Department of Health

NHS

Redbridge Primary Care Trust

2012-13 Annual Report and Accounts

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Redbridge Primary Care Trust

2012-13 Annual Report

NHS

North East London and the City

Redbridge Primary Care Trust

Annual report 2012/13

Creating a healthier future

Contents

1 Foreword

2012/13 was a year to remember for north east London and the City. This was the year of the Olympics and Paralympics, when north east London was the centre of world attention. Thousands of visitors came to east London and many local people and NHS staff were able to take part in the opening or closing ceremonies or work as volunteers.

The opening ceremony celebrated the NHS; and staff from many local NHS organisations took part.

Behind the scenes, NHS staff ensured plans were in place, and changed their pattern of work where necessary, so that local people would continue to get the care they needed, and so that the NHS would cope if there were any major incidents during that period.

Staff did that while delivering on the PCT's roles in improving health, commissioning services and ensuring the performance of the NHS locally was maintained and improved. They did this while supporting preparations to bring new public health and NHS commissioning arrangements into place ready for reformed statutory arrangements from April 2013.

And that was all done within a new "clustering" for north east London PCTs. In April we brought staff together from seven PCTs to work under a single management structure, under a joint board; all designed to use our resources as effectively as possible.

I would like to put on record my thanks to them for outstanding work during 2012/13. Further than that, I congratulate all those who have worked for the PCTs in the past decade for their contribution to many great achievements in improving health and health services locally.

Also, I would like to thank our partners in general practice, in provider services; hospitals, mental health and community health services, in the local authority, voluntary sector and local community groups who all have played essential roles in improving health. Thanks to their input we improved services and supported people in a variety of ways – as well as encouraging more people to take greater care of their own health.

The year also marked the 70th anniversary of the *Report of the Inter-Departmental Committee on Social Insurance and Allied Services* – more popularly called the Beveridge report. In that William Beveridge wrote of the need for a health service for all, free at the point of need, as a key element of how this country would tackle disease and inequality.

Though the NHS is changing, those principles remain and for patients and the public, the principle of access to NHS services on the basis of need and not ability to pay continues.

I have sought and received assurance from former responsible officers on statements presented in this annual report.

This report reflects what we have achieved together across the PCT areas, with specific information about this PCT, as the statutory organisation until 31 March 2013.

Peter Coates CBE
Designated Signing Officer

2. The primary care trust

Redbridge Primary Care Trust (known publically as NHS Redbridge) was established in 2001. It covers the same area as the London Borough of Redbridge.

It was abolished, along with all primary care trusts (PCTs), on 31 March 2013.

Its purpose was to improve the health of local people by ensuring that appropriate services are available in the right place and at the right time. It was responsible for leading the local NHS and for commissioning health services on behalf of the local population.

It was one of seven primary care trusts to come together in a cluster, as NHS North East London and the City, on 1 April 2012. This was a partnership with the primary care trusts for Barking and Dagenham, City and Hackney, Havering, Newham, Tower Hamlets, and Waltham Forest. For the previous year 2011/12, these PCTs had been in clusters known as NHS East London and the City (ELC) or NHS Outer North East London (ONEL), which included Redbridge PCT. All PCTs continued to exist as separate statutory organisations, but to ensure efficiency and reduced costs they shared a management structure.

The overarching purpose of primary care trust clusters was to keep a strong grip on quality, safety, finances and performance of NHS services while ensuring the smooth transfer of services to the new structures within the NHS.

3. The role of the primary care trust

The main purpose of the primary care trust was to improve health and to commission health services to meet the needs of the local communities.

It assessed the healthcare needed by the local population by looking at a wide range of public health and other population data.

We asked local people what they thought of services and what they want us to develop. We then looked at the different ways those needs could be met, and we enter into contracts with a range of organisations to provide services for people in Redbridge. These included hospital, mental health, community and primary care services such as GP and dental care.

We worked to ensure more outpatient and diagnostic services were offered in the community (in health centres, pharmacies and GP surgeries) instead of in hospitals.

Our main hospital providers for local people was Barking, Havering and Redbridge University Hospital Trust and, at Whipps Cross Hospital, Barts Health NHS Trust.

Mental health services are available to patients in many places in the community. For those with more complex or severe needs, local hospitals, managed by North East London NHS Foundation Trust provides inpatient and specialist care.

We made arrangements with many other organisations and individuals, including the local authority, independent providers, dentists, pharmacists and optometrists, for them to provide a wide range of services under the NHS. We join with other primary care trusts to commission ambulance services and specialist hospital services for rarer conditions.

Our vision and goals

We developed common vision and goals across NHS North East London and the City (NHS NELC) for 2012/13;

To create a healthier future for local residents.

We said we would do this through:

- Ensuring the performance of the local NHS is maintained and improved
    - Improving the health of the public
    - Giving local people effective and high quality acute, community and primary care
    - Meeting financial targets.
- Implementing the NHS reforms
    - Managing the transition to new NHS commissioning arrangements.
- Improving the quality of care delivered by Barking, Havering and Redbridge University Hospital Trust and ensure it has a sustainable future
    - Delivering on quality, finance and key performance indicators for the trust and ensuring effective plans are in place for it to become an NHS Foundation Trust.
- Preparing for London 2012 and ensuring a health legacy
    - Ensuring NHS services meet the needs of local people through the 2012 Games period and that there is ongoing benefit to the health of local people.

4 Boards and committees

NHS Redbridge approved a shared governance arrangement for 2012/13 which meant that board meetings were held jointly with those of the PCTs for Barking and Dagenham, City and Hackney, Havering, Newham, Tower Hamlets and Waltham Forest. This arrangement was described as a North East London and the City cluster. This cluster was supported by a management team across the seven PCTs but each of the seven PCTs retained its own statutory identity. As a result of changes for this year a common board membership was established where possible but the directors of public health and the former professional executive committee chairs remained unique to their original organisations.

The membership of the Board is outlined below.

Chair

Marie Gabriel, 1 April 2012 to 30 September 2012
Afzal Akram from 1 October until 27 October 2012
Dr John Carrier became interim Chair from 28 October 2012 until 31 March 2013 when Mr Akram was unavailable.

Non-executive directors (NEDs)

There were seven non-executive directors, including the chair, above, appointed across the seven primary care trusts. The NEDS were;

- Kash Pandya as Audit Chair from 1 April 2012 to 31 March 2013
- Jane Winder, 1 April 2012 to 31 March 2013
- Paul Hendrick, 1 April 2012 to 31 March 2013
- John Lock, 1 April 2012 to 31 March 2013
- Philip Wilson, 1 April 2012 to 14 September 2012
- Alan Wells, 17 September 2012 to 31 March 2013
- Afzal Akram, 1 April 2012 to 31 March 2013

In addition, seven former NHS Outer North East London and NHS East London and the City Non-Executive Directors have been retained as Associate Non-Executive Directors (ANEDs) and have performed specific statutory and non-statutory duties delegated by the Boards. Those ANEDs were:

- Taric Ahmed
- Charles Beaumont
- Lesley Buckland
- Mariette Davis
- Andrea Lippett
- Catherine Max
- Jill Pullen
- Honor Rhodes

Executive members

The executive members of the Boards are listed below. These directors are shared across all seven PCTs:

- Alwen Williams, Chief Executive, 1 April 2012 to 31 March 2013
- Stuart Saw, Director of Finance, 1 April 2012 to 31 March 2013
- Terry Huff, Chief Operating Officer and Deputy CEO, 1 April 2012 to 31 August 2012
- Heather Mullin, Director of Transition, 1 September 2012 to 31 March 2013
- Caroline Alexander, Director of Nursing and Quality, 1 April 2012 to 27 November 2012

- Vanessa Lodge, Deputy Director of Nursing and Quality 28 November 2012 to 31 March 2013
- Dr Ken Aswani ONEL Medical Director,1 April 2012 to 31 March 2013
- Dr May Cahill ELC Medical Director, 1 April 2012 to 31 March 2013
- Peter Coles the NHS Commissioning Board North East and North Central London Local Delivery Director was co-opted onto the Cluster Board as an associate (non-voting). Member from 19 September 2012 to 31 March 2013
- Dr Ian Basnett, Director of Public Health, 1 April 2012 to 31 March 2013
- Dr Lesley Mountford, Director of Public Health, 1 April 2012 to 31 March 2013

Two further executive voting Board members were appointed from each PCT; the CCG Chair, and the Director of Public Health.

For Redbridge Primary Care Trust these were:

- Dr Hector Spiteri, Clinical Commissioning Committee Chair, 1 April 2012 to 31 March 2013
- Dr Jane Moore, Director of Public Health, 1 April 2012 to 12 May 2012
- Dr Lesley Mountford, Director of Public Health, 13 May 2012 to 31 March 2013

Audit Committee arrangements

The audit committee was made up of Non-Executive Director Kash Pandya as Chair, and Associate Non-Executive Directors Charles Beaumont and Mariette Davis. The chair of the PCT is not a member of the committee.

Within the cluster arrangements each PCT retained a separate audit committee function but these met together through 2012/13 with the membership shown above.

Our directors have confirmed that as far as they are aware there is no relevant audit information of which the auditors are unaware. They have also confirmed that they have taken all appropriate steps to make sure they are aware of any relevant audit information and to establish that the auditors are aware of that information.

Declarations of Interest

All Board members declare any interests which might be relevant and material to their NHS responsibilities. This includes details of company directorships or other significant interests where the company involved might do business with the NHS and where this might cause a conflict with the individual's managerial responsibilities. Interests declared by Board members and other directors are stored in an Interests Register and detailed below. Where there is no entry, this means there are no relevant declared interests.

Register of interests 2012/13

Name	Role	Organisation	Nature of interest
Dr Hector Spiteri	Chair – Redbridge CCG	Spearpoint Surgery Partnership of East London Co-operative	GP Principal Executive Clinical Director
Kash Pandya	Non-Executive Director & Audit Chair	Hillcroft College Surbiton Ministry of Justice Essex Advisory Committee Health & Safety Executive Havering CCG Barking & Dagenham CCG Citizens Advice Bureau	Council Member and Audit Chair Lay Member Independent Audit Committee Member Lay Member Lay Member Advisor
John Carrier	Chair	Shoreditch Park Surgery University College London Hospitals NHS Foundation Trust Camden CCG Marks & Spencer PLC Tottenham Hotspur Cancerkin, Royal Free Hospital NHS Trust British cardio-vascular society Bar standards board education and training committee London Deanery boards in surgery, O&G public health and London deanery strategic partnership board	Daughter is GP partner Governor Vice Chair/Lay member Wife is shareholder Wife is shareholder Chair Trustee Advisor Chair
Afzal Akram	Non Executive Director	London Borough of Waltham Forest	Councillor
Frances Pennell-Buck	Vice Chair/Non Executive Director	Havering Crossroads Care	Trustee
Heather Mullin	Director of Transition	Newham CCG London Borough of Newham Outlook care	Husband providing coaching support Husband providing project support. Husband is Non-Executive Director
Dr May Cahill	Joint Medical Director - NELC	Well Consortium City, Hackney Pathfinder CCG GP Premises the London Fields Medical Centre 38 -44 Broadway Market, London E8 4QJ	Joint Chair Owner

Name	Role	Organisation	Nature of interest
Dr Ken Aswani	Joint Medical Director - NELC	Allum Medical Practice NHJ Alliance RCGP	Partner Member Member
Dr Lesley Mountford	Director of Public Health	Homerton Hospital NHS Foundation Trust	Partner Governor
John Lock	Non Executive Director – NELC	2012 Office, University of East London	Director
Stuart Saw	Cluster Director of Finance	NICE diagnostics Advisory Committee	Board Member
Alan Wells	Non Executive Director, NELC Vice Chair/Lay Member, WF CCG	Capacity LTD The Simplification Centre The Alzheimer's Society CCG working Group, Institute of Chartered Secretaries and Administration	Director Director Trustee Member
Paul Hendrick	Non Executive Director	Greater London Enterprise Ltd Harevale LTD LFIG Ltd Activenewham	Director Non Executive Director
Vanessa Lodge	Deputy Director Quality and Clinical Governance (Acting Director Nursing/DIPC)	Kingston CCG	Board Nurse – 1 session per week

Managing our risks

We had an agreed risk management approach and we managed our principal risks within a Board assurance framework. This meant we assessed risks at different levels, from project, to departmental to directorate level. Our approach included a risk scoring and escalation process that sought to ensure that risks were rated consistently across the organisation. The process drew on the best practice elements of ISO 31000 (a set of international risk management standards).

The assurance framework was comprehensive in scope, consistent with the Department of Health's template, and covered the key operational areas of the organisation. It identified zero tolerance risks and horizon scanning risks, along with assurances around risk prevention and risk deterrence (such as fraud-related risks) and the way in which we manage manifested and potential risks. It mapped objectives against pertinent risks, controls and assurances and also described the ways in which public stakeholders were involved in managing risks which impact on them.

Individual directors were held accountable for the risks associated with their directorates. Their risks were reviewed and challenged by an internal risk sub-committee, which acted on behalf of the audit committee in assuring the Board that risks within the organisation were effectively managed. The risk sub-committee also scrutinised the Board assurance framework. The effectiveness of the risk management system was monitored through a series of key performance indicators which highlights movements and trends of the risk profile.

5 The new system

The Health and Social Care Act 2012

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

Clinical commissioning – CCGs and CSU

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

NHS Redbridge Clinical Commissioning Group worked in shadow form during 2012/13 and underwent a national assessment programme in readiness to take on full statutory responsibilities for commissioning acute, mental health and community health services from April 2013. NHS Redbridge Clinical Commissioning Group is chaired by Dr. Hector Spiteri and its chief officer is Conor Burke**.**

The boards of the PCTs in NHS Outer North East London agreed in March 2012 fully to delegate eligible budgets to the CCGs from 1 April 2012. This delegation was subject to: a risk assessment of the finance and quality, innovation, productivity and prevention (QIPP) plans for 2012/13; and the finalising of the performance management framework.

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

In November the NHS Commissioning Board (now known as NHS England) finalised its assessment of the North and East London Commissioning Support Unit's full business plan which set out a detailed plan for establishing and operating as a CSU.

In its assessment of the plan, the NHS Commissioning Board rated the CSU as low risk, stating: "The CSU has performed really well and has placed itself as a centre of good practice in terms of the existing NHS CSUs.

"There is a clear and concise business and development journey with strong service improvement plans underpinned by a range of innovative partnership arrangements."

NHS England

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

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

The London regional office of the NHS England will have close relationships with clinical commissioning groups, professional and clinical leadership functions and relationships with local government and Healthwatch, the new independent consumer champion created to gather and represent the views of the public.

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

Health and wellbeing boards

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

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

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

Public health

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

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

6 Our performance

The board scrutinised performance, with a report discussed at each meeting.

Last year we did well in the following areas, achieving national standards:

Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT);

- met all requirements that patients are treated in hospital within 18 weeks of referral
- achieved national standards for access to cancer care
- met the standards for ensuring hospital patients were assessed for Venous thromboembolism risk on admission.

Barts Health NHS Trust at Whipps Cross Hospital:

- met all requirements that patients are treated in hospital within 18 weeks of referral
- achieved national standards for cancer care
- met requirements on limiting cases of MRSA, with no cases during the year
- was within the national standard for the number of cases of C Difficile.

North East London NHS Foundation Trust;

- met its 18 week referral requirements for its children's, adult and specialist services

Some targets were not met:

Barking, Havering and Redbridge University Hospital Trust:

- failed to meet the A&E four hour wait standard
- failed to meet requirements on limiting cases of MRSA
- exceeded the number of cases of C Difficile required I n national standards.

Barts Health at Whipps Cross:

- failed to meet the A&E four hour wait standard
- failed to meet the standards for ensuring hospital patients were assessed for Venous thromboembolism risk on admission, although this was improving at the end of the year

The London Ambulance Service

- failed to meet the ambulance handover standards at Whipps Cross and BHRUT.

The Care Quality Commission issued two reports on A&E and maternity services at Barking, Havering and Redbridge University Hospitals NHS Trust in February 2013. This followed unannounced visits made to the trust during November and December 2012.

The CQC's A&E report highlighted that urgent action was needed to improve the quality of care. Inspectors found some poor care, unacceptable practices and waits. Our response outlines the work we are undertaking with the Trust and partners to improve the standard of care.

The CQC's maternity report shows that services have significantly improved and the trust is now meeting all standards of care, safety and staffing. The opening of the Barking Birthing Centre and the Queen's Birth Centre provides additional capacity and choice of birth environment for women with low-risk pregnancies.

In Redbridge life expectancy for both men and women is higher than the England average. Life expectancy is 7.3 years lower for men in the most deprived areas of Redbridge than in the least deprived areas. Over the last ten years, all-cause mortality rates have fallen. Priorities in Redbridge have been rolling out NHS Health Checks for those between the ages of 40-74, reducing the levels of obesity in the population, and reducing alcohol consumption.

Redbridge Local Area Agreement has prioritised tackling childhood obesity, increasing physical activity among children and adults and improving end of life care.

The PCTs within NHS North East London and the City were accountable for performance issues during 2012/13. With the transition to new organisations in the NHS in April 2013, responsibility for these areas will move. In preparation for this PCTs worked closely with the developing new bodies, such as the CCGs and local authority, to ensure that good performance is maintained and that areas of poor performance are tackled.

Summary of Serious Incidents involving personal data as reported to the Information Commissioner's Office in 2012/13

All NHS organisations need to include details of serious untoward incidents involving data loss or confidentiality breaches in their annual reports. The more severe need to be detailed individually but the less serious should be aggregated and reported in terms of total numbers.

One severe incident involving data loss or confidentially breaches were reported for the period in NHS North East London and the City.

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
June 2012	nhs.net account in Tower Hamlets hacked into and used by unauthorised "phisher" to send out SPAM	Patient names, addresses, conditions, medication, consultant names.	2,500 (although it was likely that the majority of patients could not be identified by the information).	Degrees of confidentiality assessed and those with sensitive data potentially disclosed were sent letters informing of breach
Further action on information risk	Tower Hamlets PCT – communications bulletin sent to all members of staff alerting them to phishing scam. Handover CSU/CCG policies including IG / e-mail security elements. NHSMail contacted to strengthen and make own phishing filters proactive rather than re-active. Recommendations to decrease chance of recurrence included, where possible, not using patient names in communications, removing emails from the in-box and sent items and archiving them on a secured network if required for future reference. Action plan completed.			

The table overleaf shows less severe serious incidents in NHS North East London and the City (NELC).

Summary of other personal data related incidents in 2012/13

Category	Nature of incident	Barking and Dagenham	Havering	Redbridge	Waltham Forest	City and Hackney	Newham	Tower Hamlets	Total NELC
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0	0	0	0	0	0	1	1
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside NHS secured premises	0	0	0	0	0	0	0	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0	0	0	0	0	0	0	0
IV	Unauthorised disclosure	0	0	0	0	0	0	0	0
V	Other	0	0	0	0	0	0	0	0

7 Patient and public engagement

The PCT listened to the views of local people formally through engagement with the Local Involvement Network (LINk) and other local groups. LINk members attended Board meetings and had speaking rights.

Reports on patients experience were considered by the Board.

Formal consultation with the public and stakeholders took place on:

- Moving community health services at Highams Court in Chingford to more appropriate settings in outer north east London
- Emergency Dental Care

8 Our workforce

Following the introduction of a single management structure across the seven PCTs we established an effective working partnership with staff trade unions as we addressed the challenges of working through transition.

The human resources and finance teams have worked effectively together to ensure consistent management information in relation to budget planning and forecasting future staffing. Internal audits, including recruitment and payroll, have provided additional assurance in terms of developing robust procedures and processes across the cluster and our payroll provider.

The chief executive and her senior team have held regular staff briefings across various PCT sites, allowing health engagement and interaction with employees. This, alongside newsletters and dedicated areas on the intranet, created opportunities for staff to receive and discuss updates on plans for the future of the NHS, including the successor organisations coming into place in 2013.

Consultation with staff and staffside representatives took place on structures for the commissioning support unit (CSU) and CCGs, and on the matching and recruitment process for the CSU.

Staff development and support

Skills development has focused on resilience and change management in order to prepare staff for their future roles across the new NHS landscape or beyond.

We have provided a variety of learning experiences including masterclasses which have allowed staff to explore the wider health economy and the new developments of health strategy. Practical approaches to training included CV and recruitment preparation. To allow staff to receive support and explore future options according to their own aspirations for career development we commissioned an extensive coaching programme. Our managers and aspiring managers accessed an accredited management development programme which will result in further recognised qualifications and hopefully better career options.

Workforce Information

Sickness absence

Based on the 2012 calendar year, staff sickness amounted to 2,231 days lost. This was with a full-time equivalent of 254 members of staff. The average number of working days lost was 8.8. This was a sickness rate average of 3.9% across the calendar year.

'Two Tick' symbol (positive about disability)

All the PCTs are recognised as 'Positive about Disability' through the Government's 'Two Tick symbol' certification. This applies to positively embracing disability in the workplace and has included providing staff with 'Access to Work' registration. Human resources provide advice regarding job applicants declaring disability and requiring reasonable adjustments. We work in partnership with Job Centre Plus to access support for staff with disability. Approximately 2.5% of our staff describe themselves as being disabled.

Staff nominated each other for work in a number of categories for individuals and teams.

Health and wellbeing

Staff welcomed the opportunities offered through staff health and wellbeing programme. During the Olympic period we were pleased to encourage participation and attendance at the Olympic and Paralympic Games – a few staff participated in the opening and closing ceremonies, supported with time off from work. We also offered flexible working to enable staff to survive disruption in this period, and maintain a work life balance.

Health opportunities included free sports and exercise taster classes; massage at work; stress management workshops and advice; signposting to counselling and welfare services; active travel planning including workplace walks and cycle schemes; healthy eating demonstrations. We provided a stand alone 'health kiosk' which allowed staff to access up to date personal health information and monitoring over several months with the object of encouraging health and lifestyle improvements.

The programme was supported and promoted in partnership with trade unions and has created a sense of 'belonging together' within a transient organisation.

Equality objectives

We revised all our 2012 equality information to ensure the information was most relevant to the equality and diversity work of the Cluster and the CCGs. Information was ratified by the Board in March 2013.

Off payroll engagements

The Treasury requires NHS bodies to publish information on off payroll engagements. These are shown in the table below.

Table 1: For off payroll engagement at a cost of over £58,200 per annum that were in place as of 31 January 2012

	FTE
No. In place on 31 January 2012	5,00
No that have since come onto the organisation's payroll	0.00
No. that since been re-negotiated/re-engaged to include contractual clauses allowing the (organisation) to seek assurance as to their tax obligations	0.00
No that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (organization) to seek assurance as to their tax obligations	0.00
No that have come to an end	5.00
Total FTE	5.00

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

	FTE
No. of new engagements	16.00
No. of new engagements which include contractual clauses giving the organisation the right to request assurance in relation to income tax and National insurance obligations	16.00
Of which:	
No. for whom assurance has been accepted and received	0.00
No. for whom assurance has been accepted and not received	16.00
No that have been terminated as a result of assurance not being received	0.00
Total	16.00

We have defined "off payroll engagements" to mean that it relates to interim staff who have occupied substantive roles.

9 Taking care of the environment

NHS organisations have a responsibility for the environment. We are committed to the NHS Sustainable Development Unit's target of reducing carbon by 10% by 2015 (based on 2007 levels) and a key element of this is our commitment and registration to the good corporate citizen model. This required NHS trusts to explore their environmental credentials, identify any deficiencies and plan for future improvements. It also allowed benchmarking between trusts. We had to investigate, take action and monitor sustainability issues with the goal of reducing the carbon footprint. This brings financial as well as environmental benefits.

Redbridge PCT had an approved sustainability action plan. This sets out desired outcomes and helps in the development of a plan for sustainable health. Some sample outcomes are set out below across the eleven headings:

Energy and carbon management
Encourage all staff to take responsibility for energy consumption and carbon reduction, including dissemination of the climate change staff survey findings.

Procurement
Consider local procurement, whole lifecycle costs and the environmental impact of financial decisions, in preparation for the use of carbon as a currency.

Water
Measure and monitor water costs and consumption, including the results in an annual report.

Waste
Monitor and manage the quantity and cost of all waste streams and set trajectories to monitor, manage and reduce them over time.

Commissioning
Routinely mandate providers through service specifications to consider and minimise carbon impact of their service delivery proposals

Designing the built environment
Ensure that buildings are designed to promote sustainable behaviours in staff, patients and visitors, and are adaptable to support change towards low carbon patient pathways.

Role of partnerships and networks
Ensure that we use leverage within local partnerships and performance frameworks to promote carbon reduction.

Governance
Complete the good corporate citizen assessment model and produce an action plan with clear milestones to measure, monitor and reduce direct carbon emissions.

Investment
Develop carbon literacy and embed carbon reduction in financial mechanisms.

Green information technology programme
Reduce power consumption and paper usage and increase use of recycled paper and toners for printers.

We produced an annual sustainability report, as required by the NHS Sustainable Development Unit. This is part of the process of making the NHS more financially and environmentally sustainable and showing patients and other stakeholders that the NHS is adapting to change.

10 Emergency preparedness

A major incident such as a fire or pandemic flu outbreak can occur at any time. In order to respond effectively to such challenges and to comply with statutory guidance, we had in place a robust, tested major incident plan built on the principles of integrated emergency preparedness.

During 2012 NHS North East London and the City worked with local authorities, providers, primary care and NHS London to ensure business continuity, communications and other plans were in place for the Olympics and Paralympics.

11 Accounts

The financial statements contained in this section provide a summary of the PCT's financial position and performance. Further information is available in the full annual accounts.

Managing our finances

We have talked earlier in this report about what we do and how our performance is measured. This section talks about how we manage our money and how our financial performance is measured. We are accountable for what we do with public money and we have a track record of balancing the books and achieving good value for money for our patients. This continued in 2012/13.

As a business, we have been on a sound financial footing as we have consistently delivered surpluses over recent years.

During 2012/13 we managed cash within the funding limits laid down by parliament.

In 2012/13 Redbridge PCT was given a revenue resource limit of £435.496 million from the Department of Health.

We spent the money on services as follows:

Acute hospital care	55%
Non-acute care	19%
Prescribing and primary care	21%
Corporate and other costs	5%

Primary care trusts are set three primary financial targets and in 2012/13 we met all three:

- **Cash limit** Our cash limits were £429.572 million (for revenue) and £2.124 million (capital). We drew down cash from the Department of Health on a monthly basis in accordance with these limits.
- **Revenue resource limit** The revenue resource limit sets a limit on the net expenditure of the organisation. We were given a limit of £435.496 million. We agreed with NHS London at the beginning of the year to achieve a surplus of £4.026 million and we were successful in achieving the revised target.
- **Capital resource limit** We also have to keep our capital expenditure (the money we spend on something that we then own, such as a building or piece of equipment, which has a value of £5,000 or over) within a 'capital resource limit', which was set by NHS London. Our limit for the year was set at £2.124 million. The PCT spent £0.693 million in the year for the achievement of the capital programme.

We also have to pay our bills within a reasonable time. There is a 'better payment practice code' which says that NHS organisations should pay creditors within 30 days. Last year we paid 90% of non-NHS invoices (82% by value) and 93% of NHS invoices (93% by value) within this 30 day target.

We also signed up to the 'prompt payments code' which helped us to make further improvements to our payment processes.

We successfully managed our financial risks during 2012/13. We identified the top financial risks as:

- the increased costs of acute care
- the transition of the current NHS system to the new organisations.

To mitigate against these risks, we took a proactive approach to financial monitoring, which means we will be able to identify any potential problems in plenty of time.

As described in section 5 of this report, the Health and Social Care Act 2012 abolished primary care trusts from April 2013. PCTs worked collectively across North East London and the City with GP clinical commissioning groups to prepare for the new arrangements, however with all change there was a degree of risk facing the PCTs through the process of rationalisation of the infrastructure, setting up new structures and establishing new legal entities. To mitigate against this risk, we worked collaboratively with the shadow GP clinical commissioning group board and the local authority, as well as NHS London, to ensure there were robust transitional arrangements in place over the next year.

In addition, we continued to maintain contingencies to address in-year unforeseen risks and to generate a planned surplus, in line with best practice, to ensure the legacy for the GP clinical commissioning group is as robust as possible.

12 Remuneration report

The NHS has adopted the recommendations outlined in the Greenbury report in respect of the disclosure of senior managers' remuneration and the manner in which it is determined. Senior managers 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. This report outlines how those recommendations have been implemented by the PCT in the year to 31 March 2013.

Remuneration and terms of service committee

Primary care trusts are required to have a remuneration committee to oversee the pay, terms and conditions of service of senior managers.
The main function of the committee is to make recommendations to the board on the remuneration, allowances and terms of service of other officer members to ensure they are fairly rewarded for their individual contribution to the organisation, having regard for the organisation's circumstances and performance, and taking into account national arrangements.

Remuneration

We operate a system of performance-related pay for those senior management posts subject to the Very Senior Managers (VSM) pay framework. There has been no payment of performance related pay during the year ending 31 March 2013. Future performance related pay for directors will be subject to the terms and conditions of service for very senior managers and will be considered by the remuneration committee.

No compensation was payable during the year and no amounts are included that are payable to third parties for the services of senior managers. In the event of redundancy standard NHS packages will apply.

Contractual arrangements

The chair and non-executive directors are appointed by the Appointments Commission, an independent organisation, on behalf of the Secretary of State. Their terms of service are set nationally and cannot be varied by the PCT. Non-executive directors are on fixed term contracts up to five years in length, depending on individual circumstances.

The chief executive and directors are on permanent contracts, subject to a six month notice period for the chief executive and three months for directors.

Pensions

All staff, including senior managers, are eligible to join the NHS pensions scheme. The scheme has fixed the employer's contribution at 14% of the individual's salary as per the NHS Pension Agency regulations. Employee contribution rates for PCT officers and practice staff, and the prior year comparators, are as follows:

2012/13 Member Contribution Rates before tax relief (gross)

Tier	Annual pensionable pay (full time equivalent) 2012/13	Contribution Rate 2012/13
1	Up to £15,278.99	5.0%
2	£15,279.00 - £21,175.99	5.0%
3	£21,176.00 - £26,557.99	6.5%
4	£26,558.00 - £48,982.99	8.0%
5	£48,983.00 - £69,931.99	8.9%
6	£69,932.00 - £110,273.99	9.9%
7	£110,274.00 and over	10.9%

2011/12 Member Contribution Rates before tax relief (gross)

Tier	Annual pensionable pay (full time equivalent) 2011/12	Contribution Rate 2011/12
1	Up to £21,175.99	5.0%
2	£21,175.99 - £69,931.99	6.5%
3	£69,932.00 - £110,273.99	7.5%
4	£110,174.00 and over	8.5%

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

Past and present employees are covered by the provisions of the NHS pension scheme. For full details of how pension liabilities are treated please see note 1 in the annual accounts.

Expenses policy

We reimburse expenses in line with the Agenda for Change terms and conditions Part III Sections 17 and 18, and HM Revenue and Customs guidelines. Agenda for Change is the single pay system in operation in the NHS.

Expenses which are reimbursed include public transport costs and mileage for use of own car or, where appropriate, a lease car may be provided. If a member of staff is on official duties away from home, the cost of necessary meals and accommodation costs will be reimbursed. All claims for expenses must be authorised by the employee's manager and receipts must be provided.

Executive Directors	**2012/13 Expenses £**
Heather Mullin	£111
Terry Huff	£2,161
Alwen Williams	£976
May Cahill	£368
Ian Basnett	£208
Lesley Mountford	£859
Vanessa Lodge	£102
Other Directors	
Conor Burke	£747
Jane Gateley	£464
Jane Mehta	£78
Andrew Ridley	£319
Chair, Non-Executive Directors and Associate NEDs	
Frances Pennell-Buck	£1,083
Lesley Buckland	£215
Kash Pandya	£835
Jill Pullen	£75
Charles Beaumont	£1,458
Phil Wilson	£316
Jane Winder	£101
Catherine Max	£97
Mariette Davis	£175

Termination agreements or exit packages

Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements (specified in 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.

Details of any exit packages are given in note 7.4 of the annual accounts.

Non-Executive Directors

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

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

Non-executive members do not receive pensionable remuneration and therefore are not eligible to join the NHS Pension Scheme.

The relationship between the highest paid director and median remuneration

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 Redbridge PCT in the year 2012/13 was £24,147.69 (2011/2012 = £33,733.63). This was 2.44 times (2011/2012 = 2.60) the median remuneration of the workforce, which was £9,900.37 (2011/2012 = £12,959.44). The reason for the variances between 2011/2012 and 2012/2013 is that the highest paid director salary is now spread across seven PCTs (For 2011/2012 this was 4 PCTs) in the North East London Cluster.

The highest paid director's salary is based upon the estimated cost to Redbridge PCT. Some staff who are not recharged across the sector (7 PCTS) cost Redbridge PCT more than the highest paid director only due to the fact that they have not been recharged across all 7 PCTs. As a result 45 staff cost Redbridge PCT more than the highest paid director.

The Hutton review of fair pay in the public sector guidance suggests that all staff irrespective of any recharges should be shown as 100% charged to Redbridge PCT compared to the highest paid director as only being shown as the element of cost the PCT is charged for that director's service

Redbridge PCT has moved away from this guidance as it would result in a negative pay multiple, and as such has based the calculation on the element recharged to Redbridge PCT only for those staff who work across other entities.

Notes

Salary and pension entitlements of directors and senior managers

The following schedules disclose further information regarding remuneration and pension entitlements.

Salary entitlements (Share of PCT)

Non-executive and associate NE directors		2012/2013			2011/2012		
Name and Title		**Share of Salary Charged to PCT (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (bands of £5,000)**	**Share of Salary Charged to PCT (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (bands of £5,000)**
Frances Pennell-Buck	Non Executive Director	5-10	n/a	n/a	n/a	n/a	n/a
Dr John Carrier	Interim Chair (from 29/10/2012 to 31/03/2013)	0-5	n/a	n/a	n/a	n/a	n/a
Marie Gabriel	Chair (01/04/2012 to 30/09/2012)	0-5	n/a	n/a	n/a	n/a	n/a
Afzal Akram	Non Executive Director and Chair (01/10/12 to 31/03/2013)	0-5	n/a	n/a	n/a	n/a	n/a
Lesley Buckland	Associate Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Kash Pandya	Non Executive Director and Audit Committee Chair	0-5	n/a	n/a	n/a	n/a	n/a
Jill Pullen	Associate Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Alan Wells	Associate Non Executive Director and Non Executive Director (from 17/09/2012)	0-5	n/a	n/a	n/a	n/a	n/a
Charles Beaumont	Associate Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Phil Wilson	Non Executive Director (left 17/09/2012)	0-5	n/a	n/a	n/a	n/a	n/a
Jane Winder	Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
John Lock	Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Paul Hendrick	Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Taric Ahmed	Associate Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Honor Rhodes	Associate Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Catherine Max	Associate Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a

Andrea Lippett	Associate Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Mariette Davis	Associate Non Executive Director	0-5	n/a	n/a	n/a	n/a	n/a
Executive directors		**2012/2013**			**2011/2012**		
Name and Title		**Share of Salary Charged to PCT (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (bands of £5,000)**	**Share of Salary Charged to PCT (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (bands of £5,000)**
Alwen Williams	Chief Executive	20-25	n/a	n/a	n/a	n/a	n/a
Heather Mullin	Director of Transition	20-25	n/a	n/a	n/a	n/a	n/a
Ken Aswani	Medical Director	10-15	n/a	n/a	n/a	n/a	n/a
May Cahill	Medical Director	5-10	n/a	n/a	n/a	n/a	n/a
Eirlys Evans	Acting Director of Nursing (terminated 30/11/2012)	5-10	n/a	n/a	n/a	n/a	n/a
Caroline Alexander	Director of Quality & Clinical Governance	15-20	n/a	n/a	n/a	n/a	n/a
Terry Huff	Chief Operating Officer and Deputy Chief Executive	15-20	n/a	n/a	n/a	n/a	n/a
Stuart Saw	Director of Finance	15-20	n/a	n/a	n/a	n/a	n/a
Ian Basnett	Director of Public Health	15-20	n/a	n/a	n/a	n/a	n/a
Lesley Mountford	Director of Public Health	10-15	n/a	n/a	n/a	n/a	n/a
Vanessa Lodge	Acting Director of Nursing	10-15	n/a	n/a	n/a	n/a	n/a
Other directors							
Marie Price	Director of Communications and Engagement	10-15	n/a	n/a	n/a	n/a	n/a
Helen Bullers	Director of People and Organisational Development	15-20	n/a	n/a	n/a	n/a	n/a
Conor Burke	Director of Commissioning Support	15-20	n/a	n/a	n/a	n/a	n/a
Jane Gateley	Director of Planning and Delivery	15-20	n/a	n/a	n/a	n/a	n/a
Andrew Ridley	Managing Director, Commissioning Support Unit	15-20	n/a	n/a	n/a	n/a	n/a
David Butcher	Director of Estates and Capital Development	10-15	n/a	n/a	n/a	n/a	n/a

Salary entitlements

Non-executive and associate NE directors		2012/2013			2011/2012		
Frances Pennell-Buck	Non Executive Director	40-45	n/a	n/a	40-45	n/a	n/a
Dr John Carrier	Interim Chair (from 29/10/2012-31/03/2013)	5-10	n/a	n/a	n/a	n/a	n/a
Marie Gabriel	Chair (from 01/04/2012 to 30/09/2012)	20-25	n/a	n/a	35-40	n/a	n/a
Afzal Akram	Non Executive Director and Chair (01/10/12 to 31/03/2013)	25-30	n/a	n/a	10-15	n/a	n/a
Lesley Buckland	Associate Non Executive Director	10-15	n/a	n/a	10-15	n/a	n/a
Kash Pandya	Non Executive Director and Audit Committee Chair	20-25	n/a	n/a	10-15	n/a	n/a
Jill Pullen	Associate Non Executive Director	10-15	n/a	n/a	10-15	n/a	n/a
Alan Wells	Associate Non Executive Director and Non Executive Director (from 17/09/2012)	15-20	n/a	n/a	10-15	n/a	n/a
Charles Beaumont	Associate Non Executive Director	10-15	n/a	n/a	5-10	n/a	n/a
Phil Wilson	Non Executive Director (left 17/09/2012)	0-5	n/a	n/a	5-10	n/a	n/a
Jane Winder	Non Executive Director	10-15	n/a	n/a	10-15	n/a	n/a
John Lock	Non Executive Director	20-25	n/a	n/a	30-35	n/a	n/a
Paul Hendrick	Non Executive Director	15-20	n/a	n/a	5-10	n/a	n/a
Taric Ahmed	Associate Non Executive Director	5-10	n/a	n/a	5-10	n/a	n/a
Honor Rhodes	Associate Non Executive Director	5-10	n/a	n/a	n/a	n/a	n/a
Catherine Max	Associate Non Executive Director	5-10	n/a	n/a	5-10	n/a	n/a
Andrea Lippett	Associate Non Executive Director	5-10	n/a	n/a	5-10	n/a	n/a
Mariette Davis	Associate Non Executive Director	15-20	n/a	n/a	n/a	n/a	n/a

Executive directors		2012/2013			2011/2012		
Name and Title		**Salary (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (bands of £5,000)**	**Salary (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (bands of £5,000)**
Alwen Williams	Chief Executive	150-155	n/a	n/a	150-155	n/a	n/a
Heather Mullin	Director of Transition	145-150	n/a	n/a	145-150	n/a	n/a
Ken Aswani	Medical Director	80-85	n/a	n/a	80-85	n/a	n/a
May Cahill	Medical Director	60-65	n/a	n/a	55-60	n/a	n/a
Eirlys Evans	Acting Director of Nursing (terminated 30/11/2012)	55-60	n/a	n/a	25-30	n/a	n/a
Caroline Alexander	Director of Quality & Clinical Governance	110-115	n/a	n/a	95-100	n/a	n/a
Terry Huff	Chief Operating Officer and Deputy Chief Executive	120-125	n/a	n/a	120-125	n/a	n/a
Stuart Saw	Director of Finance	120-125	n/a	n/a	110-115	n/a	n/a
Mathew Cole	Director of Public Health	85-90	n/a	n/a	85-90	n/a	n/a
Ian Basnett	Director of Public Health	130-135	n/a	n/a	145-150	n/a	n/a
Lesley Mountford	Director of Public Health	75-80	n/a	n/a	110-115	n/a	n/a
Vanessa Lodge	Acting Director of Nursing	90-95	n/a	n/a	n/a	n/a	n/a
Other directors							
Marie Price	Director of Communications and Engagement	90-95	n/a	n/a	85-90	n/a	n/a
Charles Allen	Director of Workforce and Transformation	n/a	n/a	n/a	100-105	n/a	n/a
Helen Bullers	Director of People and Organisational Development	110-115	n/a	n/a	85-90	n/a	n/a
Conor Burke	Director of Commissioning Support	120-125	n/a	n/a	115-120	n/a	n/a
Jane Gateley	Director of Planning and Delivery	105-110	n/a	n/a	105-110	n/a	n/a
Andrew Ridley	Managing Director, Commissioning Support Unit	130-135	n/a	n/a	125-130	n/a	n/a
David Butcher	Director of Estates and Capital Development	100-105	n/a	n/a	95-100	n/a	n/a
Jane Milligan	Borough Director	100-105	n/a	n/a	100-105	n/a	n/a
Jane Mehta	Borough Director	105-110	n/a	n/a	51-55	n/a	n/a

Pension entitlements

Name and Title		Real increase / (decrease) in pension at 60 (bands of £2,500)	Real increase / (decrease) in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013 (rounded to the nearest £000)	Cash Equivalent Transfer Value at 31 March 2012 (rounded to the nearest £000)	Real increase / (decrease) in Cash Equivalent Transfer Value(rounded to the nearest £000)	Employer's contribution to stakeholder pension (rounded to the nearest £000)
Alwen Williams	Chief Executive	(0-2.5)	(2.5-5)	60-65	185-190	1,254	1,179	13	n/a
Heather Mullin	Director of Transition	(0-2.5)	(0-2.5)	45-50	145-150	935	875	14	n/a
Ken Aswani	Medical Director	0-2.5	2.5-5	65-70	200-205	1,258	1,135	64	n/a
May Cahill	Medical Director	n/a	n/a	45-50	145-150	934	n/a	n/a	n/a
Eirlys Evans	Acting Director of Nursing	n/a	n/a	35-40	115-120	784	n/a	n/a	n/a
Caroline Alexander	Director of Quality & Clinical Governance	0-2.5	5-7.5	20-25	65-70	379	314	49	n/a
Terry Huff	Chief Operating Officer and Deputy Chief Executive	(0-2.5)	(0-2.5)	35-40	120-125	617	577	10	n/a
Stuart Saw	Director of Finance	2.5-5	7.5-10	30-35	95-100	609	512	70	n/a
Mathew Cole	Director of Public Health	(0-2.5)	(0-2.5)	25-30	80-85	465	430	12	n/a
Ian Basnett	Director of Public Health	(0-2.5)	(2.5-5)	55-60	165-170	1,137	1,073	8	n/a
Lesley Mountford	Director of Public Health	0-2.5	2.5-5	25-30	85-90	451	401	29	n/a
Vanessa Lodge	Acting Director of Nursing	n/a	n/a	25-30	90-95	567	n/a	n/a	n/a
Marie Price	Director of Communications and Engagement	0-2.5	0-2.5	5-10	n/a	61	46	13	n/a
Helen Bullers	Director of People and Organisational Development	2.5-5	12.5-15	25-30	85-90	485	380	86	n/a
Conor Burke	Director of Commissioning Support	0-2.5	5-7.5	10-15	40-45	229	183	36	n/a

Jane Gateley	Director of Planning and Delivery	0-2.5	0-2.5	20-25	65-70	354	324	13	n/a
Andrew Ridley	Managing Director, Commissioning Support Service	(0-2.5)	(0-2.5)	20-25	65-70	361	337	6	n/a
David Butcher	Director of Estates and Capital Development	0-2.5	0-2.5	35-40	115-120	818	752	27	n/a

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 pointing 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.

Real increase in cash equivalent transfer values

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.

Peter Coates CBE
Designated Signing Officer

13 Statement of accounting officer's responsibilities

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

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

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

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

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

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

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

Peter Coates, CBE
Designated Signing Officer

14 Annual governance statement

Name of organisation: Redbridge Primary Care Trust

The Board was accountable for internal control. During 2012/13 the Chief Executive of the Board had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives. She also had responsibility for safeguarding the public funds and the organisation's assets.

As Designated Signing Officer I have sought assurance from the Chief Executive of the PCT on these matters.

The Chief Executive of the PCT was accountable to the Chair of the PCT and the Chief Executive of the Strategic Health Authority. The Chief Executive was regularly performance managed through twice yearly performance appraisals undertaken by the Chair of the Board.

In addition, the Strategic Health Authority (NHS London) met regularly with the directors and the chief executive during the year to formally review performance on delivering the organisation's objectives. These meetings were formally minuted.

Systems and processes were in place to enable effective working with these partner organisations.

In recognition of the risk in establishing an appropriate management structure to manage seven PCTs as a cluster with robust governance arrangements and organisational form to deliver its objectives significant assurance was received from the internal auditors, RSM Tenon and Parkhill, that the cluster governance arrangements and controls upon which the organisation relies to manage the risk were suitably designed, consistently applied and effective.

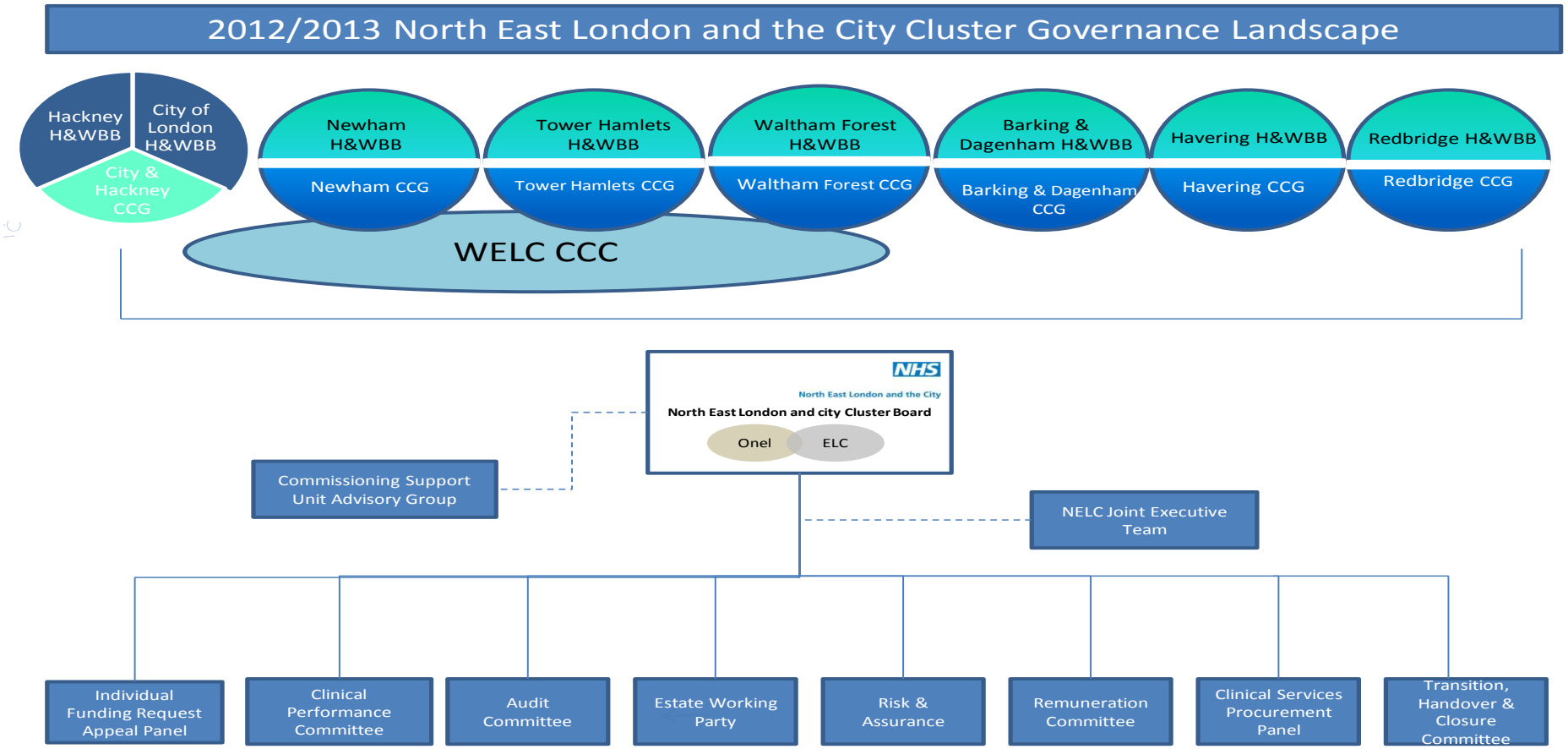
1. The governance framework of the organisation

The governance structure was designed to ensure that there was a balance between having robust governance arrangements for the organisation and being able to deliver an effective end state.

In January 2012 the boards of the seven PCTs in North East London and City agreed to work as a Cluster through an integrated management structure with effect from April 2012. This arrangement encompassed the Chair and non-executive director team being appointed across the seven PCTs and a single management team. The governance model met the requirements of the Department of Health guidance 'model 2'. These comply with the Corporate Governance Code without departure. Arrangements in place for the discharge of statutory functions have been checked for irregularities, and to ensure they are legally compliant.

The model was delivered through a joint committee structure from April 2012, shown below:

NHS North East London and City committee structure



Agreed April 2012

The Cluster Board for North East London and the City met on a bimonthly basis during 2012/2013 until March when two meetings were necessary to complete Board business and close down all seven PCTs.

The work of the Board was underpinned by a single Corporate Governance Framework for the transition year together with a single set of Standing Orders, Standing Financial Instructions and Scheme of Delegation. This framework has enabled the Cluster to conduct its business during a period of significant change in the NHS. It also supported the establishment of the Clinical Commissioning Groups as sub-committees of the Board and a robust Performance Management Framework to ensure accountability.

The Board's work has been supported by a number of committees as evidenced in the structure diagram. These committees have been chaired by Non-Executive Directors or Associate Non-Executive Directors. The role of Associate Non-Executive Director was created as part of the governance arrangements for the Cluster and has ensured that a wide range of non-executive knowledge and experience was retained and used in the assurance process.

The Audit Committee met on a bi-monthly basis through to September 2012 and then met monthly from October 2012 to March to strengthen assurance. It has been quorate on each occasion. It has considered internally and externally audit reports along with updates from the counter-fraud officer. It received updates and reviewed reports on finance, the Board Assurance Framework and Corporate Risk Register together with feedback from the Risk and Assurance Committee. It also reviewed work in relation to transition, handover and closure and from November 2012 received reports from the Transition, Handover and Closure Committee.

The Risk and Assurance Committee was established from April 2012 and met on a bi-monthly basis from May. The role of the Committee has been to review management action in relation to risks that impact on the delivery of the operating plans and the achievement of the corporate objectives in order to give assurance to the Board. The committee has been quorate on all occasions.

The Transition, Handover and Closure Committee chaired by a Non-Executive Director was established in October 2012 to provide additional assurance to the Board during the final months up until closure. It has met on a monthly basis since November and undertaken in depth reviews of plans, including the Transfer Schemes for staff, assets and liabilities and the closedown plans.

The Remuneration Committee met seven times in 2012/13 to consider matters relative to remuneration and terms of service of the senior management team and staff matters relating to handover and closure. All meetings were quorate.

3 Board effectiveness

All Board members were asked to complete a board evaluation questionnaire in March 2013. The questions covered the broad themes on the key functions of the Board. Board members were requested to indicate the extent to which they agreed or disagreed (to varying degrees) with the statements contained in the questionnaire. Board members also had the additional opportunity of providing comments.

Just over half of the Executive and Non-Executive Directors completed the questionnaire and their responses have been kept confidential. The general picture that emerges from the responses to the board evaluation questionnaire is that the Board is generally confident:

- that the members individually and collectively understand what is expected of them
- that it effectively carries out its functions in relation to its provision of strategic leadership to the organisation
- that it monitors the implementation of the strategic plan that it sets for the organisation
- that the Board provides leadership to the organization in the delivery of quality improvement
- that it is assured that a sound system of internal control and risk management is in place within the organisation and is functioning effectively
- that there is an effective working relationship between the Board and the management team
- that the Board has an effective working relationship with its internal and external stakeholders
- that Board members are satisfied that they make meaningful, informed and robust contributions to discussions at Board meetings and makes effective use of its meetings

4. Assurance

- Since 1 October 2012 the Board's Governance arrangements focused on the final phase of transition, handover and closure with assurance through CCG shadow governing bodies for performance and service development issues and the Director of Transition providing assurance for transition, handover and closure arrangements. Regular reports have been provided to the Board on transition and handover progress and the process for the formal transfer of assets and liabilities and staff to receiving organisations. The seven PCTs as sender organisations are transferring their functions, both statutory and non statutory to 47 other organisations. The process for making this transfer is through a legal transfer scheme, one for staff and one for assets and liabilities for each PCT that makes up the Cluster. The draft transfer scheme was approved by the Board at its final meeting in March 2013.

The Risk and Assurance Committee met for the last time on 27 February. At that meeting the Committee agreed to write to the chairs of the CCGs and the chairs of the CCG Audit Committees drawing their attention to the risks that would continue beyond the end of March and would be the receiving organisations' responsibility.

5. Risk assessment

5.1 Risk management strategy

The Cluster governance structure was designed to ensure that there was a balance between having robust governance arrangements for the organisation and being able to deliver an effective end state.

The risks to the achievement of the Cluster's Corporate Objectives were identified through the process detailed in the North East London and the City Risk Management Strategy. This document was created following a review of the risk management strategies for:

- The East London and the City (comprising City and Hackney PCT, Newham PCT and Tower Hamlets PCT) Risk Management Strategy, and
- Outer North East London (comprising Barking and Dagenham PCT, Havering PCT, Redbridge PCT and Waltham Forest PCT) Risk Management Strategy.

Elements of best practices from these documents in terms of: risk definitions, identification processes, templates and risk matrix were taken out and combined to create the NHS North East London and the City Risk Management Strategy. This was approved by the Board at its May meeting.

The Risk Management Strategy included a scoring and escalation process that ensures as far as reasonably practicable that there is a consistency of applied risk ratings across the organisation.

In analysing risks the risk rating takes the following into account:

- Cluster ability to deliver its objectives and projects
- Harm/Injury to patients, staff, visitors and others
- Potential for complaints/claims
- Service/business disruption
- Staffing and competence
- Financial
- Inspection/audit
- Adverse publicity

The risk assessment process drew on the best practice elements of ISO31000 and therefore embraces the concept of enterprise, integrated risk management in ensuring achievement of best outcomes. The Risk Management Strategy sets out the approach to risk which demands embedding risk within all business processes.

In moving forward the North East London and the City Risk Management Strategy has been adopted for use by several of the North East London and the City Clinical Commissioning Groups (CCGs). Additionally, the Cluster Board Assurance Framework was reviewed by the CCGs ensuring that where appropriate, risks were handed over.

5.2 Risk identification

The risks to the achievement of Cluster objectives were identified through two main processes.

- Review of the Board Assurance Frameworks from NHS East London and City and NHS Outer North East London and the City to identify risks, controls, assurances and gaps that remained a threat to NHS North East London and the City, and

- A risk assessment of the Corporate Objectives. The Cluster Board set its Corporate Objectives at the beginning of the 2012/13 year. Subsequent review meetings with the Directorate Risk Leads identified the risks, controls, assurances and gaps. From these discussions the risks were graded in line with the NHS North East London and the City Risk Management Strategy.

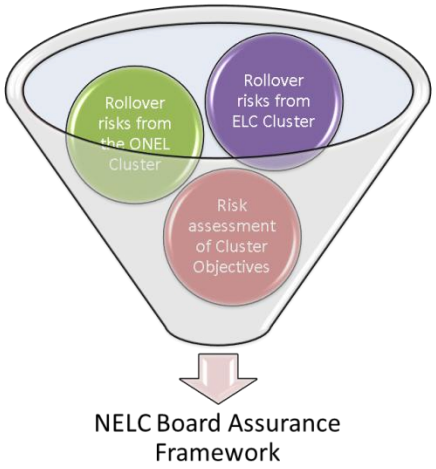


Figure 1 showing the 2 main processes that led to the creation of the NELC Board Assurance Framework

Supplementing this "top down" process of risk identification was that of Corporate Risk Register. Operational risks were identified at a Directorate level and added to the Corporate Risk Register. This process provided a "bottom up" view of risks that were both specific to the individual PCTs and those specific to the Cluster.

In September 2012 NHS London requested that all risks were categorised as at least one of the following:

- In year delivery
- Transition/closure
- Decommissioning
- Zero Tolerance Risk

This categorisation was added to the Board Assurance Framework and the Corporate Risk register in quarter 3.

5.3 Accountability for risks

Individual Directors are held accountable for the risks associated with their Directorates. The Board Assurance Framework and Corporate Risk Register were refreshed quarterly through

meetings with the Directorate risk leads. Once reviewed and revised the documents were reported to the following bodies:

- Transition, Handover and Closure Committee
  This Committee retained oversight for all the risks pertaining to Transition, Handover and Closure.
  It met on a monthly basis from November 2012
- Risk and Assurance Committee
  This Committee reviews both the Board Assurance Framework and Corporate Risk Register in its entirety at least once a quarter to provide probity of the documents and thus the risks facing the organisation.
  This Committee also had the power to request "Deep Dives" to provide assurance to the Board that the Cluster has effective systems of internal control in relation to risk management and governance. The Committee held one deep dive on the issue of "Quality and handover to the CCGs".
  It met bi-monthly.
- Audit Committee
  The Audit Committee was responsible for reviewing the effectiveness of the internal control and risk management systems and received reports from management on the effectiveness of the risk systems that the Cluster had established.
- Cluster Board
  The Board received the Board Assurance Framework once a quarter to ensure that the Board retained oversight of all the risks to the achievement of the Corporate Objectives and allow Board members to challenge executives on areas of weak control, assurance or high risk rating.

5.4 Board Assurance Framework 2012/13

Key risks for Redbridge PCT identified during 2012/13, which populated the Board Assurance Framework **(**BAF) for 2012/13, and how their risk rating changed over the financial year are summarised below.

	Risk description	Initial risk	June 12	Aug 12	Nov 12	Mar 13
1.1	There is a risk that some public health targets (including screening) across PCTs will not be met					
1.2	Risk of overspend on revenue resource limit. Risk of not meeting agreed control target surpluses.					
1.3	Risk of financial consequences for future arising from the final year of PCTs, exit/closedown and the overall transition agenda.					
1.4	Ensure we support CCGs to deliver operating plans, QIPP and achieve key strategic aims in 2012/13.This is in relation to improvements in healthcare and financial management.					
1.5	CCG failure to manage all local healthcare providers with support from CSU and the cluster could result in key quality and performance not being achieved as well as the detriment of healthcare delivered to the local population.					
1.6	Failure to meet emergency care access standards at Barts Health could adversely affect service users and other organisations					
1.8	Maintaining an effective and proactive quality assurance					

	framework during periods of transition for both the provider and commissioner landscape across all provider groups					
1.9	Barts Health merger: failure of new, larger trust to deliver requisite levels of performance across all sites due to transition.					
2.1	Progress in quality improvement is not achieved in the timeframe set out and inability to sustain quality and safety of maternity services at BHRUT in the context of CIP and requirement to operate					
2.2	Failure to meet emergency care access standards at BHRUT/Queens Hospital adversely impacting on service users and other organisations					
2.3	Failure to deliver BHRUT 2012/13 financial plan – deficit reduced in line with plan to maximum £40m. Dependent on £23m CIP delivery and 10.3 commissioner QIPP delivery					
2.4	Failure to develop a clear plan for clinical and financial sustainability, including a plan to implement Health for North East London acute reconfiguration decisions					
3.1	Loss of talent and organisational memory in both sender and receiver organisations, leading to increased staff costs and the potential of new organisations unable to function and to take on their statutory and other roles by April 2013.					
3.2	There is risk that key performance issues regarding contractors are not managed effectively and key information is not passed on during transition due to delays in clarifying roles, structure and functions in the NHS Commissioning Board London Region and its local area teams.					
3.3	Divestment of remaining provider services and non-commissioning services – via procurement and other transfers. All transfers and procurements must be complete by 31 March 2013. Range and scope of the functions increases the risk.					
3.4	Information risks associated with records management, FoI timescales, Information Governance Toolkit requirements and data protection issues are not effectively managed during transition. Size and scope of records in the legacy PCTs increases this risk.					
3.5	Public Health transition to local authority end state is not achieved within required timescales (also see 3.2)					
3.6	Organisational memory on quality and safety (including safeguarding) is lost to the system and handover is ineffective.					
3.7	IM&T transition is not effectively aligned to transition end state in terms of asset transfer – potential issues around delays in deciding future arrangement of GP ICT at a London level.					
3.8	Failure to develop a robust and sustainable commissioning support organisation through migration					
4.1	There is a risk that the 2012 Olympics and Paralympics will impact on delivery of healthcare, thereby preventing business as usual.					

Risks to the achievement of the corporate objectives were determined at the beginning of the 2012/13 year and reported to the Board in May. From this a Board Assurance Framework (BAF) was constructed and reviewed at the July meeting and at every meeting through the year. The BAF focus was on risks across the system to the delivery of the corporate objectives; The Risk Register identifies risks on a PCT specific basis as appropriate.

The assessment of risks was undertaken in accordance with the Cluster's risk strategy and Board Assurance Framework. This included a risk scoring and escalation process that ensured as far as is practicably possible that there is consistency of applied risk ratings across the organisation. In depth scrutiny of the BAF was undertaken by the Risk and Assurance committee. This Committee had undertaken a "deep dive" challenge into particular areas of risks, for example quality and safety and has held individual directors to account for the risks associated with their areas of responsibility.

The Assurance Framework was comprehensive in scope, covering the key operational areas of the PCT. Through its inclusion of zero tolerance and horizon scanning risks it ensured the assurances around risk prevention, risk deterrence (eg fraud related risks) and the management of manifested and potential risks.

The Framework was consistent with the template promulgated by the Department of Health and explicitly maps objectives against pertinent risks, controls and assurances. It also describes the ways in which public stakeholders are involved in managing risks which impact on them.

Risks to data security were managed by the Information Governance team. This had limited resources during the year and an audit of the Information Governance Toolkit highlighted a number of deficiencies. These deficiencies were addressed but in the limited time available it was only possible to achieve Level 1 compliance by the end of March 2013.

5.5 Corporate Risk Register

The 12/13 BAF was supplemented by a corporate risk register which highlighted other corporate risks as follows:

- Insufficient and ineffective communications during the transition may lead to some staff, stakeholders and the public not understanding the changes
- Review of creditors and debtors as part of the formal "winding up" process may necessitate write of uncollectable debts and non-payable income potentially causing waste of Cluster finances, loss of reputation and potential adverse media attention.
- Information Governance risks relating to non-compliance with the Information Governance Toolkit.

These corporate risks have been managed as follows:

- The delivery team for Transition, Handover and Closure put in place relationship managers to ensure there was effective communication with receiving organisations. Regular bulletins have been issued to staff and public communication statements issued in the local press and on website
- A finance closedown team was put in place to manage "wind up" effectively
- Remedial action was taken to ensure compliance with Information Governance Toolkit by 31 March 2013. Lessons learn from the deficiencies have been

passed on the CCGs and the CSU to inform their IG toolkit compliance for 2013/14

5.6 The Risk and control framework

The Board has considered and developed an Assurance Framework as part of the overall Business Planning cycle. Throughout the year, the Assurance Framework has been continuously amended and updated to refine and develop strategic understanding of the assurance agenda and its various requirements.

A rolling review of the Assurance Framework for 2012/2013, carried out by the PCT's internal auditors, RSM Tenon and Parkhill has demonstrated that there is an effective system of internal control to manage the principle risks identified by the organisation. However it notes that there is scope for some improvement when articulating the mechanisms that provide assurances that the controls put in place to manage risks are indeed effective. The specific issues that have been highlighted for improvement are listed below:

i. Information Governance

ii. Continuing Care

6. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.

For 2012/13 the Head of Internal Audit has advised me that based on the work undertaken in 2012/13, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

However, he has issued an Information Governance report with a RED opinion rating whilst at the same time noting that we are drawing up a response to the recommendations made which we expect to mitigate any gaps in controls identified moving forwards.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

- The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by other sources including;
- Scrutiny from our external auditors
- Information Governance Assurance tool kit compliance submission
- The Cluster's internal monitoring and review process for its quality of commissioned services described in the Department of Health's Operating Framework and delivered through the Risk and Assurance Committee
- Reports by Internal and External Audit and the results of patient and staff surveys

- Annual Care Quality Commission (CQC) assessment for safeguarding children
- Local Safeguarding Children Board (LSCB) annual report
- Robust incident and complaints monitoring processes, ensuring compliance with national Serious Incident reporting.
- NHS London's review of the plans to support the 2012/13 QIPP programme and consequential financial impacts at both PCT and Outer North East London levels
- Assurance on fraud and potential fraud is provided through the work of the local counter fraud officer who provides updates, communications and training on all appropriate counter fraud issues to PCT staff and emerging CCG pathfinder organisations.
- My review confirms that Redbridge PCT has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.
- The Audit Committee provides the Board with an independent and objective view of arrangements for internal financial control within the PCT, ensuring that the Internal Audit service complies with mandatory auditing standards including the review of all fundamental financial systems.
- The Board and Executive Directors have managed and reviewed their principal risks through their Performance reviews both with NHS London and the cluster's Operating Plan and the Business Planning process and their contribution to the development of the Assurance Framework.

The gaps in control and assurance identified within the Assurance Framework are the subject of action plans which are approved by the Board.

Significant Issues

The following significant control issues during the year 2012/13 have taken place:

- Deficiencies in compliance with the Information Governance Toolkit. With remedial action in year the PCT only achieved level 1 compliance.
- The backlog in continuing care assessments carries significant financial risks for ONEL CCGs.

Peter Coates CBE
Designated Signing Officer

15 Independent auditor's statement (internal)

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT REDBRIDGE PCT FOR THE YEAR ENDED 31 MARCH 2013

1 Roles and responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework is one of the key mechanisms that the Accountable Officer can use to support their AGS.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its AGS.

2 The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board in the completion of its AGS.

My opinion, based on work undertaken up to 31 March 2013, is set out as follows:

Based on the work undertaken in 2012/13, ***significant assurance*** *can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, we have noted one area of weakness, where a RED rated report was issued.*

We were unable to provide assurance over the effectiveness of controls over Information Governance. There had been limited work done to update the Information Governance

Toolkit throughout the year. The key risks that underpin the failings around information governance and impacted on the control environment in 2012/13 are:

- *Failings to ensure staff were appropriately trained to mitigate the risk of staff failing to handle and store data securely;*
- *Ineffective management of information governance, information security, clinical information assurance, corporate information assurance and secondary use assurance increasing the likelihood that patients' and staff data will not be effectively handled.*

Management has committed to being able to reach a Level 1 Standard by the end of the financial year, when the final Toolkit assessment is uploaded. Whilst this is not to a satisfactory level (level 2 is deemed satisfactory) there is evidence that Management is responding to the weaknesses identified in our report and further actions identified will be transferred to receiver organisations from 1 April 2013 to help improve the controls over handling patients and staff personal data in line with legislative requirements.

3 Issues Judged Relevant to the preparation of the Annual Governance Statement

There are no specific issues we would expect the PCT to consider in the formulation of the AGS, other than consideration being given to referencing the point raised above regarding the failings in information governance identified. We would also anticipate reference to issues identified elsewhere in the Cluster concerning Continuing Care where considered relevant to the PCT. These were in relation to:

- how evidence on the eligibility of Continuing Care patients could not be provided through the submission of checklists and Decision Support Tools prior to invoices being paid to continuing care providers; and the inability to provide sufficient evidence to demonstrate that care reviews were being consistently undertaken for all patients within three months of them being deemed eligible for continuing care funding.

RSM Tenon Limited

16 Independent auditor's report (external)

Independent Auditors' Report to the officer responsible for preparing the accounts of Redbridge Primary Care Trust

We have audited the financial statements of Redbridge Primary Care Trust ("the PCT") for the year ended 31 March 2013 which 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 the accounting policies directed by the Secretary of State for Health with the consent of the Treasury as relevant to the National Health Service in England set out therein.

Respective responsibilities of the officer responsible for preparing the accounts and auditors

As explained more fully in the Statement of Responsibilities the officer responsible for preparing the accounts is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with accounting policies directed by the Secretary of State, with the consent of the Treasury, as being relevant to the National Health Service in England. Our responsibility is to audit and express an opinion on the financial statements in accordance with Part II of the Audit Commission Act 1998, the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the officer responsible for preparing the accounts of Redbridge Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as being relevant to the National Health Service in England;

- 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; and

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

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the Code of Audit Practice issued by the Audit Commission requires us to report to you if:

- in our opinion, the Governance Statement does not comply with the Department of Health's requirements set out in "2012/13 Governance Statements – Guidance " issued on 31 January 2013 or is misleading or inconsistent with information of which we are aware from our audit; or

- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because 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.

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

Respective responsibilities of the PCT and auditors
The PCT is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the PCT has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the PCT has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the PCT's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

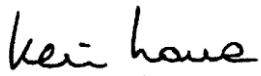
Scope of the review of the arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its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

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

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Trust; and
- our locally determined risk-based work on governance, financial management, asset and information management, and workforce management.

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

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



Kevin Lowe, Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP
Appointed Auditors
7 More London Riverside,
London,
SE1 2RT

4 June 2013

17 External auditor's costs

Redbridge PCT's external auditor is Price Waterhouse Coopers. They were paid £100,829 (inclusive of VAT) in 2012/13 to carry out the statutory audit. In 2011/12 the fees were £168,048.

18 Glossary of organisation names

Clinical commissioning groups (CCGs).
These are led by GPs and other clinicians and have taken statutory responsibility for commissioning local hospital, mental health and community health services, from April 2013.

Commissioning support unit, CSU
These have been established to provide technical support to clinical commissioning groups in carrying out their commissioning responsibilities.

NHS East London and the City; ELC, also referred to as inner north east London.
The cluster of PCTs – City and Hackney, Newham and Tower Hamlets – that worked together under a single management team from April 2010 to March 2011.

Inner North East London; INEL
The area comprising City and Hackney, Newham and Tower Hamlets primary care trusts (see NHS East London and the City; ELC). This comprised the former East London and the City PCTs; City and Hackney, Newham and Tower Hamlets, and the Outer North East London PCTs; Barking and Dagenham, Havering, Redbridge, and Waltham Forest.

NHS North East London and the City; NELC
The cluster of primary care trusts brought together under a single management team from April 2013 to March 2013.

NHS Outer North East London; ONEL
The cluster of PCTs – Barking and Dagenham, Havering, Redbridge, and Waltham Forest that worked together under a single management team from April 2010 to March 2011.

Department of Health

NHS

Redbridge Primary Care Trust

2012-13 Accounts

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Redbridge Primary Care Trust

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13 Statement of accounting officer's responsibilities

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

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

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

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

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

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

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

Peter Coates, CBE
Designated Signing Officer

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

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

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

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

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

Name: **Alwen Williams**
Chief Executive

Signed..... A W Williams .....

Date.... 4.6.13.

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

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

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

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

Name: **Stuart Saw**
Director of Finance

Signed.....

Date.4th June 2013

FOREWORD TO THE FINANCIAL STATEMENTS

REDBRIDGE PRIMARY CARE TRUST

The financial statements for the year ended 31 March 2013 have been prepared by the Redbridge Primary Care Trust under section 98(2) of the National Health Service Act 1977 in the form which the Secretary of State has, with the approval of the Treasury, directed.

Registered Office:-

Becketts House
2-14 Ilford Hill
Ilford
Essex
IG1 2QX

Statement of Comprehensive Net Expenditure for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**9,967**	22,638
Other costs	5.1	**432,356**	411,638
Income	4	**(11,604)**	(17,723)
Net operating costs before interest		**430,719**	416,553
Investment income	9	**(32)**	(102)
Other (Gains)/Losses	10	**-**	-
Finance costs	11	**779**	676
Net operating costs for the financial year		**431,466**	417,127
Of which:			
Administration Costs			
Gross employee benefits	7.1	**7,115**	12,961
Other costs	5.1	**4,566**	5,545
Income	4	**(278)**	(7,058)
Net administration costs before interest		**11,403**	**11,448**
Investment income	9	**-**	-
Other (Gains)/Losses	10	**-**	-
Finance costs	11	**-**	-
Net administration costs for the financial year		**11,403**	**11,448**
Programme Expenditure			
Gross employee benefits	7.1	**2,852**	9,677
Other costs	5.1	**427,790**	406,093
Income	4	**(11,326)**	(10,665)
Net programme expenditure before interest		**419,316**	**405,105**
Investment income	9	**(32)**	(102)
Other (Gains)/Losses	10	**-**	-
Finance costs	11	**779**	676
Net programme expenditure for the financial year		**420,063**	**405,679**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**437**	671
Net gain on revaluation of property, plant & equipment	**(293)**	(51)
Total comprehensive net expenditure for the year	**431,610**	**417,747**

This statement summarises, on an accruals basis, the net operating costs of the PCT.

The notes on pages 5 to 44 are an integral part of these financial statements. Going concern disclosure is within note 1.1 on page 5.

The provision of Redbridge Children's Services transferred from Redbridge PCT on 1st June 2012 to North East London NHS Foundation Trust (NELFT) as a result of a competitive tendering process. 220 staff (180.5 whole time equivalents) transferred under TUPE from Redbridge PCT to NELFT. No assets or liabilities transferred. The payroll cost of the staff transferred is accounted within Redbridge PCT up to the transfer date. Absorption accounting has been applied and comparators have not been restated for this transfer of function.

Statement of Financial Position as at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**35,022**	37,139
Intangible assets	13	**61**	93
Other financial assets	19	**254**	256
Total non-current assets		**35,337**	37,488
Current assets:			
Inventories	17	**-**	-
Trade and other receivables	18	**4,905**	8,154
Cash and cash equivalents	21	**38**	20
Total current assets		**4,943**	8,174
Total assets		**40,280**	**45,662**
Current liabilities			
Trade and other payables	22	**(26,222)**	(30,044)
Provisions	24	**(5,161)**	(1,172)
Borrowings	23	**(56)**	(55)
Total current liabilities		**(31,439)**	(31,271)
Non-current assets plus/less net current assets/liabilities		**8,841**	**14,391**
Non-current liabilities			
Provisions	24	-	(3,456)
Borrowings	23	(6,250)	(6,306)
Total non-current liabilities		**(6,250)**	(9,762)
Total Assets Employed:		**2,591**	**4,629**
Financed by taxpayers' equity:			
General fund		(6,232)	(4,762)
Revaluation reserve		8,823	9,391
Total taxpayers' equity:		**2,591**	4,629

As a NHS Primary Care Trust no interest can be received in relation to balances held within its bank accounts.

The notes on pages 5 to 43 are an integral part of these financial statements. Going concern disclosure is within note 1.1 on page 5.

The financial statements on pages 5 to 43 were authorised for issue by the board of directors on 4 June 2013 and were signed on its behalf by Peter Coates.

Designated Signing Officer
Peter Coates CBE

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

	Note	General fund	Revaluation reserve	Total reserves
		£000	£000	£000
Changes in taxpayers' equity for 2012-13				
Balance at 1 April 2012		**(4,762)**	**9,391**	**4,629**
Net operating cost for the year		(431,466)	-	**(431,466)**
Net gain on revaluation of property, plant and equipment		-	293	**293**
Impairments and reversals		-	(437)	**(437)**
Transfers between reserves*		424	(424)	-
Total recognised income and expense for 2012-13		**(431,042)**	**(568)**	**(431,610)**
Net Parliamentary funding		429,572	-	**429,572**
Balance at 31 March 2013		**(6,232)**	**8,823**	**2,591**
Changes in taxpayers' equity for 2011-12				
Balance at 1 April 2011		**(4,255)**	**10,011**	**5,756**
Net operating cost for the year		(417,127)	-	(417,127)
Net gain on revaluation of property, plant and equipment		-	51	51
Impairments and reversals		-	(671)	(671)
Total recognised income and expense for 2011-12		(417,127)	(620)	(417,747)
Net Parliamentary funding		416,620	-	416,620
Balance at 31 March 2012		**(4,762)**	**9,391**	**4,629**

The general fund reflects the cumulative surplus/deficit arising each year from the Statement of Comprehensive Net Expenditure. The PCT's Parliamentary funding is also accounted for in this reserve. This balance cannot be released back to the Statement of Comprehensive Net Expenditure.

The revaluation reserve reflects movements in the value of property, plant and equipment as set out in the respective accounting policies for each asset category. The revaluation reserve balance relating to each asset is released to the general fund on disposal of that asset.

*A transfer between the revaluation reserve and general fund has taken place for an amount of £424,000 in respect of assets which carried a revaluation reserve balance which was no longer required.

The notes on pages 5 to 44 are an integral part of these financial statements.

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		**(430,719)**	(416,553)
Depreciation and amortisation		**1,329**	1,766
Impairments and reversals		**1,369**	288
Interest paid	11	**(601)**	(566)
Decrease/(increase) in trade and other receivables		**3,249**	(3,262)
(Decrease)/increase in trade and other payables		**(3,654)**	3,735
Provisions utilised	24	**(4,579)**	(1,195)
Increase in provisions		**4,934**	377
Net cash outflow from operating activities		**(428,672)**	**(415,410)**
Cash flows from investing activities			
Interest received	9	**32**	102
Payments for property, plant and equipment		**(861)**	(1,123)
Payments for intangible assets		**-**	(90)
Loans repaid in respect of LIFT		**2**	-
Net cash outflow from investing activities		**(827)**	**(1,111)**
Net cash outflow before financing		**(429,499)**	**(416,521)**
Cash flows from financing activities			
Capital element of payments in respect of finance leases and on-SoFP LIFT		**(55)**	(94)
Net Parliamentary Funding		**429,572**	416,620
Net cash inflow from financing activities		**429,517**	**416,526**
Net increase in cash and cash equivalents		**18**	**5**
Cash and cash equivalents at beginning of the period	21	**20**	15
Cash and cash equivalents at year end		**38**	**20**

This statement provides information on the PCT's liquidity, viability and financial adaptability.

Notes to the financial statements

1. Accounting policies

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

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

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.

Going Concern

The financial statements have been prepared on a going concern basis.

On 19 January 2011 the Government announced its intention to abolish PCT's and transfer their functions into new organisations within the umbrella of the Department of Health. On the 27 March 2012 the Health and Social Care Bill received Royal Assent.

This transfer of services is due to come into effect from 1 April 2013.

After the closure it is proposed that all the PCTs functions will continue either with Commissioning Support Organisations, Clinical Commissioning Groups, National Commissioning Board or Local Authorities. Estates functions are due to be transferred to NHS Property Services Limited. Ultimate control will still reside with the Department of Health.
At the point of closure it is proposed that the PCT, in its current legal form, will be abolished. Refer to note 33 page 43 'Events after the end of the reporting period.'

Notes to the financial statements

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

Critical judgements in applying accounting policies
The following are the critical judgments, 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.

LIFT schemes
The PCT has recognised, under IFRIC 12, the need to account for a Local Improvement Finance Trust (LIFT) scheme at Hainault Health Centre as a service concession arrangement. The indications of a service concession include the provision of a healthcare service, control over the services and control over the asset at the end of the lease. The lease for this scheme satisfies these conditions. Previously the 25 year lease was treated as an operating lease under UK GAAP. The lease is now treated as a finance lease and the asset is included within property, plant and equipment, with a corresponding liability also recognised on the Statement of Financial Position (SoFP).
In addition the PCT has also recognised under IFRIC 12 the need to account for a number of properties, which were sold by the preceding NHS organisation, Redbridge and Waltham Forest Health Authority, as service concession arrangements. The sale of the properties was arranged through the provision of capital grants and a legal charge was attached to each sale. Under the terms of the sales the healthcare services previously provided were to continue and the PCT or London Borough of Redbridge (through a partnership agreement with the PCT) has control over these services. If sold, proceeds of the sales will revert back to the PCT to an amount equal to that portion of the market value of the property which is assessed as being attributable to the original capital grant. These conditions satisfy the requirements under IFRIC 12 as outlined above. These properties are now included within Property, Plant and Equipment on the SoFP.
Continuing Care Provision
Under IAS 37 the PCT has recognised the need to provide for an amount of £4,576,000 in respect of continuing care claims based upon the following judgements:-
- Where claims have been received with no dates as to which the period claim related an assumption of 52 weeks was used as a prudent estimate.
- The provision was based upon a payout of £700 per week based upon the national London Procurement LPP Pan London Price.
- A percentage of 32% was assumed against the potential total liability. Where by 30% was informed by the Independant review panels conducted by NHSL on a sample basis plus an element which the PCT felt needed to cover the PCT's demographic population.

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.

Notes to the financial statements

Non-current asset valuations

During the financial year the District Valuation Office conducted an interim asset valuation review of all land and buildings held by the PCT. A valuation report has been prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as these terms are consistent with the requirements of HM Treasury, the National Health Service and Department of Health.

Public sector bodies including the NHS are required to apply the revaluation model set out in IAS 16 and value their capital assets to fair value. Fair value is defined in IAS16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction. The fair value of land and buildings is usually determined from market-based evidence by appraisal undertaken by professionally qualified valuers.

The interim asset valuation was undertaken in February and March 2013 as at the prospective valuation date of 31st March 2013, an agreed departure from the RICS Valuation Standards.

The age and remaining lives of buildings and their component parts have been assessed as at the valuation date.

Quality outcome framework (QOF)
The liability for the QOF payment as part of the GP contract is based on the Quality Management and Analysis System giving the PCT objective feedback on quality of care delivered to patients. It shows how well the practice is performing measured against national achievement targets. Through the QOF, general practices are rewarded financially for aspects of the quality of care they provide.

Accruals
For goods and/or services that have been delivered but for which no invoice has been received/sent, the PCT makes an accrual based on the contractual arrangements that are place and it's legal obligations.

Prescribing and pharmacy liabilities
The Department of Health actions monthly cash charges to the PCT for prescribing and pharmacy contracts. These are issued approximately six weeks in arrears. The PCT uses a forecast provided by the NHS Business Authority to estimate the full year expenditure.

Outer North East London (ONEL) Recharges
A proportion of the pay and non pay costs incurred in year by the PCT have been recharged to Havering PCT, Waltham Forest PCT and Barking and Dagenham PCT. These three organisations, along with the PCT, operate within a cluster arrangement including having a shared management team, along with a number of functions. Shared costs incurred by the other three ONEL PCTs have also been recharged to the PCT.

Costs which are specific to the running of each PCT are not recharged and remain as costs within each specific PCT's statement of comprehensive net expenditure. Shared payroll costs are recharged across ONEL based upon the estimated proportion of the contribution made by each employee to the ONEL PCTs. Shared non pay costs are also recharged on this basis as it is considered a reasonable proxy of the relative share of expenditure.

Pay recharges are shown net within the statement of comprehensive net expenditure. Non pay and agency payroll cost items are shown net of related income.

Notes to the financial statements

1.2 Revenue and Funding

The main source of funding for the PCT is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the general fund of the PCT. 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 PCT. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work and includes recharges to other PCTs. 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.

Refer to note 4 for analysis.

1.3 Pooled budgets

The PCT has entered into a number of partnership agreements.

Each partnership is hosted by one of the partners. Under the arrangements, the PCT accounts for its contribution to the partnership and for its share of the assets, liabilities, income and expenditure of the partnership within its own accounts as determined by the Partnership Agreements. Further information is available in note 31.

1.4 Taxation

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

1.5 Administration and Programme Costs

HM 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 of Health has defined "admin and programme" in terms of running costs.

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

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

Refer to note 5.1 for further disclosure.

1.6 Capital Charges

As per the HM Treasury guidance for 2012/13 cost of capital charges and credits have been removed entirely from the PCT's reported financial position. As a result an amount of £125,000 (2011/12 £181,000) has been removed from the resource limit and not charged to the statement of comprehensive net expenditure.

The cost of capital charge is calculated at 3.5% of the net of average assets less liabilities, except for donated assets and cash balances with the Government Banking Services.

Notes to the financial statements

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

Land and buildings are measured subsequently at fair value. Plant and equipment is stated at historical cost less depreciation.

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

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.

As a result of a downward valuation of land and buildings the PCT has incurred an impairment of £379,000 (£288,000 2011/12) which was charged to the statement of comprehensive net expenditure and £437,000 was charged to the revaluation reserve (£671,000 2011/12) in relation to several buildings owned by the PCT, further disclosure of this matter can be found at note 14.

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 ready for use.
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.

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.

Increases in the carrying amount on revaluation of land and buildings are credited to revaluation reserve in taxpayers equity.

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.

1.8 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.

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), as a proxy for fair value. Internally-developed software is held at amortised historic cost to reflect the opposing effects of increases in development costs and technological advances.

Amortised replacement costs (modern equivalent asset basis) is indexed for relevant price increases, as a proxy for fair value.

Refer to note 13 for additional disclosure.

Notes to the financial statements

1.9 Depreciation, amortisation and impairments
Freehold land is 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, usually on a straight line basis. 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

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. A transfer is required from the revaluation reserve to retained earnings of an amount representing the lower of the impairment charged and the balance for the asset in the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 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, if their carrying amount is to be recovered principally through a sale transaction rather than continuing use. 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 the general fund.
Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale.

Notes to the financial statements

1.11 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.

1.12 Losses and Special Payments

Losses and special payments are items that Government 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).

Losses and special payments are compiled on an accruals basis excluding any provisions in relations to such payments.

1.13 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 24.

Any provision in respect of clinical negligence claims are included within the accounts of the NHSLA and do not form part of the PCT's accounts.

1.14 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of leave earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following year.

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.

Termination benefits

Notes to the financial statements

Termination benefits are payable when employment is terminated by the PCT before the normal retirement date, or whenever an employee accepts voluntary redundancy in exchange for these benefits. The PCT recognises termination benefits when it is demonstrably committed to a termination when the entity has a detailed formal plan to terminate the employment of current employees without possibility of withdrawal. In the case of an offer made to encourage voluntary redundancy, the termination benefits are measured based on the number of employees expected to accept the offer. Benefits falling due more than 12 months after the end of the reporting period are discounted to their present value.

1.15 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.

1.16 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.

1.17 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.

1.18 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.

Notes to the financial statements

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.

1.19 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. Provisions are measured at the present value of the expenditures expected to be required to settle the obligation using a pre tax rate that reflects current market assessments of the time value of money and the risks specific to the obligation (being HM Treasury's discount rate of 2.2% (2.8% in respect of early staff departures) in real terms). The increase in provision due to passage of time is recognised as interest expensed.

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.

1.20 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. Refer to note 28 for additional disclosure.

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.

Notes to the financial statements

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

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

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

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

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

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

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or 'other financial liabilities'. The PCT only has financial liabilities categorised as 'other financial liabilities'.

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

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the LIFT asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Refer to note 26.1 for additional disclosure.

Notes to the financial statements

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

b) LIFT assets, liabilities, and finance costs
The LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the PCT's approach for each relevant class of asset in accordance with the principles of IAS 16. These assets have been revalued as at 31st March 2013.
A LIFT liability is recognised at the same time as the asset is recognised. It is measured initially at the same amount as the fair value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

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

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

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

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

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

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

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

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

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

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

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

2 Operating segments

Segment	Acute	Non Acute	Prescribing and Primary Care	Corporate	Total
	2012/13 £000	2012/13 £000	2012/13 £000	2012/13 £000	2012/13 £000
Actual net expenditure	238,599	81,917	89,326	21,624	431,466
Revenue Resource Limit	235,673	74,350	93,132	32,341	435,496
(Deficit)/Surplus	(2,926)	(7,567)	3,806	10,717	4,030
	2011/12 £000	2011/12 £000	2011/12 £000	2011/12 £000	2011/12 £000
Actual net expenditure	230,063	77,183	91,907	17,974	417,127
Revenue Resource Limit	222,732	76,601	93,617	30,821	423,771
(Deficit)/Surplus	(7,331)	(582)	1,710	12,847	6,644

Included within the segments are material spend as follows:-	2012-13 £000	2011-12 £000
Prescribing and Primary Care Segment		
Prescribing Costs	34,947	39,087
G/PMS, APMS and PCTMS (excluding employee benefits)	31,790	32,149
Acute Segment		
Goods and services from NHS Trusts	181,046	185,141
Non Acute Segment		
Purchase of Healthcare from Non-NHS Bodies	42,661	32,259
Corporate Segment		
Depreciation	1,303	1,740
Amortisation	26	26
Impairments and Reversals of Property, plant and equipment	1,363	288

Note: Total Operating Segments reconcile to Net Operating Cost as shown in note 3.1

The Chief Operating Decision Maker (CODM) is considered to be the Board, which evaluates performance of the organisation based on net expenditure of the segments. The statement of financial position, and cash flow statements are not reported on a segmental basis. The activities of the reportable segments are as follows:

Acute
Acute has the largest budget and accounted for 55% of total net expenditure in 2012/13 (2011/12 55%). Secondary Care Services are commissioned from NHS Trusts, Foundation Trusts and the Independent Sector. Barking Havering and Redbridge University Hospitals NHS Trust is the main provider of services totalling £89m (2011/12 £88m), followed by Barts Health NHS Trust at £77m (2011/12 £44m Whipps Cross University Hospital Trust and Barts and the London NHS Trust £31m).

Non Acute
Non Acute commissioning includes adult community services and nursing care from the private sector. Non acute services are largely commissioned from Local Authorities and nursing homes. Non acute commissioning also includes mental health. North East London NHS Foundation Trust (NELFT) is the PCT's largest provider of mental health services. Expenditure with NELFT was £44m in 2012/13 (£40m 2011/12).

Prescribing and Primary Care
The PCT commissions medical services from a number of GPs and dentists. It also takes responsibility for pharmacy services. Contracts with GP Practices totalled £32m in 2012/13 (£32m 2011/12) and Prescribing Costs £35m in 2012/13 (£39m 2011/12) as included in Note 5.1.

Corporate
The Corporate function facilitates all areas of Pay and Non Pay expenditure to provide the services within other segments.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCT's performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**431,466**	417,127
Revenue Resource Limit	**435,496**	423,771
Underspend Against Revenue Resource Limit (RRL)	4,030	6,644

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	**2,124**	1,383
Charge to Capital Resource Limit	**693**	1,381
Underspend Against CRL	**1,431**	**2**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total charge to cash limit	**429,572**	416,620
Cash limit	**429,572**	416,620
Under/(Over)spend Against Cash Limit	**-**	**-**

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

	2012-13 £000	2011-12 £000
Total cash received from DH (Gross)	374,505	360,520
Plus: cost of dentistry schemes (central charge to cash limits)	13,918	13,738
Plus: drugs reimbursement (central charge to cash limits)	41,149	42,362
Parliamentary funding credited to general fund	**429,572**	**416,620**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**2,694**	-	2,694	2,670
Prescription Charge income	**1,727**	-	1,727	1,653
Strategic Health Authorities	**174**	14	160	571
NHS Trusts	**60**	60	-	-
NHS Foundation Trusts	**1,578**	1	1,577	820
Primary Care Trusts - Other	**2,689**	180	2,509	1,951
Department of Health - Other	**50**	-	50	-
Recoveries in respect of employee benefits	**-**	-	-	6,582
Local Authorities	**145**	-	145	1,117
Education, Training and Research	**2,038**	-	2,038	1,877
Rental revenue from operating leases	**271**	-	271	412
Other revenue	**178**	23	155	70
Total miscellaneous revenue	**11,604**	**278**	**11,326**	**17,723**

Admin income is income incurred that is not directly attributable to the provision of healthcare or healthcare services.

Income shown in this note does not include cash received from the Department of Health and drawn down directly into the bank account of the PCT and credited to the General Fund.

As per the manual for accounts the overarching principle is that transactions should be accounted for in accordance with accounting standards, with all treatments having been agreed by both parties. Generally, this means revenue income and expenditure should be recorded gross unless the transaction is of a non-trading nature and an organisation is deemed to be acting solely as an agent and does not gain any economic benefit from the transaction. Therefore recoveries in respect of employee benefits are shown on a net basis as disclosed within note 1.1. Only the element of the salary relating to the PCT has been recorded as expenditure as in substance the employee works for both organisations and the recharge is merely an administrative arrangement. This is in contrast to last financial year where pay recharges were shown gross

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	22,831		22,831	20,448
Non-Healthcare	324	324	-	292
Total	23,155	324	22,831	20,740
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	181,046	127	180,919	185,141
Goods and services (other, excl Trusts, FT and PCT))	1,430	-	1,430	1,373
Total	182,476	127	182,349	186,514
Goods and Services from Foundation Trusts	71,740	4	71,736	59,480
Purchase of Healthcare from Non-NHS bodies	42,661		42,661	32,259
Social Care from Independent Providers	10		10	-
Expenditure on Drugs Action Teams	2,512		2,512	1,873
Non-GMS Services from GPs	1,412	-	1,412	1,461
Contractor Led GDS & PDS (excluding employee benefits)	17,038		17,038	16,502
Chair, Non-executive Directors & PEC remuneration	2	2	-	32
Executive committee members costs	-	-	-	4
Consultancy Services	461	452	9	241
Prescribing Costs	34,947		34,947	39,087
G/PMS, APMS and PCTMS (excluding employee benefits)	31,790	-	31,790	32,149
New Pharmacy Contract	8,694		8,694	6,667
General Ophthalmic Services	2,879		2,879	2,752
Supplies and Services - Clinical	274	18	256	243
Supplies and Services - General	653	(20)	673	537
Establishment	1,030	245	785	1,415
Transport	13	2	11	191
Premises	5,901	2,772	3,129	5,024
Impairments & Reversals of Property, plant and equipment	1,363	-	1,363	288
Depreciation	1,303	-	1,303	1,740
Amortisation	26	-	26	26
Impairment & Reversals Intangible non-current assets	6	-	6	-
Impairment of Receivables	(6)	-	(6)	-
Audit Fees	101	101	-	157
Other Auditors Remuneration	9	9	-	61
Education and Training	123	80	43	270
Other	1,783	450	1,333	1,925
Total Operating costs charged to Statement of Comprehensive Net Expenditure	432,356	4,566	427,790	411,638
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	216	-	216	215
PCT Officer Board Members	709	709	-	1,314
Other Employee Benefits	9,042	6,406	2,636	21,109
Total Employee Benefits charged to SOCNE	9,967	7,115	2,852	22,638
Total Operating Costs	442,323	11,681	430,642	434,276

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	11,608	10,602	1,006
Weighted population (number in units)*	249,444	249,444	249,444
Running costs per head of population (£ per head)	46.54	42.50	4.03
PCT Running Costs 2011-12			
Running costs (£000s)	11,653	9,687	1,966
Weighted population (number in units)	249,444	249,444	249,444
Running costs per head of population (£ per head)	46.72	38.83	7.88

Running costs are costs incurred by an NHS Organisation which are not directly linked to patient treatment or well being.

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

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

5.2 Analysis of operating expenditure by expenditure classification

	2012-13 £000	2011-12 £000
GMS,PMS, APMS and PCTMS	31,790	32,149
Prescribing costs	34,947	39,087
Contractor led GDS & PDS	17,038	16,502
General Ophthalmic Services	2,879	2,752
New Pharmacy Contract	8,694	6,667
Non-GMS Services from GPs	1,412	1,461
Total Primary Healthcare purchased	**96,760**	98,618
Purchase of Secondary Healthcare		
Learning Difficulties	4,054	4,059
Mental Illness	32,809	35,808
Maternity	14,144	14,774
General and Acute	216,665	207,766
Accident and emergency	10,452	8,669
Community Health Services	42,572	36,507
Total Secondary Healthcare Purchased	**320,696**	307,583
Total Healthcare Purchased by PCT	**417,456**	**406,201**
Healthcare from NHS FTs included above	71,736	59,319

The expenditure shown above analyses the PCT's total expenditure on patient treatment for its own residents. Figures are net of any income recovery from other NHS organisations where the PCT acts as lead commissioner.

6. Operating Leases

6.1 PCT as lessee

	Buildings £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense			
Minimum lease payments	1,399	1,399	1,247
Contingent rents	-	-	-
Sub-lease payments	-	-	-
Total	1,399	1,399	1,247
Payable:			
No later than one year	1,044	1,044	1,210
Between one and five years	3,247	3,247	3,355
After five years	13,934	13,934	14,787
Total	18,225	18,225	19,352
Total future sublease payments expected to be received		-	-

The following operating leases are of significance:

Loxford Polyclinic lease from May 2009 for a term of 25 years. RPI is the basis for the contingent rent after a five year period where the rental remains unchanged. The lease is renegotiated when due for renewal based on current market rates.

Becketts House lease is due to expire on 31st July 2013.

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	271	412
Contingent rents	-	-
Total	271	412
Receivable:		
No later than one year	271	268
Between one and five years	732	699
After five years	2,140	2,318
Total	3,143	3,285

The PCT has two sub-leases with GPs in Hainault Health Centre. The leases, uplifted in line with RPI are for 25 years, but there are break clauses every five years. GPs also have arrangements to occupy a number of health clinics. These arrangements are evidence of a lease however as the arrangement does not have a defined term it is not possible to analyse the financial impact of the arrangement over future years.

General Medical Services (GMS)
The GMS contract entered into by the PCT with GPs includes conditions relating to the use of GP premises under IFRIC 4, Determining whether an arrangement contains a lease.

The PCT has determined that those conditions are operating leases. As the GMS contract does not contain defined terms, it is not possible to analyse the financial impact of the arrangements over future financial years. The premises costs include the GMS payments in the statement of comprehensive net expenditure for 2012/13 is £1,168,744 (£1,077,000 2011/12).

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13								
		Permanently employed				Other		
	Total	Admin	Programme	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	**8,375**	6,278	2,097	**4,621**	3,102	1,519	**3,754**	3,176	578
Social security costs	**594**	403	191	**594**	403	191	**-**	-	-
Employer Contributions to NHS BSA - Pensions Scheme	**595**	434	161	**595**	434	161	**-**	-	-
Termination benefits	**403**	-	403	**403**	-	403	**-**	-	-
Total employee benefits	**9,967**	**7,115**	**2,852**	**6,213**	**3,939**	**2,274**	**3,754**	**3,176**	**578**
Less recoveries in respect of employee benefits (table below)	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net Employee Benefits including capitalised costs	**9,967**	**7,115**	**2,852**	**6,213**	**3,939**	**2,274**	**3,754**	**3,176**	**578**
Employee costs capitalised	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Gross Employee Benefits excluding capitalised costs	**9,967**	**7,115**	**2,852**	**6,213**	**3,939**	**2,274**	**3,754**	**3,176**	**578**
Recognised as:									
Commissioning employee benefits	**9,967**			**6,213**			**3,754**		
Net Employee Benefits excluding capitalised costs	**9,967**			**6,213**			**3,754**		

Employee Benefits - Prior year

	Total	Permanently employed	Other
	£000	£000	£000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**19,579**	14,522	5,057
Social security costs	**1,243**	1,243	-
Employer Contributions to NHS - Pensions Scheme	**1,816**	1,816	-
Total gross employee benefits	**22,638**	**17,581**	**5,057**
Less recoveries in respect of employee benefits	**(6,582)**	(6,582)	-
Total - Net Employee Benefits including capitalised costs	**16,056**	**10,999**	**5,057**
Employee costs capitalised	**-**	**-**	**-**
Gross Employee Benefits excluding capitalised costs	**22,638**	**17,581**	**5,057**

As per the manual for accounts the overarching principle is that transactions should be accounted for in accordance with accounting standards, with all treatments having been agreed by both parties. Generally, this means revenue income and expenditure should be recorded gross unless the transaction is of a non-trading nature and an organisation is deemed to be acting solely as an agent and does not gain any economic benefit from the transaction. Therefore employee benefits are shown on a net basis as disclosed within note 1.1. Only the element of the salary relating to the PCT has be recorded as expenditure as in substance the employee works for both organisations and the recharge is merely an administrative arrangement. This is in contrast to last financial year where pay recharges were shown gross.

The provision of Redbridge Children's Services transferred from Redbridge PCT on 1st June 2012 to North East London NHS Foundation Trust (NELFT) as a result of a competitive tendering process. 220 staff (180.5 whole time equivalents) transferred under TUPE from Redbridge PCT to NELFT. No assets or liabilities transferred. The payroll cost of the staff transferred is accounted within Redbridge PCT up to the transfer date. Absorption accounting has been applied and comparators have not been restated for this transfer of function.

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	**4**	4	-	**8**	7	1
Administration and estates	**124**	70	54	**161**	86	75
Healthcare assistants and other support staff	**14**	14	-	**44**	44	-
Nursing, midwifery and health visiting staff	**25**	18	7	**76**	68	8
Nursing, midwifery and health visiting learners	-	-	-	**5**	5	-
Scientific, therapeutic and technical staff	**9**	8	1	**42**	38	4
TOTAL	**176**	**114**	**62**	**336**	**248**	**88**
Of the above - staff engaged on capital projects	-	-	-	-	-	-

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	2,231	3,255
Total Staff Years	254	365
Average working Days Lost	9	9

The figures included above are based upon 31 December 2012 of calendar year 2011/12 due to timing difficulties with financial year data. The Department of Health considers the above figures to be a reasonable proxy for financial year equivalents.

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

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	-	-	-	3	-	**3**
£10,001-£25,000	-	-	-	3	-	**3**
£25,001-£50,000	**2**	-	**2**	2	-	**2**
£50,001-£100,000	-	-	-	2	-	**2**
£100,001 - £150,000	-	-	-	3	-	**3**
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total number of exit packages by type (total cost	**2**	-	**2**	**13**	-	**13**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	53,148	-	**53,148**	648,000	-	**648,000**

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 Compulsory Redundancy 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 agreed with staff in the year. Note; The expense associated with these departures may have been recognised in part or in full in a previous period.

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service. With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	15,045	64,025	15,538	52,413
Total Non-NHS Trade Invoices Paid Within Target	13,479	52,617	12,902	39,598
Percentage of non-NHS Trade Invoices Paid Within Target	89.59%	82.18%	83.04%	75.55%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,677	286,254	3,389	271,071
Total NHS Trade Invoices Paid Within Target	3,411	265,255	2,858	264,178
Percentage of NHS Trade Invoices Paid Within Target	92.77%	92.66%	84.33%	97.46%

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.

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: equity dividends receivable	-	-	-	70
LIFT: loan interest receivable	32	-	32	32
Total investment income	32	-	32	102

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	-	-	-	-
Gain/(Loss) on disposal of assets other than by sale (intangibles)	-	-	-	-
Total	-	-	-	-

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest on obligations under LIFT contracts:				
- main finance cost	441	-	441	447
- contingent finance cost	160	-	160	119
Total interest expense	601	-	601	566
Provisions - unwinding of discount	178		178	110
Total	779	-	779	676

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2012	15,004	19,326	2,127	85	4,469	314	41,325
Additions purchased	-	411	-	-	282	-	693
Reclassifications	-	494	-	-	(494)	-	-
Disposals other than for sale	-	-	(1,338)	(85)	(3,025)	(33)	(4,481)
Upward revaluation/positive indexation	-	293	-	-	-	-	293
Impairments/negative indexation	-	(437)	-	-	-	-	(437)
At 31 March 2013	15,004	20,087	789	-	1,232	281	37,393
Depreciation							
At 1 April 2012	-	-	1,210	85	2,750	141	4,186
Reclassifications	-	135	-	-	(135)	-	-
Disposals other than for sale	-	-	(1,338)	(85)	(3,025)	(33)	(4,481)
Upward revaluation/positive indexation	-	-	-	-	-	-	-
Impairments	-	379	463	-	509	12	1,363
Charged during the year	-	683	128	-	410	82	1,303
At 31 March 2013	-	1,197	463	-	509	202	2,371
Net Book Value at 31 March 2013	15,004	18,890	326	-	723	79	35,022
Purchased	15,004	18,890	326	-	723	79	35,022
Total at 31 March 2013	15,004	18,890	326	-	723	79	35,022
Asset financing:							
Owned	13,229	14,233	326	-	723	79	28,590
Held on finance lease	-	-	-	-	-	-	-
On-SOFP LIFT contracts	1,775	4,657	-	-	-	-	6,432
Total at 31 March 2013	15,004	18,890	326	-	723	79	35,022

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	5,880	3,479	-	32	-	-	9,391
Net gain on property plant and equipment	-	293	-	-	-	-	293
Impairments and reversals	-	(437)	-	-	-		(437)
Transfer between general fund	49	(441)	-	(32)	-	-	(424)
At 31 March 2013	5,929	2,894	-	-	-	-	8,823
At 1 April 2011	5,915	4,064	-	32	-	-	10,011
Impairments	(35)	(585)	-	-	-		(620)
At 31 March 2012	5,880	3,479	-	32	-	-	9,391

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2011	14,902	21,469	2,126	85	4,145	314	43,041
Additions - purchased	137	829	1	-	324	-	1,291
Revaluation & indexation gains	7	44	-	-	-	-	51
Impairments	(42)	(629)	-	-	-	-	(671)
Cumulative dep netted off cost following revaluation	-	(2,387)	-	-	-	-	(2,387)
At 31 March 2012	15,004	19,326	2,127	85	4,469	314	41,325
Depreciation							
At 1 April 2011	-	1,483	893	85	1,998	86	4,545
Impairments	-	288	-	-	-	-	288
Charged during the year	-	616	317	-	752	55	1,740
Cumulative dep netted off cost following revaluation	-	(2,387)	-	-	-	-	(2,387)
At 31 March 2012	-	-	1,210	85	2,750	141	4,186
Net Book Value at 31 March 2012	15,004	19,326	917	0	1,719	173	37,139
Purchased	15,004	19,326	917	-	1,719	173	37,139
At 31 March 2012	15,004	19,326	917	-	1,719	173	37,139
Asset financing:							
Owned	13,229	14,359	917	-	1,719	173	30,397
Held on finance lease	-	-	-	-	-	-	-
On-SOFP LIFT contracts	1,775	4,967	-	-	-	-	6,742
At 31 March 2012	15,004	19,326	917	-	1,719	173	37,139

12.3 Property, plant and equipment

Of the total net cost or valuation at 31 March 2013, £13,229,000 (2011/12 £13,229,000) related to land valued at open market value and £14,233,000 (2011/12 £14,359,000) related to buildings installations and fittings valued at Modern Equivalent Asset Value which were owned by the PCT. £1,775,000 related to land at open market value (2011/12 £1,775,000) and £4,657,000 (2011/12 £4,967,000) related to buildings, installations and fittings valued at open market value which were not owned by the PCT but came under its LIFT Co arrangement and assets held under legal charges.

During the financial year a revaluation of all properties, including those owned and those included under the LIFT Co arrangement, was undertaken to value assets as at 31 March 2013. This is in line with the accounting policies of the PCT. An independent valuation report has been produced by the District Valuation office which has been prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as these terms are consistent with the requirements of HM Treasury, the National Health Service and Department of Health.

Public sector bodies including the NHS are required to apply the Revaluation model set out in IAS 16 and value their capital assets to fair value.

Fair value is defined in IAS16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. The fair value of land and buildings is usually determined from market-based evidence by appraisal undertaken by professionally qualified valuers.

The valuation of each property is therefore on the basis of Market Value, subject to the following:

The RICS advises that assumptions underpinning the concepts of fair value should be explicitly stated and identifies two potential qualifying assumptions:

"the Market Value on the assumption that the property is sold as part of the continuing enterprise in occupation" (effectively EUV); or

"the Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the traditional understanding of Market Value).

The Department of Health has indicated that for NHS assets it requires the former assumption to be applied for operational assets.

The valuation has neither changed the value of land assets held under legal Charges (2011/12 a reduction of £42,300) nor the value owned by the PCT (2011/12 an increase of £6,500).

The valuation has had the following impact on Buildings:-

	Increase in Value	Impairment charge to revaluation reserve	Impairment charge to the statement of comprehensive net expenditure	Total
	£000	£000	£000	£000
Cranbrook Road		(1)		(1)
Newbury Park HC	18			18
Sevenkings HC			(44)	(44)
Fullwell Cross HC		(14)		(14)
Kenwood Gardens Clinic		(6)		(6)
John Telford Clinic	55			55
Diabetic Centre		(11)		(11)
Heronwood & Galleon wards		(133)		(133)
Wanstead Physiotherapy			(40)	(40)
Wanstean Hydrotherapy	29			29
Coleridge Road Day Unit		(48)		(48)
Madeira Grove Green Lodge	86			86
Madeira Grove Clinic			(16)	(16)
South Woodford HC		(30)	(24)	(54)
Wanstead Place HC		(23)	(208)	(231)
Aldersbook HC			(16)	(16)
Assets held under LIFT Co arrangement		(171)		(171)
Assets held under legal charges	105		(31)	74
	293	(437)	(379)	(523)

12.3 Property, plant and equipment (cont'd)

Where a building has increased in value the amount has been charged against the revaluation reserve. Those buildings which have decreased in value have firstly been offset by balances within the revaluation reserve for those specific assets which totalled £436,513 (2011/12 £628,540), and any further decrease in value has been charged to the statement of comprehensive net expenditure as an impairment, which totals £379,036 (2011/12 £288,000). For more information on this impairment please refer to note 14.

Economic Lives of Property, Plant and Equipment:-

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings excluding dwellings	1	46
Plant and machinery	1	7
Information technology	1	5
Furniture and fittings	4	5

Land is not depreciated

Open Market Value of tangible non-current assets	**Land**	**Buildings excl. dwellings**	**Total**
	£000s	**£000s**	**£000s**
Open Market Value at 31 March 2013	15,004	18,890	33,894
Open Market Value at 31 March 2012	15,004	19,326	34,330

13 Intangible non-current assets

2012-13	Software purchased	Total
	£000	£000
At 1 April 2012	**228**	**228**
Disposals other than by sale	(138)	**(138)**
At 31 March 2013	**90**	**90**
Amortisation		
At 1 April 2012	**135**	**135**
Disposals other than by sale	(138)	**(138)**
Impairments charged to operating expenses	6	**6**
Charged during the year	26	**26**
At 31 March 2013	**29**	**29**
Net Book Value at 31 March 2013	**61**	**61**
Net Book Value at 31 March 2013 comprises		
Purchased	61	**61**
Total at 31 March 2013	**61**	**61**

All assets have a finite useful life and are amortised over five years on a straight line basis.

2011-12	Software purchased	Total
	£000	£000
At 1 April 2011	**138**	**138**
Additions - purchased	90	**90**
At 31 March 2012	**228**	**228**
Amortisation		
At 1 April 2011	**109**	**109**
Charged during the year	26	**26**
At 31 March 2012	**135**	**135**
Net Book Value at 31 March 2012	**93**	**93**
Net Book Value at 31 March 2012 comprises		
Purchased	93	**93**
Total at 31 March 2012	**93**	**93**

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011_12 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCNE				
Loss or damage resulting from normal operations	351	-	351	-
Over-specification of assets	-	-	-	-
Abandonment of assets in the course of construction	-	-	-	-
Total charged to Departmental Expenditure Limit	**351**	**-**	**351**	**-**
Unforeseen obsolescence	-	-	-	-
Loss as a result of catastrophe	-	-	-	-
Other	-	-	-	-
Changes in market price	1,012	-	1,012	288
Total charged to Annually Managed Expenditure	**1,012**	**-**	**1,012**	**288**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve				
Changes in market price	437	-	437	671
Total impairments for PPE charged to reserves	**437**	**-**	**437**	**671**
Total Impairments of Property, Plant and Equipment	**1,449**	**-**	**1,449**	**959**
Intangible assets impairments and reversals charged to SoCNE				
Changes in market price	6	-	6	
Total charged to Annually Managed Expenditure	**6**	**-**	**6**	
Total impairments for Intangible Assets charged to Reserves	-	-	-	
Total Impairments of Intangibles	**6**	**-**	**6**	

As part of the 31st March 2013 valuation carried out by the District Valuation Office an impairment charge of £379,036 was charged to the statement of comprehensive net expenditure for several of the PCT's buildings. £207,930 was in respect of The Wanstead Place Health Centre. The remaining impairment charge of £171,106 was due to the way in which buildings are valued as explained in the accounting policies of these accounts at note 1.7

Funding of £1,019,000 was received from the Department of Health into the PCT's Revenue Resource Limit to offset the impairment charge in the year.

Impairment charged to the revaluation reserve in the year relates to those buildings which decreased in value due to the District Valuation Office report. Those buildings which were reduced in value were offset by specific balances held within the revaluation reserve for each individual asset. £436,513 was charged to the revaluation reserve for buildings.

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.

15 Commitments

15.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	0	0

The PCT had not entered into capital commitments at the date of the statement of financial position. (2011-12 £nil)

15.2 Other financial commitments

The PCT had not entered into other financial commitments at the date of the statement of financial position. (2011-12 £183,156 main other financial commitments).

16 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	1,284	-	2,152	-
Balances with Local Authorities	-	-	1,465	-
Balances with NHS Trusts and Foundation Trusts	1,957	-	4,788	-
Balances with bodies external to government	1,664	-	17,817	-
At 31 March 2013	**4,905**	**-**	**26,222**	**-**
prior period:				
Balances with other Central Government Bodies	5,677	-	1,262	-
Balances with Local Authorities	921	-	3,159	-
Balances with NHS Trusts and Foundation Trusts	837	-	5,669	-
Balances with bodies external to government	719	-	19,954	-
At 31 March 2012	**8,154**	**-**	**30,044**	**-**

17 Inventories

	Other £000	Total £000	Of which held at NRV £000
Balance at 1 April 2012	-	-	-
Additions	-	-	-
Inventories recognised as an expense in the period	-	-	-
Balance at 31 March 2013	**-**	**-**	**0**

18.1 Trade and other receivables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	**2,804**	3,078
NHS prepayments and accrued income	**437**	3,139
Non-NHS receivables - revenue	**238**	1,007
Non-NHS prepayments and accrued income	**1,126**	650
Provision for the impairment of receivables	**(27)**	(33)
VAT	**321**	297
Other receivables	**6**	16
Total	**4,905**	8,154

Trade and other receivables are stated at their fair values.

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

18.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**178**	196
By three to six months	**-**	12
By more than six months	**20**	626
Total	**198**	834

18.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(33)**	(33)
Amount written off during the year	**-**	-
Amount recovered during the year	**-**	-
Decrease in receivables impaired	**6**	-
Balance at 31 March 2013	**(27)**	**(33)**

19 NHS LIFT investments

	Loan £000
Balance at 1 April 2012	**256**
Additions	**-**
Disposals	**-**
Loan repayments	**(2)**
Revaluations	**-**
Loans repayable within 12 months	**-**
Balance at 31 March 2013	**254**
Balance at 1 April 2011	257
Loan repayments	(1)
Balance at 31 March 2012	**256**

IAS 39 defines a financial instrument as a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. In order to comply with IAS requirements all necessary steps have been taken by the PCT to identify and review basic short-term financial instruments, the value of which have generally remained unchanged by the adoption of these standards. Much consideration has been given to checking whether longer-term or more complex financial instrument accounting arrangements have changed. The measurement and recognition of the LIFT Co investment at cost is deemed to be a reasonable approximation of fair value.

20 Other Financial Assets - Non Current - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	-	-
Capital Income	-	-

21 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**20**	15
Net change in year	**18**	5
Closing balance	**38**	20
Made up of		
Cash with Government Banking Service	38	20
Cash and cash equivalents as in statement of financial position	**38**	20
Cash and cash equivalents as in statement of cash flows	**38**	20
Patients' money held by the PCT, not included above	-	5

22 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
NHS payables - revenue	**4,830**	3,300	-	-
NHS accruals and deferred income	**2,110**	3,571	-	-
Family Health Services (FHS) payables	**11,673**	11,829	-	-
Non-NHS payables - revenue	**2,765**	6,469	-	-
Non-NHS payables - capital	**-**	168	-	-
Non_NHS accruals and deferred income	**4,790**	4,100	-	-
Social security costs	**-**	183	-	-
Tax	**-**	221	-	-
Other	54	203	-	-
Total	**26,222**	30,044	-	-
Total payables (current and non-current)	**26,222**	**30,044**		

23 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
LIFT liabilities:				
Main liability	**56**	55	**6,250**	6,306
Total	**56**	**55**	**6,250**	**6,306**
Total other liabilities (current and non-current)	**6,306**	**6,361**		

Borrowings/Loans - Payment of Principal Falling Due in:

	Other £000s
0 - 1 Years	56
1 - 2 Years	73
2 - 5 Years	449
Over 5 Years	5,728
TOTAL	**6,306**

24 Provisions for other liabilities and charges

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**4,628**	-	3,831	8	-	629	160
Arising during the Year	**5,019**	-	-	-	4,576	-	443
Utilised during the Year	**(4,579)**	-	(4,009)	(8)	-	(562)	-
Reversed unused	**(85)**	-	-	-	-	(67)	(18)
Unwinding of discount	**178**	-	178	-	-	-	-
Balance at 31 March 2013	**5,161**	-	-	-	**4,576**	-	**585**
Expected Timing of Cash Flows:							
No Later than One Year	**5,161**	-	-	-	**4,576**	-	**585**
Later than One Year and not later than Five Years	-	-	-	-	-	-	-
Later than Five Years	-	-	-	-	-	-	-

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	306
As at 31 March 2012	-

Provisions for pensions include both pensions of the PCT and the preceding organisation Redbridge & Waltham Forest Health Authority for staff who have taken early retirement or have retired through ill health, the cost of which the PCT is responsible for. In addition the PCT is notified of provision amounts from NHS Trusts and Foundation Trusts under "Back to Back" arrangements. These provisions are recognised on a discounted basis (using a discount rate of 2.8%) due to the long period over which the provision is held. The amounts are also adjusted for inflation annually using rates advised by the Department of Health. Provisions values are reviewed to ensure accuracy. The provision is based on actual payments made to members of the scheme, with life expectancy reviewed periodically.

Due to the abolishment of PCT's the Department of Health has advised PCT's to clear as many long term provisions as possible prior to the 31st March 2013. As a result the PCT utilised £4,008,978 in respect of early retirement provisions, of which £2,074,559 was in relation to "Back to Back" provisions.

A closing provision of £4,576,000 has been made in respect of continuing care cost. In April 2012, the Department of Health announced the deadline of 31 March 2013 for individuals to request an assessment of eligibility for NHS Continuing Healthcare funding, for cases during the period 1 April 2004 - 31 March 2011 from the previous deadline of 30 September 2012, the review of the claims for the second dead-line has not yet commenced.

Likewise given the subjective nature and process of assessing claim for the period 1 April 2004 to 31 March 2011 there is a possibility of further costs arsing that cannot be qualified.

A closing provision of £585,000 has been made in respect of redundancy costs that will be incurred due to the abolishment of PCT's. This amount represents the expected element of staff redundancies associated with Redbridge PCT as part of the Outer North East London Sector.

The value of provisions carried forward is a close estimate of actual cost expected.

25 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	-	-
Non Clinical Contingency	(2)	-
Net Value of Contingent Liabilities	(2)	-

In accordance with IAS 37 the PCT recognises a contingent liability in regards to Liabilities to Third Parties Scheme (LTPS) and Practice Based Commissioning savings schemes.

There is currently one case ongoing at the statement of financial position date in relation to LTPS for which a provision of £750 (2011/12 nil) has been included within provisions. A contingent liability of £2,250 (201112 nil) exists due to the uncertainty of these cases, as the liability depends on the outcome of the litigation which is at present is uncertain.

It is not anticipated that any material liabilities will arise from the contingent liabilities other than those provided for in note 24.

26.1 NHS LIFT schemes off-statement of financial position

The PCT has no NHS LIFT Schemes which are deemed to be off-statement of financial position

26.2 NHS LIFT schemes on-statement of financial position

The PCT currently has one LIFT (Local Improvement Finance Trust) Scheme which involves the PCT procuring the design, building, financing and operation of healthcare faculties to the Redbridge & Waltham Forest LIFT Company for the benefit of Redbridge residents. The scheme operates under the same contractual arrangements as a lease plus agreement. The LIFT Co acquires the site and builds the medical faculty with an option available to the PCT to purchase the asset. The term of the arrangement is 25 years over which a finance charge and lease rental is incurred. Contract payments are increased year on year based on RPI. Further to this the basis of the liabilities for the future are computed using the universal model prescribed by the Department of Health and are therefore subject to possible changes as some assumptions have been made around data input such as asset useful economic lives and elements surrounding component accounting. As the scheme falls within the scope of a service concession it has been accounted for under IFRIC 12. The asset is therefore accounted for as on statement of financial position.

Imputed "finance lease" obligations for on SoFP LIFT Contracts due

	31 March 2013 £000	31 March 2012 £000
No later than one year	**494**	497
Later than one year, no later than five years	**2,087**	2,045
Later than five years	**10,512**	11,046
Subtotal	**13,093**	13,588
Less: Interest element	**(6,787)**	(7,227)
Total	**6,306**	6,361

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT

	31 March 2013 £000	31 March 2012 £000
Service element of on SOFP LIFT charged to operating expenses in year	**260**	195
Total	**260**	195

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	**854**	822
Later than One Year, No Later than Five Years	**3,484**	3,411
Later than Five Years	**13,682**	14,378
Total	**18,020**	18,611

The lease plus arrangement for the three scheme states that the PCT has an option to purchase the LIFT asset at the end of the 25 year period at an adjusted market price. This price effectively measures the difference between the actual open market value at the end of the contract and the residual value of the asset. As the purchase option price for the three scheme is considerably lower than the fair value and residual value as per the LIFT Co model, a decision was made by the PCT to exercise the option to purchase the asset at the end of the term. This decision is further supported by the specialist nature of the building and how it meets the health needs of the local community.

The nature and extent of the LIFT Co arrangement is that of a Lease Plus Agreement (LPA) entered into by both Redbridge & Waltham Forest LIFT Company and the PCT in respect of a specific building in which the floor plan and space and configuration of the building for Hainault Health Centre has been determined and costed at the financial close. The LIFT LPA scheme is over a period of 25 years in which a base contract price has been set for the above at £435,000 per annum. The base contract price figure is then uplifted by the retail price index from the inception of the lease, up to the conclusion of the lease term to arrive at a nominal contract price for each year of the lease.

Under this joint arrangement, this affords the PCT the rights, and not the option to expect the provision of services in the maintenance of the LIFT scheme involving planned improvements and replacement programmes for e.g. lifecycle costs. Any failure on the part of the Redbridge & Waltham Forest LIFT Company to provide such services will contravene not only the relevant legislation, and regulations, but will give rise to a reduction in the lease plus payments where evidence of a landlord event of default has occurred.

In addition to the above, the LIFT contract offers the PCT the option and not the obligation to purchase the scheme at a price at the end of the term subject to adjustments to the actual open market value as stipulated by schedule 14 of the LPA contracts. Linked in with this option, is the granting to the PCT if it so wishes, a pre-emption right to purchase the scheme in line with schedule 14 of the Lease plus agreement. Similarly the PCT has the option and not the obligation to purchase as a result of any forced sale of shares of the scheme above in line with Schedule 14 of the contract. Lastly, the contract affords the PCT in the event of a landlord event of default for e.g. Redbridge & Waltham Forest Lift Company failing to achieve actual completion dates or abandoning works, the PCT can terminate the lease in its entirety by notice in writing having immediate effect subject to the provisions of the funder's direct agreement.

27 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	**213**	-	213
Interest Expense	**441**	-	441
Impairment charge - AME	**32**	-	32
Impairment charge - DEL	**-**	-	-
Other Expenditure	**417**	-	417
Total IFRS Expenditure (IFRIC12)	**1,103**	**-**	**1,103**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(858)**	-	(858)
Net IFRS change (IFRIC12)	**245**	**-**	**245**

28 Financial Instruments

Financial risk management
IFRS 7 financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks and entity faces in undertaking these activities.

The PCT is not exposed to significant financial risk factors arising from financial instruments. The main source of funding for PCT's are allocations (Parliamentary Funding) from the Department of Health within an approved cash limit. Other income principally comprises fees and charges for services provided to external customers, the majority of whom are within the NHS boundary. The way in which the PCT is financed, and its role as healthcare commissioner and provider, determines that it is not exposed to the degree of financial risk faced by business entities. Financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the PCT in undertaking its activities.

Market Risk
Market Risk is the possibility that financial risk might arise as a result of changes in such measures as interest rates and stock market movements. The PCT's transactions are all undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no significant investments other than short term bank deposits. Other than cash balance, the PCT's financial assets and liabilities carry no fixed rates of interest and the PCT's income and operating cash flows are consequently independent of changes in market interest rates.

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

Credit Risk

Credit risk is the possibility that other parties might fail to pay amounts due to the PCT. Credit risk arises from deposits with banks as well as credit exposures to the PCT's debtors. The PCT does not operate with surplus cash as this is drawn down from the Department of Health when needed for use. The PCT's cash assets are held within the Government banking service only. The PCT's net operating costs are incurred largely under annual service level agreements with local trusts and foundation trusts.

Liquidity Risk

Liquidity risk is the possibility that the PCT may not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding for an adequate amount of committed credit facilities. The PCT must draw down cash from its annual allocation when needed and it must not exceed this limit.

28 Financial Instruments continued

28.1 Financial Assets	Loans and receivables	Total
	£000	£000
Receivables - NHS	3,241	3,241
Receivables - non-NHS	238	238
Cash at bank and in hand	38	38
Other financial assets	1,132	1,132
Total at 31 March 2013	**4,649**	**4,649**
Receivables - NHS	6,217	6,217
Receivables - non-NHS	1,657	1,657
Cash at bank and in hand	20	20
Other financial assets	257	257
Total at 31 March 2012	8,151	8,151

28.2 Financial Liabilities	Other £000	Total £000
NHS payables	6,940	**6,940**
Non-NHS payables	7,555	**7,555**
LIFT obligations	6,306	**6,306**
Other financial liabilities	54	**54**
Total at 31 March 2013	**20,855**	**20,855**
NHS payables	6,871	6,871
Non-NHS payables	10,737	10,737
LIFT obligations	6,361	6,361
Total at 31 March 2012	23,969	23,969

29 Related party transactions

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

	2012-13		2011-12	
	Payments to related party £000	Receipts from related party £000	Payments to related party £000	Receipts from related party £000
Barking Havering & Redbridge NHS University Trust	88,732	-	87,647	-
Barts Health NHS Trust	77,359	60	74,420	-
North East London NHS Foundation Trust	44,306	1,508	40,209	820
Barking & Dagenham Primary Care Trust	8	724	5,329	2,827
London Ambulance Service NHS Trust	7,844	-	7,731	-
University College London Foundation Trust	7,872	-	6,686	-
NHS London	-	1,851	100	2,337
Great Ormond Street	3769	-	3,313	-
Waltham Forest Primary Care Trust	376	213	1,441	2,855
Croydon Primary Care Trust	18,541	4	15,123	2
Moorfields Eye Hospital	3294	70	2,950	-
Havering Primary care Trust	152	530	1,204	2324

	2012-13		2011-12	
	Amounts Owed to related party £000	Amounts due from related party £000	Amounts Owed to related party £000	Amounts due from related party £000
Barking Havering & Redbridge NHS University Trust	439	-	2,682	-
Barts Health NHS Trust	1,020	-	1,929	-
North East London NHS Foundation Trust	113	1,727	1,119	133
London Ambulance Service NHS Trust	-	22	27	-
Moorfields Eye Hospital	169	-	72	-
NHS London	14	-	9	503
Waltham Forest Primary Care Trust	-	165	254	1,791
Croydon Primary Care Trust	89	-	-	312
Havering Primary care Trust	29	267	466	1,071
Barking & Dagenham Primary Care Trust	-	74	191	1,408
Great Ormond Street	261	-	-	122
University College London Foundation trust	676	-	-	264

29 Related party transactions (cont'd)

Other entities are considered to be a related party if Redbridge Primary Care Trust can:

*have direct or indirect control of the other party

*have influence over the financial and operational policies of the other party; or the parties are subject to common control or influence from the same source.

The below individuals declared interests which related to the full financial year for the PCT unless stated.

Name	Position in sector	Name of organisation where interest held	Position held/interest held
Afzal Akram	Deputy Chair	London Borough of Waltham Forest	Elected Councillor and Cabinet Member
Lesley Buckland	Non Executive	Age Concern Havering	Trustee
Ken Aswani	Medical Director	Allum Medical Centre	Partner
Ken Aswani	Medical Director	NHJ Alliance	Member
Ken Aswani	Medical Director	RCGP	Member

30 Losses and special payments

The total number of losses cases in 2012-13 was nil, involving a total loss of £nil (2011-12 nil cases and £nil).

The total number of special payments in 2012-13 was nil, involving a total of £Nil (2011-12 nil cases and £nil).

31 Pooled Budgets

Redbridge PCT has the following pooled budget arrangements hosted by London Borough of Redbridge. Redbridge PCT has no assets or liabilities in respect of the pooled budgets as at 31 March 2013.

The PCT's shares of the income and expenditure handled by the pooled budget in the financial year were:	**2012-13 £000**	2011-12 £000
Learning Disabilities Partnership	3,916	4,256
Children Trust	1,349	7,714
Integrated Community Equipment Services	508	300
Mental Health	18,920	22,285

As of 1st June 2012 children's services transferred to North East London NHS Foundation Trust, as a result the pooled budget arrangement also transferred in respect of this service.

32 Independent Sector Treatment Centre

The PCT operates an Independent Sector Treatment Centre in partnership with PHG (North East London) Ltd, The Secretary of State for Health, Barking and Dagenham PCT, Redbridge PCT, Waltham Forest PCT and Barking, Havering and Redbridge Hospitals NHS Trust. Barking and Dagenham PCT hold these premises within their accounts at a value of £4,288,435 for Buildings and receive funding from the Department of Health in relation to capital charges incurred on this property.

The contract in respect of this service expired on 31st December 2011 and a new contract was awarded to PHG (North East London) Ltd. The current contract is due to expire on 31st December 2014.

Each party to the ISTC agreement made payments to PHG (North East London) Ltd. Redbridge PCT made payments of £3,508,427 in 2012/13 (2011/12 payments of £902,232 to PHG (North East London) Ltd and £3,851,413 to Barking and Dagenham PCT.

33 Events after the end of the reporting period

As disclosed within note 1.1 due to the Health and Social Care Bill as of 1st April 2013 Redbridge PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either a Commissioning Support Unit, Clinical Commissioning Group (CCG), NHS England, NHS Foundation Trusts or Local Authorities. Estates functions will be transferred to NHS Property Services Limited. Ultimate control will still reside with the Department of Health. CCGs will not have ownership of legacy debt.

The total taxpayers' equity of the PCT as at 31 March 2013 represented by the PCTs assets and liabilities will be split between different 'Receivers' as follows:

	Balances held by PCT at 31st March 2013 £000s	Department of Health £000s	Clinical Commissioning Groups £000s	Commissioning Board £000s	NHS Foundation Trusts £000s	NHS Property Services £000s	Community Health Partnerships £000s
	£000						
Non-current assets:							
Property, plant and equipment	35,022	-	419	434	3,348	24,389	6,432
Intangible assets	61	-	-	-	61	-	-
Other financial assets	254	-	-	-	-	-	254
Total non-current assets	35,337	-	419	434	3,409	24,389	6,686
Current assets:							
Trade and other receivables	4,905	4,905	-	-	-	-	-
Cash and cash equivalents	38	38	-	-	-	-	-
Total current assets	4,943	4,943	-	-	-	-	-
Total assets	40,280	4,943	419	434	3,409	24,389	6,686
Current liabilities							
Trade and other payables	(26,222)	(25,651)	(70)	-	-	(501)	-
Provisions	(5,161)	(585)	(4,576)	-	-	-	-
Borrowings	(56)	-	-	-	-	-	(56)
Total current liabilities	(31,439)	(26,236)	(4,646)	-	-	(501)	(56)
Non-current assets plus/less net current assets/liabilities	8,841	(21,293)	(4,227)	434	3,409	23,888	6,630
Non-current liabilities							
Borrowings	(6,250)	-	-	-	-	-	(6,250)
Total non-current liabilities	(6,250)	-	-	-	-	-	(6,250)
Total Assets Employed:	2,591	(21,293)	(4,227)	434	3,409	23,888	380
Financed by taxpayers' equity:							
General fund	(6,232)	(21,293)	(4,227)	434	2,347	16,654	(147)
Revaluation reserve	8,823	-	-	-	1,062	7,234	527
Total taxpayers' equity:	2,591	(21,293)	(4,227)	434	3,409	23,888	380

As at 31/05/13 Trade & Other Receivables have reduced by £4,797k from £4,905 to £108k. Trade & Other Payables have reduced by £10,410k from £26,222k to £15,812k

The majority of assets and liabilities (including all land and buildings) will transfer by way of a 'Sender' organisation's Transfer Schemes. A Transfer Scheme is an instrument in writing made by the Secretary of State under sections 300 to 302 of the Act. It can deal with the transfers of staff, property and liabilities between those entities as specified in Schedules 22 and 23 to the Act but unlike Transfer Orders does not need to be laid before Parliament.

Where functions transfer, any claim, liability and financial asset, which relate to that will follow. However NHS England will take historical NHS Litigation Authority (NHSLA) indemnified clinical negligence claims, including those incurred but not reported relating to new functions of CCG's or Local Authorities.

16 Independent auditor's report (external)

Independent Auditors' Report to the officer responsible for preparing the accounts of Redbridge Primary Care Trust

We have audited the financial statements of Redbridge Primary Care Trust ("the PCT") for the year ended 31 March 2013 which 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 the accounting policies directed by the Secretary of State for Health with the consent of the Treasury as relevant to the National Health Service in England set out therein.

Respective responsibilities of the officer responsible for preparing the accounts and auditors
As explained more fully in the Statement of Responsibilities the officer responsible for preparing the accounts is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with accounting policies directed by the Secretary of State, with the consent of the Treasury, as being relevant to the National Health Service in England. Our responsibility is to audit and express an opinion on the financial statements in accordance with Part II of the Audit Commission Act 1998, the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the officer responsible for preparing the accounts of Redbridge Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

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

Opinion on financial statements
In our opinion the financial statements:

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

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as being relevant to the National Health Service in England;

- 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; and

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

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the Code of Audit Practice issued by the Audit Commission requires us to report to you if:

- in our opinion, the Governance Statement does not comply with the Department of Health's requirements set out in "2012/13 Governance Statements – Guidance " issued on 31 January 2013 or is misleading or inconsistent with information of which we are aware from our audit; or

- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because 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.

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

Respective responsibilities of the PCT and auditors
The PCT is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the PCT has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the PCT has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the PCT's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

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

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Trust; and
- our locally determined risk-based work on governance, financial management, asset and information management, and workforce management.

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

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

Kevin Lowe, Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP
Appointed Auditors
7 More London Riverside,
London,
SE1 2RT

4 June 2013

17 External auditor's costs

Redbridge PCT's external auditor is Price Waterhouse Coopers. They were paid £100,829 (inclusive of VAT) in 2012/13 to carry out the statutory audit. In 2011/12 the fees were £168,048.

14 Annual governance statement

Name of organisation: Redbridge Primary Care Trust

The Board was accountable for internal control. During 2012/13 the Chief Executive of the Board had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives. She also had responsibility for safeguarding the public funds and the organisation's assets.

As Designated Signing Officer I have sought assurance from the Chief Executive of the PCT on these matters.

The Chief Executive of the PCT was accountable to the Chair of the PCT and the Chief Executive of the Strategic Health Authority. The Chief Executive was regularly performance managed through twice yearly performance appraisals undertaken by the Chair of the Board.

In addition, the Strategic Health Authority (NHS London) met regularly with the directors and the chief executive during the year to formally review performance on delivering the organisation's objectives. These meetings were formally minuted.

Systems and processes were in place to enable effective working with these partner organisations.

In recognition of the risk in establishing an appropriate management structure to manage seven PCTs as a cluster with robust governance arrangements and organisational form to deliver its objectives significant assurance was received from the internal auditors, RSM Tenon and Parkhill, that the cluster governance arrangements and controls upon which the organisation relies to manage the risk were suitably designed, consistently applied and effective.

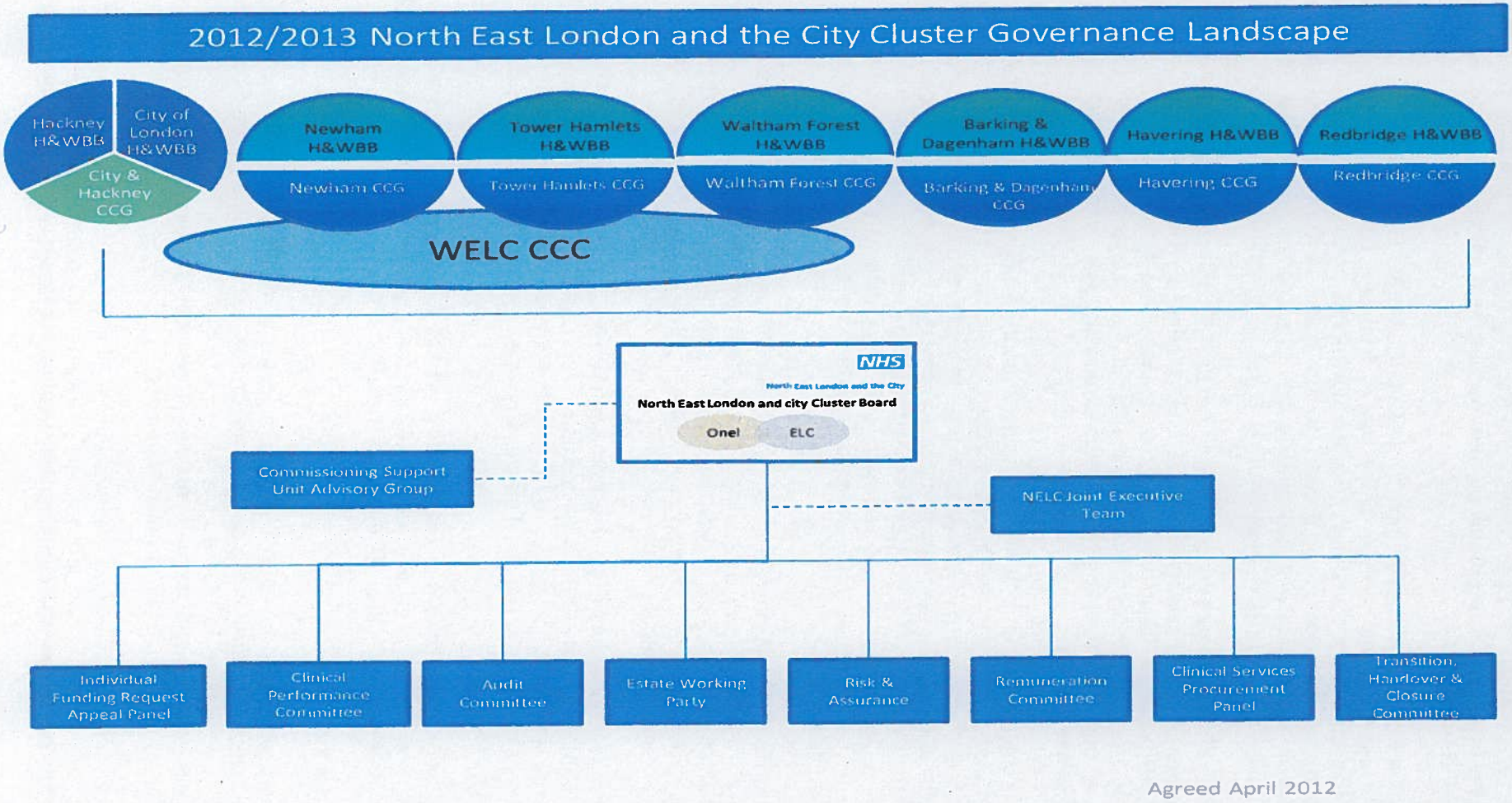
1. The governance framework of the organisation

The governance structure was designed to ensure that there was a balance between having robust governance arrangements for the organisation and being able to deliver an effective end state.

In January 2012 the boards of the seven PCTs in North East London and City agreed to work as a Cluster through an integrated management structure with effect from April 2012. This arrangement encompassed the Chair and non-executive director team being appointed across the seven PCTs and a single management team. The governance model met the requirements of the Department of Health guidance 'model 2'. These comply with the Corporate Governance Code without departure. Arrangements in place for the discharge of statutory functions have been checked for irregularities, and to ensure they are legally compliant.

The model was delivered through a joint committee structure from April 2012, shown below:

NHS North East London and City committee structure



Agreed April 2012

The Cluster Board for North East London and the City met on a bimonthly basis during 2012/2013 until March when two meetings were necessary to complete Board business and close down all seven PCTs.

The work of the Board was underpinned by a single Corporate Governance Framework for the transition year together with a single set of Standing Orders, Standing Financial Instructions and Scheme of Delegation. This framework has enabled the Cluster to conduct its business during a period of significant change in the NHS. It also supported the establishment of the Clinical Commissioning Groups as sub-committees of the Board and a robust Performance Management Framework to ensure accountability.

The Board's work has been supported by a number of committees as evidenced in the structure diagram. These committees have been chaired by Non-Executive Directors or Associate Non-Executive Directors. The role of Associate Non-Executive Director was created as part of the governance arrangements for the Cluster and has ensured that a wide range of non-executive knowledge and experience was retained and used in the assurance process.

The Audit Committee met on a bi-monthly basis through to September 2012 and then met monthly from October 2012 to March to strengthen assurance. It has been quorate on each occasion. It has considered internally and externally audit reports along with updates from the counter-fraud officer. It received updates and reviewed reports on finance, the Board Assurance Framework and Corporate Risk Register together with feedback from the Risk and Assurance Committee. It also reviewed work in relation to transition, handover and closure and from November 2012 received reports from the Transition, Handover and Closure Committee.

The Risk and Assurance Committee was established from April 2012 and met on a bi-monthly basis from May. The role of the Committee has been to review management action in relation to risks that impact on the delivery of the operating plans and the achievement of the corporate objectives in order to give assurance to the Board. The committee has been quorate on all occasions.

The Transition, Handover and Closure Committee chaired by a Non-Executive Director was established in October 2012 to provide additional assurance to the Board during the final months up until closure. It has met on a monthly basis since November and undertaken in depth reviews of plans, including the Transfer Schemes for staff, assets and liabilities and the closedown plans.

The Remuneration Committee met seven times in 2012/13 to consider matters relative to remuneration and terms of service of the senior management team and staff matters relating to handover and closure. All meetings were quorate.

3 Board effectiveness

All Board members were asked to complete a board evaluation questionnaire in March 2013. The questions covered the broad themes on the key functions of the Board. Board members were requested to indicate the extent to which they agreed or disagreed (to varying degrees) with the statements contained in the questionnaire. Board members also had the additional opportunity of providing comments.

Just over half of the Executive and Non-Executive Directors completed the questionnaire and their responses have been kept confidential. The general picture that emerges from the responses to the board evaluation questionnaire is that the Board is generally confident:

- that the members individually and collectively understand what is expected of them
- that it effectively carries out its functions in relation to its provision of strategic leadership to the organisation
- that it monitors the implementation of the strategic plan that it sets for the organisation
- that the Board provides leadership to the organization in the delivery of quality improvement
- that it is assured that a sound system of internal control and risk management is in place within the organisation and is functioning effectively
- that there is an effective working relationship between the Board and the management team
- that the Board has an effective working relationship with its internal and external stakeholders
- that Board members are satisfied that they make meaningful, informed and robust contributions to discussions at Board meetings and makes effective use of its meetings

4. Assurance

- Since 1 October 2012 the Board's Governance arrangements focused on the final phase of transition, handover and closure with assurance through CCG shadow governing bodies for performance and service development issues and the Director of Transition providing assurance for transition, handover and closure arrangements. Regular reports have been provided to the Board on transition and handover progress and the process for the formal transfer of assets and liabilities and staff to receiving organisations. The seven PCTs as sender organisations are transferring their functions, both statutory and non statutory to 47 other organisations. The process for making this transfer is through a legal transfer scheme, one for staff and one for assets and liabilities for each PCT that makes up the Cluster. The draft transfer scheme was approved by the Board at its final meeting in March 2013.

The Risk and Assurance Committee met for the last time on 27 February. At that meeting the Committee agreed to write to the chairs of the CCGs and the chairs of the CCG Audit Committees drawing their attention to the risks that would continue beyond the end of March and would be the receiving organisations' responsibility.

5. Risk assessment

5.1 Risk management strategy

The Cluster governance structure was designed to ensure that there was a balance between having robust governance arrangements for the organisation and being able to deliver an effective end state.

The risks to the achievement of the Cluster's Corporate Objectives were identified through the process detailed in the North East London and the City Risk Management Strategy. This document was created following a review of the risk management strategies for:

- The East London and the City (comprising City and Hackney PCT, Newham PCT and Tower Hamlets PCT) Risk Management Strategy, and
- Outer North East London (comprising Barking and Dagenham PCT, Havering PCT, Redbridge PCT and Waltham Forest PCT) Risk Management Strategy.

Elements of best practices from these documents in terms of: risk definitions, identification processes, templates and risk matrix were taken out and combined to create the NHS North East London and the City Risk Management Strategy. This was approved by the Board at its May meeting.

The Risk Management Strategy included a scoring and escalation process that ensures as far as reasonably practicable that there is a consistency of applied risk ratings across the organisation.

In analysing risks the risk rating takes the following into account:

- Cluster ability to deliver its objectives and projects
- Harm/Injury to patients, staff, visitors and others
- Potential for complaints/claims
- Service/business disruption
- Staffing and competence
- Financial
- Inspection/audit
- Adverse publicity

The risk assessment process draws on the best practice elements of ISO31000 and therefore embraces the concept of enterprise, integrated risk management in ensuring achievement of best outcomes. The Risk Management Strategy sets out the approach to risk which demands embedding risk within all business processes.

In moving forward the North East London and the City Risk Management Strategy has been adopted for use by several of the North East London and the City Clinical Commissioning Groups (CCGs). Additionally, the Cluster Board Assurance Framework was reviewed by the CCGs ensuring that where appropriate, risks were handed over.

5.2 Risk identification

The risks to the achievement of Cluster objectives were identified through two main processes.

- Review of the Board Assurance Frameworks from NHS East London and City and NHS Outer North East London and the City to identify risks, controls, assurances and gaps that remained a threat to NHS North East London and the City, and

- A risk assessment of the Corporate Objectives. The Cluster Board set its Corporate Objectives at the beginning of the 2012/13 year. Subsequent review meetings with the Directorate Risk Leads identified the risks, controls, assurances and gaps. From these discussions the risks were graded in line with the NHS North East London and the City Risk Management Strategy.

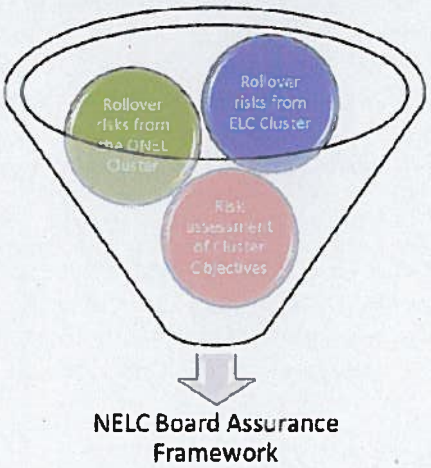


Figure 1 showing the 2 main processes that led to the creation of the NELC Board Assurance Framework

Supplementing this "top down" process of risk identification was that of Corporate Risk Register. Operational risks were identified at a Directorate level and added to the Corporate Risk Register. This process provided a "bottom up" view of risks that were both specific to the individual PCTs and those specific to the Cluster.

In September 2012 NHS London requested that all risks were categorised as at least one of the following:

- In year delivery
- Transition/Closure
- Decommissioning
- Zero Tolerance Risk

This categorisation was added to the Board Assurance Framework and the Corporate Risk register in quarter 3.

5.3 Accountability for risks

Individual Directors are held accountable for the risks associated with their Directorates. The Board Assurance Framework and Corporate Risk Register were refreshed quarterly through

meetings with the Directorate risk leads. Once reviewed and revised the documents were reported to the following bodies:

- Transition, Handover and Closure Committee
  This Committee retained oversight for all the risks pertaining to Transition, Handover and Closure.
  It met on a monthly basis from November 2012
- Risk and Assurance Committee
  This Committee reviews both the Board Assurance Framework and Corporate Risk Register in its entirety at least once a quarter to provide probity of the documents and thus the risks facing the organisation.
  This Committee also had the power to request "Deep Dives" to provide assurance to the Board that the Cluster has effective systems of internal control in relation to risk management and governance. The Committee held one deep dive on the issue of "Quality and handover to the CCGs".
  It met bi-monthly.
- Audit Committee
  The Audit Committee was responsible for reviewing the effectiveness of the internal control and risk management systems and received reports from management on the effectiveness of the risk systems that the Cluster had established.
- Cluster Board
  The Board received the Board Assurance Framework once a quarter to ensure that the Board retained oversight of all the risks to the achievement of the Corporate Objectives and allow Board members to challenge executives on areas of weak control, assurance or high risk rating.

5.4 Board Assurance Framework 2012/13

Key risks for Redbridge PCT identified during 2012/13 which populated the Board Assurance Framework (BAF) for 2012/13 and how their risk rating changed over the financial year are summarised below.

	Risk description	Initial risk	June 12	Aug 12	Nov 12	Mar 13
1.1	There is a risk that some public health targets (including screening) across PCTs will not be met					
1.2	Risk of overspend on revenue resource limit. Risk of not meeting agreed control target surpluses.					
1.3	Risk of financial consequences for future arising from the final year of PCTs, exit/closedown and the overall transition agenda.					
1.4	Ensure we support CCGs to deliver operating plans, QIPP and achieve key strategic aims in 2012/13.This is in relation to improvements in healthcare and financial management.					
1.5	CCG failure to manage all local healthcare providers with support from CSU and the cluster could result in key quality and performance not being achieved as well as the detriment of healthcare delivered to the local population.					
1.6	Failure to meet emergency care access standards at Barts Health could adversely affect service users and other organisations					
1.8	Maintaining an effective and proactive quality assurance					

	framework during periods of transition for both the provider and commissioner landscape across all provider groups					
1.9	Barts Health merger: failure of new, larger trust to deliver requisite levels of performance across all sites due to transition.					
2.1	Progress in quality improvement is not achieved in the timeframe set out and inability to sustain quality and safety of maternity services at BHRUT in the context of CIP and requirement to operate					
2.2	Failure to meet emergency care access standards at BHRUT/Queens Hospital adversely impacting on service users and other organisations					
2.3	Failure to deliver BHRUT 2012/13 financial plan – deficit reduced in line with plan to maximum £40m. Dependent on £23m CIP delivery and 10.3 commissioner QIPP delivery					
2.4	Failure to develop a clear plan for clinical and financial sustainability, including a plan to implement Health for North East London acute reconfiguration decisions					
3.1	Loss of talent and organisational memory in both sender and receiver organisations, leading to increased staff costs and the potential of new organisations unable to function and to take on their statutory and other roles by April 2013.					
3.2	There is risk that key performance issues regarding contractors are not managed effectively and key information is not passed on during transition due to delays in clarifying roles, structure and functions in the NHS Commissioning Board London Region and its local area teams.					
3.3	Divestment of remaining provider services and non-commissioning services – via procurement and other transfers. All transfers and procurements must be complete by 31 March 2013. Range and scope of the functions increases the risk.					
3.4	Information risks associated with records management, FoI timescales, Information Governance Toolkit requirements and data protection issues are not effectively managed during transition. Size and scope of records in the legacy PCTs increases this risk.					
3.5	Public Health transition to local authority end state is not achieved within required timescales (also see 3.2)					
3.6	Organisational memory on quality and safety (including safeguarding) is lost to the system and handover is ineffective.					
3.7	IM&T transition is not effectively aligned to transition end state in terms of asset transfer – potential issues around delays in deciding future arrangement of GP ICT at a London level.					
3.8	Failure to develop a robust and sustainable commissioning support organisation through migration					
4.1	There is a risk that the 2012 Olympics and Paralympics will impact on delivery of healthcare, thereby preventing business as usual.					

Risks to the achievement of the corporate objectives were determined at the beginning of the 2012/13 year and reported to the Board in May. From this a Board Assurance Framework (BAF) was constructed and reviewed at the July meeting and at every meeting through the year. The BAF focus was on risks across the system to the delivery of the corporate objectives; The Risk Register identifies risks on a PCT specific basis as appropriate.

The assessment of risks was undertaken in accordance with the Cluster's risk strategy and Board Assurance Framework. This included a risk scoring and escalation process that ensured as far as is practicably possible that there is consistency of applied risk ratings across the organisation. In depth scrutiny of the BAF was undertaken by the Risk and Assurance committee. This Committee had undertaken a "deep dive" challenge into particular areas of risks, for example quality and safety and has held individual directors to account for the risks associated with their areas of responsibility.

The Assurance Framework was comprehensive in scope, covering the key operational areas of the PCT. Through its inclusion of zero tolerance and horizon scanning risks it ensured the assurances around risk prevention, risk deterrence (eg fraud related risks) and the management of manifested and potential risks.

The Framework was consistent with the template promulgated by the Department of Health and explicitly maps objectives against pertinent risks, controls and assurances. It also describes the ways in which public stakeholders are involved in managing risks which impact on them.

Risks to data security were managed by the Information Governance team. This had limited resources during the year and an audit of the Information Governance Toolkit highlighted a number of deficiencies. These deficiencies were addressed but in the limited time available it was only possible to achieve Level 1 compliance by the end of March 2013.

5.5 Corporate Risk Register

The 12/13 BAF was supplemented by a corporate risk register which highlighted other corporate risks as follows:

- Insufficient and ineffective communications during the transition may lead to some staff, stakeholders and the public not understanding the changes
- Review of creditors and debtors as part of the formal "winding up" process may necessitate write of uncollectable debts and non-payable income potentially causing waste of Cluster finances, loss of reputation and potential adverse media attention.
- Information Governance risks relating to non-compliance with the Information Governance Toolkit.

These corporate risks have been managed as follows:

- The delivery team for Transition, Handover and Closure put in place relationship managers to ensure there was effective communication with receiving organisations. Regular bulletins have been issued to staff and public communication statements issued in the local press and on website
- A finance closedown team has been put in place to manage "wind up" effectively
- Remedial action was taken to ensure compliance with Information Governance Toolkit by 31 March 2013. Lessons learn from the deficiencies have been

passed on the CCGs and the CSU to inform their IG toolkit compliance for 2013/14

5.6 The Risk and control framework

The Board has considered and developed an Assurance Framework as part of the overall Business Planning cycle. Throughout the year, the Assurance Framework has been continuously amended and updated to refine and develop strategic understanding of the assurance agenda and its various requirements.

A rolling review of the Assurance Framework for 2012/2013, carried out by the PCT's internal auditors, RSM Tenon and Parkhill has demonstrated that there is an effective system of internal control to manage the principle risks identified by the organisation. However it notes that there is scope for some improvement when articulating the mechanisms that provide assurances that the controls put in place to manage risks are indeed effective. The specific issues that have been highlighted for improvement are listed below:

i. Information Governance

ii. Continuing Care

6. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.

For 2012 / 13 the Head of Internal Audit has advised me that based on the work undertaken in 2012/13, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

However, he has issued an Information Governance report with a RED opinion rating whilst at the same time noting that we are drawing up a response to the recommendations made which we expect to mitigate any gaps in controls identified moving forwards.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

- The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by other sources including;
- Scrutiny from our external auditors
- Information Governance Assurance tool kit compliance submission
- The Cluster's internal monitoring and review process for its quality of commissioned services described in the Department of Health's Operating Framework and delivered through the Risk and Assurance Committee
- Reports by Internal and External Audit and the results of Patient and Staff Surveys

delivered through the Risk and Assurance Committee

- Reports by Internal and External Audit and the results of Patient and Staff Surveys
- Annual Care Quality Commission (CQC) assessment for safeguarding children
- Local Safeguarding Children Board (LSCB) annual report
- Robust incident and complaints monitoring processes, ensuring compliance with national Serious Incident reporting.
- NHS London's review of the plans to support the 2012/13 QIPP programme and consequential financial impacts at both PCT and Outer North East London levels
- Assurance on fraud and potential fraud is provided through the work of the local counter fraud officer who provides updates, communications and training on all appropriate counter fraud issues to PCT staff and emerging CCG pathfinder organisations.
- My review confirms that Redbridge PCT has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.
- The Audit Committee provides the Board with an independent and objective view of arrangements for internal financial control within the PCT, ensuring that the Internal Audit service complies with mandatory auditing standards including the review of all fundamental financial systems.
- The Board and Executive Directors have managed and reviewed their principal risks through their Performance reviews both with NHS London and the cluster's Operating Plan and the Business Planning process and their contribution to the development of the Assurance Framework.

The gaps in control and assurance identified within the Assurance Framework are the subject of action plans which are approved by the Board.

Significant Issues

The following significant control issues during the year 2012/13 have taken place:

- Deficiencies in compliance with the Information Governance Toolkit. With remedial action in year the PCT only achieved level 1 compliance.
- The backlog in continuing care assessments carries significant financial risks for ONEL CCGs.

Peter Coates CBE
Designated Signing Officer