Department of Health

NHS

Sutton and Merton Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

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Sutton and Merton Primary Care Trust

2012-13 Annual Report

NHS

South West London

NHS Sutton and Merton
Annual Report 2012/13

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1. Welcome

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

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

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

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

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

Section 3

Introduction from CCG Chair, Vice Chair and CCG Lead

2. Introduction from CCG Chair, Vice Chair and CCG Lead

This has been Sutton and Merton PCT's final year of operation. Across the country, from April 2013, local commissioning became the responsibility of Clinical Commissioning Groups, GP-led organisations responsible for spending the local NHS budget, and ensuring that local health services meet the needs both of individual patients and of the community. At the same time, we have worked hard to deliver high-quality care for our boroughs.

At the start of the year it became clear that Sutton and Merton would need to split into two CCGs in order to meet the co-terminosity requirements of the government's reforms. This led to the formation of two separate clinical commissioning groups one for each borough. They have been operating in shadow form since April 2012, building local relationships, setting their priorities and business plans for the coming year, establishing their Boards, and making sure that they were ready to take on their new responsibilities in the new health system.

For Sutton this was the first time the practices from across the whole of Sutton had come together like this and we have achieved a great deal over the last year. For the first time we have been actively involved in the development of Sutton's Joint Strategic Needs Assessment (JSNA), providing us with vital insights into our local population that we can use to inform our commissioning decisions as we go forward. We have been part of the successful programme of 'turnaround' for Sutton and Merton PCT and helped to deliver a QIPP programme of £22m over the last two years; this means that we will start life as a CCG in a strong financial position.

We have worked hard to make a difference to the areas that we know matter to patients; we have low waiting times for planned care, we have helped to reduce the number of unplanned admissions into hospital as well as lowering the number of admissions for people with a long-term condition.

We continue to look for new opportunities and new ways of improving local health and health care services. We have introduced a number of innovative services such as the 'virtual' Cardiology testing. Sutton is the location for the first of four new local health care centres, the Jubilee Health Centre that opened in May 2012 and was officially opened by David Weir, Paralympic Champion, in October 2012.

One of the biggest challenges for many of the local CCGs, but particularly for us here in Sutton, is south west London's Better Services Better Value reconfiguration programme. A number of our members sit on various BSBV working groups and will continue to do so until the work is complete. In the coming months there may be public consultation on BSBV if the six south west London CCGs and Surrey Downs CCG unanimously agree on the proposals.

More recently our focus has been on the establishment of the CCG itself and making sure that we have established robust systems and that we are fully staffed. On 15 February 2013 we were authorised as a CCG, declaring us ready to take on the commissioning role for Sutton from 1 April 2013. To make this new system work it is vital that we engage with the GPs from across our 28 member practices, a wider circle of local doctors and nurses from other local NHS providers, and our patients. We want to make sure that we have robust ways of talking and listening to our stakeholders and patients so that we can incorporate their views into everything we do.

In Merton, we have continued to build on the Better Value Closer to Home programme, designed to modernise health care and bring services together in new, specially-designed Local Care Centres (LCCs) to improve access and convenience for patients. Planning consent for an LCC on the Nelson hospital site was granted in December 2012 and the business case agreed with NHS London in March 2013. Work is progressing on developing the LCC in Mitcham, looking at an alternative to the Wilson Hospital site with better access to public transport.

We are delighted that the Learning Disabilities programme is almost complete, with the final development of supported living self-contained flats close to south Wimbledon underground station now open.

Other achievements in Merton this year include continuing to drive up performance, working with clinicians at St Helier to redesign the rheumatology service to support patients to self-administer their drug at home, saving them the journey to the hospital; and a new fracture liaison service at Epsom and St Helier aimed at reducing falls in older people. Epsom and St Helier NHS Trust also reduced turnaround times for cervical screening services. The Trust performed well in a recent audit of acute hospitals in south west London.

Our work to ensure patients at the end of their life are able to receive care and die in their preferred place of death has resulted in a marked increase in residents who are on the Coordinate My Care register being able to die in their preferred place.

In order to respond to our diverse population and ensure they access services appropriately we have set up an ethnic diversity project.

For the CCG, we have achieved a great deal in a short time in setting up the organisation, with its Board and constitution, and establishing relationships, both within the borough, in neighbouring CCGs and across the capital as a whole.

The 26 practices in Merton are fortunate in having a history of working together in practice-based commissioning groups, and we have been able to build on and enhance these existing relationships. All the Merton practices took part in a series of member events where we developed our commissioning intentions, based on the Joint Strategic Needs Assessment.

We also held face-to-face meetings for different groups of staff: practice nurse forum, practice manager meetings, GP leads forum to ensure that staff across the system were able to hear about and contribute to developments.

Equally important was engaging with patients and the public. We held a range of public meetings, events and surveys to identifying Merton residents' health needs and aspirations and involve them in decisions about priorities and strategies. Key to this was our mental health consultation, and the major Health and Wellbeing Strategy consultation, where we worked in partnership with the London Borough of Merton to consult through their Merton i-information portal.

Both Sutton CCG and Merton CCG received authorisation in February. Our preparation and engagement mean that the CCG can take on its statutory responsibilities with a set of agreed priorities and an operating plan genuinely based on local need.

Section 3

Who we are and what we do

3. Who we are and what we do

Sutton and Merton PCT was the statutory organisation responsible for commissioning and monitoring NHS services in the two boroughs. Under the Health and Social Care Act 2012, PCTs ceased to operate in April 2013, with most of their functions transferring to clinical commissioning groups. In preparation for this, the five PCTs in South West London have been working together since April 2012 as NHS South West London to share one management team, resources, roles and other functions.

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

3.1. How we spent your money

Introduction

The PCT commissions and provides healthcare services to meet the needs and improve the health of the population of the London Borough of Sutton & Merton. This healthcare is purchased from a wide variety of NHS and non NHS Providers across London. The main NHS providers are Epsom & St Helier University Hospitals NHS Trust, St George's Healthcare NHS Trust, South West London and St Georges Mental Health Trust, and The Royal Marsden NHS Foundation Trust. In addition, the PCT pays for services from Primary Care Practitioners such as GPs, Dentists, Pharmacist and Opticians.

The PCT faced significant financial pressure in 2012/13 as it dealt with historic levels of expenditure and lower levels of growth. To counteract this, the PCT developed a £19.1m Quality, Innovation, Productivity and Prevention (QIPP) Programme, which was designed to address the immediate financial challenges.

Performance against the budget is monitored throughout the year, allowing prompt action to be taken to alleviate any further financial pressures and make use of any financial benefits that should arise. The outturn for the PCT for 2012/13 is year is a surplus of £4.6m.

This surplus is slightly in excess of the control total set for the year of £4.5m.

2012/13 Financial Performance

The PCT achieved financial balance in 2012/13,

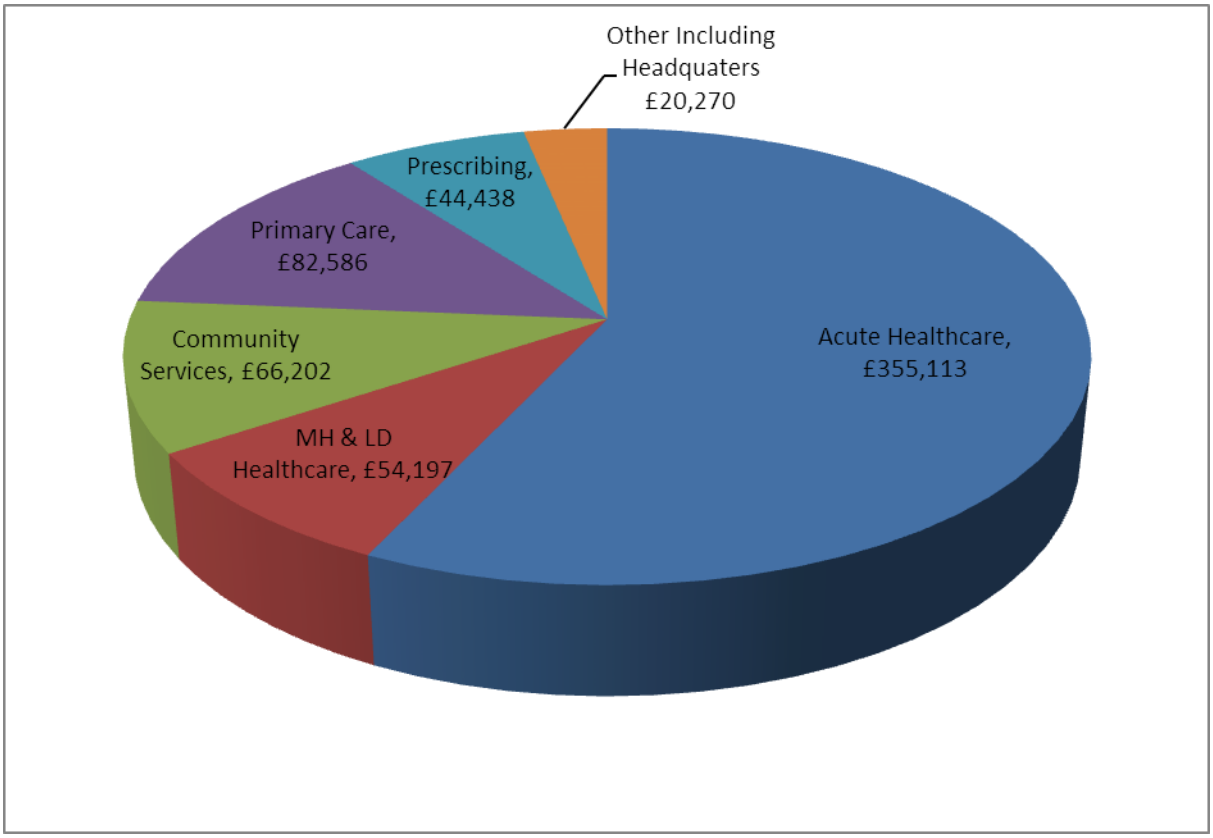
The following section outlines achievement against its other financial targets:

- Remaining within its Capital Resource limit, with an under spend of £5.8m. (Annual Accounts Note 3.2). The surplus arose mainly as a result of contingency planning actions related to the disposal of the Nelson Hospital Car Park.

- The PCT has underdrawn £9.2m against its cash limit and therefore has remained within the cash resources allocated to the PCT (Annual Accounts Note 3.4).

- Compliance with the Better Payment Practice code shows that 84.8 per cent of non-NHS invoices by number were paid on time in 2012-13 (Annual Accounts Note 8.1).

The 2012/13 expenditure has been incurred on following healthcare groups:
All Expenditure in £'000s



Financial Plans 2013/14

NHS Sutton & Merton (SMPCT) as a statutory financial body ceased to exist after 31st March 2013 and has been replaced in part by new Clinical Commissioning Groups (CCGs). CCG's were established by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients.

CCGs will operate by commissioning healthcare services including:

- Elective hospital care.
- Rehabilitation care.
- Urgent and emergency care.
- Most community health services.
- Mental health and learning disability services.

NHS Sutton & Merton (SMPCT) has been replaced by two new CCGs, NHS Merton CCG and NHS Sutton CCG, and these new organisations will take the lead for commissioning the services listed above.

Other areas previously commissioned by the PCT will now be commissioned by either NHS England, Public Health England, NHS Property Services or Local Authorities, these services include:

- Primary healthcare including GP contractual payments, dental, pharmacy and ophthalmic services.
- Secondary care dental services.
- Specialist commissioning.
- Public health services.
- NHS Estate services.

The CCGs will be expected to maintain recurrent financial balance by keeping expenditure within is resource limits. They will also be required by the operating framework to deliver financial targets of a 0.5% contingency, 1.0% planned surplus and a 2% non-committed transition fund.

NHS Sutton CCG & NHS Merton CCG start 2013/14 with a challenging financial year. Rigorous financial control and the delivery of a challenging QIPP plan are required to deliver the required 1.0% planned financial surplus. Additionally both CCGs need to plan to build contingency reserves to balance risk associated with delivering key initiatives and changes in the financial regime. Achieving this level of financial health is a key priority.

For 2013/14 both Merton CCG and Sutton CCGs immediate priority is to deliver in year financial balance with challenging QIPP plans of £7.5m and £7.1m respectively.

The key risks in achieving a balanced position over the medium term are as follows:

- Underlying demand for acute hospital services growing by no more than 2% per annum.

- Delivering and extending the QIPP Plan in 2013/14.

- Ensuring that costs follow funding under the new NHS finance regime.

The following table shows the planned spend for both CCGs for 2013/14

Financial Projections for 2013/14

	Merton CCG 2013/14 Plan £m	Sutton CCG 2013/14 Plan £m
Acute Commissioning	124.31	124.52
Mental Health & LD Commissioning	22.57	23.21
Community Services	23.53	23.81
Primary Care	1.44	1.88
Prescribing	22.15	21.71
Other Inc Reserves	7.17	6.99
Management Costs	4.96	4.50
Total Expenditure	**206.13**	**206.62**
Resources Available	208.21	208.71
Surplus	**2.08**	**2.09**

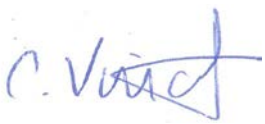
Principles for Remedy

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

Annual Accounts - Summary Financial Statements

The following statements represent a summary of financial information for Sutton and Merton Primary Care Trust for the year ended 31 March 2013. For a full understanding of the financial position and performance, the full accounts are available on request from: Director of Finance, NHS Sutton & Merton, 4th Floor, 120 The Broadway, Wimbledon, SW20 1RH. They are also available on the PCT website at www.suttonandmerton.nhs.uk

Signed on behalf of the Board



Carl Vincent
Director of Provider Finance & Transition
Department of Health

4 June 2013

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH's ACCOUNTING OFFICER IN RESPECT OF SUTTON & MERTON PRIMARY CARE TRUST

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

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

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

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

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

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

Opinion

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

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

Annual Accounts - Summary Financial Statements

Operating Cost Statement For The Year Ended 31st March 2013

	2012/13 £000	2011/12 £000
Programme		
Employee benefits	**1,342**	1,802
Other costs	**618,994**	598,800
Less: Income	**(13,769)**	(10,755)
Net Operating Costs for the Financial Year	**606,567**	589,847
Administration		
Employee benefits	**4,550**	4,138
Other costs	**17,421**	15,123
Less: Income	**(6,973)**	(6,997)
Net Operating Costs for the Financial Year	**14,998**	12,264
Total		
Employee benefits	**5,892**	5,940
Other costs	**636,415**	613,923
Less: Income	**(20,742)**	(17,752)
Net Operating Costs for the Financial Year	**621,565**	602,111
Other (gains)/losses	**143**	(549)
Finance costs	**1,098**	694
Net operating costs for the financial year	**622,806**	602,256

Note 3. Financial Performance Targets

	2012/13 £000	2011/12 £000
3.1 Revenue Resource Limit		
Total Net Operating Cost for the Financial Year	**622,806**	602,256
Revenue Resource Limit	**627,423**	608,713
Underspend Against Revenue Resource Limit	**4,617**	6,457
3.2 Capital Resource Limit		
Capital Resource Limit	**795**	1,898
Charge to Capital Resource Limit	**(5,016)**	1,125
Underspend Against Capital Resource Limit	**5,811**	773
3.4 Under/(Over)spend against cash limit		
Total charge to Cash Limit	**611,380**	590,155
Cash Limit	**620,580**	599,535
Under/(Over)spend Against Cash Limit	**9,200**	9,380

Balance Sheet Statement of Financial Position at 31 March 2013

	31 March 2013 £000	31 March 2012 £000
Non-current assets:		
Property, plant and equipment	**37,439**	47,465
Intangible assets	**547**	436
investment property	**0**	0
Other financial assets	**2**	2
Trade and other receivables	**357**	408
Total non-current assets	**38,345**	48,311
Current assets:		
Inventories	**0**	0
Trade and other receivables	**2,077**	20,114
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**4,165**	35
Total current assets	**6,242**	20,149
Non-current assets held for sale	**0**	8,000
Total current assets	**6,242**	28,149
Total assets	**44,587**	76,460
Current liabilities		
Trade and other payables	**(32,648)**	(44,220)
Other liabilities	**0**	0
Provisions	**(2,879)**	(606)
Borrowings	**(181)**	(169)
Other financial liabilities	**0**	0
Total current liabilities	**(35,708)**	(44,995)
Non-current assets plus/less net current assets/liabilities	**8,879**	31,465
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(2,810)	(3,724)
Borrowings	(7,824)	(8,073)
Other financial liabilities	0	0
Total non-current liabilities	**(10,634)**	(11,797)
Total Assets Employed:	**(1,755)**	19,668
Financed by taxpayers' equity:		
General fund	(11,097)	(6,854)
Revaluation reserve	9,342	26,522
Other reserves	0	0
Total taxpayers' equity:	**(1,755)**	19,668

Statement of cash flows for the year ended
31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(621,565)**	(602,111)
Depreciation and Amortisation	**2,866**	2,829
Impairments and Reversals	**36**	4,083
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(606)**	(694)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**2,169**	8,005
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(10,310)**	(8,592)
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(3,614)**	(627)
Increase/(Decrease) in Provisions	**4,480**	135
Net Cash Inflow/(Outflow) from Operating Activities	**(626,544)**	**(596,972)**
Cash flows from investing activities		
Interest Received	**0**	86
(Payments) for Property, Plant and Equipment	**(3,971)**	(1,113)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**7,582**	7,933
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**3,611**	**6,906**
Net cash inflow/(outflow) before financing	**(622,933)**	**(590,066)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(236)**	(90)
Net Parliamentary Funding	**611,380**	590,155
Capital Receipts Surrendered	**0**	0
Capital grants and other capital receipts	**15,919**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**627,063**	**590,065**
Net increase/(decrease) in cash and cash equivalents	**4,130**	**(1)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**35**	**36**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**4,165**	**35**

Annual Accounts: Summary Financial Statements

Better Payment Practice

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

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**10,903**	**63,920**	11,031	50,592
Total Non-NHS Trade Invoices Paid Within Target	**8,992**	**54,194**	10,170	45,728
Percentage of NHS Trade Invoices Paid Within Target	**82.47%**	**84.78%**	**92.19%**	**90.39%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,409**	**483,013**	4,068	438,341
Total NHS Trade Invoices Paid Within Target	**3,923**	**478,408**	3,395	397,972
Percentage of NHS Trade Invoices Paid Within Target	**88.98%**	**99.05%**	**83.46%**	**90.79%**

The PCT is an approved signatory to the Prompt Payment Code.

There were no amounts arising from claims made by businesses under the Late Payment of Commercial Debts (Interest) Act 1998 Legislation.

PCT Administration Costs

The PCT's Administration costs in 2012-13 were £15.0m (2011-12: £12.3m). These accords with the Department of Health's definition of administration costs. As well as the cost of the PCT's management teams, this total includes central functions such as Clinical Governance, Public Health and recharges from the South West Lo0nd Cluster. The PCT's weighted population (number of patients registered with the PCT's practices weighted for age and deprivation in accordance with a nationally accepted formula) is 341,069 (2011-12 341,069). The PCT's management cost per head of weighted population is £45.30 (2011-12: £35.96).

Sickness Absence (Financial Statements Note 7.3)

Total days lost through sickness in 2012/13 amounted to 850 days, (2011/12 - 384 days). This equates to an average of 10 days per whole time equivalent employee (2011/12 - 5 days).

Auditors

The PCT's external auditor is Grant Thornton. In 2012/13 fees charged in respect of the annual financial audit amounted to £111,777.

Audit Committee Members

As part of the governance arrangements for NHS South West London, a Governance Framework was developed to enable five statutory PCTs to function in a cluster operating arrangement; this received NHS London and legal assurance of compliance with primary and secondary legislation governing PCTs, and also with the Cluster Implementation Guidance published by the Department of Health.

In line with the arrangements, a Joint Audit Committee was established that provides the PCT statutory Boards with an independent and objective review on their financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.

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

With the impending abolition of Primary Care Trusts on 31 March 2013, the Department of Health sought nominations for membership of a (local) Audit Sub Committee which would oversee legacy governance arrangements and the sign-off of 2012-13 Accounts between 1 April and 30 June 2013. For south west London, the appointed non-executive directors were Paul Gallagher (Chair), Toni Letts, John Simpson and Vidya Verma OBE. All four were members of the Joint Audit Committee for NHS South West London.

Remuneration Committee Members

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

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

Related Party Transactions

During the year, two Board Members have undertaken transactions with the PCT as set out below:

	2012/13		2011/12	
	Payments to related party	**Amounts owed to related party**	Payments to related party	Amounts owed to related party
	£	**£**	£	£
Dr Howard Freeman (PMS contract)*	**770,604**	**12,345**	669,523	30,615
Dr Martyn Wake (PMS contract)	**1,871,869**	**45,774**	1,632,656	84,868

* In addition, Dr Freeman is a partner in a practice that is part of the South West London Primary Care Organisation. The Primary Care Trust made PMS contract payments to the South West London Primary Care Organisation of £2,268,294 in 2012/13 (£9,081,526 in 2011/12). The amounts shown above are Dr Freeman's practice's share of this total contract payment.

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

	2012/13		2011/12	
	Expenditure with related party	**Revenue from related party**	Expenditure with related party	Revenue from related party
	£000	**£000**	£000	£000
London Strategic Health Authority	**2**	**2,282**	125	2,075
Epsom & St Helier University Hospitals NHS Trust	**142,468**	**-**	138,914	10
St Georges Healthcare NHS trust	**104,645**	**-**	99,665	-
Kingston Hospital NHS Trust	**9,866**	**-**	10,954	-
The Royal Marsden Hospital NHS Foundation Trust	**63,109**	**4,248**	56,714	3,651
South West London and St George's Mental Health NHS Trust	**33,932**	**-**	35,523	145
Wandsworth Teaching Primary Care Trust	**8,659**	**4,260**	5,784	2,941

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

	2012/13		2011/12	
	£000	**£000**	£000	£000
	Expenditure with related party	**Revenue from related party**	Expenditure with related party	Revenue from related party
London Borough of Merton	**6,962**	**557**	6,894	130
London Borough of Sutton	**7,889**	**85**	6,155	307

The PCT acted as corporate Trustee for the Sutton and Merton Primary Care Trust Charity. The Charitable Funds were passed to the management of Sutton CCG on the 3rd April 2013.

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

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

REMUNERATION REPORT

Remuneration Committee

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

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

Remuneration Policy

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

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

Basic Salary

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

The reward package set by the Very Senior Management Pay Framework is as follows:

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

Incentive Arrangements

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

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

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

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

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

Level of Awards

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

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

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

NHS Pension Entitlement

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

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

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

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

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

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

The banded remuneration of the highest paid director in the financial year 2012/13 was £217,500 (2011/12, £207,500). This was 4.4 times (2011/12, 4.2 times) the median remuneration of the workforce, which was £49,605 (2011/12, £49,605).

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

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

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

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

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

Executive Director	Role	Contract Date	Leave date
Ann Radmore	Chief Executive	28/02/2011	06/01/2013
Christina Craig	Interim Chief Executive	07/01/2013	31/03/2013
Jill Robinson	Director of Finance	28/02/2011	31/03/2013
Dr Val Day	Director of Public Health	09/03/2011	31/03/2013
Dr Martyn Wake	Joint Chair of the Professional Executive Committee	01/04/2002	31/03/2013
Dr Howard Freeman	Joint Chair of the Professional Executive Committee	01/04/2002	31/03/2013
Debbie Stubberfield	Director of Nursing	01/02/2012	31/03/2013

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

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

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

Termination Arrangements

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

Non Executive Directors

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

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

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

The Non Executive appointments became effective on the following dates:

Non Executive Director	Role	Contract Date	Leave date
Sian Bates	Chair	01/04/2011	31/03/2013
Paul Gallagher	Audit Committee Chair	01/04/2011	31/03/2013
Peter Derrick	Non Executive Director	01/04/2011	31/03/2013
Joy Tweed	Non Executive Director	01/04/2011	31/03/2013
John Thompson	Non Executive Director	01/04/2011	31/03/2013
David Knowles	Partner Non Executive Director	01/04/2011	31/03/2013
Vidya Verma	Partner Non Executive Director	01/04/2011	31/03/2013

Expenses and Benefits in kind - Unaudited

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

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

Sutton & Merton Primary Care Trust

Directors' and Senior Managers' salaries and allowances

NAME AND TITLE	Note	2012/13 Salary (bands of £5,000) £000	2012/13 Other remuneration (bands of £5,000) £000	2012/13 Benefits in kind (to the nearest £100) £	2011/12 Salary (bands of £5,000) £000	2011/12 Other remuneration (bands of £5,000) £000	2011/12 Benefits in kind (to the nearest £100) £
Chair and Non Executive							
Sian Bates (Chair - from 01/04/11)	1	-	10-15	-	-	10-15	-
Paul Gallagher (Audit Committee Chair)	2	-	0-5	-	-	0-5	-
Peter Derrick (Non Executive)		-	10-15	-	-	10-15	-
Joy Tweed (Non Executive)		-	5-10	-	-	5-10	-
John Thompson (Non Executive)		-	5-10	-	-	5-10	-
David Knowles (Partner Non Executive)	3	-	-	-	-	-	-
Vidya Verma (Partner Non Executive)	3	-	-	-	-	-	-
Executive Directors							
Ann Radmore (Chief Executive - to 06/01/13)	4	30-35	-	-	35-40	-	-
Christina Craig (Interim Chief Executive - from 07/01/13)	5	5-10					
Jill Robinson (Director of Finance)	6	30-35	-	-	30-35	-	-
Dr Val Day (Director of Public Health)	7	215-220	-		205-210	-	4,200
Dr Martyn Wake (Joint Chair of the Professional Executive Committee)		10-15	-	-	10-15	-	-
Dr Howard Freeman (Joint Chair of the Professional Executive Committee)		10-15	-	-	10-15	-	-
Sarah Timms (Director of Nursing - from 29/06/11 to 15/12/11)		N/A	-	-	5-10	-	-
Debbie Stubberfield (Director of Nursing - from 01/02/12)	8	25-30	-	-	0-5	-	-
Senior Managers							
Penny Taylor (Borough Managing Director - Merton - to 30/11/11)		N/A	-	-	55-60	-	-
Adam Wickings (Borough Managing Director - Sutton and Merton to 05/08/12)		25-30	-	-	75-80	-	-
Bill Gillespie (Director of Strategy and Performance - to 19/02/12)		N/A	-	-	30-35	-	-
Dominic Conlin (Managing Director ACU - to 31/12/11)		N/A	-	-	20-25	-	-
Dr Jonathan Hildebrand (Cluster Director of Public Health)	9	10-15	-	-	5-10	-	-
Dr David Finch (Joint Medical Director)	10	15-20	-	-	15-20	-	-
Dr Howard Freeman (Joint Medical Director)	11	15-20	-	-	15-20	-	-
Charlotte Gawne (Director of Communications)	12	20-25	-	-	20-25	-	-
Jacqui Harvey (Director of Transition)	13	40-45	-	-	40-45	-	-
Jocelyn Fisher (Director of Human Resources, OD and Workforce)	14	30-35	-	-	40-45	-	-
Paula Swann (Director of Financial Management)	15	0-5	-	-	10-15	-	-
Neil Ferrelly (Director of Strategic Financial Planning - to 14/08/11)		N/A	-	-	5-10	-	-
Hardev Virdee (Director of Strategic Financial Planning - from 02/01/12 to 30/06/12)	16	5-10	-	-	5-10	-	-
Neil Roberts (Director of Primary Care Contracting)	17	20-25	-	-	20-25	-	-

Notes

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

Sutton & Merton Primary Care Trust

Directors' and Senior Managers' pension benefits

NAME AND TITLE	Note	Real increase in pension at age 60 (bands of £2,500) £000	Real Increase in lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 at 31 March 2013 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase in cash equiv transfer value funded by employer £000
Executive Directors								
Ann Radmore (Chief Executive)	5	0-2.5	0-2.5	10-15	40-45	290	260	10
Christina Craig (Interim Chief Executive)	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jill Robinson (Director of Finance)	7	0-2.5	0	0-5	0	28	20	4
Dr Val Day (Director of Public Health)	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr Martyn Wake (Joint Chair of the Professional Executive Committee)	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr Howard Freeman (Joint Chair of the Professional Executive Committee)	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debbie Stubberfield (Director of Nursing)	9	0-(2.5)	0-(2.5)	10-15	30-35	231	N/A	N/A
Senior Managers								
Dr Jonathan Hildebrand (Cluster Director of Public Health)	10	0-2.5	0-2.5	0-5	5-10	59	54	1
Dr David Finch (Joint Medical Director)	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr Howard Freeman (Joint Medical Director)	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Charlotte Gawne (Director of Communications)	11	0-2.5	0-2.5	0-5	10-15	59	53	2
Jacqui Harvey (Director of Transition)	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jocelyn Fisher (Director of Human Resources, OD and Workforce)	12	0-2.5	0	0-5	0	6	0	4
Hardev Virdee (Director of Strategic Financial Planning)	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Neil Roberts (Director of Primary Care Contracting)	14	0-2.5	0-2.5	5-10	25-30	192	176	4

Notes

1. As non-executive members do not receive pensionable remuneration, there are no disclosures in respect of pensions for them.

2. There were no employer's contributions to stakeholder pensions in 2012/13.

3. Cash Equivalent Transfer Values
   A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing

additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

4. Real increase in CETV
   This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
5. Ann Radmore was also Chief Executive of Croydon, Kingston, Richmond & Twickenham and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £55,000 - £60,000; the full value of her lump sum at age 60 was in the range £170,000 - £175,000; and the full CETV of her pension benefits was £1,122,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
6. Christina Craig, Dr Val Day and Jacqui Harvey were not directly employed by the NHS in 2012/13 and their pension entitlements are managed by their employer.
7. Jill Robinson was also Director of Finance of Croydon, Kingston, Richmond & Twickenham and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £5,000 - £10,000; the full value of her lump sum at age 60 was £0; and the full CETV of her pension benefits was £108,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

8. Dr Martyn Wake, Dr Howard Freeman and Dr David Finch are also general practitioners. The NHS Pensions Agency is unable to separate their pension entitlements as employees of the Primary Care Trust from their pension entitlements as general practitioners.

9. Debbie Stubberfield was also Director of Nursing of Croydon, Kingston, Richmond & Twickenham and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £40,000 - £45,000; the full value of her lump sum at age 60 was in the range £120,000 - £125,000; and the full CETV of her pension benefits was £894,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
10. Dr Jonathan Hildebrand also supported Croydon, Kingston, Richmond & Twickenham and Wandsworth PCTs. As at 31 March 2013, the full value of his accrued pension at age 60 was in the range £40,000 - £45,000; the full value of his lump sum at age 60 was in the range £120,000 - £125,000; and the full CETV of his pension benefits was £765,000. His pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
11. Charlotte Gawne was also Director of Communications of Croydon, Kingston, Richmond & Twickenham and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £15,000 - £20,000; the full value of her lump sum at age 60 was in the range £45,000 - £50,000; and the full CETV of her pension benefits was £230,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
12. Jocelyn Fisher was also Director of Human Resources, OD and Workforce of Croydon, Kingston, Richmond & Twickenham and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £0 - £5,000; the full value of her lump sum at age 60 was £0; and the full CETV of her pension benefits was £24,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

13. No information was available for Hardev Virdee, who is on secondment from Hounslow PCT.

14. Neil Roberts was also Director of Primary Care Contracting of Croydon, Kingston, Richmond & Twickenham and Wandsworth PCTs. As at 31 March 2013, the full value of his accrued pension at age 60 was in the range £35,000 - £40,000; the full value of his lump sum at age 60 was in the range £105,000 - £110,000; and the full CETV of his pension benefits was £745,000. His pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

Section 4
About our boroughs

4. About our borough

Merton

Merton's population is 199,693. It is a young borough compared to the England average with children and young people aged 0-19 making up almost a quarter (23.5%) of the population. This is expected to rise by almost 20% by 2021, compared to14.5% for London and 7.9% for England as a whole.

In contrast, over 65-year olds make up just under 12% of the population. This is forecast to increase by 21% by 2011. However, the number of people aged over 85 is forecast to rise much more steeply, by nearly 41% or an extra 1,300 people.

The population is becoming more diverse, with 35% of the population from black, Asian and minority ethnic groups. This diversity has broadened over the past 5-10 years with emerging Polish, Urdu and Tamil communities.

Merton is a healthy place to live overall. Life expectancy exceeds both the national and regional average and increased by 5 years for men, and 4years for women between 1994-96 and 2008-10. Fewer people die of conditions that could be avoided, such as heart disease in the under 75s.

There are however significant differences between the east and the west of the borough, in line with areas of deprivation. There is a difference in life expectancy of 9 years for men, and 13 years for women, between the most deprived and more affluent parts of Merton.

Sutton

Sutton's population is 191,123. Like Merton, it is a young borough compared to the England average with children and young people aged 0-19 making up almost a quarter (23.5%) of the population. This is expected to rise by almost 20% by 2021, compared to 14.5% for London and 7.9% for England as a whole.

The child population and the parent-age population (35-44) is also higher than the England average and increasing at a faster rate. The change suggests a significant inward migration of people to Sutton.

As in Merton, the age profile is also increasing. Over 65-year olds make up 14.3% of the population and this is forecast to rise by 18.7% by 2021, in line with London.

In the 2011 census, a fifth of people in Sutton were from black, Asian and ethnic minority groups. Taking into account people from non-British white communities (mainly South African, Polish and Irish) almost three in ten people come from ethnic minority, making Sutton's profile more like London and less like England as a whole.

Sutton is a healthy place to live with good life expectancy (higher than the national and London average) for both men and women and fewer people dying from avoidable conditions. Fewer children live in poverty and there is less infant mortality compared to London and the England average. Overall the borough has good educational attainment and less long-term unemployment.

However, inequalities are increasing:

- Sutton has areas that are in the 20% most deprived in the country – and certain areas have become more deprived since 2007
- there has been a significant widening of inequalities for both men and women between 1999-03 and 2006-19, and the difference in life expectancy has also increased, from 5.4 years to 8.1 for men, and from 5.8 to 7.9 for women.

4.1. Health and Wellbeing Boards

Under the Health and Social Care Act 2012, local authorities are required to establish a health and wellbeing board by 1 April 2013. NHS Sutton and Merton worked closely with their local Councils on the shadow health and wellbeing board.

The board, which included representatives from the then shadow CCGs and the council, with patient representation from the shadow Healthwatch, was the forum for developing the Joint Strategic Needs Assessments for Merton and Sutton, which set out the health needs and priorities for the coming year. The JSNAs can be seen on Sutton and Merton council websites.

4.2. Improving health

The performance of all health services providing care for Sutton and Merton residents was measured by NHS South West London, working with the Merton Clinical Commissioning Group (MCCG) and the Sutton Clinical Commissioning Group (SCCG).

The CCGs identify areas where performance is strong, working with services to learn lessons that can be implemented across the boroughs to enhance service delivery and the quality of care all patients receive. Similarly, services that are struggling to deliver the required outcomes are identified and support provided to improve quality and outcomes.

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

Below is a snapshot of how we have performed in Sutton and Merton over the last year (full performance reports will be available in July 2013 on the Sutton CCG and Merton CCG websites – www.mertonccg.nhs.uk and www.suttonccg.nhs.uk).

Healthcare acquired infections

Healthcare acquired infections are infections that occur as a result of healthcare interventions. There are a number of factors that influence the risk of infection, but high standards of infection control practice minimise the risk of occurrence. Data is collected on two infections, meticillin-resistant *Staphylococcus aureus (MRSA) and Clostridium difficile* infection (C. diff/CDI).

There are continuing concerns about the numbers of cases of both MRSA and C.Diff affecting residents of Sutton and Merton, with levels of infections at the main hospitals used by residents (Epsom and St Helier Hospitals NHS Trust and St Georges Healthcare NHS Trust) being above target levels. We continue to work with those and other providers to eradicate MRSA and significantly reduce the number of C.Diff infections.

Diabetic eye screening

The NHS Diabetic Eye Screening Programme aims to reduce the risk of sight loss among people with diabetes by the early detection and treatment, if needed, of diabetic retinopathy. All people aged 12 and over with diabetes (type 1 and 2) are offered annual screening appointments, except people with diabetic eye disease who are already under the care of an ophthalmology specialist. The programme covers around 17,000 people, which is an increase of 5% in the last year. In 2012/13 the programme has invited all of the eligible population with an uptake of 84% against a target of 70%. Around 97% of the screen-positives are informed within three weeks of the result, and the most proliferative forms of retinopathy identified receive timely consultation for onward management.

The main challenges facing the programme are capacity planning to adequately cope with a likely increase of population with type 2 diabetes over the coming years.

Cancer

Shorter waiting times for investigation and treatment of cancer can lead to earlier diagnosis, quicker treatment, a lower risk of complications, and improved patient outcomes. Shorter waiting times can help to lessen patient and family anxiety and improve experience. Data is collected on the percentage of patients seen by a specialist within 2 weeks of urgent referral by their GP, the percentage waiting less than 31 days from diagnosis to first treatment and the percentage waiting less than 62 days from urgent GP referral to first definitive treatment for cancer. For all these measures, targets were exceeded, maintaining the position in 2010/11. At least 9 out of every 10 patients with cancer are seen and treated within target times.

Cancer screening programmes

Screening is a process of identifying people who may be at increased risk of a disease or condition. Once identified, they should be offered information, further tests and appropriate treatment to reduce their risk and complications arising from the disease or condition. Ideally all the criteria relating to the condition, the test, the treatment and the screening programme management, should be met before screening for a condition is implemented (http://www.screening.nhs.uk/criteria). Cervical, breast and bowel cancer screening are the three UK National Screening Committee (NSC) approved population cancer screening programmes in England.

Cervical screening

Frequency of cervical screening varies with age, because of the different risks and disease progression in different age groups. For women aged 25 – 49, screening takes place every 3 years, and for those aged 50 – 64, it is every 5 years. To allow time for women to attend for screening following their invitation, data is collected on screening in the last 3.5 and 5 years. In 2011/12 coverage for women aged 25 to 49, fell just below the 70% London target, although for women aged 50 to 64 years the 75% target was met. Action to address the drop in coverage amongst younger women will continue.

Once screened, it is important for women to get their results as quickly as possible. This is measured as ‘turn around time’, that is the length of time from the day the smear is taken until the day the women receives her results in the post. The target time is within 14 days. NHS Sutton and Merton was the only PCT in London to meet the cervical screening ‘turn around time’ requirement of 98% within 14 days every month for the 12 months from February 2012 – January 2013, and we are confident that this local excellence will be maintained.

Breast screening

The aim of the programme is to detect early breast cancers, which are more likely to be treatable and therefore reduce the mortality rate; breast cancer is the second biggest cause of cancer deaths among women in England. National policy is that eligible women aged 50-70 are invited for breast screening every 3 years, while women over 70 years are screened on request. The coverage requirement is that ≥70% of eligible women aged 53-70 years should be invited to attend for screening every three years, with a national target of 80%. In Sutton and Merton around 73% of women have been screened within the previous 3 years.

Healthy lifestyles

- **Smoking**: Overall in Sutton and Merton there appears to be lower than average levels of smoking, but some areas within the borough are significantly higher than regional and national averages suggesting that in future we are likely to have increased numbers of people with circulatory diseases and cancer that are potentially avoidable.
- **Healthy weight**: Overall there appear to be lower levels than average of excess weight (overweight and obesity) among adults than nationally, but some areas within the borough are significantly higher. For children there is a significant increase in excess weight between 4/5 year olds and 10/11 year olds, and the proportion of children with excess weight by age 10/11 is higher than England.
- **Physical activity**: Less than 8% of adults in Merton, and 9% in Sutton are physically active enough to benefit their health, and over half of adults do no physical activity. This is lower than regional and national averages, although for children levels are above regional and national averages (physical inactivity and being overweight increases the risks of diabetes, cardiovascular disease and cancer).
- **Alcohol**: The levels of risky drinking are higher than both regional and national levels; although these figures are estimated levels, they are supported by the increases we are seeing in hospital admissions for alcohol related harm.
- **Drugs misuse**: Overall estimated levels of opiate and crack cocaine use are lower in than London or England, but 65% of estimated users are not or have never been in treatment. Once in treatment however outcomes are good.
- **Dental health**: A fifth of 5-year olds and a quarter of 12-year olds have experience of tooth decay, which is slightly better than England. However children from lower socio-economic backgrounds are disproportionately affected.
- **Teenage pregnancy**: Overall in Sutton and Merton the under-18 conception rate is below that of London and England and there has been a significant reduction since 1998. However, this masks significant variation across the Borough with the rates of some wards in line with inner London.

Local Insight research in 2010 asked what is important to local people in terms of being healthy and how they can be supported to make positive lifestyle changes to live healthier lives. This research supported the development of a co-ordinated programme of personalised advice and support to help people make healthy lifestyle choices. The service, LiveWell, was launched in September 2011 and has been re-commissioned in 2013 for a further three years to support and enable people to make healthy lifestyle choices.

The specific focus for LiveWell is on supporting people to eat well, manage their alcohol intake and be more active and from 2013 it will be integrated with the Stop Smoking Service. For more specialist services such as contraceptive and sexual health services and mental well-being, LiveWell, has links into existing services.

NHS Health Check Programme

The NHS Health Check is a programme that aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. This programme was introduced in Sutton and Merton late in 2011/12. In 2012/13 the

programme exceeded the targets for offers made to residents for the NHS Health Check, and for uptake of the opportunity to be checked.

Immunisations

Childhood immunisation levels remain below that which properly protects the population from the diseases for which immunisation is provided. The reasons for under-performance in immunisation in Sutton and Merton are likely to be a combination of several factors. A highly mobile population, which is a feature of London regions, gives rise to an inaccurate database of eligible population. This is compounded by inaccurate, inconsistent and incomplete coding of immunisation history, further complicated by change in vaccines, scheduling and revision of codes. There has been a lack of regular updating of information between the GP practices and child health records system, some of which is hampered by incompatible IT systems. Often, delayed immunisation of children is not captured in performance figures, particularly in children moving in to the area. Some parents/guardians are reluctant to immunise children, which may be due to lack of information about, or knowledge of opportunities to immunise children. There may be an inadequacy of clinical champions and performance management of immunisation as a priority.

NHS Sutton and Merton has worked closely with NHS London in formulating a strategy to improve performance of immunisation in children. The three-pronged strategy is directed at improvement in performance management of key health professionals, approach to target patient population, and information management.

A series of measures has been introduced to improve immunisation performance in Sutton and Merton for 2012-13. An incentive related payment scheme, which is being introduced for 2012-13 for GPs who demonstrate proof of best-practices and processes to improve immunisation by second birthday of the child, is nearing finalisation. A project is underway to upgrade software for more timely and accurate information from the GPs to Child Health Records System and back, and will include consistent and accurate coding (READ codes) of information on immunisation history of the child. A call-recall process for children due for immunisation, and timely follow-up of children who have been immunised, is being considered along with immunisation promotion activities. There is a need for verification of accuracy of registered children, an audit of unusually low rates for some of the vaccinations, involvement of GPs/ nurses as clinical champions, and regular and intensive performance management.

Childhood Obesity

In Sutton, one in 11 4-5 year-olds is obese, rising to nearly 1 in 5 11 year-olds. Children in the borough are less active than the London and the national average. In Merton, there is an 11% increase in obesity in children between the age of 5 and 11. A fifth of Merton 5-year-olds are overweight or obese, which rises to more than a third of 11-year-olds.

Teenage Pregnancy

The national focus for teenage pregnancy work is on conception under 18 as most potential mothers in this age group would be in full time education or training. High rates of teenage pregnancy are most often associated with low educational attainment and disengagement from school, economic deprivation, and poor mental health.

Under 18 conceptions are concentrated in relatively few wards, most of which are recognised as deprived in a range of indicators. In Sutton the wards with the highest rate of under 18 conceptions are Wandle Valley, St Helier and Sutton Central. Conception rates in these wards are similar to those in Inner London boroughs. As ward conception numbers are relatively small (even when aggregated for three years) rates may vary markedly from year to year and should be interpreted with some caution.

However, Sutton is not on trajectory to meet the 2010 target. After early successes in the borough, progress has slowed and in the first quarter data for 2008, Sutton had the worst profile in London with a steep rising trajectory, although still at or below the average for England. More recent local data suggests that although still increasing Sutton's level of teenage pregnancy may be stabilising.

Overall in Merton, the under 18 conception rate is 30.4 per 1,000 (2010), which is below that of London and national rates. This is a significant reduction from the 1998 rate of 51 per 1,000. However, this masks significant variation across the Borough with the rates of some wards in line with inner London. The electoral wards with the highest under 18 conception rates (aggregated data for 2007-09) are Pollards Hill, Lavender Fields, Ravensbury and Figge's Marsh. As ward conception numbers are relatively small (even when aggregated for three years) rates may vary markedly from year to year and should be interpreted with some caution. Merton has set a new local teenage pregnancy target of 27 per 1,000 15 to 17 year olds by the year 2015.

In Merton 65% of under 18 conceptions lead to a termination of pregnancy, this is higher than both England and London (2008-10). Evidence suggests it is the most disadvantaged, vulnerable young women with the greatest number of risk factors who are most likely to have a conception aged under 18 and are more likely to see the pregnancy through. This is supported by a strong association locally (85%) between women aged under 19 giving birth and living in more deprived areas. This in turn perpetuates the cycle of poor outcomes including health outcomes, not just for young parents but for their babies as well.

Given the 14 months delay in receiving conception statistics nationally, due to the need to correlate deliveries with terminations; in order to look at local trends using more timely data, the number of births to women 19 and under living in Merton have been analysed in more detail to help understand the current situation.

According to national figures, in 2011 overall there were 1,737 terminations performed on Sutton and Merton residents (all ages). The termination rate in Sutton and Merton in 2011 was 19.5 per 1,000 women aged 15-44 which was higher than the national rate (16.9 per 1,000), but lower than for London (23.4 per 1,000). The highest number of terminations (450) were performed in women aged 20-24, followed by the 25-29 age group (418). Women aged under 25 have a repeat termination rate of 29%. This clearly suggests more work is needed focusing on prevention and ensuring good access to contraceptive services, particularly in young women, not just those under 18 but also women in their early to mid 20s.

The Department of Health National Strategy for Sexual Health and HIV (2001) recommended that at least 75% of terminations are NHS funded to improve inequalities in access. One measure of access is the percentage of NHS funded terminations as a proportion of all terminations. In 2011 the PCT funded 95% of all terminations performed for local residents (only 6% were privately funded). 70% were provided by the independent sector and 25% in NHS hospitals.

A secondary measure of access to terminations is that all PCTs should aim for at least 70% of NHS funded terminations being performed under 10 weeks gestation. In 2011, 82% of terminations in Sutton and Merton were performed under 10 week's gestation. This is higher than London (79%) and England (78%).

Breastfeeding

Higher levels of breastfeeding are linked to better child health, but both Sutton and Merton have a lower prevalence than both regional and national levels. The PCT worked closely with the council to improved breastfeeding rates, and community services across the boroughs have signed up to UNICEF's Baby Friendly accreditation which aims to increase rates.

Section 5
Improving performance

5. Commissioning healthcare

Until April 2013 Sutton and Merton PCT was the organisation responsible for making sure that local people receive high-quality NHS services, planning where services are needed and commissioning them from healthcare professionals, NHS Trusts and other organisations.

In 2012/13, we were allocated over £600million, which was spent on funding acute services, primary care, learning disability, mental health, community services and prescribing. Key developments at major local providers we commission services from are described below.

Epsom and St Helier University Hospitals NHS Trust

Epsom and St Helier University Hospitals NHS Trust has two 24-hour Accident and Emergency (A&E) departments and provides an extensive range of general and specialist services.

- The urgent care centre (UCC) at St Helier Hospital continues to support A&E and sees approximately 1,500 patients a month. It is based next to the A&E and treats people who come to hospital with minor injuries, such as cuts and sprains, allowing the A&E team to focus on people with critical or life-threatening conditions. In addition, a large building project has been underway to expand the area occupied by both the UCC and A+E – this will allow even more patients to be treated within the urgent care centre.

- St Helier Hospital has significantly reduced the mixed sex accommodation on site. This supports the Trust in delivering care that respects patients' dignity and cultural requirements.

- The PCT has commissioned a service for patients who regularly attend St Helier for rheumatology conditions that require weekly injections. The pathway for these patients has been redesigned with the clinicians to support patients to self-administer this drug at home. The service reduces the visits to hospital for patients and supports patients to manage their own condition with the support of secondary care and primary care.

- The Trust has recently implemented a fracture liaison service. Patients over 70 years of age who attend A&E following a fall are seen by the fracture liaison nurse where diagnostics are undertaken and a care plan implemented. The aim is to identify the underlying reason for their fall and to ensure falls are prevented. The service started in November 2012 offering weekly clinics seeing 3-4 patients at a time.

Epsom and St Helier NHS Trust has also reduced the turnaround times for cervical screening services, and improved the proportion of all adult inpatients that have had a VTE risk assessment on admission to hospital, using national clinical criteria.

- Epsom and St Helier NHS Trust performed well in a recent audit of acute hospitals in South West London. The audit, by NHS London Health Programmes looked at emergency services and demonstrated that Epsom and St Helier Trust was compliant with the emergency care standards.

St George's Healthcare NHS Trust

St George's Healthcare NHS Trust provides a range of services, including A&E, maternity, care for older people and children and specialist services for complex injuries and illnesses such as trauma (serious injury), neurology, cardiac care, renal dialysis and transplantation and cancer. As well as acute services, the Trust also provides a wide variety of specialist and community hospital based care and a full range of community services to children, adults, older people and people with learning disabilities. These services are provided from Queen Mary's Hospital, Roehampton, 11 health centres and clinics, schools and nurseries, patients' homes and Wandsworth Prison.

NHS Sutton & Merton work closely with NHS Wandsworth as coordinating commissioners to ensure quality services are commissioned for the residents of Sutton & Merton.

South west London and St George's NHS Mental Health Trust

South west London and St George's Mental Health NHS Trust operates from almost 100 locations and is responsible for providing community and hospital psychiatric services to the communities of Sutton and Merton, as well as Kingston, Richmond, and Wandsworth.

The trust provides Improving access to psychological therapies (IAPT) for people in Sutton and Merton. IAPT can help people suffering from mild to moderate mental health problems like depression, anxiety or phobias.

The IAPT service is currently piloting methods and pathways to explore psychological models of treatment and increase access for people with long-term conditions and common mental health problems. They will report on outcomes and the impact on wider health services towards the end of the 2013.

The Trust managed a successful transition of its Sutton Community Mental Health Teams to the Jubilee Health Centre (East), Wallington in 2012.

The Trust won the National Health Service Journal Award for its multi-systemic therapy service that helps young people who have social, behavioural and educational problems. Therapists work intensively with the young people and their families for three to five months, using a combination of cognitive behavioural therapy, parent management training and family therapy and behavioural approaches. This has enabled more people to live at home, return to school, and stop criminal activity.

The Trust has been working closely with mental health service users and commissioners to implement changes following the Sutton Mental Health consultation in 2011-12 including:

- Setting up a 'real-time feedback' service on the new ward at Springfield whereby patients can answer a set of questions covering care planning, safety, environment, information and relationship issues using a 'touch controlled' electronic kiosk. The Trust can then implement changes in real time. Service user feedback has repeatedly reported improvements across all domains over the last year.
- Service users report a preference for the new ward at Springfield Hospital site
- Employing a discharge coordinator on the ward, resulted in improvements in discharge time and closer working with social care services
- The Trust have implemented support for patients and their carers to travel from Sutton to Springfield Hospital which is now common practice
- Developing a range of patient and carer information (information packs, leaflets and pathway information) has been developed in partnership with service users and carer organisations
- The new community provision for older people is now well established and receives positive feedback from patients and carers
- Implemented mechanisms to measure the quality of the new community provision for older people. It will start reporting on these from March 2013.

The Royal Marsden NHS Foundation Trust

The Royal Marsden is dedicated to cancer diagnosis, treatment, research and education. The Trust provides inpatient, day care and outpatient services for all areas of cancer treatment. Sutton and Merton Community Services are now in the second year of a three year contract with the Royal Marsden NHS Foundation Trust after transferring from NHS Sutton and Merton.

Sutton and Merton Community Services employs over 850 healthcare staff, including nurses, physiotherapists, occupational therapists, dieticians, podiatrists, speech and language therapists as well as some specialist medical staff in the family planning service.

The transfer has enabled patients who use the community service to benefit from the Marsden's ethos of personalised care, evidence based medicine and excellence in care and to ensure safe and speedy discharge from hospital back into the community

Section 6
Working in partnership

6. Working in partnership

6.1. Patient and Public Involvement: Engaging with Partners and the Public

Better Services: Better Value

Better Services: Better Value review continued to be a major focus for public and patient involvement in Sutton and Merton. As part of the review NHS South West London worked with LINks/shadow Healthwatch and local authority partners, including Sutton and Merton to arrange large-scale meetings, community outreach sessions, e-bulletins, online surveys and other social media engagement.

Service development and improvement: Duty to Involve

All NHS primary care trusts have a legal duty to report annually on the influence people's views have had on their decisions. This includes not only consultations carried out directly by the Sutton and Merton PCT but also those done by other organisations that influence local commissioning. The April 2012 to March 2013 report will be published in July 2013.

Improving mental health services

In 2011 NHS Sutton & Merton held a public consultation on changes to Sutton-based mental health services. The aim of this consultation was to agree permanent solutions to temporary changes made in 2009 to Sutton mental health inpatient services, and propose changes to Sutton's older people's day hospital service. The proposed changes were in line with best practice and in the context of NHS Sutton and Merton's Joint Mental Health Strategy (2010–15):

- hospital beds for Sutton adults with severe mental health needs to be permanently moved to Springfield Hospital in Tooting
- to continue to provide a community model of care for people who require mental health rehabilitation service as opposed to providing a hospital bed service
- to continue to provide a community model of care (an intensive home treatment) for older adults with serious mental health needs and have up to three inpatient beds on a shared ward at Springfield
- to change the current day hospital service at Sutton Hospital for older adults to an outreach community based model of care.

The public consultation also asked for views on additional community resources people would like to see in Sutton.

Following the consultation, these recommendations were approved by both Sutton Clinical Commissioning (Delegation) Committee (CCDC) and the South West London Joint PCT Board in May 2012.

Next steps and all documentation relating to this consultation can be accessed on NHS South West London's website: *www.southwestlondon.nhs.uk/haveyoursay/consultations/suttonmentalhealth*

Expert Patients Programme

NHS SWL Sutton and Merton Borough Pilot Expert Patients Programme was initiated early 2012 to support the provision of self-management courses, led by non-professionals, for patients living with Type 2 diabetes registered with a Sutton or Merton GP. During the pilot phase, four courses were delivered across Sutton and Merton in partnership with local groups and organisations.

The Expert Patients Programme is a free self-management course offering a toolkit of techniques to support those with long-term health conditions. It enables participants to better manage their condition by increasing their confidence and improving their quality of life. Courses run for 6 weekly sessions, with each session taking 2.5 hours.

Participant's completing the course reported they were more confident in managing:

- pain and fatigue caused by their condition
- symptoms and other health problems
- emotional distress
- tasks and activities needed to manage their health condition better to reduce need to see a doctor or other healthcare professional
- medication usage, and techniques other than medication.

Three participants who complete the EPP course were trained as tutors, and will continue to support the Clinical Commissioning Groups to deliver future courses.

Training and outreach

Sutton and Merton borough team supports patients and the public in getting involved by recruiting people to key decision-making groups such as the Sutton and Merton Diabetes Network and the Sutton and Merton-led cervical Screening working group.

Sutton LINk and Merton LINk have been working with the PCT to support the set up and development of Patient Participation Groups within general practices. The aim is to strengthen the work with patients and enable them to take part in the decision-making process.

LINk /Shadow Healthwatch members also sit on:

- London Borough of Merton Overview and Scrutiny
- South West London Patient and Public Advisory Group
- One Merton Group (previously the Merton Clinical Commissioning Group)
- Shadow Health and Wellbeing Board.

6.2. Complaints

NHS Sutton and Merton encourages feedback, positive and negative, so that we can make improvements based directly on patient's concerns. During 2012/13, there were 175 formal complaints, compared with 181 in 2011/12, a further decrease since responsibility for complaints relating to community services transferred to the Royal Marsden.
Of those complaints, 70 related to Sutton and Merton independent contractors (including GPs, community pharmacists and optometrists). There were 11 complaints about the funding and commissioning of services.

Our investigation of complaints resulted in a number of changes including:

- After investigation of a complaint about the processing of an application for Continuing Care Funding, this was reviewed and changes implemented: permanent administrative staff appointed; measures introduced to improve communication pathways with applicants.
- Incorrect medication prescribed by a GP led to a patient having fits. Practice reviewed as "significant event," changing the way the practice recorded repeat medications for new patients. Computer software to be upgraded so details would be updated automatically.
- Patient seen by GP and at walk-in centre having trouble swallowing was told by a nurse that they had plenty of room to swallow and to gargle with soluble aspirin. Patient later diagnosed with epiglotitis. Practice made changes to prevent any other patients having the same experience.

- A patient's GP medical notes became accidentally mixed with another patient of a similar name. This led to the patient being given incorrect and distressing information. The practice logged this as a "significant event" and reminded all staff of the importance of checking patients' name, DOB and address before entry. The practice has also brought forward installation of new software to prevent such incidents recurring.
- A patient had been upset by a practice receptionist. The practice manager met with patient and as a result the receptionist was sent on customer care training.

Complaints about care – following the Ombudsman's principles

The Health Service Ombudsman is responsible for handling complaints from the public that relate to maladministration and has set out the six principles which underpin this work, which are to:

- Get it right
- Be customer focused
- Be open and accountable
- Act fairly and proportionately
- Put things right
- Seek continuous improvement

Throughout 2012-13, the PCT strove to follow these principles when handling complaints.

6.3. Patient Advice and Liaison Service

The Primary Care Trust provides a Patient Advice and Liaison Service (PALS) to deal with information requests, issues and concerns raised by patients and members of the public.

In 2012/13, the PALS office took 1234 calls from residents and patients, more than in 2011/12 but still less than previous years, due to the PCT no longer having direct responsibility for community services such as district nursing or podiatry.

The PALS office works closely with GPs, dentists, opticians, community pharmacists and other NHS Trusts to make sure concerns are dealt with promptly and services are improved.

Benefits from the involvement of the PALS 2012/2013 include:

- Patient concerned that the PCT advised GPs to prescribe generic, rather than brand name drugs, as she had serious side effects from the generic medication. PALS, supported by the prescribing team, advised that with clinical reasons the GP could prescribe the brand name drug.
- Age UK contacted PALS, wanting copies of the PCT guide to local services that they had found to be "very helpful". The caller was directed to the website, which has updated information.
- An orthodontist had refused to replace patient's brace after the wire had broken four times. With the assistance of dental advisers and contracts managers PALS managed to make alternative arrangements for the patient to complete their treatment.

Section 7
Making it happen

7.1 Better Services Better Value

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

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

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

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

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

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

7.2 Patient and Public Involvement

We worked closely with our Local Involvement Networks (LINKs), which provided a voice for patients and carers in Sutton and Merton.

Under the Health and Social Care Act, LINks have evolved into Healthwatch, with a strengthened voice and a direct link into the Health and Wellbeing Boards, which bring together interested stakeholders, from the CCG and the councils to formulate a coordinated health policy for the two boroughs.

7.3 Equality delivery

Developing and maintaining equalities during transition

Over the last year we have worked closely with Sutton and Merton CCGs to ensure that our health service commissioning takes account of the diverse needs of local people. Our goal is to remove the obstacles that some groups face when accessing services that can negatively affect the health of those groups.

Making a difference for patients and staff

The Equality Act 2010 provides a legal framework to strengthen and advance equality and human rights. In 2012, we used the Department of Health's Equality Delivery System (EDS) tool to assess our equalities performance in a wide range of areas related to patients and staff, and to identify future priorities and actions.

The work to grade our performance was done with help from groups across local authority, voluntary and community sectors including Local Involvement Networks (LINks), carers and older people, organisations that support black and Asian minority groups and interfaith groups.

Public bodies are required to set specific, measurable equality objectives every four years, supported by a plan for how the organisation will implement and monitor them. Sutton and Merton CCGs, supported by NHS Sutton and Merton Borough Team, have both developed their own set of equality objectives. This has included gathering data, analysing this to identify common themes and engaging patients, partners and colleagues on draft equality objectives to finalise these. This will set the foundation to develop future equality plans.

Supporting strategic decision-making

During 2012 the Joint Strategic Needs Assessment (JSNA) for Sutton and Merton was split by borough to more effectively support the CCGs. The JSNA, developed in partnership with local authorities, provides a wealth of information about local health needs and inequalities. The JSNA supports local public bodies to work together to address these needs and highlights issues such as age, disability, deprivation, ethnicity, gender, religion and sexual orientation, as they affect specific population groups.

Information from the JSNA has been used to develop Commissioning Strategy Plans for both Sutton and Merton CCGs, and provided content for their Equality and Diversity Strategies. This ensures that equality and diversity is taken into consideration for future planning.

Further work will be undertaken to strengthen the CCG's long term equalities priorities and outcomes through the development of Equality Objectives in the following commissioning areas: Maternity and Newborn; Children and Young People, Staying Healthy, Acute Care, Long Term Conditions, Planned Care, Mental Health and End of Life Care.

Engaging with diverse communities

We have used a variety of ways to involve and consult staff, patients and the public over the last 12 months to ensure that everyone has an opportunity to share their views. Highlights include:

- Transgender in Health learning event (September 2012)
- Jubilee Health Centre opening Health Fair (October 2012)
- Merton CCG Equality Objectives panel event (February 2013)
- Sutton CCG Equality Objectives panel event (February 2013)

Helping communities 'LiveWell'

A new programme of health improvement called LiveWell has been commissioned to support our strategic vision to promote health and wellbeing and reduce health inequalities in Sutton and Merton, enabling the organisation to tailor and target any future service planning.

The programme became operational in October 2011. It has successfully engaged over 400 service users in its first 10 months. The service has also seen a marked increase in uptake resulting from GP referrals via the NHS Health Checks Programme.

Much work has been undertaken to target diverse communities, who may be less likely to access the programme, and actions are being taken to redress any gaps. For example, attending more male-orientated events and finding a greater amount of activities and support groups amongst younger age groups.

Planning for the move to GP-led commissioning

From 1 April 2013, Clinical Commissioning Groups (CCGs) will be responsible for equalities duties. The past year has seen intense collaborative working with the CCGs take shape, ensuring that both Sutton and Merton CCGs have equality and diversity strategies; equalities requirements have been embedded in business plans; evidence-based equality objectives have been defined in partnership with patients and partners; and CCGs have been supported with the production of an extensive equality and diversity handover pack.

For a full update on equalities progress over the last year, please see our Public Sector Equality Duty report 2012/13.

7.4 Safeguarding children and adults

Both Merton and Sutton CCGs have arrangements in place for ensuring that within the services they commission all staff working with children or adults who are parents are able to keep them safe. This includes ensuring safeguarding supervision and training is in place so that vulnerable children are identified early and timely intervention occurs. They work closely with partner agencies, for example, social services, police, education, housing and the voluntary sector to share information that protects children and review cases when children have been seriously harmed or died through abuse and/or neglect.

Both Sutton and Merton CCGs are members of their local Safeguarding Children Board, a multi-agency statutory partnership tasked with improving outcomes for children, monitoring and holding to account all public and private organisations with regards to their arrangements to safeguard children and young people (0 - 18 years).

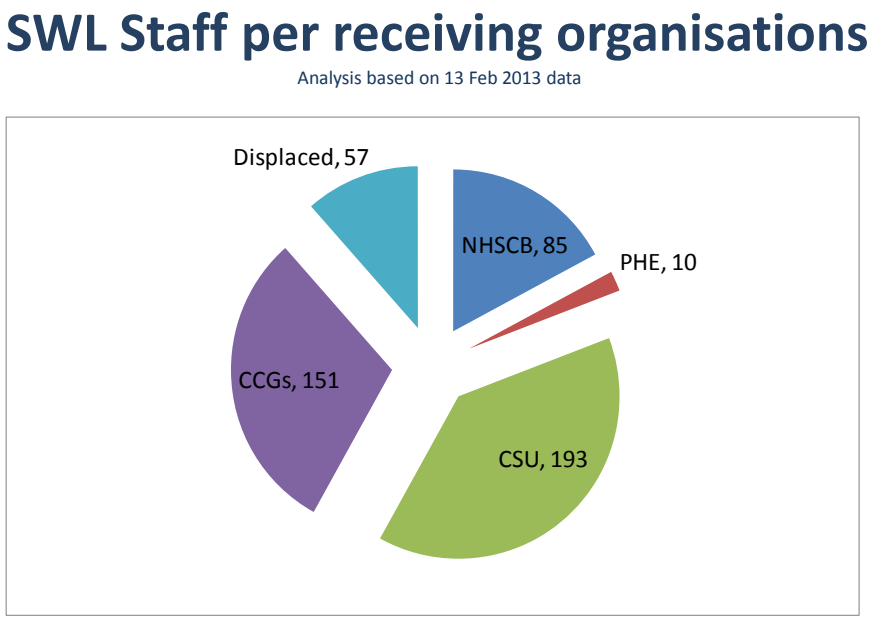
Merton CCG is part of the Merton Safeguarding Adults Board, which works with partners across the borough to promote the safety and well-being of vulnerable adults who may be at risk of being abused, neglected or exploited. This partnership brings together the organisations in Merton with a role to play in protecting vulnerable adults from harm, including, Merton Council Adult and Community Services, the police, local health trusts, voluntary organisations, care providers and supported housing providers.

Sutton CCG is part of Sutton Safeguarding Adults Board. This is a partnership of all the organisations in Sutton involved in protecting vulnerable adults, including Sutton's adult social services and community service, the police, local health service providers and voluntary organisations. Together they work to promote the safety and wellbeing of vulnerable people.

7.5 Our staff

Transition to new organisations

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



Staff development

NHS South West London was committed during transition to helping all staff improve their working lives and develop professionally through our education and development programmes.

Our Development Passport programme helped staff plan for their futures and equipped them for transition into the new NHS organisations. We worked with Croft Management Centre to produce a Development Passport with a two-tiered approach to training; Level One for bands 6 and below, and Level Two for bands 7 and above.

From September 2011 up to the end of January 2013 more than 1400 delegates attended sessions delivered over 150 separate training days. 83 delegates achieved an Award, Certificate or Diploma in Management and Leadership qualifications drawing on a range of 21 different topics around personal, commercial and leadership effectiveness.

In addition to the passport programme staff also had access to support services that assisted them to update and develop their personal curriculum vitae and interview skills. Staff also had access to an employee assistance programme which is a free confidential 24 hour access to advice and counselling online or on the telephone.

Workplace health

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

Staff profile

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

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

7.6 Communicating with staff

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

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

Senior management was very involved in face-to-face briefings and discussions with staff and the transition team was central to ensuring that staff had the most up-to-date information available at the time.

As staff moved into the new organisations in their shadow form, cluster team briefings were replaced by a weekly Transition Update newsletter supported by face-to-face briefings led by the cluster Chief Executive and directors. Staff whose functions were moving to the South London Commissioning Support Unit or NHS Commissioning Board were also invited to briefings run by the new organisations.

7.7 Our estate

The estate continued to be transformed in 2012/13. The changes to the estate have supported the learning Disabilities Programme with local authority partners, and the Better Healthcare: Closer to Home modernisation programme.

Commissioners in Sutton and Merton are working to align Better Healthcare: Closer to Home (BHCH), a wide estates strategy and our contracts with the major local providers. The significant investment in estate that BHCH brings has to be accompanied by a rigorous process of review of other, older healthcare estate, which is now under way. Part of this review involves a disposal programme.

In addition, commissioning intentions are being developed with the Royal Marsden Foundation Trust (Community Provider Directorate) and the Epsom and St Helier NHS Trust to extend the hours over which health care buildings are used and improve the information as to the use of clinical and office spaces.

The Jubilee Health Centre, the first of the BHCH Local Care Centres to open, brings many health care services closer to patients' homes that will be more co-ordinated and supported by an innovative and effective IT system, allowing primary, secondary and community providers, as well as social services, to share information and better co-ordinate their care.

The PCT Commissioners are developing a three year estates strategy with a view to ensuring a good legacy for future commissioners (following the transition to CCGs and the NHS Commissioning Board), and are doing so in the context of the current uncertainty over estates responsibilities. Multi-use buildings such as LCCs present special opportunities and risks for commissioners and providers. Our aim is to ensure that such innovative new centres are operated in the best interests of the patients and the health economy, rather than being driven by organisational needs.

Learning Disabilities Programme

Following the closure of the NHS Campus accommodation, and transfer of NHS campus residents to new self-contained supported living flats, the PCT has continued to dispose of surplus estate with land at Cedar Close, Carshalton sold off, and sites at Osborne House, Hastings and Carshalton War Memorial Hospital, and Belmont Hospital, being prepared for sale. The final development of supported living self-contained flats close to south Wimbledon underground station has started, and the future of Birches Close is under review by the Better Healthcare Closer to Home team.

Delivering Better Healthcare Closer to Home

Construction of the new £13 million Wallington LCC building was completed at the end of 2011 and the new centre opened at the end of May 2012. The refurbishment of the second phase for south west London and St. Georges Mental Health Trust has begun and is expected to be complete by the end of July, 2012. Following public canvassing the centre is now known as the Jubilee Health Centre.

The Jubilee Health Centre project team has implemented an innovative technological system to enable optimal use of the new building. Team members also worked with clinical and PCT commissioners to ensure a good range of services were available to patients when the building opened.

Working in partnership with our LIFT Company (South West London Health Partnerships), the BHCH team has made significant progress on the plans for the new Nelson LCC and submitted a planning application for the development, and a business case to NHS London. The team is expecting decisions over both issues during the summer of 2012.

Working in partnership with our LIFT Company and the regeneration team at the London Borough of Merton work has progressed on developing the LCC in Mitcham. The programme team is now reviewing the Birches Close site as alternative to the Wilson Hospital site due to its improved access to public transport.

The BHCH team continues to work with Epsom and St Helier University Hospitals NHS Trust on the final business case to redevelop St Helier Hospital. The redevelopment will see the demolition of almost a third

of the current site and the construction of a new building which will house the majority of the hospital's wards and clinics and the St Helier LCC.

7.8 Information governance

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

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

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

Reported Information Governance Incidents

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

Summary of other personal data related incidents in 2012/13

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

7.9 Sustainability

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

We have in place a Sustainable Development Management Plan (SDMP), through which we drive our environmental performance improvement actions. The SDMP includes details of our carbon footprint year-

on-year since 2007/08 for all areas of activity including energy and water consumption, waste disposal, staff and business travel and procurement.

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

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

7.10 Informatics

During the year the South West London Cluster started the process of merging with the South East London Cluster to form the South London Commissioning Support Unit. As part of the setup of the new organisation, an active investment programme in Informatics started in mid-2012 building on previous projects to evolve the Business Intelligence and ICT capability.

Our vision for Informatics is to:

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

Our investment programme has already started delivering the following benefits:

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

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

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

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

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

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

7.11 Risk Assessment

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

The 3 central planks underpinning our risk management approach are:

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

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

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

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

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

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

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

Key risks during 2012/13 have included:

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

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

The Risk and Control Framework

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

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

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

Executive Management Team and Board Committee Scrutiny of Risks

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

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

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

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

Managing risks around delegation to CCGs under shadow working arrangements.

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

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

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

Review of the Effectiveness of Risk Management and Internal Control

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

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

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

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

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

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

Final Board Assurance Framework Report to Joint Boards in March 2013

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

7.12 Risk Management

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

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

Transfer of the risk management function was part of the overall handover of statutory functions programme. Since October 2012, PCT risk registers were disaggregated and transferred to the relevant parts of the new system for on-going management i.e. CCGs, NHS Commissioning Board (primary care

and specialised commissioning), Local Authorities (Public Health) and NHS Property Services, etc.

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

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

7.13 Register of Joint Boards member interest 2012/13

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

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

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

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

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

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

Department of Health

NHS

Sutton and Merton Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

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Sutton and Merton Primary Care Trust

2012-13 Accounts

SUTTON & MERTON PRIMARY CARE TRUST

ANNUAL ACCOUNTS 2012-13

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

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

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

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

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

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

Signed: 

Date: 4/6/2013

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

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

Signed: 

Date: 4/6/13

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

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

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

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

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

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

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

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

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

Signed.....

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

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

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

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

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

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

Respective responsibilities of the signing officer and auditor

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

Scope of the audit of the financial statements

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

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

We are required under Section 5 of the Audit Commission Act 1998 to satisfy

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

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

· our review of the annual governance statement;

· the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and

· our locally determined risk-based work on arrangements to manage the abolition of the Primary Care Trust and the transition to new commissioning arrangements.

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

Certificate

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

S. M. Exton

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

Grant Thornton House, Melton Street, London NW1 2EP

7 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**5,892**	5,940
Other costs	5.1	**636,415**	613,923
Income	4	**(20,742)**	(17,752)
Net operating costs before interest		**621,565**	602,111
Investment income	9	**0**	0
Other (Gains)/Losses	10	**143**	(549)
Finance costs	11	**1,098**	694
Net operating costs for the financial year		**622,806**	602,256
Transfers by absorption -(gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**622,806**	**602,256**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**4,550**	4,138
Other costs	5.1	**17,421**	15,123
Income	4	**(6,973)**	(6,997)
Net administration costs before interest		**14,998**	**12,264**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**14,998**	**12,264**
Programme Expenditure			
Gross employee benefits	7.1	**1,342**	1,802
Other costs	5.1	**618,994**	598,800
Income	4	**(13,769)**	(10,755)
Net programme expenditure before interest		**606,567**	**589,847**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**143**	(549)
Finance costs	11	**1,098**	694
Net programme expenditure for the financial year		**607,808**	**589,992**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**9,130**	182
Net (gain) on revaluation of property, plant & equipment	**(358)**	(5,851)
Net (gain) /loss on Assets Held for Sale	**0**	(8,094)
Release of Reserves to Statement of Comprehensive Net Expenditure	**1,225**	0
Total comprehensive net expenditure for the year*	**632,803**	**588,493**

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**37,439**	47,465
Intangible assets	13	**547**	436
Investment property	15	**0**	0
Other financial assets	21	**2**	2
Trade and other receivables	19	**357**	408
Total non-current assets		**38,345**	48,311
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**2,077**	20,114
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**4,165**	35
Total current assets		**6,242**	20,149
Non-current assets held for sale	24	**0**	8,000
Total current assets		**6,242**	28,149
Total assets		**44,587**	76,460
Current liabilities			
Trade and other payables	25	**(32,648)**	(44,220)
Other liabilities	26,28	**0**	0
Provisions	32	**(2,879)**	(606)
Borrowings	27	**(181)**	(169)
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(35,708)**	(44,995)
Non-current assets less net current liabilities		**8,879**	31,465
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(2,810)	(3,724)
Borrowings	27	(7,824)	(8,073)
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(10,634)**	(11,797)
Total Assets Employed:		**(1,755)**	19,668
Financed by taxpayers' equity:			
General fund		(11,097)	(6,854)
Revaluation reserve		9,342	26,522
Other reserves		0	0
Total taxpayers' equity:		**(1,755)**	19,668

The notes on pages 5 to 45 form part of this account.

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

C Vincent Date: 4/6/13

Carl Vincent
DH Director, Provider Finance and Finance Transition

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(6,854)**	**26,522**	**0**	**19,668**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(622,806)	0	0	**(622,806)**
Net gain on revaluation of property, plant, equipment	0	358	0	**358**
Impairments and reversals	0	(9,130)	0	**(9,130)**
Transfers between reserves*	7,183	(7,183)	0	**0**
Release of Reserves to SOCNE	0	(1,225)	0	**(1,225)**
Total recognised income and expense for 2012-13	**(615,623)**	**(17,180)**	**0**	**(632,803)**
Net Parliamentary funding	611,380			**611,380**
Balance at 31 March 2013	**(11,097)**	**9,342**	**0**	**(1,755)**
Balance at 1 April 2011	**725**	**17281**	**0**	**18,006**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(602,256)	0	0	(602,256)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	5,851	0	5,851
Net Gain / (loss) on Assets Held for Sale	0	8,094	0	8,094
Impairments and Reversals	0	(182)	0	(182)
Transfers between reserves*	4,522	(4,522)	0	0
Total recognised income and expense for 2011-12	(597,734)	9,241	0	(588,493)
Net Parliamentary funding	590,155			590,155
Balance at 31 March 2012	**(6,854)**	**26,522**	**0**	**19,668**

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		**(621,565)**	(602,111)
Depreciation and Amortisation		**2,866**	2,829
Impairments and Reversals		**36**	4,083
Interest Paid		**(606)**	(694)
(Increase)/Decrease in Trade and Other Receivables		**2,169**	8,005
Increase/(Decrease) in Trade and Other Payables		**(10,310)**	(8,592)
Provisions Utilised		**(3,614)**	(627)
Increase/(Decrease) in Provisions		**4,480**	135
Net Cash Inflow/(Outflow) from Operating Activities		**(626,544)**	**(596,972)**
Cash flows from investing activities			
Interest Received		**0**	86
(Payments) for Property, Plant and Equipment		**(3,971)**	(1,113)
Proceeds of disposal of assets held for sale (PPE)		**7,582**	7,933
Net Cash Inflow/(Outflow) from Investing Activities		**3,611**	**6,906**
Net cash inflow/(outflow) before financing		**(622,933)**	**(590,066)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(236)**	(90)
Net Parliamentary Funding		**611,380**	590,155
Capital grants and other capital receipts		**15,919**	0
Net Cash Inflow/(Outflow) from Financing Activities		**627,063**	**590,065**
Net increase/(decrease) in cash and cash equivalents		**4,130**	**(1)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**35**	**36**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**4,165**	**35**

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

The Primary Care Trust has a health centre acquired under the NHS Local Improvement Finance Trust (LIFT) arrangements. This health centre is accounted for as property, plant and equipment on the Statement of Financial Position with a corresponding liability accounted for under borrowings. The scheme will be in place until 28th April 2030 and the Primary Care Trust has taken the view that its successor organisation is likely to buy the property from the LIFT company at this date.

The Primary Care Trust has four properties that are occupied under leases. An assessment of the risks and rewards associated with these leases has been made to determine whether they should be accounted for as finance leases or operating leases. As a result, three of the properties are accounted for as finance leases and one property is accounted for as an operating lease.

Critical judgements in applying accounting policies

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

Key sources of estimation uncertainty

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

1. Actual prescribing costs for March were unknown at the time of the completion of the accounts
2. Value of land under PPE was assessed by the Valuation Agency as at 31 December 2012

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The Primary Care Trust has entered into pooled budgets with the London Borough of Merton and the London Borough of Sutton. Funds are pooled under S75 NHS Act 2006 for the following purposes: (i) provision of community teams and day services to people with learning disabilities in Merton, (ii) the provision of integrated community equipment stores (ICES) for the people of Sutton and Merton.

The pools are hosted by the London Boroughs. As a commissioner of healthcare services, the Primary Care Trust makes contributions to the pools, which are then used to purchase healthcare services. The Primary Care Trust accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreements

1.4 Taxation

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

1.5 Administration and Programme Costs

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

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

1. Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.7 Intangible Assets

Recognition

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

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

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

Measurement

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

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

1.8 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.9 Donated assets

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

1.10 Government grants

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

1.11 Non-current assets held for sale

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

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

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

1.12 Inventories

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

1.13 Cash and cash equivalents

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

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

1.14 Losses and Special Payments

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

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

1.15 Clinical Negligence Costs

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

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

1. Accounting policies (continued)

1.16 Employee benefits

Short-term employee benefits

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

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

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

1.17 Research and Development

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

1.18 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.

1.19 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.

1.20 EU Emissions Trading Scheme

The Primary Care Trust does not account for EU Emission Trading Scheme allowances as these are not material.

1. Accounting policies (continued)

1.21 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.

1.22 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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.

1.23 Foreign exchange

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

1.24 Provisions

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

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

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

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

1. Accounting policies (continued)

1.25 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

The Primary Care Trust holds an investment representing 4% of the issued share capital of South West London Health Partnerships Ltd. This is a long-term investment and is valued at cost since this is not materially different from market value

Held to maturity investments

The Primary Care Trust has no held to maturity investments.

Loans and receivables

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

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

1.26 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

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

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

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

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement

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

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

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

Assets contributed by the PCT to the operator for use in the scheme

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

Other assets contributed by the PCT to the operator

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

1. Accounting policies (continued)

1.27 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
IAS 19 (Revised 2011) Employee Benefts
IAS 32 Financial Instruments: Presentation
IFRS 7 Financial Instruments: Disclosures

1.28 Going Concern.

As a result of the Health and Social Care Act 2012, PCT's ceased to exist on 31 March 2013.
It is expected that the PCT's functions will be transferred to other public sector bodies. As a result, in accordance with the interpretation of going concern set out in the NHS manual for accounts, the accounts are prepared on a going concern basis because the services will continue to be provided by government.
Where some contract and functions are not expected to transfer to other public sector bodies, the directors have reviewed the carrying values of any associated assets and liabilities. No adjustments are considered necessary.
See note 41 for further details.

2 Operating segments

The Primary Care Trust did not recognise segments during 2012-13 and 2011-12.
On the 1st April 2011, the provider functions of the Primary Care Trust were transferred to The Royal Marsden Hospital NHS Foundation Trust, therefore no amounts are disclosed.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**622,806**	602,256
Revenue Resource Limit	**627,423**	608,713
Under/(Over)spend Against Revenue Resource Limit (RRL)	4,617	6,457

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	**795**	1,898
Charge to Capital Resource Limit	**(5,016)**	1,125
(Over)/Underspend Against CRL	**5,811**	**773**

3.3 Provider full cost recovery duty

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

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**611,380**	590,155
Cash Limit	**620,580**	599,535
Under/(Over)spend Against Cash Limit	**9,200**	**9,380**

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

	2012-13 £000
Total cash received from DH (Gross)	543,130
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**543,130**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	14,096
Plus: drugs reimbursement (central charge to cash limits)	54,154
Parliamentary funding credited to General Fund	**611,380**

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	**3,772**	0	3,772	4,042
Prescription Charge income	**2,620**	0	2,620	2,576
Strategic Health Authorities	**282**	9	273	86
NHS Trusts	**25**	25	0	11
NHS Foundation Trusts	**0**	0	0	371
Primary Care Trusts - Other	**3,486**	948	2,538	2,079
Local Authorities	**642**	85	557	437
Education, Training and Research	**2,072**	0	2,072	1,989
Rental revenue from operating leases	**7,203**	5,905	1,298	6,018
Other revenue	**640**	1	639	143
Total miscellaneous revenue	**20,742**	**6,973**	**13,769**	**17,752**

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	30,456		30,456	26,135
Non-Healthcare	6,490	6,490	0	6,454
Total	36,946	6,490	30,456	32,589
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	311,105	0	311,105	307,224
Goods and services (other, excl Trusts, FT and PCT))	344	0	344	912
Total	311,449	0	311,449	308,136
Goods and Services from Foundation Trusts	93,488	3,416	90,072	85,347
Purchase of Healthcare from Non-NHS bodies	43,248	0	43,248	35,896
Expenditure on Drugs Action Teams	2,975	0	2,975	2,673
Non-GMS Services from GPs	0	0	0	2,054
Contractor Led GDS & PDS (excluding employee benefits)	19,867	0	19,867	17,564
Chair, Non-executive Directors & PEC remuneration	62	62	0	40
Executive committee members costs	24	24	0	64
Consultancy Services	1,961	1,335	626	1,788
Prescribing Costs	44,489	0	44,489	46,619
G/PMS, APMS and PCTMS (excluding employee benefits)	54,618	0	54,618	52,054
Pharmaceutical Services	7,905	0	7,905	7,632
New Pharmacy Contract	4,197	0	4,197	4,391
General Ophthalmic Services	2,898	0	2,898	2,653
Supplies and Services - Clinical	1,867	35	1,832	1,623
Supplies and Services - General	19	9	10	8
Establishment	702	610	92	525
Transport	95	24	71	104
Premises	3,581	2,445	1,136	2,487
Impairments & Reversals of Property, plant and equipment	36	0	36	4,083
Depreciation	2,707	0	2,707	2,757
Amortisation	159	0	159	72
Impairment of Receivables	63	0	63	(9)
Audit Fees	112	112	0	209
Clinical Negligence Costs	0	0	0	57
Education and Training	44	19	25	20
Grants for capital purposes	0	0	0	730
Other	2,903	2,840	63	1,757
Total Operating costs charged to Statement of Comprehensive Net Expenditure	636,415	17,421	618,994	613,923
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	104	104	0	163
Other Employee Benefits	5,788	4,446	1,342	5,777
Total Employee Benefits charged to SOCNE	5,892	4,550	1,342	5,940
Total Operating Costs	642,307	21,971	620,336	619,863
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	0	0	0	0
Grants to Local Authorities to Fund Capital Projects	0	0	0	730
Grants to Private Sector to Fund Capital Projects	0	0	0	0
Grants to Fund Capital Projects - Dental	0	0	0	0
Grants to Fund Capital Projects - Other	0	0	0	0
Total Capital Grants	0	0	0	730
Grants to fund revenue expenditure				
To Local Authorities	0	0	0	0
To Private Sector	0	0	0	0
To Other	0	0	0	0
Total Revenue Grants	0	0	0	0
Total Grants	0	0	0	730

In 2011/12 Croydon, Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs combined their management functions as part of the SW London cluster of PCTs. NHS SW London operates as one management team, sharing resources roles and functions. The income and expenditure relating to cluster-wide functions are shown in the accounts of Wandsworth PCT in 2012/13. Sutton and Merton PCT's contribution to cluster-wide functions is included under "Goods and services from other PCTs" in the analysis of operating costs.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	15,449	14,264	1,185
Weighted population (number in units)*	341,069	341,069	341,069
Running costs per head of population (£ per head)	45.30	41.82	3.48
PCT Running Costs 2011-12			
Running costs (£000s)	12,264	10,735	1,529
Weighted population (number in units)	341,069	341,069	341,069
Running costs per head of population (£ per head)	35.96	31.47	4.49

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

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	54,618	52,054
Prescribing costs	44,489	46,619
Contractor led GDS & PDS	19,867	17,564
General Ophthalmic Services	2,898	2,653
Pharmaceutical services	7,905	7,632
New Pharmacy Contract	4,197	4,391
Non-GMS Services from GPs	0	2,054
Total Primary Healthcare purchased	**133,974**	132,967
Purchase of Secondary Healthcare		
Learning Difficulties	2,202	4,504
Mental Illness	51,995	53,376
Maternity	22,093	21,331
General and Acute	319,343	303,570
Accident and emergency	13,677	12,809
Community Health Services	53,595	49,679
Other Contractual	14,586	10,111
Total Secondary Healthcare Purchased	**477,491**	455,380
Grant Funding		
Grants for capital purposes	0	730
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**611,465**	**589,077**
Healthcare from NHS FTs included above	91,699	70,249

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**1,306**	1,315
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**1,306**	**1,315**
Payable:					
No later than one year	**0**	**1,507**	**0**	**1,507**	1,507
Between one and five years	**0**	**6,030**	**0**	**6,030**	6,030
After five years	**0**	**9,045**	**0**	**9,045**	10,552
Total	**0**	**16,582**	**0**	**16,582**	**18,089**
Total future sublease payments expected to be received				0	0

The operating lease rentals due are in relation to leases for the Primary Care Trust's headquarters in Wimbledon. The lease is for a term of 15 years expiring on 10 June 2024. The future rent payable is subject to review every 5 years.

No rent is payable for the first two years. Thereafter the rent payable is £1,256,000 per annum plus VAT. For accounting purposes the Primary Care Trust has apportioned the total rent payable during the term of the lease annually over the full 15 year term of the lease.

The Primary Care Trust may break the leases after 5 years or 10 years on payment of a penalty.

The Primary Care Trust has entered into a financial arrangement involving the use of GP premises. Under:

IAS 17 Leases
SIC 27 Evaluating the substance of transactions involving the legal form of a lease
IFRIC 4 Determining whether an arrangement contains a lease.

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**7,203**	5,992
Contingent rents	**0**	26
Total	**7203**	6,018
Receivable:		
No later than one year	**5,849**	5,849
Between one and five years	**3,388**	3,388
After five years	**0**	0
Total	**9,237**	9,237

The operating lease rentals are in relation to several short-term leases that the Primary Care Trust has with NHS and non NHS organisations that occupy space within its buildings.

The PCT receives rents from The Royal Marsden NHS Foundation Trust in respect of buildings occupied in the provision of Community services in the two Boroughs. In addition, the Primary Care Trust also receives rental income from NHS SW London that occupies part of the offices at 120 The Broadway Wimbledon.

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13								
				Permanently employed			Other	
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure								
Salaries and wages	4,654	3,596	1,058	4,439	3,430	1,009	215	166	49
Social security costs	412	318	94	411	318	93	1	0	1
Employer Contributions to NHS BSA - Pensions Division	573	442	131	572	442	130	1	0	1
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	253	194	59	253	194	59	0	0	0
Total employee benefits	5,892	4,550	1,342	5,675	4,384	1,291	217	166	51
Less recoveries in respect of employee benefits (table below	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised cost	5,892	4,550	1,342	5,675	4,384	1,291	217	166	51
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised cost	5,892	4,550	1,342	5,675	4,384	1,291	217	166	51
Recognised as:									
Commissioning employee benefits	5,892			5,675			217		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised cost	5,892			5,675			217		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-1			
Salaries and wages	4,909	4,773	136
Social security costs	430	427	3
Employer Contributions to NHS BSA - Pensions Division	601	597	4
Total gross employee benefits	5,940	5,797	143
Less recoveries in respect of employee benefit	0	0	0
Total - Net Employee Benefits including capitalised cost	5,940	5,797	143
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised cost	5,940	5,797	143
Recognised as:			
Commissioning employee benefits	5,940		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised cost	5,940		

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

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	3	3	0	3	3	0
Administration and estates	73	71	2	70	68	2
Nursing, midwifery and health visiting staff	6	6	0	7	7	0
Scientific, therapeutic and technical staff	10	8	2	9	8	1
TOTAL	92	88	4	89	86	3
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

This information is reported in the Annual Report of the PCT

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	4	0	4	0	0	0
£10,001-£25,000	4	0	4	0	0	0
£25,001-£50,000	3	0	3	0	0	0
£50,001-£100,000	2	1	3	0	0	0
£150,001 - £200,000	1	0	1	0	0	0
Total number of exit packages by type (total cost	**14**	**1**	**15**	**0**	**0**	**0**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	467,857	83,399	**551,256**	0	0	0

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

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these 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.

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

a) Full actuarial (funding) valuation

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

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

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

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

b) Accounting valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**10,903**	**63,920**	11,031	50,592
Total Non-NHS Trade Invoices Paid Within Target	**8,992**	**54,194**	10,170	45,728
Percentage of NHS Trade Invoices Paid Within Target	82.47%	84.78%	92.19%	90.39%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,409**	**483,013**	4,068	438,341
Total NHS Trade Invoices Paid Within Target	**3,923**	**478,408**	3,395	397,972
Percentage of NHS Trade Invoices Paid Within Target	88.98%	99.05%	83.46%	90.79%

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

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

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

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	0	0	0	0
PFI finance lease revenue (contingent)	0	0	0	0
Other finance lease revenue	0	0	0	0
Subtotal	0	0	0	0
Interest Income				
LIFT: equity dividends receivable	0	0	0	0
LIFT: loan interest receivable	0	0	0	0
Bank interest	0	0	0	0
Other loans and receivables	0	0	0	0
Impaired financial assets	0	0	0	0
Other financial assets	0	0	0	0
Subtotal	0	0	0	0
Total investment income	0	0	0	0

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)	0	0	0	549
Gain (Loss) on disposal of assets held for sale	(143)	0	(143)	0
Total	(143)	0	(143)	549

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	153	0	153	158
Interest on obligations under PFI contracts:				
Interest on obligations under LIFT contracts:				
- main finance cost	452	0	452	449
Total interest expense	605	0	605	607
Provisions - unwinding of discount	493		493	87
Total	1,098	0	1,098	694

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**23,281**	**29,274**	**122**	**1,980**	**980**	**0**	**8,197**	**702**	**64,536**
Additions of Assets Under Construction				2,027					2,027
Additions Purchased	14	48	0		0	0	577	8	647
Additions Leased	35	0	0		0	0	0	0	35
Reclassifications	(48)	48	0	(1,665)	506	0	453	436	(270)
Reclassifications as Held for Sale	(950)	0	0	0	0	0	0	0	(950)
Disposals other than for sale	0	(10,452)	(122)	0	0	0	0	0	(10,574)
Upward revaluation/positive indexation	0	358	0	0	0	0	0	0	358
Impairments/negative indexation	(9,130)	0	0	0	0	0	0	0	(9,130)
At 31 March 2013	**13,202**	**19,276**	**0**	**2,342**	**1,486**	**0**	**9,227**	**1,146**	**46,679**
Depreciation									
At 1 April 2012	**1,393**	**10,452**	**122**	**37**	**769**	**0**	**4,124**	**174**	**17,071**
Disposals other than for sale	0	(10,452)	(122)		0	0	0	0	(10,574)
Impairments	25	11	0	0	0	0	0	0	36
Charged During the Year	0	972	0		124	0	1,506	105	2,707
At 31 March 2013	**1,418**	**983**	**0**	**37**	**893**	**0**	**5,630**	**279**	**9,240**
Net Book Value at 31 March 2013	**11,784**	**18,293**	**0**	**2,305**	**593**	**0**	**3,597**	**867**	**37,439**
Purchased	11,784	18,293	0	2,305	593	0	3,597	867	37,439
Total at 31 March 2013	**11,784**	**18,293**	**0**	**2,305**	**593**	**0**	**3,597**	**867**	**37,439**
Asset financing:									
Owned	10,829	11,423	0	2,305	593	0	3,597	867	29,614
Held on finance lease	0	3,239	0	0	0	0	0	0	3,239
On-SOFP PFI contracts	955	3,631	0	0	0	0	0	0	4,586
Total at 31 March 2013	**11,784**	**18,293**	**0**	**2,305**	**593**	**0**	**3,597**	**867**	**37,439**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**12,775**	**5,537**	**116**	**0**	**0**	**0**	**0**	**0**	**18,428**
Movements (specify)	(9,445)	359	0	0	0	0	0	0	(9,086)
At 31 March 2013	**3,330**	**5,896**	**116**	**0**	**0**	**0**	**0**	**0**	**9,342**

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	2,027
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**2,027**

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**19,687**	**27,491**	**122**	**340**	**1,032**	**0**	**7,877**	**702**	**57,251**
Additions - purchased	0	0	0	1,640	0	0	433	0	**2,073**
Reclassifications	48	(2)	0	0	0	0	(60)	0	**(14)**
Reclassified as held for sale	(8,433)	0	0	0	0	0	0	0	**(8,433)**
Disposals other than by sale	0	0	0	0	(52)	0	(53)	0	**(105)**
Revaluation & indexation gains	12,005	1,941	0	0	0	0	0	0	**13,946**
Impairments	(26)	(156)	0	0	0	0	0	0	**(182)**
At 31 March 2012	**23,281**	**29,274**	**122**	**1,980**	**980**	**0**	**8,197**	**702**	**64,536**
Depreciation									
At 1 April 2011	**1,393**	**5,202**	**122**	**0**	**713**	**0**	**2,660**	**104**	**10,194**
Impairments	0	4,083	0	0	0	0	0	0	**4,083**
Charged During the Year	0	1,167	0	37	56	0	1,464	70	**2,794**
At 31 March 2012	**1,393**	**10,452**	**122**	**37**	**769**	**0**	**4,124**	**174**	**17,071**
Net Book Value at 31 March 2012	**21,888**	**18,822**	**0**	**1,943**	**211**	**0**	**4,073**	**528**	**47,465**
Purchased	21,888	18,822	0	1,943	211	0	4,073	528	**47,465**
At 31 March 2012	**21,888**	**18,822**	**0**	**1,943**	**211**	**0**	**4,073**	**528**	**47,465**
Asset financing:									
Owned	20,978	11,715	0	1,943	211	0	4,073	528	**39,448**
Held on finance lease	0	3,230	0	0	0	0	0	0	**3,230**
On-SOFP PFI contracts	910	3,877	0	0	0	0	0	0	**4,787**
At 31 March 2012	**21,888**	**18,822**	**0**	**1,943**	**211**	**0**	**4,073**	**528**	**47,465**

12.3 Property, plant and equipment

The Valuation Office Agency undertook a revaluation of the Primary Care Trust's land and buildings as at 31st March 2013. This valuation has been used as the basis of valuation of land and buildings within these accounts.

Note movements

The land and buildings were valued at market value on an existing use basis. This resulted in a net decrease in their value of £10,034,000 out of which an impairment of £36,000 has been charged to the operating cost statement and a loss of £9,998,000 to the revaluation reserve. The £9,998,000 comprises a gain in the value of land and buildings of £502,000 based on the valuation by the District Valuer and a loss of £10,500,000 all reflected as a movement in the revaluation reserve.

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**508**	**0**	**0**	**0**	**508**
Reclassifications	0	270	0	0	0	**270**
At 31 March 2013	**0**	**778**	**0**	**0**	**0**	**778**
Amortisation						
At 1 April 2012	**0**	**72**	**0**	**0**	**0**	**72**
Charged during the year	0	159	0	0	0	**159**
At 31 March 2013	**0**	**231**	**0**	**0**	**0**	**231**
Net Book Value at 31 March 2013	**0**	**547**	**0**	**0**	**0**	**547**
Net Book Value at 31 March 2013 comprises						
Purchased	0	547	0	0	0	**547**
Total at 31 March 2013	**0**	**547**	**0**	**0**	**0**	**547**

13.2 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2011	**0**	**494**	**0**	**0**	**0**	**494**
Reclassifications	0	14	0	0	0	**14**
At 31 March 2012	**0**	**508**	**0**	**0**	**0**	**508**
Amortisation						
At 1 April 2011	**0**	**0**	**0**	**0**	**0**	**0**
Charged during the year	0	72	0	0	0	**72**
At 31 March 2012	**0**	**72**	**0**	**0**	**0**	**72**
Net Book Value at 31 March 2012	**0**	**436**	**0**	**0**	**0**	**436**
Net Book Value at 31 March 2012 comprises						
Purchased	0	436	0	0	0	**436**
Total at 31 March 2012	**0**	**436**	**0**	**0**	**0**	**436**

13.3 Intangible non-current assets

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	5	5
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Property, Plant and Equipment		
Buildings ex. Dwellings	2	44
Dwellings	6	6
Plant & Machinery	5	10
Transport Equipment	7	7
Information Technology	5	5
Furniture and Fittings	10	10

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Changes in market price	36		36
Total charged to Annually Managed Expenditure	**36**		**36**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	9,130		
Total impairments for PPE charged to reserves	**9,130**		
Total Impairments of Property, Plant and Equipment	**9,166**	**0**	**36**
Total Impairments charged to Revaluation Reserve	9,130		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	36		36
Overall Total Impairments	**9,166**	**0**	**36**

15 Investment property

	31 March 2013 £000	31 March 2012 £000
At fair value		
Balance at 1 April 2012	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Gain from Fair Value Adjustments - Reversal of Impairments	**0**	0
Gain from Fair Value Adjustments	**0**	0
Transfers (to)/from Other Public Sector Bodies	**0**	0
Other Changes	**0**	0
Balance at 31 March 2013	**0**	0
Investment property capital transactions in 2012-13		
Capital expenditure	**0**	0
Capital income	**0**	0
	0	0

16 Commitments

16.1 Capital commitments

There were no capital commitments at 31 March 2013 (2012 Nil)

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	158	0	840	0
Balances with Local Authorities	138	0	1,449	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	690	0	8,292	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,091	357	22,067	0
At 31 March 2013	**2,077**	**357**	**32,648**	**0**
prior period:				
Balances with other Central Government Bodies	1,027	0	2,621	0
Balances with Local Authorities	477	0	877	0
Balances with NHS Trusts and Foundation Trusts	2,465	0	8,550	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	16,145	408	32,172	0
At 31 March 2012	**20,114**	**408**	**44,220**	**0**

18 Inventories

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

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**848**	3,492	**0**	0
Non-NHS receivables - revenue	**299**	532	**0**	0
Non-NHS receivables - capital	**0**	15,919	**0**	0
Non-NHS prepayments and accrued income	**880**	635	**198**	209
Provision for the impairment of receivables	**(145)**	(464)	**0**	0
VAT	**195**	0	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**159**	199
Total	**2,077**	20,114	**357**	408
Total current and non current	**2,434**	20,522		
Included above:				
Prepaid pensions contributions	**0**	0		

Orchard Hill Land Sale
The reduction in the capital receivable of £15.919m arises mainly as a result of the payment of the balance of the consideration relating to the Orchard Hill land sale. (£14.669m) The sale which was concluded in March 2011 allowed the purchaser to pay the consideration in 3 parts. The second and third instalment were received in April 2012 and March 2013 respectively. The balance of £1.2501m related to the receipt of the consideration for the disposal of the Cedar Close site.

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**0**	2,674
By three to six months	**0**	45
By more than six months	**0**	333
Total	**0**	3,052

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

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(464)**	**(473)**
Amount written off during the year	**382**	0
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(63)**	9
Balance at 31 March 2013	**(145)**	(464)

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**199**	**2**	**201**
Loan repayments	**(40)**	**0**	**(40)**
Balance at 31 March 2013	**159**	**2**	**161**
Balance at 1 April 2011	204	2	206
Loan repayments	(5)	0	(5)
Balance at 31 March 2012	**199**	**2**	**201**

21.1 Other financial assets - Current

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

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**2**	2
Total Other Financial Assets - Non Current	**2**	2

21.3 Other Financial Assets - Capital Analysis

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

22 Other current assets

	31 March 2013 £000	31 March 2012 £000
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**35**	36
Net change in year	**4,130**	(1)
Closing balance	**4,165**	35
Made up of		
Cash with Government Banking Service	**4,165**	32
Cash and cash equivalents as in statement of financial position	**4,165**	35
Cash and cash equivalents as in statement of cash flows	**4,165**	35

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	8,000	0	0	0	0	0	0	0	0	**8,000**
Plus assets classified as held for sale in the year	950	0	0	0	0	0	0	0	0	**950**
Less assets sold in the year	(7,725)	0	0	0	0	0	0	0	0	**(7,725)**
Less impairment of assets held for sale	(1,225)	0	0	0	0	0	0	0	0	**(1,225)**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	515	0	0	0	0	0	0	0	0	**515**
Plus assets classified as held for sale in the year	8,433	0	0	0	0	0	0	0	0	**8,433**
Less assets sold in the year	(948)	0	0	0	0	0	0	0	0	**(948)**
Balance at 31 March 2012	**8,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8,000**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	**0**

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

At 31 March 2012	8,094
At 31 March 2013	0

The opening balance of £8.0m at 1st April 2012 relates to surplus land located at the Nelson Hospital Merton (£5.4m) Osborne House located in Hastings (£2.1m) and Homeland Drive Sutton (£0.5m). These properties were sold during the year.

25 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS payables - revenue	**9,132**	11,171	**0**	0
Family Health Services (FHS) payables	**9,317**	9,978		
Non-NHS payables - revenue	**4,639**	4,475	**0**	0
Non-NHS payables - capital	**86**	1,348	**0**	0
Non_NHS accruals and deferred income	**9,466**	17,072	**0**	0
Social security costs	**2**	90		
Tax	**6**	71		
Payments received on account	**0**	15	**0**	0
Total	**32,648**	44,220	**0**	0
Total payables (current and non-current)	**32,648**	**44,220**		

Other payables included nil (2011-12 Nil) in respect of payments due in future years under arrangements to buy out the liability for early retirements over 5 instalments; and £Nil (2011-12: £42,878) in respect of outstanding pension contributions at 31 March 2013.

26 Other liabilities

The PCT had no amounts to report in this category 2012-13 (2011-12: nil)

27 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
LIFT liabilities:				
Main liability	**73**	70	**5,550**	5,687
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**108**	99	**2,274**	2,386
Other (describe)	**0**	0	**0**	0
Total	**181**	**169**	**7,824**	**8,073**
Total other liabilities (current and non-current)	**8,005**	**8,242**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	Other	Total
	£000s	**£000s**	**£000s**
0 - 1 Years	0	181	**181**
1 - 2 Years	0	185	**185**
2 - 5 Years	0	614	**614**
Over 5 Years	0	7,025	**7,025**
TOTAL	**0**	**8,005**	**8,005**

28 Other financial liabilities

The PCT had no Other financial liabilities to report (2012: nil)

29 Deferred income

The PCT had no deferred income to report (2011-12: nil)

30 Finance lease obligations

Amounts payable under finance leases (Buildings)	Minimum lease payments		Present value of minimum lease payments	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**255**	255	**108**	99
Between one and five years	**1,018**	1,018	**608**	497
After five years	**2,381**	2,636	**1,666**	1,889
Less future finance charges	**(1,272)**	(1,424)		
Present value of minimum lease payments	**2,382**	2,485	**2,382**	2,485
Included in:				
Current borrowings			**108**	99
Non-current borrowings			**2,274**	2,386
			2,382	2,485

31 Finance lease receivables as lessor

The PCT has no finance leases as a lessor.

32 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**4,330**	9	3,057	6	0	916	0	0	0	342
Arising During the Year	**4,645**	0	559	418	0	3,336	0	0	210	122
Utilised During the Year	**(3,614)**	(2)	(3,310)	0	0	(103)	0	0	0	(199)
Reversed Unused	**(165)**	0	(16)	(6)	0	0	0	0	0	(143)
Unwinding of Discount	**493**	0	493	0	0	0	0	0	0	0
Balance at 31 March 2013	**5,689**	**7**	**783**	**418**	**0**	**4,149**	**0**	**0**	**210**	**122**
Expected Timing of Cash Flows:										
No Later than One Year	**2,879**	**2**	**52**	**418**	**0**	**2,075**	**0**	**0**	**210**	**122**
Later than One Year and not later than Five Years	**2,287**	**5**	**208**	**0**	**0**	**2,074**	**0**	**0**	**0**	**0**
Later than Five Years	**523**	**0**	**523**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	0
As at 31 March 2012	6

In light of the transition to Clinical Commissioning Groups, the PCT has been reviewing future accommodation requirements. Other provisions (£210k) is an estimate of the potential costs that would arise on exercising a break clause relating to one the leases for the offices at 120 The Broadway.

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other - Continuing Care	**(213)**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(213)**	0
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

34 PFI and LIFT - additional information

The Primary Care Trust has no PFI schemes and no off-Statement of Financial Position LIFT schemes.

The Primary Care Trust occupies a health centre at Green Wrythe Lane, Carshalton, under the NHS LIFT arrangements. Under IFRIC12 the health centre is treated as an asset of the Primary Care Trust and the substance of the contract comprises two elements - imputed finance lease charges and service charges.

The agreement is for a term of 25 years ending in 2030. Under the agreement the landlord is responsible for maintaining the building to a high standard and for the provision of certain services associated with the operation of the health centre. The amount payable under the agreement is apportioned between operating costs, maintenance costs and costs of the building. The amount payable is indexed annually by reference to the retail price index. The Primary Care Trust has an option to purchase the property at the end of the agreement and for accounting purposes it has been assessed that this option will be exercised.

The capital value of the asset at 31 March 2013 is £4,586,000 (land £955,000, building £3,631,000). The capital value of the asset at 31 March 2012 was £4,640,000 (land £920,000, building £3,720,000).

The PCT has recently had stage 2 of the Business case for a new LIFT Scheme at The Nelson Hospital approved. These accounts include payments of £2,086,000 reported as Assets Under Construction. There are no other related assets, liabilities or finance costs reported in these Accounts relating to this Scheme.

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013 £000**	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**210**	837
Total	**210**	837

	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	**215**	858
Later than One Year, No Later than Five Years	**981**	3,653
Later than Five Years	**4,212**	19,070
Total	**5,408**	23,581

The estimated annual payments in future years are expected to be materially different from those which the NHS Trust is committed to make during the next year. The likely financial effect of this is:	**31 March 2013 £000**	31 March 2012 £000
Estimated capital value of project - off SOFP LIFT	0	0
Value of Deferred Assets - off SOFP LIFT	0	0
Value of Residual Interest - off SOFP LIFT	0	0

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013 £000**	31 March 2012 £000
No Later than One Year	**520**	519
Later than One Year, No Later than Five Years	**2,025**	2,045
Later than Five Years	**10,033**	10,534
Subtotal	**12,578**	13,098
Less: Interest Element	**(6,955)**	(7,341)
Total	**5,623**	5,757

35 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. LIFT/PFI)			
Depreciation charges	**0**	0	0
Interest Expense	**452**	452	0
Total IFRS Expenditure (IFRIC12)	**452**	**452**	**0**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**0**	0	0
Net IFRS change (IFRIC12)	**452**	**452**	**0**

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	0
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0

36 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit Risk

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

Liquidity Risk

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	848	0	**848**
Receivables - non-NHS	0	353	0	**353**
Cash at bank and in hand	0	4,165	0	**4,165**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**5,366**	**0**	**5,366**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	3,492	0	3,492
Receivables - non-NHS	0	16,311	0	16,311
Cash at bank and in hand	0	35	0	35
Other financial assets	0	0	0	0
Total at 31 March 2012	0	19,838	0	19,838

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	9,132	**9,132**
Non-NHS payables	0	23,940	**23,940**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	8,005	**8,005**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**41,077**	**41,077**
Embedded derivatives	0	0	0
NHS payables	0	11,171	11,171
Non-NHS payables	0	32,888	32,888
Other borrowings	0	0	0
PFI & finance lease obligations	0	8,242	8,242
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	52,301	52,301

37 Related party transactions

Sutton and Merton Primary Care Trust is a body corporate established by the Secretary of State for Health.

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

	2012/13		2011/12	
	Payments to related party	Amounts owed to related party	Payments to related party	Amounts owed to related party
	£	£	£	£
Dr Howard Freeman (Personal Medical Services contract)*	770,604	12,345	669,523	30,615
Dr Martyn Wake (Personal Medical Services contract)	1,871,869	45,774	1,632,656	84,868

*In addition, Dr Freeman is a partner in a practice that is part of the South West London Primary Care Organisation. The Primary Care Trust made PMS contract payments to the South West London Primary Care Organisation of £2,268,294 in for 2012/13 (£9,081,526 in 2011/12). The amount disclosed for 2012/13 is for the 3 months to 30th June, the point at which this arrangement ceased. The amounts shown above are Dr Freeman's practice's share of this total contract payment.

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

	2012/13		2011/12	
	Expenditure with related party	Revenue from related party	Expenditure with related party	Revenue from related party
	£000	£000	£000	£000
London Strategic Health Authority	2	2,282	125	2,075
Epsom & St Helier University Hospitals NHS Trust	142,468	-	138,914	10
St Georges Healthcare NHS trust	104,645	-	99,665	-
Kingston Hospital NHS Trust	9,866	-	10,954	-
The Royal Marsden Hospital NHS Foundation Trust	63,109	4,248	56,714	3,651
South West London and St George's Mental Health NHS Trust	33,932	-	35,523	145
Wandsworth Teaching Primary Care Trust	8,659	4,260	5,784	2,941

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

	2012/13		2011/12	
	Expenditure with related party	Revenue from related party	Expenditure with related party	Revenue from related party
	£000	£000	£000	£000
London Borough of Merton	6,962	557	6,894	130
London Borough of Sutton	7,889	85	6,155	307

The PCT acted as corporate Trustee for the Sutton and Merton Primary Care Trust Charity. The Charitable Funds were passed to the management of Sutton CCG on the 3rd April 2013.

At the 31st March the total funds were valued at £1.78m (2012 - £1.65m)
The surplus of income over expenditure for the year to 31 March was £134,000 (2011/12 £40,000 deficit).

38 Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	315,277	7
Special payments - PCT management costs	235	1
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	315,277	7
Total special payments	235	2
Total losses and special payments	315,512	9

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

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

39 Third party assets

The Primary Care Trust held no third party assets at 31st March 2013. (£nil - 2011/12)

40 Cashflows relating to exceptional items

There were no exceptional items in 2011-12.

41 Events after the end of the reporting period

The passing of the Health and Social Care Bill in March 2012 has far-reaching implications for the organisation. The Primary Care Trust ceased to exist as an entity after March 31st 2013 however, these accounts have been prepared on the going concern basis, as the PCTs statutory duties and responsibilities will be undertaken by a successor NHS organisation from 1 April 2013. During the course of the transitional 2012-13 financial year, the organisation has worked with its partners across South West London to establish successor organisations to ensure a smooth transition to the new organisational structures.

Sutton & Merton Primary Care Trust
Annual Governance Statement 2012 - 2013

NHS Sutton and Merton

Organisation Code:

Governance Statement

1 Scope of responsibility

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

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

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

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

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

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

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

2 The Governance Framework of the Organisation

2.1 Governance Framework

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

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

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

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

arrangements have been transferred in a measured way to the new system, to underpin this planned shadow operating period.

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

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

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

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

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

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

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

2.2 NHS SWL Joint Boards' Committee Structure

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

In terms of remit, the Committees cover:

Statutory Committees

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

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

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

(iv) **PEC/Clinical Commissioning** (CCC) – the former to exercise functions specified in the Directions 2007 and the latter to be directly accountable to the appointing PCT for delegated commissioning functions to enable each PCT to achieve its statutory commissioning functions in a locally applicable way, with GP leadership. The CCCs supported the delivery and development of local GP consortia and their initiatives through making recommendations to its appointing Board, and undertaking delegated functions. Where PECs and CCCs met together, the combined membership ensured the statutory functions of the PEC were fulfilled.

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

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

Non Statutory Committees

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

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

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

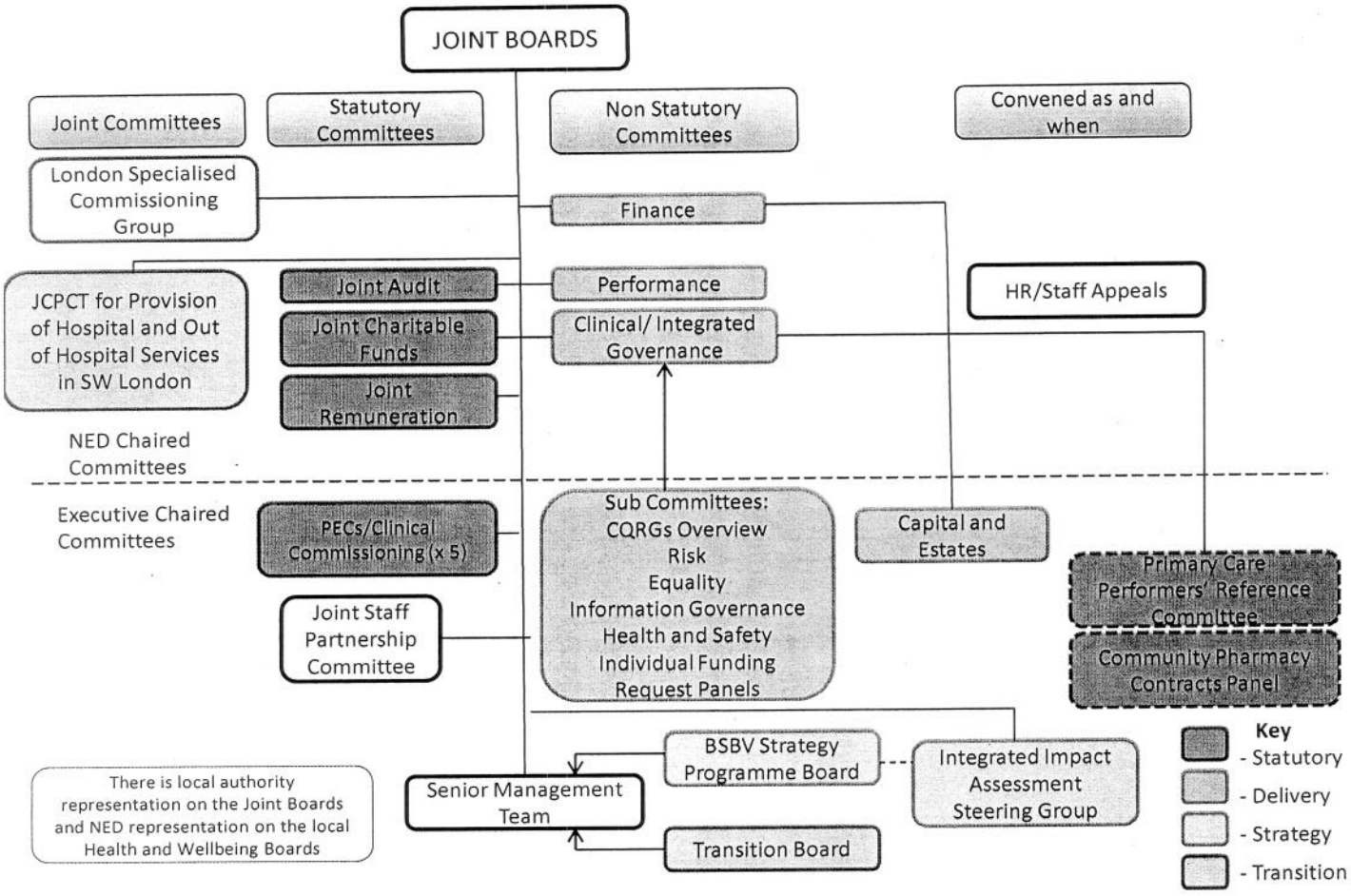
(ix) **(Joint Committees ((ix) Pan London; (x) South West and South East Clusters)**

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

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

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

JOINT BOARDS' COMMITTEE STRUCTURE



2.3 NHS SWL Joint Boards' Performance

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

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

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

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

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

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

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

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

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

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

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

- Board Assurance Framework and Key Risks Exception Report
- Finance Reports
- Annual Accounts
- Performance Reports

- QIPP Plans
- SWL PCTs Operating Plan
- Commissioning Strategic Plan
- Quality and Patient Safety Reporting
- Transition

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

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

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

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

- A&E Waiting time: Whilst there has been an improvement against the 4 hour wait, this has continued to be an area for constant monitoring and the lessons learnt from the winter of 2011/12 were used to strengthen the plans for winter 2012/13. Achieving compliance with 95% standard for Type-1 performance at Croydon University Hospital has been a particular focus for 2012/13. Performance during February and March across London has been challenging for all Trusts as a result of a multitude of factors including: higher than predicted levels of acuity and emergency admissions, intermittent loss of beds due to beds due to Norovirus, and poor discharge profile. All Trusts have recovery plans to improve performance and the YTD positions shows that they are still on track to achieve the 95% Standard for All Type performance and Type-1 performance, with the exception of Croydon University Hospital.

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

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

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

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

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

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

2.4 Highlights of Boards Committee Reports

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

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
			closedown for 2012/13 – covering Annual Accounts, Annual Governance Statements and Annual Reports – was received, and the delegation to the DH Audit Sub Committee approved, by Joint Boards in March 2013.
Remuneration and Terms of Service	Met 9 times	Yes	
Joint PEC/ Commissioning Board	Met 3 times	Yes	Sutton and Merton PEC continued to meet as a separate committee distinct from the CC(d)C. Revised terms of reference were approved at the November meeting. These took account of the relationship with the emerging Clinical Commissioning groups (CCGs).
Merton Clinical Commissioning (Delegation) Committee Sutton Clinical Commissioning (Delegation) Committee Merton CCG Governing Body Sutton CCG Governing Body	Met 3 times Met 4 times Met 4 times Met 6 times	Yes	• Reviewing and monitoring CCG and PCT performance, the financial position and Quality, Innovation, Productivity and Prevention plan. • Commissioning strategy and intentions • Transition to clinically-led commissioning NHS organisation structures, including CCG Authorisation • Clinical involvement /overview .e.g. Sutton Mental Health Consultation. • Clinical Effectiveness • Better Healthcare Closer to Home programme, including overview of primary care estates. • Better Services Better Value programme

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

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

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

2.5 An Account of Corporate Governance

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

2.5.1 Information Governance:

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

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

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

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

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

3. Risk

3.1 Risk Assessment

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