Department of Health

NHS

Camden Primary Care Trust

2012-13 Annual Report and Accounts

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Camden Primary Care Trust

2012-13 Annual Report

NHS

North Central London

Annual Report and Accounts 2012/13

Camden Primary Care Trust

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Welcome from the Camden PCT Chair and Vice Chair

Welcome to the 2012/13 Annual Report on your local NHS healthcare services in Camden.

Camden Primary Care Trust's performance against key national measures had remained strong this year. Our performance is detailed elsewhere in this report but some of the highlights include:

- sustained achievement of most of the cancer waiting time targets during 2012/13
- excellent performance against the national measures for stroke services with Camden CCG exceeding the 80% threshold for time on a stroke unit and also achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours
- compliance with the zero tolerance standard for single sex wards since August 2012
- Camden had increased to 42.6% from 39.52% over 2011/12 against the 60% standard for bowel cancer screening. For breast cancer screening Camden had the lowest percentage coverage within North Central London of 61.68% but had implemented robust actions throughout the year to improve this
- Camden is exceeding its year to date plan for health checks offered and uptake with 10,800 health checks offered in 2012/3 and 3,500 checks delivered so far in 2012/13
- Camden is the only CCG within North Central London to currently achieve the 90% standard with the majority of Camden women accessing maternity services at UCLH and the Royal Free.

Looking back over the life of Camden Primary Care Trust (Camden PCT), there is much to be proud of. Our achievements have benefited the residents of Camden both in their overall health and in their health needs in times of emergency.

The development of quality primary care services across the borough led to local people being able to access faster appointments in their GP surgeries and in accessing treatment in hospitals. We worked hard to ensure that surgeries were open for extended hours, to offer those who wanted early morning or evening appointments the same access to healthcare.

There had been considerable investment in GP and hospital buildings with the upgrade of some GP surgeries and our capital investment in a new build in Kentish Town, rebuilds of Solent Road, Parliament Hill and Queen's Crescent. These are just a few of the surgeries which have benefitted from significant capital investments over the past ten years.

We also saw through the development of Haverstock Health and the Urgent Care Centre at the Royal Free Hospital. In 2011/12 the UCC centre saw 22,567 people who would otherwise have gone to A&E.

We pushed our partnership working along and were determined to see strong partnerships with our local authority colleagues and other partners which stood us in good stead with the introduction of the new commissioning landscape in 2013. Our

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successes here include the assertive outreach and crisis resolution schemes which saw fewer people staying in hospital after they had been discharged.

Camden had had a good history of meeting its public health targets and strong financial performance across the lifetime of the Trust which we also can be proud to have delivered.

As we hand over our services, and on behalf of our Board, we would like to thank our partner organisations and stakeholders and our staff for their support during this transition period.

We wish all those working to deliver health care across Camden a successful future, building on the firm foundation inherited from Camden PCT.

Thank you

Paula Kahn
Chair

John Carrier
Vice-Chair

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Directors' Report

Camden PCT and NHS North Central London - providing health care for Camden residents

NHS North Central London was established in April 2011 and was a collaborative working arrangement between Barnet, Camden, Enfield, Haringey and Islington Primary Care Trusts.

Camden PCT held the budget for all health services across Camden. We were responsible for a number of different things including:

- measuring the health needs of local residents and developing an understanding of these needs
- commissioning (buying) the right services to meet local people's needs, for instance from GPs, hospitals and mental health services
- monitoring the quality of local health services
- improving the overall health of local communities, and
- making sure local organisations delivering NHS services, such as hospitals and GP surgeries, worked well together.

Camden PCT was responsible for planning and buying all local NHS health services for approximately 256,243 people living in Camden and making sure local people have good health and access to good healthcare.

As part of the changes to the NHS brought about by the Health and Social Care Act 2012, all NHS North Central London responsibilities (and those of Camden PCT) were taken over by Clinical Commissioning Groups (CCGs), NHS England (formerly the NHS Commissioning Board), Local Authorities and other organisations. Camden PCT and all other PCTs which made up the NHS North Central London cluster ceased to exist at the end of March 2013.

CCGs are made up of local GPs and other local clinical professionals, who will ensure that local healthcare services are commissioned by local clinical leaders in Camden with good knowledge of the needs of local people.

Camden PCT met the control total surplus of £23.8m as set by the Department of Health.

Camden PCT met all of our statutory duties, namely:

- financial balance in year
- spending within our capital allocation, and
- spending within our cash limits

These achievements were a credit to the whole organisation, which maintained focus on delivering value for money for our patients and public at a time of substantial organisational change within the NHS.

The top priorities for Camden PCT for 2012/13 were to ensure we commissioned services which were safe and of increasing quality for the people we serve; to deliver the NHS North Central London Commissioning Strategy and Quality, Innovation,

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Productivity and Prevention (QIPP) Plan; and to deliver key organisational objectives and a secure transition to the commissioning landscape in line with the Health and Social Care Act 2012.

Throughout the year, we kept our focus clearly on improving services for local people, by working closely with Camden CCG and with the local authority, local hospitals, mental health and community healthcare Trusts and other partner organisations.

The PCT also liaised closely with the Camden Local Involvement Network (LINk) and local charity health providers and organisations providing health services in Camden to ensure a smooth transition of health services. Formal assurances for this handover have been given to the relevant receiving organisations.

Camden Primary Care Trust – who was who

Camden PCT's Board met concurrently with the Boards of the other four PCTs which made up the NHS North Central London cluster of PCTs (Barnet, Camden, Enfield, Haringey and Islington).

Each of the five PCT Boards shared a Board Chair, an Audit Committee Chair, a Chief Executive and a Director of Finance. The PCTs also shared some non-executive directors between them, as well as some executive directors.

Camden PCT's Board provided the strategic leadership of the organisation and was responsible for making sure that the PCT works in the best interests of the local community. The Board was accountable to the public for the services provided in Camden for the organisation's use of public funds. In 2012/13 the following people made up the Camden PCT's Board:

Voting Members

Name	Title	Notes
Non-executive Directors		
Paula Kahn	Chair	
John Carrier	Vice Chair	Resigned December 2012
Ellen Schroder	Non-Executive Director	From December 2013
Robert Sumerling	Non-Executive Director	
Karen Trew	Non-Executive Director	
Deborah Fowler	Non-Executive Director	
Caroline Rivett	Audit Chair	
Executive Directors		
Caroline Taylor	Chief Executive	
Ann Johnson	Director of Finance	To August 2012
Bev Evans	Director of Finance	From August 2012
Dr Quentin Sandifer	Director of Public	To October 2012

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	Health	
Penny Bevan	Acting Director of Public Health	From October 2012 to March 2013 (Joint Director of Public Health Camden and Islington)
Julie Billett	Director of Public Health	From 1 March 2013 (Joint Director of Public Health Camden and Islington)

Non-voting Members

Name	Title	Notes
Executive Directors		
Jeremy Burden	Director of Contracts	To July 2012
Simon Currie	Director of Contracts	From July 2012 to December 2012
Liz Wise	Director of QIPP	From April 2011 to March 2013
Alison Pointu	Director of Quality & Safety	
Helen Pettersen	Director of Transition and Corporate Affairs	To December 2012
Dr Douglas Russell	Medical Director – Primary Care	To July 2012
Dr Henrietta Hughes	Medical Director – Primary Care	From July 2012
Dr Nick Losseff	Medical Director – Secondary Care	
Aurea Jones	Director of Workforce Transformation	To June 2012
Ian Fuller	Director of HR	To October 2012
Marion McCrindle	Director of HR	From October 2012
David Cryer	Borough Director Camden	
Sarah Price	Joint Director of Public Health	From April 2011 to March 2013

Professional Executive Committee (PEC) Members

Name	Title	Notes
Dr Marek Koperski	PEC Chair	
Joanne Wickens	PEC Nurse	
Denise Bavin	PEC Member	
Philip Wee	PEC Member	
Tom Aslan	PEC Member	

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The Patient Advice and Liaison Service (PALS) and Complaints Service

The Patient Advice and Liaison Service (PALS) and Complaints Service was set up to provide information and advice on local healthcare services, help the public resolve problems with healthcare services quickly and effectively and, where necessary, advise people on how to make formal complaints.

All compliments, comments, concerns and complaints were monitored, to help PCTs and healthcare providers to improve services.

The PALS and Complaints Service for NHS North Central London had 4131 contacts between April and March 2013.

- 71% of contacts were seeking advice or information on accessing services in NCL
- 12% were concerns handled by the PALS team
- 16% were complaints about services
- 92% of complaints were acknowledged within 3 working days
- 69% of complaints were responded to within the 25 working day timeframe

Table 1: Type of contact

	Barnet	Camden	Enfield	Haringey	Islington	NCL	NCL Providers	Other	**Total**
Complaint	143	120	120	127	86	20	44	8	**668**
Concern	105	81	89	83	64	25	47	7	**501**
Advice & Information	448	465	385	437	328	458	228	197	**2,946**
FOI	2	2	1	0	0	4	0	0	**9**
Compliment	3	1	0	0	0	1	2	0	**7**
Total	**701**	**669**	**595**	**647**	**478**	**508**	**321**	**212**	**4,131**

There were a high number of issues relating to appointments at GP practices and a majority of manner and attitude issues related to how issues with access were handled by practices. Access to GP practices in the morning and evening were the key issues raised along with difficulty accessing practices by phone. A number of reviews of complaints have taken place by the Practitioner Performance team; these reviews resulted in recommendations for service improvement.

As the first point of contact for patients or their families raising concerns about services commissioned by NHS North Central London, the PALS and Complaints Service held an important role in identifying the need for service improvements through the complaints or concerns raised by service users.

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- A number of areas of concern regarding charging by dental practices and quality of work undertaken have been highlighted with the assistance of the Primary Care team and were investigated.
- Letters relating to concerns raised by patients and their advocates in 2012 about difficulties in registering with GP practices led to NHS London completing and approving GP registration guidelines for London; these have been distributed and provide further clarity for practices in London on this process.
- Following contact from the General Dental Council (GDC) contact information for dentists in the cluster were updated on NHS Choices.

From April 2013 complaints about primary care services (including GPs, dentists and pharmacists) are being managed by NHS England (formerly NHS Commissioning Board). Contact details or information about complaints can be found on www.ncl.nhs.uk or on CCG websites.

Making it happen in NHS North Central London

In January 2013, NHS North Central London published its annual report on equalities which highlighted how we provided 'due regard' to our Public Sector Equality Duty (PSED) as defined by the Equality Act 2010 through each of the five PCTs. In addition we also reported on our workforce broken down by their 'Protected Characteristics'. Each PCT had good examples of how they have addressed equality issues including use of services for people in Barnet who are deaf, deafened or hard of hearing. For instance, in Camden, the PCT worked with the National Children's Bureau to seek the views of young people in Camden about their local health care services. The full report is available on the website www.ncl.nhs.uk

NHS North Central London cluster staff

From November 2011, the cluster moved to a single employer arrangement hosted via Islington Primary Care Trust. Human Relations employment terms and conditions were harmonised to enable ease of working for all staff and managers and equity wherever possible.

Wherever possible, staff transitioned into new roles across the CCG or CSU or other new NHS bodies such as NHS England. Displaced staff were mentored and coached to find alternative roles.

NHS North Central London's policies in relation to discrimination and equal opportunity

NHS North Central London and its constituent Primary Care Trusts recognised that discrimination and victimisation was unacceptable and worked hard to ensure that no employee or job applicant received less favourable facilities or treatment (either directly or indirectly) in recruitment or employment on grounds of age, disability, gender/ gender reassignment, marriage/ civil partnership, pregnancy/ maternity, race, religion or belief, sex, or sexual orientation (the protected characteristics). It had policies in place which

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were published to ensure that staff were made aware that no form of discrimination would be tolerated and that each employee was respected. These policies and associated arrangements operated in accordance with statutory requirements. In addition, full account was taken of guidance and Codes of Practice issued by the Equality and Human Rights Commission, Government Departments, and other statutory bodies.

Number of staff employed [1]

	2012/13	2011/12
Camden PCT	162	376

Gender

	Whole cluster (%) [1]
Male	37.85%
Female	62.15%

Ethnicity

	Whole cluster (%)[1]
White	61.45%
Mixed	3.21%
Asian/Asian British	14.96%
Black or Black British	13.86%
Other ethnic group	3.31%
Unknown	0.80%
Declined to provide	2.41%

[1] Data extracted from ESR system as at 31 March 2013.

Sickness absence

The rate of sickness for NHS North Central London was 2.73%. This is under the average rate for NHS England as a whole (3.09%[2]).

[2] Data taken from NHS Information Centre for sickness absence rates for the NHS in England for the calendar year January to December 2012

National Staff Survey

A national decision was taken to allow close-down organisations not to take part in 2012 National Staff Survey.

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Estates across North Central London

The Estates and Facilities teams developed a single management operating model across the five PCTs to enhance operational effectiveness and prepare for the transfer of properties in line with the national transition plans.

Properties owned by the PCTs (in their own name and that of their predecessors)

In accordance with central direction some properties were transferred to other NHS Trusts or transferred to NHS Property Services Limited. In the case of LIFT schemes, these transferred to Community Health Partnerships Limited. Both NHS Property Services and Community Health Partnerships Limited are wholly owned by the Government.

Capturing significant assets within the properties

The Estates and Facilities team had worked to capture all service contracts and map activity against each property portfolio.

During this process a high quality facilities management service was delivered to the tenants of our buildings. In 2012/13 we completed a number of significant capital projects which included:

- Health and safety works in line with CQC guidelines
- Opening of the new Finchley Memorial Hospital
- Completion of the refurbishment of Brunswick Park Health Centre.

All these schemes will benefit the local community by enabling and supporting the delivery of better quality care.

In 2012/13 there were no service failures which had a significant impact on patients.

Emergency planning for NHS North Central London

Over the last twelve months the NCL Cluster Emergency Planning and Business Continuity Team instigated measures to ensure robust and resilient systems were in place to coordinate the response of NHS North Central London, local NHS Trusts and Primary Care Contractors to any major incident or business continuity event that may have occurred.

The team took the lead in coordinating North Central London's planning for the London 2012 Olympic and Paralympic Games. A North Central London Olympic Planning Group was established and work programme of actions created to ensure the organisation and provider Trusts were fully prepared for the games. We ran a series of staff Olympic briefings to ensure all staff were aware of the likely transport impact and worked with provider Trusts and primary care contractors to support their Olympic Planning.

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During the Games the North Central London Olympic Control Room provided a coordination point for the management of issues that affected NHS operations and shared updates with the NHS London Games-Time Coordination Centre.

Overall the impact of the Games was far less than anticipated both in terms of transport and capacity/demand for services for provider Trusts and primary care providers.

The success of the Games in terms of logistics, transport and coordination can be attributed to the excellent coordinated planning between agencies and staff across all sectors, heeding advice to work in different ways to avoid causing severe transport congestion.

A key legacy from the Olympic Games was the development of closer working relationships between NHS and Local Authority organisations, particularly through Safety Advisory Groups and a 'system-wide' consideration of local impacts from large events taking place within London. Teleconference arrangements for managing seasonal surge capacity in acute trusts will build on the successful formula used during the Olympics. Finally, NHS organisations noted that Olympic Planning had provided more resilience to the supply chain for key commodities.

In addition to support during the Olympics, the Emergency Planning Team was involved in supporting provider organisations with the response to a number of other incidents. These included a siege situation on Tottenham Court Road in April 2012, a fire and power failure at Chase Farm Hospital in June 2012 and a suspect package incident at Whittington Hospital in August 2012.

To embed lessons identified from these events, NHS North Central London was involved in or ran a number of training and exercise events. These included monthly communications tests with provider Trusts, a winter planning event called Exercise Bleak Winter in October 2012, a Cluster Public Health Emergency Planning transition event in November 2012 and a transition planning event called Exercise Ermine, in January 2013.

As part of the wider changes under the Health and Social Care Act 2012, Emergency Preparedness is now led by NHS England under the revised system from April 2013. The cluster team had been central in supporting the transition of the service into NHS England as well as providing expert advice and training to assist the Clinical Commissioning Groups embed their support role as a Category Two responder under the Civil Contingencies Act.

Sustainability

The latest version of our sustainability report was developed during the year, presented to the Joint Boards of the cluster and approved in September 2012. Having an up to date Sustainable Development Management Plan ensured that the organisation fulfilled its commitment to conducting all activities with due consideration to sustainability, whilst providing high quality patient care.

NHS North Central London remained committed to the Government's target for the environment including lower carbon emissions and sustainability. The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015, thereby reducing the amount of energy used as well as contributing to a financial benefit.

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Plans were put in place across North Central London to reduce carbon emissions and improve our environmental sustainability. The potential for delivering cost effective savings through schemes such as the Mayor of London's REFIT scheme (which offers assistance under a structured framework to achieve carbon reductions in London) was investigated.

A staff energy awareness campaign ran throughout 2012/13. Surveys carried out for the NHS Sustainable Development Unit showed that we compare well against peers.

NHS North Central London had a Sustainable Transport Plan.

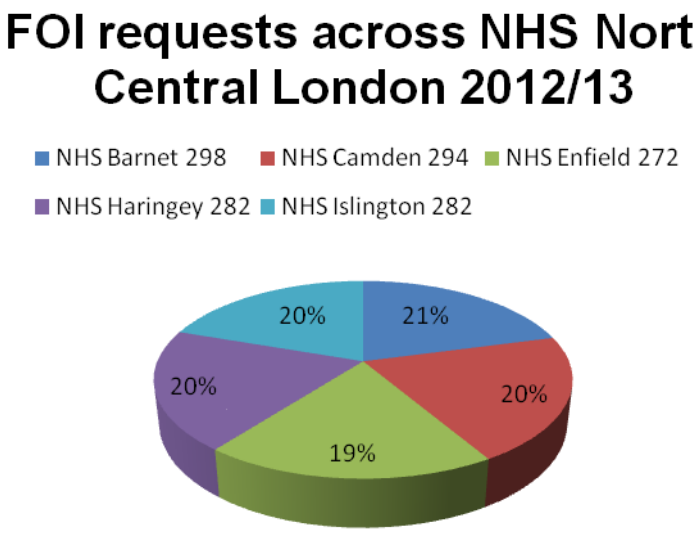
Freedom of Information Act management

The Freedom of Information Act 2000 (FOIA) recognises that the public has the right to know how public services are organised, how they carry out their duties, why they make the decisions they do and how they spend public money.

All Primary Care Trusts within NHS North Central London were required to respond to freedom of information requests within 20 working days. NHS North Central London monitors the performance of the targets to identify the causes of any delays and to see how these can be addressed to improve future performance.

The majority of requests were responded to within 20 working days. Those missing the target were largely due to the complexity of the information requested, or multiple issues needing investigating.

Between 1 April 2012 and 28 March 2013, a total of 1,428 Freedom of Information requests were processed across the cluster.



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The FOI disclosure logs of information provided by NHS North Central London were published on the website at http://www.ncl.nhs.uk/about/freedom-of-information.aspx

From April 2013, all Freedom of Information requests are managed by the Commissioning Support Units (CSUs) on behalf of the five new Clinical Commissioning Groups. Their contact details are at the rear of this report.

Annual General Meeting

Because of the closure of PCTs in March 2013, these organisations no longer legally exist and therefore it is not deemed possible for Camden PCT to hold an AGM.

Camden PCT Annual Governance Statement: April 2012 to March 2013

Scope of responsibility

I am assured by the former Chief Executive of Camden Primary Care Trust (PCT), who was the Accountable Officer responsible for ensuring the proper stewardship of public funds and assets and who was accountable for the overall performance of the executive functions of the PCT, that the work of ensuring the discharge of obligations under Financial Directions was carried out in line with the requirements of the Accountable Officer Memorandum for PCT Chief Executives issued by the Department of Health.

I am assured by the Accountable Officer that she had carried out her responsibilities which included ensuring the following:

- management systems for safeguarding public funds and assets and assisting in the implementation of corporate governance;
- achieving value for money with the resources available;
- expenditure and income; and
- effective and sound financial management systems.

I am reassured by the former Accountable Officer who was accountable to the Chair and Non-Executive members of the PCT Board for ensuring that its decisions were implemented, that the organisation worked effectively, in accordance with Government policy and public service values, and for the maintenance of proper financial stewardship. Within the Standing Financial Instructions, it was acknowledged that the Chief Executive was ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the PCT Board met its obligation to perform its functions within the available financial resources.

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The former Chief Executive as Accountable Officer had overall executive responsibility for the PCT's activities and the achievement of its objectives; responsibility to the Chair and the PCT Board for ensuring that its financial obligations and targets are met; and have overall responsibility for the PCT's system of internal control. The essence of that role as Accountable Officer was to see that the Trust carried out these functions in a way which ensured the proper stewardship of public money and assets. Effective and sound financial management and information are of fundamental importance. I am assured by the former Accountable Officer that this occurred.

The system of internal control had been in place at Camden PCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

With these assurances from the former Accountable Officer I have signed the Summarised Accounts of Health Bodies in England, and the Resource Accounts of the Department of Health. The Summarised Accounts are derived from the statutory accounts of the PCT. Together with the Director of Finance, the former Accountable Officer was responsible for ensuring that the accounts of the PCT were prepared under principles and in a format directed by the Secretary of State with the approval of the Treasury. These accounts disclose a true and fair view of the PCT's income and expenditure, and of its state of affairs. These accounts have been signed by the former Director of Finance on behalf of the PCT Board.

Robust arrangements were put in place for the preparation and audit of the accounts of the PCT following closedown of North Central London PCTs as statutory bodies. Those arrangements were in line with Department of Health Guidance for financial closedown. A local delivery team was secured to prepare the accounts and a sub-committee of the Department of Health Audit and Risk Committee was established to review the accounts with retained non executive directors, the former Director of Finance, the external and internal auditors and the former Accountable Officer.

The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework Manual issued to NHS Boards by the Secretary of State were fundamental in exercising my responsibilities for regularity, propriety and probity. Every member of the PCT Board had subscribed to these codes which were adopted in April 2011.

In April 2011, the PCT entered into a collaborative arrangement with other PCTs in North Central London and underwent significant structural and organisational change.

The "Cluster" of NHS North Central London was formed of five PCTs: Barnet, Camden, Enfield, Haringey and Islington.

The Strategic Health Authority confirmed the "Cluster" was compliant with Primary Care Trust regulations and Primary Care Trust Cluster Implementation Guidance. The Strategic Health Authority reviewed the Corporate Governance Framework outlining the shared working arrangements that was agreed by the PCT Board in February 2011 and confirmed it as compliant with PCT regulations and PCT Cluster Implementation Guidance.

The Framework was revised in September 2012 to reflect the transitional development of the new system as described in the Health and Social Care Act 2012. A single management team performed its role on behalf of each of the PCTs, who retained their statutory duties and powers. All PCT statutory functions, powers and duties were mapped to ensure that they were aligned to the new cluster management structure. The former Chief Executive of Camden Primary Care Trust (PCT) and Accountable Officer was also the Accountable Officer for the other four PCTs.

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In February 2012, Camden CCG received delegated responsibility for all eligible budgets including medicines' management, community services, secondary care services and mental health services.

In December 2012 all Clinical Commissioning Groups were accorded the right to sign contracts from February 2013 through a new Statutory Instrument as part of the Health & Social Care Act 2012.

Camden CCG was authorised on 20 February 2013 with nine conditions which were addressed through action plans.

The governance framework of the organisation

The Primary Care Trust was a statutory body which came into existence on 1 April 2002 under The Primary Care Trust (Establishment) Order 2002 No 100, (the Establishment Order). The principal place of business was Stephenson House, 75 Hampstead Road, London, NW1 2PL.

Composition of the Board

The Primary Care Trust (PCT) Board met concurrently with the other four Primary Care Trusts Boards of NHS North Central London. The Chair, Audit Chair, Chief Executive and Director of Finance also fulfilled these roles for the other PCTs within NHS North Central London. The other Non-Executive Directors of each PCT had Non-Executive Director roles in one other PCT within NHS North Central London. This change to the membership arrangements was made permissible by the passing of Statutory Instrument 2010 2539 which removed the disqualification which prevents a person who is a Chair or member of one PCT from being appointed as the Chair or a non-officer member of another PCT.

Each PCT Board also had a Professional Executive Committee (PEC) Chair, PEC Nurse and Director of Public Health as voting members. In the case of the PEC Nurse and Director of Public Health, there was a cluster designated PEC Nurse (Barnet) and Director of Public Health (Islington), who attended on behalf of their peers unless there was specific business relating to an individual PCT for which the presence of a specific member would be required. The PCT Cluster-designated PEC Nurse and Director of Public Health were only eligible to vote on decisions for their own PCT Board.

Committees

In line with statutory requirements, the Camden Primary Care Trust (PCT) Board resolved in April 2011 to establish the:

- Audit Committee;
- Professional Executive Committee;
- Remuneration Committee; and
- Primary Care Reference Committee.

The Board also established such other Committees, as required, to discharge the PCT's responsibilities. It resolved to establish the:

- Quality and Safety Committee;
- Financial Recovery and Quality, Innovation, Productivity and Prevention Committee;
- London Specialised Commissioning Group Board; and
- Joint Committee of PCTs for the purposes of formal public consultation and decision making about the provision of Paediatric Cardiac Surgery Services in England.

The PCT Board agreed the terms of reference of these Committees and their delegated powers and responsibilities in April 2011 and reviewed the terms of reference in September 2012 to reflect the increased role in assurance to the Joint Boards and the increasing delegated responsibilities to Clinical Commissioning Groups (CCGs) and other new legal entities as set out in the Health and Social Care Act 2012.

The Remuneration Committee of the Joint Boards was established in September 2012 to manage the oversight of all transition, handover and closure business required as a consequence of the Health and Social Care Act 2012. This Committee reflected the governance arrangements for transition and closure across the NHS in London.

In September 2011 the PCT Board established the Trust and Charitable Funds Committee to discharge the function of corporate trustee for the funds held on trust as required by the Charities Commission. This Committee ceased to function in November 2012 following the transfer of Camden and Barnet Charitable Funds to new trustees via the Charities Commission.

The PCT Board established the Camden CCG Board as a Committee on 23 March 2012.

The Board's performance

The Chair of the Joint Boards of NHS North Central London conducted a review of the effectiveness of the Board and its Committees in early 2012 and presented the findings of the review at the March 2012 Board meeting. This internal assessment indicated that Board members were satisfied with the working of the Committees and their effectiveness in discharging their delegated responsibilities, and these were seen as an

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essential part of Board governance. Since the review NHS North Central London continued to embed best practice in governance across all functions.

Highlights of Board Committees' reports

Highlights of the work of key Committees are provided below.

Audit Committee:

- The Audit Committee met concurrently with the Audit Committees of the other PCTs within NHS North Central London. Whilst each Committee had a discrete agenda, shared membership and meeting arrangements further enabled positive assurance across all areas of business.
- The Committee approved the annual accounts, external and internal audit opinions and an Annual Governance Statement for 2011/12 on behalf of Primary Care Trust (PCT) Board for submission to the Department of Health. Legacy and key control issues identified during 2011/12 were factored in to the planning of the internal audit programme for 2012/13.
- The Committee reviewed internal and external audit plans and reports, and sought assurance that recommended actions were completed and that all issues were managed comprehensively. The Committee received reports on counter fraud and security services, and waivers to competitive tender requirements.
- The Committee provided assurance to the PCT Board on areas of governance and risk, providing detailed oversight of the Board Assurance Framework (BAF). Meetings considered specific areas of business in depth to enable substantive assurance through focussed discussion and challenge with Executive officers on their areas of responsibility within the BAF.
- The Committee looked in detail at risks and assurances on a number of key topics including PCT finance and Quality, Innovation, Productivity and Prevention (QIPP) targets, primary care performance, and quality and safety.

Quality and Safety Committee:

- Clinical Quality Review meetings were established for all services, including acute, mental health and community services.
- The Organisational Intelligence Tool and the quality and safety dashboard provided information on key quality indicators for all providers. The report was a standing agenda item for the Quality and Safety Committee and the Clinical Commissioning Group (CCG) Quality Committees.
- A high-level review of quality and safety across mental health and learning disability services was completed; a series of recommendations were made and an action plan agreed.

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- A multi-agency working group was established to improve the quality of nursing home service and patient experience in the northern boroughs of NHS North Central London.
- Workshops, shadowing opportunities for CCG staff to prepare for transfer of quality & safety functions and accountability.
- Supporting emerging CCGs to introduce Patient Stories to CCG Governing Body meetings to ensure that patient experience sets the context for the business of the meeting.
- Working to improve patient experience with other organisations e.g. the Making a Difference Board at University College London Hospitals NHS Foundation Trust (UCLH) and the implementation of the "walk the pathway" programme led by the Patient Experience Manager involving Local Involvement Networks (LINks) and Non-Executive Directors, including visits to dementia and stroke services.
- Quality summits were held to share intelligence about providers ensuring that early warning systems are in place to improve patient safety.

Financial Recovery and Quality, Innovation, Productivity & Prevention (QIPP) Committee:

The Committee provided a robust mechanism for review and challenge of progress against financial targets for each PCT. This was achieved through oversight of the delivery of savings plans and budgets; review and development of the NHS North Central London QIPP Plan and associated implementation plans; and review and approval of procurements, contracts and investment business cases in line with the Scheme of Delegation.

Highlights from the year include:

- Completion of an alignment process to ensure leadership and ownership of finance and QIPP plans for 2012/13. The Clinical Commissioning Groups (CCGs) were actively engaged in developing QIPP and investment plans achieved through programme management support which was phased over to the CCGs to help the CCGs in their delivery of the programme for 2013/14. Additional resource was given to support the development of local ownership and skills. There was a strong commitment to ensuring that investments were supported by future commissioning plans and that QIPP plans were in place to deliver savings earlier in the financial year going forward. All this could not have been achieved without the enthusiasm and commitment of the CCGs to produce a QIPP plan that reflected local need understood through direct clinical experience.
- Increased focus on underlying recurrent run rate positions of the PCTs in the Cluster.
- Review and monitoring of delivery against action plans for addressing outstanding debtors and creditors including reduced aged debtor day.
- Revised terms of reference to include monitoring the legacy, handover and closedown arrangements for the PCT including finance department transition to the new NHS bodies.

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Trust and Charitable Funds Committee:

- The Committee discharged its delegated responsibilities to make and monitor arrangements for the control and management of the charitable funds for which the Camden PCT Board was Corporate Trustee until November 2012.
- The Committee reviewed and endorsed the 2012/13 annual accounts for submission to the Charities Commission, managed oversight and approval of fund applications and oversaw the programme for the transfer of funds to new Corporate Trustees.
- In November 2012 the transfer of all charitable funds to new Trustees was completed, the committee met for a final time and ceased its function.

An account of Corporate Governance

The Primary Care Trust's (PCT) Corporate Governance arrangements were set out in the Corporate Governance Framework Manual agreed by the Board in April 2011 and revised in September 2012. The Manual included the organisation's Standing Orders, Standing Financial Instructions, Schemes of Reservation & Delegation and Codes of Accountability & Conduct. These arrangements were drawn up in line with:

- The Primary Care Trust (Executive Committees and Standing Financial Instructions) Directions 2007, National Health Service Act 2006; and
- Department of Health PCT Cluster Implementation Guidance (31 January 2011).

The Manual was regularly reviewed and updated throughout the year to take account of changes in the governance environment:

- The creation of new legal entities and their authorisation to undertake delegated responsibilities: Clinical Commissioning Groups (CCG) and NHS England; NHS Trust Development Authority (NTDA).
- States of readiness through the transition period as organisations become ready to exercise their new responsibilities.

In September 2012, the Corporate Governance Framework Manual was revised to take account of changes in NHS commissioning landscape and the introduction of London's Interim Operating Plan.

The internal auditors conducted an audit of the PCT's governance as part of the approved internal audit plan for 2012/13. The objective of the review was to provide assurance that there was an appropriate management structure, robust governance arrangements and organisational form to deliver the organisation's objectives. The auditor opinion provided substantial assurance in the design, application and effectiveness of the governance arrangements and the audit report highlighted a number of areas of good practice.

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Risk management and the control framework

The Primary Care Trust (PCT) Board approved the NHS North Central London Cluster Risk Management Strategy in December 2011 and the PCT embedded the strategy into practice throughout 2012. The emerging Clinical Commissioning Groups (CCGs) worked within the Strategy throughout 2012/13. The strategy outlined the organisation's approach to risk management, including:

- Identifying committees and groups which had a responsibility for risk management;
- Roles and responsibilities of staff with regards to risk management;
- The process for identification, assessment and management of risk;
- The process for managing, and Board review of, the Risk Register and Board Assurance Framework; and
- The risk appetite of the organisation, which set out the thresholds for toleration, management and reporting of different orders of risk.

The Risk Management Strategy reflected current best practice, taking into account a range of governance standards.

Risk assessment

Risk assessment is a systematic and effective method of determining the level of risks. All identified risks are assessed using a clearly defined risk assessment matrix by determining the likelihood and consequence of the risk to calculate an overall risk rating. Risks are categorised as low, moderate, high or extreme, and their categorisation informs the organisation's approach to management and monitoring of the risk.

The risk and control framework

The Board Assurance Framework (BAF) and Risk Register assess the effectiveness of systems of internal control and provide assurances that risk management processes are effective. Both are dynamic documents that capture the understanding of the risk environment at any given time. The BAF outlined NHS North Central London Cluster's principal objectives, the risks to achieving those objectives, key controls and assurances, and gaps in controls and assurances. The Risk Register contained a mixture of strategic and operational risks at organisational and directorate level as well as the arrangements in place to mitigate these.

Risks were identified through a variety of ways, including incidents, complaints and claims; committee reports; external assessments and audits; and management reviews. All risks were assigned a relevant Executive Director who had accountability for overseeing the management of the risk by identifying the most effective means to minimise, transfer or remove it, and ensuring the quality of action plans, controls and

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assurances. A Lead Officer was also assigned with management responsibility for delivering the action plan, developing robust controls and identifying sources of assurance.

The PCT had a structured approach for the reporting and monitoring of risk. The Joint Boards reviewed the BAF and Extreme Risk Report at every meeting, and risk and BAF were a standing item on all committee agendas. The Senior Leadership Team reviewed the Board Assurance Framework and Risk Register on a monthly basis. The PCT Board also took assurance from external assessments and audits, and from the work programme of the Audit Committee.

Risk profile

The 2012/13 Board Assurance Framework (BAF) identified the following strategic risks within three Principal Objectives:

1. To ensure we commission services, which are safe, and of increasing quality for the people we serve.

   1.1 Transition and the underlying financial position in North Central London may impact on the quality and safety of services.

   1.2 Increased alerts received in relation to standards of care in nursing / care homes in particular Barnet, Enfield and Haringey and capacity issues at Borough level could lead to safety / safeguarding concerns for adult resident patients.

   1.3 Due to the effect of transition on workforce capacity, recruitment & retention, organisational memory and differing stages of receiving organisations' readiness of quality arrangements –there was a risk that embedding Quality and Safety in the new health system will not be effective.

2. To deliver the NHS North Central London Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan.

   2.1 Sustainable QIPP delivery on the scale and timescales required given the scale of financial challenge; there was a risk that we do not deliver the transformational change programme needed to bring the health economy back into balance at the required pace – due to:

   - Capacity, capability and clinical leadership;
   - Pace of delivery; and
   - Engagement with providers.

   2.2 Following the delegation of responsibility to Clinical Commissioning Groups (CCGs), and during the period of shadow running and transition to March 2013, there was a risk that the cluster could lose its grip on the delivery of QIPP and financial turnaround.

   2.3 There was a risk that the CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:

   - Capacity and capability of CCGs;
   - Ownership of the agenda; and

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- Underlying financial position of the Cluster.

2.4 There was a risk of dislocation between or misalignment of different elements of the commissioning system leading to:

- Gaps in delivery;
- Differences in expectations between parts of the system (e.g. Commissioning Support Unit offer does not align to CCG need); and
- Ineffective commissioning partnerships.

2.5 The scale and complexity of forthcoming changes means there was a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.

2.6 There was a risk that ineffective alignment of resources during the transition period (1 October 2012 - 31 March 2013) would impact the delivery of key Cluster objectives and reduce organisational effectiveness.

3. To deliver key organisational objectives and a secure transition to the commissioning landscape in line with the Health and Social Care Act 2012.

3.1 Following the delegation of responsibility to CCGs and during the period of shadow running and transition to March 2013, there was a risk that the Cluster loses grip on the delivery of QIPP and financial turnaround.

3.2 There was risk that the CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:

- Capacity and capability of CCGs;
- Ownership of the agenda; and
- Underlying financial position of the Cluster.

3.3 There was a risk of dislocation between or misalignment of different elements of the commissioning system leading to:

- Gaps in delivery;
- Differences in expectations between parts of the system (e.g. Commissioning Support Unit offer does not align to CCG need); and
- Ineffective commissioning partnerships.

3.4 The scale and complexity of forthcoming changes means there was a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.

3.5 There was a risk that ineffective alignment of resources during the transition period (1 October 2012 - 31 March 2013) would impact the delivery of key Cluster objectives and reduces organisational effectiveness.

4. Other significant risks on the PCT's Risk Register:

- Risks to development of the model underpinning the integrated care strategy could lead to delay. The implementation programme therefore involved key stakeholders including the major acute service providers.

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- There was a risk of potential failure to meet the Primary Care Trust's Stop Smoking 4 week quitter target. Robust delivery plans were developed with on-going monitoring of performance.

Review of Effectiveness of risk management and internal control

The PCT Board and its committees were fully supportive of the risk management process which was scrutinised and challenged as part of the PCT Board, Financial Recovery and QIPP, and Audit Committees functions.

RSM Tenon undertook an audit of the Risk Management and Assurance Framework as part of its audit plan for 2012/13. The final advisory report was issued in October 2012.

NHS North Central London Cluster continued to embed the use of their Board Assurance Framework into their routine procedures and this was evidenced by the commitment from the Joint Boards of NHS NCL, Audit Committee and Senior Leadership Team in ensuring that this Framework operates as effectively as possible.

Board Assurance Framework (including Risk Management) 4.12/13 p1

RSM Tenon identified the need to keep focus on where risks would be transferred to during transition. As a consequence a revised BAF and Risk Register was received and accepted by the Board in September 2012 which had been reviewed in order to focus and refine the content so that it accurately reflects the main strategic risks for the remainder of the financial year.

Significant issues in 2012/13

Over the year the PCT Board and its committees considered issues that might have had a prejudicial impact on the corporate objectives, the business plan or the reputation of the NHS locally.

Continuing Care Reviews

The Joint Boards of NHS North Central London Cluster requested a review of continuing care across all PCTs areas in 2012/13. In-year review of action showed a considerable improvement in the level of compliance and paperwork around continuing care commissioning but identified a number of issues in borough teams' performance in 2012/13. This resulted in an amber/ red opinion being issued. An action plan was in place to support the improvement across all areas and was closely monitored by the Financial Recovery and QIPP Committee. Continuing care services are complex and high volume. Issues were identified in accounts payable and these highlighted to the management team particular issues in relation to the control and management of continuing care and funded nursing care. The requirement to manage these services properly was a clinical priority to ensure quality of services, as well as a financial

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imperative. As a result, Internal Audit was asked to prioritise the audit of continuing care arrangements. A number of weaknesses in control were identified including:

- Quality of care – backlogs in assessment;
- The budget setting process;
- Implementation of service level agreements and contracts for care packages; and
- The adequacy of management information tools to manage and control this complex service.

The management team, including the Director of Quality and Safety, agreed a detailed action plan to close the identified gaps in control and progressed the implementation of internal audit recommendations.

Primary Care Payments

An internal review of the accuracy and authorisation of primary care payments was undertaken in 2012/13.

It found that Enfield, Haringey and Islington Primary Care Trusts (PCTs) still used manual systems to manage the process. During 2012 this has been rectified and all PCTs now operate the same electronic system.

An action plan was put in place to address a further five medium rated recommendations. The Joint PCT Boards were able to take some assurance at this point that the controls upon which the organisations relied to manage risk were suitably designed, consistently applied and effective.

Transition to new commissioning arrangements in the NHS

The Joint Boards agreed the NHS North Central London Cluster Transition Plan in December 2011. Detailed function led work streams have supported this high-level plan in 2012/13.

A sub-committee of the Joint Boards was established in December 2013 building on the working group that had led the implementation of the action plan and monitored the delivery in line with national policy and guidance.

The organisation agreed and handed over functions in January 2013 to nominated legal receivers: NHS England (formerly the NHS Commissioning Board), Clinical Commissioning Groups, Local Authorities, NHS Property Services and Public Health England.

General assets and liabilities were also transferred after dialogue with nominated receivers.

Property and leases transferred to NHS Property Services Limited in most cases, some buildings were transferred to Foundation Trusts when identified as most the appropriate

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receiver and some to Community Health Partnerships Limited. NHS Property Services Limited and Community Health Partnerships are both Government owned bodies.

A Statutory Instrument was approved by Parliament giving NHS England and Clinical Commissioning Groups powers to enter into contracts from the 1 February 2013.

NHS England (formerly the NHS Commissioning Board) entered full operating mode on 7 January 2013 following transfer of functions from PCTs.

National Priorities set out in the NHS Operating Framework: Improving performance in Camden 2012/13

Acute Measures

Waiting times in A&E

Acute performance for Camden PCT patients focused on Royal Free and UCLH. Performance under the A&E four hour maximum waiting time target for both Trusts was strong throughout the first two quarters of 2012/13. However, autumn and winter of 2012/13 proved more challenging than the previous year. During November and December 2012 outbreaks of Norovirus resulted in 236 bed closures at UCLH. The allocation of winter funding to both Trusts aimed to support whole-system resilience plans.

Referral-to treatment times

At a PCT level Camden's performance against all referral to treatment standards remained strong throughout the year, consistently achieving the admitted, non-admitted and incomplete pathways standards. At a provider level both Royal Free and UCLH achieved all three standards throughout 2012/13 to date.

Cancer waiting times' targets met

At a PCT level Camden sustained achievement of most of the cancer waiting time targets during 2012/13. North Central London continued intensive monitoring and analysis of trusts who fail these standards to ensure plans remain focused on turnaround and sustainability of performance.

Access to Stroke Services

There was excellent performance against the national measures for stroke services with Camden PCT exceeding the 80% threshold for time on a stroke unit and also achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours. Higher activity volumes and sustained performance shows that more people are accessing the right service within Camden for stroke.

Access to Diagnostics

Up until November 2012, Camden PCT maintained performance within the tolerance level of less than 1% of patients waiting longer than six weeks for a diagnostic test. However in November 2012 Camden's performance reached 2.1% which was the result of underperformance at UCLH. The high volume of breaches at UCLH was the result of

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staff and capacity shortages. North Central London's Performance Team continues to work closely with UCLH to ensure that recovery plans are robust, a sustained reduction in outstanding volumes was delivered and a satisfactory level of performance regained.

Access to Single Sex Accommodation

Patient privacy and dignity remain high on the NHS agenda with a zero tolerance against mixed sex accommodation. The execution of plans to deliver this target was challenging for providers as set within a context of quality and efficiency drives that have reduced their overall beds numbers. Camden PCT had reported compliance with the zero tolerance standard since August 2012.

Non-acute performance update

Access to screening services

Diabetic Retinopathy

All boroughs continued to excel against the target of 95% for diabetic retinopathy screening and this will be further enhanced by the recent commissioning of the UCLH site and new referral pathways that are scheduled for implementation from 1 April 2013.

Cancer Screening

The coverage of cervical screening over the first nine months of the year generally mirrored that of last year. Camden showed a slight drop in performance at 66.9%. Work continued to raise awareness and identify exclusions such as women who have received total hysterectomy. The turnaround time of cervical screening results continued to be good with Camden achieving the 98% threshold since June 2012.

Despite continued underperformance across NHS North Central London for bowel screening Camden increased to 42.6% from 39.52% over 2011/12 against the 60% standard. For breast cancer screening Camden had the lowest percentage coverage within North Central London of 61.68% but had implemented robust actions throughout the year to improve this.

NHS Health Checks

Increased offering and take-up of NHS health checks supports the reduction in health inequalities by identifying and addressing health needs in previously undiagnosed people.

Camden PCT exceeded its year to date plan for health checks offered and uptake with 10,800 health checks offered in 2012/13 and 3,500 checks delivered so far in 2012/13.

Early Access to Maternity Care

Improving healthier outcomes for babies and children was one of the priorities for NHS North Central London and closely aligned to women accessing maternity care before 12 completed weeks of pregnancy. Camden was the only PCT within North Central London to achieve the 90% standard with the majority of Camden women accessing maternity services at UCLH and the Royal Free.

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Childhood Immunisations Coverage

2012/13 was a successful year for Camden PCT in its childhood immunisation coverage in particular for the five year vaccines where coverage increased by over 4%. In 2012/13 Camden introduced a catch-up programme involving immunisation nurse sessions to vaccinate children who have missed their planned date. This also provided administrative support to check that children included on practice lists exist and that practice records and immunisations were up to date.

Financial recovery

There was a clear difference in the financial health between the north (Barnet, Enfield and Haringey) and south (Camden and Islington) of the North Central London Cluster over recent years. The financial strategy was focussed on transformational change across the whole £2.5 billion portfolio with programmes to rebalance the health economy in the patch, without destabilising hospitals. The financial plan for 2012/13 was the second in an original three year programme to return all five PCTs to financial stability on a recurrent basis. By exception the Department of Health agreed deficit plans for Barnet, Enfield and Haringey PCTs at the start of the year. In year revised plans were agreed resulting in all five PCTs delivering a surplus income and expenditure position. Camden and Islington PCTs had a history of financial stability, underpinned by well funded, sound community and primary care provision, and planned to deliver a healthy surplus.

Review of Quality and Safety

As a result of a review of quality and safety in 2011 which found that services were of a generally high quality and safe; improvement trajectories were agreed in 2012 with providers. Implementation and performance was monitored through the Clinical Quality Review Groups. These recommendations have been worked on throughout 2012 and now:

- Organisational Intelligence Tool quality and safety dashboard embedded for key indicators for all providers. The report was a standing agenda item for the Quality & Safety Committee and the CCG quality committees;
- Multi-agency Working Group established to continue to improve quality of nursing home service and patient experience in the northern boroughs of NHS North Central London; and
- There were no significant areas of slippage at the time of this annual report.

Data Loss Incidents

There have been no data loss incidents in Camden Primary Care Trust in 2012/13.

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Primary Care Strategy

2012/13 had been the first year of implementing the three-year strategy 'Transforming Primary Care'. There was progress in all the workstreams including the development of networks, service improvements focusing on improving access, the delivery of care closer to home including the development of integrated care. The enabling workstreams of Information Management & Technology and premises have made significant progress this year. The one area of workforce development had proved challenging in the first year. There was a plan to spend a full year budget of £12m in Year 1, of the £47.7m identified over three years. The majority of the budget was spent but there was an element of underspend due to time to engage fully at a local level, delay in approvals processes across the system and delay in time to implement some of the schemes in the year of CCG authorisation.

Plans for the remaining two years of the implementation of the strategy are that the five Clinical Commissioning Groups will lead the implementation locally and ensure that all developments are in line with local strategies whilst being committed to the overall ambition of the initial strategy adopted by NHS North Central London in January 2012.

Clinical Commissioning Groups (CCGs)

- All five CCGs in North Central London successfully secured delegated responsibility for all eligible budgets within agreed timeframes
- All five CCGs in North Central London submitted authorisation documentation within agreed national timeframes
- Positive external assurance was received from NHS London on the progress of CCGs' authorisation
- A CCGs' Integrated Performance management approach was in place – CCGs demonstrating leadership and financial management through monthly Integrated Performance Meetings
- Positive assurance was received through internal audit of CCGs development activity, management and support given by NHS North Central London PCTs.

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Hosted organisations

The Primary Care Trust was host to:

- London Health Programmes (LHP):
- North Central London Cardiac & Stroke Network; and
- Camden Public Health Provider Services

London Health Programmes functions were dispersed and the organisation ceased to exist on 31 March 2013. The transfer of staff and assets and liabilities followed the Department of Health's Transfer Scheme guidance following agreement by all partner organisations.

For LHP the hosting arrangements were documented formally in Establishment and Hosting Agreements, and the Audit Committee reviewed a mapping process of LHP hosting arrangements in September 2012.

North Central London Cardiac and Stroke Network functions transferred to NHS England.

Public Health Providers Services functional transfer to Camden Local Authority was being progressed in January 2013. The service followed the Department of Health Transfer Schemes guidance in respect of staff and assets and liabilities.

The network was integrated into the management structure of the Cluster. Both these organisations follow the governance and assurance processes of the host. In the reporting year, all employees of the hosted bodies were consulted prior to transferring to Islington PCT as host employer.

The new health system in Camden: April 2013 onwards

The Health and Social Care Act 2012

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

Clinical commissioning – CCGs and CSU

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

NHS Camden Clinical Commissioning Group has been working in shadow form during 2012/13 and undergoing a national assessment programme in readiness to take on full

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statutory responsibilities for commissioning acute, mental health and community health services from April 2013.

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

NHS England

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

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

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

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

Health and wellbeing boards

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

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

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

Public health

From April 2013 local authorities took on a new duty to take steps to improve the health of their population. They are largely free to determine their own priorities and services,

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to meet the needs of the local population, but will also be required to provide a small number of mandatory services, including:

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

The London Borough of Camden took responsibility for these public health functions.

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Financial overview and summary financial statements

Financial Performance

Camden Primary Care Trust met the control total surplus of £23.8m as set by the Department of Health.

Camden PCT met all of our statutory duties, namely;

- Financial balance in year
- Spending within capital allocation
- Spending within cash limits.

These achievements were a credit to the whole organisation, which maintained focus on delivering value for money for patients and public at a time of substantial organisational change within the NHS.

Capital Structure

The PCT funded its assets using an annual allocation set by the Department of Health. It had no bank borrowings. Where the PCT had revalued assets, the extent of that revaluation was reflected in the revaluation reserve.

The PCT normally carries out a full revaluation of its estate every five years. A full revaluation was been undertaken this financial year.

Treasury Policy and Objectives

The total limited cash available was based on the PCT's revenue reserve and capital resource limits. There was no flexibility to exceed the notified cash limit and the PCT managed this source of cash.

The PCT planned cash requisitions to ensure that there were minimal month end balances and no supplementary advances in month. Monthly cash drawings were requisitioned by the date advised by the DH. This was managed by forecasting all material cash transactions in the forthcoming month. Month and year end balances were maintained to a minimum level and closing cash balances for the year were less than £100k. The PCT maximised use of Citi Bank services. CHAPs payments were only made in exceptional circumstances.

Charging for Information

The PCT had complied with Treasury guidance for setting charges as per appendix 6.3 of the Managing Public Money guidance. This advices that it is government policy that as much information as possible about public services should be made available at either free or at low cost. The PCT freely posted information about activities and services on the internet.

Principles for Remedy

The PCT had complied with Treasury guidance for Principles for Remedy as per appendix 4.14 of the Managing Public Money guidance. There are six principles that represent best practice and these were directly applicable to the PCT.

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Summary financial statements

The financial statements for Camden PCT have been prepared in accordance with International Financial Reporting Standards (IFRS) and the 2012/13 Financial Reporting Manual issued by HM Treasury.

The accounts have been prepared under the historical cost convention, modified by the application of current cost principles to tangible fixed assets, and in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

The summary financial statements attached are an extract from the PCT's full audited annual accounts for the year ended 31 March 2013.

A copy of the full accounts will be available on the Department of Health's website at https://www.gov.uk/government/organisations/department-of-health

The accounts for the year ended 31 March 2013 have been prepared by the PCT under Section 98(2) of the NHS Act 1977 (as amended by Section 24(2), Schedule 2, of the National Health Service and Community Care Act 1990) in the form which the Secretary of State had directed. The main source of funding was income from the Department of Health.

Audit Functions

Camden PCT's Audit Committee had two Non-Executive Directors and members. At the end of 2012/13 they were Ellen Schroder and Robert Sumerling.

Camden PCT's external auditor for 2012/13 was KPMG and the cost of Audit Services provided by them in the year was £111k.

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Statement of the Responsibilities of the Signing Officer of Camden Primary Care Trust 2012-13 Accounts

The Department of Health's Accounting Officer had designated the role of signing officer for the final accounts of Camden 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 was achieved from the resources available to the primary care trust;

- the expenditure and income of the primary care trust had 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.

Signed 

Peter Coates
Director of PICD, Strategy, Finance and NHS
Department of Health

Date 5 June 2013

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Independent Auditor's Report to the Department of Health's Accounting Officer in respect of Camden PCT

We have examined the summary financial statement for the year ended 31 March 2013 set out on pages 38 to 41.

This report is made solely to the Signing Officer of Camden PCT in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Signing Officer of the PCT those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Signing Officer of the PCT for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

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

Basis of opinion

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of Camden PCT for the year ended 31 March 2013 on which we have issued an unqualified opinion.

Fleur Nieboer for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
London E14 5GL

Date: 6 June 2013

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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	**12,483**	19,883
Other costs	**539,416**	522,969
Income	**(27,518)**	(27,488)
Net operating costs before interest	**524,381**	515,364
Investment income	**(15)**	(21)
Finance costs	**1,418**	811
Net operating costs for the financial year including absorption transfers	**525,784**	516,154
Of which:		
Administration Costs		
Gross employee benefits	**11,288**	14,294
Other costs	**24,719**	23,185
Income	**(8,046)**	(17,068)
Net administration costs before interest	**27,961**	**20,411**
Investment income	**(15)**	0
Finance costs	**1,227**	811
Net administration costs for the financial year	**29,173**	**21,222**
Programme Expenditure		
Gross employee benefits	**1,195**	5,589
Other costs	**514,697**	499,784
Income	**(19,472)**	(10,420)
Net programme expenditure before interest	**496,420**	**494,953**
Investment income	**0**	(21)
Finance costs	**191**	0
Net programme expenditure for the financial year	**496,611**	**494,932**
Other Comprehensive Net Expenditure	**2012-13 £000**	**2011-12 £000**
Impairments and reversals put to the Revaluation Reserve	**1,290**	1,546
Net (gain) on revaluation of property, plant & equipment	**(10,525)**	(3,149)
Total comprehensive net expenditure for the year*	**516,549**	**514,551**

***This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.

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Statement of financial position as at 31 March 2013

	31 March 2013 £000	31 March 2012 £000
Non-current assets:		
Property, plant and equipment	**77,903**	72,219
Intangible assets	**0**	10
Other financial assets	**257**	257
Trade and other receivables	**2,295**	2,386
Total non-current assets	**80,455**	74,872
Current assets:		
Trade and other receivables	**14,070**	25,452
Cash and cash equivalents	**28**	108
Total current assets	**14,098**	25,560
Total assets	**94,553**	100,432
Current liabilities		
Trade and other payables	**(32,695)**	(57,616)
Provisions	**(1,876)**	(2,232)
Borrowings	**(344)**	(328)
Total current liabilities	**(34,915)**	(60,176)
Non-current assets plus/less net current assets/liabilities	**59,638**	40,256
Non-current liabilities		
Trade and other payables	0	(750)
Provisions	(4,874)	(9,278)
Borrowings	(11,370)	(11,714)
Total non-current liabilities	**(16,244)**	(21,742)
Total Assets Employed:	**43,394**	18,514
Financed by taxpayers' equity:		
General fund	(44)	(17,664)
Revaluation reserve	43,438	36,178
Total taxpayers' equity:	**43,394**	18,514

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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	**(17,664)**	**36,178**	**18,514**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(525,784)	0	**(525,784)**
Net gain on revaluation of property, plant, equipment	0	10,525	**10,525**
Impairments and reversals	0	(1,290)	**(1,290)**
Transfers between reserves*	1,975	(1,975)	**0**
Total recognised income and expense for 2012-13	**(523,809)**	**7,260**	**(516,549)**
Net Parliamentary funding	541,429		**541,429**
Balance at 31 March 2013	**(44)**	**43,438**	**43,394**
Balance at 1 April 2011	**300**	**34574**	**34,874**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(516,154)	0	(516,154)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	3,149	3,149
Impairments and Reversals	0	(1,545)	(1,545)
Total recognised income and expense for 2011-12	(516,154)	1,604	(514,550)
Net Parliamentary funding	498,190	0	498,190
Balance at 31 March 2012	**(17,664)**	**36,178**	**18,514**

*The transfer between reserves relates to the realised depreciation impact upon the revaluation reserve.

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Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(524,381)**	(515,364)
Depreciation and Amortisation	**3,794**	3,143
Impairments and Reversals	**803**	7,050
Interest Paid	**(1,227)**	(590)
(Increase)/Decrease in Trade and Other Receivables	**11,473**	2,934
Increase/(Decrease) in Trade and Other Payables	**(26,111)**	10,211
Provisions Utilised	**(11,941)**	(4,498)
Increase/(Decrease) in Provisions	**6,990**	294
Net Cash Inflow/(Outflow) from Operating Activities	**(540,600)**	**(496,820)**
Cash flows from investing activities		
Interest Received	**15**	21
(Payments) for Property, Plant and Equipment	**(596)**	(1,166)
Net Cash Inflow/(Outflow) from Investing Activities	**(581)**	**(1,145)**
Net cash inflow/(outflow) before financing	**(541,181)**	**(497,965)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(328)**	(262)
Net Parliamentary Funding	**541,429**	498,190
Capital grants and other capital receipts	**0**	94
Net Cash Inflow/(Outflow) from Financing Activities	**541,101**	**498,022**
Net increase/(decrease) in cash and cash equivalents	**(80)**	**57**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**108**	**51**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**28**	**108**

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Statutory financial duties

Camden PCT was required to meet three statutory financial duties in 2011/12, namely:

- In year financial balance
- Spending within capital allocation
- Spending within cash limit.

Camden PCT's performance for the year ended 31 March 2013 was as follows:

Revenue Resource Limit	**2012-13**	**2011-12**
	£000	**£000**
The PCTs' performance for the year ended 2012-13 was as follows:		
Total Net Operating Cost for the Financial Year		516,154
Net operating cost plus (gain)/loss on transfers by absorption	**525,784**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**549,603**	559,316
Underspend Against Revenue Resource Limit (RRL)	23,819	43,162
The underspend in 2012/13 (and in 2011/12) against Revenue Resource limit was planned and agreed with the Department of Health and the NHS London Strategic Health Authority.		

Capital Resource Limit	**2012-13**	**2011-12**
	£000	**£000**
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**1,973**	2,713
Charge to Capital Resource Limit	**1,036**	518
Underspend Against CRL	**937**	**2,195**
The PCT kept within its Capital Resource Limit.		

Under/(Over)spend against cash limit	**2012-13**	**2011-12**
	£000	**£000**
Total Charge to Cash Limit	**541,429**	498,190
Cash Limit	**541,429**	524,490
Under/(Over)spend Against Cash Limit	**0**	**26,300**
The PCT kept within its Cash Limit.		

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Better Payment Practice Code

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. The disclosure below shows the value of invoices by volume and amount paid within 30 days, with the remaining invoices being paid later than 30 days.

The PCT's measure of compliance with this policy is:

Measure of compliance	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**14,747**	**62,351**	20,691	56,932
Total Non-NHS Trade Invoices Paid Within Target	**8,567**	**38,218**	14,510	37,887
Percentage of NHS Trade Invoices Paid Within Target	58.09%	61.29%	70.13%	66.55%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,302**	**395,889**	3,503	378,385
Total NHS Trade Invoices Paid Within Target	**1,976**	**351,615**	1,470	351,697
Percentage of NHS Trade Invoices Paid Within Target	45.93%	88.82%	41.96%	92.95%

Running costs

The PCT's running costs for 2012/13 are shown in the table below.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**19,713**	17,211	2,502
Weighted population (number in units)*	**256,243**	256,243	256,243
Running costs per head of population (£ per head)	**76.9**	**67.2**	**9.8**
PCT Running Costs 2011-12			
Running costs (£000s)	**21,222**	16,738	4,484
Weighted population (number in units)	**256,243**	256,243	256,243
Running costs per head of population (£ per head)	**82.8**	**65.3**	**17.5**

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

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The management costs figures have been calculated using the definition provided by the Department of Health, based on staff costs only, excluding infrastructure and headquarter costs. The staff costs that are included in the Department of Health definition incorporate the following elements:

- Board and Executive committee functions
- Corporate functions
- Clinical and operational functions
- Support service functions.

Related party transactions

Camden PCT is a body corporate established by order of the Secretary of State for Health. During the year, with the exception of the GP Board members and GP Professional Executive Committee Members, none of the Board Members or members of the key management staff or parties related to them had undertaken any material transactions with Camden Primary Care Trust.

The members of the Clinical Executive Committee are also practicing GPs in the borough of Camden, and as such receive practice income from the PCT.

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities controlled or influenced by them, as being parties related to NHS bodies. Related party transactions are to be disclosed if material to either party.

The table below shows the relationship between Camden PCT's Senior Managers and related parties, i.e. organisations they control or can influence. The amounts disclosed below are transactions with the related parties and not the individuals.

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Name/ Title	Related Party	Relationship with Related Party	Annual		31 March 2013	
			Expenditure	Income	Payables	Receivable
			£000's	£000's	£000's	£000's
Paula Kahn - Chair						
	Barnet PCT	Chair	179	3,479	0	4,461
	Enfield PCT	Chair	448	500	446	500
	Haringey PCT	Chair	1	412	0	672
	Islington PCT	Chair	7,313	1,843	0	500
Caroline Rivett - Non-Executive Director						
	Barnet PCT	Audit Chair	179	3,479	0	4,461
	Enfield PCT	Audit Chair	448	500	446	500
	Haringey PCT	Audit Chair	1	412	0	672
	Islington PCT	Audit Chair	7,313	1,843	0	500
Robert Sumerling - Non-Executive Director						
	Barnet PCT	Non Executive Director	179	3,479	0	4,461
Karen Trew - Non-Executive Director						
	Enfield PCT	Non Executive Director	448	500	446	500
Deborah Fowler - Non-Executive Director						
	Camden & Islington Foundation Trust	Member	49,356	4,231	1,013	2,423
	Enfield PCT	Non Executive Director	448	500	446	500
	UCL Hospital NHS Foundation Trust	Member	120,755	1,107	6,392	157
Caroline Taylor - Chief Executive						
	Barnet PCT	Chief Executive	179	3,479	0	4,461
	Enfield PCT	Chief Executive	448	500	446	500
	Haringey PCT	Chief Executive	1	412	0	672
	Islington PCT	Chief Executive	7,313	1,843	0	500
Marek Koperski - PEC Member						
	James Wigg Practice	GP Principal	772	0	0	316
Quentin Sandifer - Director of Public Health						
	Iplato	Unpaid Former Advisor	52	0	0	0
Daniel Bernstein - CCG Member-Elective GP Representative						
	Dr Daniel Bernstein	GP Principal	18	0	0	0
	The Abbey Medical Centre	GP Principal	11	16	0	0
Caroline Sayer - CCG Chair-Elective GP Representative						
	Haverstock Healthcare	Practice is a Shareholder	66	0	0	0
	Adelaide Road Medical Centre	GP Principal	14	0	0	0
Ammara Hughes - CCG Member-Elective GP Representative						
	Bloomsbury Surgery	GP Principal	3	36	0	29
John Carrier - CCG Member-Lay Member for Camden						
	Barnet PCT	Non Executive Director	179	3,479	0	4,461
	Great Ormond Street Hospital	Council Member	14,313	0	215	0
	North East London NHS Foundation Trust	Interim Chair	158	0	0	22
	UCL Hospital NHS Foundation Trust	Governor	120,755	1,107	6,392	157

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	Margaret Pyke Memorial Trust Board	Trustee	67	0	0	65
Nick Losseff - Medical Director						
	UCL Hospital NHS Foundation Trust	Consultant	120,755	1,107	6,392	157
Simone Hensby - CCG Member-VAC						
	Voluntary Action Camden	Executive Director	151	0	0	0

The Department of Health is regarded as a related party. During the year Camden PCT had 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.

NHS Organisation	Annual expenditure £000's
University College London NHS Foundation Trust	120,755
Royal Free London NHS Foundation Trust	87,704
Camden And Islington NHS Foundation Trust	49,356
Croydon PCT	30,689
Central And North West London MH NHS Foundation Trust	29,470
Great Ormond Street Hospital for Children NHS Foundation Trust	14,343
Whittington Hospital NHS Trust	12,750
Imperial College Healthcare NHS Trust	9,624
London Ambulance Service NHS Trust	8,780
Islington PCT	7,313
Tavistock And Portman NHS Foundation Trust	5,287
Barts Health NHS Trust	3,638
Guys And St Thomas NHS Foundation Trust	2,675
Moorfields Eye Hospital NHS Foundation Trust	1,985
Barnet, Enfield And Haringey Mental Health NHS Trust	1,668

In addition, the PCT had had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions were with the London Borough of Camden, in respect of joint enterprises.

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Remuneration report

The Remuneration Committee had as a key purpose to advise the Board on the remuneration and terms of service for the Chief Executive and board level Directors. The committee also oversees exit terms for this group of staff and all other staff.

The Joint Boards Remuneration Committee Membership 2012/13 was as follows:

- John Carrier (Chair) – Camden PCT Vice Chair and NED Barnet
- David Riddle – Barnet PCT Vice Chair and NED Islington
- Karen Trew – Enfield PCT Vice Chair and NED Camden
- Cathy Herman – Haringey PCT Vice Chair and NED Enfield
- Anne Weyman – Islington PCT Vice Chair and NED Haringey
- Paula Kahn – Chair of Joint Boards

The Chief Executive and Director of Human Resources and Corporate Affairs attend the meeting to provide support as required. The Chief Executive was not present for discussions related to her own remuneration.

Statement of the remuneration policy for senior managers:

The Cluster's remuneration policy for senior manager was to use the standard NHS Very Senior Manager (VSM) guidelines and to set salaries in conjunction with NHS London procedures.

Performance related remuneration:

The VSM performance assessment processes were used during 2012/13 including NHS London review of performance bonuses for appropriate roles. The remuneration committee made the decision not to pay any performance bonuses in 2012/13 regardless of level of performance.

Policy on duration of contracts and notice periods:

Contract and notice terms are standard to the VSM guidelines. The cluster of PCTs had been cognisant of future changes and had employed and retained some new to the NHS senior staff on fixed term or interim contracts to reduce future redundancy liabilities. Notice periods for senior staff are normally three months but in some historical instances are six months.

Policy on termination and exit payments:

Termination payments were made in accordance with the standard NHS policy and regulations that apply to redundancy or early retirement with no additional or non contractual payment.

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Salary and allowances of Senior Managers 2012/13 (PCT Share)

(The tables on pages 48 to 52 have been audited as referred to in the external audit opinion on the PCT's full financial statements dated 6 June 2013)

	NAME	TITLE	2012-13 Salary (bands of £5,000) £000	Other Rem'n (bands of £5000) £000	Bonus Pmts (bands of £5000) £000	Benefits in kind (bands of £100 £00	Dates served Commenced	Ceased
	VOTING MEMBERS							
	Non Executive Directors							
*	Ms Paula Kahn	Chair	5-10	0	0	0	01/04/2011	31/03/2013
**	Prof John Carrier	Vice Chair NED Barnet	5-10	0	0	0	01/04/2011	31/03/2013
**	Mr Robert Sumerling	NED Barnet	0-5	0	0	0	01/04/2011	31/03/2013
**	Ms Karen Trew	Vice Chair Enfield	5-10	0	0	0	01/04/2011	31/03/2013
**	Ms Deborah Fowler	NED Enfield	0-5	0	0	0	01/04/2011	31/03/2013
*	Ms Caroline Rivett	Audit Chair	0-5	0	0	0	01/04/2011	31/03/2013
	Executive Directors							
*	Ms Caroline Taylor	Chief Executive Officer	25-30	0	0	0	01/04/2011	31/03/2013
*	Ms Ann Johnson	Director of Finance	10-15	0	0	0	01/04/2011	04/09/2012
*	Mrs Bev Evans (1)	Director of Finance	35-40	0	0	0	05/09/2012	31/03/2013
***	Dr Quentin Sandifer	Director of Public Health - Camden	70-75	0	0	0	01/04/2011	07/10/2012
***	Ms Penny Bevan	Director of Public Health - Camden	60-65	0	0	0	01/11/2012	31/01/2013
**	Ms Julie Billett	Director of Public Health – Camden & Islington	5-10	0	0	0	01/02/2013	31/03/2013
	NON VOTING MEMBERS							
	Executive Directors							
*	Mr Jeremy Burden (4)	Director of Contracts	0-5	0	0	0	01/05/2011	31/03/2013
*	Mr Simon Currie (1)	Director of Contracts	20-25	0	0	0	11/06/2012	26/11/2012
*	Ms Liz Wise (5)	Director of QIPP	20-25	0	0	0	01/04/2011	31/03/2013
*	Ms Alison Pointu	Director of Quality & Safety	20-25	0	0	0	01/04/2011	31/03/2013
*	Ms Sarah Price (5)	Director of Public Health	20-25	0	0	0	01/04/2011	31/03/2013
*	Ms Helen Pettersen (3)	Director of Transition and Corporate	20-25	0	0	0	01/04/2011	31/03/2013
*	Dr Douglas Russell	Medical Director (Primary Care)	05-10	0	0	0	01/04/2011	31/07/2012
*	Dr Henrietta Hughes	Medical Director (Primary Care)	15-20	0	0	0	01/07/2012	31/03/2013
*	Dr Nick Losseff (2)	Medical Director (Secondary Care)	5-10	0	0	0	01/04/2011	31/03/2013
*	Mr Ian Fuller	Director of HR	10-15	0	0	0	01/04/2011	31/10/2012
*	Ms Marion McCrindle (1)	Director of HR	15-20	0	0	0	15/10/2012	31/03/2013
***	Mr David Cryer	Borough Director Camden	95-100	0	0	0	18/07/2011	31/03/2013
	PEC Members							
***	Ms Joanne Wickens	Nurse Rep – Camden	5-10	0	0	0	01/04/2011	31/03/2013
***	Dr MarekKoperski	PEC Chair Camden	15-20	0	0	0	01/04/2011	31/03/2013
***	Dr Denise Bavin	PEC Member Camden	20-25	0	0	0	01/04/2011	31/03/2013
***	Mr Philip Wee	PEC Member – Camden	0	0	0	0	01/04/2011	31/03/2013
***	Dr Tom Aslan	PEC Member – Camden	10-15	0	0	0	01/04/2011	30/11/2012

(1) Paid through consultancy company
(2) Seconded from another NHS organisation
(3) North East London CSU from October 2012
(4) Seconded to another NHS organisation from July 2012
(5) Accountable Officer Haringey CCG from November 2012

Main Board members serve on all 5 PCT's of the NCL Cluster and their remuneration is charged to all five PCT's accordingly. The PCT's share is shown above and the members full amount below.
Prior year comparison figures are included below but not apportioned to individual PCT's.

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Full salary and allowances of Senior Managers 2012/13

	NAME	TITLE	2012-13 Salary (bands of £5,000) £000	2012-13 Other Rem'n (bands of £5000) £000	2012-13 Bonus Pmts (bands of £5000) £000	2011-12 Salary (bands of £5,000) £000	2011-12 Other Rem's (bands of £5000) £000	2011-12 Bonus Pmts (bands of £5000) £000
	VOTING MEMBERS							
	Non Executive Directors							
*	Ms Paula Kahn	Chair	40-45	0	0	40-45	0	0
**	Prof John Carrier	Vice Chair NED Barnet	10-15	0	0	10-15	0	0
**	Mr Robert Sumerling	NED Barnet	5-10	0	0	5-10	0	0
**	Ms Karen Trew	Vice Chair Enfield	10-15	0	0	10-15	0	0
**	Ms Deborah Fowler	NED Enfield	5-10	0	0	5-10	0	0
*	Ms Caroline Rivett	Audit Chair	0-5	0	0	10-15	0	0
	Executive Directors							
*	Ms Caroline Taylor	Chief Executive Officer	145-150	0	0	145-150	0	0
*	Ms Ann Johnson	Director of Finance	60-65	0	0	120-125	0	0
*	Mrs Bev Evans (1)	Director of Finance	180-185	0	0	0	0	0
***	Dr Quentin Sandifer	Director of Public Health - Camden	70-75	0	0	105-110	0	35-40
***	Ms Penny Bevan	Director of Public Health - Camden	60-65	0	0	0	0	0
**	Ms Julie Billett	Director of Public Health – Camden & Islington	15-20	0	0	0	0	0
	NON VOTING MEMBERS							
	Executive Directors							
*	Mr Jeremy Burden (4)	Director of Contracts	20-25	0	0	95-100	0	0
*	Mr Simon Currie (1)	Director of Contracts	115-120	0	0	0	0	0
*	Ms Liz Wise (5)	Director of QIPP	115-120	0	0	115-120	0	0
*	Ms Alison Pointu	Director of Quality & Safety	100-105	0	0	95-100	0	0
*	Ms Sarah Price	Director of Public Health	100-105	0	0	100-105	0	0
*	Ms Helen Pettersen (3)	Director of Transition and Corporate affairs	115-120	0	0	115-120	0	0
*	Dr Andy Watts	Medical Director (Primary Care)	0	0	0	30-35	0	0
*	Dr Douglas Russell	Medical Director (Primary Care)	40-45	0	0	95-100	0	0
*	Dr Henrietta Hughes	Medical Director (Primary Care)	95-100	0	0	0	0	0
*	Dr Nick Losseff (2)	Medical Director (Secondary Care)	45-50	0	0	40-45	0	0
*	Mr Ian Fuller	Director of HR	60-65	0	0	85-90	0	0
*	Ms Marion McCrindle (1)	Director of HR	80-85	0	0	0	0	0
***	Mr David Cryer	Borough Director Camden	95-100	0	0	65-70	0	0
****	Ms Sarah Thompson (1)	Borough Director Camden	0	0	0	110-115	40-45	0
	PEC Members							
***	Ms Joanne Wickens	Nurse Rep - Camden	5-10	0	0	5-10	0	0
***	Dr MarekKoperski	PEC Chair Camden	15-20	0	0	15-20	0	0
***	Dr Denise Bavin	PEC Member Camden	20-25	0	0	15-20	0	0
***	Mr Philip Wee	PEC Member - Camden	0	0	0	0-5	0	0
***	Dr Tom Aslan	PEC Member - Camden	10-15	0	0	0-5	0	0

* Salary costs apportioned to the 5 PCT's (20%)

** Salary costs apportioned to 2 PCT's (50%)

*** Salary costs charged to the PCT (100%)

**** Salary costs to date transferred to Enfield PCT

Note: There were no benefits in kind in respect of Senior Managers in 2012/13

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Full salary and allowances for Directors and Senior Managers 2011/12 (PCT Share)

	NAME	TITLE	2012-13			Dates served	
			Salary (bands of £5,000) £000	Other Rem'n (bands of £5000) £000	Bonus Pmts (bands of £5000) £000	Commenced	Ceased
	VOTING MEMBERS						
	Non Executive Directors						
*	Ms Paula Kahn	Chair	5-10	0	0	01/04/2011	31/03/2013
**	Prof John Carrier	Vice Chair NED Barnet	5-10	0	0	01/04/2011	31/12/2012
**	Mr Robert Sumerling	NED Barnet	0-5	0	0	01/04/2011	31/03/2013
**	Ms Karen Trew	Vice Chair Enfield	5-10	0	0	01/04/2011	31/03/2013
**	Ms Deborah Fowler	NED Enfield	0-5	0	0	01/04/2011	31/03/2013
*	Ms Caroline Rivett	Audit Chair	0-5	0	0	01/04/2011	31/03/2013
	Executive Directors						
*	Ms Caroline Taylor	Chief Executive Officer	25-30	0	0	01/04/2011	31/03/2013
*	Ms Ann Johnson	Director of Finance	10-15	0	0	01/04/2011	04/09/2012
*	Mrs Bev Evans (1)	Director of Finance	35-40	0	0	05/09/2012	31/03/2013
***	Dr Quentin Sandifer	Director of Public Health - Camden	70-75	0	0	01/04/2011	07/10/2012
***	Ms Penny Bevan	Director of Public Health - Camden	60-65	0	0	01/11/2012	31/03/2013
	NON VOTING MEMBERS						
	Executive Directors						
*	Mr Jeremy Burden	Director of Contracts	20-25	0	0	01/05/2011	31/03/2013
*	Mr Simon Currie (1)	Director of Contracts	20-25	0	0	11/06/2012	26/11/2012
*	Ms Liz Wise (4)	Director of QIPP	20-25	0	0	01/04/2011	31/03/2013
*	Ms Alison Pointu	Director of Quality & Safety	20-25	0	0	01/04/2011	31/03/2013
*	Ms Sarah Price (3)	Director of Public Health	20-25	0	0	01/04/2011	31/03/2013
*	Ms Helen Pettersen	Director of Transition and Corporate affairs	20-25	0	0	01/04/2011	31/03/2013
*	Dr Douglas Russell	Medical Director (Primary Care)	05-10	0	0	01/04/2011	31/07/2012
*	Dr Henrietta Hughes	Medical Director (Primary Care)	15-20	0	0	01/07/2012	31/03/2013
*	Dr Nick Losseff (2)	Medical Director (Secondary Care)	5-10	0	0	01/04/2011	31/03/2013
*	Ms Aurea Jones	Director of workforce Transformation	????	0	0	01/04/2011	????
*	Mr Ian Fuller	Director of HR	10-15	0	0	01/04/2011	31/10/2012
*	Ms Marion McCrindle (1)	Director of HR	15-20	0	0	15/10/2012	31/03/2013
***	Mr David Cryer	Borough Director Camden	95-100	0	0	18/07/2011	31/03/2013
****	Ms Sarah Thompson (1)	Borough Director Camden	0	0	0	18/09/2011	27/06/2011
	PEC Members						
***	Ms Joanne Wickens	Nurse Rep - Camden	5-10	0	0	01/04/2011	31/03/2013
***	Dr MarekKoperski	PEC Chair Camden	15-20	0	0	01/04/2011	31/03/2013
***	Dr Denise Bavin	PEC Member Camden	20-25	0	0	01/04/2011	31/03/2013
***	Mr Philip Wee	PEC Member - Camden	0	0	0	01/04/2011	
***	Dr Tom Aslan	PEC Member - Camden	10-15	0	0	01/04/2011	30/11/2012

(1) Paid through consultancy company
(2) Seconded from another NHS organisation
(3) Accountable Officer Haringey CCG from November 2012
(4) Accountable Officer Enfield CCG from October 2012

Main Board members serve on all 5 PCT's of the NCL Cluster and their remuneration is charged to all five PCT's accordingly.
The PCT's share is shown above and the members full amount below.
Prior year comparison figures are included below but not apportioned to individual PCT's.
There are no benefits in kind for Senior Managers in 2011/12.

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Pension benefits of Senior Managers 2012/13 (PCT share)

Name	Title	Real increase/ decrease in pension at age 60 (bands of 2500)	Real increase/ decrease in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5000)	Total accrued related lump sum at age 60 at 31 March 2013 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2013	Cash Equivalent Transfer Value (CETV) at 31 March 2012	Real increase/ decrease in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Ms Caroline Taylor	Chief Executive Officer	0-2.5	0-2.5	10-15	35-40	280	258	9	0
Ms Ann Johnson	Director of Finance	0-2.5	0-2.5	0-5	5-10	29	23	4	0
Mr Jeremy Burden	Director of Contracts	(0-2.5)	(0-2.5)	5-10	20-25	128	120	2	0
Ms Liz Wise	Director of QIPP	0-2.5	0-2.5	0-5	10-15	95	87	4	0
Ms Alison Pointu	Director of Health & Safety	0-2.5	0-2.5	5-10	25-30	202	179	14	0
Ms Sarah Price	Director of Public Health	0-2.5	0-2.5	5-10	15-20	88	81	3	0
Ms Helen Pettersen	Director of Transformation	0-2.5	0-2.5	5-10	20-25	129	118	4	0
Mr Nick Losseff	Medical Director	0-2.5	0-2.5	5-10	25-30	149	138	4	0
Mr Ian Fuller	Director of Human Resources	0-2.5	0-2.5	2.5-5	10-15	67	63	0	0
David Cryer	Borough Director Camden	0-2.5	0	5-10	0-5	62	42	18	0
Ms Penny Bevan	Director of Public Health Camden	(0-2.5)	(2.5-5)	20-25	60-65	633	570	33	0
Ms Julie Billett	Director of Public Health Camden & Islington	0-2.5	0-2.5	5-10	15-20	85	72	10	0
PEC Members									
Dr Quentin Sandifer	Director of Public Health Camden	(0-2.5)	(2.5-5)	40-45	130-135	824	792	(9)	0
Note:									
Dr Henrietta Hughes	Medical Director Primary Care	Information not available as sessional figures not collated by the pension agency.							

Some board members serve on more than one of the boards of the five PCTs of the NHS North Central London Cluster and their remuneration is shared between the relevant PCTs.

The PCT's share is shown above and the members full amount below.

Prior year comparison figures are included below but not apportioned to individual PCTs.

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Full pension benefits of Senior Managers 2012/13

Name	Title	Real increase in pension at age 60 (bands of 2500)	Real increase in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5000)	Total accrued related lump sum at age 60 at 31 March 2013 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2013	Cash Equivalent Transfer Value (CETV) at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Ms Caroline Taylor	Chief Executive Officer	0-2.5	0-2.5	60-65	190-195	1,400	1,288	45	0
Ms Ann Johnson	Director of Finance	0-2.5	2.5-5	5-10	25-30	144	115	23	0
Mr Jeremy Burden	Director of Contracts	(0-2.5)	(0-2.5)	35-40	105-110	639	598	9	0
Ms Liz Wise	Director of QIPP	0-2.5	0-2.5	20-25	65-70	477	433	21	0
Ms Alison Pointu	Director of Health & Safety	0-2.5	2.5-5	45-50	145-150	1,012	895	70	0
Ms Sarah Price	Director of Public Health	0-2.5	0-2.5	25-30	75-80	440	406	13	0
Ms Helen Pettersen	Director of Transformation	0-2.5	0-2.5	35-40	105-110	643	592	19	0
Mr Nick Losseff	Medical Director	0-2.5	0-2.5	40-45	125-130	747	690	22	0
Mr Ian Fuller	Director of Human Resources	0-2.5	0-2.5	15-20	50-55	334	316	1	0
David Cryer	Borough Director Camden	0-2.5	0	5-10	0	62	42	18	0
Ms Penny Bevan	Director of Public Health Camden	(0-2.5)	(2.5-5)	20-25	60-65	633	570	33	0
Ms Julie Billett	Director of Public Health Camden & Islington	0-2.5	2.5-5	10-15	35-40	170	143	20	0
PEC Members									
Dr Quentin Sandifer	Director of Public Health Camden	(0-2.5)	(2.5-5)	40-45	130-135	824	792	(9)	0
Note:									
Dr Henrietta Hughes	Medical Director Primary Care	Information not available as sessional figures not collated by the pension agency.							

As Non-Executive members do not receive pensionable remuneration, there will be not entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

The Government Actuary Department ('GAD') factors for the calculation of Cash Equivalent Transfer Factors ('CETVs') assume that benefits are indexed in line with CPI which is expected to be lower than RPI which was used previously and hence will tend to produce lower transfer values.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme

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arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to benefits that the individual had accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and other pension details include the value of any benefits in another scheme or arrangement which the individual had transferred to the NHS Pension scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pension liability

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 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.

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 Camden PCT the financial year 2012-13 was £95k to £100k (2011/12: £140k-£145k). This was 2.4 (2011/12: 3.7) times the median remuneration of the workforce, which was £40,517 (2011/12: £38,790). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. In 2012/13 The workforce median calculation is based on the North Central London sector average, due to the fact that the majority of staff in 2012/13 were employed by Islington PCT and costs recharged to other sector bodies through inter PCT recharges.

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Off Payroll Engagements

The PCT is from 2012/13 required to disclose information about 'off payroll engagements'. The following tables show the number of off payroll engagements in place at 31st January 2012 (Table 1), and new engagements during the period 23 August 2012 and 31 March 2013 (Table 2).

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

No. Inplace on 31 January 2012	**14**
Of which:	
No. that have since been re-negotiated /reengaged 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	
No. that have come to an end	(14)
Total as at 31 March 2013	**0**

Table 2: For 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	**8**
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:	0
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
No. that have been terminated as a result of PCT closure.	(8)
Total as at 31 March 2013	**0**

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Register of Board Members' interests

NAME	NAME OF ORGANISATION AND NATURE OF ITS BUSINESS	POSITION HELD/ NATURE OF INTEREST	DATE DECLARED	DATE UPDATED
Non-Executive Directors				
Paula Kahn	Cripplegate Foundation	Governor	24/05/12	24/05/12
	THE EW Group which had contracts with a number of NHS Trusts/SHA/Institute of Innovation - none with the NCL Cluster or Islington PCT	Partner is Freelance Consultant	24/05/12	24/05/12
	NHS Barnet, Enfield, Haringey and Islington Primary Care Trusts	Chair	24/05/12	24/05/12
Caroline Rivett	Synodex UK (Provides Medical Record Analysis)	Director	07/03/12	07/03/12
	NHS Haringey, Islington, Barnet, Camden and Enfield Primary Care Trusts	Audit Chair	07/03/12	07/03/12
	Unthank Consulting	Spouse is Director	07/03/12	07/03/12
Robert Sumerling	Diapason Ltd [charitable company providing music education]	Director	16/04/12	16/04/12
	HM Courts and Tribunals Service [Mental Health]	Tribunal Judge	16/04/12	16/04/12
	NHS Barnet Primary Care Trust	Non-Executive Director	16/04/12	16/04/12
	Camden and Islington Foundation Trust	Nominated Governor		
Karen Trew	NHS Enfield Primary Care Trust	Vice-Chair	24/05/12	24/05/12
Deborah Fowler	NHS Enfield Primary Care Trust	Non Executive Director	22/05/12	22/05/12
	Employment Tribunals for Her Majesty's Courts Service	Lay Member	22/05/12	22/05/12
	Health Professions Council Fitness to Practise Panel	Lay Member	22/05/12	22/05/12
	Landscape Institute	Trustee	22/05/12	22/05/12
	Camden PCT and Islington Mental Health Trust	Member	22/05/12	22/05/12
	University College Hospitals London	Member	22/05/12	22/05/12
Voting Executive Directors				
Caroline Taylor	Husband is an education consultant who might on occasions work as an associate with a company with whom the NHS does business. If this arises, I will declare immediately.		23/04/12	23/04/12
	NHS Barnet, Enfield, Haringey and Islington Primary Care Trusts	Chief Executive Officer	24/05/12	24/05/12
Beverley Evans	White House Accountancy and Consulting Limited	Owner, Director and majority share holder	28/02/13	28/02/13
	Maidstone and Turnbridgewells NHS Trust	Non-Executive Director	28/02/13	28/02/13
Caroline Sayer	Practice (Adelaide Medical Centre) is a shareholder in Haverstock Healthcare Ltd.		03/05/12	03/05/12
	Imperial Trust	Husband is a consultant physician	03/05/12	03/05/12
Alison Pointu	No interests declared		19/03/12	19/03/12
David Cryer	No interests declared		23/04/12	23/04/12
Nick Losseff	UCLH	Consultant	23/05/12	23/05/12

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Professional Executive Committee Representatives				
Marek Koperski	James Wigg Medical Practise	Principal GP	05/03/12	05/03/12
	Queens Crescent Practise	Principal GP	05/03/12	05/03/12
	Neuroscience Research Charitable Trust	Director of Research	05/03/12	05/03/12
	Haverstock Health GP Provider Group	Member of a Member Practice	05/03/12	05/03/12
Joanne Wickens	Brondesbury Medical Centre - A Camden Practice	Employee	02/03/12	02/03/12

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Glossary

Expenditure:	Payments made and accruals, where an accrual is a payment due to be made but not yet released
Assets:	Resources, properties and possessions owned by the PCT
Current Assets:	Cash and other possessions which are likely to be converted into cash or used within a year
Fixed Assets:	Possessions and resources which are likely to be owned for more than a year
Tangible Assets:	Physical resources and possessions
Intangible Assets:	Non physical resources such as the PCT's software programmes
Liabilities:	Amounts owed by the PCT including any long-term financial obligation
Provisions:	Amounts retained by the PCT due to obligations to make future payments, for example ill-health and premature retirement pension payments
Taxpayer's equity:	Contribution by taxpayers to the net assets of the PCT
Impairment:	Reduction in value
Surplus:	Excess of income or gains over expenditure or losses
Operating costs:	Expenses that have arisen from the performance of the PCT's usual activities
Gross:	Overall or whole figure
Net:	The remaining amount after taking into account offsetting reductions
Capital:	Resources, properties and possessions owned by the PCT which are likely to be owned for more than a year or used to purchase property and possessions which are likely to be owned for more than a year
Revenue:	Resources and income to be used within a year
Remuneration:	Salaries and allowances
Operating Cost Statement:	Summarises, on an accruals basis, the net operating costs of the PCT. Operating costs and miscellaneous incomes are shown analysed between the commissioning and provider functions of the PCT.
Balance Sheet:	A quantitative summary of a company's financial condition at a specific point in time, including assets, liabilities and net worth.
IFRS:	International Financial Reporting Standards: accounting standards
Public Sector Payments Policy:	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.
Related Party Transactions:	A material transaction (i.e. a payment or a contract) between the PCT and a senior employee, other than salary or expenses. This can also extend to material transactions between the PCT and the senior employee's close family members, entities controlled by the senior employee or entities controlled by a close family member.

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Further information

How to contact those responsible for providing health services for Camden residents:

Camden Clinical Commissioning Group
Camden Borough Office
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

www.camdenccg.nhs.uk

London Borough of Camden
Town Hall Argyle
Street London
WC1H 8NJ

www.camden.gov.uk/

NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

www.england.nhs.uk

North & East London Commissioning Support Unit
Clifton House
75-77 Worship Street
London
EC2A 2DU

www.nelondoncsu.nhs.uk

Public Health England

www.healthandcare.dh.gov.uk/category/public-health/phe/

Department of Health

NHS

Camden Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Camden Primary Care Trust

2012-13 Accounts

Department of Health

NHS

Camden Primary Care Trust

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August 2013

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www.gov.uk/dh

Camden Primary Care Trust

2012-13 Accounts

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

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

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

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

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

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

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

Peter Coates
Director of PICD, Strategy, Finance and NHS
Department of Health

Signed.....

Date: 5 June 2013

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

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

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

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

Name: Beverley Evans (Former Director of Finance)

Signed:  .....

Date: 5 June 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 Camden Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

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

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

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

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

Name: Caroline Taylor (Former Chief Executive)

Signed:.....

Date: 5 June 2013

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF CAMDEN PCT

We have audited the financial statements of Camden PCT for the year ended 31 March 2013 on pages 1 to 31. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Signing Officer of Camden PCT in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Signing Officer of the PCT those matters we are required to state to him in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Signing Officer of the PCT for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Signing Officer and auditor

As explained more fully in the Statement of Signing Officer's Responsibilities set out on page 36 of the Annual Report, the Signing Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the 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 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 financial position of Camden PCT as at 31 March 2013 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on regularity prescribed by the Code of Audit Practice 2010 for local NHS bodies

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

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

- the information given in the director's 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 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the Department of Health's requirements;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of, the audit.

Conclusion on the PCT's 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 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 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 2010 for local NHS bodies, 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 PCT; and

- our locally determined risk-based work relating to PCT abolition and the transition to new local commissioning arrangements

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

Certificate

We certify that we have completed the audit of the accounts of Camden PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Fleur Nieboer for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
London
E14 5GL

Date 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	**12,483**	19,883
Other costs	5.1	**539,416**	522,969
Income	4	**(27,518)**	(27,488)
Net operating costs before interest		**524,381**	515,364
Investment income	9	**(15)**	(21)
Finance costs	10	**1,418**	811
Net Operating Costs for the Financial Year including absorption transfers		**525,784**	**516,154**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**11,288**	14,294
Other costs	5.1	**24,719**	23,185
Income	4	**(8,046)**	(17,068)
Net administration costs before interest		**27,961**	**20,411**
Investment income	9	**(15)**	0
Finance costs	10	**1,227**	811
Net administration costs for the financial year		**29,173**	**21,222**
Programme Expenditure			
Gross employee benefits	7.1	**1,195**	5,589
Other costs	5.1	**514,697**	499,784
Income	4	**(19,472)**	(10,420)
Net programme expenditure before interest		**496,420**	**494,953**
Investment income	9	**0**	(21)
Finance costs	10	**191**	0
Net programme expenditure for the financial year		**496,611**	**494,932**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,290**	1,546
Net (gain) on revaluation of property, plant & equipment	**(10,525)**	(3,149)
Total comprehensive net expenditure for the year*	**516,549**	**514,551**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.

The notes on pages 5 to 33 form part of these accounts.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	11.1	**77,903**	72,219
Intangible assets		**0**	10
Other financial assets	17.1	**257**	257
Trade and other receivables	16.1	**2,295**	2,386
Total non-current assets		**80,455**	74,872
Current assets:			
Trade and other receivables	16.1	**14,070**	25,452
Cash and cash equivalents	18	**28**	108
Total current assets		**14,098**	25,560
Total assets		**94,553**	100,432
Current liabilities			
Trade and other payables	19	**(32,695)**	(57,616)
Provisions	22	**(1,876)**	(2,232)
Borrowings	20	**(344)**	(328)
Total current liabilities		**(34,915)**	(60,176)
Non-current assets plus/less net current assets/liabilities		**59,638**	40,256
Non-current liabilities			
Trade and other payables	19	0	(750)
Provisions	22	(4,874)	(9,278)
Borrowings	20	(11,370)	(11,714)
Total non-current liabilities		**(16,244)**	(21,742)
Total Assets Employed:		**43,394**	18,514
Financed by taxpayers' equity:			
General fund		(44)	(17,664)
Revaluation reserve		43,438	36,178
Total taxpayers' equity:		**43,394**	18,514

The notes on pages 5 to 33 form part of these accounts.

The financial statements on pages 1 to 33 were approved by the signing officer on 5 June 2013.

Peter Coates ..... Date: 05/06/13

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

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**(17,664)**	**36,178**	**18,514**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(525,784)	0	**(525,784)**
Net gain on revaluation of property, plant, equipment	0	10,525	**10,525**
Impairments and reversals	0	(1,290)	**(1,290)**
Transfers between reserves*	1,975	(1,975)	**0**
Total recognised income and expense for 2012-13	**(523,809)**	**7,260**	**(516,549)**
Net Parliamentary funding	541,429		**541,429**
Balance at 31 March 2013	**(44)**	**43,438**	**43,394**
Balance at 1 April 2011	**300**	**34574**	**34,874**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(516,154)	0	(516,154)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	3,149	3,149
Impairments and Reversals	0	(1,545)	(1,545)
Total recognised income and expense for 2011-12	(516,154)	1,604	(514,550)
Net Parliamentary funding	498,190	0	498,190
Balance at 31 March 2012	**(17,664)**	**36,178**	**18,514**

* The transfer between reserves relates to the realised depreciation impact upon the revaluation reserve.

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(524,381)**	(515,364)
Depreciation and Amortisation	**3,794**	3,143
Impairments and Reversals	**803**	7,050
Interest Paid	**(1,227)**	(590)
(Increase)/Decrease in Trade and Other Receivables	**11,473**	2,934
Increase/(Decrease) in Trade and Other Payables	**(26,111)**	10,211
Provisions Utilised	**(11,941)**	(4,498)
Increase/(Decrease) in Provisions	**6,990**	294
Net Cash Inflow/(Outflow) from Operating Activities	**(540,600)**	**(496,820)**
Cash flows from investing activities		
Interest Received	**15**	21
(Payments) for Property, Plant and Equipment	**(596)**	(1,166)
Net Cash Inflow/(Outflow) from Investing Activities	**(581)**	**(1,145)**
Net cash inflow/(outflow) before financing	**(541,181)**	**(497,965)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(328)**	(262)
Net Parliamentary Funding	**541,429**	498,190
Capital grants and other capital receipts	**0**	94
Net Cash Inflow/(Outflow) from Financing Activities	**541,101**	**498,022**
Net increase/(decrease) in cash and cash equivalents	**(80)**	**57**
Cash and Cash Equivalents at Beginning of the Period	**108**	**51**
Cash and Cash Equivalents at year end	**28**	**108**

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Going Concern

Under the provisions of the Health and Social Care Act 2012 (Commencement No.4. Transitional Savings and Transitory Provisions) Order 2013, Camden Primary Care Trust was dissolved on 1st April 2013. The PCTs functions, assets and liabilities transferred to other public sector entities as outlined in Note 30 Events after the Reporting period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The Statement of Financial Position has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. The usual annual revaluation of land and buildings has been undertaken by the District Valuer, on the same basis as any other year again assuming continuing operations.

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

PFI & LIFT

The PCT has determined that a LIFT building under IFRS is recorded as a Finance Lease. The Statement of Comprehensive Net Expenditure only reflects the service charge and Interest payment element of the rents. The asset has been capitalised and a long term liability with the relevant party is shown in the accounts.

The measurement and recognition of the LIFT Co. investment at cost is deemed to be a reasonable approximation of fair value given that the nature of the future dividends and subordinated debt repayments is uncertain.

1. Accounting policies (continued)

Key sources of estimation uncertainty

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

- Land and buildings are restated at current cost using professional DV valuations. The PCT obtained an up to date revaluation at 31st March 2013 from the District Valuer. This valuation was completed on a Modern Equivalent Asset basis which is in accordance with the recent RICS guidance. The PCT has taken the option to using annual full DV valuations of its assets rather than applying any indices to index its assets and has accounted for movements mainly through its asset reserves. Assets brought into use for the first time have also been revalued with other assets and where there is an impairment any excesses over reserves are charged to the Operating Cost Statement.

- All assets are depreciated over their useful economic lives (UEL) in accordance with the PCTs depreciation policy. For equipment assets the PCT has made an assumption of the average asset life for each category of assets (see Note 12.3 on page 24). For land and building assets the UEL is determined by the District Valuer when a formal revaluation is undertaken. The PCT has reviewed the useful economic lives of IT assets and estimated that all IT assets should be depreciated over 3 years.

Although the PCT believes that its estimates of the relevant expected useful lives, its assumptions concerning the environment and developments in the industry in which the PCT operates and its estimations of the discounted future cashflows are appropriate, changes in assumptions or circumstances could require changes in the analysis. This could lead to additional impairment charges in the future or to valuation write-backs should the trends expected by the PCT reverse.

- The central costs of the North Central Cluster have been equally apportioned across all the 5 PCTs that comprise the cluster.

- The PCT has estimated a provision in respect of retrospective continuing care claims which are likely to arise, relating to episodes of care during the period 1st April 2004 to 31st March 2013.

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. Accounting policies (continued)

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 arrrangements and so is recorded as such in the financial statements.

1.5 Capital Charges

The Department of Health no longer applies a cost of capital charge of 3.5% of the net average assets less liabilities (excluding donated assets and cash balances with the Government Banking Services), so this item of expenditure does not appear in the 2012/13 expenditure analysis. The Department continues however to apply the cost of capital charge to the PCTs resource allocation and this is reflected in the revenue resource limit shown in the accounts.

1.6 Property, Plant & Equipment

Recognition

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

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

Valuation

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

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

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

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

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

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.

1. Accounting policies (continued)

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.

1.7 Intangible Assets

Recognition

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

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

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

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

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

1.8 Depreciation, amortisation and impairments

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

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

1. Accounting policies (continued)

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

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

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.9 Donated assets

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

1.10 Government grants

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

1.11 Non-current assets held for sale

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

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

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

1.12 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. Accounting policies (continued)

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).

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 22.

1.15 Employee benefits

Short-term employee benefits

As with previous years' accounts the cost of leave earned but not taken by employees at the end of the period is not recognised in the financial statements to the extent that it is not material as employees are only exceptionally permitted to carry forward leave into the following period. In 2012/13 the policy to allow carry forward was reviewed and payment in lieu was made instead. The overall impact was not material.

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 Research and Development

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

1.17 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.

1.18 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. 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.

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 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)

1.22 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.

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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

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. Accounting policies (continued)

1.23 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 the present value of the minimum lease payments 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 present value of the minimum lease payments and is subsequently measured as a finance lease liability in accordance with IAS 17.

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

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

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

c) Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the PCT's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

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

1. Accounting policies (continued)

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.

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

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

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

2. Operating segments

The PCT has no separate Operating segments to report in 2012/13 and there were no Operating Segments reported in 2011/12.

3. Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 2012-13 is as follows:

	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year		516,154
Net operating cost plus (gain)/loss on transfers by absorption	**525,784**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**549,603**	559,316
Underspend Against Revenue Resource Limit (RRL)	23,819	43,162

The underspend in 2012/13 (and in 2011/12) against Revenue Resource limit was planned and agreed with the Department of Health and the NHS London Stategic Health Authority.

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	**1,973**	2,713
Charge to Capital Resource Limit	**1,036**	518
Underspend Against CRL	**937**	**2,195**

The PCT kept within its Capital Resource Limit.

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**541,429**	498,190
Cash Limit	**541,429**	524,490
Under/(Over)spend Against Cash Limit	**0**	**26,300**

The PCT kept within its Cash Limit.

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

	2012-13 £000
Total cash received from DH (Gross)	504,589
Sub total: net advances	**504,589**
Plus: cost of Dentistry Schemes (central charge to cash limits)	9,445
Plus: drugs reimbursement (central charge to cash limits)	27,395
Parliamentary funding credited to General Fund	**541,429**

4. Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Dental Charge income from Contractor-Led GDS & PDS	**2,008**	0	2,008	2,041
Prescription Charge income	**1,150**	0	1,150	1,097
Strategic Health Authorities	**256**	0	256	2,167
NHS Trusts	**255**	0	255	244
NHS Foundation Trusts	**7,546**	7,546	0	10,677
Primary Care Trusts - Other	**7,094**	500	6,594	3,203
Department of Health - Other	**0**	0	0	131
Local Authorities	**1,798**	0	1,798	2,401
Education, Training and Research	**2,796**	0	2,796	2,753
Rental revemue from finance leases	**812**	0	812	0
Rental reenue from operating leases	**652**	0	652	282
Other revenue	**3,151**	0	3,151	2,492
Total miscellaneous revenue	**27,518**	**8,046**	**19,472**	**27,488**

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	**36,785**	0	36,785	35,595
Non-Healthcare	**7,962**	7,962	0	295
Total	**44,747**	**7,962**	**36,785**	**35,890**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**41,680**	0	41,680	139,159
Goods and services (other, excl Trusts, FT and PCT)	**437**	0	437	1,238
Total	**42,117**	**0**	**42,117**	**140,397**
Goods and Services from Foundation Trusts *	**314,065**	0	314,065	207,683
Purchase of Healthcare from Non-NHS bodies	**25,340**	0	25,340	15,640
Social Care from Independent Providers	**3,363**	0	3,363	4,366
Non-GMS Services from GPs	**4**	0	4	0
Contractor Led GDS & PDS (excluding employee benefits)	**11,501**	0	11,501	11,431
Chair, Non-executive Directors & PEC remuneration	**110**	110	0	49
Executive committee members costs	**482**	482	0	71
Consultancy Services	**1,120**	1,120	0	661
Prescribing Costs	**21,960**	0	21,960	24,916
G/PMS, APMS and PCTMS (excluding employee benefits)	**38,712**	0	38,712	38,330
Pharmaceutical Services	**704**	0	704	638
New Pharmacy Contract	**6,579**	0	6,579	5,937
General Ophthalmic Services	**2,485**	0	2,485	2,288
Supplies and Services - Clinical	**652**	177	475	409
Supplies and Services - General	**1,662**	1,334	328	2,272
Establishment	**499**	499	0	664
Transport	**222**	0	222	1,265
Premises	**9,797**	9,797	0	13,047
Impairments & Reversals of Property, plant and equipment	**803**	0	803	7,050
Depreciation	**3,784**	0	3,784	3,138
Amortisation	**10**	0	10	5
Impairment of Receivables	**(412)**	0	(412)	2,966
Audit Fees	**133**	133	0	226
Other Auditors Remuneration	**0**	0	0	0
Clinical Negligence Costs	**2**	0	2	37
Education and Training	**2,754**	2,754	0	2,707
Other **	**6,221**	351	5,870	886
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**539,416**	**24,719**	**514,697**	**522,969**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**380**	380	0	434
Other Employee Benefits	**12,103**	4,308	7,795	19,449
Total Employee Benefits charged to SOCNE (See Note 7.1)	**12,483**	**4,688**	**7,795**	**19,883**
Total Operating Costs	**551,899**	**29,407**	**522,492**	**542,852**

* Increase in spend on goods and services from Foundation Trusts is due to an increased number of Trusts becoming Foundation Trusts. This is confirmed by a like reduction in goods and services from NHS Trusts.

** Increase in "Other" as it includes costs to settle early retirement and back to back provisions with the NHS Pensions Agency and NHS Trusts.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**19,713**	17,211	2,502
Weighted population (number in units)*	**256,243**	256,243	256,243
Running costs per head of population (£ per head)	**76.9**	**67.2**	**9.8**
PCT Running Costs 2011-12			
Running costs (£000s)	**21,222**	16,738	4,484
Weighted population (number in units)	**256,243**	256,243	256,243
Running costs per head of population (£ per head)	**82.8**	**65.3**	**17.5**

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula.Therefore, 2011-12 weighted populations have been used when calculating the running costs per head of population 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	38,712	38,330
Prescribing costs	21,960	24,916
Contractor led GDS & PDS	11,501	11,431
General Ophthalmic Services	2,485	2,288
Pharmaceutical services	704	638
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	6,579	5,937
Non-GMS Services from GPs	4	0
Total Primary Healthcare purchased	**81,945**	83,540
Purchase of Secondary Healthcare		
Learning Difficulties	4,177	4,149
Mental Illness	69,411	69,043
Maternity	11,908	13,259
General and Acute	270,181	257,612
Accident and emergency	12,816	10,923
Community Health Services	62,113	59,775
Other Contractual	0	0
Total Secondary Healthcare Purchased	**430,606**	414,761
Total Healthcare Purchased by PCT	**512,551**	**498,301**
Included above:		
Social Care from Independent Providers	3,363	4,366
Healthcare from NHS FTs included above	314,065	207,682

6. Operating Leases

6.1 PCT as lessee	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**2,596**	2,963
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**2,596**	**2,963**
Payable:					
No later than one year	**53**	**2,400**	**0**	**2,453**	2,921
Between one and five years	**120**	**7,516**	**0**	**7,636**	10,496
After five years	**58**	**4,000**	**0**	**4,058**	7,241
Total	**231**	**13,916**	**0**	**14,147**	**20,658**
Total future sublease payments expected to be received				0	0

All significant operating leases relate to leasehold property for a variety of buildings for periods ranging from 5 to 10 years. There are no purchase options or escalation clauses or significant restrictions.

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**652**	282
Contingent rents	**0**	0
Total	**652**	282
Receivable:		
No later than one year	**224**	282
Between one and five years	**895**	856
After five years	**6,027**	6,251
Total	**7,146**	7,389

The PCT is the lessor of several properties that are let on commercial leases to other NHS bodies, including G.P.practices.

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	Prog £000	Total £000	Admin £000	Prog £000
Employee Benefits - Gross Expenditure									
Salaries and wages	**10,089**	9,066	1,023	**7,099**	6,271	828	**2,990**	2,795	195
Social security costs	**790**	713	77	**790**	713	77	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**971**	876	95	**971**	876	95	**0**	0	0
Termination benefits	**633**	633	0	**633**	633	0	**0**	0	0
Total employee benefits	**12,483**	**11,288**	**1,195**	**9,493**	**8,493**	**1,000**	**2,990**	**2,795**	**195**
Less recoveries in respect of employee benefits	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**12,483**	**11,288**	**1,195**	**9,493**	**8,493**	**1,000**	**2,990**	**2,795**	**195**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**12,483**	**11,288**	**1,195**	**9,493**	**8,493**	**1,000**	**2,990**	**2,795**	**195**
Recognised as:									
Commissioning employee benefits	**12,483**			**9,493**			**2,990**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**12,483**			**9,493**			**2,990**		

Islington PCT became the host payroll provider for NHS North Central London Sector in 2012/13 and host for staff providing services across NHS North Central London Sector. Staff working solely for each of the PCTs remained on their respective payrolls and are included within the employee benefits note above. Therefore, employee benefits increased considerably in 2012/13 within Islington PCT and decreased in the other Sector PCTs, Barnet PCT, Enfield PCT, Haringey PCT and Camden PCT. Islington PCT recharged Camden PCT and the other Sector PCTs their share of the pay costs on an equal apportionment which is shown within Note 5.1, Goods and services from other PCTs - Non Healthcare.

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**16,646**	13,611	3,035
Social security costs	**1,273**	1,273	0
Employer Contributions to NHS BSA - Pensions Division	**1,578**	1,578	0
Termination benefits	**386**	386	0
Total gross employee benefits	**19,883**	**16,848**	**3,035**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**19,883**	**16,848**	**3,035**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**19,883**	**16,848**	**3,035**
Recognised as:			
Commissioning employee benefits	**19,883**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**19,883**		

7.2 Staff Numbers

	Total Number	2012-13 Permanently employed Number	Other Number	Total Number	2011-12 Permanent employed Number	Other Number
Average Staff Numbers						
Medical and dental	**2**	2	0	**5**	5	0
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**186**	130	56	**280**	231	49
Healthcare assistants and other support staff	**33**	23	10	**79**	64	15
Nursing, midwifery and health visiting staff	**0**	0	0	**6**	6	0
Scientific, therapeutic and technical staff	**7**	7	0	**6**	6	0
TOTAL	**228**	**162**	**66**	**376**	**312**	**64**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

7.3 Staff Sickness absence and ill health retirements

The rate of sickness for NHS North Central London was 2.8%.(2011/12: 2.73%) This is under the average rate for NHS England as a whole *3.9%(2011/12: *3.97%).

* Data taken from NHS Information Centre for sickness absence rates for the NHS in England for the calandar year January to December 2012 (2011/12: July to September 2011)

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**0**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**0**	28

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**2**	**0**	**2**	3	0	**3**
£10,001-£25,000	**2**	**0**	**2**	2	0	**2**
£25,001-£50,000	**2**	**0**	**2**	2	2	**4**
£50,001-£100,000	**2**	**0**	**2**	4	1	**5**
£150,001 - £200,000	**1**	**0**	**1**	0	0	**0**
>£200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost)	**10**	**0**	**10**	**11**	**3**	**14**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	617	0	**617**	445	139	**584**

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 Agenda for Change. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**14,747**	**62,351**	20,691	56,932
Total Non-NHS Trade Invoices Paid Within Target	**8,567**	**38,218**	14,510	37,887
Percentage of NHS Trade Invoices Paid Within Target	58.09%	61.29%	70.13%	66.55%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,302**	**395,889**	3,503	378,385
Total NHS Trade Invoices Paid Within Target	**1,976**	**351,615**	1,470	351,697
Percentage of NHS Trade Invoices Paid Within Target	45.93%	88.82%	41.96%	92.95%

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. The disclosure above shows the value of invoices by volume and amount paid within 30 days, with the remaining invoices being paid later than 30 days.

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: loan interest receivable	**15**	**15**	**0**	21
Total investment income	**15**	**15**	**0**	21

10. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under LIFT contracts:				
- main finance cost	**576**	**576**	**0**	590
- contingent finance cost	**651**	**651**	**0**	0
Total interest expense	**1,227**	**1,227**	**0**	**590**
Provisions - unwinding of discount	**191**	**0**	**191**	221
Total	**1,418**	**1,227**	**191**	**811**

11.1 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	**34,430**	**47,925**	**2,349**	**35**	**845**	**51**	**4,222**	**3,133**	**92,990**
Additions of Assets Under Construction				0					**0**
Additions Purchased	0	812	0		0	0	224	0	**1,036**
Reclassifications	0	6	0	(35)	0	0	29	0	**0**
Upward revaluation/positive indexation	2,040	8,166	319	0	0	0	0	0	**10,525**
Impairments/negative indexation	0	(1,260)	(30)	0	0	0	0	0	**(1,290)**
At 31 March 2013	**36,470**	**55,649**	**2,638**	**0**	**845**	**51**	**4,475**	**3,133**	**103,261**
Depreciation									
At 1 April 2012	**132**	**14,468**	**307**	**0**	**560**	**45**	**2,142**	**3,117**	**20,771**
Impairments	0	709	0	0	0	0	94	0	**803**
Charged During the Year	150	1,839	93		83	3	1,614	2	**3,784**
At 31 March 2013	**282**	**17,016**	**400**	**0**	**643**	**48**	**3,850**	**3,119**	**25,358**
Net Book Value at 31 March 2013	**36,188**	**38,633**	**2,238**	**0**	**202**	**3**	**625**	**14**	**77,903**
Purchased	36,188	37,689	2,238	0	202	3	625	14	**76,959**
Donated	0	944	0	0	0	0	0	0	**944**
Total at 31 March 2013	**36,188**	**38,633**	**2,238**	**0**	**202**	**3**	**625**	**14**	**77,903**
Asset financing:									
Owned	36,188	30,118	2,238	0	202	3	625	14	**69,388**
On-SOFP PFI contracts	0	8,515	0	0	0	0	0	0	**8,515**
Total at 31 March 2013	**36,188**	**38,633**	**2,238**	**0**	**202**	**3**	**625**	**14**	**77,903**

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	**14,082**	**18,323**	**2,859**	**0**	**32**	**2**	**113**	**767**	**36,178**
Movements (Note 1 below)	2,010	6,004	160	0	(32)	(1)	(113)	(768)	**7,260**
At 31 March 2013	**16,092**	**24,327**	**3,019**	**0**	**0**	**1**	**0**	**(1)**	**43,438**

Note 1: Revaluation of assets

Land and buildings have been independently and externally revalued by The District Valuer as at 31 March 2013 which has been reflected in the accounts. The valuation was carried out on a Modern Equivalent Asset (MEA) basis in accordance with International Financial Reporting Standards (IFRS). This resulted in an upward revaluation of £10,525k. Impairments totalled £1,999k of which £1,290k was offset against the revaluation reserve and £709k was charged to the operating cost statement. The previous valuation was also carried out by the District Valuer on 31 March 2012 on a MEA basis. Information Technology assets were also impaired in 2012/13 by £94k.

11.2 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	**32,636**	**44,332**	**2,414**	**3,236**	**845**	**51**	**4,222**	**3,133**	**90,869**
Additions - purchased	0	512	0	6	0	0	0	0	**518**
Reclassifications	0	3,207	0	(3,207)	0	0	0	0	**0**
Revaluation & indexation gains	1,794	1,355	0	0	0	0	0	0	**3,149**
Impairments	0	(1,481)	(65)	0	0	0	0	0	**(1,546)**
At 31 March 2012	**34,430**	**47,925**	**2,349**	**35**	**845**	**51**	**4,222**	**3,133**	**92,990**
Depreciation									
At 1 April 2011	**132**	**5,175**	**196**		**478**	**42**	**1,446**	**3,114**	**10,583**
Impairments	0	7,050	0	0	0	0	0	0	**7,050**
Charged During the Year	0	2,243	111		82	3	696	3	**3,138**
At 31 March 2012	**132**	**14,468**	**307**	**0**	**560**	**45**	**2,142**	**3,117**	**20,771**
Net Book Value at 31 March 2012	**34,298**	**33,457**	**2,042**	**35**	**285**	**6**	**2,080**	**16**	**72,219**
Purchased	34,298	32,923	2,042	35	285	6	2,080	16	**71,685**
Donated	0	534	0	0	0	0	0	0	**534**
At 31 March 2012	**34,298**	**33,457**	**2,042**	**35**	**285**	**6**	**2,080**	**16**	**72,219**
Asset financing:									
Owned	34,298	28,138	2,042	35	285	6	2,080	16	**66,900**
On-SOFP PFI contracts	0	5,319	0	0	0	0	0	0	**5,319**
At 31 March 2012	**34,298**	**33,457**	**2,042**	**35**	**285**	**6**	**2,080**	**16**	**72,219**

12.1 Intangible non-current assets

2012-13	Software purchased	Total
	£000	£000
At 1 April 2012	431	431
At 31 March 2013	431	431
Amortisation		
At 1 April 2012	421	421
Charged during the year	10	10
At 31 March 2013	431	431
Net Book Value at 31 March 2013	0	0

12.2 Intangible non-current assets

2011-12	Software purchased	Total
	£000	£000
At 1 April 2011	431	431
At 31 March 2012	431	431
Amortisation		
At 1 April 2011	416	416
Charged during the year	5	5
At 31 March 2012	421	421
Net Book Value at 31 March 2012	10	10
Net Book Value at 31 March 2012 comprises		
Purchased	10	10
Total at 31 March 2012	10	10

12.3 Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	0	1
Property, Plant and Equipment		
Buildings exc Dwellings	7	90
Dwellings	17	45
Plant & Machinery	3	6
Transport Equipment	0	7
Information Technology	0	3
Furniture and Fittings	0	7

Open Market Value of Assets at balance sheet date	Land	Buildings excl. dwellings	Dwellings	Total
	£000s	£000s	£000s	£000s
Open Market Value at 31 March 2013	36,188	38,633	2,238	77,059
Open Market Value at 31 March 2012	34,298	33,457	2,042	69,797

13. 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			
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Changes in market price	803		803
Total charged to Annually Managed Expenditure	**803**		**803**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	1,290		
Total impairments for PPE charged to reserves	**1,290**		
Total Impairments of Property, Plant and Equipment	**2,093**	**0**	**803**
Total Impairments charged to Revaluation Reserve	1,290		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	803		803
Overall Total Impairments	**2,093**	**0**	**803**

14. Commitments

14.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**0**	200
Total	**0**	200

15. 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	7,318	0	1,501	0
Balances with Local Authorities	2	0	2,071	0
Balances with NHS Trusts and Foundation Trusts	5,795	0	12,343	0
Balances with bodies external to government	955	2,295	16,780	0
At 31 March 2013	**14,070**	**2,295**	**32,695**	**0**
Prior period:				
Balances with other Central Government Bodies	3,201	0	7,823	0
Balances with Local Authorities	468	0	2,043	0
Balances with NHS Trusts and Foundation Trusts	15,912	0	25,997	0
Balances with bodies external to government	5,871	2,386	21,753	750
At 31 March 2012	**25,452**	**2,386**	**57,616**	**750**

16.1 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	**12,927**	18,911	**0**	0
NHS prepayments and accrued income	**(2)**	0	**0**	0
Non-NHS receivables - revenue	**1,493**	3,455	**0**	0
Non-NHS receivables - capital	**0**	0	**2,295**	2,386
Non-NHS prepayments and accrued income	**1,033**	5,842	**0**	0
Provision for the impairment of receivables	**(1,569)**	(2,862)	**0**	0
VAT	**188**	106	**0**	0
Total	**14,070**	25,452	**2,295**	2,386
Total current and non current	**16,365**	27,838		
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.

16.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	3,128	477
By three to six months	94	0
By more than six months	712	0
Total	3,934	477

16.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	(2,862)	104
Amount written off during the year	881	0
Amount recovered during the year	605	0
(Increase)/decrease in receivables impaired	(193)	(2,966)
Balance at 31 March 2013	(1,569)	(2,862)

17. NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	225	0	225
Additions	31	1	32
Balance at 31 March 2013	256	1	257
Balance at 1 April 2011	225	0	225
Balance at 31 March 2012	225	0	225

17.1 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	257	257
Total Other Financial Assets - Non Current	257	257

18. Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	108	51
Net change in year	(80)	57
Closing balance	28	108
Made up of		
Cash with Government Banking Service	28	87
Commercial banks	0	21
Cash and cash equivalents as in statement of financial position	28	108
Cash and cash equivalents as in statement of cash flows	28	108

19. Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS payables - revenue	**10,494**	21,014	**0**	0
NHS payables - capital	**250**	0	**0**	0
NHS accruals and deferred income	**2,221**	12,806	**0**	0
Family Health Services (FHS) payables	**6,251**	6,653		
Non-NHS payables - revenue	**6,433**	3,202	**0**	0
Non-NHS payables - capital	**425**	235	**0**	750
Non_NHS accruals and deferred income	**5,290**	13,074	**0**	0
Social security costs	**116**	0		
Tax	**294**	0		
Other	921	632	0	0
Total	**32,695**	57,616	0	750
Total payables (current and non-current)	**32,695**	**58,366**		

20. Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
LIFT liabilities:				
Main liability	**344**	328	**11,370**	11,714
Total	**344**	**328**	**11,370**	**11,714**
Total other liabilities (current and non-current)	**11,714**	**12,042**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	Other £000s	Total £000s
0 - 1 Years	0	344	**344**
1 - 2 Years	0	360	**360**
2 - 5 Years	0	1,187	**1,187**
Over 5 Years	0	9,823	**9,823**
TOTAL	**0**	**11,714**	**11,714**

21. Finance lease obligations

Finance Leases (as a Lessor)

Rental Income	**31 March 2013 £000**	31 March 2012 £000
Contingent rent	**0**	0
Other	**812**	0
Total rental income	**812**	0

22. Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**11,510**	64	6,625	27	0	3,394	1,400
Arising During the Year	**8,617**	173	4,129	0	1,878	2,437	0
Utilised During the Year	**(11,941)**	(239)	(10,803)	0	0	(652)	(247)
Reversed Unused	**(1,627)**	0	(137)	(25)	0	(312)	(1,153)
Unwinding of Discount	**191**	2	186	0	0	3	0
Balance at 31 March 2013	**6,750**	**0**	**0**	**2**	**1,878**	**4,870**	**0**
Expected Timing of Cash Flows:							
No Later than One Year	**1,876**	**0**	**0**	**2**	**470**	**1,404**	**0**
Later than One Year and not later than Five Years	**983**	**0**	**0**	**0**	**939**	**44**	**0**
Later than Five Years	**3,891**	**0**	**0**	**0**	**469**	**3,422**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2013	4,803
As at 31 March 2012	43

The closing balance of 'Other' Provisions includes Injury Benefits of £60k, Dilapidations of £3,362k and £1,393k in respect of an Onerous Contract.

23. Contingencies

Contingent liabilities

Camden PCT received claims for continuing Healthcare costs relating to episodes of care from the period 1st April 2004 to 31st March 2012 amounting to £ 6,259k as at 31st March 2013. The PCT has sought internal and external advice on the range of likely outcomes and success factors to determine the likelihood of claims being paid and made a provision of £1,878k (30%) included in Note 22 above, Provisions – Continuing Care. The PCT therefore recognises a contingent liability of up to £4,381k in 2012/13 (2011/12 - £500k to £1,500k).

The PCT also has a contingent liability in respect to an ongoing legal claim, currently in the hands of the NHS Litigation Authority, which amounts to £1k.

24. PFI and LIFT - additional information

The PCT has one LIFT scheme which is for the provision of and supply of services to Kentish Town Health Centre for a period of 25 years. The Kentish Town Health Centre opened in December 2008. There is no obligation to purchase the building at the end of the contract which is subject only to inflationary increases. Under IFRIC 12, the asset is treated as an asset of the PCT and that the substance of the contract is that the PCT has a finance lease and payments comprise two elements - imputed finance lease charges and service charges.

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013 £000**	31 March 2012 £000
Service element of on SOFP LIFT charged to operating expenses in year	**356**	356
Total	**356**	356

	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	**356**	368
Later than One Year, No Later than Five Years	**1,426**	1,472
Later than Five Years	**5,599**	5,898
Total	**7,381**	7,738

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	**903**	903
Later than One Year, No Later than Five Years	**3,613**	3,614
Later than Five Years	**14,192**	15,095
Subtotal	**18,708**	19,612
Less: Interest Element	**(6,994)**	(7,570)
Total	**11,714**	12,042

25. Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit Risk

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

Liquidity Risk

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

25.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Receivables - NHS		12,925		**12,925**
Receivables - non-NHS		1,899		**1,899**
Cash at bank and in hand		28		**28**
Other financial assets	0	257	0	**257**
Total at 31 March 2013	**0**	**15,109**	**0**	**15,109**
Receivables - NHS		18,911		18,911
Receivables - non-NHS		8,927		8,927
Cash at bank and in hand		108		108
Other financial assets	0	257	0	257
Total at 31 March 2012	0	28,203	0	28,203

25.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
NHS payables		12,965	**12,965**
Non-NHS payables		19,320	**19,320**
Other borrowings		11,714	**11,714**
Other financial liabilities	0	6,750	**6,750**
Total at 31 March 2013	**0**	**50,749**	**50,749**
NHS payables		35,280	35,280
Non-NHS payables		23,086	23,086
Other borrowings		12,042	12,042
Other financial liabilities	0	11,510	11,510
Total at 31 March 2012	**0**	81,918	81,918

26. Related party transactions

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities controlled or influenced by them, as being parties related to NHS bodies. Related party transactions are to be disclosed if material to either party.

The table below shows the relationship between Camden PCTs Senior Managers and related parties, ie organisations they control or can influence. The amounts disclosed below are transactions with the related parties and not the individuals.

Name / Title	Related Party	Relationship with Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
			£000's	£000's	£000's	£000's
Paula Kahn - Chair						
	Barnet PCT	Chair	179	3,479	0	4,461
	Enfield PCT	Chair	448	500	446	500
	Haringey PCT	Chair	1	412	0	672
	Islington PCT	Chair	7,313	1,843	0	500
Caroline Rivett - Non-Executive Director						
	Barnet PCT	Audit Chair	179	3,479	0	4,461
	Enfield PCT	Audit Chair	448	500	446	500
	Haringey PCT	Audit Chair	1	412	0	672
	Islington PCT	Audit Chair	7,313	1,843	0	500
Robert Sumerling - Non-Executive Director						
	Barnet PCT	Non Executive Director	179	3,479	0	4,461
Karen Trew - Non-Executive Director						
	Enfield PCT	Non Executive Director	448	500	446	500
Deborah Fowler - Non-Executive Director						
	Camden & Islington Foundation Trust	Member	49,356	4,231	1,013	2,423
	Enfield PCT	Non Executive Director	448	500	446	500
	UCL Hospital NHS Foundation Trust	Member	120,755	1,107	6,392	157
Caroline Taylor - Chief Executive						
	Barnet PCT	Chief Executive	179	3,479	0	4,461
	Enfield PCT	Chief Executive	448	500	446	500
	Haringey PCT	Chief Executive	1	412	0	672
	Islington PCT	Chief Executive	7,313	1,843	0	500
Marek Koperski - PEC Member						
	James Wigg Practice	GP Principal	772	0	0	316
Quentin Sandifer - Director of Public Health						
	Iplato	Unpaid Former Advisor	52	0	0	0
Daniel Bernstein - CCG Member-Elective GP Representative						
	Dr Daniel Bernstein	GP Principal	18	0	0	0
	The Abbey Medical Centre	GP Principal	11	16	0	0
Caroline Sayer - CCG Chair-Elective GP Representative						
	Haverstock Healthcare	Practice is a Shareholder	66	0	0	0
	Adelaide Road Medical Centre	GP Principal	14	0	0	0
Ammara Hughes - CCG Member-Elective GP Representative						
	Bloomsbury Surgery	GP Principal	3	36	0	29
John Carrier - CCG Member-Lay Member for Camden						
	Barnet PCT	Non Executive Director	179	3,479	0	4,461
	Great Ormond Street Hospital	Council Member	14,313	0	215	0
	North East London NHS Foundation Trust	Interim Chair	158	0	0	22
	UCL Hospital NHS Foundation Trust	Governor	120,755	1,107	6,392	157
	Margaret Pyke Memorial Trust Board	Trustee	67	0	0	65
Nick Losseff - Medical Director						
	UCL Hospital NHS Foundation Trust	Consultant	120,755	1,107	6,392	157
Simone Hensby - CCG Member-VAC						
	Voluntary Action Camden	Executive Director	151	0	0	0

The Department of Health is regarded as a related party. During the year Camden PCT 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.

	£000's		£000's
University College London NHS Foundation Trust	120,755	London Ambulance Service NHS Trust	8,780
Royal Free London NHS Foundation Trust	82,991	Islington PCT	7,313
Camden And Islington NHS Foundation Trust	49,356	Tavistock And Portman NHS Foundation Trust	5,287
Croydon PCT	35,402	Barts Health NHS Trust	3,638
Central And North West London MH NHS Foundation Trust	29,470	Guys And St Thomas NHS Foundation Trust	2,675
Great Ormond Street Hospital for Children NHS FT	14,343	Moorfields Eye Hospital NHS Foundation Trust	1,985
Whittington Hospital NHS Trust	12,750	Barnet, Enfield And Haringey Mental Health Trust	1,668
Imperial College Healthcare NHS Trust	9,624		

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Camden, in respect of joint enterprises.

Related party transactions 2011-12

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities controlled or influenced by them, as being parties related to NHS bodies. Related party transactions are to be disclosed if material to either party.

The table below shows the relationship between Camden PCTs Senior Managers and related parties, ie organisations they control or can influence. The amounts disclosed below are transactions with the related parties and not the individuals.

Name	Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£000's	£000's	£000's	£000's
Deborah Fowler					
	Camden And Islington NHS Foundation Trust	49,298	3,660	2,323	3,246
	University College London Hospitals NHS FT	110,498	322	10,561	322
Joanne Wickens					
	Brondesbury Medical Centre	2,060	-	-	-
John Carrier					
	Great Ormond Street Hospital NHS Trust	13,786	1	663	-
	Margaret Pyke Memorial Trust Board	-	-	-	135
	The Royal College of Physicians	1	-	-	-
	Royal Free Hampstead NHS Trust	85,753	580	4,740	580
	University College London Hospitals NHS FT	110,498	322	10,561	322
Marek Koperski					
	James Wigg Medical Practise	4,736	-	-	1,013,848
Quentin Sandifer					
	iPlato	19	-	-	-
	London Borough of Camden	9,851	2,788	-	451,786
	University College London Hospitals NHS FT	110,498	322	10,561	322
Tom Aslan					
	Dr Tom Aslan	11			
	Havestock Heath	106			
Phil wee					
	General Dental Practice of 102A Cricklewood Broadway. NW2 3EJ	76			
Denise Bavin					
	The Museam Practice	653			

The Department of Health is regarded as a related party. During the year Camden PCT 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.

	£000's
University College London Hospitals NHS Foundation Trust	110,498
Royal Free Hampstead NHS Trust	85,754
Camden And Islington NHS Foundation Trust	49,298
Croydon PCT	32,468
Central And North West London Mental Health NHS Foundation Trust	31,581
Great Ormond Street Hospital NHS Trust	13,787
Whittington Hospital NHS Trust	12,790
Imperial College Healthcare NHS Trust	9,663
London Ambulance Service NHS Trust	8,877
Tavistock And Portman Foundation NHS Trust	4,670
Guy's And St Thomas' NHS Foundation Trust	3,083
London Strategic Health Authority	2,483
Barts and The London NHS Trust	2,189
Moorfields Eye Hospital NHS Foundation Trust	2,059
Chelsea And Westminster Hospital NHS Foundation Trust	1,802
Enfield PCT	1,551

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Camden, in respect of joint enterprises.

Camden PCT operates a charitable fund which is pooled with other NHS organisations under the management of the Central North West London NHS Charitable Fund. A member of staff sits on the Charitable Fund Committee. There were no material transactions with the Fund during the year under review.

27. 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	678,156	70
Special payments - PCT management costs	65,907	2
Total losses	678,156	70
Total special payments	65,907	2
Total losses and special payments	744,063	72

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	10,000	1
Total losses	10,000	1
Total special payments	0	0
Total losses and special payments	10,000	1

Details of cases individually over £250,000

- CAMIDOC North London Care Co-operative: £303,824.39 Bad debt written off, company gone into administration.

Losses - PCT management costs: Relates to debts written off in year by the PCT, after having first exhausted all methods of collection, including referral to a third party debt collection agency. All such write-offs are then the subject of pre-approval by the Audit Committee.

28. Events after the end of the reporting period

The main functions carried out by Camden PCT in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:
NHS Camden Clinical Commissioning Group.
NHS England (NHS Commissioning Board)
NHS Business Services Authority
The London Borough of Camden
Public Health England
NHS Property Services

All assets and liabilities have transferred to receiver organisations as at 1st April 2013.

Fixed asset have been transferred to the following receivers:
NHS Camden Clinical Commissioning Group.
NHS Property Services.
Community Health Partnerships Ltd
Central and North West London NHS Foundation Trust
Camden & Islington NHS Foundation Trust

These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.

Current assets and liabilities to be managed by the local legacy management teams to wind down these balances.

The Department of Health has made detailed arrangements for the transfer of balances (assets / liabilities / contractual commitments) at their recognised carrying value such that there will be no profit or loss arising from this transfer.

Camden PCT has a Transfer Agreement showing the expected destination of these balances but the final details have not yet been confirmed The Department's arrangements ensure that all assets, liabilities and contractual obligations of Camden PCT will be transferred to other bodies that form part of the NHS controlled by the Department of Health.

Camden PCT Annual Governance Statement: April 2012 – March 2013

Scope of Responsibility

I am assured by the former Chief Executive of Camden Primary Care Trust (PCT), who was the Accountable Officer responsible for ensuring the proper stewardship of public funds and assets and who was accountable for the overall performance of the executive functions of the PCT, that the work of ensuring the discharge of obligations under Financial Directions was carried out in line with the requirements of the Accountable Officer Memorandum for PCT Chief Executives issued by the Department of Health.

I am assured by the Accountable Officer that she had carried out her responsibilities which included ensuring the following:

- management systems for safeguarding public funds and assets and assisting in the implementation of corporate governance;
- achieving value for money with the resources available;
- expenditure and income; and
- effective and sound financial management systems.

I am reassured by the former Accountable Officer who was accountable to the Chair and Non-Executive members of the PCT Board for ensuring that its decisions were implemented, that the organisation worked effectively, in accordance with Government policy and public service values, and for the maintenance of proper financial stewardship. Within the Standing Financial Instructions, it was acknowledged that the Chief Executive was ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the PCT Board met its obligation to perform its functions within the available financial resources.

The former Chief Executive asAccountable Officer had overall executive responsibility for the PCT's activities and the achievement of its objectives; responsibility to the Chair and the PCT Board for ensuring that its financial obligations and targets are met; and have overall responsibility for the PCT's system of internal control. The essence of that role as Accountable Officer was to see that the Trust carried out these functions in a way which ensured the proper stewardship of public money and assets. Effective and sound financial management and information are of fundamental importance. I am assured by the former the Accountable Officer that this occurred.

The system of internal control had been in place at Camden PCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

With these assurances from the former Accountable Officer I have signed the Summarised Accounts of Health Bodies in England, and the Resource Accounts of the Department of Health. The Summarised Accounts are derived from the statutory accounts of the PCT. Together with the Director of Finance, the former Accountable

Officer was responsible for ensuring that the accounts of the PCT were prepared under principles and in a format directed by the Secretary of State with the approval of the Treasury. These accounts disclose a true and fair view of the PCT's income and expenditure, and of its state of affairs. These accounts have been signed by the former Director of Finance on behalf of the PCT Board.

Robust arrangements were put in place for the preparation and audit of the accounts of the PCT following closedown of North Central London PCTs as statutory bodies. These arrangements are in line with Department of Health Guidance for financial closedown. A local delivery team was secured to prepare the accounts and a sub-committee of the Department of Health Audit and Risk Committee was established to review the accounts with retained non executive directors, the former Director of Finance, the external and internal auditors and the former Accountable Officer.

The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework Manual issued to NHS Boards by the Secretary of State were fundamental in exercising my responsibilities for regularity, propriety and probity.Every member of the PCT Board had subscribed to these codes which were adopted in April 2011.

In April 2011, the PCT entered into a collaborative arrangement with other PCTs in North Central London and underwent significant structural and organisational change.

The "Cluster" of NHS North Central London was formed of five PCTs: Barnet, Camden, Enfield, Haringey and Islington.

The Strategic Health Authority confirmed the "Cluster" was compliant with Primary Care Trust regulations and Primary Care Trust Cluster Implementation Guidance. The Strategic Health Authority reviewed the Corporate Governance Framework outlining the shared working arrangements that was agreed by the PCT Board in February 2011 and confirmed it as compliant with PCT regulations and PCT Cluster Implementation Guidance.

The Framework was revised in September 2012 to reflect the transitional development of the new system as described in the Health and Social Care Act 2012. A single management team performed its role on behalf of each of the PCTs, who retained their statutory duties and powers. All PCT statutory functions, powers and duties were mapped to ensure that they were aligned to the new cluster management structure. The former Chief Executive of Camden Primary Care Trust (PCT) and Accountable Officer was also the Accountable Officer for the other four PCTs.

In February 2012, Camden CCG received delegated responsibility for all eligible budgets including medicines' management, community services, secondary care services and mental health services.

In December 2012 all Clinical Commissioning Groups were accorded the right to sign contracts from February 2013 through a new Statutory Instrument as part of the Health & Social Care Act 2012.

Camden CCG was authorised on 20 February 2013 with nine conditions which are being addressed through action plans.

The Governance Framework of the Organisation

The Primary Care Trust was a statutory body which came into existence on 1 April 2002 under The Primary Care Trust (Establishment) Order 2002 No 100, (the Establishment Order). The principal place of business of the NHS North Central London Cluster was Stephenson House, 75 Hampstead Road, London, NW1 2PL.

Composition of the Board

The Primary Care Trust (PCT) Board met concurrently with the other four Primary Care Trusts Boards of NHS North Central London. The Chair, Audit Chair, Chief Executive and Director of Finance also fulfilled these roles for the other PCTs within NHS North Central London. The other Non-Executive Directors of each PCThad Non-Executive Director roles in one other PCT within NHS North Central London. This change to the membership arrangements was made permissible by the passing of Statutory Instrument 2010 2539 which removed the disqualification which prevents a person who is a Chair or member of one PCT from being appointed as the Chair or a non-officer member of another PCT.

Each PCT Board also had a Professional Executive Committee (PEC) Chair, PEC Nurse and Director of Public Health as voting members. In the case of the PEC Nurse and Director of Public Health, there was a designated PEC Nurse (Barnet) and Director of Public Health (Islington), who attended on behalf of their peers unless there was specific business relating to an individual. The PCT Cluster-designated PEC Nurse and Director of Public Health were only eligible to vote on decisions for their own PCT Board.

Committees

In line with statutory requirements, the Camden Primary Care Trust (PCT) Board resolved in April 2011 to establish the:

- Audit Committee;
- Professional Executive Committee;
- Remuneration Committee; and
- Primary Care Reference Committee.

The Board also established such other Committees, as required, to discharge the PCT's responsibilities. It resolved to establish the:

- Quality and Safety Committee;
- Financial Recovery and Quality, Innovation, Productivity and Prevention Committee;
- London Specialised Commissioning Group Board; and
- Joint Committee of PCTs for the purposes of formal public consultation and decision making about the provision of Paediatric Cardiac Surgery Services in England.

The PCT Board agreed the terms of reference of these Committees and their delegated powers and responsibilities in April 2011

In September 2011 the PCT Board established the Trust and Charitable Funds Committee to discharge the function of corporate trustee for the funds held on trust as required by the Charities Commission. This Committee ceased to function in November 2012 following the transfer of Camden and Barnet Charitable Funds to new trustees via the Charities Commission.

The PCT Board established the Camden CCG Board as a Committee on 23 March 2012.

The Board's performance

The Chair of the Joint Boards of NHS North Central London conducted a review of the effectiveness of the Board and its Committees in early 2012 and presented the findings of the review at the March 2012 Board meeting. This internal assessment indicated that Board members were satisfied with the working of the Committees and their effectiveness in discharging their delegated responsibilities, and these were seen as an essential part of Board governance. Since the review NHS North Central London continued to embed best practice in governance across all functions.

Highlights of Board Committees' reports

Highlights of the work of key Committees are provided below.

Audit Committees:

- The Audit Committee met concurrently with the Audit Committees of the other PCTs within NHS North Central London. Whilst each Committee had a discrete agenda, shared membership and meeting arrangements further enabled positive assurance across all areas of business.
- The Committee approved the annual accounts, external and internal audit opinions and an Annual Governance Statement for 2011 / 2012 on behalf of Primary Care Trust (PCT) Board for submission to the Department of Health. Legacy and key control issues identified during 2011 / 2012 were factored in to the planning of the internal audit programme for 2012 / 2013.
- The Committee reviewed internal and external audit plans and reports, and sought assurance that recommended actions were completed and that all issues were managed comprehensively. The Committee received reports on counter fraud and security services, and waivers to competitive tender requirements.
- The Committee provided assurance to the PCT Board on areas of governance and risk, providing detailed oversight of the Board Assurance Framework (BAF). Meetings considered specific areas of business in depth to enable substantive assurance through focussed discussion and challenge with Executive officers on their areas of responsibility within the BAF. The Committee looked in detail at risks and assurances on a number of key topics including PCT finance and Quality, Innovation, Productivity and Prevention (QIPP) targets, primary care performance, and quality and safety.

Quality and Safety Committee:

- Clinical Quality Review meetings were established for all services, including acute, mental health and community services.
- The Organisational Intelligence Tool and the quality and safety dashboard provided information on key quality indicators for all providers. The report was a standing agenda item for the Quality and Safety Committee and the Clinical Commissioning Group (CCG) Quality Committees.
- High-level review of quality and safety across mental health and learning disability services was completed; a series of recommendations were made and an action plan agreed.
- Multi-agency working group was established to improve the quality of nursing home service and patient experience in the northern boroughs of NHS North Central London.
- Workshops, shadowing opportunities for CCG staff to prepare for transfer of quality& safety functions and accountability.
- Supporting CCGs introduced Patient Stories to CCG Governing Body meetings to ensure that patient experience sets the context for the business of the meeting.
- Working to improve patient experience with other organisations e.g., the Making a Difference Board at University College London Hospitals NHS Foundation Trust (UCLH) and the implementation of the "walk the pathway" programme led by the Patient Experience Manager involving Local Involvement Networks (LINks) and Non-Executive Directors, including visits to dementia and stroke services.
- Quality summits were held to share intelligence about providers ensuring that early warning systems are in place to improve patient safety.

Financial Recovery and QIPP Committee

The Committee provided a robust mechanism for review and challenge of progress against financial targets for each PCT. This was achieved through oversight of the delivery of savings plans and budgets; review and development of the NHS North Central London QIPP Plan and associated implementation plans; and review and approval of procurements, contracts and investment business cases in line with the Scheme of Delegation.

Highlights from the year include:

- Completion of an alignment process to ensure leadership and ownership of finance and QIPP plans for 2012 / 2013. The Clinical Commissioning Groups (CCGs) were actively engaged in developing QIPP and investment plans achieved through programme management support which was phased over to the CCGs to help the CCGs in their delivery of the programme for 2013/14 Additional resource was given to support the development of local ownership and skills. There was a strong commitment to ensuring that investments were supported by future commissioning plans and that QIPP plans were in place to deliver savings earlier in the financial year going forward. All this could not have been achieved without the enthusiasm and commitment of the CCGs to produce

a QIPP plan that reflected local need understood through direct clinical experience.

- Increased focus on underlying recurrent run rate positions of the PCTs in the Cluster
- Review and monitoring of delivery against action plans for addressing outstanding debtors and creditors including reduced aged debtor day
- Revised terms of reference to include monitoring the legacy, handover and closedown arrangements for the PCT including finance department transition to the new NHS bodies.

Trust and Charitable Funds Committee

- The Committee discharged its delegated responsibilities to make and monitor arrangements for the control and management of the charitable funds for which the PCT Board was Corporate Trustee until November 2012.
- The Committee reviewed and endorsed the 2012 / 2013 annual accounts for submission to the Charities Commission, managed oversight and approval of fund applications and oversaw the programme for the transfer of funds to new Corporate Trustees.
- In November 2012 the transfer of all charitable funds to new Trustees was completed the committee met for a final time and ceased its function.

An account of Corporate Governance

The Primary Care Trust's (PCT) Corporate Governance arrangementswere set out in the Corporate Governance Framework Manual agreed by the Board in April 2011 and revised in September 2012. The Manual included the organisation's Standing Orders, Standing Financial Instructions, Schemes of Reservation & Delegation and Codes of Accountability & Conduct. These arrangements were drawn up in line with:

- The Primary Care Trust (Executive Committees and Standing Financial Instructions) Directions 2007, National Health Service Act 2006; and
- Department of Health PCT Cluster Implementation Guidance (31 January 2011).

The Manual was regularly reviewed and updated throughout the year to take account of changes in the governance environment:

- The creation of new legal entities and their authorisation to undertake delegated responsibilities: Clinical Commissioning Groups (CCG) and NHS England; National Training Development Agency.
- States of readiness through the transition period as organisations become ready to exercise their new responsibilities.

In September 2012, the Corporate Governance Framework Manual was revised to take account of changes in NHS commissioning landscapeand the introduction of London's Interim Operating Plan.

The internal auditors conducted an audit of the PCT's governance as part of the approved internal audit plan for 2012 / 2013. The objective of the review was to provide assurance that there was an appropriate management structure, robust governance arrangements and organisational form to deliver the organisation's objectives. The auditor opinion provided substantial assurance in the design, application and effectiveness of the governance arrangements and the audit report highlighted a number of areas of good practice.

Risk Management and the Control Framework

The Primary Care Trust (PCT) Board approved the NHS North Central London Cluster Risk Management Strategy in December 2011 and the PCT embedded the strategy into practice throughout 2012. The emerging Clinical Commissioning Groups (CCGs) worked within the Strategy throughout 2012 / 2013. The strategy outlined the organisation's approach to risk management, including:

- Identifying committees and groups which hadresponsibility for risk management;
- Roles and responsibilities of staff with regards to risk management;
- The process for identification, assessment and management of risk;
- The process for managing, and Board review of, the Risk Register and Board Assurance Framework; and
- The risk appetite of the organisation, which set out the thresholds for toleration, management and reporting of different orders of risk.

The Risk Management Strategy reflected current best practice, taking into account a range of governance standards.

Risk assessment

Risk assessment is a systematic and effective method of determining the level of risks. All identified risks are assessed using a clearly defined risk assessment matrix by determining the likelihood and consequence of the risk to calculate an overall risk rating. Risks are categorised as low, moderate, high or extreme, and their categorisation informs the organisation's approach to management and monitoring of the risk.

The risk and control framework

The Board Assurance Framework (BAF) and Risk Register assess the effectiveness of systems of internal control and provide assurances that risk management processes are effective. Both are dynamic documents that capture the understanding of the risk environment at any given time. The BAF outlined NHS North Central London Cluster's principal objectives, the risks to achieving those objectives, key controls and assurances, and gaps in controls and assurances. The Risk Register contained a mixture of strategic and operational risks at organisational and directorate level as well as the arrangements in place to mitigate these.

Risks were identified through a variety of ways, including incidents, complaints and claims; committee reports; external assessments and audits; and management reviews. All risks wereassigned a relevant Executive Director who had accountability for overseeing the management of the risk by identifying the most effective means to minimise, transfer or remove it, and ensuring the quality of action plans, controls and assurances. A Lead Officer was also assigned with management responsibility for delivering the action plan, developing robust controls and identifying sources of assurance.

The PCT had a structured approach for the reporting and monitoring of risk. The Joint Boards reviewed the BAF and Extreme Risk Report at every meeting, and risk and BAF are a standing item on all committee agendas. The Senior Leadership Team reviewed the Board Assurance Framework and Risk Register on a monthly basis. The PCT Board also tookassurance from external assessments and audits, and from the work programme of the Audit Committee.

Risk profile

The 2012 / 2013 Board Assurance Framework (BAF) identified the following strategic risks within three Principal Objectives:

1. To ensure we commission services, which are safe, and of increasing quality for the people we serve.

1.1 Transition and the underlying financial position in North Central London may impact on the quality and safety of services.

1.2 Increased alerts received in relation to standards of care in nursing / care homes in particular Barnet, Enfield and Haringey and capacity issues at Borough level could lead to safety / safeguarding concerns for adult resident patients.

1.3 Due to the effect of transition on workforce capacity, recruitment & retention, organisational memory and differing stages of receiving organisations' readiness of quality arrangements –therewasa risk that embedding Quality and Safety in the new health system will not be effective.

2. To deliver the NHS North Central London Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan.

2.1 Sustainable QIPP delivery on the scale and timescales required given the scale of financial challenge; therewasa risk that we do not deliver the transformational change programme needed to bring the health economy back into balance at the required pace – due to:

- Capacity, capability and clinical leadership;
- Pace of delivery; and
- Engagement with providers.

2.2 Following the delegation of responsibility to Clinical Commissioning Groups (CCGs), and during the period of shadow running and transition to March 2013, there was a risk that the cluster could lose its grip on the delivery of QIPP and financial turnaround.

2.3 There was a risk that the CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:

- Capacity and capability of CCGs;
- Ownership of the agenda; and
- Underlying financial position of the Cluster.

2.4 There was a risk of dislocation between or misalignment of different elements of the commissioning system leading to:

- Gaps in delivery;
- Differences in expectations between parts of the system (e.g. Commissioning Support Unit offer does not align to CCG need); and
- Ineffective commissioning partnerships.

2.5 The scale and complexity of forthcoming changes means there was a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.

2.6 There was a risk that ineffective alignment of resources during the transition period (1 October 2012 - 31 March 2013) will impact the delivery of key Cluster objectives and reduces organisational effectiveness.

3. To deliver key organisational objectives and a secure transition to the commissioning landscape in line with the Health and Social Care Act 2012.

3.1 Following the delegation of responsibility to CCGs and during the period of shadow running and transition to March 2013, there was a risk that the Cluster loses grip on the delivery of QIPP and financial turnaround.

3.2 There was risk that the CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:

- Capacity and capability of CCGs;
- Ownership of the agenda; and
- Underlying financial position of the Cluster.

3.3 There was a risk of dislocation between or misalignment of different elements of the commissioning system leading to:

- Gaps in delivery;
- Differences in expectations between parts of the system (e.g. Commissioning Support Unit offer does not align to CCG need); and
- Ineffective commissioning partnerships.

3.4 The scale and complexity of forthcoming changes means there was a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.

3.5 There was a risk that ineffective alignment of resources during the transition period (1 October 2012 - 31 March 2013) will impact the delivery of key Cluster objectives and reduces organisational effectiveness.

4. Other significant risks on the PCT's Risk Register:

4.1 Risks to development of the model underpinning the integrated care strategy could lead to delay. The implementation programme therefore involved key stakeholders including the major acute service providers.

4.2 There was a risk of potential failure to meet the Primary Care Trust's Stop Smoking 4 week quitter target. Robust delivery plans were developed with on-going monitoring of performance.

Review of Effectiveness of Risk Management and Internal Control

The PCT Board and its committees were fully supportive of the risk management process which was scrutinised and challenged as part of the PCT Board, Financial Recovery and QIPP, and Audit Committees functions.

RSM Tenon undertook an audit of the Risk Management and Assurance Framework as part of its audit plan for 2012/13.The final advisory report was issued in October 2012

NHS North Central London Cluster continued to embed the use of their Board Assurance Framework into their routine procedures and this was evidenced by the commitment from the Joint Boards of NHS NCL, Audit Committee and Senior Leadership Team inensuring that this Framework operates as effectively as possible[1].

The RSM Tenon identified the need to keep focus on where risks would be transferred to during transition. As a consequence a revised BAF and Risk Register was received and accepted by the Board in September 2012 which had been reviewed in order to focus and refine the content so that it accurately reflects the main strategic risks for the remainder of the financial year.

Significant Issues in 2012 / 2013

Over the year the PCT Board and its committees considered issues that might have had a prejudicial impact on the corporate objectives, the business plan or the reputation of the NHS locally.

Continuing Care Reviews

The Joint Boards of NHS North Central London Cluster requested a review of continuing care across all PCTs areas in 2012 / 2013. In-year review of action showed a considerable improvement in the level of compliance and paperwork around continuing care commissioning but identified a number of issues in borough teams' performance in 2012 / 2013. This resulted in an amber / red opinion being issued. An action plan was in place to support the improvement across all areas and was closely monitored by the Financial Recovery and QIPP Committee. Continuing care services are complex and high volume. Issues were identified in accounts payable and these highlighted to the

[1] Board Assurance Framework (including Risk Management) 4.12/13 p1

management team particular issues in relation to the control and management of continuing care and funded nursing care. The requirement to manage these services properly was a clinical priority to ensure quality of services, as well as a financial imperative. As a result, Internal Audit was asked to prioritise the audit of continuing care arrangements. A number of weaknesses in control were identified including:

- Quality of care – backlogs in assessment;
- The budget setting process;
- Implementation of service level agreements and contracts for care packages; and
- The adequacy of management information tools to manage and control this complex service.

The management team, including the Director of Quality and Safety, agreed a detailed action plan to close the identified gaps in control and progressed the implementation of internal audit recommendations.

Primary Care Payments

An internal review of the accuracy and authorisation of primary care payments was undertaken in 2012 / 2013.

An action plan was put in place to address a further five medium rated recommendations. The Joint PCT Boards were able to take some assurance at this point that the controls upon which the organisations relied to manage risk were suitably designed, consistently applied and effective.

Transition to new commissioning arrangements in the NHS

The Joint Boards agreed the NHS North Central London Cluster Transition Plan in December 2011. Detailed function led work streams have supported this high-level plan in 2012.

A sub-committee of the Joint Boards was established in December 2013 building on the working group that had led the implementation of the action plan and monitored the delivery in line with national policy and guidance.

The organisation agreed and handed over functions in January 2013 to nominated legal receivers: NHS England (formerly the NHS Commissioning Board (London)), Clinical Commissioning Groups, Local Authorities, NHS Property Services and Public Health England.

General assets and liabilities were also transferred after dialogue with nominated receivers.

Property and leases transferred to NHS Property Services in most cases, some buildings were transferred to Foundation Trusts when identified as most the appropriate receiver.

A Statutory Instrument was approved by Parliament giving NHS England and Clinical Commissioning Groups powers to enter into contracts from the 1 February 2013.

NHS England (formerly the NHS Commissioning Board (London)) entered full operating mode on 7 January 2013 following transfer of functions from PCTs.

National Priorities set out in the NHS Operating Framework: Improving performance in Camden 2012/2013

Acute Measures

Waiting times in A&E

Acute performance for Camden PCT patients focused on Royal Free and UCLH. Performance under the A&E four hour maximum waiting time target for both Trusts was strong throughout the first two quarters of 2012 / 2013. However, autumn and winter of 2012 / 2013 proved more challenging than the previous year. During November and December 2013 outbreaks of Norovirus resulted in 236 bed closures at UCLH. The allocation of winter funding to both Trusts aimed to support whole-system resilience plans.

Referral-to treatment times

At a PCT level Camden's performance against all referral to treatment standards remained strong throughout the year, consistently achieving the admitted, non-admitted and incomplete pathways standards. At a provider level both Royal Free and UCLH achieved all three standards throughout 2012 / 2013 to date.

Cancer waiting times' targets met

At a PCT level Camden sustained achievement of most of the cancer waiting time targets during 2012 / 2013. North Central London continued intensive monitoring and analysis of trusts who fail these standards to ensure plans remain focused on turnaround and sustainability of performance.

Access to Stroke Services

There was excellent performance against the national measures for stroke services with Camden PCT exceeding the 80% threshold for time on a stroke unit and also achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours. Higher activity volumes and sustained performance shows that more people are accessing the right service within Camden for stroke.

Access to Diagnostics

Up until November 2012, Camden PCT maintained performance within the tolerance level of less than 1% of patients waiting longer than six weeks for a diagnostic test. However in November 2012 Camden's performance reached 2.1% which was the result of underperformance at UCLH. The high volume of breaches at UCLH was the result of staff and capacity shortages. North Central London's Performance Team continues to work closely with UCLH to ensure that recovery plans are robust, a sustained reduction in outstanding volumes was delivered and a satisfactory level of performance regained.

Access to Single Sex Accommodation

Patient privacy and dignity remain high on the NHS agenda with a zero tolerance against mixed sex accommodation. The execution of plans to deliver this target was challenging for providers as set within a context of quality and efficiency drives that have reduced their overall beds numbers. Camden PCT had reported compliance with the zero tolerance standard since August 2012.

Non-acute Performance Update

Access to screening services

Diabetic Retinopathy

All boroughs continued to excel against the target of 95% for diabetic retinopathy screening and this will be further enhanced by the recent commissioning of the UCLH site and new referral pathways that are scheduled for implementation from 1 April 2013.

Cancer Screening

The coverage of cervical screening over the first nine months of the year generally mirrored that of last year. Camden showed a slight drop in performance at 66.9%. Work continued to raise awareness and identify exclusions such as women who have received total hysterectomy. The turnaround time of cervical screening results continued to be good with Camden achieving the 98% threshold since June 2012.

Despite continued underperformance across NCL for bowel screening Camden increased to 42.6% from 39.52% over 2011/12 against the 60% standard. For breast cancer screening Camden had the lowest percentage coverage within North Central

London of 61.68% but had implemented robust actions throughout the year to improve this.

NHS Health Checks

Increased offering and take-up of NHS health checks supports the reduction in health inequalities by identifying and addressing health needs in previously undiagnosed people.

Camden PCT exceeded its year to date plan for health checks offered and uptake with 10,800 health checks offered in 2012 / 2013 and 3,500 checks delivered so far in 2012 / 2013.

Early Access to Maternity Care

Improving healthier outcomes for babies and children was one of the priorities for NHS North Central London and closely aligned to women accessing maternity care before 12 completed weeks of pregnancy. Camden was the only PCT within North Central London to achieve the 90% standard with the majority of Camden women accessing maternity services at UCLH and the Royal Free.

Childhood Immunisations Coverage

2012 / 2013 was a successful year for Camden PCT in its childhood immunisation coverage in particular for the five year vaccines where coverage increased by over 4%. In 2012 / 2013 Camden introduced a catch-up programme involving immunisation nurse sessions to vaccinate children who have missed their planned date. This also provided administrative support to check that children included on practice lists exist and that practice records and immunisations were up to date.

Financial Recovery

There was a clear difference in the financial health between the north (Barnet, Enfield and Haringey) and south (Camden and Islington) of the North Central London Cluster over recent years. The financial strategy was focussed on transformational change across the whole £2.5 billion portfolio with programmes to rebalance the health economy in the patch, without destabilising hospitals. The financial plan for 2012/13 was the second in an original three yearprogramme to return all five PCTs to financial stability on a recurrent basis. By exception the Department of Health agreed deficit plans for Barnet, Enfield and Haringey PCTs at the start of the year. In year revised plans were agreed resulting in all five PCTs delivering a surplus income and expenditure position. Camden and Islington PCTs had a history of financial stability, underpinned by well funded, sound community and primary care provision, and planned to deliver a healthy surplus.

During 2012/13 there was a continuation of the previous years' programme of financial recovery and turnaround including identification, development and delivery of QIPP plans in year and looking forward to the future clinical commissioning groups. All five PCTs over-delivered against agreed budgets. Camden PCT and Islington PCT exit in recurrent run rate surplus and Barnet PCT, Enfield PCT and Haringey PCT improved their respective run rate positions. Delivery of this programme was and remains

fundamental to ensuring the financial resilience of the future commissioning organisations.

Review of Quality and Safety

As a result of a review of quality and safety in 2011 which found that services were of a generally high quality and safe; improvement trajectories were agreed in 2012 with providers. Implementation and performance was monitored through the Clinical Quality Review Groups. These recommendations have been worked on throughout 2012 and now:

- Organisational Intelligence Tool quality and safety dashboard embedded for key indicators for all providers. The report was a standing agenda item for the Quality & Safety Committee and the CCG quality committees;
- Multi-agency Working Group established to continue to improve quality of nursing home service and patient experience in the northern boroughs of NHS North Central London; and

Continuing care services are complex and high volume. The issues in accounts payable highlighted to the management team particular issues in relation to the control and management of continuing care and funded nursing care. The requirement to manage these services properly was a clinical priority to ensure quality of services, as well as a financial imperative. As a result, Internal Audit was asked to prioritise the audit of continuing care arrangements. A number of weaknesses in control were identified including:

- Quality of care – backlogs in assessment;
- The budget setting process;
- Implementation of service level agreements and contracts for care packages; and
- The adequacy of management information tools to manage and control this complex service.

The management team, including the Director of Quality and Safety, agreed a detailed action plan to close the identified gaps in control and was progressing the implementation of internal audit recommendations.

There were no significant areas of slippage at the time of this annual report.

Data Loss Incidents

There have been no data loss incidents in Camden Primary Care Trust in 2012 / 2013.

Primary Care Strategy

2012/13 had been the first year of implementing the three-year strategy 'Transforming Primary Care'. There had been progress in all the work streams including the development of networks, service improvements focusing on improving access, the delivery of care closer to home including the development of integrated care. The enabling work streams of Information Management & Technology and premises have made significant progress this year. The one area of workforce development had

proved challenging in the first year. There was a plan to spend a full year budget of £12m in Year 1, of the £47.7m identified over three years.

The majority of the budget was spent but there was an element of underspend due to time to engage fully at a local level, delay in approvals processes across the system and delay in time to implement some of the schemes in the year of CCG authorisation.

Plans for the remaining two years of the implementation of the strategy were that the five Clinical Commissioning Groups would lead the implementation locally and ensure that all developments werein line with local strategies whilst being committed to the overall ambition of the initial strategy adopted by NHS North Central London in January 2012.

Clinical Commissioning Groups (CCGs)

- All five CCGs in North Central London successfully secured delegated responsibility for all eligible budgets within agreed timeframes
- All five CCGs in North Central London submitted authorisation documentation within agreed national timeframes
- Positive external assurance was received from NHS London on the progress of CCGs' authorisation
- CCGs' Integrated Performance management approach in place – CCGs demonstrating leadership and financial management through monthly Integrated Performance Meetings
- Positive assurance received through internal audit of CCGs development activity, management and support given by NHS North Central London PCTs.

Hosted organisations

The Primary Care Trust was host to:

- London Health Programmes (LHP):
- North Central London Cardiac & Stroke Network; and
- Camden Public Health Provider Services

London Health Programmes will transfer to either NHS England (formerly the NHS Commissioning Board) or to Public Health England; although many of its current functions will cease on 31 March 2013. The transfer of staff and assets and liabilities followed the Department of Health's Transfer Scheme guidance following agreement by all partner organisations.

For LHP the hosting arrangements are documented formally in Establishment and Hosting Agreements, and the Audit Committee reviewed a mapping process of LHP hosting arrangements in September

North Central London Cardiac & Stroke Network functions transferred to NHS England.

Public Health Providers Services functional transfer to Camden Local Authority was being progressed in January 2013. The service followed the Department of Health Transfer Schemes guidance in respect of staff and assets and liabilities.

The network was integrated into the management structure of the Cluster. Both these organisations follow the governance and assurance processes of the host. In the reporting year, all employees of the hosted bodies were consulted prior to transferring to Islington PCT as host employer.

Organisation: Camden Primary Care Trust

Peter Coates, Director of PICD, Strategy, Finance and NHS, Department of Health

Signature: .....

Date: 5th June 2013