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Greenwich Teaching Primary Care Trust

2012-13 Annual Report and Accounts

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Greenwich Teaching Primary Care Trust

2012-13 Annual Report

Greenwich Teaching Primary Care Trust Annual Report 2012/13

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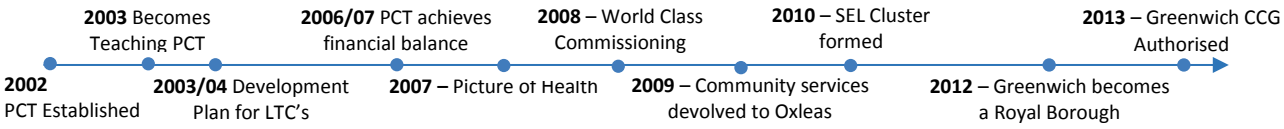
1. WELCOME

Welcome to the NHS Greenwich Teaching Primary Care Trust (PCT) annual report for 2012/2013, a year in which there has been significant change in the NHS as a result of the Health and Social Care Act (2012). This will be our final annual report as a PCT, which, along with all other PCTs and Strategic Health Authorities in England, will close down on the 31st of March 2013. From the 1st of April 2013 a number of successor organisations will take on statutory responsibilities for commissioning including NHS Greenwich Clinical Commissioning Group whose development has been one of the focal points of the past year.

As we look back over the past ten years, during which the PCT has worked to improve the health and wellbeing of people who live in, work in, or visit Greenwich, there are many achievements worth celebrating:

- Average life expectancy has increased by more than 3 years
- Premature mortality (<75yrs) from Cardiovascular Disease has decreased by 37%
- Premature mortality (<75yrs) from Cancer has decreased by 15%
- Establishment of out of hours GP services and an Urgent Care Centre at Queen Elizabeth Hospital
- Establishment of integrated services (community, hospital, and social care) which have improved care for patients with long term conditions such as diabetes

We have taken the PCT from running a deficit of nearly 14% in 2002 to generating a 1% surplus in 2012/13 and this has been done primarily through investments in community health and prevention programmes which have helped to reduce the use of emergency hospital services, particularly for long term conditions, where patients can be better managed in their homes or communities. Our innovative approach to service development has been recognised nationally with prestigious awards such as the Health Service Journal 'winner of winners' award given by the Secretary of State for Health in 2011 for our integrated community services. Below is a timeline of key milestones in the life of the PCT:



As of February 2013 NHS Greenwich Clinical Commissioning Group has been authorised by the National Commissioning Board, and from April 2013 it will take on responsibility for a commissioning budget of £342 million. In addition, some duties formerly undertaken by the PCT will transition to new organisations including the transfer of public health to the Local Authority and commissioning of primary care (GP services) and specialist services to the National Commissioning Board.

NHS Greenwich Clinical Commissioning Group's authorisation is testament to the efforts of our staff, many of whom will transfer to the new Clinical Commissioning Group and have been working with it in shadow form (running in tandem with the PCT) over the past year. During this time we have developed the roles of GPs as clinical commissioners and they have been instrumental in bringing about improvements across our portfolio of contracts.

In 2012/13, the PCT (and CCG in shadow form) delivered a number of improvements for patients including the following:

- Greenwich was one of the top commissioners in England for avoiding unplanned admissions to hospital
- Our Falls Team pilot was shortlisted for a 2012 NHS Innovations award for the work they have done to reduce falls related hospital attendances, care home admissions, falls rates, and falls related injuries.
- Our End of life care project is one of only two pilots nationally to coordinate community and hospice services and to quickly provide the appropriate resources, and 24 hour a day 7 day a week support, to enable people at the end of their live their remaining days in their preferred care setting (including in their home) with the right level of care.

In addition to these achievements 2012 was a time of great celebration with Greenwich hosting 6 Olympic sporting events in three venues (Greenwich Park, the North Greenwich Arena, and the Royal Artillery Barracks) and Greenwich PCT, as part of the NHS South East London Olympic Business Planning and Assurance Group, helped to coordinate healthcare personnel and resources to ensure emergency preparedness and the wellbeing of athletes, spectators and supporting staff and volunteers. Not only were the games a tremendous boost to the local economy, they will also leave a lasting legacy for Greenwich which will make a real difference to the health and wellbeing of our community and includes:

- Development of three new skills centres
- Acceleration of the Royal Borough's regeneration programmes, with public realm improvements in Greenwich and Woolwich
- Investments in sport facilities including £6.5m on community sports facilities at Crown Woods College and Thomas Tallis School and a £3m sports hub in Hornfair Park
- A £4.8m 'playground to podium' programme to provide new sports facilities

Many hard working and talented individuals have been involved in our progress over the last ten years. We would like take this opportunity to thank all our staff both past and present, local clinicians, partners and the public, all of whom have contributed in our ambitious work to reduce health inequalities and improve the health and wellbeing of our local population.

2. WHAT WE DO

Greenwich Teaching PCT is responsible for improving the health and wellbeing of people, who live, work in or visit the borough. Working with our partners in the local NHS - GPs, pharmacists, dentists, hospitals and mental health providers – and other borough partners (such as the Royal Borough of Greenwich and local voluntary and community groups) we seek to protect and improve health and wellbeing and reduce health inequalities, ensuring everyone has equal access to healthcare services. We are responsible for assessing the healthcare needs of the borough and then for arranging and paying for health and care services to meet those needs (we call this 'commissioning').

3. HEALTH AND WELLBEING IN GREENWICH

3.1 The population of Greenwich

Greenwich is a borough of great contrasts, shaped by a history of social and economic change, including industrial decline, unemployment and migration. It is a magnet for tourists from around

the world, with internationally-renowned sites such as the Royal Observatory, the Cutty Sark and the O2 Arena. Alongside these iconic sites and areas of relative affluence Greenwich is mainly a borough with significant deprivation and this can be seen in records dating back to the early 1800s. There is a significant amount of regeneration in the borough, with major housing developments underway. As part of the Diamond Jubilee Year celebrations in 2012, Greenwich was made a Royal Borough, joining just three other such boroughs in the country.

Greenwich is an outer London borough, on the south bank of the Thames. Its neighbouring boroughs are Lewisham to the west, Bexley to the east and Bromley to the south. It has some eight miles of river frontage (the longest of any borough in London), and significant areas of green and open space (approximately 15% of the total area).

Greenwich is an ethnically diverse inner London borough with high levels of deprivation, inequalities and unemployment. Greenwich is the 19th most deprived local authority in England out of 326 local authorities.

There are approximately 254,600 residents in Greenwich in (census 2012). There were 274,951 people registered with Greenwich GPs, of which 260,385 (95 per cent) are Greenwich residents. Five per cent of Greenwich's registered population resides in neighbouring boroughs. Similarly some Greenwich residents (10.1 per cent) are registered with GPs elsewhere, most commonly in Bexley and Lewisham.

Greenwich has a mobile population with estimates that as many as 18 per cent of people move in and out of the borough each year. Predictions are that Greenwich will experience the largest population increase of any borough in south east London, with a 13 per cent growth over the next five years. Predictions also indicate that Greenwich will experience the biggest increase in births, with an 11 per cent increase during 2011 to 2016.

All of these factors place a greater demand on health services. Other factors include:

- 67 per cent of Greenwich's population is estimated to be aged between 15 and 64 years (160,900 people), while 51,500 (21 per cent) are under the age of 15, and 28,950 (12 per cent) are aged 65 and over
- 33.8 per cent of the population are from a black and ethnic minority background
- 51,229 people smoke
- 34,221 regularly binge drink (men drank more than eight units on their heaviest day in the past week, women more than six units)
- 29,570 adults are obese
- between 2006 and 2010 there was a 12.5 per cent fall in the rate (adjusted for age) of deaths from cancers, a 23 per cent fall in circulatory disease, no significant change in respiratory deaths, a 44.2 per cent fall in chronic liver disease, and a 43.6 per cent increase in deaths where diabetes was a contributing factor. There was a 39.3 per cent fall in deaths from suicide and undetermined intent between 2006 and 2009 (the most recent year where complete data is available).

3.2 Health inequalities

Greenwich residents are living longer than they did 10 years ago. Compared to 1997 – 1998, the gap in life expectancy between Greenwich and England has reduced for men and remained similar for women.

Male life expectancy in Greenwich was 76.7 years in 2008 – 2010, an increase of 3.4 years

since 1996 - 1998. Recent local data suggests that male life expectancy has increased by 0.5 years to 77.2 years. For males the gap in life expectancy between Greenwich and England was 1.88 years in 2008 – 2010, down from 2.75 years in 2005 - 2007 (a 31.6 per cent reduction).

Female life expectancy in Greenwich was 81.9 years in 2008 - 2010, an increase of 3.2 years since 1996 – 1998. Recent local data suggests that female life expectancy has increased by 0.4 years to 82.3 years. For females the gap in life expectancy between Greenwich and England was 0.8 years in 2008 - 2010, an increase from 0.4 years in 2007 – 2010. However there has been a sustained reduction in the gap since 2003 - 2005 when it was 0.94 years (a fall of 14.9 per cent).

Infant mortality rate declined steadily from 6.8 per 1,000 live births in 2001 - 2003 to 4.4 per 1,000 live births in 2007 – 2009. This is just below England's infant mortality rate of 4.7 per 1,000 live births.

The Joint Strategic Needs Assessment identifies the following 10 major causes of ill health and 7 main disorders:

10 Major Causes of Ill Health	7 Main Disorders
Smoking	Cardiovascular disease
Alcohol	Cancers
High blood pressure	Respiratory disorders
Physical inactivity	Mental Health
Diet	Falls and fractures in older adults
Commissioning & service issues	Alcohol related harm
40% most deprived populations	Diabetes
Social isolation	
Anti-social behaviour	
New populations	

This assessment has informed Greenwich PCT's aims and strategic goals.

We aim to:

- secure the best possible health and care services
- reduce health inequalities and improve health outcomes in primary care and community settings when possible, and in hospital when necessary.

Our strategic goals are:

- **staying healthy and health protection** – tackling root causes and risk factors, screening, immunisations, healthy start in life, and sexual health
- **a whole system approach for children and young people focusing on prevention and developing integrated care pathways and services** – improving outcomes of pregnancy for mother and baby, children with additional needs and long term conditions
- **improve mental health care** – alcohol, mental wellbeing services for people with mental health problems including dementia
- **improve long term conditions care** – cardiovascular disease, musculoskeletal health (falls), respiratory health, diabetes
- **co-ordinate the provision of urgent care and out of hours care** – reducing A&E

attendances and emergency admissions, reducing winter deaths

- **increase capacity in high quality cost effective alternatives to hospital based planned care** – community hospital model, community cardiology, Referral Management and Booking Service
- **enhance end of life care** – evaluation and tendering of integrated model, implementation of best practice pathways.

The progress we make in these areas will help us to improve health and wellbeing and to reduce health inequalities. But we also know that we must continue to deliver a programme of radical service transformation to realise these ambitions, particularly in the context of increasing need for healthcare and the difficult financial environment.

Our local plans identify our key health goals and associated outcome measures which we believe will, if achieved, have the biggest impact on the health of people in Greenwich. Our health goals and the specific interventions to support their delivery were determined through a systematic process of prioritisation, working with Greenwich stakeholders.

4 HEALTH SERVICES IN GREENWICH

In 2012/13 we spent £503.7m to commission health services, using funds we receive from the Department of Health. In this report we show how we spent this money on behalf of Greenwich's communities.

The vast majority of people using the NHS in Greenwich will use primary and community health services. We commission these services from:

- GPs, pharmacists, opticians and dentists;
- community services, provided by Oxleas NHS Foundation Trust, such as district and school nursing, health visiting, specialist child health, therapy services and care for older people.
- GP Practices - 44
- Dental practices - 40
- Community pharmacies - 57
- Opticians – 18

For people who require secondary or more specialist care, we also commission:

- South London Healthcare NHS Trust (a hospital trust) to provide inpatient, outpatient, day and emergency care; and
- Specialist services from a range of acute hospitals including Guy's and St Thomas' and King's College Hospital.
- Oxleas NHS Foundation Trust (a mental health trust) to provide mental health services.
- Oxleas NHS Foundation Trust also provides mental health services including Time to Talk, which is a counselling service
- Greenwich Healthy Living Service (GHLIS) to provide services such as support to stop smoking, physical activity, expert patient programme, mental wellbeing services
- Harmoni for Health to provide health services for prisoners at HMP Belmarsh and HMP YOI Isis

- Bexley and Greenwich Community Hospice to provide services to people in the last year of life.

Historically, learning disabilities services were also provided by the PCT. However, over the past five years Greenwich PCT has been working with the London Borough of Greenwich to re-design the commissioning and provision arrangements for learning disabilities clients, and this is now complete.

4.1 The Changing Nature of the NHS Landscape in South East London

4.1.1 Trust Special Administrator

In July 2012 a Trust Special Administrator (TSA) was appointed to South London Healthcare NHS Trust by the Secretary of State for Health to resolve the significant and worsening financial situation and create a sustainable health service in South East London. All of the commissioners in South East London along with members of the public and a number of other organisations replied to the public consultation held during November and December. During the consultation residents expressed concerns, particularly with respect to the proposed downgrading of Lewisham Hospital's A&E department. On February 1st the Secretary of State for Health accepted the TSA recommendations but maintained a consultant led A&E unit at Lewisham Hospital.

Subject to judicial review, the changes approved by the Secretary of State will begin to take effect in the coming year. For Greenwich residents this will mean that Queen Elizabeth Hospital in Woolwich will merge with Lewisham Healthcare NHS Trust but will maintain all of its services. Throughout the transition we will continue to work closely alongside commissioners and providers (including South London Healthcare NHS Trust) in South East London to ensure that we achieve the best possible outcomes for Greenwich residents.

A small number of residents who would normally have given birth at Lewisham Hospital or who would have attended Lewisham A&E may be diverted or transferred to an appropriate maternity unit or A&E. Such a system already exists, for example, to treat stroke patients in hyper acute stroke units at King's Hospital and the Princess Royal University Hospital and it is worth noting that these changes are in line with new clinical standards to increase the safety of A&E and Maternity units and have been designed to save lives.

4.1.1 Health and Wellbeing Boards

Local Health and Wellbeing Boards have been establish as forums where key leaders from the health and care system work together to improve the health and wellbeing of their local populations to reduce health inequalities. The boards play a key part to ensuring stronger democratic legitimacy and involvement, strengthening working relationships between health and social care, and encouraging the development of more integrated commissioning of services.

In Greenwich, a Shadow Health and Social Care Board is in place which will become the Health and Wellbeing Board. A development programme is supporting a smooth transition to the new board arrangements.

We have a range of joint commissioning arrangements between Greenwich Clinical Commissioning Committee and the Royal Borough of Greenwich and the Health and Wellbeing Board will play a key role in developing integrated approaches in the future. All parties have signed up to the joint Health and Wellbeing Strategy for the NHS and the local authority. Implementation of the strategy is co-ordinated by a senior officer group jointly chaired by a GP commissioner and the Royal Borough of Greenwich cabinet member for Health and Adult Services.

4.1.3 Other New National and Local Health Bodies

In addition to Health and Wellbeing Boards a number of National and Local organisations have been established as a result of the Health and Social Care Act (2012). As previously mentioned, the National Commissioning Board and its local office in London will take on commissioning responsibility for primary care services from the PCT and the commissioning of specialised services such as cancer care. Public health will be partly undertaken by the Local Authority, but a new national body, Public Health England, will be responsible for protecting and improving the nation's health and wellbeing, and reducing inequalities. Health Education England will be responsible for commissioning education for NHS employees including medical education and training and will be locally managed by a Local Education and Training Board for South London. Healthwatch England will be the new, independent consumer champion for health and social care whose job it is to argue for the consumer interest of all those who use health and social care services, Healthwatch England will be supported locally by the Greenwich Local Involvement Network (LINk). Finally Clinical Senates have been established on a regional basis to help Clinical Commissioning Groups, Health and Wellbeing Boards and the NHS Commissioning Board to make the best decisions about healthcare for local populations (London wide) by providing strategic advice and leadership.

5. COMMISSIONING HEALTHCARE

5.1 Clinical Commissioning

Since April 2011 the Greenwich Clinical Commissioning Committee, as a committee of the PCT board, has had responsibility for overseeing all commissioned services for the population of Greenwich in terms of cost, quality and performance and has had responsibility for all those aspects of health commissioning that will fall within the remit of Clinical Commissioning Groups. PCT non-executive directors Jeremy Fraser and Susan Free also sat on the committee. Clinical commissioners have already helped to add value across the commissioning portfolio and to drive improvements in patient care, safety, and productivity.

Committee members membership is currently drawn from Greenwich practices through selection and election. Committee meetings were held in public and details are available at www.selondon.nhs.uk.

Listed below are the clinical leads in Greenwich for 2012/13:

- Dr. Hany Wabha, St Mark's Medical Centre (Chair)
- Dr. Eugenia Lee, Gallions Reach Health Centre
- Dr. Rebecca Rosen, Ferry View Health Centre
- Dr. Nayan Patel, The Blackheath Standard Surgery
- Dr. Junaid Bajwa, Conway Medical Centre
- Dr. Niraj Patel, Thamesmead Medical Associates (part year)
- Dr. Ram Aggarwal, Plumstead Health Centre (part year)
- Dr. Robert Hughes (part year)

In addition, the following lay representatives sat on the committee:

- Dr. Greg Usher, The Metro Centre
- Yemi Osho (Nurse)
- Tan Vandal (Secondary Care Doctor)
- Jim Wintour

Annabel Burn as Chief Officer, and Chris Costa as Chief Financial Officer also sat on the committee. Non-voting members of the committee also included:

- Simon Hall, Director of Integrated Commissioning
- Nicola Havutcu, Director of Integrated Governance
- Dr. Hilary Guite, Director of Public Health
- Steve Whiteman, Acting Director for Public Health
- Councillor John Fahy, Cabinet Member for Health, Adults and Older Peoples' Services

Specifically, with respect to our key areas of commissioning responsibility, the following developments have helped us to realise our strategic objectives in 2012/13:

Staying Healthy and Health Protection - A number of services have been funded in collaboration with the local authority to tackle public health issues, focused particularly on the areas of greatest need in Greenwich. Smoking cessation was a particular area of focus, as was tackling obesity, providing dietary advice and promoting physical activity. Thousands of Greenwich residents have also now received health checks. Targeted specifically at those in high risk groups, these health checks help to identify people at risk of suffering from long term conditions such as diabetes and cardiovascular disease.

A whole system approach for children and young people - In 2012/13 we began a strategic review of mental health services for Children and Young People which focused on greater continuity of care, improving relationships between families and services and focusing attention on prevention and intervention earlier in the patient pathway. Since the completion of the review we have agreed to fund a pilot to deliver an enhanced community service. This model will provide a platform to meet the needs of children and young people before their needs become acute and then present in crisis with high risk behaviours and in need of hospital admission. In addition, a Children's Joint Commissioner was appointed with the Local Authority to continue to improve joint working and to support the repatriation of looked after children back to Greenwich local services. We have also supported Oxleas as a pathfinder for establishment of a Children's IAPT (Improving Access to Psychological Therapies) service

Improving mental health care - Over the past year we have collaborated with the local authority in the appointment of a Service User Coordinator who has increased representation from service users and introduced a service user involvement programme to allow for greater user involvement in the planning and commissioning of mental health services. We have also adopted a Shared Care Model of service delivery which has helped to create a more holistic assessment of mental health service users' needs including their physical health. Further development of the Greenwich talking therapies service (Greenwich Time to Talk) has seen significant increases in self-referrals (70%+) and good recovery rates at 47% compared to a London average of 40%.

Improving long term conditions care - Greenwich PCT has a number of projects aimed at improving and integrating services for patients with long term conditions. New pathways for Chronic Obstructive Pulmonary Disorder, Musculoskeletal Health (including arthritis), and Falls were implemented in 2012/13 and have helped to reduce unnecessary A&E visits and admissions to

hospital. Our work with Diabetes has seen a major shift of care into the community, providing services closer to people's homes whilst maintaining the quality and safety of the service. New services were also launched to help identify and minimise alcoholism and to provide in-reach for the elderly population living in care homes.

Co-ordinating the provision of urgent care and out of hours care - The urgent care centre at Queen Elizabeth Hospital has moved into a new location allowing for a greater number of patients to be seen from 8am to 10pm, 7 days a week.

Increasing capacity in high quality cost effective alternatives to hospital based planned care - In 2012/13 we delivered a number of services that have historically been done in hospital in the community, either as part of our community health contract with Oxleas or by tendering contracts through the use of 'Any Qualified Providers' including private sector health providers. These services include orthodontics, minor oral surgery, dermatology, gynaecology, ophthalmology, and minor surgery which are now delivered across a number of providers, offering greater choice for patients, improved access and better value for money.

Enhancing end of life care - In the past year we commissioned integrated services designed around the needs and wishes of patients in their last year of life to ensure that the right equipment, support, and care is available to enable people at the end of their lives to live their remaining days in their preferred care setting (including in their home) with the right level of care.

In addition to our local priorities, services have also been commissioned in line with national priorities including the following:

Dementia and care of Older People

In 2012/13 the Memory Assessment Service commissioned through Oxleas has increased the number of diagnostic assessments for dementia and it is estimated that 53% of the predicted number of people with dementia in Greenwich have been diagnosed (this compared to a national average of 46%). We have also worked with providers, particularly A&E departments, wards, and residential and nursing homes to increase awareness of dementia. As previously mentioned, our Finding the Vulnerable programme involves the commissioning of a healthy ageing workstream to help keep seniors independent and healthy as long as possible as well as a care homes programme to provide in-reach into care homes and to reduce the number of admissions to hospital.

Carers

A joint strategy for carers is in place with the Royal Borough of Greenwich and this has been updated in the last year, for example, to look at the use of Personal Health Budgets as a pilot in Greenwich (one of five nationally). In addition, a carers budget was put in place in April 2012 to support Carers' breaks. All of this is to recognise the huge contribution of carers to healthcare and the sometimes detrimental impact that caring for loved ones has in terms of health, and the personal and work lives of carers.

Safeguarding Adults and Children

We fulfil our role for safeguarding adults and children through a variety of assurance measures. A lead nurse for safeguarding adults is in place. A designated doctor and designated nurse for safeguarding children are in place. In addition, leads for adults and children's safeguarding were identified within the membership of the Greenwich Clinical Commissioning Committee. Regular review meetings take place and are attended by the lead clinicians in which we seek assurance from providers that they are regularly reviewing their compliance with standards. Any breaches to

standards are investigated to ensure that lessons learned are translated into changes in practice. In addition training and education for staff and for GP practices is delivered on a monthly basis.

Prison Health
Health services were commissioned to meet the health needs of the prison population in Greenwich, and delivered in H.M.P. Belmarsh, HMP/YOI Isis and HMP Thameside. This was undertaken in collaboration with prison management and overseen by a Prison Health Partnership Board which included key stakeholders with an interest in offender management to contribute towards reducing offending. Offender Health services will be commissioned by the National Commissioning Board (NHS England).

NHS 111
NHS 111 was rolled out in 2012/13 as a single point of call for non-emergency health advice. The South East London 111 pilot was the largest pilot of its kind in London, including GP clinical assessment. This new service is a critical component of our out of hospital strategy in that it ensures that proper advice is delivered which can reduce ambulance calls and unscheduled admissions and that when further diagnosis and treatment are required that the most appropriate services (GPs, Urgent Care Centres, Walk in Centres, or A&E) are accessed.

6. IMPROVING QUALITY AND PERFORMANCE

6.1 Quality

During 12/13, Greenwich Teaching PCT strengthened its quality processes to monitor key fundamental quality standards and put in place mechanisms to ensure they were being met across the provider landscape. Additionally, it formally monitored quality of services through the following:

Quality Sub Committee: The key aim of this committee is to assure itself of the quality of services delivered to patients in Greenwich which would in turn inform future commissioning of services (service redesign, procurement and contract management). The QSC reported into the Joint Integrated Governance Committee Bexley, Bromley and Greenwich (BBG) which was responsible for reviewing quality across South East London. The focus of the QSC falls into three main dimensions:

- patient experience
- patient safety
- clinical effectiveness

Assurance from these dimensions provides sufficient focus to the oversight of quality and is used as a driver to undertake more detailed work. In addition, monitoring of quality issues ensures that the Greenwich Clinical Commissioning Committee (GCCG) kept abreast of, managed and monitored key processes and procedures to ensure all commissioning activity and key actions were delivered accordingly.

Clinical Quality Review Group: Quality of care by our main providers, South London Healthcare Trust and Oxleas Foundation Trust (Mental Health and Community Services) are monitored though separate Quality Review Groups held monthly. The SLHT Clinical Quality Review Group is made up of representation by key commissioners (Greenwich, Bexley and Bromley) who seek assurance that fundamental quality indicators and ensures its acts as a driver for ensuring quality improvement where needed. The use of soft intelligence has been made use of as a means to drill down on potential quality issues. Such intelligence has included the following:

- GP Alerts
- Complaints
- PALs issues

By triangulating the above with quality key performance data, the PCT has been able to focus on improvements in specific areas, e.g. pressure ulcer management and reduction of incidence and reduction in falls.

6.2 Quality, Innovation, Productivity and Prevention (QIPP)

Greenwich Teaching PCT and the shadow NHS Greenwich Clinical Commissioning Group have made significant improvements to patient care by commissioning new services redesigned around patient needs (for example by delivering integrated care in a patient's home) and in line with international clinical best practice. One of the ways in which we make improvements is through our Quality, Innovation, Productivity, and Prevention (QIPP) programme. QIPP is a large-scale, national initiative for the NHS which will improve the quality of care the NHS delivers while making up to £20 billion of efficiency savings by 2014/15 to ensure that there are more funds available for treating patients and to allow the NHS to respond to changing demands and new technologies.

Our 2012/13 QIPP programme comprised a series of projects linked to our 7 main strategic objectives summarised in the introduction to this report and themselves derived from the needs of our local population. Many of these projects have been described in previous sections as examples of our achievements. Below are some headline figures that demonstrate the difference we have made in each of the four main areas of QIPP:

Quality:

- Pilot programme to enable patients in their last year of life to live their remaining days in the care setting of their choice (including in their home) with the right support
- Redesigned pathway providing integrated community and hospital support for patients with Chronic Obstructive Pulmonary Disease (COPD)
- New arrangements for the provision of health care to care homes to ensure all residents have access to high quality services

Innovation:

- Integrated Care at Home pilot to deliver community healthcare and social services as a single package enabling better outcomes

Productivity:

- A reduction of 10-15% in A&E attendances (year on year Dec.2011 to Dec. 2012) at Queen Elizabeth Hospital by treating minor illness and injuries in the on-site Urgent Care Centre
- GP referrals into hospital have been reduced through our Referrals Management and Booking Service which reviews all referrals to ensure they contain necessary details and are clinically appropriate

Prevention

- A reduction in falls and falls related injuries as a result of the Falls project
- Brief interventions offered at Queen Elizabeth Hospital to help reduce excessive alcohol consumption
- Prevention programmes for smoking cessation, diet, and physical wellbeing

- A programme of visits to older people receiving social care services in their own homes, linking them in appropriate services with the aim of reducing admissions to both care homes and to hospital.

In addition to these improvements our QIPP Programme saved £10.8 million in 2012/13 which has been reinvested in patient care across the borough. In this way we are able to realise sustainable growth within our financial allocation from the Department of Health whilst still balancing our accounts.

As part of the Trust Special Administrator process mentioned earlier in this report, NHS Greenwich Shadow Clinical Commissioning Group was fully engaged and the Managing Director for Greenwich led the development of the Community Based Care Strategy for South East London.

The Community Based Care strategy, which is available online from the Office of the Trust Special Administrator (http://www.tsa.nhs.uk/document-folders/final-report), was developed in collaboration with all six commissioners in South East London and gained input from partners from across primary, community, acute and social care services. The strategy includes aspirations for improvements to care in the following areas:

- **Primary and Community Care**: providing easy access to high quality, responsive primary and community care as the first point of call for people in order to provide a universal service for the whole population and to proactively support people in staying healthy.

- **Integrated Care**: ensuring there is high quality integrated care for high risk groups (such as those with long term conditions, the frail elderly and people with long term mental health problems) and that providers (health and social care) are working together, with the patient at the centre. This will enable people to remain active, well and supported in their own homes wherever possible.

- **Planned Care**: for episodes where people require it, they should receive simple, timely, convenient and effective planned care with seamless transitions across primary and secondary care supported by a set of consistent protocols and guildelines for referrals and the use of diagnostics.

Greenwich Teaching PCT's strategy for achieving service improvement objectives set out in the QIPP programme centres on robust programme management and governance. The governance of our QIPP programme consists of a number of key elements:

- Each initiative has a designated clinical lead drawn from amongst the elected GP clinical commissioners and they are supported by a named manager. Each initiative is aligned to our strategic priorities.

- All new initiatives are subject to the QIPP Gateway process, which ensures that business cases for new initiatives meet the required quality standards as well as producing a productivity benefit.

- The programme is reviewed through regular operational QIPP meetings and is further scrutinised by the Finance, Performance & QIPP Sub Committee which takes the primary role in assuring the Governing Body on the progress in achieving financial, service and QIPP elements of our plans.

These governance arrangements ensured that grip is maintained throughout the year on the delivery of the QIPP programme, both in terms of financial savings, but crucially also in respect of quality.

6.3 Performance

The PCT has been responsible for monitoring and holding providers to account for their performance against a range of key performance indicators (KPIs) set out in the 2012/13 NHS Operating Framework. This consists of a range of quality, system performance and financial indicators.

Good performance was achieved for most KPIs including referral to treatment waiting times, ambulance response times, the majority of two week and 31 day cancer wait standards, mental health standards, improved performance on venous thrombo-embolism screening, smoking quitters and the number of people offered a NHS health check.

However, there were persistent problems with performance in some areas some of the quality metrics within these KPIs are showing performance that does not meet the planned level. The main areas of concern for the PCT were as follows:

- A&E 4 hour waiting time standard: Performance at South London Healthcare Trust (SLHT) fell below the 95% standard in the second half of the year, and has not recovered. A programme plan is in place to support improvement, and is monitored through the Emergency Care Programme Board attended by commissioners and the Trust.

- Healthcare Associated Infections: Higher than expected numbers of healthcare associated infections have affected Greenwich patients in 2012/13. As at 31st March 2013, five cases of MRSA (methicillin-resistant staphylococcus aureus) were reported to the Health Protection Agency against a target of maximum one case per year. For Clostridium difficile, 43 cases had been reported against an expected 38 or fewer cases. The majority of Greenwich cases occurred at the local Trust, SLHT. SLHT continues to implement actions to minimise both MRSA and Clostridium difficile including a focus on hand hygiene, environmental cleanliness, and antibiotic prescribing.

- Cancer waiting time standards: Performance against the 62 day standard at South London Healthcare Trust (SLHT) was not consistently met in 2012/13, although Improvements in performance were seen towards year end.

7. WORKING IN PARTNERSHIP

Greenwich Teaching PCT will leave a legacy of strong local collaboration and partnership working. We believe that the health of our community requires cooperation between all members of the community and we work with a diverse set of partners in and around Greenwich including:

- Local residents and patients
- Greenwich GP practices
- Neighbouring PCTs/CCGs in S.E. London
- The Royal Borough of Greenwich
- Greenwich Local Involvement Network
- Local non-profit and voluntary organisations
- Independent healthcare providers
- GAVs

And our main providers:

- South London Healthcare Trust
- Oxleas NHS Foundation Trust
- Guy's and St. Thomas' Foundation Trust
- King's College Hospital Foundation Trust
- Lewisham University Hospital Trust
- Bexley and Greenwich Hospice

We have an excellent track record of collaboration with our key partners including the following achievements:

- The integration of community health and social care services with Oxleas and the Royal Borough of Greenwich
- Work with the Children's Trust Board to refresh and implement a Greenwich Children' Plan which is driving improvements in the health of children in the borough
- Adoption of a 'Shared Standards; Local Delivery' approach with commissioners in Bexley and Bromley which facilitates joint commissioning approaches with our shared providers (South London Healthcare Trust) while allowing for differences in the needs of our local populations. Redesigning the way in which Diabetes services are offered to patients across the three boroughs is an example of this.
- Supporting the establishment of a south London 'commissioning support service' which has been in place since October 2012 to generate economies of scale for Clinical Commissioning Groups for services such as HR and IT.
- Working with the Prison Partnership Board to secure the best health outcomes for prisoners.

7.1 Stakeholder reference groups

One of the mechanisms by which we engage partners in the community is through the use of Stakeholder Reference Groups (SRGs). SRGs were established in 2011 by the NHS South East London Clinical Strategy Group and the joint South East London PCT Boards of Directors to improve relationships with stakeholders and ensure that they are informed of changes to the local NHS. Since then, we have worked closely with the Bexley, Bromley, and Greenwich SRG as well as the South East London SRG to improve our local engagement plans and to monitor the impact of our plans on patients and the local community.

In 2012/13 our shared achievements with Stakeholder Reference Groups include:

- Reviewing local engagement plans for service developments and improvements
- Responding to major national public engagements such as NHS Future Forum which was set up by government to guide the implementation of the Health and Social Care Act (2012)
- Improving our approach to patient and public engagement in collaboration with other commissioners and providers

A South London Stakeholder Reference Group will continue to provide this valuable feedback to Clinical Commissioning Groups including Greenwich CCG from April 2013.

7.2 Working with the LINk

The Greenwich Local Involvement Network (LINk) is one of 150 statutory local involvement networks set up by government to make people's views known to those who run health and social care services. We have worked systematically with Greenwich LINk to develop ways in which residents and community organisations can comment on and influence how we plan and deliver healthcare across the borough. We have been to LINk meetings to talk about our strategic priorities and how we plan to improve health and reduce health inequalities for and with the people of Greenwich, and we always respond in a full and timely manner to questions and reports on specific issues of interest to the LINk membership. From April 2013 LINks will be part of Health Watch England.

7.3 Overview and Scrutiny Committee

We work closely with the Royal Borough of Greenwich's Overview and Scrutiny Committee (which has statutory powers to call from and make recommendations to the NHS) on the local implementation of national NHS reforms and on plans and proposals for service change. We have presented papers and responded to questions at committee meetings in 2012/13.

7.4 Engaging with patients and the public

Central to the work of Greenwich PCT is the delivery and design of health services around the needs of patients and carers. We achieve this through meaningful involvement and the development of partnerships between patients, carers and healthcare providers to shape current and future service delivery.

As listed above, there are a number of community groups, such as Local Involvement Networks who represent the public and with whom we regularly discuss service developments. In addition though, we communicate and engage directly with members of the public, patients, and carers through a variety of channels around specific service developments as well as to discuss our planning and delivery generally.

In 2012/13 some examples of engagement with patients and the public include:

- Our expert patient programme for people with long term conditions
- Work with our 44 GP practices in Greenwich to develop patient groups which will help provide input for the surgery as well as influencing commissioning decisions
- Public board meetings (held on alternating months)
- Communications via Twitter with 3,750 followers so far
- A Greenwich Health Panel comprised of about 500 members of the community who are invited to engagement activities during the year based on their interests and experience
- Public workshops to engage on the Community Based Care strategy as part of the Trust Special Administrator process for South London Healthcare Trust

The feedback we receive in workshops and events helps us to refine and tailor our strategies to the needs and views of the public. As much as possible we try to report back on how we have responded to feedback. In March 2012 we ran an event called 'Have your Say' for members of the public to input into Greenwich Clinical Commissioning Group's plans for 2013/14 and to report back on lessons learned from previous such events.

A full report on the detailed consultation and engagement work over the year is in our Duty to Engage report at www.selondon.nhs.uk/greenwich.

Patient satisfaction

We gather information on patient satisfaction from a huge range of sources including the NHS patient survey programme, surveys carried out by our local NHS providers, and our quality and complaints monitoring systems.

The NHS Constitution

The NHS Constitution brings together in one place what patients, the public, and staff can expect from the NHS. It sets out the rights of patients, the public and staff, and the pledges the NHS is committed to achieve. It also outlines the responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies, and private and third sector providers supplying NHS services, are required by law to take account of the Constitution in their decisions and actions. The Government will have a legal duty to renew the Constitution every 10 years. No government will be able to change the Constitution, and therefore how the NHS works, without the full involvement of staff, patients and the public. Find out more at www.nhs.uk/nhsconstitution

Patient Advice and Liaison and Complaints Service

Anyone can express a view or find out more about their local NHS through our Patient Advice and Liaison Service (PALS). The majority of these enquiries are handled through our local PALS helpline. Where enquiries need more than just signposting and are more complex, patients are offered individual support and guidance from our Greenwich PALS officer.

Anyone who is unhappy about the quality of service they receive can complain through the NHS complaints process. We take all complaints seriously, investigating them thoroughly and making it clear that a complaint will not affect the quality of care provided. In 2012/13 105 complaints were received and investigated. The majority of complaints related to the provision of services commissioned by the PCT.

All NHS organisations are expected to have their own procedures for dealing with complaints. However, we also provide support to those wishing to make a complaint involving any of our independent contractors including GPs, dentists, opticians and pharmacists. Our complaints policy was updated in 2011 and is compliant with the 'Principles for Remedy' published by the Parliamentary and Health Service Ombudsman in 2009. It can be found on our website at www.selondon.nhs.uk

8. MAKING IT HAPPEN

8.1 WORKFORCE

8.1.1 Our Staff

NHS South East London currently employs 753.45 full time equivalent (FTE) staff across five PCTs and one care trust. Following the last organizational change process in March 2011 which led to the creation of NHS South East London, a new human resources (HR) team was formed. Staff in Greenwich receive HR expertise, advice and support from this central team together with workforce transformation support as we continue to develop our services towards delivering GP commissioning.

8.1.2 NHS staff survey

Staff feedback forms an important part of our development as an organisation. As a result of the Health and Social Care Act (2012) and the significant amount of upheaval created by organisational change, it was agreed that PCTs would not be subject to a Staff Survey in 2012/13. We remain committed to seeking staff views and will continue to do so in the new Clinical Commissioning Group.

8.1.3 Sickness absence

Monthly sickness absence reports include individual sickness absence trends. These are discussed with appropriate managers to ensure that the right support is provided to staff who are absent due to sickness to enable appropriate and timely returns to work.

The sickness absence rate for the NHS in England for the period July to September 2012 was 4.06 per cent.

The following sickness information relating to Greenwich PCT has been provided by Department of Health ESR system:

	2012-13 Number	2011-12 Number
Total Days Lost	**834**	**3,642**
Total Staff Years	**101**	**365**
Average working Days Lost	8.28	9.98

8.1.4 Training and development

A staff development programme was launched in September 2011 based on the training needs identified in personal development plans. The programme also ensures that all staff work in a safe and effective way and are up to date with their statutory and mandatory training. Staff can also apply for external training that is not covered by the programme.

Additionally, in March 2012, NHS South East London launched the 'Piecing Together Change' programme designed specifically to help support staff during transition. The second part of the programme was comprised of a series of one to one clinics providing additional support to staff affected by change.

8.2 Equal opportunity for all

After adopting the Equality Delivery System (EDS) in 2011, we have built upon our achievements made during 2011/12. The EDS aims to achieve positive cultural change in the NHS by creating an environment where services for patients and workplaces for staff are more equitable, diverse and that fairly represent the wider community. The Corporate Equalities Group, set up to implement the EDS across NHS organisations in South East London, continued the work of embedding equality into mainstream business activity.

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

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

Adoption of the EDS was an essential requirement in order for the new Clinical Commissioning Groups (CCGs) to become authorised.

Achievements during 2012/13 include:

- Equality embedded into the new CCG organisations

- Joint Strategic Needs Assessments cover all the protected characteristics and key disadvantaged groups.
- Cluster-wide performance in the Learning Disability – Self Assessment Framework (LD-SAF) 2012 improved significantly, with central co-ordination and monitoring.
- All local NHS organisations complied with the Public Sector Equality Duty (PSED).
- CCGs have Equality Leads at Non Executive and Executive Levels and/or they have purchased an Equality and Diversity Service from the South London Commissioning Support Unit.

The efforts of staff at many levels within the NHS organisations, in implementing the EDS have played a part in improving health outcomes for all and reducing health inequalities across South East London.

For more information visit http://www.selondon.nhs.uk/about_us/equality_and_diversity

8.3 Equalities Action Plan for NHS South East London staff and leadership

As part of the development of the NHS South East London equality objectives for 2012/13, the HR team has developed equality objectives for the staff and leadership of NHS South East London. The purpose of setting these objectives is to strengthen our performance under the Public Sector Equality Duty (PSED) of the Equality Act 2010. The development of the equality objectives has been aligned to the outcome of our Equality Delivery System (EDS) grading for staff and leadership, the EDS goals and outcomes, and our priorities for people transition. The EDS grading for the staff and leadership of NHS South East London was carried out at the beginning of March 2012.

To comply with our statutory duty to publish workforce information on the nine protected characteristics in the Equality Act 2010, NHS South East London recently carried out a process of data cleansing of personal information held on the HR Electronic Staff Record (ESR) system.

This process has enabled us to collect non-personalised data to provide an initial equality and diversity baseline across the six PCTs. This indicates the coverage of information collection across the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, race, religion and belief, sexual orientation, ethnicity, and pregnancy and maternity. The data collection process was done again in early 2012/13 to improve the accuracy and completeness of personal information held on the HR information system. This will be used to form the baseline for equality impact assessments to ensure a fair and consistent transition process for all staff.

8.4 Communicating with our staff

This year has been one of huge change and uncertainty for our staff. The clustering of five primary care trusts and one care trust in April 2011 resulted in a reduced workforce with staff working either within a borough based business support unit or within one of the main cluster wide departments of NHS South East London.

In Greenwich communicating with our staff has always been a priority, particularly during periods of uncertainty. We know that good communication is vital to the effective implementation of organisational change and a number of systems have been put in place to provide clear and consistent information to staff and enable them to contribute and engage in developments. These include:

- regular staff communication through the staff fortnightly update and monthly management brief
- monthly staff briefings with the opportunity for questions and feedback

- interactive staff road shows for updates on key organisational change such as the development of a commissioning support service
- lunch and learn sessions
- updated databases to ensure all staff are included in regular communications
- establishment of an NHS South East London intranet and website
- video messages from the chief executive on key policy areas uploaded onto the staff intranet
- confidential comment box and email addresses for questions raised and responded to.

As part of our commitment to effective and productive conduct of employee relations we are part of a cluster wide joint partnership forum with staff side representatives. The purpose of the forum is to identify and facilitate workforce and employment business. This involves negotiation and consultation on policies and impending organisational changes. The forum meets on a bimonthly basis and is committed to continuously improving the working lives, health and wellbeing of staff.

During the last year, we have also worked collaboratively across London on communication campaigns and initiatives. This has enabled us to benefit from shared expertise and consistent public messaging around key organisational priorities. This includes a:

- London wide flu campaign encouraging people at risk to get vaccinated
- south east London Choose Well campaign based on patient insight and evaluation
- bowel cancer awareness campaign.

Effective communications will remain an important component of successfully moving to the new commissioning healthcare system in 2013.

8.5 ICT Services

ICT services for Greenwich are provided by a South East London ICT Services, which formed by joining our local team with a shared ICT infrastructure service. This new service is responsible for providing co-ordinated, consistent and value for money services across a range of NHS organisations in South East London. The shared service has prioritised a number of key areas for investment and improvement in 2012/13, including:

- The **Primary Care ICT Improvement Programme**, including
    - Implementing a standard three year rolling equipment refresh
    - Upgrading the N3 network for the majority of practices in South East London
    - Continuing and/or completing the rollout of mandated national systems such as the Summary Care Record and the Electronic Prescription Service
    - Upgrading practices to the latest version of their GP clinical information system.
- A **core infrastructure upgrade**, including:
    - Upgrading the core data centre at Lower Marsh
    - Upgrading infrastructure at Southwark's Tooley Street
    - Rationalising core infrastructure where this is the right thing to do, is cost effective, and improves the resilience and availability of the core network, and leads to a greener ICT infrastructure.
- Ensuring that the requirements associated with the **Handover and Closure** programme are delivered, including ensuring that:
    - staff can continue to access their emails by migrating their accounts to their new organisations
    - smartcards controls are in place

- all staff leavers system access rights are managed and/or deleted.

8.6 Protecting your information

To provide the best possible healthcare services, NHS organisations collect sensitive and/or confidential information, often called Personal Identifiable Data (PID). The key elements of Information Governance set the standards to ensure that this information is dealt with legally, securely, efficiently and effectively. Throughout this year we have focused on the management and preparation of change in the NHS to ensure continuity of service and appropriate controls around patient information. All our staff have to undertake Information Governance training and we continue to be committed to the standards set out by the Care Record Guarantee and the Information Governance Toolkit.

Areas of focus during 2011/12 and 2012/13 included:

- Records management in response to Department of Health guidance published in October 2011.
- Information security – ensuring that patient information continues to be handled safely and securely.
- Registration Authority – ensuring there is an appropriate framework in place that meets NHS and legal requirements to provide, monitor and manage access to NHS Care Record Service systems such as GP clinical systems.

We have put in place arrangements for investigating if there is any potential breach of our procedures or policies. As part of this process, we consider whether we need to report breaches to NHS London and the independent Information Commissioner's Office.

Statement on public information
NHS Greenwich complies with HM Treasury's guidance on setting charges for information in 'Managing Public Money'.

8.7 Serious incidents in relation to information governance

Staff are encouraged to report incidents and 'near miss' events so they can be investigated and so that we can reduce the risk of such incidents in future. We are also legally required to assess whether any incident constitutes a serious incident. A serious incident is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service.

In the context of information governance, a serious incident is defined as any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals. Incidents of this type must be reported to the Department of Health and the Information Commissioner's Office. During 2012/13 no incidents of this type were reported.

8.8. Risk Management – how we are managing risk across NHS South East London

The Greenwich approach to risk management and board assurance is in accordance with legislation and national and local guidance. It seeks to embed recognised and developed best practice through

a process of ongoing review and improvement whilst underpinning the production of the annual governance statement.

We have a sound governance structure to serve our local population. As part of this we use effective risk management to ensure that our corporate and key objectives are met. Full details of the NHS South East London approach to risk management are in the Final Accounts and Annual Governance Statement.

8.9. Our Estate and Sustainability

Greenwich Estate
2012/13 has been a year of Capital investment in the Greenwich community estate in order to reduce backlog maintenance and to cut CO2 output across a number of sites. Financial and technical support has provided in support of improvements to GP practices prior to their registration with the CQC by 1 April 2013.

Business Cases have been approved for two major premises developments – Eltham Community Hospital, and Heart of East Greenwich where work is progressing to reach Financial Close. A Business Case for the transfer of properties under the learning disability programme is being developed. Leases have been completed with the current care provider.

Support has been provided to Primary Care including ongoing rent reviews and the development of a number of new Primary Care facilities and reviewing Business Cases for a number of other potential new GP developments.

Considerable time has been given to DoH completing due diligence returns in support of the transfer of the estate planned for 31st March 2013 to community service providers, Community Health Partnership or to NHS Property Services Ltd. Additional resources have been made available to progress where possible, outstanding TSC and other tenant leases prior to transfer.

Oxleas have retendered the Hard FM and Soft FM contracts resulting in substantial cost savings.

Sustainability Report (statement)
The Climate Change Act 2008 sets a legally binding framework to reduce carbon emissions, mitigate and adapt to climate change. The NHS Sustainable Development Unit has estimated that as at 2004 the NHS in England was responsible for 25% of England's public sector emissions and 2.6% of total UK emissions. As such the NHS has a significant role to play in carbon reduction. The Greenwich Teaching PCT Sustainable Development Project Plan, based on the NHS Carbon Reduction Strategy for England, addresses sustainability both in how the PCT operates as an organisation in its own right, and in terms of how it contracts for services from providers of healthcare. The plan aims to:

- Drive down the CCG's direct C02 emissions and energy usage whilst also reducing revenue expenditure.
- Influence commissioned services to reduce their carbon footprint in support of the 10% target reduction. Commissioned services account for almost the entire PCT carbon footprint.
- Ensure that all new buildings and other initiatives are developed with reference to the plan. The PCT has ensured that all new capital developments achieve a *Building Research Establishment Environmental Assessment* (BREEAM) rating of 'excellent'.

8.10 Emergency Preparedness, Resilience and Response

With the formation of the PCT Cluster, emergency planning and response has been coordinated at the Cluster level with participation of PCT emergency planning leads through a combined steering group. This group formed policies and plans and ensured that the PCTs remained resilient through transition and this was evidenced in an assurance process conducted by NHS London in 2012.

The highlight of 2012 was, of course, the London Olympic and Paralympic Games. One third of the games time events took place within Greenwich and considerable time and effort went into ensuring that South East London's health service was games-ready. A high-level senior coordinating committee planned and coordinated all providers, from the major acute trusts to small community pharmacies and nursing homes, to ensure everyone was prepared. The Cluster also worked closely with local authorities and Transport for London to ensure that staff and service users were aware of the possible impacts of the games and that disruption was kept to a minimum.

9. GOVERNANCE

Governance is the framework of rules and practices by which an organisation's accountable officers ensures accountability, fairness, and transparency in its relationship with its all stakeholders, service users, management, employees, government, and the community).

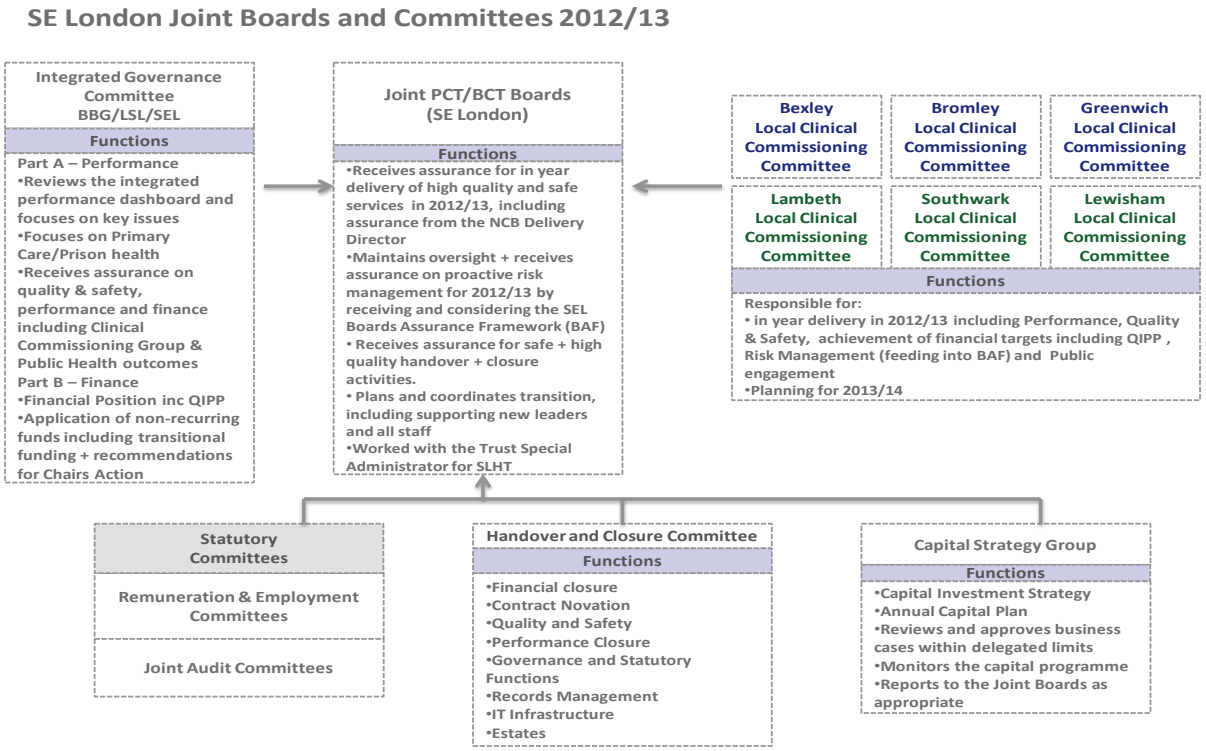
The corporate governance framework consists of the following:

1. explicit and implicit contracts between the organisation and its stakeholders
2. procedures for reconciling the sometimes conflicting interests of stakeholders in accordance with their duties, privileges, and roles, and
3. procedures for proper supervision, control, and information-flows to serve as a system of checks-and-balances.

Effective systems and processes ensure good governance including:

- transparency, accountability and effective scrutiny
- setting of strategic aims and goals
- identification of strategic and operational risks and effective mitigation
- monitoring and measuring performance
- appointing and ensuring the effectiveness of our governing body

Greenwich Teaching PCT board and committee structures were as set out in the diagram below:



Throughout 2012/13 the boards met every two months, in public. All meetings were quorate for all boards. During 2012/13, the Greenwich Board members were as follows:

Name	Position
Caroline Hewitt	Chair, NHS South East London
Steven Corbishley	Non Executive Director
Andrew Kenworthy	Chief Executive NHS South East London (undertook a secondment from 4 September 2011)[1]
Christine Craig	Interim Chief Executive NHS South East London (from 3 September 2012)
Richard Chapman	Acting Director of Finance[2]
Malcolm Dennett	Interim Director of Finance (from 14 November 2012)
Alison Tonge	Interim Director of Finance (from 6 August 2012 – 15 November 2012)
Jane Schofield	Director of Operations and Joint Deputy Chief Executive
Gill Galliano	Director of Development and Joint Deputy Chief Executive (until 30 July 2012)
Donna Kinnair	Director of Nursing Nursing (undertook a secondment from 1

	October 2012)
Jane Clegg	Interim Director of Nursing (from 1 October 2012)
Susan Free	Non Executive Director
Harvey Guntrip	Non Executive Director
Keith Wood	Non Executive Director
Paul Cutler	Non Executive Director
Jeremy Fraser	Non Executive Director
James Gunner	Non Executive Director
Dr Hany Wahba	Chair, Greenwich Clinical Commissioning Group
Annabel Burn	Managing Director, Greenwich Business Support Unit
Dr Hilary Guite	Director of Public Health

[1] Mr Kenworthy retained Accountable Officer status for the whole of 2012/13

[2] Mr Chapman retained Director of Finance Accountable Officer status for the whole of 2012/13

The declared interests of the Board members are in the following table:

Declaration of personal and financial interests – March 2013

NON EXECUTIVE DIRECTORS			
NAME	**Company/ Organisation**	**Position/ Shareholding/ remuneration**	**Directorships and or other significant interests**
Steven Corbishley	BT	A small number of shares of insignificant value	Nil
Paul Cutler	None	None	• Trustee UK Charity Interaction • Associate for the National Children's Bureau, the Centre for Public Scrutiny and the Health Foundation
Susan Free	Nil	Nil	Nil
Jeremy Fraser	Four Communications	Managing director of public affairs division Shareholder and NED Holds shares Remuneration paid	• Vicar, Church of England – stipend paid • Member of the Labour Party – no pay
	London Transport Museum	Trustee and Board member No remuneration paid	
	Globe Academy	Advisor No remuneration paid	
	St Michael and All Angel School	Governor No remuneration paid	
James Gunner	London Specialised Commissioning Group	Non Executive Director No remuneration paid	All of my other business interests have no impact on my NHS responsibilities. They are completely separate and no conflict of interest arises.
	Bromley Healthcare	Governor No remuneration paid	
Harvey Guntrip	Hadlow College, Kent	Chairman No remuneration paid	Nil
	SDM Biomass Limited	Director 50% shareholding	

NON EXECUTIVE DIRECTORS			
NAME	**Company/ Organisation**	**Position/ Shareholding/ remuneration**	**Directorships and or other significant interests**
		No remuneration paid	
	Berties Wood Fuel Ltd	Partner 1/3 shareholder Remuneration paid	
Caroline Hewitt	Withers LLP	Husband is partner in law firm whose clients include some NHS organisations. Remuneration: benefits from profit share	Nil
	VSO UK/VSO International	Member of Audit Committee No remuneration paid	
	Kings College Hospital Charity	Trustee No remuneration paid	
Keith Wood	(a) Greenwich & Bexley Community Hospice Ltd (b) Different Strokes (Trustees) Ltd	I hold no office in either company nor do I receive any remuneration	Each company is limited by guarantee & I am a member of each company, each member guarantees its liabilities up to a maximum of £1; there are approximately 20 members of (a) & 12 members of (b). (a) has material Service level agreements with Bexley Care Trust & Greenwich TPCT. (b) has no such financial relationships but has a representative on the Bexley stroke round table & is in a position to provide community services in SEL I am a long term user of hospital services in Bromley.

DIRECTORS			
NAME	**Company/ Organisation**	**Position/ Shareholding/ remuneration**	**Directorships and or other significant interests**
Richard Chapman	None	None	Nil
Malcolm Dennett	None	None	Non-executive director Independent Living Association. Primarily a charity in Social Care but diversifying into health personal

DIRECTORS			
NAME	**Company/ Organisation**	**Position/ Shareholding/ remuneration**	**Directorships and or other significant interests**
			budgets – Worthing
Alison Tonge (left)	None	None	Nil
Ann-Marie Connolly (left)	None	None	Nil
Sarah Cottingham	None	None	Nil
Una Dalton (left)	None	None	Nil
Penny Emerit (left)	None	None	Nil
Marie Farrell (left)	None	None	Nil
Jane Fryer	1. Dr Cliffe and Partners 2. The Hurley Group	1. Employed half a day a week as a salaried GP in East Dulwich 2. Employed half a day a week as a salaried doctor in Fulham	Director of Chapel Street Community Health CIC (Unpaid)
Gill Galliano (left)	PCC CIC (Social Enterprise)	Trustee	Nil
Andrew Kenworthy	Diabetes UK Alzheimer's Society British Heart Foundation	Fund-raising for these organisations Wife – Consultancy business, training health professionals on cardio-vascular health and stroke for health communities/organisations across the UK	Nil
Christina Craig	None	None	Nil
Donna Kinnair (left)	Royal College of	Consultant Editor	Nil

DIRECTORS			
NAME	**Company/ Organisation**	**Position/ Shareholding/ remuneration**	**Directorships and or other significant interests**
	Nursing Publications	Expenses paid	
	CWfI (Mouchell)	Board Member No remuneration paid	
	Walworth Academy	School Governor No remuneration paid	
Jane Clegg	None	None	Nil
Oliver Lake (left)	None	None	Nil
Susanna Masters (left)	None	None	Nil
Sean Morgan	None	None	Nil
Tony Read	None	None	Nil
Jane Schofield	None	None	Nil
David Sturgeon	None	None	Nil

GREENWICH CLINICAL COMMISSIONING COMMITTEE CHAIR			
NAME	**Company/ Organisation**	**Position/ Shareholding/ remuneration**	**Directorships and or other significant interests**
Hany Wahba	GP partner at St Mark's Medical Centre.	Member of GRABADOC; Currently work out of hours (OOH) paid sessions at GRABADOC.	Special interest in surgery, currently provide minor surgery services paid by NHS Greenwich.

MANAGING DIRECTOR:GREENWICH BUSINESS SUPPORT UNIT			
NAME	**Company/ Organisation**	**Position/ Shareholding/ remuneration**	**Directorships and or other significant interests**
Annabel Burn	None	None	User of NHS SEL services

GREENWICH DIRECTOR OF PUBLIC HEALH			
NAME	**Company/ Organisation**	**Position/ Shareholding/ remuneration**	**Directorships and or other significant interests**
Hilary Guite	None	None	Nil

Board committees

Greenwich Clinical Commissioning Committee
The local clinical commissioning committees (LCCCs) are forerunners to the clinical commissioning groups (CCGs) replacing PCTs and care trusts as the commissioners of local health services on 1 April 2013. These clinically led bodies are supported by BSUs to identify local healthcare needs and prioritise commissioning accordingly, providing a local focus to cluster wide strategies. They also undertake the duties of the professional executive committees (PECs) and provide oversight of local performance.

Greenwich Clinical Commissioning Committee is chaired by Hany Wahba. It meets monthly in public. The full membership is listed below:

- Dr. Hany Wabha, St Mark's Medical Centre (Chair)
- Dr. Eugenia Lee, Gallions Reach Health Centre
- Dr. Rebecca Rosen, Ferry View Health Centre
- Dr. Nayan Patel, The Blackheath Standard Surgery
- Dr. Junaid Bajwa, Conway Medical Centre
- Dr. Niraj Patel, Thamesmead Medical Associates (part year)
- Dr. Ram Aggarwal, Plumstead Health Centre (part year)
- Dr. Robert Hughes (part year)

In addition, the following lay representatives sat on the committee:

- Dr. Greg Usher, The Metro Centre
- Yemi Osho (Nurse)
- Tan Vandal (Secondary Care Doctor)
- Jim Wintour

Annabel Burn as Chief Officer, and Chris Costa as Chief Financial Officer also sat on the committee. Non-voting members of the committee also included:

- Simon Hall, Director of Integrated Commissioning
- Nicola Havutcu, Director of Integrated Governance
- Dr. Hilary Guite, Director of Public Health
- Steve Whiteman, Acting Director for Public Health
- Councillor John Fahy, Cabinet Member for Health, Adults and Older Peoples' Services

Joint Audit Committee
The Joint Audit Committee fulfils the statutory audit functions required of PCTs and care trusts, ensuring that the governance and machinery of the cluster and the BSUs is functioning as it should. Its work programme includes reviewing governance arrangements (including information governance), assurance mechanisms including the work of internal and external audit, local counter fraud services, debt and waiver management, and reviewing the board assurance framework to make sure that corporate objectives and organisational risks are properly addressed. The Committee meets four times a year and all meetings in 2012/13 were quorate.

Chair: Steven Corbishley
Executive members: Richard Chapman, Acting Director of Finance, Malcolm Dennett, Interim Director of Finance and Jane Schofield, Deputy Chief Executive
Non executive members: Keith Wood, Harvey Guntrip, Graham Laylee, Rona Nicholson, Robert Park and Jeremy Fraser

Integrated Governance Committee (IGC)
The IGC has the following roles and responsibilities:-

- To oversee the integrated governance of the shadow CCGs and give the Joint Boards assurance that actions and plans put in place by the CCGs are appropriate, adequate and followed through as they work towards Authorisation.
- To give a forum for the shadow CCGs to operate at scale to manage the performance and quality of the major acute, community and mental health providers
- To help enable the Cluster Chief Executive to exercise his role as Accountable Officer through consideration and review of the aggregate Cluster position with respect to performance, finance, quality and emergency planning
- To review and consider the quality and performance of Primary Care, Prison Health and Specialist Services prior to full establishment of the National Commissioning Board
- To oversee the procedures for identifying, investigating and learning for serious incidents and for safeguarding children and vulnerable adults.

The Committee meets monthly and all meetings were quorate during 2012/13. Meetings are not held in public but a summary report detailing issues discussed and actions proposed is provided at each Joint Boards meeting. Meetings rotate on a three monthly cycle:

- Lambeth, Southwark and Lewisham (LSL)
- Bexley, Bromley and Greenwich (BBG)
- NHS South East London Cluster (SEL)

Joint Chairs (rotation): Jim Gunner (BBG), Robert Park (LSL), Caroline Hewitt (SEL)
Executive members: Andrew Kenworthy/ Christina Craig, Chief/Interim Chief Executive; Jane Schofield, Deputy Chief Executive; Richard Chapman, Acting Director of Finance; Malcolm Dennett, Interim Director of Finance; Donna Kinnair/ Jane Clegg, Director/ Interim Director of Nursing
Non executive members: Keith Wood, Susan Free, Rona Nicholson and Sue Gallagher

Handover and Closure Committee
The Handover and Closure Committee oversees all aspects of the Handover and Closure programme in the NHS in South East London leading up to the new NHS commissioning arrangements that come into force on the 1 April 2013. The Committee meets in private but provides its minutes to the Joint Boards. All meetings in 2012/13 were quorate.

Chair: Steven Corbishley
Executive members: Christina Craig, Interim Chief Executive; Jane Schofield, Deputy Chief Executive; Malcolm Dennett, Interim Director of Finance
Non executive members: All non-executive directors are members of this Committee. At least three must be present (including one from LSL and one from BBG) for the meeting to be quorate.

Capital Strategy Group
The Capital Strategy Group oversees all aspects of Capital Strategy, planning and progress in the NHS in South East London. The Group meets in private but considers issues prior to their decision at public meetings of LCCCs or the Joint Boards. All meetings in 2012/13 were quorate.

Chair: Caroline Hewitt
Executive members: Malcolm Dennett, Interim Director of Finance, Richard Chapman, Director of Finance. All BSU Managing Directors are members of this Committee; at least two must be present for the meeting to be quorate.
Non executive members: Richard Gibbs, Keith Wood

Employment and Remuneration Committee
The Employment and Remuneration Committee meets to consider the employment packages for those employees of the cluster whose remuneration falls outside the scope of Agenda for Change.

Chair: Caroline Hewitt
Executive members: Una Dalton, Director of Human Resources
Non executive members: Sue Gallagher, Graham Laylee, Richard Gibbs, Robert Park, Rona Nicholson, David Whiting, Keith Wood, Paul Cutler, Harvey Guntrip, James Gunner, Susan Free and Jeremy Fraser

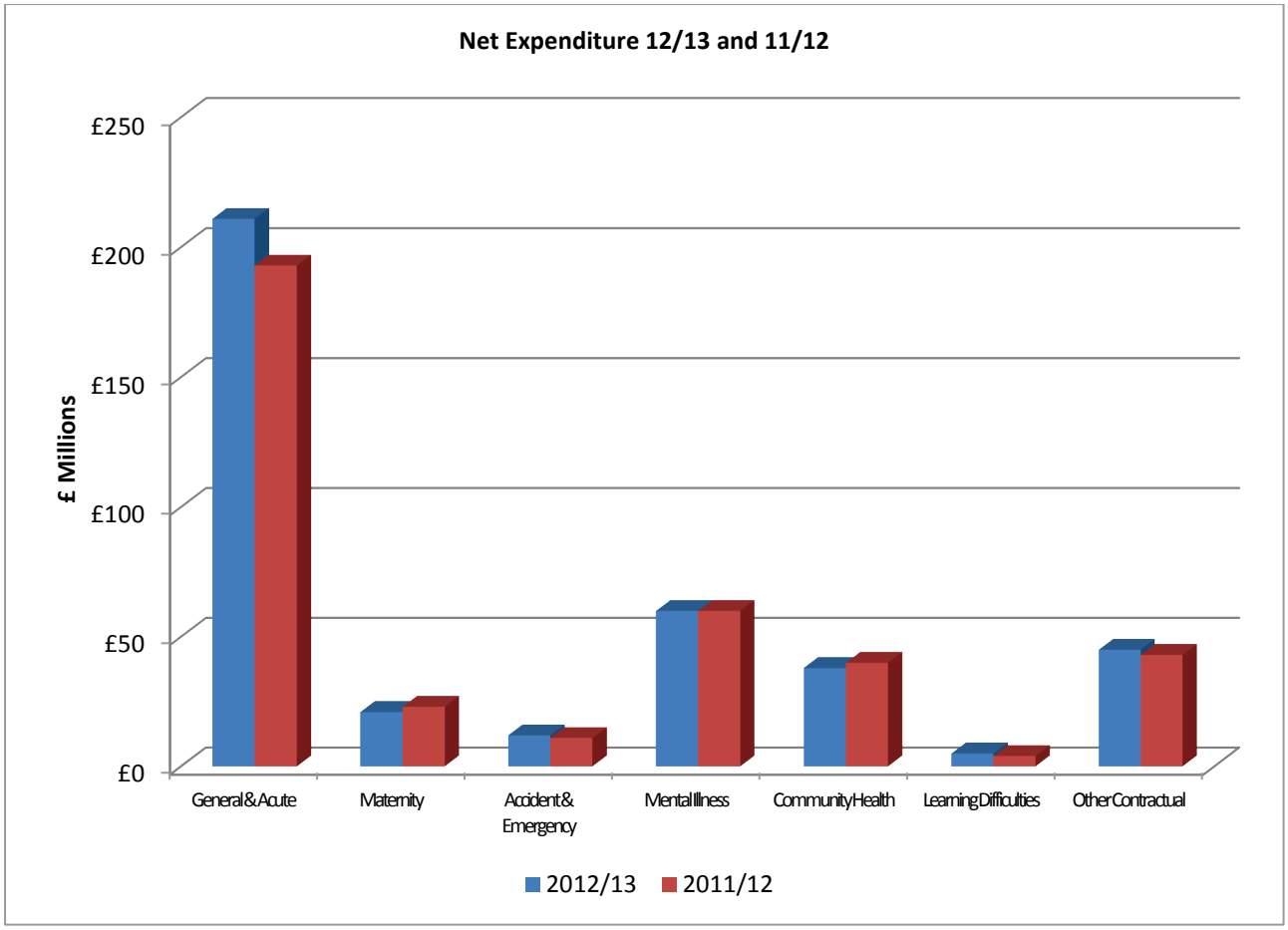
Governance Statement

The PCT's Annual Governance statement is a separate document included as part of Annual Accounts reporting framework and is available on request.

10. HOW WE SPENT YOUR MONEY

During 2012/13 we spent:

- **£388.6m on secondary and community healthcare** of which mental health £59.9m; general & acute £210.8m, accident & emergency £11.9m, community £38.2m, maternity £20.9m, learning difficulties £5.3m and other contractual £41.6m.
- **£98.4m on primary healthcare** of which, primary medical services £37.6m; prescribing £33m; dental services £15.5m; Ophthalmic services £2.2m, new pharmacy contract £9.3m and non GMS services from GPs £0.8m.



11. REMUNERATION REPORT

11.1 Unaudited

The Employment and Remuneration committee of Cluster PCT's meets to consider the employment arrangements for those employees across NHS South East London whose remuneration falls outside the scope of agenda for Change.

The following information relates to the employment of Cluster executive directors and non-executive directors and Chair, Managing Director and Director of Public Health for the PCT.

11.2 Contract details

As a consequence of implementing Health and Social Care Act 2012, all the PCTs and SHAs were abolished on 31st March 2013. Contractual arrangements for officer Board members and Non-executive members, therefore, also terminate on the same date.

Name	Title	Start Date	End Date
Andrew Kenworthy * (to 4/9/2012)	Chief Executive, NHS SEL Cluster	03/10/2011	31/03/2013
Christina Craig *	Interim Chief Executive, NHS SEL Cluster	03/09/2012	31/03/2013
Gill Galliano	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	01/04/2011	30/06/2012
Richard Chapman *	Director of Finance, NHS SEL Cluster	01/11/2011	31/03/2013
Alison Tonge *	Interim Director of Finance, NHS SEL Cluster	06/08/2012	15/11/2012
Malcolm Dennett *	Interim Director of Finance, NHS SEL Cluster	14/11/2012	31/03/2013
Jane Schofield	Director of Operations, NHS SEL Cluster	01/04/2011	31/03/2013
Donna Kinnair	Director of Nursing, NHS SEL Cluster	01/04/2011	01/10/2012
Jane Clegg	Director of Nursing, NHS SEL Cluster	09/11/2012	31/03/2013
Caroline Hewitt	Chair, NHS SEL Cluster	01/04/2011	31/03/2013
Steven Corbishley	Non Executive Director, NHS SEL Cluster	14/04/2011	31/03/2013
Paul Cutler	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Susan Free	Non Executive Director, NHS SEL Cluster	01/04/2007	31/03/2013
Jeremy Fraser	Non Executive Director, NHS SEL Cluster	15/07/2009	31/03/2013
James Gunner	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Keith Wood	Non Executive Director, NHS SEL Cluster	14/04/2011	31/03/2013
Dr Hany Wahba	Local Clinical Commissioning Committee Chair	01/02/2011	31/03/2013
Annabel Burn	Managing Director	01/04/2001	31/03/2013

Dr Hilary Guite	Director of Public Health	01/07/2007	31/03/2013

* During 2012-13 both the Accountable Officer and the Statutory Director of Finance moved to new roles within the NHS. However, for the purposes of these statutory roles they continued to assume this accountability through to the 31 March 2013 and they attended both Joint Boards and Audit Committees. To recognise the requirement for leadership, as a result of these moves, an interim Chief Executive was appointed through to the 31 March and an Interim Finance Director. The Interim Finance Director appointment changed during the course of the year.

11.3 Senior Management cost sharing arrangements

The PCT senior management comprises cluster posts of Chair, Chief Executive and Directors of Finance, Corporate Development, Operations and Nursing shared equally across the five PCTs and the Care Trust in the Cluster. The Non-Executive directors appointed to the Cluster Board are shared equally across their representation of separate health economies of LSL (Lambeth, Southwark and Lewisham PCTs) and BBG (Bexley Care Trust, Bromley and Greenwich PCTs). The rest of the PCT Board consists of local Managing Director, Director of Public Health and GP lead Chair of the PCT's Clinical Commissioning Committee.

11.4 The costs of the Executive and Non-Executive members reported below are the PCT's share of costs, where relevant, in the line with the arrangements described above.

Audited

Cluster Board Executive and Non-Executive members (*PCT's share of costs*)

Salaries and allowances

		2012/13				2011/12			
Name	**Title**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**
Andrew Kenworthy (to 4/9/2012)	Chief Executive, NHS SEL Cluster	5-10				10-15			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					10-15			
Christina Craig (from 3/9/2012)	Interim Chief Executive, NHS SEL Cluster	25-30							
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	5-10				20-25			
Richard Chapman	Director of Finance, NHS SEL Cluster	15-20				10-15			
Alison Tonge (from 6/8/2012 to 15/11/2012)	Interim Director of Finance, NHS SEL Cluster	10-15							
Malcolm Dennett (from 14/11/2012)	Interim Director of Finance, NHS SEL Cluster	10-15							
Jane Schofield	Director of Operations, NHS SEL Cluster	20-25	40-45			20-25			
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	15-20	15-20			15-20			
Jane Clegg (from 1/10/2012)	Director of Nursing, NHS SEL Cluster	5-10							
Caroline Hewitt	Chair, NHS SEL Cluster	5-10				5-10			
Steven Corbishley (No remuneration paid)	Non Executive Director, NHS SEL Cluster	0				0			
Paul Cutler	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Susan Free	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Jeremy Fraser	Non Executive Director, NHS SEL Cluster	1-5				1-5			
James Gunner	Non Executive Director, NHS SEL Cluster	1-5				5-10			
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Keith Wood	Non Executive Director, NHS SEL Cluster	1-5				1-5			

Greenwich PCT senior staff – these staff represent Greenwich PCT on Cluster Board.
Salaries and allowances

		2012/13				2011/12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
Dr Hany Wahba	Local Clinical Commissioning Committee Chair	65-70				55-60			
Annabel Burn	Managing Director	90-95				90-95			
Dr Hilary Guite	Director of Public Health	80-85		15-20		80-85		10-15	

Pension Benefits (*PCT's share of Pension entitlement costs*)

Non-Executive directors on the Board and General Practitioners on Clinical Commissioning Collaborative Committee are not employed by the PCT and are not members of the NHS pension scheme. Their pension benefits are, therefore, not required to be reported in the remuneration report.

In line with the guidance in the Manual of Accounts, it is not possible to apportion the cash equivalent transfer value (CETV) across the PCTs and Care Trust in the Cluster on any systematic basis. This has been, therefore, reported below in full.

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	896	872	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	20-25	0	912	-912	
Richard Chapman	Director of Finance, NHS SEL Cluster	0-2.5	2.5-5	2.5-5	10-15	287	202	84	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	1157	1217	-60	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	5-10	10-15	565	500	65	
Annabel Burn	Managing Director	0-2.5	0-2.5	30-35	95-100	609	595	14	
Dr Hilary Guite	Director of Public Health	0-2.5	0-2.5	40-45	125-130	886	904	-18	

11.5 The costs of Cluster Board executive and Non-Executive members, reported below are the total remuneration and pension entitlement of the individual. These costs are shared across the six PCTs and Care Trust in South East London.

Cluster Board Executive and Non-Executive members *(Total remuneration)*

Salaries and allowances

Name	Title	2012/13 Salary (bands of £5,000	2012/13 Other Remuneration (bands of £5,000)	2012/13 Bonus Payments (bands of £5,000)	2012/13 Benefits in kind (rounded to the nearest £00)	2011/12 Salary (bands of £5,000	2011/12 Other Remuneration (bands of £5,000)	2011/12 Bonus Payments (bands of £5,000)	2011/12 Benefits in kind (rounded to the nearest £00)
		£000	£000	£000	£00	£000	£000	£000	£00
Andrew Kenworthy (to 4.9.2012)	Chief Executive, NHS SEL Cluster	45-50				85-90			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					60-65			
Christina Craig (from 3.9.2012)	Interim Chief Executive, NHS SEL Cluster	155-160							
Gill Galliano (to 30.6.2012)	Director of Development, NHS SEL Cluster	30-35				125-130			
Jane Schofield	Director of Operations, NHS SEL Cluster	130-135	260-265			130-135			
Richard Chapman	Director of Finance, NHS SEL Cluster	110-115				65-70			
Alison Tonge (from 6.8.12 to 15.11.2012)	Interim Director of Finance, NHS SEL Cluster	80-85							
Malcolm Dennett (from 14.11.2012)	Interim Director of Finance, NHS SEL Cluster	70-75							
Donna Kinnair (to 1.10.2012)	Director of Nursing, NHS SEL Cluster	95-100	105-110			95-100			
Jane Clegg (from 9.11.2012)	Director of Nursing, NHS SEL Cluster	50-55							
Caroline Hewitt	Chair, NHS SEL Cluster	40-45				40-45			
Steven Corbishley	Non Executive Director, NHS SEL Cluster	Nil Remuneration				Nil Remuneration			
Paul Cutler	Non Executive Director, NHS SEL Cluster	5-10				5-10			
Susan Free	Non Executive Director, NHS SEL Cluster	5-10				5-10			
Jeremy Fraser	Non Executive Director, NHS SEL Cluster	5-10				5-10			
James Gunner	Non Executive Director, NHS SEL Cluster	10-15				15-20			
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	10-15				5-10			
Keith Wood	Non Executive Director, NHS SEL Cluster	10-15				10-15			

Greenwich PCT senior staff – these staff represent Greenwich PCT on Cluster Board.
Salaries and allowances

		2012/13 Salary (bands of £5,000)	2012/13 Other Remuneration (bands of £5,000)	2012/13 Bonus Payments (bands of £5,000)	2012/13 Benefits in kind (rounded to the nearest £00)	2011/12 Salary (bands of £5,000)	2011/12 Other Remuneration (bands of £5,000)	2011/12 Bonus Payments (bands of £5,000)	2011/12 Benefits in kind (rounded to the nearest £00)
Dr Hany Wahba	Local Clinical Commissioning Committee Chair	65-70				55-60			
Annabel Burn	Managing Director	90-95				90-95			
Dr Hilary Guite	Director of Public Health	80-85		15-20		80-85		10-15	

Pension Benefits *(Total Pension entitlement)*

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	50-55	155-160	896	872	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	45-50	145-150	0	912	-912	
Richard Chapman	Director of Finance, NHS SEL Cluster	5-7.5	17.5-20	20-25	60-65	287	202	84	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	55-60	165-170	1157	1217	-60	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	25-30	85-90	565	500	65	
Annabel Burn	Managing Director	0-2.5	0-2.5	30-35	95-100	609	595	14	
Dr Hilary Guite	Director of Public Health	0-2.5	0-2.5	40-45	125-130	886	904	-18	

* The information for the increase in real pension and lump sum cannot be calculated for new members of staff as the information reported in the previous year is not available.

11.6 Cash Equivalent Transfer Values

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

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.

11.7 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 Greenwich PCT in the financial year 2012-13 was £102,500 (2011-12, £92,307). This was 2.66 times (2011-12 2.85 times) the median remuneration of the workforce, which was £38,540 (2011-12 £32,391)

In 2012-13, 0 (2011-12, one) employee received remuneration in excess of the highest paid director. Remuneration ranged from £18,374 to £103,695 (2011-12 £7,882 to £131,531). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind excluding severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The decrease in the multiple between 2011-12 and 2012-13 is due to the changes in the salary of the highest paid director from £92,307 to £103,695 as well as the increase in the median salary from £32,391 to £38,540.

11.8 Exit Packages

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**1**	**0**	**1**	0	0	**0**
£10,001-£25,000	**2**	**0**	**2**	0	0	**0**
£25,001-£50,000	**4**	**0**	**4**	0	0	**0**
£50,001-£100,000	**0**	**0**	**0**	0	0	**0**
£100,001 - £150,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost	**8**	**0**	**8**	**0**	**0**	**0**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	311,546	0	**311,546**	0	0	**0**

11.9 Off Payroll Engagements – *(unaudited)*

Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012	Greenwich PCT
	No.
No. in place on 31 January 2012	**4**
of which	
No that have since come onto the organisation's payroll	0
of which	
No. that have since been re-negotiated/re-engaged, 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	1
No. that have come to an end (**31st March 2013**)	3
Total	**4**

Table 2: For all off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.	
	Greenwich PCT
No. of new engagements	5
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	5
of which	
No. for whom assurance has been requested and received	0
No. for whom assurance has been requested but not received (See Below)	0
No. that have been terminated as a result of assurance not being received	
No. for whom assurance was not required due to	
Left the organisation	3
Joined an agency	0
Enetered substantive employment	0
Request not made	2

11.10 Related Party Transactions

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

During the year the following Board Members and members of Clinical Commissioning Collaborative Committee and parties related to them have undertaken material transactions with Greenwich Teaching Primary Care Trust as follows:

	Services Received For Organisation	Payments to Related Party
		£
Dr Hany Wahba - St Mark's Medical Centre	Primary Care	1,165,376
Dr Eugenia Lee - Thamesmead Medical	Primary Care	1,839,307
Dr Nayan Patel - Blackheath Standard Surgery- Greenwich	Primary Care	924,440
Dr Ellen Wright - Vanburgh Group Practice	Primary Care	1,220,017
Dr Junaid Bajwa - Conway PMS	Primary Care	517,040

The Department of Health is regarded as a related party. During the year Greenwich Teaching Primary Care Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

		'£000s
South London Healthcare Trust	Provision of Health Care	118,684
Guys And St Thomas NHS Foundation Trust	Provision of Health Care	33,644
Oxleas NHS Foundation Trust	Provision of Health Care	86,550
Kings College Hospital NHS Foundation Trust	Provision of Health Care	17,522
Croydon Primary Care Trust	Provision of Health Care	31,092
London Borough of Greenwich	Healthcare from non-NHS Bodies	22,918

Greenwich Teaching PCT Charitable Trust Fund is regarded as a related party.

12. HOW WE SPENT YOUR MONEY

GREENWICH PCT SUMMARY FINANCIAL STATEMENTS 2012/13

These summary financial statements are a summary of the information in the PCT's full annual accounts for 2012/13. The summary financial statements might not contain sufficient information for a full understanding of the PCT's financial position and performance.

IFRSs are accounting standards issued by the International Accounting Standards Board (IASB). The term IFRS refers to the international equivalent to UK GAAP, the set of Generally Accepted Accounting Principles that includes accounting standards, interpretations, the IASB's framework and established accounting practice. The Chancellor's 2007 Budget announced that the accounts of central government departments and entities in the wider public sector will be produced using IFRS, as interpreted for the public sector in the IFRS-based Financial Reporting Manual (FReM). Central government, NHS Trusts, Primary Care Trusts and NHS Foundation Trusts all need to adopt IFRS and the annual accounts for government organisations and the NHS are to be prepared using IFRS standards.

12.1 PCT FINANCIAL PERFORMANCE 2012/2013

Statutory and other financial duties

The PCT is required by statute to meet certain financial duties in order to ensure that public funds are used appropriately. These duties are:

- not to exceed the PCT's revenue resource limit;
- not to exceed the PCT's capital resource limit;
- not to exceed the (combined) revenue and capital cash limits

Greenwich PCT met all of its statutory duties in full in 2012/13.

Financial balance

PCTs have a statutory duty to keep expenditure within the resource limits set by the Department of Health for revenue and capital separately. The PCT's audited annual accounts show a surplus of £4.717m on revenue and £0.899m on capital.

	2012/13 Revenue £000	**2012/13 Capital £000**	**2012/13 Total £000**
Resource Limit	508,398	2,890	511,288
Net Operating Costs	503,672	1,991	505,663
Surplus / (Deficit)	**4,726**	**899**	**5,625**

All the Primary Care Trusts and Strategic Health Authorities were abolished from 1 April 2013. Under Department of Health year-end carry forward arrangements and guidance around financial planning for 2013/14, Greenwich PCT has been advised by DH to assume 1% (£4.623m) as a carry forward resource in 2013/14 plans. Underspends against Capital Resource Limits are not carried forward. PCTs bid for capital resources on an annual basis.

Cash performance

The PCT has a statutory duty to remain within its set cash limit. There is a single cash limit covering both revenue and capital. The PCT under drew its 2012/13 cash limit of £504.984m by £4.0m. The Department of Health also sets a maximum year-end cash balance for PCTs of £50k. The PCT's cash balance as at 31st March 2013 was £219k.

	£000
Opening Cash balance 1 April 2012	213
Cash drawings including cash top sliced by DH	504,984
Cash Outgoings	(500,978)
Cash returned to DH	(4,000)
Closing cash balance 31 March 2013	**219**

Capital charges

Capital charges were introduced in the NHS in 1991 to increase awareness of the cost of owning assets. The amount payable is based on the actual opening and closing Balance Sheets for the year. There are two elements to this: depreciation of fixed assets and a charge of 3.5 per cent on net relevant assets. The Department of Health has revised the mechanism for charging capital charges interest since 2011/12. The PCT revenue resources

for 2012/13 were increased by £239k for capital charges interest. Capital charges for Greenwich PCT for 2012/13 were as follows:

	£000
Depreciation	1,157
3.5% cost of capital charge on net relevant assets	(173)
Total	**984**

Public sector payment targets

In addition to the PCT's statutory targets, the Department of Health requires that NHS bodies pay their creditors in accordance with the Prompt Payment Code (PPC) and government accounting rules. The target is to pay 95 per cent of all creditors within 30 days of receipt of the goods or a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. Greenwich PCT is an approved signatory to the Prompt Payment Code. The PCT's performance against this target is reported below:

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**11,010**	**68,104**	8,505	87,944
Total Non-NHS Trade Invoices Paid Within Target	**8,828**	**64,457**	7,471	74,293
Percentage of NHS Trade Invoices Paid Within Target	80.18%	94.64%	87.84%	84.48%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,645**	**364,916**	3,706	357,506
Total NHS Trade Invoices Paid Within Target	**4,122**	**360,924**	3,388	355,658
Percentage of NHS Trade Invoices Paid Within Target	88.74%	98.91%	91.42%	99.48%

Comparisons of 2012/13 annual accounts with previous years

1 Net operating costs

The overall growth in net operating costs of £16.4m (3.4%) since 2011/12 reflects the funding growth received by the PCT during 2012/13.

	2010/11	2011/12	2012/13	Change from 2011/12	
	£000	£000	£000	£000	%
Gross Operating Costs	482,520	494,525	513,293	18,768	3.8%
Including income of	11,603	7,259	9,621	2,362	32.5%
Net Operating Costs	**470,917**	**487,266**	**503,672**	**16,406**	**3.4%**

2 Non-Current Assets

Greenwich PCT's land and buildings have been revalued by the District Valuer as at 31 March 2013 by carrying out a full valuation exercise. This resulted in a net decrease in asset values of £2.767m. During the year the PCT incurred capital spend of £1.991m. The PCT did not dispose of any properties during the year. The net reduction in Property, Plant & Equipment assets of £1.932m reflects these transactions as well as the depreciation charges.

	2010/11 £000	2011/12 £000	2012/13 £000	Change £000
Property, Plant & Equipment	34,793	35,193	32,770	(2,423)

3 Net Current liabilities

	2010/11 £000	2011/12 £000	2012/13 £000	Change £000
Current Assets	3,552	5,961	3,056	(2,905)
Current Liabilities	31,961	39,601	37,192	2,409)
Net Current Liabilities	28,409	33,640	**34,136**	**(496)**

4 Taxpayers' equity

	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
General Fund	(16,956)	(22,542)	(25,230)	(2,688)
Revaluation Reserve	19,805	20,799	17,542	(3,257)
Total	2,849	(1,743)	(7,688)	(5,945)

5 Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. For full details of how pension liabilities are treated please see Note 1.24 Accounting Policies in the Annual Accounts. For details of senior manager's pension entitlements please see the PCT's remuneration report.

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	**(503,530)**	(486,910)
Depreciation and Amortisation	**1,399**	1,417
Interest Paid	**(275)**	(378)
(Increase)/Decrease in Trade and Other Receivables	**2,911**	(2,417)
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(4,188)**	8,306
Provisions Utilised	**(268)**	(915)
Increase/(Decrease) in Provisions	**4,826**	(7)
Net Cash Inflow/(Outflow) from Operating Activities	**(499,125)**	**(480,904)**
Cash flows from investing activities		
Interest Received	**110**	0
(Payments) for Property, Plant and Equipment	**(1,783)**	(491)
(Payments) for Other Financial Assets	**(66)**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(1,739)**	**(491)**
Net cash inflow/(outflow) before financing	**(500,864)**	**(481,395)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(114)**	(106)
Net Parliamentary Funding	**500,984**	481,680
Net Cash Inflow/(Outflow) from Financing Activities	**500,870**	**481,574**
Net increase/(decrease) in cash and cash equivalents	**6**	**179**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**213**	**34**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**219**	**213**

Statement of Financial Position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**32,770**	35,193
Intangible assets	**198**	440
Other financial assets	**282**	212
Total non-current assets	**33,250**	35,845
Current assets:		
Trade and other receivables	**2,830**	5,741
Other financial assets	**7**	7
Cash and cash equivalents	**219**	213
Total current assets	**3,056**	5,961
Non-current assets held for sale	**0**	0
Total current assets	**3,056**	5,961
Total assets	**36,306**	41,806
Current liabilities		
Trade and other payables	**(34,183)**	(38,822)
Provisions	**(2,889)**	(557)
Borrowings	**(120)**	(222)
Total current liabilities	**(37,192)**	(39,601)
Non-current assets plus/less net current assets/liabilities	**(886)**	2,205
Non-current liabilities		
Trade and other payables	(640)	0
Provisions	(2,277)	(51)
Borrowings	(3,885)	(3,897)
Total non-current liabilities	**(6,802)**	(3,948)
Total Assets Employed:	**(7,688)**	(1,743)
Financed by taxpayers' equity:		
General fund	(25,230)	(22,542)
Revaluation reserve	17,542	20,799
Total taxpayers' equity:	**(7,688)**	(1,743)

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**7,362**	6,173
Other costs	**505,789**	487,996
Income	**(9,621)**	(7,259)
Net operating costs before interest	**503,530**	486,910
Investment income	**(110)**	(22)
Finance costs	**252**	378
Net operating costs for the financial year	**503,672**	487,266
Net Operating Costs for the Financial Year including absorption transfers	**503,672**	**487,266**
Of which:		
Administration Costs		
Gross employee benefits	**4,355**	3,221
Other costs	**7,183**	9,588
Income	**(32)**	(67)
Net administration costs before interest	**11,506**	**12,742**
Investment income	**0**	(22)
Finance costs	**0**	94
Net administration costs for the financial year	**11,506**	**12,814**
Programme Expenditure		
Gross employee benefits	**3,007**	2,952
Other costs	**498,606**	478,408
Income	**(9,589)**	(7,192)
Net programme expenditure before interest	**492,024**	**474,168**
Investment income	**(110)**	0
Finance costs	**252**	284
Net programme expenditure for the financial year	**492,166**	**474,452**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**3,511**	1,487
Net (gain) on revaluation of property, plant & equipment	**(254)**	(2,481)
Total comprehensive net expenditure for the year*	**506,929**	**486,272**

10 POST BALANCE SHEET EVENTS

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

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

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability. The principles for the split of residual balances is still subject to Department of Health guidance.

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

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

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

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

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

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

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

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

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

11 Running costs

PCTs are required to report the proportion of their costs per head of local weighted population that is spent on management. The Department of Health (DH) has issued guidance on the definition of running costs.

	2012/13	2011/12	Change
Running costs (£000s)	11,919	12,814	(895)
Weighted population (number)	265,704	265,704	-
Management cost per head of weighted population (£)	**45**	**48**	(7.0%)

The PCT measures its running costs according to the definitions provided by the Department of Health.

The PCT running costs for 2012/13 have been reduced by £0.895m (7.0%) in the year.

Audit

The PCT's external auditor is Grant Thornton. During the financial year 2012/13 £104k (including VAT) was paid in respect of carrying out the external audit of the PCT in accordance with the Code of Audit Practice.

2012/13 Accounts Certificate of Financial 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 Greenwich 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.

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature: 

Date: 24 April 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 Greenwich 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: Andrew Kenworthy

Signature: 

Date: 24 April 2013

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

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Greenwich 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 Care Trust Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed.....

Date 31 May 2013

Carl Vincent
Director of Provider Finance and Finance Transition

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

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

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

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

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

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

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

Opinion

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

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

The Annual Report including the remuneration report was approved by the DH authorised signatory at the DH sub Audit Committee for South East London on 31 May 2013.

Carl Vincent
Director of Provider Finance and Finance Transition

12. FURTHER INFORMATION

A copy of the 2012/13 audited annual accounts including the PCT's Annual Governance Statement is available from:

Chris Costa
Chief Financial Officer
Greenwich CCG
31-37 Greenwich Park Street, London SE10 9LR
Tel 020 8293 7238
chris.costa@nhs.net

Department of Health

NHS

Greenwich Teaching Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Greenwich Teaching Primary Care Trust

2012-13 Accounts

Greenwich Primary Care Trust

Annual Accounts

Year Ended 31st March 2013

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

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Greenwich 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.

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

Date.....31/5/13.....

Carl Vincent
Director of Provider Finance and Finance Transition

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 Greenwich 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
- 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.

Andrew Kenworthy
Accountable Officer 2012/13

Signature: 

Date: 24 April 2013

2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director 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 Greenwich 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.

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature:

Date: 24 April 2013

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF GREENWICH TEACHING PCT

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

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

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

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

Respective responsibilities of the Signing Officer and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are also required by the Audit Commission's Code of Audit Practice to report any matters that prevent us being

satisfied that the audited body has put in place such arrangements.

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

- our review of the annual governance statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and
- our locally determined risk-based work on transition arrangements.

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

Certificate

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

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

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

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	**7,362**	6,173
Other costs	5.1	**505,789**	487,996
Income	4	**(9,621)**	(7,259)
Net operating costs before interest		**503,530**	486,910
Investment income	9	**(110)**	(22)
Finance costs	11	**252**	378
Net operating costs for the financial year		**503,672**	487,266
Net Operating Costs for the Financial Year including absorption transfers		**503,672**	**487,266**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**4,355**	3,221
Other costs	5.1	**7,183**	9,588
Income	4	**(32)**	(67)
Net administration costs before interest		**11,506**	**12,742**
Investment income	9	**0**	(22)
Finance costs	11	**0**	94
Net administration costs for the financial year		**11,506**	**12,814**
Programme Expenditure			
Gross employee benefits	7.1	**3,007**	2,952
Other costs	5.1	**498,606**	478,408
Income	4	**(9,589)**	(7,192)
Net programme expenditure before interest		**492,024**	**474,168**
Investment income	9	**(110)**	0
Finance costs	11	**252**	284
Net programme expenditure for the financial year		**492,166**	**474,452**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**3,511**	1,487
Net (gain) on revaluation of property, plant & equipment	**(254)**	(2,481)
Total comprehensive net expenditure for the year*	**506,929**	**486,272**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 11 to 48 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	32,770	35,193
Intangible assets	13	198	440
Other financial assets	18	282	212
Total non-current assets		33,250	35,845
Current assets:			
Trade and other receivables	16	2,830	5,741
Other financial assets	18	7	7
Cash and cash equivalents	19	219	213
Total current assets		3,056	5,961
Non-current assets held for sale		0	0
Total current assets		3,056	5,961
Total assets		36,306	41,806
Current liabilities			
Trade and other payables	20	(34,183)	(38,822)
Provisions	25	(2,889)	(557)
Borrowings	21	(120)	(222)
Total current liabilities		(37,192)	(39,601)
Non-current assets plus/less net current assets/liabilities		(886)	2,205
Non-current liabilities			
Trade and other payables	20	(640)	0
Provisions	25	(2,277)	(51)
Borrowings	21	(3,885)	(3,897)
Total non-current liabilities		(6,802)	(3,948)
Total Assets Employed:		(7,688)	(1,743)
Financed by taxpayers' equity:			
General fund		(25,230)	(22,542)
Revaluation reserve		17,542	20,799
Total taxpayers' equity:		(7,688)	(1,743)

The notes on pages 11 to 48 form part of this account.

The financial statements on pages *7 to 10* were approved by the DH Audit Committee on 31 May 2013 and signed on its behalf by

C Vincent

Carl Vincent
Director of Provider Finance and Finance Transition

Date: 31/5/13

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(22,542)**	**20,799**	**0**	**(1,743)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(503,672)			**(503,672)**
Net gain on revaluation of property, plant, equipment		254		**254**
Impairments and reversals		(3,511)		**(3,511)**
Movements in other reserves			0	**0**
Reclassification Adjustments				
Total recognised income and expense for 2012-13	**(503,672)**	**(3,257)**	**0**	**(506,929)**
Net Parliamentary funding	500,984			**500,984**
Balance at 31 March 2013	**(25,230)**	**17,542**	**0**	**(7,688)**
Balance at 1 April 2011	**(16,956)**	**19805**	**0**	**2,849**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(487,266)			(487,266)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		2,481		2,481
Impairments and Reversals		(1,487)		(1,487)
Total recognised income and expense for 2011-12	(487,266)	994	0	(486,272)
Net Parliamentary funding	481,680			481,680
Balance at 31 March 2012	**(22,542)**	**20,799**	**0**	**(1,743)**

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	**(503,530)**	(486,910)
Depreciation and Amortisation	**1,399**	1,417
Interest Paid	**(275)**	(378)
(Increase)/Decrease in Trade and Other Receivables	**2,911**	(2,417)
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(4,188)**	8,306
Provisions Utilised	**(268)**	(915)
Increase/(Decrease) in Provisions	**4,826**	(7)
Net Cash Inflow/(Outflow) from Operating Activities	**(499,125)**	**(480,904)**
Cash flows from investing activities		
Interest Received	**110**	0
(Payments) for Property, Plant and Equipment	**(1,783)**	(491)
(Payments) for Other Financial Assets	**(66)**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(1,739)**	**(491)**
Net cash inflow/(outflow) before financing	**(500,864)**	**(481,395)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(114)**	(106)
Net Parliamentary Funding	**500,984**	481,680
Net Cash Inflow/(Outflow) from Financing Activities	**500,870**	**481,574**
Net increase/(decrease) in cash and cash equivalents	**6**	**179**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**213**	**34**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**219**	**213**

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.

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Greenwich PCT was dissolved on 1st April 2013. The PCT's 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 SOFP 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. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

1.1 Accounting Conventions

The financial statements have been prepared in accordance with EU endorsed International Financial Reporting Standards and IFRIC's as applicable to the NHS under the FReM.

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

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

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

Revenue recognition

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

Classification of property
The PCT owns a number of properties, which are maintained primarily to provide services. The receipt of market-based rental from these properties is incidental to holding these properties. These properties are held for service delivery objectives as part of the PCT's Community Strategy Plan and Strategic Services Development Plan. These properties are accounted for as property, plant and equipment

LIFT

The PCT's accounting policies regarding its LIFT scheme are disclosed in Note 1.23 to these financial statements. The PCT accounts for these assets under IFRIC 12 as a service concession and when the applicable elements of IAS 17 are met these are capitalised.

1. Accounting policies (continued)

The PCT initially recognised the LIFT assets and associated finance lease liability at the assets' fair value. The PCT's LIFT asset is being accounted for in two ways, an element as if it was a freehold building and an element as plant and equipment, the accounting judgements and estimation uncertainty for both of which are disclosed below. The PCT has taken the judgement that, due to the uncertainty over the size and structure of the health care economy at the end of the lease, it is unlikely that it will exercise its repurchase option over the LIFT at the end of the lease life. It is therefore depreciating the asset over the life of the lease rather than the asset's useful economic life. The LIFT finance lease liabilities are being amortised over the lives of the lease using the rate of return required by the assets' operators. This rate has been estimated using the assets' operators' financial models, as agreed with the PCT at the schemes' inception, and is estimated to spread that return over the life of the leases.

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

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

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Provisions

The significant critical judgments for the PCT's pension provisions are disclosed in Note 7.5

The PCT has provided for significant material provisions around continuing care claims, details of which are included in Note 25 The PCT has no other material provisions. The PCT is not aware of any material estimation uncertainty over the completeness of its provisions. Contingent liabilities are disclosed in Note 22.

Redundancy Payment Accruals and Provisions – PCT Reorganisation : The accounts include accruals for redundancies that incurred during March 2013. Number of payments for these redundancies were made in March 2013 and reported as cash expenditure. Payments for redundancies due and not paid have been accrued in the Accounts.

Property, plant, and equipment

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

The PCT recognises leases when in the judgement of the board the transaction meets the definition of a lease as set down by IAS 17 or transactions where there is no formal lease but where there is a substance of a lease as require by IFRIC 4. The PCT will decide on whether to recognise leases as finance or operating leases using the criteria laid down by IAS 17 with a rebuttable presumption that leases where the net present of future lease payments exceeds 90% of the asset's fair value at the inception of the lease the lease will be capitalised as a finance lease. Where other factors suggest a finance lease category better reflects the substance of the transaction and the transfer of risks and rewards of the leased asset the PCT will capitalise the lease even if the 90% target is not met.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

The Primary Care Trust has exercised its judgement on the appropriate classification of building leases and has determined a number of lease arrangements are finance leases.

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

Recoverability of NHS debtors

The PCT does not provide against amounts due from other NHS bodies; the PCT is not aware of dispute or any other factors that could impact the recoverability of those debts..

Property, plant, and equipment

The PCT's estimates regarding property, plant, and equipment used are disclosed in Note 1.5. They are annually reviewed by the PCT, using external specialist advice where appropriate. Where there is indication that the PCT's assets are impaired, the estimation technique used to calculate the level of impairment is to compare the current holding amount of the asset to the assets fair value as derived by a professional valuer and using a valuation basis suitable for the asset (normally open market value for alternative use). The difference is then accounted for in line with the applicable accounting standards.

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Taxation

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

1.4 Administration and Programme Costs

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

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

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

1.5 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.6 Intangible Assets

Recognition

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

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

1.7 Depreciation, amortisation and impairments

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

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit 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 the financial year, any expected increases in AME require Treasury approval.

1.8 Donated assets

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

1.9 Government grants

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. Accounting policies (continued)

1.10 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.

1.11 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 goverr 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).

1.12 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 25.

1.13 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which, on the grounds of immateriality.

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

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.

1.14 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.

1.15 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)

1.16 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.

1.17 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.18 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)

1.19 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

Greenwich Teaching PCT has reviewed its contracts and determined that it does not have any contracts with embedded derivatives.

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

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

1.20 NHS LIFT transactions

HM Treasury has determined that government bodies shall account for infrastructure LIFT schemeswhere the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The PCT therefore recognises the LIFT asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating 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 LIFT 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) LIFT assets, liabilities, and finance costs
The LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the PCT's approach for each relevant class of asset in accordance with the principles of IAS 16.

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

1. Accounting policies (continued)

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

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

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

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

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

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

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

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

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

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

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

2 Operating segments

The provider services transferred to Oxleas NHS Foundation Trust on 1st April 2011, therefore Greenwich Teaching PCT no longer has a separate operating segment.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**503,672**	487,266
Net operating cost plus (gain)/loss on transfers by absorption	**508,398**	492,036
Revenue Resource Limit	**4,726**	4,770
Under/(Over)spend Against Revenue Resource Limit (RRL)		

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**2,890**	982
Charge to Capital Resource Limit	**1,991**	543
(Over)/Underspend Against CRL	**899**	**439**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**500,984**	481,680
Cash Limit	**504,984**	485,280
Under/(Over)spend Against Cash Limit	**4,000**	**3,600**

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

	2012-13 £000
Total cash received from DH (Gross)	449,550
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**449,550**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	12,668
Plus: drugs reimbursement (central charge to cash limits)	38,766
Parliamentary funding credited to General Fund	**500,984**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**351**	0	351	0
Dental Charge income from Contractor-Led GDS & PDS	**2,533**		2,533	2,773
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**1,905**		1,905	1,857
Strategic Health Authorities	**294**	2	292	20
NHS Trusts	**4**	0	4	8
NHS Foundation Trusts	**1,531**	0	1,531	398
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**1,314**	0	1,314	730
Primary Care Trusts - Lead Commissioning	**0**	0	0	38
Local Authorities	**52**	0	52	1,347
Education, Training and Research	**412**	0	412	1
Other Non-NHS Patient Care Services	**462**	0	462	9
Rental revenue from operating leases	**620**	0	620	0
Other revenue	**143**	30	113	78
Total miscellaneous revenue	**9,621**	**32**	**9,589**	**7,259**

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	**32,700**		32,700	22,626
Non-Healthcare	**3,178**	3,178	0	3,763
Total	**35,878**	**3,178**	**32,700**	**26,389**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**149,760**	0	149,760	151,449
Goods and services (other, excl Trusts, FT and PCT))	**464**	1	463	864
Total	**150,224**	**1**	**150,223**	**152,313**
Goods and Services from Foundation Trusts	**147,877**	16	147,861	155,019
Purchase of Healthcare from Non-NHS bodies	**61,387**		61,387	42,434
Social Care from Independent Providers	**0**		0	0
Expenditure on Drugs Action Teams	**3,040**		3,040	2,665
Non-GMS Services from GPs	**889**	0	889	915
Contractor Led GDS & PDS (excluding employee benefits)	**15,470**		15,470	15,042
Chair, Non-executive Directors & PEC remuneration	**30**	30	0	26
Executive committee members costs	**251**	251	0	189
Consultancy Services	**1,857**	178	1,679	1,049
Prescribing Costs	**33,012**		33,012	34,640
G/PMS, APMS and PCTMS (excluding employee benefits)	**37,596**	0	37,596	36,508
New Pharmacy Contract	**9,305**		9,305	9,079
General Ophthalmic Services	**2,177**		2,177	1,914
Supplies and Services - Clinical	**196**	0	196	286
Supplies and Services - General	**36**	28	8	22
Establishment	**1,391**	1,099	292	610
Transport	**5**	5	0	1,079
Premises	**2,512**	1,362	1,150	2,822
Depreciation	**1,157**	0	1,157	1,137
Amortisation	**242**	242	0	280
Impairment of Receivables	**35**	35	0	(89)
Audit Fees	**104**	104	0	159
Other Auditors Remuneration	**25**	25	0	24
Education and Training	**282**	271	11	162
Grants for capital purposes	**435**	0	435	0
Other	**376**	358	18	3,322
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**505,789**	**7,183**	**498,606**	**487,996**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**535**	410	125	389
Other Employee Benefits	**6,827**	3,945	2,882	5,784
Total Employee Benefits charged to SOCNE	**7,362**	**4,355**	**3,007**	**6,173**
Total Operating Costs	**513,151**	**11,538**	**501,613**	**494,169**
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to Local Authorities to Fund Capital Projects	**435**	0	435	0
Total Capital Grants	**435**	**0**	**435**	**0**
Total Grants	**435**	**0**	**435**	**0**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,919**	10,959	960
Weighted population (number in units)*	**265,704**	265,704	265,704
Running costs per head of population (£ per head)	**45**	**41**	**4**
PCT Running Costs 2011-12			
Running costs (£000s)	**12,814**	12,021	793
Weighted population (number in units)	**265,704**	265,704	265,704
Running costs per head of population (£ per head)	**48**	**45**	**3**

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

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	37,596	36,508
Prescribing costs	33,012	34,640
Contractor led GDS & PDS	15,470	15,042
General Ophthalmic Services	2,177	1,914
New Pharmacy Contract	9,305	9,079
Non-GMS Services from GPs	889	915
Total Primary Healthcare purchased	**98,449**	98,098
Purchase of Secondary Healthcare		
Learning Difficulties	5,272	3,569
Mental Illness	59,913	60,200
Maternity	20,906	23,537
General and Acute	210,769	199,976
Accident and emergency	11,879	11,455
Community Health Services	38,213	40,361
Other Contractual	41,653	34,981
Total Secondary Healthcare Purchased	**388,605**	374,079
Grant Funding		
Grants for capital purposes	435	0
Total Healthcare Purchased by PCT	**487,489**	**472,177**
Healthcare from NHS FTs included above	147,861	155,019

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				1,878	1,878
Total				1,878	1,878
Payable:					
No later than one year	0	1,789	0	1,789	1,789
Between one and five years	0	4,361	0	4,361	5,154
After five years	0	4,548	0	4,548	5,461
Total	0	10,698	0	10,698	12,404
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	620	0
Total	620	0
Receivable:		
No later than one year	859	0
Between one and five years	1,464	0
After five years	3,130	0
Total	5,453	0

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13			Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	6,085	3,580	2,505	4,182	1,677	2,505	1,903	1,903	0
Social security costs	421	202	219	421	202	219	0	0	0
Employer Contributions to NHS BSA - Pensions Division	544	261	283	544	261	283	0	0	0
Termination benefits	312	312	0	312	312	0	0	0	0
Total employee benefits	7,362	4,355	3,007	5,459	2,452	3,007	1,903	1,903	0
Total - Net Employee Benefits including capitalised costs	7,362	4,355	3,007	5,459	2,452	3,007	1,903	1,903	0
Gross Employee Benefits excluding capitalised costs	7,362	4,355	3,007	5,459	2,452	3,007	1,903	1,903	0
Recognised as:									
Commissioning employee benefits	7,362			5,459			1,903		
Gross Employee Benefits excluding capitalised costs	7,362			5,459			1,903		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	5,262	4,649	613
Social security costs	380	380	0
Employer Contributions to NHS BSA - Pensions Division	531	531	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total gross employee benefits	6,173	5,560	613
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	6,173	5,560	613
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	6,173	5,560	613
Recognised as:			
Commissioning employee benefits	6,173		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	6,173		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	2	2	0	2	2	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	99	99	0	96	90	6
Healthcare assistants and other support staff	1	1	0	1	1	0
Nursing, midwifery and health visiting staff	2	2	0	5	5	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	2	2	0	2	2	0
Social Care Staff	0	0	0	0	0	0
Other	14	0	14	1	1	0
TOTAL	119	106	14	108	101	6
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	834	3,642
Total Staff Years	101	365
Average working Days Lost	8.28	9.98

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	0	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	0	46

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**1**	**0**	**1**	0	0	**0**
£10,001-£25,000	**2**	**0**	**2**	0	0	**0**
£25,001-£50,000	**4**	**0**	**4**	0	0	**0**
£50,001-£100,000	**0**	**0**	**0**	0	0	**0**
£100,001 - £150,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost	**8**	**0**	**8**	**0**	**0**	**0**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	311,546	0	**311,546**	0	0	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme or Mutually Agreed Resignation Scheme (MARS). 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 intervenir 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 31March 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

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 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.

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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 infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**11,010**	**68,104**	8,505	87,944
Total Non-NHS Trade Invoices Paid Within Target	**8,828**	**64,457**	7,471	74,293
Percentage of NHS Trade Invoices Paid Within Target	80.18%	94.64%	87.84%	84.48%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,645**	**364,916**	3,706	357,506
Total NHS Trade Invoices Paid Within Target	**4,122**	**360,924**	3,388	355,658
Percentage of NHS Trade Invoices Paid Within Target	88.74%	98.91%	91.42%	99.48%

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

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: equity dividends receivable	36	0	36	0
LIFT: loan interest receivable	19	0	19	22
Other loans and receivables	55	0	55	0
Subtotal	110	0	110	22
Total investment income	110	0	110	22

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	0	0	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0	0	0
Gain/(Loss) on disposal of Financial Assets - other than held for sale	0	0	0	0
Gain (Loss) on disposal of assets held for sale	0	0	0	0
Gain/(loss) on foreign exchange	0	0	0	0
Change in fair value of financial assets carried at fair value through the SoCNE	0	0	0	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	0	0	0	0
Change in fair value of investment property	0	0	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0	0	0
Total	0	0	0	0

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	79	0	79	200
Interest on obligations under LIFT contracts:				
- main finance cost	173	0	173	175
Total interest expense	252	0	252	375
Total	252	0	252	375

12. 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	**20,638**	**10,804**	**468**	**1,407**	**932**	**0**	**5,536**	**937**	**40,722**
Additions of Assets Under Construction				1,577					**1,577**
Additions Purchased	0	0	0		0	0	414	0	**414**
Reclassifications	0	815	0	(1,170)	35	0	303	17	**0**
Upward revaluation/positive indexation	0	253	0	0	0	0	0	0	**253**
Impairments/negative indexation	(2,986)	(517)	(8)	0	0	0	0	0	**(3,511)**
Cumulative dep netted off cost following revaluation	0	(388)	0	0	0	0	0	0	**(388)**
At 31 March 2013	**17,652**	**10,967**	**460**	**1,814**	**967**	**0**	**6,253**	**954**	**39,067**
Depreciation									
At 1 April 2012	**0**	**0**	**0**	**0**	**642**	**0**	**4,249**	**638**	**5,529**
Charged During the Year	0	388	7		72	0	539	151	**1,157**
Cumulative dep netted off cost following revaluation	0	(388)	0	0	0	0	0	0	**(388)**
At 31 March 2013	**0**	**0**	**7**	**0**	**714**	**0**	**4,788**	**789**	**6,298**
Net Book Value at 31 March 2013	**17,652**	**10,967**	**453**	**1,814**	**253**	**0**	**1,465**	**165**	**32,769**
Purchased	17,652	10,967	453	1,814	253	0	1,465	165	**32,769**
Total at 31 March 2013	**17,652**	**10,967**	**453**	**1,814**	**253**	**0**	**1,465**	**165**	**32,769**
Asset financing:									
Owned	17,252	6,806	453	1,814	253	0	1,465	165	**28,208**
Held on finance lease	0	2,608	0	0	0	0	0	0	**2,608**
On-SOFP PFI contracts	400	1,553	0	0	0	0	0	0	**1,953**
Total at 31 March 2013	**17,652**	**10,967**	**453**	**1,814**	**253**	**0**	**1,465**	**165**	**32,769**

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	**16,552**	**4,156**	**13**	**0**	**25**	**0**	**0**	**53**	**20,799**
Movements (specify)	(2,986)	(271)	0	0	0	0	0	0	**(3,257)**
At 31 March 2013	**13,566**	**3,885**	**13**	**0**	**25**	**0**	**0**	**53**	**17,542**

Additions to Assets Under Construction in 2012-13

	£000
Buildings excl Dwellings	1,577
Balance as at YTD	**1,577**

12.1 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	**18,779**	**11,918**	**684**	**913**	**932**	**0**	**5,487**	**937**	**39,650**
Additions - purchased	0	0	0	494	0	0	49	0	**543**
Revaluation & indexation gains	2,474	7	0	0	0	0	0	0	**2,481**
Impairments	(615)	(663)	(209)	0	0	0	0	0	**(1,487)**
Cumulative dep netted off cost following revaluatio	0	(458)	(7)	0	0	0	0	0	**(465)**
At 31 March 2012	**20,638**	**10,804**	**468**	**1,407**	**932**	**0**	**5,536**	**937**	**40,722**
Depreciation									
At 1 April 2011	**0**	**0**	**0**		**598**	**0**	**3,699**	**560**	**4,857**
Charged During the Year	0	458	7		44	0	550	78	**1,137**
Cumulative dep netted off cost following revaluatio	0	(458)	(7)	0	0	0	0	0	**(465)**
At 31 March 2012	**0**	**0**	**0**	**0**	**642**	**0**	**4,249**	**638**	**5,529**
Net Book Value at 31 March 2012	**20,638**	**10,804**	**468**	**1,407**	**290**	**0**	**1,287**	**299**	**35,193**
Purchased	20,638	10,804	468	1,407	290	0	1,287	299	**35,193**
At 31 March 2012	**20,638**	**10,804**	**468**	**1,407**	**290**	**0**	**1,287**	**299**	**35,193**
Asset financing:									
Owned	20,238	6,514	468	1,407	290	0	1,287	299	**30,503**
Held on finance lease	0	2,678	0	0	0	0	0	0	**2,678**
On-SOFP PFI contracts	400	1,612	0	0	0	0	0	0	**2,012**
At 31 March 2012	**20,638**	**10,804**	**468**	**1,407**	**290**	**0**	**1,287**	**299**	**35,193**

12.2 Property, plant and equipment

Land and Property assets were revalued by the District Valuer as at 31st March 2013 prices.

The valuations have been undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition.

The valuations were carried out by Peter Ashby MRICS, RICS Registered Valuers of DVS

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

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

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

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

- "The Market Value on the assumption that the property is sold as part of the continuing enterprise in occupation" (effectively EUV); or
- "The Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the traditional understanding of Market Value).

The Department of Health has indicated that for NHS assets it requires the former assumption to be applied for operational assets and the District Valuer has confirmed that approach was followed in his report.

Disposals : The PCT did not dispose of any non-current assets materially below the valuation by professional valuers.

The valuations were carried out by Peter Ashby MRICS, RICS Registered Valuers of DVS

13. Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**1,427**	**0**	**0**	**0**	**1,427**
At 31 March 2013	**0**	**1,427**	**0**	**0**	**0**	**1,427**
Amortisation						
At 1 April 2012	**0**	**987**	**0**	**0**	**0**	**987**
Charged during the year	0	242	0	0	0	**242**
At 31 March 2013	**0**	**1,229**	**0**	**0**	**0**	**1,229**
Net Book Value at 31 March 2013	**0**	**198**	**0**	**0**	**0**	**198**
Net Book Value at 31 March 2013 comprises						
Purchased	0	198	0	0	0	**198**
Total at 31 March 2013	**0**	**198**	**0**	**0**	**0**	**198**

13.1 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2011	**0**	**1,427**	**0**	**0**	**0**	**1,427**
At 31 March 2012	**0**	**1,427**	**0**	**0**	**0**	**1,427**
Amortisation						
At 1 April 2011	**0**	**707**	**0**	**0**	**0**	**707**
Charged during the year	0	280	0	0	0	**280**
At 31 March 2012	**0**	**987**	**0**	**0**	**0**	**987**
Net Book Value at 31 March 2012	**0**	**440**	**0**	**0**	**0**	**440**
Net Book Value at 31 March 2012 comprises						
Purchased	0	440	0	0	0	**440**
Total at 31 March 2012	**0**	**440**	**0**	**0**	**0**	**440**

13.2 Economic Lives of Non-Current Assets

	2012-13		2011-12	
Remaining years as @ 31 March 2013	**Min Life Years**	**Max Life Years**	Min Life Years	Max Life Years
Intangible Assets				
Software Licences	1	5	2	5
Property, Plant and Equipment				
Buildings excl. Dwellings	16	64	15	70
Dwellings	14	70	15	70
Plant & Machinery	2	5	3	5
Information Technology	2	5	3	5
Furniture and Fittings	4	15	5	15

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	3,511	3,511	
Total impairments for PPE charged to reserves	**3,511**	3,511	
Total Impairments of Property, Plant and Equipment	**3,511**	**3,511**	**0**
Total Impairments of Financial Assets	**0**	**0**	**0**

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Total Impairments charged to Revaluation Reserve	3,511	3,511	
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	0	0	0
Overall Total Impairments	**3,511**	**3,511**	**0**

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	533	0	2,163	0
Balances with Local Authorities	0	0	2,048	0
Balances with NHS Trusts and Foundation Trusts	668	0	8,333	0
Balances with bodies external to government	1,629	0	21,639	640
At 31 March 2013	**2,830**	**0**	**34,183**	**640**
prior period:				
Balances with other Central Government Bodies	929	0	943	0
Balances with Local Authorities	1,373	0	1,331	0
Balances with NHS Trusts and Foundation Trusts	2,835	0	10,717	0
Balances with bodies external to government	604	0	25,831	0
At 31 March 2012	**5,741**	**0**	**38,822**	**0**

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	**785**	1,192	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**416**	2,501	**0**	0
Non-NHS receivables - revenue	**1,243**	1,860	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**15**	178	**0**	0
Provision for the impairment of receivables	**(6)**	(61)	**0**	0
VAT	**377**	71	**0**	0
Total	**2,830**	5,741	**0**	0
Total current and non current	**2,830**	5,741		
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	**0**	46
By more than six months	**775**	0
Total	**775**	46

16.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(61)**	(150)
Amount written off during the year	**90**	0
(Increase)/decrease in receivables impaired	**(35)**	89
Balance at 31 March 2013	**(6)**	(61)

In order to arrive at the bad debt provision, the PCT reviewed the aged debt analysis and assessed all the items over 90 days old or where queries had been raised and made an informed judgement as to the likelihood of recovery.

17 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**219**	**0**	**219**
Additions	**70**	**0**	**70**
Balance at 31 March 2013	**289**	**0**	**289**
Balance at 1 April 2011	189	0	189
Additions	30	0	30
Balance at 31 March 2012	**219**	**0**	**219**

18.1 Other financial assets - Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	7	7
Closing balance 31 March	**7**	7

18.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**212**	182
Additions	70	30
Total Other Financial Assets - Non Current	**282**	212

18.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**70**	30

19 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**213**	39
Net change in year	**6**	174
Closing balance	**219**	213
Made up of		
Cash with Government Banking Service	**219**	212
Commercial banks	**0**	1
Cash and cash equivalents as in statement of financial position	**219**	213
Cash and cash equivalents as in statement of cash flows	**219**	213

20 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS payables - revenue	**8,259**	11,442	**0**	0
NHS payables - capital	**156**	218	**0**	0
NHS accruals and deferred income	**2,081**	0	**0**	0
Family Health Services (FHS) payables	**12,155**	10,184	0	0
Non-NHS payables - revenue	**6,715**	14,721	**0**	0
Non-NHS payables - capital	**251**	0	**0**	0
Non_NHS accruals and deferred income	**4,261**	1,788	**640**	0
Social security costs	**1**	457	**0**	0
Tax	**9**	1	**0**	0
Payments received on account	**70**	2	**0**	0
Other	225	9	0	0
Total	**34,183**	38,822	**640**	0
Total payables (current and non-current)	**34,823**	**38,822**		

21 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
LIFT liabilities:				
Main liability	**26**	25	**1,540**	1,567
Finance lease liabilities	**94**	197	**2,345**	2,330
Total	**120**	**222**	**3,885**	**3,897**
Total other liabilities (current and non-current)	**4,005**	**4,119**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	Other	Total
	£000s	**£000s**	**£000s**
0 - 1 Years	0	120	**120**
1 - 2 Years	0	144	**144**
2 - 5 Years	0	389	**389**
Over 5 Years	0	3,352	**3,352**
TOTAL	**0**	**4,005**	**4,005**

23 Deferred income

The PCT had no deferred income in 2012/13 (nil - 2011/13)

24 Finance lease obligations

Greenwich Teaching PCT has two finance leases are for the premises at The Wallace Health Centre (also known as Creekside) and Millennium Village Health Centre. Services delivered from there include General Practice and Community Facilities.

The Wallace Health Centre lease expires on 1st April 2028 and has an annual rental of £158,400.
Millennium Village Health Centre lease expires on 1st January 2027 and has an annual rental of £198,000.

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**277**	197	**94**	228
Between one and five years	**1,110**	742	**459**	837
After five years	**3,999**	3,481	**1,886**	1,462
Less future finance charges	**(2,947)**	(1,893)		
Present value of minimum lease payments	**2,439**	2,527	**2,439**	2,527
Included in:				
Current borrowings			**94**	228
Non-current borrowings			**2,345**	2,299
			2,439	2,527

25 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**608**	0	74	0	0	0	0	0	271	263
Arising During the Year	**4,847**	0	0	0	0	4,535	0	0	312	0
Utilised During the Year	**(268)**	0	(18)	0	0	0	0	0	(250)	0
Reversed Unused	**(21)**	0	0	0	0	0	0	0	(21)	0
Balance at 31 March 2013	**5,166**	**0**	**56**	**0**	**0**	**4,535**	**0**	**0**	**312**	**263**
Expected Timing of Cash Flows:										
No Later than One Year	**2,889**	**0**	**18**	**0**	**0**	**2,296**	**0**	**0**	**312**	**263**
Later than One Year and not later than Five Years	**2,277**	**0**	**38**	**0**	**0**	**2,239**	**0**	**0**	**0**	**0**

Continuing Care

In March 2012 the Department of Health announced deadlines for individuals or their representatives to notify the relevant PCT if they believe there was a period of care between 1st April 2004 and 31st March 2012 where there is evidence that the individual should have been assessed for eligibility for NHS continuing healthcare (NHS CHC). This only applies to new cases ie where, the individual has not previously been assessed for NHS CHC during the identified period. The first deadline was the 30th September 2012 relating to claims between 1st April 2004 to 31st March 2011. The second deadline was 31st March 2013 relating to the period from 1st April 2011 to 31st March 2012. The PCT received a total of 342 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been ongoing through the year and a financial provision has been made based on estimates of the potential financial exposure using the latest information available at the time.

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	**£000s**
As at 31 March 2013	123
As at 31 March 2012	309

26 LIFT - additional information

The PCT entered into a 'Local Improvement Finance Trust' (LIFT) procurement arrangement in 2003. This was for premises developments and improvements with Bexley Care Trust and Bromley PCT. Garland Road Health Centre was fully operational from December 2006. Services delivered from there include General Practice and Community Facilities. The current lease plus arrangement is for a period of 25 years which expires on December 2031.

The current rental payment is £293k per annum and is linked annualily to the RPI. The PCT has the option to purchase the asset at the end of the lease. Under IFRIC 12 the asset is treated as an asset of the PCT, that the substance of the contract is that the PCT has a finance lease and payments comprise the two elements-inputted finance lease charges and service charges.

	31 March 2013	31 March 2012
	£000	£000
26.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP LIFT		
Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013**	31 March 2012
	£000	£000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**161**	161
Total	**161**	161
	31 March 2013	31 March 2012
	£000	£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	**26**	25
Later than One Year, No Later than Five Years	**75**	77
Later than Five Years	**1,466**	1,490
Total	**1,567**	1,592
Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013**	31 March 2012
	£000	£000
No Later than One Year	**196**	197
Later than One Year, No Later than Five Years	**731**	742
Later than Five Years	**3,295**	3,481
Subtotal	**4,222**	4,420
Less: Interest Element	**(2,655)**	(2,828)
Total	**1,567**	1,592

27 Impact of IFRS treatment - 2012-13

	Total	Admin	Programme
	£000	£000	£000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)			
Depreciation charges	**33**	0	33
Interest Expense	**173**	0	173
Total IFRS Expenditure (IFRIC12)	**206**	**0**	**206**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**0**	0	0
Net IFRS change (IFRIC12)	**206**	**0**	**206**

27 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 is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The PCT has no overseas operations. The PCT 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.

27.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		1,121		**1,121**
Receivables - non-NHS		1,237		**1,237**
Cash at bank and in hand		219		**219**
Other financial assets	8	281	0	**289**
Total at 31 March 2013	**8**	**2,858**	**0**	**2,866**
Embedded derivatives	0			0
Receivables - NHS		1,192		1,192
Receivables - non-NHS		1,799		1,799
Cash at bank and in hand		213		213
Other financial assets	0	219	0	219
Total at 31 March 2012	0	3,423	0	3,423

27.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		10,499	**10,499**
Non-NHS payables		23,535	**23,535**
Other borrowings		1,567	**1,567**
PFI & finance lease obligations		2,439	**2,439**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**38,040**	**38,040**
Embedded derivatives	0		0
NHS payables		11,660	11,660
Non-NHS payables		26,693	26,693
Other borrowings		1,592	1,592
PFI & finance lease obligations		2,527	2,527
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	42,472	42,472

There are no differences in the fair value of financial assets or financial liabilities from carrying book amounts.

28 Related party transactions

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

During the year the following Board Members and members of Clinical Commissioning Collaborative Committee and parties related to them have undertaken material transactions with Greenwich Teaching Primary Care Trust as follows:

	Services Received For Organisation	Payments to Related Party
		£
Dr Hany Wahba - St Mark's Medical Centre	Primary Care	1,165,376
Dr Eugenia Lee - Thamesmead Medical	Primary Care	1,839,307
Dr Nayan Patel - Blackheath Standard Surgery- Greenwich	Primary Care	924,440
Dr Ellen Wright - Vanburgh Group Practice	Primary Care	1,220,017
Dr Junaid Bajwa - Conway PMS	Primary Care	517,040

The Department of Health is regarded as a related party. During the year Greenwich Teaching Primary Care Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

		'£000s
South London Healthcare Trust	Provision of Health Care	118,684
Guys And St Thomas NHS Foundation Trust	Provision of Health Care	33,644
Oxleas NHS Foundation Trust	Provision of Health Care	86,550
Kings College Hospital NHS Foundation Trust	Provision of Health Care	17,522
Croydon Primary Care Trust	Provision of Health Care	31,092
London Borough of Greenwich	Healthcare from non-NHS Bodies	22,918

Greenwich Teaching PCT Charitable Trust Fund is regarded as a related party.

2011-12

		£
Keith Wood - Greenwich & Bexley Community Hospice Ltd	Non Acute	£2,731,831
Dr Hany Wahba - St Mark's Medical Centre	Primary Care	£1,128,483
Dr Ram Aggarwal - Plumstead Health Centre	Primary Care	£614,210
Dr Eugenia Lee - Thamesmead Medical	Primary Care	£1,925,969
Dr Niraj Patel - Thamesmead Medical	Primary Care	£1,925,969

		'£000s
South London Healthcare Trust	Provision of Health Care	121,719
Guys And St Thomas NHS Foundation Trust	Provision of Health Care	33,099
Oxleas NHS Foundation Trust	Provision of Health Care	90,549
Kings College Hospital NHS Foundation Trust	Provision of Health Care	18,636
NHS Croydon	Provision of Health Care	20,698
London Borough of Greenwich	Healthcare from non-NHS Bodies	6,315

29 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	89,972	12
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	89,972	12
Total special payments	0	0
Total losses and special payments	89,972	12

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

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

There is no single case individually over £250,000

30 Events after the end of the reporting period

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

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

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability. The principles for the split of residual balances is still subject to Department of Health guidance.

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

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

30 Events after the end of the reporting period (cont'd)

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

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

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

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

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

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

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

Greenwich Teaching Primary Care Trust

Organisation Code: 5A8

- **Scope of responsibility**

As signing officer delegated by the Department of Health's Accounting Officer I have taken assurances from the Accountable Officer for 2012-13 that he took responsibility for maintaining a sound system of internal control that supports the achievement of Greenwich Teaching Primary Care Trust (PCT) policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am responsible. I am also responsible for ensuring that Greenwich Teaching PCT is administered prudently and economically and that resources are applied efficiently and effectively. These responsibilities are as set out in the Accountable Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Greenwich Teaching PCT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Greenwich Teaching PCT for the year ended 31 March 2013. Greenwich Teaching PCT was abolished on 31st March 2013. NHS Greenwich Clinical Commissioning Group was authorised in February 2013.

NHS South East London covers a population of 1,568,000. There are four acute hospital trusts, two of which are Foundation Trusts, two mental health Foundation Trusts, and a diverse and active community sector. An Academic Health Sciences Centre consisting of Guy's and St Thomas', King's, South London and Maudsley and King's College London has also been formed. There are 271 GP practices and six community care providers, five of which have integrated with local NHS providers with one becoming a social enterprise.

There are approximately 254,600 residents in Greenwich in (census 2012). There were 274,951 people registered with Greenwich GPs, of which 260,385 (95 per cent) are Greenwich residents. The vast majority of people using the NHS in Greenwich will use primary and community health services. In Greenwich there are 44 GP practices, 40 dental practices, 57 community pharmacies

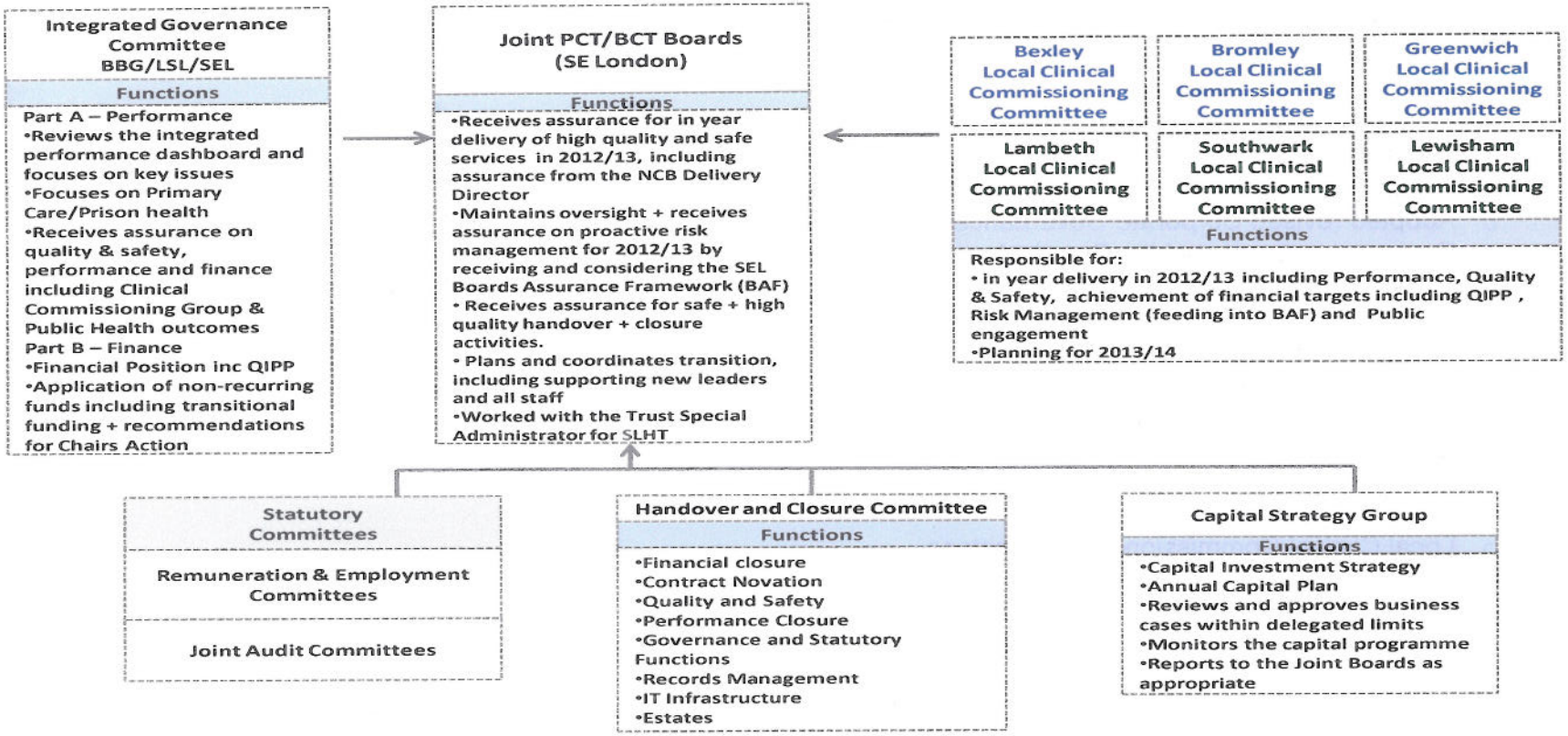
and 18 opticians. Community services such as district and school nursing, health visiting, specialist child health, therapy services and care for older people are provided primarily by Oxleas NHS Foundation Trust. For people who require secondary or more specialist care, we also commission:

- South London Healthcare NHS Trust (a hospital trust) to provide inpatient, outpatient, day and emergency care; and
- Specialist acute services from a range of acute hospitals including Guy's and St. Thomas' and King's College Hospital.
- Oxleas NHS Foundation Trust (a mental health trust) to provide mental health services.
- Greenwich Healthy Living Service (GHLIS) to provide services such as support to stop smoking, physical activity, expert patient programme, mental wellbeing services
- Harmoni for Health to provide health services for prisoners at HMP Belmarsh and HMP YOI Isis
- Bexley and Greenwich Community Hospice to provide services to people in the last year of life.

- **The governance framework of the organisation**

The Governance Framework is comprised of the Boards and Boards Committees detailed in the following diagram:

SE London Joint Boards and Committees 2012/13



Joint South East London PCT/Care Trust Boards

- The Joint Boards are six individual PCT/Care Trust Boards that work together as one entity, undertaking the duties that are enshrined in law relating to the governance of Primary Care Trusts and Care Trusts. Certain mandatory positions on the

Boards, such as the Chair and Chief Executive, are fulfilled by the same individual across all of the Boards, while other positions are taken by local Primary Care Trust (PCT) Managing Directors and locally-focused non-executive directors. The Boards focus on developing strategies and priorities for the entirety of NHS South East London (NHS SEL) (including Greenwich Teaching PCT), ensuring that the clinical commissioning committees are fulfilling their duties, in accordance with what is delegated to them.

- During 2012/13 the Joint Boards:
- Implemented the revised Governance arrangements agreed on 26 January 2012 reflecting the new shadow Clinical Commissioning Group (CCG) arrangements in place from 1 October 2012
- Agreed revised arrangements for managing conflicts of interest in NHS SEL
    - Adopted revised Corporate Governance Arrangements enacting the Transition
    - Reviewed and updated the Boards Assurance Framework at every Boards meeting.
    - Considered risk at every meeting and received assurance via an exception reporting arrangement, the format for which was considerably strengthened by the Boards during the year. This approach was supported through the delegation process whereby each borough Local Clinical Commissioning Committee (LCCC) reviewed risks relevant to their populations. The Joint Audit Committees (JAC) tested the system and process of assurance.
    - At each meeting received and considered reports on the following topics:
    - Quality and Performance
    - Finance
    - Integrated Governance
    - Local Clinical Commissioning Committees
    - Transition and Handover & Closure including:
        - Clinical Commissioning Groups
        - The South London Commissioning Support Unit
    - Individual matters reserved to the Joint Boards
- In 2012/13 the Boards met every two months, in public. All meetings were quorate for all Boards.

The Boards have assessed their own performance and effectiveness, including their compliance with key elements of the Code of Conduct and Code of Accountability for NHS Boards. Views were obtained via an anonymous online survey designed in keeping with the structure and format of a comparable survey last year. Twenty two returns were received from the Joint Boards membership of thirty four.

In the key areas of governance, there was a 100% satisfaction rating that governance arrangements enable members to identify

and, when necessary, declare potential conflicts of interest when conducting Board business. There was also a near unanimous satisfaction rating in the following areas (with one member disagreeing):

- the Joints Boards' ability to support the fulfillment of the statutory duties of the constituent PCTs and Care Trust
- ensuring effective financial control, financial planning and value for money.

Overall, members were also satisfied that:

- the Cluster's governance arrangements support the achievement of the standards and targets set out in the NHS Operating Framework;
- that there is clarity on the role of the Joint Boards and on responsibilities that can be delegated to committees and officers; and
- that the Joint Boards and their committees provide clarity on who is to take action following decisions made.

A small number of members did not agree that the Joint Boards have the opportunity to explore all the challenges and opportunities faced by the Cluster, although this was tempered by comment that such a situation was not, perhaps, surprising, given the considerable focus having to be devoted to the transition.

More members (though still a minority) recorded concerns about the amount of information sent to them for meetings, together with the limited time given to digest it. Though fewer members felt that duplication in the business and decision-making between the Joint Boards and their committees had taken place, perhaps, demonstrating the success of our arrangements for delegation and the implementation of revised governance arrangements during spring 2012.

Notwithstanding the comments noted above, the Chair and Chief Executive believe that there has been no material departure from the Code of Conduct and Code of Accountability for NHS Boards and none has been suggested by other Board members.

Greenwich Clinical Commissioning Committee (LCCC)

The Greenwich Clinical Commissioning Collaborative Committee (LCCC) was a committee of the Greenwich Teaching PCT Board. Its purpose was to develop and recommend to the Joint Boards of NHS Greenwich a commissioning plan that met the health needs of local people; ensure that there were robust local arrangements for the involvement of patients and the public and a wide range of clinicians in commissioning decisions affecting local people and; it also replaced and fulfilled the statutory duties of the PCT's

Professional Executive Committee.

The Committee was clinically led with a GP chair and GP majority and also comprised a representative from the Local Authority. The views of patients and the public were safeguarded through a representative from the Local Involvement Network (LINk). The ability of the Committee to challenge executive decisions was further enhanced through the inclusion of two voting non-executive members.

During the course of 2012/13 the LCCC met on ten occasions with five meetings held in public. To ensure effective governance members noted declarations of interests and were required to declare any conflicts of interest that affected the transaction of business on the each agenda. The LCCC was also required to approve all key items of business for which the PCT was responsible including the Commissioning Strategy Plan, Operating Plan and budgets and the Annual Report and Accounts. It also approved the terms of reference of LCCC sub-committees. The LCCC had delegated authority for all acute and non-acute services, prescribing, and corporate costs.

The LCCC managed the risks affecting the organisation through receipt and discussion of an Integrated Governance Report that was presented at each public meeting. This included a report on the work undertaken by the Quality sub-committee, a report on Finance, Performance and QIPP and a Risk Management report. The latter enabled the LCCC to monitor whether the PCT's risk profile was moving towards one of greater control and reviewed new, high and closed risks.

Joint Audit Committees

- The Joint Audit Committees (JAC) fulfils the statutory audit functions required of PCTs and Care Trusts, ensuring that the governance and machinery of the cluster and the PCTs/Care Trust is functioning as it should. Their work programme includes reviewing governance arrangements (including Information Governance), assurance mechanisms including the work of internal and external audit, local counter fraud and security management services, debt and waiver management, and reviewing the Board Assurance Framework to make sure that corporate objectives and organisational risks are properly addressed.
- During 2012/13 the JAC considered all residual risks and Assurance Frameworks from the PCTs / Care Trust in SEL. The Committee reviewed the Assurance Framework at every meeting.
- The JAC considered each of the six individual PCTs/Care Trust Annual Accounts, Audit opinions, Annual Reports and Annual Governance Statements for 2011/12 at its meetings on the 9 and 30 May 2012. .
- On 9 January 2013 the JAC received and considered the Annual Audit Letters
- On 13 and 27 March 2013 the JAC considered each of the six individual PCTs/ Care Trust draft Annual Reports and Annual

Governance Statements, along with the interim work on the 2012/13 Annual Accounts undertaken by internal and external audit. Year end documents will be finalised and approved post 31 March 2013 through the temporary mechanism being designed by the Department of Health.

- The JAC has increased its engagement with PCT/Care Trust Chief Finance Officers and Chief Officers; both are now routinely invited to meetings.
- The JAC meet at least quarterly. Meetings are not held in public but activities are reported to the Joint Boards. All meetings in 2012/13 were quorate.

Integrated Governance Committee (IGC)

The IGC has the following roles and responsibilities:-

- To oversee the integrated governance of the shadow CCGs and give the Joint Boards assurance that actions and plans put in place by the CCGs are appropriate, adequate and followed through as they work towards Authorisation.
- To give a forum for the shadow CCGs to operate at scale to manage the performance and quality of the major acute, community and mental health providers
- To help enable the Cluster Chief Executive to exercise his role as Accountable Officer through consideration and review of the aggregate Cluster position with respect to performance, finance, quality and emergency planning
- To review and consider the quality and performance of Primary Care, Prison Health and Specialist Services prior to full establishment of the National Commissioning Board
- To oversee the procedures for identifying, investigating and learning for serious incidents and for safeguarding children and vulnerable adults.
- The Committee meets monthly and all meetings were quorate during 2012/13
- Meetings are not held in public but a summary report detailing issues discussed and actions proposed is provided at each Joint Boards meeting.

Handover and Closure Committee

- Oversaw all aspects of the Handover and Closure programme in the NHS in South East London.
- The Committee meets in private but provides its minutes to the Joint Boards. All meetings in 2012/13 were quorate.

Capital Strategy Group

- Oversaw all aspects of Capital Strategy, planning and progress in the NHS in South East London
- The Group meets in private but considers issues prior to their decision at public meetings of LCCCs or the Joint Boards. All meetings in 2012/13 were quorate.

Joint Remuneration and Employment Committee

- The Joint Remuneration and Employment Committee meets to consider the employment packages for those employees of the cluster whose remuneration fall outside the scope of Agenda for Change.
- The Committee meets as required and in private. All meetings in 2012/13 were quorate.

Assurance

In July 2012 Internal Audit carried out a review of CCG Governance and Delegation. While the audit was forward looking it also encompassed aspects of current practice. The audit concluded that for Greenwich Teaching PCT the design and operation of governance arrangements for the CCG authorisation process and shadow year were **adequate** (Green RAG rating). A summary of recommendations is given below:

Organisation	Assurance Level	Recommendations by Priority		
		High	Medium	Low*
Greenwich (Made/accepted)	Adequate	0	0	4/4

3. Risk Assessment

3.1. Introduction

The Greenwich Teaching PCT approach to risk management and board assurance is in accordance with legislation, national and local guidance. It seeks to embed recognised and developed best practice through a process of ongoing review and improvement and underpins the production of the Annual Governance Statement (AGS).

Through adopting the agreed NHS SEL approach to risk management and board assurance, Greenwich Teaching PCT believes that it has in place a sound governance structure and risk management arrangements to enable it deliver its objectives and thus serve its resident population both by benefiting patients and avoiding harm.

The PCT systematically identifies, at all levels, those risks that could affect these objectives and takes every reasonable step to control risk. This includes a process to monitor, and if necessary improve, how risks are being managed and demonstrate how this is occurring.

Greenwich Teaching PCT leadership team employs effective techniques for risk management, supported by good information systems, discusses and shares risk information amongst themselves and trains and supports all their staff to an appropriate level of expertise.

Greenwich Teaching PCT also requires that the organisations and people it commissions to provide health services operate demonstrably effective risk management systems.

3.2. Purpose of risk management and board assurance

The establishment of effective risk management systems is recognised as being fundamental in ensuring good governance. Its aim is to continually improve the quality of health service commissioning through the identification, prevention, control and mitigation of risks. To do this, a systematic and consistent approach to risk management is required in Greenwich Teaching PCT and across NHS SEL commissioning and other activities.

The PCTs in NHS SEL have adopted the principles of the Australia/New Zealand Risk Management Standard (AS/NZS 4360:1999) in their approach to risk management. This is a generic model for identifying, prioritising and dealing with risks in

any situation – at local or corporate level. It comprises definition, scope and consequence of risk. It provides an effective means of controlling and mitigating the risks associated with the delivery of commissioned services, the achievement of corporate objectives and any other aspect of health in NHS SEL.

The Joint Boards ensure that they receive robust and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes. The Joint Boards therefore have overall responsibility for ensuring they have assurance that the process of risk identification, evaluation and control are effective. This is achieved through the management and application of the Joint Boards Assurance Framework. The Joint Boards Assurance Framework (JBAF) enables the NHS SEL Executive Management Team to be assured that the controls applied in the mitigation of risk are operating effectively.

3.3 Objectives

The objectives of the risk management and board assurance approach adopted by NHS SEL are:

1. Ensuring compliance with all standards and regulations that apply to health care for all commissioned services;
2. Ensuring a common and integrated approach to risk management across NHS SEL;
3. Implementation and management of a robust assurance framework that addresses risks at all levels of the organisation with relevant and appropriate escalation.

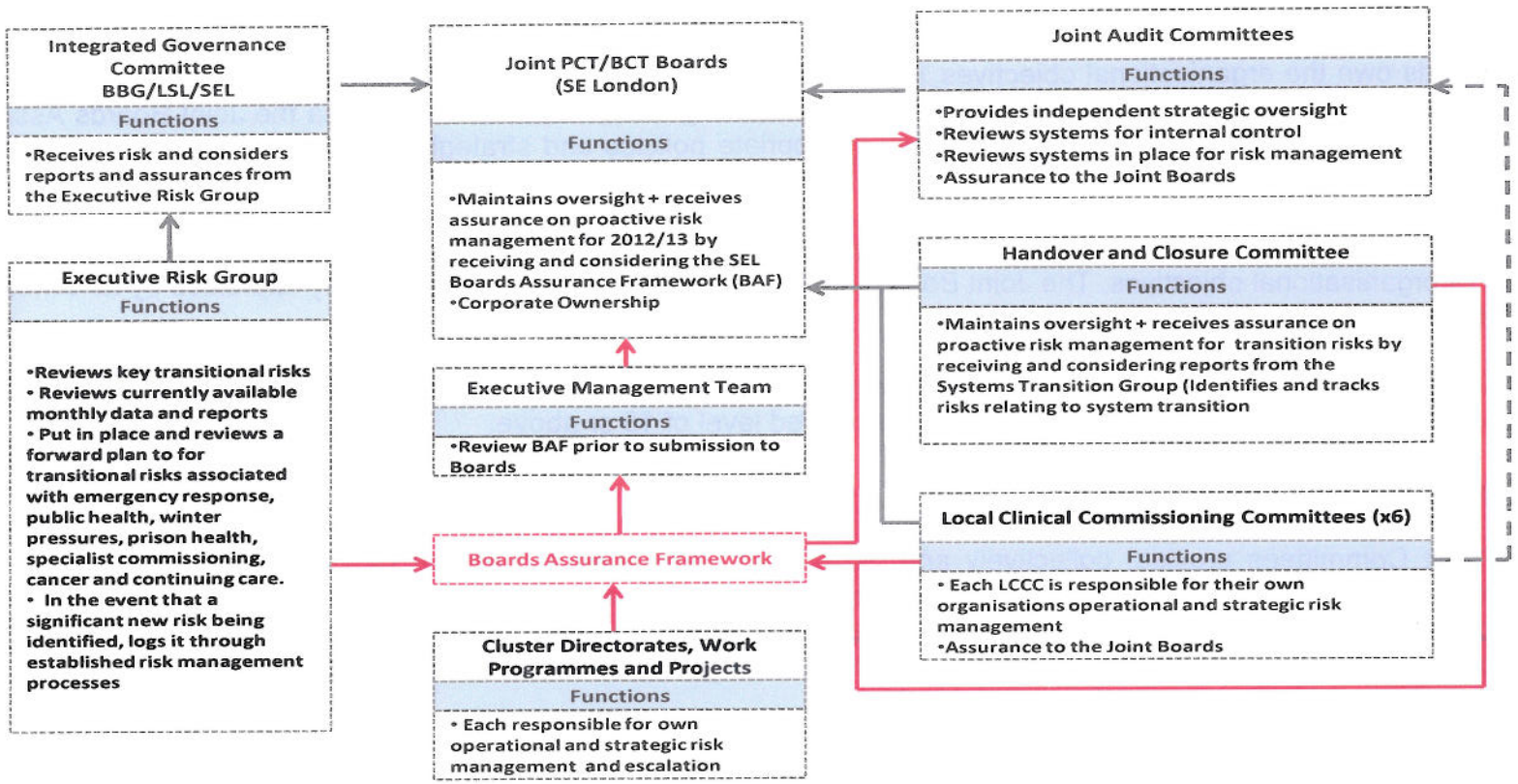
3.4. Description of terms and definitions

Risk management and assurance uses a number of terms and definitions that are necessary in order to communicate its meaning, interpretations and outcomes in a common way. The description of the terms, definitions and principles that the cluster works to are set out in the joint NHS SEL Risk Management and Assurance Toolkit, a companion document to the JBAF.

3.5. The risk management structure

3.5.1 The risk management and assurance structure allows for risk to be captured, reported and managed in a consistent way across NHS SEL. It enables risks to be considered at an operational level and strategic level depending on the nature and severity of the risk as represented by an assessment of its likelihood of occurring, the potential area impacted by that risk and the consequences resulting from its potential occurrence.

SE London Risk Management Structure 2012/13



The diagram above shows the high level linkages between operational risks, and NHS SEL strategic risks and the level at which oversight takes place. As with most models of risk management the structure recognises the principle of escalation between the lowest reported level of risk (department / function) to the highest reported level of risk (JBAF). This provides for a transparent, owned and accessible approach with in-built oversight.

Additional information on the above groups follows:

Joint Boards (Corporate Ownership)

The Joint Boards own the organisational objectives, risks to delivery and the assurance framework. It has identified all its key significant risks and they are being managed appropriately. Monitoring of the key risks is done via the Joint Boards Assurance Framework. The Joint Boards need to be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively.

The Joint Boards satisfy themselves that operational responsibility is being discharged and that risks are mitigated to support the delivery of organisational objectives. The Joint Boards are briefed on the challenge and scrutiny exercised by its committees in order to secure additional assurance.

The Joint Boards are briefed by exception on particular local risks or borough specific considerations for an NHS SEL wide risk where this is judged to have potential for local impact at a scored level of 15 or above.

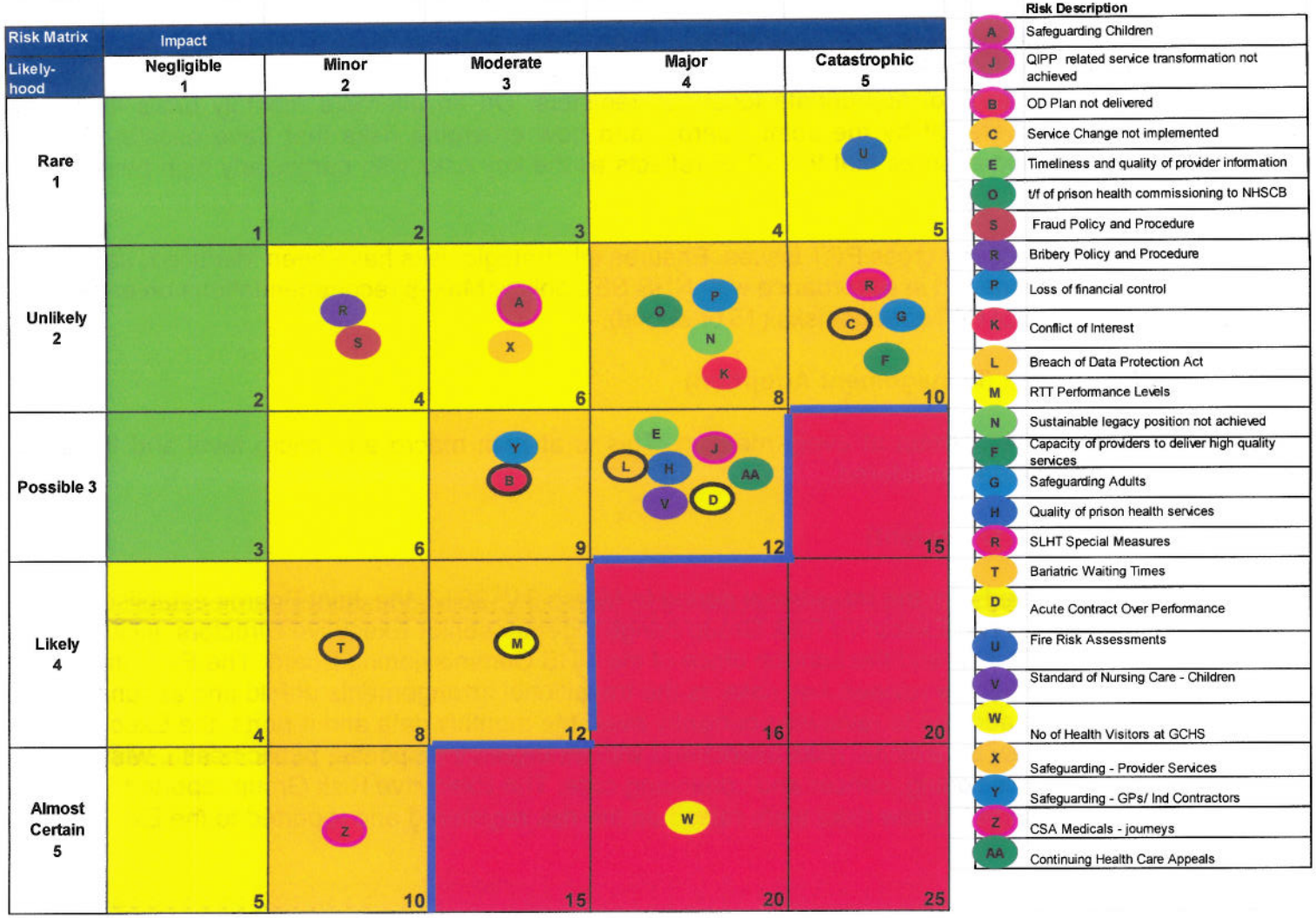
Joint Audit Committees (Assurance)

The Joint Audit Committees provide, collectively and individually, independent oversight of the governance and assurance processes on behalf of the organisations. This includes responsibility for reviewing and providing verification on the systems in place for internal control and risk management. It reviews the adequacy of the Joint Boards Assurance Framework and the structures, processes and responsibilities for identifying and managing key risks facing the Cluster.

Local Clinical Commissioning Committees (Assurance)

Greenwich LCCC provides oversight, challenge and review of local issues, management response and interaction / dependencies with cluster activities. The LCCC also reviews locally specific risks and recommend their escalation to the JBAF in line with the principles contained within the NHS SEL Assurance Framework. The LCCC monitors risk management performance and discusses risk at every meeting and considers, and acts on, its corporate risk register. This is a vital contribution to retaining local ownership and to escalating appropriate risks to the Joint Boards. The March 2013 corporate position is shown on the following page:

Greenwich Assurance Framework 2012/13 - Heat Map of Existing Residual Risks at 31 March 2013



	Risk Description
A	Safeguarding Children
J	QIPP related service transformation not achieved
B	OD Plan not delivered
C	Service Change not implemented
E	Timeliness and quality of provider information
O	t/f of prison health commissioning to NHSCB
S	Fraud Policy and Procedure
R	Bribery Policy and Procedure
P	Loss of financial control
K	Conflict of Interest
L	Breach of Data Protection Act
M	RTT Performance Levels
N	Sustainable legacy position not achieved
F	Capacity of providers to deliver high quality services
G	Safeguarding Adults
H	Quality of prison health services
R	SLHT Special Measures
T	Bariatric Waiting Times
D	Acute Contract Over Performance
U	Fire Risk Assessments
V	Standard of Nursing Care - Children
W	No of Health Visitors at GCHS
X	Safeguarding - Provider Services
Y	Safeguarding - GPs/ Ind Contractors
Z	CSA Medicals - journeys
AA	Continuing Health Care Appeals

Executive Management Team (Management Adoption)

Fulfils the corporate governance functions of a Risk Committee. It is responsible for co-ordinating and overseeing the development and implementation of the Policy & Strategy across the cluster. It oversees the development of the Joint Boards Assurance Framework and the maintenance of appropriate local risk registers. On an alternate monthly basis it reviews all significant risks on the JBAF prior to oversight by the Joint Boards, and new emerging risks that have escalated from the Directorates. The Committee monitors and ensures that the JBAF reflects all the key risks with particularly high residual scores and that it remains a dynamic document.

Assesses congruence and identification of any cross PCT issues. Ensures all strategic risks have been identified, have been appropriately allocated and are being managed in accordance with NHS SEL policy. Makes recommendations on escalation and commonality including identification of PCTspecific risks (15 or above).

The Integrated Governance Committee (Management Adoption)

Considers reports from the Executive Risk Group at every meeting. This is at both macro and micro level and the depth of discussion is dependent on the matter being considered.

Executive Risk Group (Transition Risk Oversight)

In acknowledgement of the risks associated with the transitional period to March 31st 2013, the Joint Boards established an Executive Risk Group in November 2012. The Executive Risk Group brings together senior Executive Directors, including the Nursing and Medical Director, from the Cluster and the London office of the NHS Commissioning Board. The Executive Risk Group meets every fortnight and systematically reviews key risks as the transitional arrangements unfold and as functions are handed on to the new shadow bodies. In addition to reviewing currently available monthly data and reports, the Executive Risk Group put in place a forward plan to review transitional risks associated with emergency response, public health, winter pressures, prison health, specialist commissioning, cancer and continuing care. The Executive Risk Group reported to the Integrated Governance Committee. Significant new risks were raised on the risk registered and reported to the Executive Risk Group.

PCT and Directorate Structures (Operational Management)

All directors have in place local risk management structures (in Greenwich this includes aspects of capturing LCCC intelligence). All Directors and therefore their managers are responsible for; ensuring that appropriate and effective risk management processes are in place for each department / function within their scope of responsibility; compliance to the NHS SEL approach to risk management and board assurance; bringing to the attention of their director / department lead any significant risks that have been identified where local control measures are considered to be inadequate.

3.5.2 Risk reporting and management

Risk registers are the mechanism by which identified risks and the details of the associated controls and assurances that are put in place to manage an individual risk to its agreed acceptable level are recorded.

Risk registers are used at each level of risk reporting. A core data set is required (to facilitate escalation to the JBAF which is reviewed by the Joint Boards) with local adaptation of the adopted NHS SEL approach encouraged to facilitate local management. Risks escalated to a corporate level via the JBAF will require completion of an Action Plan, thereby capturing a higher level of detail and providing the required level of additional assurance. Local processes and approaches to secure enhanced assurance are developed under the stewardship of the LCCC.

The level of risk determined to be necessary for escalation from a local or directorate risk register to the JBAF is 15 or above with impact on one of more PCTs. An action plan is completed for all risks rated as 15 or above; such reports are offered to the Boards provided that they do not contain commercially sensitive or confidential information.

3.5.3 Duties (roles & responsibilities)

A prerequisite for the effective management of risk is the need for all staff, clinicians, boards and committees to be clear on, and to fully undertake, their specific duties in respect to their roles and responsibilities within the risk management structure. These are described below.

- As signing officer delegated by the Department of Health's Accounting Officer I have taken assurance from the Accountable Officer during 2012-13 that he took overall Executive responsibility for ensuring that there is an effective risk management or assurance framework in place within the cluster, for meeting all statutory requirements, adhering to guidance issued by the

Department of Health in respect of Governance. I am required to sign the Annual Governance Statement. The Accountable Officer was accountable to the Joint Boards.

- **All Directors and Managers**
  All levels of management must understand and implement the principles of the JBAF and toolkit. All Directors/Directorate managers are responsible for: -

  - Ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility.
  - Ensuring all staff are made aware of the risks within their work environment and of their personal responsibilities.
  - Preparing specific Directorate/Departmental policies and guidelines to ensure all necessary risk assessments are carried out within their directorate/department in liaison with appropriate identified relevant advisors where necessary.
  - Implementing and monitoring any identified and appropriate risk management control measures within their functions and scope of responsibility.
  - Ensuring situations are addressed where significant risks have been identified and where local control measures are considered to be potentially inadequate, Directors/ Directorate managers are responsible for bringing these risks to the attention of the Executive Management Team
  - Ensuring that all staff are given the necessary information and training to enable them to undertake effective risk management practices.
  - Ensuring that a Risk Register is maintained for their area of responsibility.

- **All Employees** must understand the nature of risk and accept responsibility for risks associated with their area of authority. They are responsible for:-

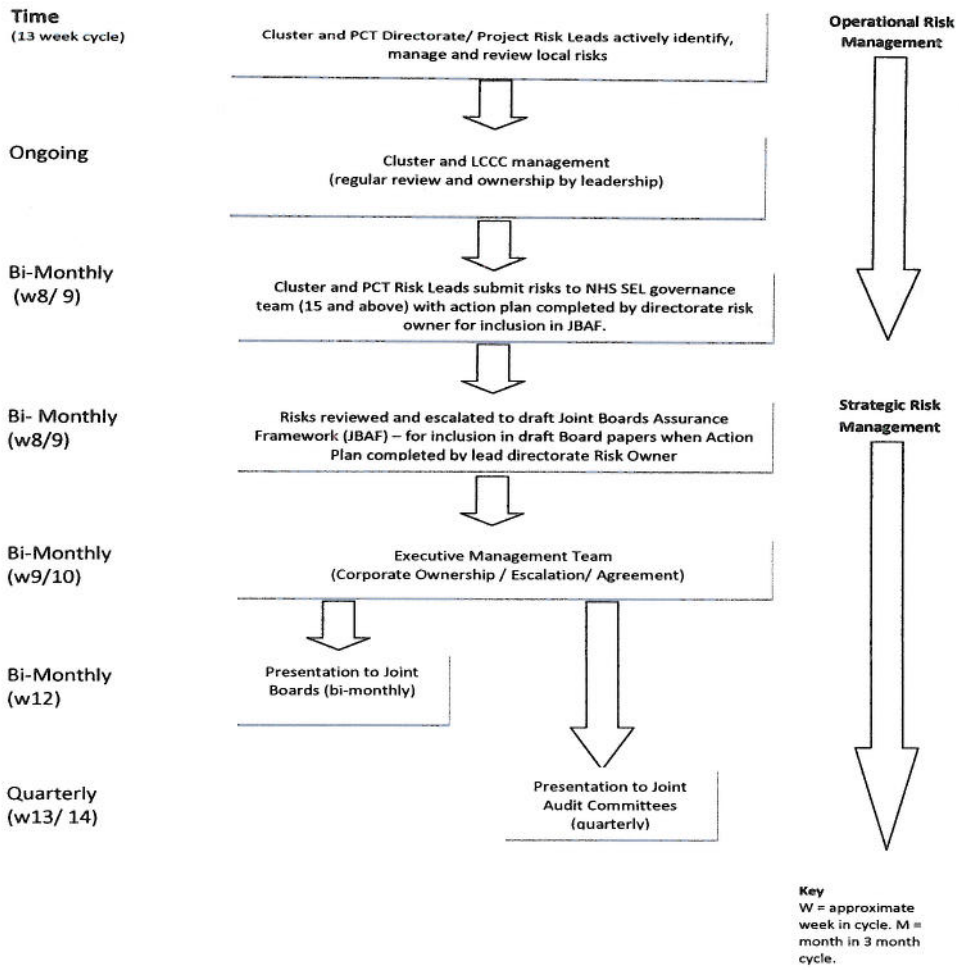
  - Reporting incidents/accidents and near misses using the agreed channels.
  - Complying with all cluster Rules, regulations, guidance and instructions to protect the health, safety and welfare of anyone affected by the Cluster's business.
  - Complying with all rules, regulations, guidance and instructions to ensure the cluster carries out its business in a safe and proper manner.

4. Risk reporting and risk ratings

4.1 Risk reporting process flow

Risks are reported and managed as shown in the diagram below. This is aligned to, and is consistent with, the operational and strategic linkages identified above and sets out the applicable timescales of the reporting process.
It illustrates the risk identification, reporting, escalations and actions at each level of risk management process.

The organisational level at which risks are managed within Directorates is set out with local determination as to application of the risk management process and reporting on outcomes. All risks recorded as strategic and those operational risks assessed to be of sufficient severity to be escalated to the JBAF (and scored above 15) require completion of action plans and is managed through the programme management process.


Time
(13 week cycle)
Cluster and PCT Directorate/ Project Risk Leads actively identify, manage and review local risks
Operational Risk Management
Ongoing
Cluster and LCCC management
(regular review and ownership by leadership)
Bi-Monthly
(w8/ 9)
Cluster and PCT Risk Leads submit risks to NHS SEL governance team (15 and above) with action plan completed by directorate risk owner for inclusion in JBAF.
Bi- Monthly
(w8/9)
Risks reviewed and escalated to draft Joint Boards Assurance Framework (JBAF) – for inclusion in draft Board papers when Action Plan completed by lead directorate Risk Owner
Strategic Risk Management
Bi-Monthly
(w9/10)
Executive Management Team
(Corporate Ownership / Escalation/ Agreement)
Bi-Monthly
(w12)
Presentation to Joint Boards (bi-monthly)
Quarterly
(w13/ 14)
Presentation to Joint Audit Committees (quarterly)
Key
W = approximate week in cycle. M = month in 3 month cycle.

4.2 Risk ratings

Every identified risk has a chance of occurring therefore each risk has its own potential likelihood. Similarly if the risk were to occur then it would have its own measure of impact (also known as a consequence). It is important to recognise that risk can never be eliminated with the aim of risk management being to progressively manage risk within acceptable levels. The acceptable level of risk is known as the 'risk appetite' of a particular risk.

The NHS in SEL determines inherent, residual (current) and target risk scores (levels of risk) for every risk and these are reviewed on a regular basis for all risks.

The NHS in SEL has determined the acceptable level of organisational risk to be '9'. That is the scoring at which the PCTs find a risk to be acceptable and less likely to be in need of regular monitoring or reporting. 9 is the preferred maximum, long term, target score for a risk.

Likelihood and impact are allocated a number between 1 and 5. The total risk score is the impact multiplied by the likelihood. Hence the risk score can lie between 1 (1x1) and 25 (5x5). The overall risk score determines the risk rating. This in turn determines the actions that are required to manage the particular risk.

The LCCC reviews risks above the stated tolerance threshold (10 and above). The Joint Boards, having delegated borough oversight to each LCCC, will review risks of 15 and above.

The diagram below illustrates the risk matrix scoring and consequential risk rating methodology.

Risk Matrix	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Rare	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

TOLERANCE THRESHOLD

Key Levels of Risk	
1-3	Low Risk
4-6	Moderate Risk
8-12	Significant Risk
15-25	High Risk

4.3 Zero tolerance risks

The risk management and joint boards assurance process shows how those risks that are reported through the SEL Joint Boards BAF (JBAF) are determined. These are those high rated risks that impact all of NHS SEL PCTs and Bexley Care Trust and all those risks that are rated as being 'high'.

However there are a number of areas where the boards might benefit from being aware of an existing risk, regardless of risk rating at any particular point in time. These risks are referred to as 'zero tolerance' risks and are noted on the JBAF. Recommendations for classification of zero based risks come from directors and are assessed by the Executive Management Team. NHS SEL has identified five zero tolerance risks, Safeguarding, Emergency planning, Staff Retention; Conflicts of Interest and reputational risk.

Where a borough specific risk is reported by exception to the Boards and this is aligned but scored more highly (15 or above) than an identified Joint Boards level risk then the latter risk will be reported as a zero tolerance risk in order to ensure that the Boards have sufficient context and access to all relevant information on the issue.

5. Independent assurance

5.1 External audit

External audit objectives are to review and report on financial statements (the audit opinion) and arrangements for securing economy, efficiency and effectiveness in use of resources (the value for money conclusion).

5. 2 Internal audit

Internal audit reviews the process for the maintenance and delivery of the JBAF and provides the assurance that it meets the requirements of the Department of Health. Internal audit also reviews other risk areas in line with an agreed annual audit plan and reports its findings to the audit committee.

5.3 NHS Litigation Authority (NHSLA)

The NHSLA perform an independent assessment against risk management standards, in order to establish the level of discount the NHS SEL receives in relation to its indemnity contribution schemes. No assessment was carried out during 2012/13.

6. Reviews and updates

The approach Joint Boards adopt to managing risk and gaining assurance is/was reviewed annually by both the Joint Audit Committees who will report to the Joint Boards upon its findings. An additional review relating to areas of best practice and practical application will be undertaken by the Governance team.

7. New risks identified in the year 2012/13

7.1 The risks in the following table scored 15 or above (High or Red rated risks) and appeared for the first time on the Joint Boards Assurance Framework during 2012/13. The risks were accepted by the Joint Boards at their bi-monthly meeting on behalf of the relevant PCT or PCTs.

ID	Work Stream	Date Raised	Risk Category	Risk Description	Initial Risk Score	Still on JBAF @ 31/03/13	Risk Score @ 31/3/13	PCT/ Care Trusts affected by Risk
ICT18	ICT	27/04/2012	Information Management and Technology	There is a risk that the amount of change to happen in 2012/13 due to changes in the NHS such as the closure of PCTs will lead to an undeliverable ICT workplan, leading to some change requirements not being met	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
E25	Governance (Approval)	01/05/2012	Governance	There is a risk that lack of clarity about the future of the Capital Strategy Group caused by internal review of corporate governance arrangements will lead to delays in reaching decisions on business cases for capital schemes, disposals etc	15	No: deescalated from JBAF or closed		All PCTs/ Care Trust
ICT25	ICT	18/05/2012	Information Management and Technology	There is a risk that the main data centre for the core ICT network covering LSLG is housed in Lower Marsh, whose lease ends on 28/9/12, leading to a significant clinical and financial risk if the lease is not extended	20	No: deescalated from JBAF or closed		All PCTs/ Care Trust
G44	Finance	05/06/2012	Transition	Risk: Inability to build capacity and capability identified in the OD plan Cause: Financial position of national and local NHS does not allow for identified ongoing development to take place Consequence: Full authorisation is not achieved	15	No: deescalated from JBAF or		Greenwich Teaching PCT

						closed		
G47	QIPP	18/06/2012	Finance	Risk: Service change is implemented but does not realise expected outcome - reduction in acute activity and/or patient take up of community pathway Cause: Failure to appreciate level of demand; failure effectively to communicate service change to stakeholders and patients; patient's do not choose to adopt new service Consequence: QIPP savings not made due under utilisation or conversely, over utilisation of acute services	15	No: deescalated from JBAF or closed		Greenwich Teaching PCT
G48	Acute over performance	18/06/2012	Finance	Risk: Acute contracts may over perform Cause: e.g. Unanticipated demand; failure to implement service changes; changes in coding; Consequence: Usage of financial reserves earmarked for service transformation	15	No: deescalated from JBAF or closed		Greenwich Teaching PCT
G49	Acute over performance	18/06/2012	Finance	Risk: Clinical commissioners may not have the activity information needed to manage performance of acute and non-acute providers Cause: Lack of timely accurate acute contract monitoring data; Underdeveloped data sets within non-acute settings Consequence: Financial over performance; risks of over or under commissioning as compared to spend	15	No: deescalated from JBAF or closed		Greenwich Teaching PCT
G61	Quality	21/06/2012	Clinical	Risk: One or more providers will fail to deliver health services to the required level of quality outcomes Cause: Lack of organisational capacity, insufficient capture of data on quality indicators Consequence: Instability of the system and insufficient capacity to respond and deliver high quality care for all.	15	No: deescalated from JBAF or closed		Greenwich Teaching PCT

G65	Safeguarding	22/06/2012	Safeguarding Adults	**Zero Tolerance Risk.** Risk: Insufficiently rigorous Adult safeguarding arrangements; Cause: No 'designated' roles for adult safeguarding in current structure; Consequence; Lack of assurance across all commissioned services.	15	Yes	10	Greenwich Teaching PCT
ICT28 (i)	ICT	02/07/2012	Information Management and Technology	There is a risk that proposed structures for the South London Commissioning Support Service are not fit for purpose and reduce ICT resources and capability at a time when increased resources are needed to meet organisational changes within South London	20	No: deescalated from JBAF or closed		All PCTs/ Care Trust
ICT28 (ii)	ICT	02/07/2012	Information Management and Technology	There is a risk that a number of staff will not have posts within SLCSS as of 01/10/12, leading to low morale, unclear line management and a lack of customer focus, leading to an increased risk of not meeting the needs of the business during the second half of 2012/13	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
G67	Quality & Governance	06/07/2012	Clinical	Risk: Special Measures imposed upon SLHT as a result of Unsustainable Provider Regime may negatively impact upon performance and quality of services Cause: Focus on financial recovery, service reorganisation, loss of knowledge and continuity from senior management team as the Board is stepped down, lack of confidence in service by patients may lead them to choose alternative providers exacerbating financial problems and reducing viability of the service. Consequence: Reduction in the quality and safety of services (5); Multiple complaints; Failure to meet contract KPI's and performance standards; (4)	15	No: deescalated from JBAF or closed		Greenwich Teaching PCT

IGR42	IG	19/08/2012	Legal & Compliance	There is a risk that successor organisations (the CSU)will not be set up to deal effectively or efficiently with information governance and information management caused by the levels of resource available and the complexity, pace and lack of clarity around transition leading to a failure to become authorised and embed efficient business processes	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
G80	Safeguarding Children	23/10/2012	Clinical	**Zero Tolerance Risk** Risk: Failure to seek assurance and ensure issues addressed with regard lack of health visitors at GCHS (9 vacancies out of 50) Cause: HV 's are going to Ferryview the PMS as they offer a better pay grade Consequence: Failure of provider to identify and manage potential safeguarding issues; Non-compliance with national standards with significant risk to patients if unresolved (4)	20	Yes	20	Greenwich Teaching PCT
IGR50	IG	14/01/2013	Legal & Compliance	The NHS Commissioning Board is a new national organisation and as such it is likely that records management processes are not yet fully developed or embedded. Therefore there is a risk that records transferred to the NHS CB may not be fully managed in keeping with NHS requirements in the short term. Records cannot be transferred until assurances are received.	16	Yes	16	All PCTs/ Care Trust

7.3 A summary of the above RED risks still on the JBAF at March 2013 by work stream is given below:

Work Stream	Red
Safeguarding Children	1
Information Governance	1
Total	2

In addition to the Zero tolerance risks detailed above, other zero tolerance risks were reported through the JBAF covering the

following areas: Adult and Child Safeguarding, Emergency planning, Staff Retention; Conflicts of Interest and reputational risk. These additional zero tolerance risks scored under 15 but were ongoing risks the Board wished to retain sight of irrespective of their current risk score. A summary of the zero tolerance risks on the JBAF at 31 March 2013 is given below

Zero Tolerance Risk	NHS Cluster	Greenwich
Adult Safeguarding		✓
Child Safeguarding		✓
Emergency planning	✓	✓
Staff Retention	✓	
Conflicts of Interest		✓
Reputational risk	✓	✓

At 31st March 2013 the following actions are underway for the above zero tolerance risks:

Child and Adult Safeguarding:

- Meeting to take place between Director of Nursing at Oxleas NHS Foundation Trust and Safeguarding Team to review progress against current recruitment and retention strategy in relation to the on-going establishment issues around Health Visitors.
- Ensure local guidance on Information Sharing is included in the Safeguarding Children's and Adult's Policy.
- Audit of GP practices in relation to CRB and recruitment processes.
- Follow up on progress made on nursing practice at Oxleas NHS Foundation Trust.

Conflicts of Interest:

- Finalise implementation of KPMG audit recommendations and ratify completed Conflict of Interest Policy.

The common risk framework used across South East London evolved over the course of 2012 and 2013. It was informed by analysis and consideration by the Joint Boards, Boards Committees and local Business Support Units. During CCG preparation in 2012 and 2013 the Clinical Commissioning Groups gained greater delegation for managing Board level risks as well as their own local risks.

The risks listed above are managed by the process described in this document.

There are other risks that are managed at PCT and Cluster Directorate level but have not warranted escalation to the Joint Boards.

8. Assurance

In October and November 2012 Internal Audit carried out a review of the BAF and Risk Management processes in each of the six Primary Care and Care Trusts in South East London. Greenwich Teaching PCT received no audit recommendations. This provided positive assurance that Greenwich Teaching PCT had a sound risk management system in operation.

9. Summary of lapses of data security, including any that were reported to the information Commissioner

There have been no significant lapses of data security.

10. Significant Issues

This section sets out: first, an overview of the major challenges that we expect Greenwich Clinical Commissioning Group to face during 2013/14 and how we are managing these at 31 March 2013; and secondly the significant issues which we have identified during 2012/13, and which have or are being addressed.

Specific issues identified during 2012/13

We continue to work with our internal auditors to identify areas where our systems and processes for governance and internal control can be further strengthened. The work of Internal Audit during 2012/13 resulted in twelve high priority recommendations where improvements could be made to internal control systems and processes. These recommendations have been agreed by PCT Management and the resultant actions have been taken, or are in the process of being taken.

These covered:

Topic	NHS SEL Cluster	Greenwich
Conflicts of Interest	1	1
HR Staff Records	3	

1. Greenwich's local acute trust, South London Healthcare NHS Trust (SLHT), is a challenged provider and there is a high degree of interdependency between the Trust's financial position and the financial health of Greenwich and its neighbouring PCTs. The Trust Special Administration was appointed in July 2012 as a result of Unsustainable Provider Regime being invoked. During the consultation period, a series of public meetings took place across Greenwich to ensure the views of both the public and local clinicians were taken into account. During consultation, residents expressed their concerns particularly in respect of the downgrading of Lewisham Hospital. The final recommendation, accepted by the Secretary of State for Health will lead to significant service reconfiguration in South East London over the next 3 years. The proposal is that SLHT is dissolved as a Trust and that the 3 hospitals are run by other Trusts in SEL. Greenwich Teaching PCT has worked with SLHT to maintain safe services to patients and this will be a major focus for NHS Greenwich CCG.

2. During 12/13, the PCT has been working through a process of systems transition, functional and quality handover to receiving organisations and building of the new CCG. During March 2013, the PCT handed over 123 functions to receiving organisations through PCT led formal and operational process. The process across SEL has been entailed detailed review of all PCT functions and a clear hand over process to successor bodies. However there remains a risk as with in all organisational change that there is loss of organisational memory and detailed understanding of functions. Continued close management of transitional areas remains important.

3. During 12/13, the PCT has been managing risks in prisons and health visiting. Although safe services are delivered, risks have not entirely been mitigated. Both prisons and health visiting have been handed to receiving organisations.

4. The NHS is faced more appeals against decisions concerning continuing healthcare funding last year. The consequence for Greenwich Teaching PCT is that there are 140 continuing care review applications dating back to 2004 with a total potential financial consequence of £3.9m. The PCT is engaging with the London Continuing Healthcare Lead and has set aside within current budget contingency funds for potential payouts.

There are no other significant issues to report.

Challenges during 2013/14

During 2013/14 CCGs face a number of significant challenges as they deliver against the NHS Operating framework. From a governance perspective these challenges fall into three areas: **building on the transition**; **doing things differently**, and

improving quality of local healthcare services.

1. Delivering the transition

2013/14 will be a challenging year for Greenwich CCG, building on the success of its shadow running which commenced on 1 October 2011. We recognise the risks associated with the transition to new commissioning arrangements. We have robust plans in place supported by governance arrangements that will enable us to address the ongoing risks associated with transition whilst continuing to fulfill our statutory duty in 2013/14 of delivering the health and wellbeing needs of our local population.

2. Doing things differently

A significant amount of transformational change is needed across the local health economy in South East London and locally in Greenwich CCG. Our commissioners are continuing to deliver service redesign schemes to maximise the benefits of our local integrated community and acute Trust, South London Healthcare Trust.

Greenwich Teaching PCT is working with other South East London clinical commissioners to deliver the NHS single number '111' programme. There is a closely managed process in place to deliver the 111 service in South East London, including the mitigation of financial and other risks associated with the Project. A 111 Project Board has been established and meets regularly.

3. Improving quality

We have set an ambitious productivity improvement targets for our health economy. Through our governance structures and processes we are monitoring and assuring execution of our plans on an ongoing basis, to ensure that we make savings without compromising the ongoing improvement of care quality, including outcomes across cancer, Referral to Treatment, A&E and waiting times.

The Olympics and Paralympics were a great success in London during the summer of 2012. The local NHS maintained "business as usual" despite the resulting operational pressures.

4. NHS Continuing Care

In March 2012 the Department of Health announced deadlines for individuals or their representatives to notify the relevant PCT if they believe there was a period of care between 1st April 2004 and 31st March 2012 where there is evidence that the individual should have been assessed for eligibility for NHS continuing healthcare (NHS CHC). This only applies to new cases ie where, the individual has not previously been assessed for NHS CHC during the identified period. The first deadline was the 30th September

2012 relating to claims between 1st April 2004 to 31st March 2011. The second deadline was 31st March 2013 relating to the period from 1st April 2011 to 31st March 2012. The PCT received a total of 112 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been ongoing through the year and a financial provision has been made based on estimates of the potential financial exposure using the latest information available at the time.

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

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

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

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

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

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

I have been satisfied that the governance statement incorporates a full description of the board's committee structure and performance together with appropriate reference to performance against national priorities set out in the NHS Operating Framework 2012/13. I have been given assurance that the Governance Statement has taken appropriate account of the guidance issued by the Department of Health.

I believe that the above, combined with the outputs of the Governance Framework give me substantial assurance that the risk management processes and systems of internal control put in place are operating effectively and that the statement has been prepared in accordance with the Department of Health Guidance.

Department of Health Designated Signing Officer
Carl Vincent – Director of Provider Finance and Finance Transition

Signature: C Vincent **Date :** 31/5/13