: • Finance report for Position To Date and Forecast Outturn; • QIPP reports • Approve single tender actions and ad hoc business cases Major decisions made by the FC in 2012/13 are as follows: • Approve all business cases from the 2% non-recurrent fund • To agree an increase in the Cluster Control Total from £25.2m to £30.2m. • To approve the transfer of funds to NHSC of £9m from 2% non-recurrent reserve.
Performance	Met 5 times (Bi-monthly)	Yes	• A&E and ambulance turnaround times at Croydon Hospital • 18 week waiting times at St George's, • HCAIs at Epsom & St Helier • Childhood Immunisations • A&E winter pressures • Ensuring focus on performance is maintained during the final stages of transition
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 Croydon has, throughout the 2012/13 reporting year, applied the principles and met the requirements of the Code of Governance. NHS Croydon 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 has been one serious incident 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		**Croydon**
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)	
V	Other	1
TOTAL		**1**

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 Delivering Financial Recovery and Stability

The PCT during 2011/12 uncovered a material misstatement in relation to its prior year (2010/11) accounts and significant irregularities in relation to its financial plan for 2011/12. A significant prior period adjustment was made to the 2010/11 accounts.

Whilst the PCT reported a small surplus in 2011/12, it was achieved with financial support from SWL Cluster risk sharing arrangements. During 2011/12, the PCT delivered a £16m QIPP savings programme which reduced the financial risk and prevented the need for a higher level of support.

The PCT planned for a statutory breakeven position in 2012/13, predicated on a net £25m QIPP savings target. The PCT is forecasting breakeven for 2012/13 reflecting £20.6m QIPP delivery and receiving £9m support from SWL Cluster Risk Sharing. The PCT's underlying recurrent deficit is £18m at the end of 2012/14.

For 2013/14, the majority (£15m) of the underlying financial deficit transfers to Croydon CCG.

4.1.1 **Remedial Actions**:

The CCG has corrective plans in place to eliminate its underlying deficit over three years by 2015/16. The recovery plan includes:

- Continue rigorous financial control through robust performance management of health service contracts, budget holders and GP Clinical Networks.
- Achieve substantial savings through its QIPP (Quality, Innovation, Productivity and Prevention) Programme. This includes expanding current Programme Management Office and retaining strong governance arrangements.
- Restrict investment to "Invest to Save" initiatives approved as part of the QIPP programme
- Establish strong GP Clinical Networks on a geographic basis to deliver quality and value for money improvements for their population
- Implement financial and value-for-money training for budget holders and GP members as part of the wider Organisational Development plan.
- Collaborative strategic redesign of South West London acute providers landscape through the 'Better Services, Better Value' programme.

4.2 **Continuing Care**

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

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

Whilst acknowledging NHS Croydon's response, which has been shared directly with the Auditors, 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.

4.3 **Information Governance Breach**

As noted under Section 3.2, 'Lapses of data security including reported to Information Commissioner', a data security incident in public health was reported and investigated. An action plan has been put in place to address the holding of patient data and associated consent issues, and to enable assurance on this going forward in successor bodies.

Department of Health Designated Signing Officer

Carl Vincent – Director of Provider Finance and Finance Transition

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