Department of Health

NHS

Wandsworth Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Wandsworth Primary Care Trust

2012-13 Annual Report

NHS

South West London

NHS Wandsworth
Annual Report 2012/13

Contents

Contents

Section 1
Welcome

1. Welcome

Welcome to NHS Wandsworth'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 Wandsworth's excellent work in 2012-13 and to celebrate their work since NHS Wandsworth was established in 2002.

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

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

This year has seen the formal handover from PCTs to the new commissioning bodies, Clinical Commissioning Groups (CCGs). The CCGs will take on most commissioning functions from PCTs and manage the majority of the NHS budget. This means that GPs will be leading the planning and organising of local health services. We are pleased to report that Wandsworth CCG became a fully authorised clinical commissioning group in December 2012.

Over the past 11 years, NHS Wandsworth 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 Wandsworth'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 Wandsworth 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 2

Welcome from Wandsworth Borough Team

2. Welcome from Wandsworth Borough Team

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

We are pleased and proud of the many achievements detailed in this report that we have delivered in Wandsworth during 2012/13 and since the start of the PCT back in 2002. Despite the challenges of the extensive change programme, as part of the government's policy to modernise the NHS, we have managed to maintain a sharp focus on improving health and health services this year whilst handing over responsibilities to the newly formed Wandsworth CCG and NHS Commissioning Board.

Throughout the year, our team of dedicated staff have focused on our five strategic goals from our Commissioning Strategy Plan 2012/15 with the aim to:

- Reduce health inequalities by helping people to live longer and healthier lives, particularly those living in our most deprived communities.
- Support young people to take control of their own health earlier, so they continue to make healthier choices throughout their lives.
- Educate people about mental wellbeing, sexual health, drugs, alcohol and obesity. To help prevent illness, diagnose earlier and improve services.
- Improve access, quality and choice of service provision across all care pathways and in appropriate settings.
- Improve the quality of life for people living with long-term and complex health conditions and their carers.

We aim to do this by improving the quality, range and choice of services and by giving people information to manage their own health better.

We would like to take this opportunity to thank Wandsworth's strategic partners for their contributions to the progress we have made in improving services for local people. In particular our thanks goes to Wandsworth Public Health Department, Wandsworth Council, Wandsworth LINk and our NHS partners, including Wandsworth's GPs, Community Services Wandsworth, St George's Healthcare NHS Trust and the South West London and St George's Mental Health NHS Trust.

We are aware that the successful advances and improvements we have achieved during the year and over the life of the PCT would not have been possible without the dedication of our staff, good working relationships with our partners and the views, feedback and comments of the local community. On behalf of the Board we would like to thank each of you for helping to contribute to a local NHS of which we can all be very proud.

Stephen Hickey	Graham Mackenzie	Tom Coffey
Vice Chair	Borough Managing Director	PEC Chair

Section 3

Who we are and what we do

3. Who we are and what we do

We are NHS Wandsworth, the local NHS primary care trust (PCT) responsible for improving the health of approximately 370,360 people who live in Wandsworth, including 71,210 patients registered with a Wandsworth GP, but living outside the borough.

We have three core functions:

- Commissioning healthcare services on behalf of the population – in the current financial climate, this can mean making some tough choices so we need to make sure we identify the right priorities for local people to meet their health and wellbeing needs
- Improving the health and wellbeing of the population and reducing inequalities in health
- Developing and performance managing health services provided by primary care contractors: GPs, dentists, pharmacists and optometrists

3.1. How the NHS in Wandsworth has changed

In April 2012 the local emerging Clinical Commissioning Group (CCG) in Wandsworth took delegated authority for the delivery of health services in line with the Health and Social Care bill. The CCG developed during the course of the year and were successfully authorised by the NHS Commissioning Board to become a statutory body on 1 April 2013.
The individual PCTs remained as statutory organisations, but NHS South West London continued to operate as one management team, sharing resources, roles and functions.
As part of this arrangement, all five PCT Boards met together as the Joint Boards of South West London Primary Care Trusts, which included NHS Wandsworth Board.

3.2. How we spent your money

You will find a complete breakdown of how your money is spent in the Operating and Financial review section " Where did the money go".

Section 4
About our borough

4. About our borough

There is a higher percentage of younger adults living in Wandsworth than anywhere else in the country. While this demographic is generally healthy, young adults are likely to have higher rates of risky behaviour around drugs, alcohol and sexual relations.

With one in five people moving out of the borough every year, Wandsworth also has the highest mobility rate in Britain.

In Wandsworth:

- Almost half of the population is aged between 20 and 39 years old
- More than 12,000 people are over 75
- One in five residents is under 20 years old
- 22% of the population come from minority ethnic backgrounds, the largest groups being black Caribbean, black African, Indian and Pakistani
- There is a huge variation in education, employment and deprivation levels
- Cancer and cardiovascular disease, including stroke, are our residents' biggest killers

4.1. Wandsworth Health and Wellbeing Board

The Wandsworth Health and Wellbeing Board first met in December 2010, and has continued to meet regularly throughout 2011/12 and 2012/13. Board Membership includes elected members and directors of Wandsworth Council, executive and non-executive directors of NHS Wandsworth, lead members of the Wandsworth Clinical Commissioning Group, and a representative of the Wandsworth Local Involvement Network.

It works closely with the Wandsworth Health and Wellbeing Partnership, which also includes representatives of NHS Trusts and private sector providers, the professional representative committees, and voluntary, community and service user organisations.

The Board has been taking forward the key actions from the Joint Strategic Needs Assessment Strategy, and focusing on:

- Promoting resilience, particularly in the more deprived parts of the Borough
- Strengthening prevention programmes, particularly tackling alcohol related harm
- Developing more effective and efficient delivery of care and treatment services, with a specific focus on integrating health and social care services

4.2. Wandsworth Adult Care and Health Overview and Scrutiny Committee

The Wandsworth Adult Care and Health Overview and Scrutiny Committee undertakes scrutiny of both health and social care. In the past year, the committee has scrutinised the following issues:

- Cardiovascular disease prevention
- Waiting times for treatment at St George's Hospital
- The performance of drug and alcohol services
- GP out of hours services and the new '111' service

Actions taken by NHS Wandsworth in response to the concerns raised by the committee include:

- Enhanced performance management arrangements for out of hours provision and the '111' service
- Concerted action to reduce waiting times at St George's Hospital

4.3.Our achievements in public health

Sexual health

In Wandsworth we have made significant efforts to help improve the sexual and reproductive health of our population in 2012/13. Experiencing improved sexual health has many benefits to our overall wellbeing as it can improve the way we feel about ourselves, our relationships, our ability to work, to socialise, and the overall role we play in society.

One of only ten London boroughs to be on target for Chlamydia diagnosis performance

As a borough we continue to have some of the highest rates of sexually transmitted infections in London. As a result NHS Wandsworth has jointly commissioned the South West London Chlamydia Screening Programme in 2012 which is co-ordinated by the Terrance Higgins Trust.

The aim of this work is to prepare for the new Public Health Outcome indicator which requires us to meet a Chlamydia diagnosis rate of 2,400 per 100,000 population (aged 15-24) to show our effectiveness at tackling the infection. From April to September 2012 we reached a diagnosis rate of 2,890 and were one of only 10 boroughs in London to meet this indicator. In this period we screened more than 5,000 15-24 year olds.

Even with this work Chlamydia rates in Wandsworth remain high. Over the next year we will improve our Chlamydia screening coverage through pharmacy and GP services while continuing to make sure we target those most at risk.

We have also introduced a free condom scheme targeting under 25's to encourage safer sexual activity and increased our online provision for Chlamydia testing to make it even easier to access testing out of hours.

Wandsworth continues to support and increase HIV testing across a variety of healthcare settings to help reduce late diagnosis. This work including offering HIV tests via GP practices (for both new patient registrations and where the need for testing is clinically indicated) and at St George's Hospital, where we are now trialling a similar approach in the Acute Medical Unit by offering patients admitted via A&E (aged 18-59) a routine HIV test.

Teenage Pregnancy

Wandsworth has had a teenage pregnancy strategy since 2001. In 1998, the conception rate in girls aged 15-17 in Wandsworth was 71.4 girls per 1000. In the most recent period for which data is available, September 2010 to September 2011, the rate was 30.4 per 1,000 – a reduction of 57%.

The biggest reduction in teenage pregnancy achieved by any London borough

This is the biggest reduction achieved in any London borough and the second biggest in any local authority in England. However our rate still remains around the middle in both London and nationally.

The Teenage Pregnancy Action Plan sets out six key objectives to reduce under 18 conceptions in Wandsworth through:

- Giving young people the knowledge and skills they need to experience positive relationships and good sexual health
- Improving access to and use of effective contraception when they need it
- Intervening early with those most at risk
- Improving outcomes for teenage parents and their children
- Investing in training for the wider children's workforce
- Getting delivery right - performance management of Wandsworth teenage pregnancy strategy

Childhood obesity

90% children in Reception and Year 6 have their height and weight measured every year as part of a national measurement programme (NCMP). We have been tracking these measurements for the last five years.

2,000 families have attended a healthy lifestyle or healthy weight programme in Wandsworth

The proportion of children in Reception with a healthy weight has been steadily going down since 2007. The most recent results (2011/12) from the NCMP report that 10.3% of reception children are obese, a 0.5% increase from the previous year.

The proportion of children with a healthy weight in year 6 has been going up over the last five years. The prevalence of obesity in Year 6 has fluctuated in recent years which have made it difficult to identify a trend. However, the last few years are starting to show rates of obesity staying the same and only a slight increase in overweight children. In 2011/12, 20% of Year 6, children were obese, a reduction of 0.9% from the previous year.

Our school health teams directly support parents of children who have been identified as having an unhealthy weight through the NCMP.

We have commissioned a variety of support for Wandsworth residents:

- Mytime Active provide obesity prevention programmes for families with children under five, as well as weight management programmes for new mothers, an accreditation scheme for early years centres and obesity awareness training for frontline staff.

- MoreLife, a new provider previously known as Carnegie Weight Management, are working closely with schools and school health teams to deliver healthy weight programmes for children aged 5–17 years and their families. MoreLife offers a wide variety of programmes, including summer camps in the holidays and an online 'self-help' programme.

- MEND (Mind, Exercise, Nutrition, Do it) has partnered with St George's Healthcare NHS Trust and DC Leisure to provide our weight management programmes for adults. These consist either of support groups or one-to-one clinics with a dietician or a healthy lifestyle advisor.

Abdominal aortic aneurysm (AAA) screening

In 2009, a national AAA screening programme was introduced in England, and was rolled out across south west London during 2009-2010.

The percentage of men in Wandsworth coming for their AAA screening has increased from 61% in 2010/11 to almost 65% and rising in 2012/13

AAA occurs when a weakness in the wall of the major blood vessel (aorta) results in a bulge, which if undetected can rupture, resulting in approximately 2% of all deaths (6,000) in men aged 65 years or over in England and Wales. Quite often there are no symptoms and it is twice as common in men as women.

The screening programme for Wandsworth is provided by St George's Hospital, and is performed in a variety of local settings including GP surgeries and local hospitals. Eligible inmates are also offered screening at Wandsworth and Highdown prisons.

The screening programme invites men for a simple ultrasound of the stomach area after they turn 64, and men over 65 can refer themselves for screening. Any man found to have a small or medium sized aneurysm is offered further scans at yearly or three monthly intervals respectively. Men with large AAA detected are referred to the vascular surgeons at St George's Hospital for to consider a surgical repair.

Survey results have shown men often don't attend due to lack of awareness of the programme and lack of understanding of the importance of getting screened. A number of health promotion activities are due to start in 2013 to increase people's awareness.

Diabetic eye screening

Diabetes is one of the biggest healthcare challenges facing the NHS today with more than 2.6 million people with diabetes in England, and the number of people developing type 2 diabetes continuing to increase.

16,790 patients with diabetes from Wandsworth and Richmond have been offered an eye screening test during 2012/13

Diabetes is the leading cause of blindness in people of working age due to diabetic retinopathy. The Diabetic Eye Screening programme aims to reduce diabetic retinopathy and the number of patients who are registered blind or seriously sight impaired by providing an annual screening programme for all diabetics aged 12 years and above.

Uptake of the Diabetic Eye Screening programme has been improving: 75% in 2009/10, 78.3% in 2010/11 and 81% in 2011/12.

Cancer

In Wandsworth cancer is the leading cause of death in people under the age of 75 and these figures are on the up compared to the rest of the country. Lung cancer is the main cause in men, whilst 1 in 5 women that die of cancer have breast cancer and another 1 in 5 die of lung cancer.

We are the only PCT in London to have been successfully awarded funding from the Department of Health for an oesophageal and stomach cancer pilot programme. We are working with specialist clinicians at St George's Hospital, local GPs, pharmacists and patient advocates.

Early findings show:

- Community pharmacies have identified over 40 members of the public who needed further information, advice and/or a referral to their GP
- A change in primary care referrals following health professional training and education
- An excellent response rate of around 20% to a direct mailing issued to nearly 5,000 men across the borough

The borough's Public Health Macmillan GP Facilitator has been busy working with local GPs and practice staff to deliver Cancer Practice Profile education sessions and raise awareness of the different diagnostic and suspected cancer referral options available to GPs.

We are also committed to working with the voluntary sector. For example, this year we have continued our relationship with Paul's Cancer Support Centre in Battersea. This year the centre has run over 20 cancer awareness sessions targeting black and minority ethnic communities. In these communities there are links to late diagnosis due to low awareness of the signs and symptoms, cultural attitudes and myths about cancer.

Olympic legacy programme

The London 2012 Olympic and Paralympic Games were a phenomenal success. In order to capitalise on the success of the Games Wandsworth Public Health Department appointed two Olympic Legacy Project Managers who were tasked with building on the enthusiasm and excitement generated in 2012 to push the wider public health agenda.

Achievements include:

- NHS Wandsworth achieved a silver accreditation in NHS Sport and Physical Activity Challenge 2012.
- The 'Health Café' concept was launched at the Wandsworth GET ACTIVE Festival, and offered the public a place to sit and have a quick drink, whilst selecting health related interventions like smoking cessation advice, physical activity taster sessions or health trainer appointments.
- Play Rangers pop up schemes targeted children in priority wards. An estimated 1,125 children attended over a three week period, many of whom attended with a parent or carer.
- Consultations with people in sheltered housing which examined their levels of physical activity and whether there were opportunities available to help support these individuals in becoming more physically active.

About 4,000 people attended our Health Cafés around the borough

NHS Health Check programme

The NHS Health Check targets individuals aged between 40 and 74 without any diagnosed form of cardiovascular disease. The programme runs in GP practices and five community pharmacies.

Since the start of the programme in 2009, over 35,000 Wandsworth residents have received an NHS Health Check

In a recently published report by Diabetes UK called *The NHS Health Check Programme – Let's Get It Right,* Wandsworth was rated as 'performing very well' offering 26.8% of our eligible population a check which was more than 6% over the national target and put us in the top 13% of PCTs ion the country.

In 2013/14 the NHS Health Check programme will be included in the list of prescribed public health services for local authorities to commission and is also included in the Public Health Outcomes Framework strengthening the profile of the programme and the commitment to the future delivery of NHS Health Checks in Wandsworth.

Childhood immunisations

Wandsworth offers a wide range of vaccinations to children in the borough including the BCG to babies under one from this year.

In order to ensure high levels of immunisation coverage are achieved and sustained, there is a need to continue with the following:

- Continue working with providers to improve uptake of all childhood vaccinations particularly MMR (dose 1 and dose 2) and the pre-school booster
- Improving systems for identifying children due or overdue immunisations and ensuring they are managed effectively
- Implementing interventions targeting vulnerable or hard to reach groups including children not registered with GP practices
- Working with providers to improve immunisation data quality
- Raising awareness of the benefits of immunisation and the severity of vaccine preventable illnesses
- Ensuring all staff involved in implementing immunisation programmes have access to immunisation training

NHS Wandsworth Childhood Immunisation Performance

Indicator	Targets	2010/11 End-of year Position	2011/12 End of year Position	Q1 2012/13 performance	Q2 2012/13 performance	Q3 2012/13 performance
DtaP/IPV at 1 year	**93.7%**	91.2%	92%	90.6%	91.2%	92.7%
MMR at 2 years	**95.0%**	89.7%	86%	84.8%	77.3%	84.8%
PCV at 2 years	**90.0%**	95.2%	95%	96.1%	76.3%	86.1%
Hib/Men C at 2years	**92.0%**	87.8%	92%	90.9%	77.9%	85.6%
MMR 2 at 5 years	**90.0%**	86.5%	80%	79.9%	64.4%	66.2%
Pre-school booster at 5 years	**90.0%**	72.6%	74%	76.6%	76.9%	77.9%

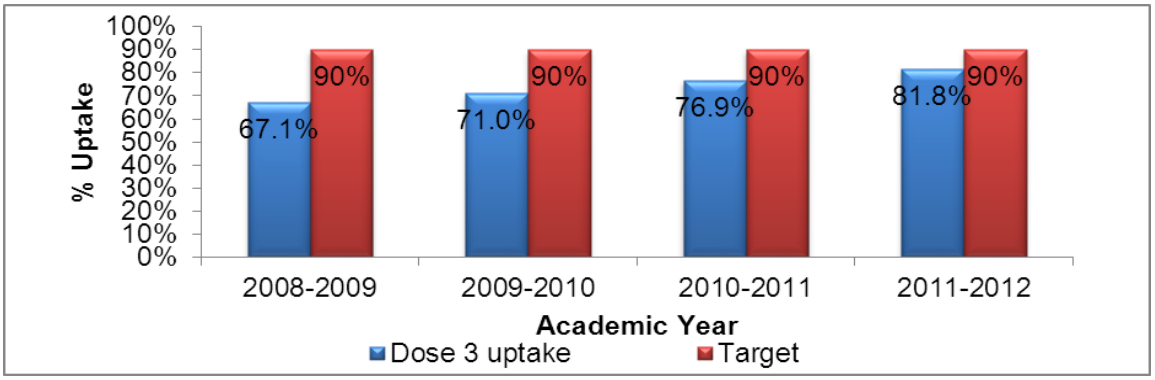
Teenage immunisation

NHS Wandsworth commissioned the provision of the school leaver booster immunisation programme for Wandsworth independent schools. The service has been well received and will ensure that all children attending schools in Wandsworth receive the same immunisation service whatever school they go to.

HPV

The Human Papilloma Virus (HPV) vaccine offers protection against the HPV types 16 and 18 which cause approximately 70% of cervical cancers in the UK. HPV vaccine uptake in Wandsworth has continued to rise steadily year on year (see below). To further improve uptake, an educational DVD is now given to all girls in Year 7 attending Wandsworth schools.

HPV vaccine uptake in Wandsworth 2008/09 - 2011/12

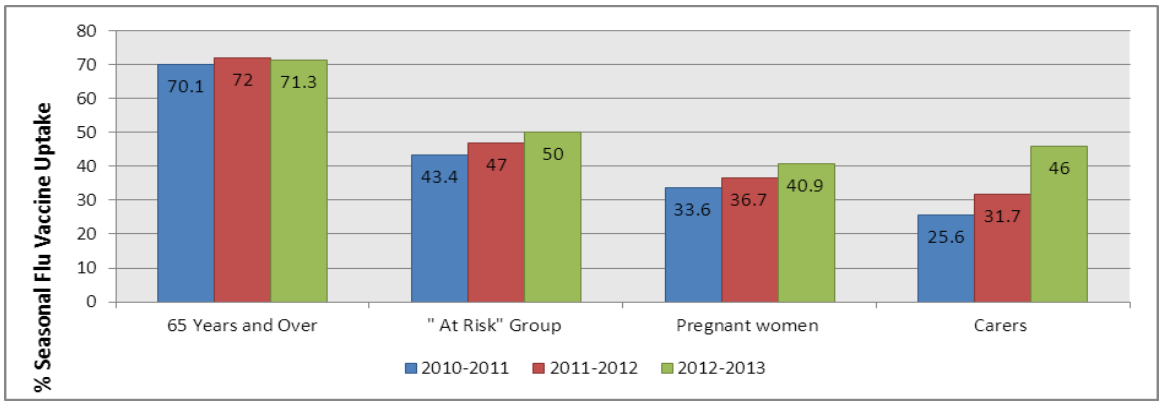


Seasonal flu campaign

Flu is a highly infectious illness caused by a virus which can result in serious complications particularly in elderly people, pregnant women and individuals with certain pre-existing medical conditions. The flu campaign aims to protect these groups of people.

To maximise flu vaccine uptake, NHS Wandsworth commissioned local pharmacies to deliver the flu programme and St George's Hospital to offer flu vaccination to pregnant women. Although flu vaccine uptake in all the categories in Wandsworth falls short of the recommended targets, there has been an increase in vaccine uptake among pregnant women, individuals at risk and carers (see below).

Seasonal flu vaccine uptake in Wandsworth 2010/11 - 2012/13



Breastfeeding

Increasing breastfeeding rates at six to eight weeks is a key public health priority. Breastfeeding initiation rates in Wandsworth have increased steadily from 69.8% in 2004/05 to 93.1% in 2011/12. This is mainly due to the major maternity units serving Wandsworth following the UNICEF Baby Friendly Accreditation pathway.

However, achieving the local breastfeeding at six to eight weeks target of 75.7% remains a challenge. Breastfeeding at six to eight weeks has declined from 75.4% in 2008/09 to 72.8% in 2011/12.

At six to eight weeks 72.8% of women are still breastfeeding in Wandsworth which is the 11th highest rate in England

The following interventions are being implemented to improve and sustain breastfeeding rates across Wandsworth:

- Antenatal breastfeeding workshop for mothers being provided by National Childbirth Trust (NCT)
- 'Breastfeeding Welcome' Scheme commissioned with the NCT
- Provision of breastfeeding reference books "Medications and Mothers' Milk" for GP practices
- Provision of Milk and More packs to health visiting teams to train staff and provide health education sessions for mothers on breastfeeding and weaning
- Breastfeeding telephone support pilot using breastfeeding peer supporters with specific focus on deprived areas with low breastfeeding rates. Will be commissioned early in 2013/14 financial year.

Smoking

2012/13 saw the Stop Smoking Team develop the stop smoking services offered within primary care, secondary care and other specific settings, making the support to quit much more widely available to the general public and special groups.

The Stop Smoking Team has now trained community advisors within GP and pharmacy settings to offer one-to-one support for clients wishing to quit. All GPs within Wandsworth are now asking clients if they smoke and referring them for stop smoking support if they do.

Within secondary care settings the Stop Smoking Team have trained and supported staff to offer drop-in clinics at St George's and Queen Mary's hospitals and have developed an excellent in-house support service for patients within St George's with a referral system from 14 units, from various departments and wards, to the stop smoking clinics run within that hospital.

537 patients at St George's were referred to stop smoking clinics and 21 members of staff completed the nationally approved 'Very Brief Advice' training

The Stop Smoking team have also trained relevant healthcare staff to offer stop smoking support for clients at Springfields, the mental health trust, and Wandsworth Prison. This, alongside the work happening in some of the most deprived wards in Wandsworth, like Roehampton, Queenstown and Latchmere, means that we are developing services that will reduce the inequalities between the most affluent and most deprived wards of Wandsworth – smoking is still the largest cause of inequalities, above all other causes.

This year the Stop Smoking Team trialled 'pop-up clinics' to attract smokers in their shopping environment. This started with the 'Stoptober' campaign in October 2012 with stalls in Asda Roehampton and Clapham Junction running support over six weeks and helping 48 people make the decision to quit. This was followed up again with a 'New Year's Resolution' campaign and has meant that 53 people were helped to take the steps to quit smoking.

The Stop Smoking Team have also worked alongside Catch 22, to raise the profile of services offered to young people. The service ran a poster competition with a local school so that young people got the chance to design a stop smoking poster for their peers. The winning poster has been reproduced as a poster and business card to tell young people about stop smoking services.

For the second year in a row the Wandsworth Stop Smoking team have over achieved on meeting their Department of Health quit target; achieving 1,513 against a target of 1355.

Wandsworth tobacco control programme

The NHS Wandsworth Tobacco Control Alliance (WTCA) continues to work to reduce the number of people who smoke or use tobacco in Wandsworth. This past year the WTCA has continued to support partners to develop and implement projects that assist in reducing smoking prevalence and communicating messages that encourage those that use tobacco to consider others and to quit.

Some of the projects and successes include:

79 families pledged to make their home smokefree at local children's centres

- **Smokefree homes** – the fire service now has a trained stop smoking advisor in their team who can help local residents, the housing team has promoted the smokefree homes initiatives to local residents and the project has been promoted at children's centres around the borough
- **Work with trading standards** made front page of the local papers when we highlighted from the 50 attempts of proxy sales made by children 21 retailers sold to an adult knowing they were purchasing the tobacco for a child.
- Healthy schools department at Wandsworth Borough Council rolled out **Operation Smoke Storm**, an online learning tool for students in schools and colleges, to gain access and support within schools on tobacco control.
- Involved with the development of national tobacco control policy on **Plain Packaging** of all tobacco products.
- More **partnership working** between GPs, local hospitals and pharmacists so that smokers attending for treatment can be referred for support.
- Developed and implemented a **communications strategy** to raise awareness of the impact of tobacco products and smoking locally and highlight local activities to help people wanting to quit.

Falls Risk Assessment Project

The Wandsworth Falls and Bone Health Needs Assessment and Strategy (2010) clearly identified that there were significant unmet needs for falls prevention services as well as services to address poor bone health. Wandsworth has significantly higher admissions and mortality rates related to falls than seen at national level and only about a quarter of patients with osteoporosis are on appropriate medication. The population in Wandsworth is expected to age over the next 20 years resulting in an increased demand for falls and bone health services.

In March 2012, the emerging Wandsworth Clinical Commissioning Group agreed funding to support the development of a number of services aimed at the early identification of patients at risk of developing osteoporosis, better management of patients who already have osteoporosis and earlier identification and management of patients at risk of falls.

Over the past year, Wandsworth has been successful in:

- Expanding the Integrated Falls Service to ensure that the service is able to offer specialist falls assessments and individually tailored exercise programmes to a greater number of patients
- Developing a "bone health" service to ensure that patients who have been diagnosed with osteoporosis or may be at risk of developing osteoporosis are appropriately supported. Some of the exercise programmes on offer are Nordic Walking and modified zumba
- Increasing case-finding systems within the Fracture Liaison Service at St George's Hospital to identify patients over the age of 50 years that have suffered a fragility fracture
- Increasing the capacity for DEXA scanning (the x-ray used to measure bone density and helps in the diagnosis of bone conditions) to ensure that an increased number of clients who have poor bone health are identified

There is also ongoing work with GPs to increase prescribing levels of calcium and vitamin D preparations and bisphosphonates to ensure patients who are identified as osteoporotic or at risk of developing osteoporosis are treated appropriately.

Section 5
Commissioning healthcare

5. Commissioning healthcare

5.1. Local health needs

In order to commission services effectively we need to understand the health needs of our local population. NHS Wandsworth and Wandsworth Borough Council identified the following 11 key health and care needs for Wandsworth in the Joint Strategic Needs Assessment:

- There are significant variations in health across Wandsworth
- Childhood obesity is a major concern
- Wandsworth still has a high teenage pregnancy rate
- The rates of sexually transmitted infections are high
- Alcohol-related hospital admissions have risen
- There is a high level of mental health needs
- Wandsworth has higher than expected rates of mortality from circulatory disease and cancer
- There is a high rate of excess winter deaths
- The mortality rate from accidental falls is high
- Carers may have unmet health and support needs
- Enabling the over-75s to maintain their independence remains a significant challenge

For further information please see the leaflet, JSNA health and care needs for Wandsworth, which can be found here: www.wandsworth.gov.uk/JSNA

5.2. Wandsworth's health priorities for 2012/13

In order to address the 11 key health and care needs identified in the JSNA, Wandsworth CCG will be focussing on eight priority areas during 2012/13 – 2014/15. Brief examples of some of the initiatives/focus areas are provided below. Please see the full copy of the Commissioning Strategy Plan (2012-2015) for further details.

Every year we produce an operating plan which is the action plan that defines how we will deliver the improvements set out in the Commissioning Strategy Plan in the coming year.

The eight priority areas are in our Commissioning Strategy Plan are:

Prevention, screening, early diagnosis and awareness initiatives
Initiatives include smoking cessation, childhood immunisation, cervical screening and healthy eating.

Sexual health
Focus areas include reducing teenage pregnancy and providing Chlamydia screening.

Substance misuse (drugs and alcohol)
Focus areas include increasing the number of people in effective treatment and planned discharges and reducing alcohol-related hospital admissions.

Children's services

Focus areas include building upon existing weight management services for children and families, delivering the Children & Young People's Plan with Wandsworth Borough Council and increasing the uptake of breastfeeding and childhood immunisations.

Urgent care/older people
Initiatives include improving care and services to people with dementia and their carers, improve end of life care services and reducing A&E attendances during practice opening hours by providing same-day access to primary care.

Long-term conditions
Focus areas include improving services and supporting self-management approaches for a number of long-term conditions, including stroke, diabetes, asthma and sickle cell disease. This priority also includes initiatives to support carers' needs, such as access to carers' breaks.

Mental health
Initiatives include reducing waiting times for Improving Access to Psychological Therapies (IAPT) and ensuring the service reaches hard-to reach groups, such as people with learning disabilities. It also includes embedding recently agreed changes to the Community Mental Health Teams and Crisis Intervention Services.

Borough specialised commissioning
Focus areas include improving the rehabilitative pathway for forensic patients and ensuring regular reviews of continuing care patients.

5.3. Our plans for health services in Wandsworth 2012/13

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

Vision and values: Better care and a healthier future for Wandsworth

We will achieve this by being:

Patient focused
Our first responsibility is to our patients, their carers and to the people and communities of Wandsworth. We will involve and engage them in designing services, support them to co-produce systems of care and empower them to look after their own health and help others to do the same.

Outcomes driven
We will measure our success by the improvements we are able to secure in the health of local people and the range and quality of services provided. We will commission services based on evidence of need, clinical effectiveness, patient experience, and in response to defined local and national strategic priorities.

Principled
We are part of the NHS and will ensure that we uphold its principles and values as reflected in the NHS Constitution. We will demonstrate honesty and integrity in all of our work. We will be thoughtful and transparent in our decision-making and governance. We will be responsible stewards of public money, ensuring that we make adequate provision for adverse times.

Collaborative
We are responsible to our fellow members, the practices of Wandsworth. As members we will co-operate to ensure that local services are delivered to the highest standards and that we collectively commission services of high quality, the best value possible and which are responsive to patients' needs. We will work collaboratively with partner organisations to ensure that care is co-ordinated and patient-centred.

Progressive and professional
We are responsible to our employees, and will support individuals and teams to experiment and succeed, to learn and develop. We will treat people with respect and value diversity. We will enable people to fulfil their responsibilities to their families. We will encourage innovation and experiment with new ways of working, learning from our experiences and celebrating successes.

5.4. QIPP

The QIPP (Quality, Innovation, Prevention, Productivity) programme is a national Department of Health strategy that aims to improve the quality and delivery of NHS care whilst reducing costs. It aims to make £20 billion inefficiency savings by 2014/15.

The Wandsworth QIPP Programme for 2012/13 comprised 29 schemes and is on target to deliver £10.8 million in recurrent savings. This follows on from the 2011/12 QIPP programme which delivered savings of £7.1 million.

Clinical reference groups have been the key to developing proposals for robust service redesign with quality and safety driving through innovation and productivity. The key priorities for 2012/13 were Falls and Bone Health, Alcohol and Sexual Health. Programmes of work have been established that concentrate on prevention and health improvement through a series of interventions. Investment in these areas is already showing a positive impact on emergency attendances, admissions and an increase in patient engagement in prevention and self-management.

The continued involvement of the localities groups and the GP engagement process have ensured key messages are communicated and clinicians continue to contribute and remain focussed on priority areas.

During 2012/13 preparations for developing a strategic approach to investment in a rolling QIPP programme have been put in place. A continued emphasis on quality and prevention and robust clinically led service redesign will not only ensure targets continue to be met but that future funds for investment are available and are targeted at areas of health need.

Section 6
Improving performance

6. Improving performance

The 2012/13 NHS Operating Framework sets out the national priorities that Wandsworth PCT has been focussing on during this year of transition.

During 2012/13 Wandsworth has continued to build on the 2011/12 Operating Plan performance and is confirmed to have achieved targets for Mental Health (Early Intervention – new cases and Care Programme Approach 7 day follow-up), Stroke, Retinal Screening and Bowel Screening Programmes, Health Visitor Numbers and NHS Health Checks. Wandsworth is also on track to achieve targets for Cancer Waits, 18-week Referral to Treatment time, A&E waiting times and Smoking Cessation, although final data for the year end is still awaited at the time of writing.

There are a few measures for which more effort has been focused on during 2012/13 and these are as follows:

- Reducing Healthcare Associated Infections (HCAI) – Wandsworth has continued to work with providers throughout the year to promote learning and best practice and produce detailed plans to support the reduction of the rates of MRSA and Clostridium Difficult Infections in 2012/13.
- Childhood Immunisation – This was as a particular challenge for 2011/12. Improving childhood immunisation has been a focus for 2012/13 and Wandsworth have developed performance improvement plans and improvement trajectories to address this.
- Improving Access to Psychological Therapies (IAPT) – The increased targets for 2012/13, both in terms of referrals and recovery rates, has been challenging and has required a significant investment to increase capacity. Wandsworth has detailed plans in place to deliver improvements which are being monitored through the contracting route. Performance during 2011/12 shows a pattern of improvement throughout the year and similar trend is expected during 2012/13.

Wandsworth has been focusing on working with Wandsworth Public Health, NHS South West London, the National Commissioning Board and Wandsworth Borough Council to ensure the smooth transition and handover of performance to Wandsworth CCG and the NHS Commissioning Board.

6.1. CQUINS

Higher Quality of Care for All is a Government policy that proposed a proportion of each provider's income should be 'conditional on quality and innovation', payable through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In the 2012/13 the value of CQUIN was worth 2.5% of all NHS providers' income.

Wandsworth Public Health Department, in partnership with the emerging CCG, identified five CQUIN goals which covered 19 areas that could be commissioned through CQUIN. This means that these areas demonstrate quality and innovation. They were delivered through Community Services Wandsworth in 2012/13. The indicators agreed for the CQUIN framework were:

- Pressure ulcers assessment

- Urine infection in patients with catheters
- Quality assurance of falls risk profiles completed by CSW nursing
- Multidisciplinary team working
- Initiative to support ‘End of Life’
- Single Point of Contact to support NHS 111
- Reducing short stay admission
- Baby friendly accreditation
- Newborn BCG immunisation
- Unregistered children
- Hepatitis immunity test for two years olds
- Increasing uptake of HPV dose 1
- Development of care plans and follow up for sickle cell patients
- Follow up after discharge from hospital for sickle cell patients
- Tackling obesity in children
- Signposting young people to sexual health clinics
- Development of multidisciplinary clinics to support teenage mothers
- Reducing smoking in mothers of newborn babies

Section 7
Working in partnership

7. Working in partnership

We have a strong history of partnership working in Wandsworth. We believe that health in the borough can only be improved through effective working with local partners and by fully engaging clinicians to work with local communities and patients to shape services for the future.

Our vision, values and strategic goals were reviewed in partnership with our staff, clinicians, partners and local communities for the development of our Commissioning Strategy Plan (2012/15). Since then, we have continued to seek feedback from Wandsworth patients, carers and residents.

Some of our key partners we work with are: local hospitals like St George's NHS Healthcare Trust, Community Services Wandsworth, Wandsworth Public Health Department, Wandsworth Borough Council, South West London & St George's Mental Health Trust, Adult Social Services and community and voluntary organisations.

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

The Patient Advice and Liaison Service (PALS) receive requests from patients, their relatives and members of the public for information or advice. The service is also asked to resolve any issues relating to services commissioned by NHS Wandsworth.

In the past year, PALS has dealt with 520 enquiries compared to 529 in the previous financial year) and presented reports on a quarterly basis to NHS South West London Cluster Risk Management Sub-Committee and in the Integrated Governance Report for Wandsworth Borough Team. These reports highlight the 'patient experience' and how these experiences can be used to improve services for all Wandsworth residents.

7.2. Complaints

Our Patient Advice and Liaison Service (PALS) and complaints department deal with complaints about commissioned services within NHS Wandsworth. In 2012/13, we received 76 formal complaints, compared to 98 in the previous financial year.

From April 2009, response timescales became negotiable, with the complainant's agreement. Whilst we still aim to respond to complaints within 25 working days, it can take much longer if we are dealing with a complex complaint that requires further information or the retrieval of health records. However, our dedicated complaints staff deal with these issues as quickly as possible to make sure that, wherever possible, response times do not exceed six months.

Throughout the investigation process, the complainant is kept informed on our progress, via letter, email, phone calls or face to meetings. We take all complaints very seriously and have adopted the Health Service Ombudsman's 'Principles for Remedy' initiative, whereby the department involved will begin to take steps to remedy any situation before a response to the complaint is written. For example, this might mean making sure that appointments are booked where referrals have been mislaid or where cancellations have occurred.

You can read more about 'Principles for Remedy' by typing this into the search box at www.ombudsman.org.uk. This data is presented reports on a quarterly basis to NHS South West London Cluster Risk Management Sub-Committee and in the Integrated Governance Report for Wandsworth Borough Team.

7.3. Better Services Better Value

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

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

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

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

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

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

Section 8
Making it happen

8. Making it happen

8.1. Patient and Public Involvement

The main thrust of our work over the last year has been working with the evolving Clinical Commissioning Group (CCG) to develop its patient and public involvement approach. The work that has been developed has been across four areas:

Development of a PPI Steering Group to develop a PPI Strategy
In order to ensure that the PPI strategy was patient focussed from the start, a PPI steering group was chaired by the Wandsworth LINk chair. Meeting regularly, its purpose was to develop an appropriate response to the need for a modern PPI strategy that met the needs of the CCG. The starting point for this was a workshop attended by 85 patients and GPs to develop principles and patient learning around GP commissioning and Patient Involvement. This was followed by a Conference attended by over 150 patients and staff held in
November 2011 to test the principles out with patients carers, service users
and the public. The final strategy was put to the CCG Board in April 2012.

Enabling seldom heard communities to have a voice
As part of this approach the CCG was keen to ensure that we took a robust approach to enabling those communities and community members who find it difficult to have a voice in health. As a result of this we instigated, through the Wandsworth LINk, a small grants scheme to begin supporting some of those communities having their voice heard and a report on the issues they raised has formed part of the draft strategy. This successful approach has improved access to commissioning for communities and has being extended throughout 2012/13.

Development of a PPI resource centre and toolkit
In order to ensure that patients, carers, and staff have access to both information and support around PPI, the NHS Wandsworth PPI Toolkit has been upgraded and revamped into a PPI Resource centre and Toolkit. This ensures that people have access to up to date information about PPI locally as well as access to the best techniques if they wish to encourage participation in PPI activities. The resource centre has the facility to register PPI activity and reports for analysis and reporting requirements.

Development of the customer relationship management (CRM) system
The CRM has been key to ensuring that we are in regular contact with patients and the public and we have made full use of it over the period. As a tool it enables us to make contact with the public and staff very quickly enables us to create new lists and grouping of people with similar interests so we can keep them informed of specific issues allows us to personalise communication which results in a bigger uptake from our audience

Other important areas of work

The PPI team has continued to support and advise staff who want to ensure PPI is reflected throughout their work. This has included:

- Advising on approaches to sexual health consultation
- Setting up a diabetes patient group as part of the diabetes patient pathway work

- Input into a range of procurement processes including, obesity, 111 and out of hours

The Expert Patients Programme

We have continued to run a full programme of Expert Patient Courses over the year and have to date run 12 courses including running a course for carers. We have continued to offer patients reunions and have run four reunions which have covered a variety of topics, including relaxation, yoga, nutrition and exercise and lasting power of attorney. These reunions have been extremely successful, with over 40 people attending on a regular basis.

Each is specifically organised to ensure patients get involved in healthcare projects. An important aspect of reunions is to give participants the ability to become involved further in the work of health.

We are also developing further the Expert Patients Panel, which is a group of patients, who having been through the programme want to support it further. As a result they have been participating in promotion of the programme to enable more patients to access it.

The Lay representative group

The lay representatives group consists of patients who have had significant experience at being a Lay representative within NHS Wandsworth. They continue to meet quarterly and their role is to support and critique projects that require patient and public involvement.

Wandsworth Youth Health Jury

The Youth Health Jury continues to meet on a regular basis so that they can contribute to the discussion about the development of local health services.

Two examples of their work are:

- participation in the obesity procurement process for children and families
- the completion of a report into young people's issues in the Battersea area

8.2. Equality and diversity

The new Equalities Act came into force in April 2011, bringing together previous equality legislation into a single Act and introducing new requirements to make Equality and Diversity more resolute. Under the new Act, we are required to publish our approach to Equality and Diversity.

We continue to give high priority to our Equality and Diversity agenda and are committed to making local services accessible to the diverse communities that make up Wandsworth. Both the PCT and the Clinical Commissioning Group (CCG) for Wandsworth (the organisation that will be responsible for the future commissioning of local health services) are steadfast in their commitment to making Wandsworth health services the services that people both need and want.

Equality delivery system and the public sector equality duty

In order to achieve the aspirations of the Equalities Act, the NHS brought in an Equality Delivery System to help it meet its legal obligations. We engaged with our Thinking Partners Group to help us identify how well we are doing in respect of the Equality and Diversity agenda (Thinking Partners are members of the public who have experience of communities and expertise in Equality and Diversity and who can bring new and creative thinking into our work). This will benefit all of those who use our services.

Equality impact assessment or equality analysis

Our goal is to ensure that, whenever we plan or develop services and policies, those charged with leading the projects consider its impact on all communities. They do this by using a simple but effective tool to identify any issues or risks to communities that are likely to result. Project leaders then to come up with strategies to mitigate those risks. We call this process an Equality Impact Assessment. No matter how small a project or service is, the person leading it must go through this process before they get approval.

All our Equality Impact Assessments are public documents and are available on our website.

Equal opportunities for all

We recognise the impact of institutional discrimination on our diverse communities, groups and individuals. We are committed to eliminating discrimination from employment, training and development activities and from our core services. We are part of the 'Stonewall's Diversity Champions' programme. This is Britain's good practice forum in which employers can work with Stonewall, and each other, to promote Equality and Diversity in the workplace to lesbian, gay and bisexual staff and local LGBT communities.

The Stonewall's Diversity Champions' programme has a beneficial effect on all diverse communities, not simply LGBT communities, by setting an equality agenda. Stonewall's good practice forum also presents a unique opportunity for employers to engage with one another on sexual orientation issues.

Our Thinking Partners Group continues to meet every two months to support the Equality and Diversity agenda within the PCT.

8.3. Emergency preparedness

Emergency preparedness is a legal obligation for NHS Wandsworth (PCT), until April 2013, as a category 1 responder under the Civil Contingencies Act 2004.

Although the PCT remains a statutory organisation, it operates as part of the NHS South West London (SWL) management team. Emergency preparedness is overseen by the PCT Emergency Planning Committee to consider risks, guide emergency preparedness and ensure that the PCT is ready to respond to emergencies. Reports from the Emergency Planning Committee are submitted to the Borough Management Team and the SWL Cluster Clinical Integrated Governance Committee.

The PCT has a strong borough focus. It maintains a local emergency response capability, local knowledge on risks, local relationships among partner responders, and local participation on emergency planning and resilience forums. The PCT retains a dedicated Emergency Planning Manager, who reports to the Director of Public Health. This post is shared with Wandsworth Borough Council.

NHS Wandsworth has the capability to provide a 24/7 emergency response. Each year, staff are subjected to major incident exercises to test their preparedness, directed by the SWL Cluster Emergency Plan and the PCT Emergency Plan. It uses tested on call management rotas, alerting mechanisms, and command and control arrangements. Under the generic emergency plan, the PCT maintains a number of hazard specific plans including: a business continuity plan, a flu pandemic, a mass casualty plan, a heat wave plan and a cold weather plan.

Activities through the year included:

- Contribution to the SWL Cluster Emergency Planning Assurance Audit for NHS London, in April 2012
- Continuing programme of training to on call managers, including a command post exercise
- Regular reports to the Borough Management Team
- Participation in the Olympic planning and response

Priorities for 2013 are to:

- Maintain emergency preparedness in the changing management structure of the PCT and SWL Cluster
- Ensure the PCT is ready for the transition into the NHS Commissioning Board and Clinical Commissioning Groups

The PCT's readiness to respond to an emergency is considered fit for purpose as both emergency plans and command and control arrangements are in place and up-to-date. The PCT works closely with St George's Healthcare NHS Trust, Wandsworth Borough Council and key partner agencies, and there is a rolling programme to train on call staff and engage them in PCT and multi-agency exercises.

8.4. Safeguarding adults

Wandsworth has continued to raise awareness around vulnerable adults with the recruitment of the Safeguarding Adults Manager and the Safeguarding Lead in close partnership and contribution to the work of Wandsworth Safeguarding Adults Partnership Board (WSAPB) by Board representation, active membership of sub committees and chairs of the Policy and Procedures subcommittee.

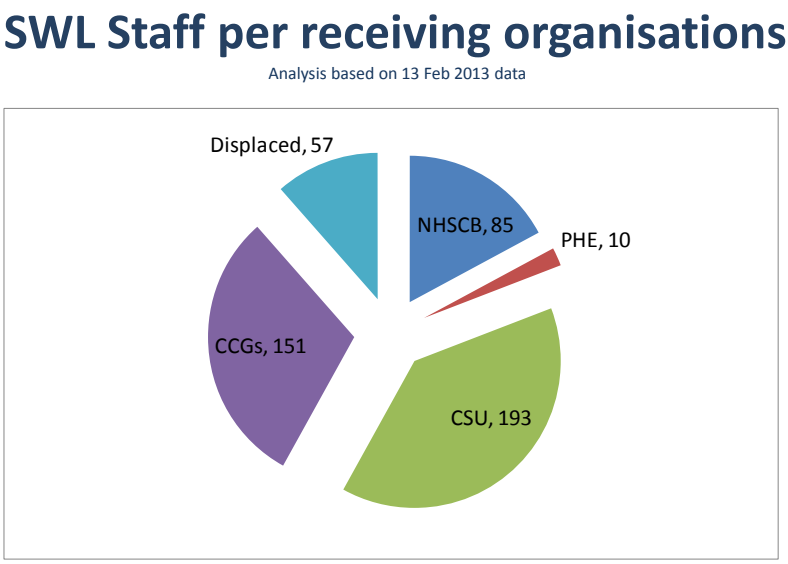
The WSAPB Audit (2012) and Wandsworth Safeguarding Assurance Framework (SAAF) (2012) have demonstrated areas of good practice and areas of development identified in the WCCG Authorisation Action Plan. Areas of development have been implementation of the WCCG Safeguarding Committee (Adults and Children) reporting to the Integrated Governance Committee, development of the Overarching Safeguarding Children and Adults Procedures and WCCG internet website information on safeguarding children and adults.

Safeguarding adults awareness training has been delivered to WCCG Board members regards accountability and assurance with regards to health commissioned services, particularly in light of the Winterbourne Serious Case Review (2012).

8.5. Our staff

Transition to new organisations

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



Staff development

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

Workplace health

The sickness absence percentage for the whole South West London Cluster for the period 1 April 2012 to 31 March 2013, based on the number of working days lost through sickness absence, is approximately 3.9%. The figure for Wandsworth PCT was 3.1%, with average sickness days per full time equivalent being 6.9. (Based on total staff days worked of 153,779 and total staff days lost of 4,710).

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**

8.6. Communicating with staff

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

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

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

8.7. Our estate

The PCT has continued to work to rationalise and make good use of the estate to ensure that services are positioned in a location best suited to serve the target population with facilities that are both appropriate and safe. Unoccupied space is kept to a minimum but sufficient to allow temporary space for services in transition or services set-up for a short specific purpose which cannot be accommodated by services in existing occupied space.

The PCT continues to invest in premises infrastructure to ensure that the estate is fit for purpose and meets or exceeds health and safety guidance, being compliant where feasible with the Disability and Equality Act 2010 and the Disability Discrimination Act 1995.

Current year

During the year the PCT transferred two freehold properties on the Springfield Site, the Joan Bicknell Centre and the Social Education Centre, to South West London and St George's Mental Healthcare Trust in order to enable the trust to proceed with its redevelopment plans.
The PCT completed its planned move to administrative offices owned by Wandsworth Borough Council at both Wandsworth Town Hall and 90 Putney Bridge Road. The relocation will realise cost savings in the medium term and is also enabling closer working relationships with the local authority services that are complementary to the PCT's activities.

The PCT has worked closely with Lambeth PCT to jointly develop an estates strategy that responds to the identified healthcare needs for the new population that will arise from the development of the Vauxhall Nine Elms Battersea Opportunity Area. This strategy has taken into account the impact that the increased population will have on the existing facilities with a view to ensuring that those services currently being developed in the areas will not be adversely impacted by the growth in population. The Programme Board will continue to work with Wandsworth and Lambeth Borough council and patient groups to ensure that the right property solutions are achieved to meet this exciting opportunity.

Within the current year the PCT has worked extensively with Lambeth PCT on the Vauxhall Nine Elms Battersea Opportunity Area Development. The project is a combination of commercial and residential properties which includes a major investment of the Northern Line Tube transport system. This is a significant development which has already commenced and is in its early stage. The overall build scheme will take place over the next 20 or so years and is seen as a major regeneration for both the Wandsworth and Lambeth communities. The project is being led by London Borough of Wandsworth who continually are engaging with health and other stakeholders to establish the health provision required for the future population. The council has established a communications and engagement strategy to support the public and patient forum groups involvement at a local level. The PCT has already commenced engagement with local GPs and other providers to ensure they can plan health services together in a structured way to maximise existing and future health and social care provision.

During the year the PCT served notice on its office premises at Wimbledon Bridge House and is to hand back the property at the end of 2013. It has also contractually agreed to dispose of 91 Bedford Hill with completion in March 2013.

Transition

PCTS will be abolished from April 2013 and in order to enable the transfer to new successor organisations the PCT has been engaged in a robust transition process which will ensure that all assets and liabilities are successfully accounted for and transferred to the new Health bodies

In Wandsworth the ownership of the PCTs Estate will be largely transferring to NHS Property Services Limited which has been established to Property manage the estate and associated facilities services.

There will however be a handful of sites that are expected to transfer to St Georges Healthcare NHS Trust as the services that operate out of these particular sites are largely provided by St Georges.

All current contracts and property services associated with the estate are expected to continue and will transfer on 01 April ensuring that there is continuity and that properties will operate with no disruption to services.

The transfer of all assets and liabilities is undertaken legally by way of a Transfer Scheme which will be complete by the end of March.

There is active engagement with the new receiving bodies to ensure that they are fully aware of the type of assets and liabilities that are transferring across and of their responsibilities from 01 April.

NHS Property Services Ltd.

NHS Property Services Limited has been established as a commercial company that from 01 April 2013 will be responsible for maintaining, managing and developing around 3,600 NHS Properties that will be transferring across from Strategic Health Authorities and Primary Care Trusts.

There will be a variety of assets transferring ranging from GP Practices to administrative buildings.

NHS Property Services Limited will have approximately 3000 staff who will be instrumental in ensuring that the Properties and associated services continue to operate seamlessly from 01 April.

NHS Property Services Limited will offer a range of *Core Services* to the NHS whilst *Additional services* will be provided where necessary in some areas of the Country. Typical core services that will be provided will include, strategic estates management, property management advice, refurbishment and maintenance, statutory compliance, health and safety, planned preventative maintenance and mechanical and engineering services.
Whilst some of the additional services that may be offered include, cleaning, catering, portering, grounds maintenance, waste management, security etc. but these services will be dependent on existing contractual obligations and it is not anticipated that these will be widely available.

In Wandsworth there are 27 properties that are either owned or leased by Wandsworth Primary Care Trust and of these 21 will be transferring to NHS Property Services Limited. The remaining six are to transfer across to St Georges Healthcare NHS Trust (5) and Community Health Partnerships (1). Whilst NHS Property Services Limited will be a limited company it will remain wholly owned by the Secretary of State for Health.

Looking forward

The ownership of the PCT's freehold and leasehold estate will be transferred to three different bodies on the 1 April 2013. NHS Property Services Ltd will take the majority of the estate, including Queen Marys Hospital at Roehampton. Community Health Partnerships will take the PCT's interests in St John's Therapy Centre, which was developed under a Local Investment Finance Trust (LIFT) agreement. St George's Healthcare NHS Trust, will take ownership of the following health clinics, Doddington, Tooting, Eileen Lecky and Stormont.

The newly created Clinical Commissioning Group will continue to have a strong influence over the development of the estates and the services that occupy that estate which it will achieve through close working relationships with these organisations.

8.8. Protecting your information: Information governance

NHS Wandsworth recognises that Information Governance 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 SW London Cluster co-ordinates the self-assessment against the IG requirements. This assessment is then independently audited by the Cluster's internal auditors RSM Tenon to ensure assurance that sufficient evidence is in place to support the attainment levels assigned by the PCT.

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

Reported Information Governance Incidents

There were no serious incidents (categorised as 3-5) reported by NHS Wandsworth during 2012-13.

There were six 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	Wandsworth
I	loss/theft of inadequately protected electronic equipment, devices or paper documents form secured NHS premises	1		1
II	loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1		1
III	insecure disposal of inadequately protected electronic equipment, devices or paper documents	1		
IV	unauthorised disclosure	17	5	4
V	other	2	1	
	total	**22**	**6**	**6**

8.9. 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

8.10. 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).

8.11. Risk Assessment

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

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

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

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

Core objectives focussed on ‘delivery for today’

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

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

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

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

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

Key risks during 2012/13 have included:

- A heightened focus on emergency planning through the Olympic period and mitigating the impact of transition on the effectiveness of NHS South West London’s response to a major incident and business continuity

- Complexity and pace of change around the requirement to integrate multiple strands of system development and transition
- complexity around the governance and transfer management arrangements for the closedown of five statutory bodies by 31 March 2013
- Loss or movement of senior leadership and capacity affecting decision-making and delivery
- maintaining positive employee relationships and staff morale during transition.

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

1.2 The Risk and Control Framework

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

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

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

1.3 Executive Management Team and Board Committee Scrutiny of Risks

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

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

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

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

1.4 Managing risks around delegation to CCGs under shadow working arrangements

1.4.1 The delegation of business to CCGs, as agreed by the Joint Boards, was fully enacted with respect to the management of risks. The adoption of risks by each CCG Governing Body was

commensurate with their new shadow accountability, their local corporate objectives for 2012/13 (sitting under the Joint Boards' corporate objectives set in May 2012), and their local context and challenges.

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

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

1.5 Review of the Effectiveness of Risk Management and Internal Control

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

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

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

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

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

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

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

8.12. 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 ongoing management i.e. CCGs, NHS Commissioning Board (primary care and specialised commissioning), Local Authorities (Public Health) and NHS Property Services, etc.

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

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

8.13. 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 &	Managing Director of Employee Relations Solutions Ltd (contracts for interim and management

Name	Position	Interests
	Workforce	services with the NHS)
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)

Name	Position	Interests
		Managing Director and 25% Shareholder (not trading) Cancer Commissioning Local Advisory Group – Commissioning for Cancer London Alliance Member Croydon PBC Ltd Queenhill Medical Practice is a shareholder
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.

Section 9
Operating and financial review

9. OPERATING AND FINANCIAL REVIEW

9.1. Introduction

The PCT commissions and provides healthcare services to meet the needs and improve the health of the population of the London Borough of Wandsworth. This healthcare is purchased from a wide variety of NHS and non-NHS providers across London.

The main providers are St George's Healthcare NHS Trust and South West London and St George's Mental Health Trust. Community services, including services at Queen Mary's Hospital, Roehampton, which are directly managed by Community Services Wandsworth, a division of St George's Healthcare NHS Trust. In addition, the PCT pays for services from primary care practitioners such as GPs, dentists, pharmacists and opticians.

In April 2011 the PCT came together with the other four PCTs in South West London (Croydon PCT, Kingston PCT, Richmond and Twickenham PCT, and Sutton and Merton PCT) to form NHS South West London. NHS South West London operates as one management team sharing resources, roles and functions.

The PCT remains as a separate statutory organisation within South West London. NHS South West London, a cluster shared services organisation of the five PCTs and not a separate legal entity in it's own right, is hosted by the PCT and the costs incurred by this shared service are recharged to the other four participating PCTs accordingly.

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

9.2. Objectives

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

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

The PCT was originally set a target under spend against its recurrent Revenue Resource Limit of £10.552m; this target was later revised in the year to £12.662m. The PCT was able to keep its expenditure within its Resource Limit target and under spend by £12.714m.
In line with other NHS bodies, Wandsworth PCT is required to prepare its accounts on a resource-accounting basis. Expenditure net of income is measured against Resource Limits set by the Department of Health. There are two resource limits – revenue for ongoing operations and capital for new investment. PCTs are required to keep their expenditure within these limits.
Performance for the year ended 31 March 2013 is detailed below:

Operational Financial Balance:

	2012/13 £000	2011/12 £000
Total net operating cost for the financial year	604,915	581,496
Adjustments for expenditure not chargeable against the resource limit	0	0
Net operating costs chargeable against the resource limit	604,915	581,496
Revenue resource limit	(617,629)	(598,205)
Operational under spend	(12,714)	(16,709)

Capital Resource Limit:

	2012/13 £000	2011/12 £000
Gross capital expenditure	2,959	1,871
Less: Net book value of assets disposed of	(8,000)	(3,500)
Less: Donations	0	0
Charge against the capital resource limit	(5,041)	(1,629)
Capital resource limit	(4,943)	(2,296)
Under spend against the capital resource limit	(98)	(3,925)

The Department of Health has introduced a mandatory requirement to report on sustainability as part of the Annual Report, this has been included as a separate part of the Annual Report in its own right. The PCT will encourage capital bids for sustainable initiatives and consider using government grants to support initiatives.

Section 10
Fixed assets

10. FIXED ASSETS

All NHS property assets are valued in accordance with the latest RICS guidance and the requirements of IFRS. Under normal conditions, the property assets are based on depreciated replacement cost which is based on a modern equivalent asset basis. This review was carried out by the District Valuer and was updated at 31 December 2012.

On 31/3/2013 it is anticipated that a part of the estate that the PCT owns or recognises as a finance lease will transfer to St George's Healthcare NHS Trust. The remaining premises are expected to transfer to a limited company owned by the government which will take over the ownership and management of the remaining properties in the PCT's estate, under the plans for healthcare reform set out in the Health and Social Care Bill. The estate ownership, being the land and buildings, will not transfer to the Wandsworth CCG.

10.1. AUDIT FEES

Audit fees paid to the PCT's external auditors PricewaterhouseCoopers LLP for the statutory audit amounted to £195,000 (incl VAT). This figure was net of a refund of £9,900 in respect of the distribution of Audit Commission reserves to NHS bodies.

10.2. WHERE DID THE MONEY GO?

In 2012-13, expenditure of £581.3m was incurred on the commissioning and provision of the following healthcare services:

	2012/13 £000	2011/12 £000
Primary Care	118,627	116,291
Learning Difficulties	2,090	1,784
Mental Illness	66,077	66,164
Maternity	22,552	20,939
General and Acute	269,676	260,660
Accident and Emergency	11,269	11,667
Community Health Services	81,385	75,086
Other healthcare	9,575	23,909
Total	581,252	576,500

The PCT's main providers of healthcare are St George's Healthcare NHS Trust and South West London and St George's Mental Health NHS Trust.

Commissioning costs are comparable with the prior year, however there have been some variations in specific health care services due to:-

- The increase in expenditure on Community Health Services is owing to an additional £4.3m of funding received for Re-ablement, NHS Social Care Funding and Winter Pressures. In addition, the funding responsibility for Substance Misuse services in prison and the young people's secure estate transferred to the PCT which caused an increase in expenditure of £1.3m. There has also been additional spend of £0.9m on Continuing Care and £1.4m on Community Services.

Value for Money

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

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

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

10.3. MANAGEMENT COSTS

The PCT for 2012/13 has measured its management costs which are classified as any cost incurred that is not a direct payment for the provision of healthcare or healthcare-related services. In the prior year annual report this was shown without non-pay costs. The comparator year management shown below have been updated to include non-pay costs as required by updated guidance from the Department of Health.

	2012/13	2011/12
Management costs (£'000)	11,373	15,305
Weighted population (number of units)	292,098	292,098
Management cost per head of weighted population (£)	**39.00**	**52.40**

The reduction reflects the ongoing commitment of the PCT to achieve efficiency savings and value for money in support functions that are not directly related to healthcare**.**

10.4. PENSION COSTS

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The scheme is subject to a full actuarial valuation every four years and an accounting valuation every year. (Further details can be found at Note 7.5 of the Annual Accounts).

10.5. LOSSES & COMPENSATION

There were 16 cases of losses and special payments (2011/12: 11 cases) totalling £15,143 (2011/12: £16,761) approved during 2012/13.

10.6. BETTER PAYMENT PRACTICE CODE PERFORMANCE

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

10.7. STATEMENT ON INTERNAL CONTROL

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

The PCT's Annual Governance Statement (AGS) forms an integral part of the PCT's Annual Accounts submission to the Department of Health. The AGS includes detailed information on the following areas of corporate governance and control:

- Governance framework
- Joint Boards and Committee structures
- Joint Boards' performance
- Highlights of Board Committee reports
- Risk assessment and the Risk & Control Framework
- Counter Fraud measures
- Review of Effectiveness of Risk Management and Internal Control

- Significant issues and lapses in security

For 2012-13, the Annual Governance Statement will be signed by a nominated representative from the Department of Health

Section 11
Summary financial statements

11. SUMMARY FINANCIAL STATEMENTS

11.1. Introduction

The following statements have been prepared to provide a summary of the PCT's full audited annual accounts for the year ended 31 March 2013. These accounts have been prepared in accordance with directions issued under the PCT Manual of Accounts for 2012/13 as directed by the Secretary of State and approved by HM Treasury. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the PCTs Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the PCT are described in the full Annual Accounts document. They have been applied consistently in dealing with items considered material in relation to the accounts. The PCT is within the government resource accounting boundary and therefore has only consolidated interests in other entities where the other entity is also within the resource accounting boundary and the PCT exercise in-year budgetary control over the other entity.

These summary financial statements do not contain sufficient information to allow as full an understanding of the results of the of the Trust and state of affairs of the Trust and of its policies and arrangements concerning directors' remuneration as would be provided by the full annual accounts and reports. A copy of the full accounts for the year ended 31 March 2013, is available on request, at no charge, from the Director of Finance, Wandsworth Teaching Primary Care Trust, 120 The Broadway, Wimbledon, London SW19 1RH.
So far as the directors are aware, there is no relevant information of which the Trust's auditors are unaware; and the directors have taken all steps that ought to have been taken as directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Signed on behalf of the Board

Carl Vincent
Director of Provider Finance and Finance Transition Department of Health
4 June 2013

Section 11

Summary financial statements

INDEPENDENT AUDITOR'S STATEMENT TO THE OFFICER RESPONSIBLE FOR PREPARING THE ACCOUNTS OF WANDSWORTH CARE TRUST

We have examined the summary financial statements for the year ended 31 March 2013 which comprises the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, the related notes comprising; financial balance, cash performance, capital charges, public sector payment targets, better payment practice code, net operating costs, non-current assets, net liabilities, taxpayers' equity, pensions, post balance sheet events, running costs, audit and the information in the Directors' Remuneration Report that is described as having been audited.

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

The officer responsible for preparing the accounts is responsible for preparing the Annual Report and summary financial statement, in accordance with directions issued by the Secretary of State.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the full annual statutory financial statements and the Directors' Remuneration Report and its compliance with the relevant requirements of the directions issued by the Secretary of State.

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

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

Section 11
Summary financial statements

We conducted our work in accordance with Bulletin 2008/03 issued by the Auditing Practices Board. Our report on the full annual statutory financial statements describes the basis of our opinion on those financial statements, the Directors' Report and the Directors' Remuneration Report.

Opinion

In our opinion the summary financial statement is consistent with the full annual statutory financial statements, and the Directors' Remuneration Report of the Wandsworth Primary Care Trust for the year ended 31 March 2013 and complies with the relevant requirements of the directions issued by the Secretary of State.

Janet Dawson, Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP

Appointed Auditors

7 More London Riverside

London SE1 2RT

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

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**26,212**	21,136
Other costs	**631,582**	608,243
Income	**(58,573)**	(51,984)
Net operating costs before interest	**599,221**	577,395
Investment income	**(23)**	(197)
Other (Gains)/Losses	**15**	(900)
Finance costs	**5,702**	5,198
Net operating costs for the financial year	**604,915**	581,496
Transfers by absorption -(gains)	**0**	0
Transfers by absorption - losses	**0**	0
Net (gain)/loss on transfers by absorption	**0**	0
Net Operating Costs for the Financial Year including absorption transfers	**604,915**	**581,496**

11.3. Statement of Financial Position as at 31 March 2013

	2012-13 £000	2011-12 £000
Non-current assets:		
Property, plant and equipment	**110,546**	119,275
Intangible assets	**132**	730
Other financial assets	**161**	201
Total non-current assets	**110,839**	120,206
Current assets:		
Trade and other receivables	**5,761**	20,400
Cash and cash equivalents	**3,050**	5
Total current assets	**8,811**	20,405
Non-current assets held for sale	**0**	640
Total current assets	**8,811**	21,045
Total assets	**119,650**	141,251
Current liabilities		
Trade and other payables	**(43,617)**	(48,922))
Provisions	**(2,130)**	(1,514)
Borrowings	**(1,983)**	(1,898)
Other financial liabilities	**0**	0
Total current liabilities	**(47,730)**	(52,334)

Non-current assets plus/less net current assets/liabilities	**71,920**	88,917
Non-current liabilities		
Trade and other payables	(790)	(951)
Provisions	(4,880)	(1,471)
Borrowings	(58,466)	(60,503)
Total non-current liabilities	**(64,136)**	(62,925)
Total Assets Employed:	**7,784**	25,992
Financed by taxpayers' equity:		
General fund	(20,952)	(7,012)
Revaluation reserve	28,736	33,004
Total taxpayers' equity:	**7,784**	25,992

11.4. Statement of Changes in Taxpayers Equity for the Year Ended 31 March 2013

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2012	(7,012)	33,004	**25,992**
Opening balance adjustments	0	0	**0**
Restated balance at 1 April 2012	(7,012)	33,004	**25,992**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(604,915)	0	**(604,915)**
Net (loss) on revaluation of property, plant, equipment	0	963	**963**
Impairments and reversals	0	(319)	**(319)**
Transfers between reserves*	4,912	(4,912)	**0**
Total recognised income and expense for 2012-13	**(600,003)**	**(4,268)**	**(604,271)**
Net Parliamentary funding	586,063		**586,063**
Balance at 31 March 2013	**(20,952)**	**28,736**	**7,784**
Changes in taxpayers' equity for 2011-12			
Restated balance at 1 April 2011	2,549	36,225	**38,774**
Net operating cost for the year	**(581,496)**	**0**	**(581,496)**
Net gain on revaluation of property, plant, equipment	**0**	**(608)**	**(608)**
Impairments and reversals	**0**	**(790)**	**(790)**
Transfers between reserves	**1,823**	**(1,823)**	**0**
Total recognised income and expense for 2011-12	**(579,673)**	**(3,221)**	**(582,894)**
Net Parliamentary funding	**570,112**	**0**	**570,112**
Balance at 31 March 2012	**(7,012)**	**33,004**	**25,992**

The **General Fund** reflects the cumulative surplus made by the PCT. The balance from the Statement of Comprehensive Net Expenditure (SoCNE) is transferred into this fund each year. The PCTs Parliamentary funding is also accounted for in this reserve. This balance cannot be released back to the SoCNE.

Since 2011-12, PCTs are no longer permitted to use a **Donated Asset Reserve.** The balance on this reserve was taken to the General Fund. Where assets have been funded by donation, there is no longer an offset of the reserves against depreciation and loss on disposal transactions, and the full expense will be taken through the SoCNE.

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

Summary Cash Flow Statement for the Year Ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(599,221)**	**(577,395)**
Depreciation and Amortisation	**5,427**	**4,528**
Impairments and Reversals	**143**	**0**
Interest Paid	**(5,358)**	**(5,153)**
(Increase)/Decrease in Trade and Other Receivables	**13,879**	**(11,140)**
Increase in Trade and Other Payables	**(6,254)**	**9,993**
Provisions Utilised	**(2,065)**	**(512)**
Increase in Provisions	**5,746**	**570**
Net Cash Inflow/(Outflow) from Operating Activities	**(587,703)**	**(579,109)**
Cash flows from investing activities		
Interest Received	**23**	**197**
Payments for Property, Plant and Equipment	**(2,171)**	**(1,170)**
Payments for Intangible Assets	**0**	**(548)**
Proceeds of disposal of assets held for sale (PPE)	**8,745**	**10,846**
Proceeds from Disposal of Other Financial Assets	**0**	**0**
Loans Repaid in respect of LIFT	**40**	**0**
Net Cash Inflow/(Outflow) from Investing Activities	**6,637**	**9,325**
Net cash (outflow) before financing	**(581,066)**	**(569,784)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases	(1,952)	(385)
Net Parliamentary Funding	586,063	570,112
Net Cash Inflow/(Outflow) from Financing Activities	**584,111**	**569,727**
Net (decrease) in cash and cash equivalents	**3,045**	**(57)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**5**	**62**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**3,050**	**5**

11 Events after the end of the reporting period

As disclosed within note 1.1 due to the Health and Social Care Bill as of 1st April 2013 the PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either NHS England (formerly known as The National Commissioning Board), Clinical Commissioning Group (CCG), NHS Trusts or Local Authorities (LA). Estates functions will be transferred to NHS Property Services Limited (NHS PS) and Community Health Partnerships . Ultimate control will still reside with the Department of Health.

All assets and liabilites contained within the statement of financial position as at 31st March 2013 must be identified and agreed for transfer to a successor body.

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability.

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

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

The final year-end aggregate surplus generated by the PCT in 2012/13 will be carried forward to NHS England in 2013/14. CCGs will not inherit legacy debt, but balances will transfer from PCTs, in line with provisions of the Act, based on the principles set out below.

- Liabilities that correspond to a non- current asset which relate to a particular function should transfer with that asset from a sender to a receiver by reference to the destination of the function.

- Liabilities that correspond to a function or policy that is being moved from a sender should transfer to the nominated receiver for that function.

- Discrete, and current assets and liabilities, even if associated with a function continuing in 2013/14 will transfer to the Department of Health.

- Liabilities relating to the PCT as a statutory body in its own right that do not relate to an ongoing function such as VAT or tax liabilities, will transfer to the Department of Health.

- Employer liabilities will transfer to the new employer, where an individual's employment is transferred to a receiver organisation.

- Where employment of staff ceases prior to 1st April 2013, the employer liabilities related to those staff members will transfer to Department of Health.

11.5. Remuneration Report

This report is made by the Board on the recommendation of the Remuneration Committee in accordance with Regulation 11, Schedule 8 of SI 2008/410 of the Companies Act 2006. The first part of the report provides details of remuneration policy; the second part provides details of the remuneration and pensions of the PCT's senior managers for the year ended 31 March 2013.
The report is in respect of the senior managers of the PCT, who are defined as *'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body'*. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.

Remuneration Committee

The Remuneration Committee comprises one non-executive director from each PCT in the Cluster, from whom a Chair is appointed; the Chief Executive also attends in an advisory capacity.
The Committee meets as frequently as is necessary to advise the Board on the appropriate remuneration and terms of service for the Chief Executive, Directors or any other senior manager remunerated under the Very Senior Manager Pay Framework and the Professional Executive Committee.

Remuneration Policy

The Committee's deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures.
The main components of the Chief Executive's, Executive Directors' and senior officers' remuneration are set out below.

Basic Salary

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

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

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

Incentive Arrangements

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

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

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

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

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

Level of Awards

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

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

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

NHS Pension Entitlement

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

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

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

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

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

Pay Multiples

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

The banded remuneration of the highest paid director in the financial year 2012/13 was £97,500 (2011/12, £97.500). This was 2.2 times (2011/12, 2.3 times) the median remuneration of the workforce, which as £44,508 (2011/12, £43,202).
In 2012/13 nine employees (2011/12, six employees) 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 Wandsworth 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
Houda Al-Sharifi	Director of Public Health	01/04/2010	31/03/2013
Dr Tom Coffey	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	1.1.1.1 Role	Contract Date	Leave Date
Graham Mackenzie	Borough Managing Director	28/02/2011	31/03/2013
Dr Jonathan Hildebrand	Cluster Director of Public Health	28/02/2011	31/03/2013
Dr David Finch	Joint Medical Director	10/03/2011	31/03/2013
Dr Howard Freeman	Joint Medical Director	01/04/2011	31/03/2013
Charlotte Gawne	Director of Communications and Corporate Affairs	28/02/2011	31/03/2013
Jacqui Harvey	Director of Transition	01/04/2011	31/03/2013
Jocelyn Fisher	Director of Human Resources, Organisational Development and Workforce	01/04/2011	31/03/2013
Paula Swann	Director of Financial Management	28/02/2011	31/05/2012
Hardev Virdee	Director of Strategic Financial Planning	02/01/2012	30/06/2012
Neil Roberts	Director of Primary Care Contracting	28/02/2011	31/03/2013

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

Termination Arrangements

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

Non Executive Directors

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

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

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

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.

Exit Packages

	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	1	0	1	0	0	0
£10,001-£25,000	5	0	5	0	0	0
£25,001-£50,000	3	0	3	0	1	1
£50,001-£100,000	6	1	7	0	0	0
£100,001 - £150,000	3	0	3	0	1	1
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	18	1	19	0	2	2
	£s	£s	£s	£s	£s	£s
Total resource cost	1,099,838	92,828	1,192,666	0	152,000	152,000

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

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

Disclosure of off-payroll engagements – Unaudited

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, all government departments and their arm's length bodies were required to published information in relation to the number of off payroll engagements – at a cost of over £58,200 per annum – that were in place on 31 January 2012.

Table 1 below provides details of off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012.

No. In place on 31 January 2012	26
Of which:	
No. that have since come onto the Organisation's payroll	1
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No that have come to an end	14
Total	15

In view of the fact that the Primary Care Trust was due to be dissolved on 31 March 2013, it was felt that there was little benefit in re-negotiating remaining contracts that were due to come to an end on or before this date.

Table 2 below provides details of all new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.

No. of new engagements	1
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	

No. for whom assurance has been accepted and received	N/A
No. for whom assurance has been accepted and not received	N/A
No. that have been terminated as a result of assurance not being received	N/A
Total	N/A

Department of Health

NHS

Wandsworth Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Wandsworth Primary Care Trust

2012-13 Accounts

WANDSWORTH PRIMARY CARE TRUST

ANNUAL ACCOUNTS 2012-2013

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 Wandsworth 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.....

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

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

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

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

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

Signed: 

Date: 4/6/2013

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

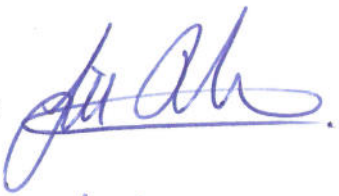
I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Wandsworth Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

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

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

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

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

Signed: 

Date: 4/6/13.

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

We have audited the financial statements of Wandsworth Primary Care Trust ("the PCT") for the year ended 31 March 2013 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is the accounting policies directed by the Secretary of State for Health with the consent of the Treasury as relevant to the National Health Service in England set out therein.

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

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

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion

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

- in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Janet Dawson, Engagement Lead

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

6 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**26,212**	21,136
Other costs	5.1	**631,582**	608,243
Income	4	**(58,573)**	(51,984)
Net operating costs before interest		**599,221**	577,395
Investment income	9	**(23)**	(197)
Other (Gains)/Losses	10	**15**	(900)
Finance costs	11	**5,702**	5,198
Net operating costs for the financial year		**604,915**	581,496
Transfers by absorption -(gains)		**0**	0
Transfers by absorption - losses		**0**	0
Net (gain)/loss on transfers by absorption		**0**	0
Net Operating Costs for the Financial Year including absorption transfers		**604,915**	**581,496**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**23,148**	18,673
Other costs	5.1	**30,290**	36,430
Income	4	**(47,887)**	(43,233)
Net administration costs before interest		**5,551**	**11,870**
Investment income	9	**0**	(197)
Other (Gains)/Losses	10	**0**	(900)
Finance costs	11	**5,358**	5,153
Net administration costs for the financial year		**10,909**	**15,926**
Programme Expenditure			
Gross employee benefits	7.1	**3,064**	2,463
Other costs	5.1	**601,292**	571,813
Income	4	**(10,686)**	(8,751)
Net programme expenditure before interest		**593,670**	**565,525**
Investment income	9	**(23)**	0
Other (Gains)/Losses	10	**15**	0
Finance costs	11	**344**	45
Net programme expenditure for the financial year		**594,006**	**565,570**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**319**	790
Net (gain) loss on revaluation of property, plant & equipment	**(963)**	608
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	0
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year	**604,271**	**582,894**

The notes on pages 5 to 48 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**110,546**	119,275
Intangible assets	13	**132**	730
investment property	15	**0**	0
Other financial assets	21	**161**	201
Trade and other receivables	19	**0**	0
Total non-current assets		**110,839**	120,206
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**5,761**	20,400
Other financial assets	21	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**3,050**	5
Total current assets		**8,811**	20,405
Non-current assets held for sale	24	**0**	640
Total current assets		**8,811**	21,045
Total assets		**119,650**	141,251
Current liabilities			
Trade and other payables	25	**(43,617)**	(48,922)
Other liabilities	26,28	**0**	0
Provisions	32	**(2,130)**	(1,514)
Borrowings	27	**(1,983)**	(1,898)
Other financial liabilities	28,36.2	**0**	0
Total current liabilities		**(47,730)**	(52,334)
Non-current assets plus/less net current assets/liabilities		**71,920**	88,917
Non-current liabilities			
Trade and other payables	25	**(790)**	(951)
Other Liabilities	26,28	**0**	0
Provisions	32	**(4,880)**	(1,471)
Borrowings	27	**(58,466)**	(60,503)
Other financial liabilities	28,36.2	**0**	0
Total non-current liabilities		**(64,136)**	(62,925)
Total Assets Employed:		**7,784**	25,992
Financed by taxpayers' equity:			
General fund		**(20,952)**	(7,012)
Revaluation reserve		**28,736**	33,004
Other reserves		**0**	0
Total taxpayers' equity:		**7,784**	25,992

The notes on pages 5 to 48 form part of this account.

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

Carl Vincent, DH Director, Provider Finance and Finance Transition **Date:** 4/6/13

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	**110,546**	119,275
Intangible assets	13	**132**	730
investment property	15	**0**	0
Other financial assets	21	**161**	201
Trade and other receivables	19	**0**	0
Total non-current assets		**110,839**	120,206
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**5,761**	20,400
Other financial assets	21	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**3,050**	5
Total current assets		**8,811**	20,405
Non-current assets held for sale	24	**0**	640
Total current assets		**8,811**	21,045
Total assets		**119,650**	141,251
Current liabilities			
Trade and other payables	25	**(43,617)**	(48,922)
Other liabilities	26,28	**0**	0
Provisions	32	**(2,130)**	(1,514)
Borrowings	27	**(1,983)**	(1,898)
Other financial liabilities	28,36.2	**0**	0
Total current liabilities		**(47,730)**	(52,334)
Non-current assets plus/less net current assets/liabilities		**71,920**	88,917
Non-current liabilities			
Trade and other payables	25	**(790)**	(951)
Other Liabilities	26,28	**0**	0
Provisions	32	**(4,880)**	(1,471)
Borrowings	27	**(58,466)**	(60,503)
Other financial liabilities	28,36.2	**0**	0
Total non-current liabilities		**(64,136)**	(62,925)
Total Assets Employed:		**7,784**	25,992
Financed by taxpayers' equity:			
General fund		**(20,952)**	(7,012)
Revaluation reserve		**28,736**	33,004
Other reserves		**0**	0
Total taxpayers' equity:		**7,784**	25,992

The notes on pages 5 to 48 form part of this account.

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

Carl Vincent, DH Director, Provider Finance and Finance Transition **Date:**

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	**(7,012)**	**33,004**	**0**	**25,992**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(604,915)	0	0	**(604,915)**
Net gain on revaluation of property, plant, equipment	0	963	0	**963**
Net gain on revaluation of intangible assets	0	0	0	**0**
Net gain on revaluation of financial assets	0	0	0	**0**
Net gain on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	(319)	0	**(319)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	4,912	(4,912)	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	**0**
On disposal of available for sale financial assets	0	0	0	**0**
Net actuarial gain/(loss) on pensions	0	0	0	**0**
Total recognised income and expense for 2012-13	**(600,003)**	**(4,268)**	**0**	**(604,271)**
Net Parliamentary funding	586,063	0	0	**586,063**
Balance at 31 March 2013	**(20,952)**	**28,736**	**0**	**7,784**
Balance at 1 April 2011	**2,549**	**36,225**	**0**	**38,774**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(581,496)	0	0	(581,496)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	(608)	0	(608)
Net Gain / (loss) on Revaluation of Intangible Assets	0	0	0	0
Net Gain / (loss) on Revaluation of Financial Assets	0	0	0	0
Net Gain / (loss) on Assets Held for Sale	0	0	0	0
Impairments and Reversals	0	(790)	0	(790)
Movements in other reserves	0	0	0	0
Transfers between reserves	1,823	(1,823)	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification Adjustments	0	0	0	0
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Total recognised income and expense for 2011-12	(579,673)	(3,221)	0	(582,894)
Net Parliamentary funding	570,112	0	0	570,112
Balance at 31 March 2012	**(7,012)**	**33,004**	**0**	**25,992**

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		(599,221)	(577,395)
Depreciation and Amortisation		5,427	4,528
Impairments and Reversals		143	0
Other Gains / (Losses) on foreign exchange		0	0
Donated Assets received credited to revenue but non-cash		0	0
Government Granted Assets received credited to revenue but non-cash		0	0
Interest Paid		(5,358)	(5,153)
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		0	0
Decrease/(Increase) in Trade and Other Receivables		13,879	(11,140)
(Increase)/Decrease in Other Current Assets		0	0
(Decrease)/Increase in Trade and Other Payables		(6,254)	9,993
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(2,065)	(512)
Increase/(Decrease) in Provisions		5,746	570
Net Cash Inflow/(Outflow) from Operating Activities		(587,703)	(579,109)
Cash flows from investing activities			
Interest Received		23	197
(Payments) for Property, Plant and Equipment		(2,171)	(1,170)
(Payments) for Intangible Assets		0	(548)
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		0	0
Proceeds of disposal of assets held for sale (PPE)		8,745	10,846
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		40	0
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		6,637	9,325
Net cash inflow/(outflow) before financing		(581,066)	(569,784)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(1,952)	(385)
Net Parliamentary Funding		586,063	570,112
Capital Receipts Surrendered		0	0
Capital grants and other capital receipts		0	0
Cash Transferred (to)/from Other NHS Bodies		0	0
Net Cash Inflow/(Outflow) from Financing Activities		584,111	569,727
Net increase/(decrease) in cash and cash equivalents		3,045	(57)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		5	62
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		3,050	5

1. Accounting policies

The Secretary of State for Health has directed that the accounts of PCTs shall meet the accounting requirements of the PCT Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following accounts 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, and certain financial assets.

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

Prescribing costs for March were unknown at the time of the completion of the accounts, an average daily cost for the previous 10 months has been used to estimate the February and March values.

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

Revenue recognition

Revenue is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where revenue has been received for a specific activity to be delivered in the following financial year, that revenue will be deferred.
Expenditure related to partially completed contracts for patient services are not accounted for as work-in-progress but expenditure is accrued in respect of part-completed treatment episodes at the statement of financial position date.

1. Accounting policies (continued)

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT)

The PCT's accounting policies regarding its PFI and LIFT scheme are disclosed in Note 1.24 to these accounts. The PCT accounts for these assets under IFRIC 12 as a service concession and when the applicable elements of IAS 17 are met these are capitalised.

The PCT initially recognised the PFI and LIFT assets and associated finance lease liability at the assets' fair value. The PCT's PFI asset is being accounted for in two ways, an element as if it was a freehold building and an element as plant and equipment, the accounting judgements and estimation uncertainty for both of which are disclosed below. The PCT has taken the judgement that, due to the uncertainty over the size and structure of the health care economy at the end of the lease, it is unlikely that it will exercise its repurchase option over the LIFT at the end of the lease life. It is therefore depreciating the asset over the life of the lease rather than the asset's useful economic life.

The PFI and LIFT finance lease liabilities are being amortised over the lives of the lease using the rate of return required by the assets' operators. This rate has been estimated using the assets' operators' financial models, as agreed with the PCT at the schemes' inception, and is estimated to spread that return over the life of the leases.

As part of the PCT's PFI contract, the PFI operator provides a Managed Equipment Service ('MES'). Through this service the PCT has access to a wide range of equipment within the scheme, and these assets are maintained and replaced at the end of their useful economic life by the PFI operator. This PCT has judged that these assets should be held as plant and equipment and therefore, in line with the PCT's accounting policies, depreciated over 5 years. Deferred income has been set up to smooth tenant's income in relation to the MES element of the PFI unitary payment to the MES costs over time.

The PCT recognises the fact that the financial models employed to account for the PFI and LIFT scheme profiles the capital additions and capital lease payments on a changeable basis each year, which causes considerable variations in the rental costs taken to the Statement of Comprehensive Net Expenditure from year to year. Subsequent rental charges for the PFI and LIFT properties to the PCT's tenants are conversely calculated on a basis which allows a more comparable and predictable charge year on year and smoothes the affect of these variations. The difference between the rental charge to tenants and the charge to the income statement relating to that rental charge is a timing difference and is accounted for as either deferred or accrued income in the year.

Key Sources of estimation uncertainty

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

Provisions

Other Provisions: an Onerous Lease provision of £2,772k has been recognised in relation to unavoidable costs for void letting periods in relation to Wimbledon Bridge House and the use, by the cluster, of 120, The Broadway, SW19 1RH.

The PCT has no other material provisions. The PCT does not believe that it has material estimation uncertainty over the completeness of its provisions. Contingent liabilities are disclosed in Note 1.19.

Property, plant, and equipment

The PCT's accounting judgments around its property, plant, and equipment base are the residual lives and value of the PCT assets, which impact the annual depreciation charge and therefore holding amount of the asset, the methodology used to ensure the assets holding amount reflect current cost, particularly around its land and buildings and the application of indexation, and the timing of when asset are capitalised (brought into use) and derecognised (and moved to assets held for resale and to be disposed of).

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 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.

1.4 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 accounts.

1. Accounting policies (continued)

1.5 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the 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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.6 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the 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

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

Measurement

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

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

1.7 Depreciation, amortisation and impairments

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the 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 are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1. Accounting policies (continued)

1.8 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. Donated income is deferred only where conditions attached to the donation have not been met.

1.9 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. Government Grant income is deferred only where conditions attached to the grant have not been met.

1.10 Non-current assets held for sale

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

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

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. 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.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.12 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.

1.13 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).

The losses and special payments note is compiled on an accruals basis excluding any provisions in relation to such payments.

1.14 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.
As the the provisions for clinical negligence claims are included in the accounts of the NHSLA, they are not included in the individual NHs bodies' accounts.

1. Accounting policies (continued)

1.15 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.

Retirement benefit costs

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

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

1.16 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.

1.17 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.

1.18 EU Emissions Trading Scheme

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

1. Accounting policies (continued)

1.19 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.

1.20 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.21 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.

1.22 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)

1.23 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

Fair value is determined by reference to their carrying value.

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

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

1.24 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

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

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

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

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

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement

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

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

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

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

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

Other assets contributed by the PCT to the operator

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

1. Accounting policies (continued)

1.25 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 1 Presentation of Financial Statements (amendment).
IAS 12 Income Taxes (amendment).
IAS 19 (Revised) Employee Benefits
IAS 27 Separate Financial Statements - subject to consultation- removal of dispensation from consolidating NHS
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IAS 32 Financial Instruments: Presentation (amendment)
IFRS 7 Financial Instruments: Disclosures (amendment)
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

1.26 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 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 the carrying values of any associated assets and liabilities. No adjustments are considered necessary.
See note 42 for further details.

2 Operating segments

A segment is a distinguishable component of the PCT that is engaged in providing services that are subject to risks and rewards that are different from those of other segments and for which discrete financial information is available. IFRS8, 'Operating Segments', states that a segment can be identified by reference to the operating results that are regularly reviewed by the entity's chief operating decision maker (CODM), whose function is to assess the performance of the operating elements of the entity and to allocate resources to address the PCT's objectives, both locally and nationally. For the PCT, the CODM has been identified as being the Board of Directors who are presented with monthly Board reports compliant with IFRS.

As all the PCT's activities take place in South West London, no segmental reporting is prepared on a geographic basis.
The Statement of Comprehensive Net Expenditure is reported to the CODM as follows:

	Acute Commissioning		Non-Acute Commissioning		Primary Care		Corporate, Reserves and Other		Total	
	2012-13 £000	2011-12 £000	2012-13 £000	2011-12 £000	2012-13 £000	2011-12 £000	2012-13 £000	2011-12 £000	2012-13 £000	2011-12 £000
Expenditure	**302,594**	**290,825**	**155,154**	**149,349**	**111,713**	**109,925**	**35,454**	**31,397**	**604,915**	**581,496**
Surplus/(Deficit)										
Segment surplus/(deficit)	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0
Common costs	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0
Surplus/(deficit)	**302,594**	**290,825**	**155,154**	**149,349**	**111,713**	**109,925**	**35,454**	**31,397**	**604,915**	581,496
Net Assets:										
Segment net assets	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0

The primary business segments comprise:
- Acute Commissioning - being, the commissioning of healthcare which, historically is delivered by hospitals.
- Non-Acute Commissioning - being, the commissioning of healthcare which, is non -acute e.g. mental health and learning disabilities.
- Primary Care - being, the first contact of a patient with a healthcare provider, usually a GP, dentist or optician, in a given episode of illness.
- Corporate, Reserves and Other - being, the support costs that are not directly attributable to a particular segment e.g. IT and accounting.

There are no common costs as all overhead and central costs have been attributed to segments on a basis that best reflects the usage by the sector of these costs.

The Statement of Financial Position and the Cash Flow Statement are not reported on a segmental basis to the CODM.

The significant sources of external revenue and expenditure in 2012/13, including those at least 10% of the PCT's total revenue and expenditure, are as follows:

	Revenue £'000	Expense £'000
St. George's Healthcare NHS Trust	16,506	208,319
Sutton and Merton PCT	8,573	4,260
Croydon PCT	9,093	31,475
South West London and St George's Mental Health Trust	5,203	43,958

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	**604,915**	581,496
Net operating cost plus (gain)/loss on transfers by absorption	**0**	0
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**617,629**	598,205
Under/(Over)spend Against Revenue Resource Limit (RRL)	12,714	16,709

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	**(4,943)**	(1,596)
Charge to Capital Resource Limit	**(5,041)**	(1,629)
(Over)/Underspend Against CRL	**98**	**33**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**586,063**	570,112
Cash Limit	**590,063**	571,887
Under/(Over)spend Against Cash Limit	**4,000**	**1,775**

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

	2012-13 £000
Total cash received from DH (Gross)	531,620
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**531,620**
(Less)/plus: transfers (to)/from other resource account bodies	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	11,722
Plus: drugs reimbursement (central charge to cash limits)	42,721
Parliamentary funding credited to General Fund	**586,063**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	6	6	0	1
Dental Charge income from Contractor-Led GDS & PDS	2,534	0	2,534	2,654
Dental Charge income from Trust-Led GDS & PDS	0	0	0	0
Prescription Charge income	2,053	0	2,053	1,977
Strategic Health Authorities	513	42	471	488
NHS Trusts	692	314	378	533
NHS Foundation Trusts	694	694	0	672
Primary Care Trusts Contributions to DATs	0	0	0	51
Primary Care Trusts - Other	23,799	23,311	488	9,264
Primary Care Trusts - Lead Commissioning	0	0	0	0
English RAB Special Health Authorities	0	0	0	0
NDPBs and Others (CGA)	53	53	0	0
Department of Health - SMPTB	0	0	0	0
Department of Health - Other	0	0	0	0
Recoveries in respect of employee benefits	0	0	0	10,389
Local Authorities	277	0	277	575
Patient Transport Services	0	0	0	0
Education, Training and Research	4,141	0	4,141	2,287
Non-NHS: Private Patients	0	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	0	0	0	0
NHS Injury Costs Recovery	0	0	0	7
Other Non-NHS Patient Care Services	407	63	344	65
Charitable and Other Contributions to Expenditure	0	0	0	0
Receipt of donated assets	0	0	0	0
Receipt of Government granted assets	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	22,922	22,922	0	21,817
Other revenue	482	482	0	1,204
Total miscellaneous revenue	58,573	47,887	10,686	51,984

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. Examples of shared functions include Acute Commissioning, IT, Informatics, Human Resources and Finance. The income and expenditure relating to cluster-wide functions are shown in the accounts of Wandsworth PCT in 2012/13 as they are acting in the capacity of an agency. The contributions from the other four PCTs towards cluster-wide functions totalled £16.0 million (31 March 2012: £16.254 million) and this sum is included under "Primary Care Trusts - Other" in the analysis of miscellaneous revenue.

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	**31,982**	0	31,982	31,794
Non-Healthcare	**7,830**	4,767	3,063	4,330
Total	**39,812**	**4,767**	**35,045**	**36,124**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**299,468**	137	299,331	297,061
Goods and services (other, excl Trusts, FT and PCT))	**0**	0	0	0
Total	**299,468**	**137**	**299,331**	**297,061**
Goods and Services from Foundation Trusts	**73,261**	1	73,260	72,653
Purchase of Healthcare from Non-NHS bodies	**55,966**	0	55,966	44,803
Social Care from Independent Providers	**0**	0	0	0
Expenditure on Drugs Action Teams	**2,884**	0	2,884	3,816
Non-GMS Services from GPs	**0**	0	0	0
Contractor Led GDS & PDS (excluding employee benefits)	**16,610**	0	16,610	14,941
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**0**	0	0	0
Chair, Non-executive Directors & PEC remuneration	**155**	155	0	179
Executive committee members costs	**204**	204	0	94
Consultancy Services	**11,121**	869	10,252	7,597
Prescribing Costs	**35,190**	0	35,190	36,922
G/PMS, APMS and PCTMS (excluding employee benefits)	**54,158**	0	54,158	51,450
Pharmaceutical Services	**491**	0	491	1,301
Local Pharmaceutical Services Pilots	**0**	0	0	0
New Pharmacy Contract	**10,109**	0	10,109	9,066
General Ophthalmic Services	**2,069**	0	2,069	2,060
Supplies and Services - Clinical	**82**	0	82	534
Supplies and Services - General	**497**	497	0	584
Establishment	**1,767**	1,767	0	1,981
Transport	**7**	7	0	5
Premises	**19,984**	19,878	106	19,902
Impairments & Reversals of Property, plant and equipment	**143**	0	143	0
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**4,999**	738	4,261	4,312
Amortisation	**428**	0	428	216
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**274**	0	274	55
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**195**	195	0	271
Other Auditors Remuneration	**158**	158	0	0
Clinical Negligence Costs	**181**	0	181	0
Education and Training	**1,175**	917	258	661
Grants for capital purposes	**0**	0	0	0
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Other	**194**	0	194	1,655
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**631,582**	**30,290**	**601,292**	**608,243**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	0
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**1,736**	1,736	0	1,342
Other Employee Benefits	**24,476**	21,412	3,064	19,794
Total Employee Benefits charged to SOCNE	**26,212**	**23,148**	**3,064**	**21,136**
Total Operating Costs	**657,794**	**53,438**	**604,356**	**629,379**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,373**	9,654	1,719
Weighted population (number in units)*	**292,098**	292,098	292,098
Running costs per head of population (£ per head)	**39**	**33**	**6**
PCT Running Costs 2011-12			
Running costs (£000s)	**15,567**	13,210	2,357
Weighted population (number in units)	**292,098**	292,098	292,098
Running costs per head of population (£ per head)	**53**	**45**	**8**

* 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	54,158	51,450
Prescribing costs	35,190	36,922
Contractor led GDS & PDS	16,610	14,941
Trust led GDS & PDS	0	0
General Ophthalmic Services	2,069	2,060
Department of Health Initiative Funding	0	0
Pharmaceutical services	491	1,301
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	10,109	9,066
Non-GMS Services from GPs	0	0
Other	0	551
Total Primary Healthcare purchased	**118,627**	116,291
Purchase of Secondary Healthcare		
Learning Difficulties	2,090	1,784
Mental Illness	66,077	66,164
Maternity	22,522	20,939
General and Acute	269,676	260,660
Accident and emergency	11,269	11,667
Community Health Services	81,385	75,086
Other Contractual	9,575	23,909
Total Secondary Healthcare Purchased	**462,594**	460,209
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**581,221**	**576,500**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	73,271	72,653

6. Operating Leases

The PCT's rental properties are for leases taken out or renewed by the PCT within the last 5 years, therefore there are no material difference between the minimum lease payments and contingent rents. The PCT's largest operating lease is for two floors of Wimbledon Bridge House at 1 Hartfield Road, Wimbledon, SW19 3RU. The lease for these premises will cease in December 2013. At the 31 March 2013, the PCT ceased to exist, for further information see Note 42.

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	92	2,544	0	2,636	2,342
Contingent rents	0	0	0	0	0
Sub-lease payments	0	0	0	0	0
Total				2,636	2,342
Payable:					
No later than one year	92	2,118	0	2,210	1,683
Between one and five years	369	581	0	950	1,448
After five years	683	0	0	683	644
Total	1,144	2,699	0	3,843	3,775
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

The PCT leases space at its clinics to various other healthcare bodies. The most significant of these arrangements is the lease of parts of Queen Mary's Hospital, Roehampton, to St Georges Hospital Trust and South West London and St. George's Mental Health Trust.

Wandsworth PCT has entered into certain financial arrangements involving the use of GP premises. Under the relevant International Financial Reporting Standards, IAS 17 Leases, and IFRIC 4, the PCT has determined that those transactions must be recognised as operating lease expenditure, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the lease payments over financial years.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	22,922	21,817
Contingent rents	0	0
Total	22,922	21,817
Receivable:		
No later than one year	19,666	19,703
Between one and five years	77,815	77,011
After five years	198,297	213,609
Total	295,778	310,323

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	21,887	19,180	2,707	15,568	13,582	1,986	6,319	5,598	721
Social security costs	1,360	1,205	155	1,360	1,205	155	0	0	0
Employer Contributions to NHS BSA - Pensions Division	1,772	1,570	202	1,772	1,570	202	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	1,193	1,193	0	1,193	1,193	0	0	0	0
Total employee benefits	26,212	23,148	3,064	19,893	17,550	2,343	6,319	5,598	721
Less recoveries in respect of employee benefits (table below)	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	26,212	23,148	3,064	19,893	17,550	2,343	6,319	5,598	721
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	26,212	23,148	3,064	19,893	17,550	2,343	6,319	5,598	721
Recognised as:									
Commissioning employee benefits	26,212			19,893			6,319		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	26,212			19,893			6,319		

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. Examples of shared functions include Acute Commissioning, IT, Informatics, Human Resources and Finance.
Expenditure relating to cluster-wide functions (including employee benefits) is shown in the accounts of Wandsworth PCT in 2012/13 as they are acting in the capacity of an agency.
The contributions from the other four PCTs towards cluster-wide functions totalled £16.0 million (31 March 2012: £16.254 million), of which £11.5 million (31 March 2012: £10.389 million related to employee benefits, analysed as follows:

	Total £000	Admin £000	Programme £000	2011/12 £000
Salaries and wages	10,090	10,090	0	8,855
Social security costs	627	627	0	613
Employer contributions to NHS Pensions scheme	817	817	0	812
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	109
Total employee benefits	11,534	11,534	0	10,389

Due to the calculation methodology, the contribution can not be allocated between permanently employed and other.

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	18,074	14,443	3,631
Social security costs	1,252	1,249	3
Employer Contributions to NHS BSA - Pensions Division	1,658	1,653	5
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	152	152	0
Total gross employee benefits	21,136	17,497	3,639
Less recoveries in respect of employee benefits	(10,389)	(10,389)	0
Total - Net Employee Benefits including capitalised costs	10,747	7,108	3,639
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	21,136	17,497	3,639
Recognised as:			
Commissioning employee benefits	21,136		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	21,136		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	6	6	0	7	7	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	343	258	85	317	257	60
Healthcare assistants and other support staff	0	0	0	1	1	0
Nursing, midwifery and health visiting staff	6	6	0	7	7	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	11	8	3	10	7	3
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	366	278	88	342	279	63
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Ill health retirements

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	1	0
	£000s	£000s
Total additional pensions liabilities accrued in the year	68	0

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	**1**	**0**	**1**	0	0	**0**
£10,001-£25,000	**5**	**0**	**5**	0	0	**0**
£25,001-£50,000	**3**	**0**	**3**	0	1	**1**
£50,001-£100,000	**6**	**1**	**7**	0	0	**0**
£100,001 - £150,000	**3**	**0**	**3**	0	1	**1**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**0**	**0**	**0**	0	0	**0**
Total number of exit packages by type (total cost	**18**	**1**	**19**	**0**	**2**	**2**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	1,099,838	92,828	**1,192,666**	0	152,000	**152,000**

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

This disclosure reports the number and value of exit packages agreed with staff 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.

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes.
The valuation of the scheme liability as at 31 March 2013, is based on detailed membership data as at 31 March 2012 updated to 31 March 2013 with summary global member and accounting data.

In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FREM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually.

These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.
The Scheme Regulations were changed to allow contribution rates to be set by the Secretary Of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**18,966**	**102,591**	15,860	90,413
Total Non-NHS Trade Invoices Paid Within Target	**15,981**	**87,174**	12,721	73,718
Percentage of NHS Trade Invoices Paid Within Target	84.26%	84.97%	80.21%	81.53%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**5,414**	**434,531**	4,562	418,497
Total NHS Trade Invoices Paid Within Target	**4,079**	**369,272**	3,726	385,592
Percentage of NHS Trade Invoices Paid Within Target	75.34%	84.98%	81.67%	92.14%

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	23	0	23	22
Bank interest	0	0	0	0
Other loans and receivables	0	0	0	175
Impaired financial assets	0	0	0	0
Other financial assets	0	0	0	0
Subtotal	23	0	23	197
Total investment income	23	0	23	197

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	900
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0	0	0
Gain/(Loss) on disposal of Financial Assets - other than held for sale	0	0	0	0
Gain (Loss) on disposal of assets held for sale	(15)	0	(15)	0
Gain/(loss) on foreign exchange	0	0	0	0
Change in fair value of financial assets carried at fair value through the SoCNE	0	0	0	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	0	0	0	0
Change in fair value of investment property	0	0	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0	0	0
Total	(15)	0	(15)	900

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	73	73	0	76
Interest on obligations under PFI contracts:				
- main finance cost	3,393	3,393	0	3,485
- contingent finance cost	1,307	1,307	0	1,070
Interest on obligations under LIFT contracts:				
- main finance cost	400	400	0	404
- contingent finance cost	185	185	0	118
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	5,358	5,358	0	5,153
Other finance costs	0	0	0	0
Provisions - unwinding of discount	344		344	45
Total	5,702	5,358	344	5,198

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	41,456	83,905	0	0	6,889	140	4,176	5,759	142,325
Additions of Assets Under Construction	0	0	0	0	0	0	0	0	0
Additions Purchased	0	642	0	0	213	0	2,109	(5)	2,959
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	(701)	0	0	505	0	170	196	170
Reclassifications as Held for Sale	(5,504)	(2,110)	0	0	0	0	0	0	(7,614)
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	669	294	0	0	0	0	0	0	963
Impairments/negative indexation	0	(319)	0	0	0	0	0	0	(319)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	36,621	81,711	0	0	7,607	140	6,455	5,950	138,484
Depreciation									
At 1 April 2012	0	8,453	0	0	6,150	125	3,821	4,501	23,050
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	(254)	0	0	0	0	0	0	(254)
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	143	0	0	0	0	0	0	143
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	2,325	0	0	1,092	7	246	1,329	4,999
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	10,667	0	0	7,242	132	4,067	5,830	27,938
Net Book Value at 31 March 2013	36,621	71,044	0	0	365	8	2,388	120	110,546
Purchased	36,621	71,044	0	0	359	8	2,388	120	110,540
Donated	0	0	0	0	6	0	0	0	6
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	36,621	71,044	0	0	365	8	2,388	120	110,546
Asset financing:									
Owned	36,621	7,913	0	0	365	8	2,388	120	47,415
Held on finance lease	0	2,149	0	0	0	0	0	0	2,149
On-SOFP PFI/ LIFT contracts	0	60,982	0	0	0	0	0	0	60,982
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	36,621	71,044	0	0	365	8	2,388	120	110,546

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	23,981	8,847	0	0	137	9	0	30	33,004
Gain on revaluation	669	294	0	0	0	0	0	0	963
Impairments	0	(319)	0	0	0	0	0	0	(319)
Transfer of Disposal	(2,925)	(2,026)	0	0	0	0	0	39	(4,912)
At 31 March 2013	21,725	6,796	0	0	137	9	0	69	28,736

Additions to Assets Under Construction in 2012-13

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

At the 31 March 2013, the PCT ceased to exist, for further information see Note 42.

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	**41,297**	**84,752**	**0**	**0**	**7,148**	**140**	**4,051**	**5,773**	**143,161**
Additions - purchased	1	1,470	0	5	(259)	0	120	(14)	**1,323**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	(5)	0	0	5	0	**0**
Reclassified as held for sale	(211)	(465)	0	0	0	0	0	0	**(676)**
Disposals other than by sale	0	(875)	0	0	0	0	0	0	**(875)**
Revaluation & indexation gains	369	443	0	0	0	0	0	0	**812**
Impairments	0	(1,420)	0	0	0	0	0	0	**(1,420)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**41,456**	**83,905**	**0**	**0**	**6,889**	**140**	**4,176**	**5,759**	**142,325**
Depreciation									
At 1 April 2011	**0**	**6,110**	**0**	**0**	**5,530**	**118**	**3,363**	**3,738**	**18,859**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	(36)	0	0	0	0	0	0	**(36)**
Disposals other than for sale	0	(85)	0	0	0	0	0	0	**(85)**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	2,464	0	0	620	7	458	763	**4,312**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative depreciation netted off cost following revaluation	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**0**	**8,453**	**0**	**0**	**6,150**	**125**	**3,821**	**4,501**	**23,050**
Net Book Value at 31 March 2012	**41,456**	**75,452**	**0**	**0**	**739**	**15**	**355**	**1,258**	**119,275**
Purchased	41,456	75,452	0	0	727	15	355	1,258	**119,263**
Donated	0	0	0	0	12	0	0	0	**12**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**41,456**	**75,452**	**0**	**0**	**739**	**15**	**355**	**1,258**	**119,275**
Asset financing:									
Owned	41,456	11,063	0	0	103	15	355	1,258	**54,250**
Held on finance lease	0	2,192	0	0	0	0	0	0	**2,192**
On-SOFP PFI/ LIFT contracts	0	62,197	0	0	636	0	0	0	**62,833**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**41,456**	**75,452**	**0**	**0**	**739**	**15**	**355**	**1,258**	**119,275**

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	**24,760**	**11,289**	**0**	**0**	**137**	**9**	**0**	**30**	**36,225**
Gain on revaluation	**369**	**443**	**0**	**0**	**0**	**0**	**0**	**0**	**812**
Impairments	**0**	**(2,210)**	**0**	**0**	**0**	**0**	**0**	**0**	**(2,210)**
Transfer of Disposal	**(1,148)**	**(675)**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,823)**
At 31 March 2012	**23,981**	**8,847**	**0**	**0**	**137**	**9**	**0**	**30**	**33,004**

12.3 Property, plant and equipment

An independent District Valuer performed a valuation on all of the PCTs owned land and buildings as at 31st December 2012, including those buildings recognised on the Statement of Financial Position as a finance lease under IFRS. Revaluations relate to the change in value as assessed by the independent District Valuer.

Economic Lives of Non-current Assets	2012/13 Minimum Life Years	2012/13 Maximum Life Years	2011/12 Minimum Life Years	2011/12 Maximum Life Years
Buildings excluding dwellings	1	64	1	64
Plant & Machinery	1	14	1	14
Transport Equipment	5	5	5	5
Information Technology	3	3	3	3
Furniture & Fittings	5	5	5	5

13.1 Intangible non-current assets

2012-13	Software purchased	Total
	£000	£000
At 1 April 2012	**1,550**	**1,550**
Additions - purchased	0	**0**
Additions - internally generated	0	**0**
Additions - donated	0	**0**
Additions - government granted	0	**0**
Additions Leased	0	**0**
Reclassifications	(170)	**(170)**
Reclassified as held for sale	0	**0**
Disposals other than by sale	0	**0**
Revaluation & indexation gains	0	**0**
Impairments	0	**0**
Reversal of impairments	0	**0**
In-year transfers to/from NHS bodies	0	**0**
At 31 March 2013	**1,380**	**1,380**
Amortisation		
At 1 April 2012	**820**	**820**
Reclassifications	0	**0**
Reclassified as held for sale	0	**0**
Disposals other than by sale	0	**0**
Revaluation or indexation gains	0	**0**
Impairments charged to operating expenses	0	**0**
Reversal of impairments charged to operating expenses	0	**0**
Charged during the year	428	**428**
In-year transfers to NHS bodies	0	**0**
At 31 March 2013	**1,248**	**1,248**
Net Book Value at 31 March 2013	**132**	**132**
Net Book Value at 31 March 2013 comprises		
Purchased	132	**132**
Donated	0	**0**
Government Granted	0	**0**
Total at 31 March 2013	**132**	**132**

The PCT does not have any revaluation reserve for intangible non-current assets.

13.2 Intangible non-current assets

2011-12	Software purchased	Total
	£000	£000
At 1 April 2011	**1,002**	**1,002**
Additions - purchased	548	**548**
Additions - internally generated	0	**0**
Additions - donated	0	**0**
Additions - government granted	0	**0**
Reclassifications	0	**0**
Reclassified as held for sale	0	**0**
Disposals other than by sale	0	**0**
Revaluation & indexation gains	0	**0**
Impairments	0	**0**
Reversal of impairments	0	**0**
In-year transfers to/from NHS bodies	0	**0**
Cumulative dep netted off cost following revaluation	0	**0**
At 31 March 2012	**1,550**	**1,550**
Amortisation		
At 1 April 2011	**604**	**604**
Reclassifications	0	**0**
Reclassified as held for sale	0	**0**
Disposals other than by sale	0	**0**
Revaluation or indexation gains	0	**0**
Impairments charged to operating expenses	0	**0**
Reversal of impairments charged to operating expenses	0	**0**
Charged during the year	216	**216**
In-year transfers to NHS bodies	0	**0**
Less cumulative depreciation written down on revaluation	0	**0**
At 31 March 2012	**820**	**820**
Net Book Value at 31 March 2012	**730**	**730**
Net Book Value at 31 March 2012 comprises		
Purchased	730	**730**
Donated	0	**0**
Government Granted	0	**0**
Total at 31 March 2012	**730**	**730**

The PCT does not have any revaluation reserve for intangible non-current assets.

13.3 Intangible non-current assets

None of the assets have been internally generated, all assets having been purchased from a third party in an arm's length transaction. All assets are software used pursuant of the PCT's objectives.

Economic Lives of Non-current Assets	2012/13 Minimum Life Years	2012/13 Maximum Life Years	2011/12 Minimum Life Years	2011/12 Maximum Life Years
Intangible Assets				
Software Licenses	3	3	3	3

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	143	0	143
Total charged to Annually Managed Expenditure	**143**	**0**	**143**
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	319		
Total impairments for PPE charged to reserves	**319**		
Total Impairments of Property, Plant and Equipment	**462**	**0**	**143**
Total Impairments charged to Revaluation Reserve	319		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	143	0	143
Overall Total Impairments	**462**	**0**	**143**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0
Donated and Government Granted Assets, included above -			
PPE - Donated and Government Granted Asset Impairments: amount charged to SoCNE - DEL	0	0	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SoCNE -AME	0	0	0

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2012-13. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

15 Investment property

The PCT does not hold any property for investment purposes. (31 March 2012: none)

16 Commitments

16.1 Capital commitments

The PCT has not entered into any contracted capital commitments as at 31 March 2013. (31 March 2012: none)

16.2 Other financial commitments

The PCT has not entered into any non-cancellable contracts as at 31 March 2013. (31 March 2012: none)

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	1,357	0	547	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,249	0	7,843	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,155	0	35,227	790
At 31 March 2013	**5,761**	**0**	**43,617**	**790**
prior period:				
Balances with other Central Government Bodies	2,552	0	2,530	0
Balances with Local Authorities	121	0	2,977	0
Balances with NHS Trusts and Foundation Trusts	9,191	0	10,807	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	8,536	0	32,608	951
At 31 March 2012	**20,400**	**0**	**48,922**	**951**

18 Inventories

The PCT does not hold any inventories for it's day to day operations. (31 March 2012 : none)

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	**2,606**	10,983	**0**	0
NHS receivables - capital	**0**	760	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**752**	1,353	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,136**	6,582	**0**	0
Provision for the impairment of receivables	**(378)**	(113)	**0**	0
VAT	**1,381**	435	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**264**	400	**0**	0
Total	**5,761**	20,400	**0**	0
Total current and non current	**5,761**	20,400		
Included above:				
Prepaid pensions contributions	**0**	0		

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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**0**	0
By three to six months	**24**	344
By more than six months	**0**	183
Total	**24**	527

19.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	**(113)**	(58)
Amount written off during the year	**9**	0
Amount recovered during the year	**0**	43
(Increase)/decrease in receivables impaired	**(274)**	(98)
Balance at 31 March 2013	**(378)**	(113)

The PCT has a risk based approach to receivable impairment provision, where previous experience highlights the expected future recoverability of different non – NHS receivable categories (non-NHS and staff).

At the 31 March 2013, the PCT ceased to exist, for further information see Note 42.

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**199**	**2**	**201**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**(40)**	**0**	**(40)**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Transfers (to) from other NHS Bodies	**0**	**0**	**0**
Balance at 31 March 2013	**159**	**2**	**161**
Balance at 1 April 2011	209	2	211
Additions	0	0	0
Disposals	0	0	0
Loan repayments	(10)	0	(10)
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**199**	**2**	**201**

Investment in LIFT Co

The PCT has the following investments in South West London Health Partnerships Limited, its local LIFT Co:

£2k: Equity investment (4% of the total equity in issue). This investment is classified as 'available for sale' and held at fair value.

£159k: Loans made to LIFT Co. This investment is held by the PCT as a loan to LIFT Co, which means that it is carried at amortised cost basis.

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	**201**	211
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	(40)	(10)
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**161**	201

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**(40)**	(10)

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	**5**	62
Net change in year	**3,045**	(57)
Closing balance	**3,050**	5
Made up of		
Cash with Government Banking Service	**3,050**	2
Commercial banks	**0**	3
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**3,050**	5
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**3,050**	5
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Total
	£000	£000	£000
Balance at 1 April 2012	211	429	**640**
Plus assets classified as held for sale in the year	5,504	1,856	**7,360**
Less assets sold in the year	(5,715)	(2,285)	**(8,000)**
Less impairment of assets held for sale	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	**0**
Revaluation	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**
Balance at 1 April 2011	3,500	0	**3,500**
Plus assets classified as held for sale in the year	211	429	**640**
Less assets sold in the year	(3,500)	0	**(3,500)**
Less impairment of assets held for sale	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	**0**
Balance at 31 March 2012	**211**	**429**	**640**
Liabilities associated with assets held for sale at 31 March 2012	0	0	**0**

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

At 31 March 2012	0
At 31 March 2013	0

During 2012/13 the PCT disposed of two properties on the Springfield Hospital site to South West London & St Georges NHS Trust.
The PCT also disposed of the land and buildings at 91, Bedford Hill, Balham.

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**8,390**	13,337	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Family Health Services (FHS) payables	**0**	0	**0**	0
Non-NHS payables - revenue	**6,461**	10,057	**0**	0
Non-NHS payables - capital	**1,067**	279	**0**	0
Non_NHS accruals and deferred income	**27,122**	24,690	**790**	951
Social security costs	**6**	70	**0**	0
VAT	**0**	0	**0**	0
Tax	**89**	31	**0**	0
Payments received on account	**0**	0	**0**	0
Other	482	458	0	0
Total	**43,617**	48,922	**790**	951
Total payables (current and non-current)	**44,407**	**49,873**	**790**	**951**

Other payables include £nil (31 March 2012: £nil) in respect of payments due in future years under arrangements to buy out the liability for early retirements over 5 instalments; and £nil (31 March 2012: £nil) in respect of outstanding pensions contributions at 31 March 2013 (31 March 2012: £nil).

At the 31 March 2013, the PCT ceased to exist, for further information see Note 42.

26 Other liabilities

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

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**1,590**	1,533	**49,746**	51,336
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**324**	299	**7,531**	7,909
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**69**	66	**1,189**	1,258
Other (describe)	**0**	0	**0**	0
Total	**1,983**	**1,898**	**58,466**	**60,503**
Total other liabilities (current and non-current)	**60,449**	**62,401**		

28 Other financial liabilities

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Embedded Derivatives at Fair Value through SoCNE	**0**	0	**0**	0
Financial liabilities carried at fair value through SoCNE	**0**	0	**0**	0
Amortised Cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at 1 April 2012	**451**	0	**951**	0
Deferred income addition	**473**	451	**0**	951
Transfer of deferred income	**(134)**	0	**(161)**	0
Current deferred Income at 31 March 2013	**790**	451	**790**	951
Total other liabilities (current and non-current)	**1,580**	**1,402**		

30 Finance lease obligations

Other financial lease obligations relate to leases on GP surgeries. Due to rental reviews on these buildings, there is no material differences between contingent and main lease costs.

At the 31 March 2013, the PCT ceased to exist, for further information see Note 42.

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	**139**	139	**69**	66
Between one and five years	**554**	554	**313**	298
After five years	**1,160**	1,299	**876**	960
Less future finance charges	**(595)**	(668)	**0**	0
Present value of minimum lease payments	**1,258**	1,324	**1,258**	1,324
Included in:				
Current borrowings			**69**	66
Non-current borrowings			**1,189**	1,258
			1,258	1,324

31 Finance lease receivables as lessor

The PCT as a lessor does not hold any leases that would be recognised as a finance lease by the lessee.

32 Provisions

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

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

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

There is an uncertainty about the timing of these payments but they are expected to be made within the next 2 years.

The "other" provisions are in respect of property onerous leases and dilapidations.

The "redundancy" costs are in respect of exit packages agreed in 2012-13 (See Note 7.4) and are expected to be paid by 30 September 2013.

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	2,985	17	1,505	120	0	150	0	0	1,193	0
Arising During the Year	5,989	0	331	16	0	2,509	0	0	2,290	843
Utilised During the Year	(2,065)	0	(2,049)	(15)	0	0	0	0	(1)	0
Reversed Unused	(243)	0	0	(93)	0	(150)	0	0	0	0
Unwinding of Discount	344	0	344	0	0	0	0	0	0	0
Change in Discount Rate	0	0	12	(12)	0	0	0	0	0	0
Transferred (to)/from other Public Sector bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	7,010	17	143	16	0	2,509	0	0	3,482	843
Expected Timing of Cash Flows:										
No Later than One Year	2,130	1	20	16	0	1,250	0	0	0	843
Later than One Year and not later than Five Years	4,826	5	80	0	0	1,259	0	0	3,482	0
Later than Five Years	54	11	43	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	60
As at 31 March 2012	111

At the 31 March 2013, the PCT ceased to exist, for further information see Note 42.

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	0	0
Other	(4)	(3)
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	(4)	(3)
Contingent Assets		
Contingent Assets	759	789
Net Value of Contingent Assets	759	789

Other contingent liabilities relate to legal claims being dealt with by the NHSLA.

In April 2012, the Department of Health announced the deadline of 31 March 2013 for individuals to request an assessment of eligibility for NHS Continuing Healthcare funding, for cases during the period 1 April 2011 – 31 March 2012. With the process still continuing to assess claims for the period 1 April 2004 – 31 March 2011 from the previous deadline of 30 September 2012, the review of the claims for the second dead-line has not yet commenced. Likewise given the subjective nature and process of assessing claims for the period 1 April 2004 to 31 March 2011 there is a possibility of further costs arising that cannot be fully quantified.

The PCT has a capital charge over Sir Jules Thorn Court, a building used for healthcare provision. If this provision of healthcare is ended either through a breach of the capital grant conditions or sale of the building, then the PCT is entitled to a proportion of the overall building value which is represented in the contingent asset.

34 PFI and LIFT

The PCT has a Private Finance Initiative ('PFI') at Queen Mary's Hospital, Roehampton, and a Local Improvement Finance Trust ('LIFT') at St. John's Therapy Centre, Clapham. The PCT's LIFT partner is South West London Local Improvement Finance Trust ('LIFT Co'). The PCT, neighbouring PCT's, the Department of Health, and various private sector bodies each own an equity stake in LIFT Co, with the level of each stake set so no one party has over all control of the entity.

The PCT sold LIFT Co land at an independently assessed open market value. LIFT Co then entered into an agreement with the PCT: LIFT Co built upon this land a new St. John's Therapy Centre, and leased this asset to the PCT for 25 years from the agreement date (unlike in PFI contracts, this lease period included the period of construction). In addition to the lease of the asset, and intrinsically linked to it, LIFT Co was also contracted to provide facilities management and other services over the 25 years of the lease, services in excess of a normal commercial rental agreement.

Financial close of the scheme and the signing of the agreement was in April 2005 and completion and opening of the Centre in December 2006. At the end of the 25 year term the PCT has the option, but not the obligation, to repurchase St. John's Therapy Centre from LIFT Co at a value assessed by a professional valuer and adjusted for changes in the asset's fair value as forecast at the scheme's inception. The PCT believes that it is unlikely that it will exercise this option at the end of the lease term.

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

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

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

34 PFI and LIFT (continued)

The PCT's PFI partner was Catalyst Healthcare (Roehampton) Limited, ('ProjCo'). ProjCo subcontracted both the construction of the hospital, and ongoing asset maintenance and service provision, to other parties, including Bovis Lend Lease and Sodexho. The PCT entered into an agreement with ProjCo in 2006, in which ProjCo built a new Queen Mary's Hospital, Roehampton, and leased this asset to the PCT for 25 years from the date the asset was handed to the PCT. In addition to the lease of the asset, and intrinsically linked to it, ProjCo was also contracted to provide facilities management and other services to the PCT over the 28 years of the lease, services in excess of a normal commercial rental agreement.

These services included an agreed cycle of replacement of key assets in the Hospital and the provision and maintenance of medical equipment. Completion and opening of the Hospital was in February 2006. The PCT continues to own the land on which the hospital was built by ProjCo. At the end of the 25 year term the PCT will receive the asset in a pre-agreed and high condition from ProjCo for no additional consideration.

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

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

Under IFRIC 12, Service Concessionary Arrangements, the PCT's agreement with ProjCo is in substance a form of asset financing. The PCT has therefore accounted for the lease as a finance lease under IAS17, and recognized both the asset, and commensurate finance lease liability, at inception. Payments are thereafter split down into amortising the finance lease liability, interest, and service costs. The imputed finance lease charge is detailed in the table below.

At the 31 March 2013, the PCT ceased to exist, for further information see Note 42.

34 PFI and LIFT - (continued)

	31 March 2013 £000	31 March 2012 £000
34.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**6,901**	6,600
Total	**6,901**	**6,600**
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**7,064**	6,901
Later than One Year, No Later than Five Years	**30,307**	29,551
Later than Five Years	**164,926**	172,746
Total	**202,297**	209,198

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

	31 March 2013 £000	31 March 2012 £000
Estimated Capital Value of Project - off SOFP PFI	**0**	0
Value of Deferred Assets - off SOFP PFI	**0**	0
Value of Reversionary Interest - off SOFP PFI	**0**	0
34.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	**4,883**	4,926
Later than One Year, No Later than Five Years	**18,069**	17,897
Later than Five Years	**72,599**	77,654
Subtotal	**95,551**	100,477
Less: Interest Element	**(44,215)**	(47,608)
Total	**51,336**	52,869

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	**385**	369
Total	**385**	369

	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	**377**	385
Later than One Year, No Later than Five Years	**1,736**	1,637
Later than Five Years	**8,452**	8,928
Total	**10,565**	10,950

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	**709**	695
Later than One Year, No Later than Five Years	**2,742**	2,784
Later than Five Years	**8,575**	9,242
Subtotal	**12,026**	12,721
Less: Interest Element	**(4,171)**	(4,513)
Total	**7,855**	8,208

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	**2,271**	2,271	0
Interest Expense	**5,285**	5,285	0
Impairment charge - AME	**0**		0
Impairment charge - DEL	**0**	0	0
Other Expenditure	**7,361**	7,361	0
Revenue Receivable from subleasing	**0**	0	0
Total IFRS Expenditure (IFRIC12)	**14,917**	**14,917**	**0**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(14,284)**	(14,284)	0
Net IFRS change (IFRIC12)	**633**	**633**	**0**

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	738
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	1,219

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 risk.

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	2,606	0	**2,606**
Receivables - non-NHS	0	752	0	**752**
Cash at bank and in hand	0	3,050	0	**3,050**
Other financial assets	0	159	2	**161**
Total at 31 March 2013	**0**	**6,567**	**2**	**6,569**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	11,743	0	11,743
Receivables - non-NHS	0	1,753	0	1,753
Cash at bank and in hand	0	5	0	5
Other financial assets	0	199	2	201
Total at 31 March 2012	0	13,700	2	13,702

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	8,390	**8,390**
Non-NHS payables	0	8,010	**8,010**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	60,449	**60,449**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**76,849**	**76,849**
Embedded derivatives	0	0	0
NHS payables	0	13,337	13,337
Non-NHS payables	0	10,794	10,794
Other borrowings	0	0	0
PFI & finance lease obligations	0	62,401	62,401
Other financial liabilities	0	0	0
Total at 31 March 2012	0	86,532	86,532

37 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Amounts owed to Related Party	Payments to Related Party	Amounts owed to Related Party
	2012-13 £000	2012-13 £000	2011-12 £000	2011-12 £000
Winstock Practice	2,819	0	2,760	0
Queenstown Road Practice	1,157	0	N/A	N/A
Earlsfield Practice	1,345	0	N/A	N/A
Bridge Lane Group Practice	1,777	0	1,760	0
Dr H M Freeman & Partners	3,445	0	3,667	0
Danebury Surgery	457	0	513	0
Wandsworth Medical Centre	1,370	0	1,179	0
Kroll Practice	N/A	N/A	1,505	0
Bower and Nightingale House Practice	N/A	N/A	2,292	0
Wandsworth Primary Care Trust Charity*	0	(19)	0	(176)

*Wandsworth Primary Care Trust exercises its trustee role through the Joint Boards of NHS South West London.

During the year payments were made to the following General Practionary Partnerships where 1 or more partners is related to one of the Joint Medical Directors.

	Payments to Related Party	Amounts owed to Related Party	Payments to Related Party	Amounts owed to Related Party
	2012-13 £000	2012-13 £000	2011-12 £000	2011-12 £000
Grannell Practice	1,457	0	1,459	0
Neil (formerly Phillips) Practice	1,577	0	1,517	0

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

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	2012-13 £000	2012-13 £000	2012-13 £000	2012-13 £000
Chelsea and Westminster Hospital NHS Foundation Trust	30,658	232	272	76
Croydon Primary Care Trust	31,475	9,093	0	228
East Sussex Downs and Weald PCT	2,402	0	0	0
Epsom and St Hellier University Hospitals NHS Trust	6,321	0	223	0
Guys and St Thomas NHS Foundation Trust	19,817	87	427	45
Imperial College Healthcare NHS Trust	7,401	0	0	411
Kings College Hospital NHS Foundation Trust	5,856	132	161	27
Kingston Hospital NHS Trust	16,471	34	107	100
Kingston Primary Care Trust	0	2,539	43	0
London Ambulance Service NHS Trust	8,039	0	34	0
London Strategic Health Authority	0	3,839	316	59
Moorfields Eye Hospital NHS Foundation Trust	5,774	8	194	2
Richmond and Twickenham Primary Care Trust	407	4,141	64	268
Royal Brompton & Harefield NHS Foundation Trust	3,936	0	230	0
South London and Maudsley NHS Foundation Trust	1,883	0	323	0
South West London and St Georges Mental Health Trust	43,958	5,203	590	0
St Georges Healthcare NHS Trust	208,319	16,506	2,401	344
Surrey and Borders Partnership NHS Foundaion Trust	1,007	0	0	0
Sutton and Merton Primary Care Trust	4,260	8,573	105	474
The Royal Marsden NHS Foundation Trust	5,899	609	0	100
University College London Hospitals NHS Foundation Trust	3,319	0	319	0

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 Wandsworth Borough Council.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	2012-13 £000	2012-13 £000	2012-13 £000	2012-13 £000
National Insurance Fund (employers contribution)	1,301	0	0	0
NHS Pension scheme (employers contribution)	6,546	0	0	0
Wandsworth Borough Council	18,806	277	0	0

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	10,241	14
Special payments - PCT management costs	5000	2
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	10,241	14
Total special payments	5,000	2
Total losses and special payments	15,241	16

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	9,049	7
Special payments - PCT management costs	7,712	4
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	9,049	7
Total special payments	7,712	4
Total losses and special payments	16,761	11

39 Third party assets

The PCT does not hold any third party assets (31 March 2012: none)

40 Pooled budget

The PCT does not have any pooled budget arrangements (31 March 2012: none)

41 Cash flows relating to exceptional items

The PCT does not have any cash flows relating to exceptional items. (31 March 2012: none)

42 Events after the end of the reporting period

As disclosed within Note 1 due to the Health and Social Care Bill as of 1 April 2013 the PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either NHS England (formerly known as The National Commissioning Board), Clinical Commissioning Group (CCG), NHS Trusts or Local Authorities (LA). Estates functions will be transferred to NHS Property Services Limited (NHS PS) and Community Health Partnerships . Ultimate control will still reside with the Department of Health.

All assets and liabilities contained within the statement of financial position as at 31 March 2013 must be identified and agreed for transfer to a successor body.

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability.

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

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

The final year-end aggregate surplus generated by the PCT in 2012/13 will be carried forward to NHS England in 2013/14. CCGs will not inherit legacy debt, but balances will transfer from PCTs, in line with provisions of the Act, based on the principles set out below.

- Liabilities that correspond to a non- current asset which relate to a particular function should transfer with that asset from a sender to a receiver by reference to the destination of the function.

- Liabilities that correspond to a function or policy that is being moved from a sender should transfer to the nominated receiver for that function.

- Discrete, and current assets and liabilities, even if associated with a function continuing in 2013/14 will transfer to the Department of Health.

- Liabilities relating to the PCT as a statutory body in its own right that do not relate to an ongoing function such as VAT or tax liabilities, will transfer to the Department of Health.

- Employer liabilities will transfer to the new employer, where an individual's employment is transferred to a receiver organisation.

- Where employment of staff ceases prior to 1 April 2013, the employer liabilities related to those staff members will transfer to Department of Health.

42.1 Events after the end of the reporting period (continued)

As a result of the Health and Social Care Bill balances within the statement of financial position as at 31 March 2013 will be transferred as follows:-

		Entities receiving assets and liabilities following the PCT's closure							
	Balances held by the PCT at 31 March 2013	Department of Health	Clinical Commissioning Groups	NHS England	NHS Trusts	NHS Foundation Trusts	NHS Property Services	Community Health Partnerships	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Non-current assets:									
Property, plant and equipment	110,546	0	151	2,396	2,855	0	94,478	10,666	0
Intangible assets	132	0	0	132	0	0	0	0	0
investment property	0	0	0	0	0	0	0	0	0
Other financial assets	161	0	0	0	0	0	0	161	0
Trade and other receivables	0	0	0	0	0	0	0	0	0
Total non-current assets	110,839	0	151	2,528	2,855	0	94,478	10,827	0
Current assets:									
Inventories	0	0	0	0	0	0	0	0	0
Trade and other receivables	5,761	4,324	34	876	0	0	527	0	0
Other financial assets	0	0	0	0	0	0	0	0	0
Other current assets	0	0	0	0	0	0	0	0	0
Cash and cash equivalents	3,050	3,050	0	0	0	0	0	0	0
Total current assets	8,811	7,374	34	876	0	0	527	0	0
Non-current assets held for sale	0	0	0	0	0	0	0	0	0
Total current assets	8,811	7,374	34	876	0	0	527	0	0
Total assets	119,650	7,374	185	3,404	2,855	0	95,005	10,827	0
Current liabilities									
Trade and other payables	(43,617)	(30,338)	(9,008)	(2,691)	0	0	(1,423)	(157)	0
Other liabilities	0	0	0	0	0	0	0	0	0
Provisions	(2,130)	(880)	(1,250)	0	0	0	0	0	0
Borrowings	(1,983)	0	0	0	0	0	(1,659)	(324)	0
Other financial liabilities	0	0	0	0	0	0	0	0	0
Total current liabilities	(47,730)	(31,218)	(10,258)	(2,691)	0	0	(3,082)	(481)	0
Non-current assets plus/less net current assets/liabilities	71,920	(23,844)	(10,073)	713	2,855	0	91,923	10,346	0
Non-current liabilities									
Trade and other payables	(790)	(790)	0	0	0	0	0	0	0
Other Liabilities	0	0	0	0	0	0	0	0	0
Provisions	(4,880)	(139)	(1,259)	0	0	0	(3,482)	0	0
Borrowings	(58,466)	0	0	0	0	0	(50,935)	(7,531)	0
Other financial liabilities	0	0	0	0	0	0	0	0	0
Total non-current liabilities	(64,136)	(929)	(1,259)	0	0	0	(54,417)	(7,531)	0
Total Assets Employed:	7,784	(24,773)	(11,332)	713	2,855	0	37,506	2,815	0
Financed by taxpayers' equity:									
General fund	(20,952)	(24,773)	(11,529)	705	1,578	0	13,282	(215)	0
Revaluation reserve	28,736	0	197	8	1,277	0	24,224	3,030	0
Other reserves	0	0	0	0	0	0	0	0	0
Total taxpayers' equity:	7,784	(24,773)	(11,332)	713	2,855	0	37,506	2,815	0

Wandsworth Primary Care Trust
Annual Governance Statement 2012 - 2013

NHS Wandsworth

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 the SWL 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 Partnerships' to provide further assurance on its governance arrangements through transition. This complemented the assurance received from the Internal Audit Plan, focussing on areas of risk, transition, mapping and transfer of statutory responsibilities and the extent to which the new Clinical Commissioning Groups were being supported to develop robust governance arrangements for authorisation and beyond.

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

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

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

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

2.2 NHS SWL Joint Boards' Committee Structure

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

In terms of remit, the Committees cover:

Statutory Committees

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

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

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

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

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

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

Non Statutory Committees

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

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

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

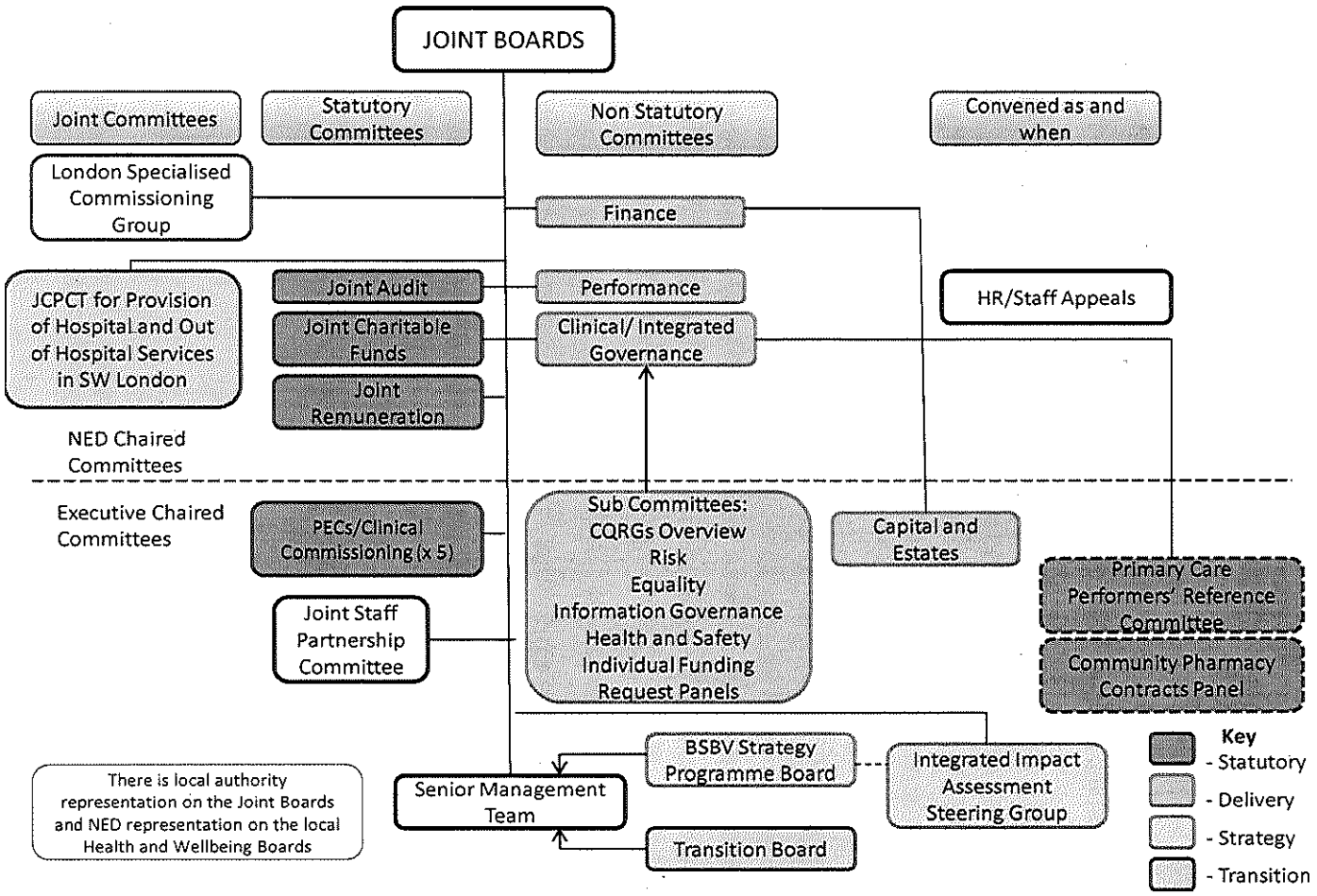
(ix) **(Joint Committees ((ix) Pan London; (x) South West and South East Clusters)**

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

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

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

JOINT BOARDS' COMMITTEE STRUCTURE



2.3 NHS SWL Joint Boards' Performance

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

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

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

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

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

[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' 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	
Wandsworth Clinical Commissioning Committee	Met 9 times	Yes	• CCG Development – Authorisation, OD • Service Delivery • Public Health Transition • Performance • Clinical Focus Areas • Operational Focus Areas • Integration of services with the Local Authority • Commissioning Support • Equality Delivery System • CSP, Operating Plan, Commissioning Intentions • Better Services Better Value • Patient and Public Engagement, Communications and Engagement • Governance assurance – Risk Register, Declarations of Interest • Policies • Clinical Reference Groups • Presentations from other NHS organisations

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

2.5.1 Information Governance:

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

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

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

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

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

3. Risk

3.1 Risk Assessment

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

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

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

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

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

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

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

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

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

Key risks during 2012-13 have included:

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

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

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

3.2 Lapses of data security including reported to Information Commissioner:

During 2012-2013 there have been four serious incidents reported to the Information Commissioner (categorised as 3-5). There were two minor incidents (categorised as 1-2). These have been analysed by each of the Cluster organisations and categorised by five types of incident, shown in the table below:

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2012-2013		**Wandsworth**
Category	**Nature of incident**	
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from 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	
IV	Unauthorised disclosure (73% involved failure to use NHS.net to e-mail identifiable data)	4
V	Other	
TOTAL		**6**

3.3 The Risk and Control Framework

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

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

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

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

3.4 Executive Management Team and Board Committee Scrutiny of Risks

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

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

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

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

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

3.5 Managing risks around delegation to CCGs under shadow working arrangements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.6 Review of the Effectiveness of Risk Management and Internal Control

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

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

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

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

3.6.2 However, internal audit have identified specific areas where high risk recommendations required action to ensure that the Primary Care Trust's strategic objectives were met and the systems of internal control remained sufficiently robust to mitigate critical financial, operational and governance risks.

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

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

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

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

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

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

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

4. Significant Issues

4.1 Continuing Care

In response to an Internal Audit review of the South West London PCTs' processes for managing continuing care, a specific project group was formed to review current operating systems across all five PCTs (covering six boroughs) and to implement consistent approaches that addressed the areas of weakness identified in the internal audit report. This work was led by the Managing Director of Richmond PCT. At the end of March 2013 the full liability for retrospective cases had been identified and the likely financial impact for future years built into the future CCGs' contingent liabilities. In addition all CCGs, (except Kingston which operates a joint service with its Borough), have secured a new common continuing care service from South London Commissioning Support Unit. This provides greater consistency of approach to applications, quality monitoring, patient safety assurance and increased staffing resilience across all South West London areas. Continuing care placements that had not been subject to a formal review within the prescribed

timelines set out in national guidelines, are now being completed, although this exercise will not be completed until the late spring/early summer of 2013.

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

Department of Health Designated Signing Officer

Carl Vincent – Director of Provider Finance and Finance Transition

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