Department of Health

NHS

Tower Hamlets Primary Care Trust

2012-13 Annual Report and Accounts

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Tower Hamlets Primary Care Trust

2012-13 Annual Report

NHS

North East London and the City

Tower Hamlets Primary Care Trust

Annual report 2012/13

Creating a healthier future

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1 Foreword

2012/13 was a year to remember for north east London and the City. It was the year of the Olympics and Paralympics, when this area was the centre of world attention. Thousands of visitors came to east London, and many local people and staff took part as volunteers

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

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

Staff delivered the Olympic and Paralympic plans and on improving health, commissioning services and ensuring the performance of the NHS locally was maintained and improved. They did this while supporting preparations to bring new public health and NHS commissioning arrangements into place ready for reformed statutory arrangements from April 2013.

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

Staff deserve thanks for their outstanding work during 2012/13, as do all those who worked for or with the PCTs over the past decade for their contribution to many great achievements in improving health and health services locally.

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

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

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

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

Peter Coates, CBE
Designated Signing Officer

2. The primary care trust

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

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

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

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

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

3. The role of the primary care trust

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

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

We asked local people what they thought of current services and what they wanted us to develop.

We then looked at the different ways those needs could be met, and we entered into contracts with a range of organisations to provide services for people in Tower Hamlets.

These included hospital, mental health, community and primary care services such as GP and dental care.

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

Our main hospital provider for local people was Barts Health NHS Trust, which was created on 1 April 2012 from a merger of Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust.

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

We made arrangements with many other organisations and individuals, including the local authority, independent providers, dentists, pharmacists and optometrists, for them to provide

a wide range of services under the NHS. We joined with other primary care trusts to commission ambulance services and specialist hospital services for rarer conditions.

Our vision and goals

We developed common vision and goals across NHS North East London and the City (NHS NELC) for 2012/13 to create a healthier future for local residents.

We said we would do this through:

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

4 Boards and committees

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

The membership of the Board is outlined below.

Chair

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

Non-executive directors (NEDs) There are seven non-executive directors, including the chair above, appointed across the seven primary care trusts.

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

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

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

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

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

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

Two further executive voting Board members were appointed from each PCT; the clinical commissioning group chair, and the director of public health.

For NHS Tower Hamlets this was:

- Dr Sam Everington, Tower Hamlets Clinical Commissioning Group chair, 1 April 2013 to 31 March 2013
- Dr Ian Basnett, Director of Public Health, 1 April 2013 to 31 March 2013.

Audit Committee arrangements

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

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

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

Declarations of interest

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

Register of interests 2012/13

Name	Role	Organisation	Nature of interest
Kash Pandya	Non Executive Director and Audit Chair	Hillcroft College Surbiton	Council Member and Audit Chair
		Ministry of Justice Essex Advisory Committee	Lay Member
		Health & Safety Executive	Independent Audit Committee Member
		Barking & Dagenham CCG Havering CCG Redbridge CCG	Lay Member Lay Member Lay Member
		Citizens Advice Bureau	Advisor
Dr Sam Everington	CCG Chair	Bromley by Bow Partnership. This includes XX Place surgery, Bromley by Bow Health Centre, St Andrews Health Centre and St Paul's Way Health Centre.	GP Partner
		Community Health Partnerships British Medical Association	Directorship
		Stanton Guildhouse in the Cotswolds	Trustee
		Gatehouse Primary School	Governor
John Carrier	Chair	Shoreditch Park Surgery	Daughter is GP partner
		University College London Hospitals NHS Foundation Trust	Governor
		Camden CCG	Vice Chair/Lay member
		Marks & Spencer PLC	Wife is shareholder
		Tottenham Hotspur	Wife is shareholder
		Cancerkin, Royal Free Hospital NHS Trust	Chair
		British cardio-vascular society	Trustee
		Bar standards board education and training committee	Advisor
		London Deanery boards in surgery, O&G public health & London deanery strategic partnership board	Chair

Name	Role	Organisation	Nature of interest
Afzal Akram	Non Executive Director	London Borough of Waltham Forest	Councillor
Frances Pennell-Buck	Vice Chair/Non Executive Director	Havering Crossroads Care	Trustee
Heather Mullin	Director of Transition	Newham CCG London Borough of Newham Outlook care	Husband providing coaching support Husband providing project support. Husband is Non Executive Director
Dr May Cahill	Joint Medical Director - NELC	Well Consortium City, Hackney Pathfinder CCG GP Premises the London Fields Medical Centre 38 -44 Broadway Market, London E8 4QJ	Joint Chair Owner
Dr Ken Aswani	Joint Medical Director - NELC	Allum Medical Practice NHJ Alliance RCGP	Partner Member Member
Dr Lesley Mountford	Director of Public Health	Homerton Hospital NHS Foundation	Partner Governor
John Lock	Non Executive Director – NELC	2012 Office, University of East London	Director
Stuart Saw	Cluster Director of Finance	NICE diagnostics Advisory Committee	Board Member
Alan Wells	Non Executive Director, NELC Vice Chair/Lay Member, Waltham Forest CCG	Capacity LTD The Simplification Centre The Alzheimer's Society CCG working Group, Institute of Chartered Secretaries and Administration	Director Director Trustee Member
Paul Hendrick	Non Executive Director	Greater London Enterprise Ltd Harevale Ltd LFIG Ltd activeNewham	Director Non Executive Director
Vanessa Lodge	Deputy Director Quality and Clinical Governance (Acting Director Nursing/DIPC)	Kingston CCG	Board Nurse – 1 session per week

Related party transactions

Other entities are considered to be a related party if the Primary Care Trust can be considered to have direct or indirect control of the other party, or the parties are subject to common control. There was one related party transaction, which appears in the table below, with the name of the Board member who has an interest in the related party. The payment was made to the body listed, and not to the Board member.

	Payments to Related Party £	Amounts owed to Related Party £
Homerton Hospital- Dr Lesley Mountford	4,903,092	295,865

Managing our risks

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

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

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

5 The new system

The Health and Social Care Act 2012

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

Clinical commissioning – CCGs and CSU

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

NHS Tower Hamlets Clinical Commissioning Group was working in shadow form during 2012/13 and underwent a national assessment programme in readiness to take on full statutory responsibilities for commissioning acute, mental health and community health services from April 2013. NHS Tower Hamlets Clinical Commissioning Group is chaired by Dr Sam Everington and its Chief Officer is Jane Milligan.

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

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

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

In its assessment of the plan, the NHS Commissioning Board rated the CSU as low risk, stating: "The CSU has performed really well and has placed itself as a centre of good practice in terms of the existing NHS CSUs. There is a clear and concise business and development journey with strong service improvement plans underpinned by a range of innovative partnership arrangements."

NHS England

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

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

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

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

Health and wellbeing boards

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

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

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

Public health

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

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

The London Borough of Tower Hamlets has assumed responsibility for these public health functions.

6 Our performance

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

Last year we achieved targets in the following areas:

- The Royal London Hospital performed well, meeting targets for treating patients who did not need to be admitted to hospital
- All patients with suspected cancer were seen within two weeks
- Low rates of the hospital-acquired infection, C-difficile

Some targets were not met:

- The A&E four hour wait target
- Zero tolerance for hospital acquired infections such as MRSA
- Improving sexual health through screening for Chlamydia
- waits of less than 62 days for treatment of suspected cancer

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

During 2012/13 two new health centres were officially opened;

- Mr Jim Fitzpatrick, MP for Poplar and Limehouse, opened the Newby Place Health and Wellbeing Centre, E14, on 20 November.
- Lutfur Rahman, Mayor of Tower Hamlets, opened the St Andrews Health and Wellbeing Centre on 27 November. This had been developed with the support of health funding from the London Borough Tower Hamlets under section 106 of the Town and Country Planning Act 1990.

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

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

One severe incident involving data loss or confidentially breaches were reported for the period across NHS North East London and the City. This took place in Tower Hamlets.

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

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

Summary of other personal data related incidents in 2012/13

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

7 Patient and public engagement

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

Reports on patients experience were considered by the Board.

Formal consultation with the public and stakeholders took place on:

- Bringing together inpatient dementia inpatient services for the City and Hackney, Newham and Tower Hamlets at Mile End Hospital in Tower Hamlets.
- Emergency Dental Care.

In addition:

- Putting the Patient First in Palliative Care, launched at St Joseph's Hospice, led to improved access to high quality end of life care, plus a dedicated Smartphone App and a new Local Directory to give east Londoners better information on end of life services and issues

- NHS North East London and the City's Both Sides NOW initiative, in partnership with Barts Health NHS Trust, on patient experience was the most popular entry in the National Patient Feedback Challenge announced by the Prime Minister in May, bringing a large proportion of the £1m fund to East London.

8 Our workforce

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

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

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

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

Staff development and support

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

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

Workforce Information

Staff sickness

Based on the 2012 calendar year, staff sickness amounted to 1,387.99 days lost. This was with total staff years of 178.46. The average number of working days lost was 7.78.

'Two Ticks' symbol (positive about disability)

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

Health and wellbeing

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

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

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

Equality objectives

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

Off payroll arrangements

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

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

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

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

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

***The data for these tables is provided in City and Hackney PCT's annual report as East London and the City (City and Hackney, Tower Hamlets and Newham) share an integrated arrangement for staff.**

9 Taking care of the environment

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

NHS Tower Hamlets is committed to reducing its carbon footprint and the impact its activities had on the environment. We have produced a Sustainable Development and Energy Management Strategy that informed and guided the way we worked. Written in accordance with the 2009 NHS Sustainable Development Unit Carbon Reduction Strategy for England Saving Carbon, Improving Health, it sets out three key objectives:

1. Improve performance in and adopt the principles of sustainable development
2. Introduce effective monitoring, reviews and reporting on carbon usage
3. Actively raise carbon usage awareness at every level within the organisation

We continued to work towards achieving a reduction in carbon footprint by the introduction of a programme of energy management performance monitoring to individual buildings.

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

10 Emergency preparedness

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

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

11 Accounts

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

Managing our finances

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

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

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

In 2012/13 Tower Hamlets PCT was given a revenue resource limit of £612.002 million from the Department of Health.

This was made up of an initial recurrent funding allocation (the money we get each year) of £490.580 million. This was an increase in recurrent funding of £13.342 million over and above what we were given in 2011/12.

We also received other non-recurrent funding (money which we have been given this year only) totalling £121.422 million during the course of the year. This funding is usually given to us to spend on something specific, so we cannot spend it on what we like. For example, money for dental services – £13.581 million – is given to us on a non-recurrent basis. This money also includes any surplus that we had made the previous year.

We used the additional funding to develop local services, and the improvements to our performance show the success of this approach.

We spent the money on services as follows:

- Acute hospital care 44%
- Specialist hospital care 5%
- Learning disabilities and mental health 8%
- Prescribing 5%
- Community health services 14%
- Primary medical services 12%
- Corporate and other costs 12%

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

- **Cash limit** Our cash limits were £599.290 million (for revenue) and £7.997 million (capital). We drew down cash from the Department of Health on a monthly basis in accordance with these limits.
- **Revenue resource limit** The revenue resource limit sets a limit on the net expenditure of the organisation. We were given a limit of £612.002 million. We agreed with NHS London at the beginning of the year to achieve a surplus of £10.363 million. This target was subsequently changed during the year to £11.119 million and we were successful in achieving the revised target.
- **Capital resource limit** We also have to keep our capital expenditure (the money we spend on something that we then own, such as a building or piece of equipment,

which has a value of £5,000 or over) within a 'capital resource limit', which was set by NHS London. Our limit for the year was set at £13.242 million. The capital funding utilised by the PCT in the year was £10.836 million.

We also have to pay our bills within a reasonable time. There is a 'better payment practice code' which says that NHS organisations should pay creditors within 30 days. Last year we paid 89.97% of non-NHS invoices (81.68% by value) and 79.36% of NHS invoices (95.21% by value) within this 30 day target.

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

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

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

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

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

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

12 Remuneration report

The NHS has adopted the recommendations outlined in the Greenbury report in respect of the disclosure of senior managers' remuneration and the manner in which it is determined. Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments. This report outlines how those recommendations have been implemented by the PCT in the year to 31 March 2013.

Remuneration and terms of service committee

Primary care trusts were required to have a remuneration committee to oversee the pay, terms and conditions of service of senior managers.

The main function of the committee was to make recommendations to the board on the remuneration, allowances and terms of service of other officer members to ensure they are fairly rewarded for their individual contribution to the organisation, having regard for the organisation's circumstances and performance, and taking into account national arrangements.

Remuneration

We operate a system of performance-related pay for those senior management posts subject to the Very Senior Managers (VSM) pay framework. There has been no payment of performance related pay during the year ending 31 March 2013.

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

Contractual arrangements

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

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

Pensions

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

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

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

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

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

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

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

Expenses policy

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

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

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

Termination agreements or exit packages

Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements (specified in Agenda for Change), and the NHS pension scheme. Specific termination arrangements will vary according to age, length of service and salary levels. The remuneration committee will agree any severance arrangements.

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

Non-executive directors

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

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

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

The relationship between the highest paid director and median remuneration

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

The banded remuneration of the highest-paid director in Tower Hamlets PCT in the year 2012/13 was £20k-£25k (2011/2012 = £55k-60k). This was 1.5 times (2011/2012 = 3.4) the median remuneration of the workforce, which was £16k (2011/2012 = £16k). The reason for the variances between 2011/2012 and 2012/2013 is that the highest paid director salary is now spread across 7 PCTs (For 2011/2012 this was 3 PCTs) in the North East London Cluster.

The highest paid director's salary is based upon the estimated cost to Tower Hamlets PCT. Some staff who are not recharged across the sector (seven PCTs) cost Tower Hamlets PCT more than the highest paid director only due to the fact that they have not been recharged across all seven PCTs. As a result 86 staff cost Tower Hamlets PCT more than the highest paid director.

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

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

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

Notes

Salary and pension entitlements of directors and senior managers

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

Salary Entitlements (Share of PCT)

There are no comparatives in the PCT share as the basis of allocation across the cluster changed from 1 April 2012. During 2011/12 the board costs were allocated based on percentage of average weighted capitation across the three East London and the City cluster PCTs. When ELC merged with Outer North East London to form NHS NELC on 1 April 2012, the Board costs were allocated equally over the seven PCTs. For further detail refer to note 1 of the Annual Accounts.

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

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

Jane Gateley	Director of Planning and Delivery	15-20	n/a	n/a	n/a	n/a	n/a
Andrew Ridley	Managing Director, Commissioning Support Unit	15-20	n/a	n/a	n/a	n/a	n/a
David Butcher	Director of Estates and Capital Development	10-15	n/a	n/a	n/a	n/a	n/a

Salary Entitlements

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

Catherine Max	Associate Non Executive Director	5-10	n/a	n/a	5-10	n/a	n/a
Andrea Lippett	Associate Non Executive Director	5-10	n/a	n/a	5-10	n/a	n/a
Mariette Davis	Associate Non Executive Director	15-20	n/a	n/a	n/a	n/a	n/a
Executive directors		**2012/2013**			**2011/2012**		
Name and Title		**Salary (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (bands of £5,000)**	**Salary (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (bands of £5,000)**
Alwen Williams	Chief Executive	150-155	n/a	n/a	150-155	n/a	n/a
Heather Mullin	Director of Transition	145-150	n/a	n/a	145-150	n/a	n/a
Ken Aswani	Medical Director	80-85	n/a	n/a	80-85	n/a	n/a
May Cahill	Medical Director	60-65	n/a	n/a	55-60	n/a	n/a
Eirlys Evans	Acting Director of Nursing (terminated 30/11/2012)	55-60	n/a	n/a	25-30	n/a	n/a
Caroline Alexander	Director of Quality & Clinical Governance	110-115	n/a	n/a	95-100	n/a	n/a
Terry Huff	Chief Operating Officer and Deputy Chief Executive	120-125	n/a	n/a	120-125	n/a	n/a
Stuart Saw	Director of Finance	120-125	n/a	n/a	110-115	n/a	n/a
Mathew Cole	Director of Public Health	85-90	n/a	n/a	85-90	n/a	n/a
Ian Basnett	Director of Public Health	130-135	n/a	n/a	145-150	n/a	n/a
Lesley Mountford	Director of Public Health	75-80	n/a	n/a	110-115	n/a	n/a
Vanessa Lodge	Acting Director of Nursing	90-95	n/a	n/a	n/a	n/a	n/a
Other directors							
Marie Price	Director of Communications and Engagement	90-95	n/a	n/a	85-90	n/a	n/a
Charles Allen	Director of Workforce and Transformation	n/a	n/a	n/a	100-105	n/a	n/a
Helen Bullers	Director of People and Organisational Development	110-115	n/a	n/a	85-90	n/a	n/a
Conor Burke	Director of Commissioning Support	120-125	n/a	n/a	115-120	n/a	n/a
Jane Gateley	Director of Planning and Delivery	105-110	n/a	n/a	105-110	n/a	n/a

Andrew Ridley	Managing Director, Commissioning Support Unit	130-135	n/a	n/a	125-130	n/a	n/a
David Butcher	Director of Estates and Capital Development	100-105	n/a	n/a	95-100	n/a	n/a
Jane Milligan	Borough Director	100-105	n/a	n/a	100-105	n/a	n/a
Jane Mehta	Borough Director	105-110	n/a	n/a	51-55	n/a	n/a

Pension Entitlements

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

Helen Bullers	Director of People and Organisational Development	2.5-5	12.5-15	25-30	85-90	485	380	86	n/a
Conor Burke	Director of Commissioning Support	0-2.5	5-7.5	10-15	40-45	229	183	36	n/a
Jane Gateley	Director of Planning and Delivery	0-2.5	0-2.5	20-25	65-70	354	324	13	n/a
Andrew Ridley	Managing Director, Commissioning Support Service	(0-2.5)	(0-2.5)	20-25	65-70	361	337	6	n/a
David Butcher	Director of Estates and Capital Development	0-2.5	0-2.5	35-40	115-120	818	752	27	n/a

Cash equivalent transfer values

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

Real increase in cash equivalent transfer values

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

Peter Coates, CBE
Designated Signing Officer

13 Statement of the responsibilities of the signing officer for the Primary Care Trust 2012/13 annual accounts

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

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

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

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

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

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

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

Peter Coates, CBE
Designated Signing Officer

14 Annual governance statement

Name of organisation: Tower Hamlets Primary Care Trust

1. Scope of responsibility

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

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

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

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

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

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

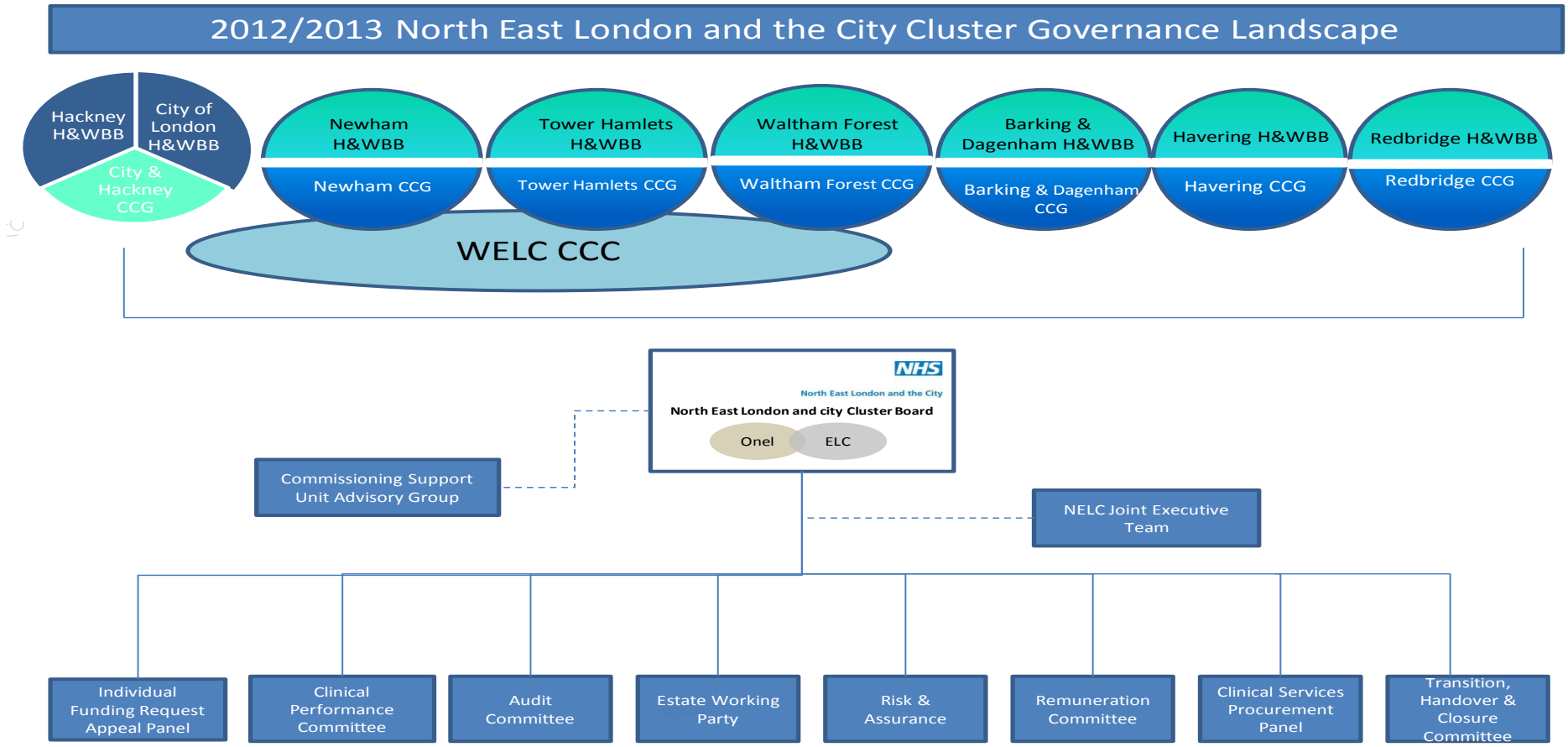
2. The governance framework of the organisation

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

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

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

NHS North East London and the City committee structure



Agreed April 2012

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

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

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

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

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

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

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

3. Board effectiveness

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

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

- that the members individually and collectively understand what is expected of them

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

4. Assurance

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

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

5. Risk assessment

5.1 Risk management strategy

The Cluster governance structure was designed to ensure that there was a balance between having robust governance arrangements for the organisation and being able to deliver an effective end state.
The risks to the achievement of the Cluster's Corporate Objectives were identified through the process detailed in the North East London and the City Risk Management Strategy. This document was created following a review of the risk management strategies for:

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

Elements of best practices from these documents in terms of: risk definitions, identification processes, templates and risk matrix were taken out and combined to create the NHS North East London and the City Risk Management Strategy. This was approved by the Board at its May 2012 meeting.

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

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

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

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

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

5.2 Risk identification

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

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

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

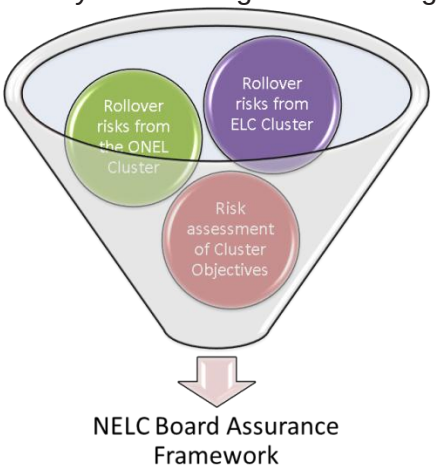


Figure 1 showing the 2 main processes that led to the creation of the NELC Board Assurance Framework

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

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

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

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

5.3 Accountability for risks

Individual Directors were held accountable for the risks associated with their Directorates. The Board Assurance Framework and Corporate Risk Register were refreshed quarterly through meetings with the Directorate risk leads. Once reviewed and revised the documents were reported to the following bodies:

- Transition, Handover and Closure Committee
  This Committee retained oversight for all the risks pertaining to Transition, Handover and Closure. It met on a monthly basis from November 2012

- Risk and Assurance Committee
  This Committee reviews both the Board Assurance Framework and Corporate Risk Register in its entirety at least once a quarter to provide probity of the documents and thus the risks facing the organisation.
  This Committee also had the power to request "deep dives" to provide assurance to the Board that the Cluster has effective systems of internal control in relation to risk management and governance. The Committee held one deep dive on the issue of "quality and handover to the CCGs". It met bi-monthly.

- Audit Committee
  The Audit Committee was responsible for reviewing the effectiveness of the internal control and risk management systems and received reports from management on the effectiveness of the risk systems that the Cluster had established.

- Cluster Board
  The Board received the Board Assurance Framework once a quarter to ensure that the Board retained oversight of all the risks to the achievement of the Corporate Objectives and allow Board members to challenge executives on areas of weak control, assurance or high risk rating.

5.4 Board Assurance Framework 2012/13

Key risks for Tower Hamlets PCT identified during 2012/13 which populated the Board Assurance Framework for 2012/13 and how their risk rating changed over the financial year are summarised below:

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

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

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

The assessment of risks has been undertaken in accordance with the Cluster's risk strategy and Board Assurance Framework. This includes a risk scoring and escalation process that ensures as far as is practicably possible that there is consistency of applied risk ratings

across the organisation. In depth scrutiny of the BAF has been undertaken by the Risk and Assurance committee. This Committee has undertaken a "deep dive" challenge into particular areas of risks, for example quality & safety and has held individual directors to account for the risks associated with their areas of responsibility.

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

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

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

5.5 Corporate Risk Register

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

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

These corporate risks have been managed as follows:

- The delivery team for Transition, Handover and Closure have put in place relationship managers to ensure there was effective communication with receiving organisations. Regular bulletins have been issued to staff and public communication statements issued in the local press and on website
- A finance closedown team has been put in place to manage "wind up" effectively
- Remedial action was taken to ensure compliance with Information Governance Toolkit by 31 March 2013. Lessons learn from the deficiencies have been passed on the CCGs and the CSU to inform their Information Governance Toolkit compliance for 2013/14

5.6 The Risk and control framework

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

A rolling review of the Assurance Framework for 2012/2013, carried out by the PCT's internal auditors, RSM Tenon and Parkhill has demonstrated that there is an effective system of internal control to manage the principal risks identified by the organisation.

However it was noted that there is scope for some improvement when articulating the mechanisms that provide assurances that the controls put in place to manage risks are indeed effective. The specific issues that have been highlighted for improvement are listed below:

i. Information Governance
ii. Continuing Care

6 Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.
For 2012 / 13 the Head of Internal Audit has advised me that based on the work undertaken in 2012/13, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

However, he has issued an Information Governance report with a RED opinion rating whilst at the same time noting that we are drawing up a response to the recommendations made which we expect to mitigate any gaps in controls identified moving forwards.
Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

- The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by other sources including;
- Scrutiny from our external auditors
- Information Governance Assurance tool kit compliance submission
- The Cluster's internal monitoring and review process for its quality of commissioned services described in the Department of Health's Operating Framework and delivered through the Risk & Assurance Committee
- Reports by Internal and External Audit and the results of Patient and Staff Surveys
- Annual Care Quality Commission (CQC) assessment for safeguarding children
- Local Safeguarding Children Board (LSCB) annual report
- Robust incident and complaints monitoring processes, ensuring compliance with national Serious Incident reporting.
- NHS London's review of the plans to support the 2012/13 QIPP programme and consequential financial impacts at both PCT and Outer North East London levels
- Assurance on fraud and potential fraud is provided through the work of the local counter fraud officer who provides updates, communications and training on all appropriate counter fraud issues to PCT staff and emerging CCG pathfinder organisations.
- My review confirms that Tower Hamlets PCT had a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.
- The Audit Committee provided the Board with an independent and objective view of arrangements for internal financial control within the PCT, ensuring that the Internal Audit service complies with mandatory auditing standards including the review of all fundamental financial systems.
- The Board and Executive Directors managed and reviewed their principal risks through their Performance reviews both with NHS London and the cluster's

Operating Plan and the Business Planning process and their contribution to the development of the Assurance Framework.

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

Significant Issues

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

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

Peter Coates, CBE
Designated Signing Officer

15 Independent auditor's statement (internal)

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

1 Roles and responsibilities

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

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

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

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

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

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

2 The Head of Internal Audit Opinion

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

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

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

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

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

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

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

We have issued a RED rated report on ***Continuing Care (Draft report****). The main weaknesses identified were in the following areas:*

- *The Continuing Care database in use, Broadcare, as it is currently configured does not enable suitable management information regarding completion of Decision Support Tools and other assessments to be produced;*
- *Weaknesses were identified regarding evidence on the eligibility of Continuing Care Patients being provided through the submission of checklists and Decision Support Tools prior to invoices being paid to continuing care providers;*
- *Insufficient evidence could be provided to demonstrate that care reviews were being consistently undertaken for all patients within three months of them being deemed eligible for continuing care funding.*

Management is developing an action plan to ensure that these issues are related to the Commissioning Support Unit, which will provide services to the CCG from 1 April 2013 and that actions are drawn up to resolve these issues.

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

There are no specific issues we would expect the PCT to consider in the formulation of the AGS, other than consideration being given to referencing the points raised above regarding Continuing Care and Information Governance. In addition, consideration should be given to any data security breaches of which it is aware and any other significant control issues not specifically covered by the work of Internal Audit.

RSM Tenon Limited

16 Independent auditor's statement (external)

Independent auditor's report to the accountable officer of Tower Hamlets Primary Care Trust

We have audited the financial statements of Tower Hamlets Primary Care Trust for the year ended 31 March 2013 on pages 19 to 32. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 31, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

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

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

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

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

In our opinion:

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

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

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

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

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

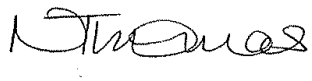
We have undertaken our audit in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance issued by the Audit Commission in November 2012. We have considered the results of the following:

- our review of the Governance Statement; and
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the PCT;

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

Certificate

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



Neil Thomas for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

5 June 2013

17 External auditor's costs

Tower Hamlets PCT's external auditor was KPMG. They were paid £95,850 in 2012/13 to carry out the statutory audit. In 2011/12 the fees were £159,750.

18 Glossary of organisation names

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

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

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

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

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

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

Department of Health

NHS

Tower Hamlets Primary Care Trust

2012-13 Accounts

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Tower Hamlets Primary Care Trust

2012-13 Accounts

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

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

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

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

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

Name: **Alwen Williams**
Chief Executive

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

Date..... 4.6.13 .....

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

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

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

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

Name: **Stuart Saw**
Director of Finance

Signed.....

Date.....4th June..... 2013

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF TOWER HAMLETS PRIMARY CARE TRUST

We have audited the financial statements of Tower Hamlets Primary Care Trust for the year ended 31 March 2013 on pages 1 to 42. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Signing Officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Primary Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Primary Care 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.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Tower Hamlets Primary Care Trust as at 31 March 2013 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

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

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

In our opinion:

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

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

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

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

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

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

We have undertaken our audit in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance issued by the Audit Commission in November 2012. We have considered the results of the following:

- our review of the Governance Statement; and

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Primary Care Trust.

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

Certificate

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

Neil Thomas for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
London E14 5GL

5 June 2013

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13 Statement of the responsibilities of the signing officer for the Primary Care Trust 2012/13 annual accounts

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

P A Coates.

Peter Coates, CBE
Designated Signing Officer

Foreword To The Financial Statements

Tower Hamlet Primary Care Trust

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

Registered Office:-

Clifton House
75-77 Worship
Street
London
EC2A 2DU

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	**13,517**	10,339
Other costs	5.1	**614,139**	654,998
Income	4	**(30,122)**	(132,565)
Net operating costs before interest		**597,534**	532,772
Investment income	9	**(116)**	(118)
Other (Gains)/Losses	10	**288**	25
Finance costs	11	**3,106**	1,729
Net operating costs for the financial year		**600,812**	534,408
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**600,812**	**534,408**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**13,365**	10,052
Other costs	5.1	**22,601**	20,031
Income	4	**(17,089)**	(7,835)
Net administration costs before interest		**18,877**	**22,248**
Investment income	9	**0**	(118)
Other (Gains)/Losses	10	**0**	25
Finance costs	11	**2,664**	1,700
Net administration costs for the financial year		**21,541**	**23,855**
Programme Expenditure			
Gross employee benefits	7.1	**152**	287
Other costs	5.1	**591,538**	634,967
Income	4	**(13,033)**	(124,730)
Net programme expenditure before interest		**578,657**	**510,524**
Investment income	9	**(116)**	0
Other (Gains)/Losses	10	**288**	0
Finance costs	11	**442**	29
Net programme expenditure for the financial year		**579,271**	**510,553**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**2,221**	1,311
Net (gain) on revaluation of property, plant & equipment	**(445)**	(28)
Total comprehensive net expenditure for the year*	**602,588**	**535,691**

The notes on pages 5 to 42 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	**85,890**	82,784
Other financial assets	19	**594**	417
Total non-current assets		**86,484**	83,201
Current assets:			
Inventories	16	**0**	12
Trade and other receivables	17	**9,848**	10,736
Other financial assets	19	**15**	12
Cash and cash equivalents	20	**4,798**	64
Total current assets		**14,661**	10,824
Non-current assets held for sale		**0**	0
Total current assets		**14,661**	10,824
Total assets		**101,145**	94,025
Current liabilities			
Trade and other payables	21	**(51,091)**	(45,878)
Provisions	25	**(1,568)**	(1,182)
Borrowings	22	**(668)**	(568)
Total current liabilities		**(53,327)**	(47,628)
Non-current assets plus/less net current assets/liabilities		**47,818**	46,397
Non-current liabilities			
Provisions	25	(2,194)	(4,138)
Borrowings	22	(20,014)	(15,481)
Total non-current liabilities		**(22,208)**	(19,619)
Total Assets Employed:		**25,610**	26,778
Financed by taxpayers' equity:			
General fund		12,906	12,193
Revaluation reserve		12,704	14,585
Total taxpayers' equity:		**25,610**	26,778

The notes on pages 5 to 42 are an integral part of these financial statements.

The financial statements on pages *1 to 4* were approved by the Board on *04 June 2013* and signed on its behalf by

Designated Signing Officer: Date:
Peter Coates CBE

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	**12,193**	**14,585**	**0**	**26,778**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(600,812)			**(600,812)**
Net gain on revaluation of property, plant, equipment		445		**445**
Impairments and reversals		(2,221)		**(2,221)**
Transfers between reserves	105	(105)		**0**
Reclassification Adjustments				
Total recognised income and expense for 2012-13	**(600,707)**	**(1,881)**	**0**	**(602,588)**
Net Parliamentary funding	601,420			**601,420**
Balance at 31 March 2013	**12,906**	**12,704**	**0**	**25,610**
Balance at 1 April 2011	**18192**	**15827**	**0**	**34,019**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(534,408)			(534,408)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		28		28
Impairments and Reversals		(1,311)		(1,311)
Transfers between reserves	(41)	41		0
Total recognised income and expense for 2011-12	(534,449)	(1,242)	0	(535,691)
Net Parliamentary funding	528,450			528,450
Balance at 31 March 2012	**12,193**	**14,585**	**0**	**26,778**

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(597,534)**	(532,772)
Depreciation and Amortisation		**4,234**	4,185
Impairments and Reversals		**1,693**	25
Interest Paid		**(2,664)**	(1,677)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**12**	53
(Increase)/Decrease in Trade and Other Receivables		**888**	16,321
Increase/(Decrease) in Trade and Other Payables		**5,772**	(6,328)
(Increase)/Decrease in Other Current Liabilities		**(261)**	0
Provisions Utilised		**(2,471)**	(3,627)
Increase/(Decrease) in Provisions		**471**	1,660
Net Cash Inflow/(Outflow) from Operating Activities		**(589,860)**	**(522,160)**
Cash flows from investing activities			
Interest Received		**116**	52
(Payments) for Property, Plant and Equipment		**(6,150)**	(5,574)
Loans Made in Respect of LIFT		**(207)**	0
Loans Repaid in Respect of LIFT		**27**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(6,214)**	**(5,522)**
Net cash inflow/(outflow) before financing		**(596,074)**	**(527,682)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(612)**	(415)
Net Parliamentary Funding		**601,420**	528,450
Capital grants and other capital receipts		**0**	(289)
Net Cash Inflow/(Outflow) from Financing Activities		**600,808**	**527,746**
Net increase/(decrease) in cash and cash equivalents		**4,734**	**64**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**64**	**0**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**4,798**	**64**

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Going Concern

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Tower Hamlets PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 31 Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The Statement Of Financial Position has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. 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.

Land and buildings have been revaluated or impaired as part of the routine activities within the annual cycle of operations. Further details are given below in the note 1.5 on the accounting policy on depreciation, amortisation and impairments 1.7 on the accounting policy on valuation and note 12 to the accounts.

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

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.

1. Accounting policies (continued)

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

LIFT scheme

The PCT has taken the view that its LIFT schemes should be recognised on the PCT's Statement of Financial Position in accordance with IFRIC 12 'Service Concession', as the scheme meets the conditions set out therein. These conditions are determined by the level of control over the asset and the pricing mechanism for delivery of service within the arrangement.

The PCT will not exercise the purchase option on the property.
Real cash flows have been used for the property rental with RPI payments accounted for as contingent rent.
The difference between the nominal rental (assuming an inflation rate of 2.5% per annum) and the real rental has been accounted for as a contingent rent.

Lifecycle costs are capitalised to plant, property and equipment when the replacement asset is received during the life of the Lease-Plus Agreement. Until the replacment asset is received the Lifecycle replacement cost is held as a prepayment.
Further details are given below in the note 1.24 on the accounting policy on Private Finance Initiative (PFI) and NHS LIFT transactions and note 27 to the accounts.

Depreciation and Amortisation
Tower Hamlets PCT accounts for deprecation and amortisation in accordance with IAS 16 Property, Plant and Equipment and IAS 38 Intangible Assets. The depreciation and amortisation expense is the recognition of the decline in the value of the asset and the allocation of the cost of the asset over the periods in which the asset will be used. Judgments are made on the estimated useful life of the assets. Further details are given below in the note 1.7 on the accounting policy on depreciation and amortisation and note 12 to the accounts.

Property Revaluations
Tower Hamlets PCT accounts for revaluation of property in accordance with IAS 16 Property, Plant and Equipment. The revaluations are based on valuations provided by District Valuation Office. A full revaluation takes place every 3-5 years with a desktop exercise valuation made in the intervening years. Further details are contained in the note 1.5 accounting policy on valuations below and note 12 to the accounts.

Non-current Asset Impairments
Tower Hamlets PCT accounts for non-current asset impairments in accordance with IAS 36 Impairments as adapted for FReM. The impairments are based on valuations provided by the District Valuation Office. Further details are contained in the note 1.7 accounting policy on impairments below and note 13 to the accounts.

Provisions

Tower Hamlets PCT accounts for provisions in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets. Provisions are made for liabilities that are uncertain in timing or amount. Calculations of these provisions are based on estimated cash flows relating to these costs, discounted at an appropriate rate where significant. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by appropriate qualified valuers/external advisors. Further details are contained in note 1.22 the accounting policy on provision below and note 25 to the accounts.

1. Accounting policies (continued)

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

NHS North East London and the City Management Allocation
NHS East London and the City was created on 1 April 2011 as a single cluster of the three primary care trusts, City and Hackney, Newham and Tower Hamlets. The NHS East London and the City worked under a single board and management team. The management structure is accounted for under the City & Hackney PCT and recharged across the three PCTs based on their average weighted capitation for shared departments e.g. Finance, or 100% for PCT specific departments e.g. borough teams. The average weighted capitation for the three PCTs is 33% for City and Hackney PCT, 32% Newham PCT and 35% Newham PCT.

On 1 April 2012, NHS North East London and the City merged with NHS Outer North East London to form NHS North East London and the City, and works with a single board. The management sturcture for the three primary care trusts excluding board continues to the acconted as in 2011-12. The board structure for NHS North East London and the City is allocated equally over the 7 primary care trusts. Further details are contained in notes 4 Miscellaneous Revenue, 5.1 Operating Costs and 7.1 Employee Benefits.

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

Tower Hamlet PCT makes an estimate on the prescribing costs and community pharmacy accruals based on two and three months in arrears respectively. The estimates are based on forecast outturns provided by the Prescribing Payment Authority.

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.

1. Accounting policies (continued)

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
- LIFT Assets - where it is not reasonably certain that the option to purchase will be exercised at the end of the lease, the minimum lease payments are capitalised at the model RPI indexation of 2.5% as set by Department of Health, for the duration of the term.

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 that financial year, any expected increases in AME require Treasury approval.

1. Accounting policies (continued)

1.8 Donated assets

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

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.

1.10 Non-current assets held for sale

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

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

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

The PCT has no non-current assets held for sale in 2012-13 or 2011-12.

1.11 Inventories

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

1.12 Cash and cash equivalents

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

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

1.13 Losses and Special Payments

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

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

1.14 Clinical Negligence Costs

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

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the PCT is disclosed at Note 25.

1. Accounting policies (continued)

1.15 Employee benefits

Short-term employee benefits

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

The liaibility was settled with NHS Pension Agency in 2012-13.

1.16 Research and Development

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

1.17 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.18 Grant making

Under section 256 of the National Health Service Act 2006, the PCT has the power to make grants to local authorities, voluntary bodies and registered social landlords to finance capital or revenue schemes. A liability in respect of these grants is recognised when the PCT has a present legal or constructive obligation which occurs when all of the conditions attached to the payment have been met.

1.19 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the PCT, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1. Accounting policies (continued)

1.20 Leases

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

The PCT as lessee

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

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

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

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

GMS Leases

Where the PCT has entered into certain financial arrangements involving the use of GP premises the PCT has determined that under IAS 17, SIC 27 and IFRIC 4 these arrangements must be recognised. Where there are no defined term in the arrangements entered into, the financial value would be included in Operating Cost Statement.

The PCT as lessor

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

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

1.21 Foreign exchange

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

1.22 Provisions

Provisions are recognised when the PCT has a present legal or constructive obligation as a result of a past event, it is probable that the PCT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% (2.35% 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.

Legal Claims: The NHSLA does not cover the excess on Liabilities to Thrid Parties Scheme (LTPS) claims or Employer Tribunal claims. These costs are provided by the PCT based on the excess costs as supplied by the NHSLA, or expenditure based on general experience of what the maximum for each type of claim is worth as supplied by solicitors engaged by the PCT in the case of Employer Tribunal claims.

1. Accounting policies (continued)

Early Retirement Costs: The PCT is meeting the additional costs of benefits beyond the normal benefits provide by the NHS defined benefit scheme for employees who have previously taken early retirement. The total value of the provision is based on the employer costs for the annual gross pension charges to age 60 and the annual enhanced pension charges from age 60 adjusted for the age factor for each member, as provided by the NHS Pension Agency. The figures, for those members who are 55 years old or over, are increased for the pension increase rate due from April in the following financial year and discounted by the discount rate, both rates are provided by HM Treasury.

Rental Review Provisions: Under the terms and conditions of General Medical Services Contracts, Personal Medical Services Contracts and Alternative Provider of Medical Services Contracts between the PCT and General Practitioners (GPs), the PCT reimburses accommodation costs in relation to the provision of services under the contracts. A number of GPs are negotiating rent increases under their leases relating to previous years. The PCT provides for it's liability for these increases under the contracts based on estimates provided by the District Valuers Office.

Back to Back Provisions: As the NHS structure has evolved a number of organsiations, in which there were future liabilities such as early retirement, redundancies and legal claims, have been divided or merged. As it was inequitable for the resulting organisation to take on the full laibility it was agreed the organisation would host the liability but the liabilities would be shared over the PCTs in the locality based on the current year's service agreements. The provisions are provided for based on the out-standing balance held by the hosting orgnisation.

Dilapidations: The provision relates to complying with lease clauses for buildings which are leased by the PCT. The PCT's dilapidation provisions are calculated based on the estimated cost of meeting future expenditure, in order to settle obligations in respect of lease clauses. The PCT has provided for this in full. The provision is regularly revalued by a qualified external valuer.

Onerous Leases: This provision relates to the unavoidable costs of meeting the obligations under the lease that exceed the economic benefits to be received under the lease. The PCT has a number of vacant leased properties that are excess to requirement which the PCT is not able to sub-lease. The provision is based on the future rental obligations to either the next break clause or the termination of the lease which ever occurs first. The PCT has provided for these in full.

Mental Health Homicide Investigations: The PCT is liable for the costs of Mental Health Homicide Investigations that occur in the borough. The estimate of costs is provided by the external body that carries out the investigations. The PCT provides for the costs in full.

Retrospective Continuing Care Claim Provision: In April 2012, the Department of Health announced the deadline of 30 September 2012 for individuals to request an assessment of eligibility for NHS Continuing Healthcare funding, for cases during the period 1 April 2004 – 31 March 2011. Due to the complexity of the review process, the claims received by the dead-line are still being reviewed. The provision for the repayment of nursing care and interest is an estimate of the number successful claims at the average cost of the claims.

Further details on provisions are contained in note 25 to the accounts.

1. Accounting policies (continued)

1.23 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Net Expenditure. The net gain or loss incorporates any interest earned on the financial asset. The net gain or loss incorporates any interest earned on the financial asset. Due to the complexity and availability of different valuation methods, the fair value is calculated according to the valuation method that is relevant to the embedded derivatives or contracts with embedded derivatives whose separate value cannot be ascertained as determined by an appropriately qualified valuer/external advisor.

Held to maturity investments

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

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. Investments in equity instruments that do not have a quoted market price in an active market and whose fair value cannot be reliably measured, and derivatives that are linked to and must be settled by delivery of such unquoted equity instruments, shall be measured at cost

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Net Expenditure. The net gain or loss incorporates any interest earned on the financial asset. Due to the complexity and availability of different valuation methods, the fair value is calculated according to the valuation method that is relevant to the embedded derivatives or contracts with embedded derivatives whose separate value cannot be ascertained as determined by an appropriately qualified valuer/external advisor.

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

1.24 Private Finance Initiative (PFI) and NHS LIFT transactions

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

Tower Hamlets PCT does not have any PFI schemes. It has 3 LIFT schemes.

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

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

b) LIFT assets, liabilities, and finance costs
LIFT assets are recognised as property, plant and equipment, when they come into use. In accordance with the principles of IAS 17, the assets are measured initially at the lower of present value of the minimum lease payments or fair value if the option to purchase is not expected to be taken up. If the option to purchase is expected to be taken up the assets are initially valued at fair value. 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 lower of present value of the minimum lease payments or fair value if the option to purchase is not expected to be taken up. If the option to purchase is expected to be taken up the assets are initially valued at fair value. Subsequently, it is 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.

Sale and finance leaseback
When land is sold by the PCT to the a LIFT company on which a LIFT assets is then constructed, the sale of land is treated as a sale and lease back in accordance with IAS 17 Leases. The profit/loss on sale is deferred and released to income/expenditure over the life of the contract. Any accumulated surplus balance in the revaluation reserve in respect of the land will remain in place until the land has been de-recognised.

1. Accounting policies (continued)

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

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

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

2 Operating segments

	Direct Commissioning	Commissioning Support Services	Other	Total
2012/2013				**31 March 2013**
	£000	£000	£000	**£000**
Actual net expenditure	92,040	447,726	61,047	**600,813**
Revenue Resource Limit	90,652	448,984	72,366	**612,002**
Surplus/(Deficit)	**(1,388)**	**1,258**	**11,319**	**11,189**
2011/2012				31 March 2012
	£000	£000	£000	£000
Actual net expenditure	62,932	453,973	17,503	534,408
Revenue Resource Limit	62,761	446,733	33,899	543,393
Surplus/(Deficit)	(171)	**(7,240)**	**16,396**	**8,985**

The Chief Operating Decision Maker is considered to be the Board, which evaluates performance of the organisation based on net expenditure of the segments. Corporate costs are not allocated across the segments and expenditure is reported net of income. SoFP and Cash Flow Statements are not reported on a segmental basis. In 2012-13 the expenditure was allocated to the likely receiver organisation in the new NHS, that is, Clinical Commissioing Group or National Commissioning Board.The activities of the reportable segments are:

Clinical Commissioning Group

Commissioning has the largest actual expenditure and accounted for 75% of total expenditure in 12/13. Secondary Care Services are commissioned from NHS Trusts, Foundation Trusts and the Independent Sector. The main provider of Acute care is NHS Barts Health Trust , with mental health services being provided by East London Foundation Trust. GP Prescribing budgets are also within this total.

National Commissioning Board

The PCT commissions medical services from a number of GPs, Dentists, Pharmacists and Optomotrists.In addition this segment also reflects the costs of commissioning specialist services, which has moved from 2011-12 when it was shown in Clinical Commissioning Group.

Other

Corporate expenditure is reported separately with no overhead allocation to other segments.

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	**600,812**	534,408
Revenue Resource Limit	**612,002**	543,393
Under/(Over)spend Against Revenue Resource Limit (RRL)	11,190	8,985

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	**13,242**	5,959
Charge to Capital Resource Limit	**10,836**	5,957
(Over)/Underspend Against CRL	**2,406**	**2**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**601,420**	528,450
Cash Limit	**607,287**	528,450
Under/(Over)spend Against Cash Limit	**5,867**	**0**

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

	2012-13 £000	2011-12 £000
Total cash received from DH (Gross)	556,000	481,303
Sub total: net advances	**556,000**	**481,303**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	10,088	9,793
Plus: drugs reimbursement (central charge to cash limits)	35,332	37,354
Parliamentary funding credited to General Fund	**601,420**	**528,450**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	83
Dental Charge income from Contractor-Led GDS & PDS	**1,350**		1,350	1,335
Prescription Charge income	**1,888**		1,888	1,857
Strategic Health Authorities	**4,301**	4,301	0	3,395
NHS Trusts	**9,226**	9,226	0	7,385
NHS Foundation Trusts	**1,347**	1,347	0	1,453
Primary Care Trusts - Other	**10,447**	652	9,795	111,363
Local Authorities	**995**	995	0	5,226
Rental reenue from operating leases	**32**	32	0	208
Other revenue	**536**	536	0	260
Total miscellaneous revenue	**30,122**	**17,089**	**13,033**	**132,565**

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	**36,803**		36,803	30,421
Non-Healthcare	**6,705**	6,705	0	3,801
Total	**43,508**	**6,705**	**36,803**	**34,222**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**347,900**	0	347,900	354,130
Goods and services (other, excl Trusts, FT and PCT))	**98**	0	98	0
Total	**347,998**	**0**	**347,998**	**354,130**
Goods and Services from Foundation Trusts	**64,419**	0	64,419	104,921
Purchase of Healthcare from Non-NHS bodies	**41,122**		41,122	42,111
Social Care from Independent Providers	**569**		569	3,723
Expenditure on Drugs Action Teams	**5,654**		5,654	653
Non-GMS Services from GPs	**520**	0	520	60
Contractor Led GDS & PDS (excluding employee benefits)	**12,096**		12,096	13,038
Chair, Non-executive Directors & PEC remuneration	**46**	46	0	0
Consultancy Services	**1,503**	1,487	16	151
Prescribing Costs	**26,635**		26,635	30,377
G/PMS, APMS and PCTMS (excluding employee benefits)	**41,169**	0	41,169	42,626
Pharmaceutical Services	**0**		0	10,873
New Pharmacy Contract	**10,364**		10,364	0
General Ophthalmic Services	**2,188**		2,188	1,720
Supplies and Services - Clinical	**114**	0	114	229
Supplies and Services - General	**2,763**	2,722	41	1,853
Establishment	**566**	499	67	740
Transport	**172**	172	0	299
Premises	**6,413**	6,412	1	7,688
Impairments & Reversals of Property, plant and equipment	**1,693**	0	1,693	25
Depreciation	**4,234**	4,234	0	4,185
Impairment of Receivables	**(868)**	(868)	0	976
Audit Services – statutory audit	**96**	96	0	176
Other Auditors Remuneration	**0**	0	0	55
Education and Training	**170**	101	69	133
Grants for capital purposes	**0**	0	0	0
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Other	**995**	995	0	34
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**614,139**	**22,601**	**591,538**	**654,998**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	0
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**634**	634	0	734
Other Employee Benefits	**12,883**	12,731	152	9,605
Total Employee Benefits charged to SOCNE	**13,517**	**13,365**	**152**	**10,339**
Total Operating Costs	**627,656**	**35,966**	**591,690**	**665,337**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**21,709**	18,851	2,858
Weighted population (number in units)*	**270,431**	270,431	270,431
Running costs per head of population (£ per head)	**80**	**70**	**11**
PCT Running Costs 2011-12			
Running costs (£000s)	**24,148**	21,337	2,811
Weighted population (number in units)	**270,431**	270,431	270,431
Running costs per head of population (£ per head)	**89**	**79**	**10**

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	41,169	42,626
Prescribing costs	26,635	30,377
Contractor led GDS & PDS	12,096	13,038
General Ophthalmic Services	2,188	1,720
Pharmaceutical services	0	10,873
New Pharmacy Contract	10,364	0
Non-GMS Services from GPs	520	60
Total Primary Healthcare purchased	**92,972**	98,694
Purchase of Secondary Healthcare		
Learning Difficulties	2,384	3,377
Mental Illness	55,097	63,788
Maternity	13,604	15,850
General and Acute	262,665	224,273
Accident and emergency	10,299	9,715
Community Health Services	101,153	100,533
Other Contractual	8,350	8,311
Total Secondary Healthcare Purchased	**453,552**	425,847
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**546,524**	**524,541**
Social Care from Independent Providers	569	3,723
Healthcare from NHS FTs included above	64,419	66,793

6. Operating Leases

Tower Hamlets PCT has entered into a number of standard commercial operating leases for office equipment, motor vehicles and premises. Renewal terms and expiry dates vary by property. Motor vehicles and photocopier leases can be renewed after their original lease term, which can vary depending upon the lease. Where the PCT has undue operating lease restrictions imposed under these lease arrangements, they are provided for in full under provisions.

The most significant leasing arrangments are for premises (Aneurin Bevan House, due to expire December 2013) and for the provision of GP Services within the Borough. Tower Hamlets PCT is the registered tenant for a number of GP premises for which the tenancy management for new leases, renewals, rent reviews and contractual negotiations are handled in house with external legal support. The PCT also has a number of financial arrangements involving the use of GP premises. These arrangements have been assessed to be operating leases under IAS 17 (Leases), SIC 27 (Evaluating the substance of transactions involving the legal form of a lease) and IFRIC 4 (Determining whether an arrangement contains a lease).

The PCT has determined that those operating leases must also be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in the Operating Cost Statement for 2012/13 is £3,124k (£2,819k in 2011/12).

Operating lease payments are recognised as an expense in the Operating Cost Statement on a straight-line basis over the lease term and contingent rent, for which the PCT has none, as an expense in the period in which it is incurred.

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				**1,431**	1,759
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**1,431**	**1,759**
Payable:					
No later than one year	**0**	**1,651**	**58**	**1,709**	1,691
Between one and five years	**0**	**5,099**	**25**	**5,124**	5,125
After five years	**0**	**17,052**	**0**	**17,052**	15,153
Total	**0**	**23,802**	**83**	**23,885**	**21,969**
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

Tower Hamlets PCT has entered into a number of standard commercial operating sub-leases for premises. Renewal terms and expiry dates vary by property. The PCT has no undue operating lease restrictions imposed by these lease arrangements.

Operating sub-lease receipts are recognised as miscelleanous revenue in the Operating Cost Statement on a straight-line basis over the lease term.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**32**	208
Contingent rents	**0**	0
Total	**32**	208
Receivable:		
No later than one year	**29**	31
Between one and five years	**118**	120
After five years	**432**	462
Total	**579**	613

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	11,571	11,539	32	9,306	9,274	32	2,265	2,265	0
Social security costs	802	802	0	802	802	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	1,024	1,024	0	1,024	1,024	0	0	0	0
Termination benefits	120	0	120	120	0	120	0	0	0
Total employee benefits	13,517	13,365	152	11,252	11,100	152	2,265	2,265	0
Less recoveries in respect of employee benefits (table below)	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	13,517	13,365	152	11,252	11,100	152	2,265	2,265	0
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	13,517	13,365	152	11,252	11,100	152	2,265	2,265	0
Recognised as:									
Commissioning employee benefits	13,517			11,252			2,265		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	13,517			11,252			2,265		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	8,434	7,598	836
Social security costs	807	807	0
Employer Contributions to NHS BSA - Pensions Division	1,052	1,052	0
Termination benefits	46	46	0
Total gross employee benefits	10,339	9,503	836
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	10,339	9,503	836
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	10,339	9,503	836
Recognised as:			
Commissioning employee benefits	10,339		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	10,339		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	3	3	0	11	11	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	230	183	47	201	170	31
Healthcare assistants and other support staff	0	0	0	0	0	0
Nursing, midwifery and health visiting staff	4	4	0	5	5	0
Nursing, midwifery and health visiting learners	1	1	0	0	0	0
Scientific, therapeutic and technical staff	0	0	0	1	1	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	2	2	0
TOTAL	238	191	47	220	189	31
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	1,388	4,305
Total Staff Years	178	508
Average working Days Lost	7.78	8.47

*The figures are based the calendar year 1 January to 31 December.

	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	67

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	3	0	3	0	0	0
£10,001-£25,000	0	0	0	2	1	3
£25,001-£50,000	0	0	0	1	1	2
£50,001-£100,000	2	0	2	0	0	0
£100,001 - £150,000	0	0	0	1	1	2
£150,001 - £200,000	0	0	0	1	0	1
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**5**	**0**	**5**	**5**	**3**	**8**
	£	£	£	£	£	£
Total resource cost	119,552	0	**119,552**	365,000	165,000	**530,000**

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

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

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**16,151**	**73,426**	16,061	79,497
Total Non-NHS Trade Invoices Paid Within Target	**14,531**	**59,974**	14,525	64,564
Percentage of Non-NHS Trade Invoices Paid Within Target	89.97%	81.68%	90.44%	81.22%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**5,136**	**556,419**	5,244	494,216
Total NHS Trade Invoices Paid Within Target	**4,076**	**529,790**	4,414	457,718
Percentage of NHS Trade Invoices Paid Within Target	79.36%	95.21%	84.17%	92.61%

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

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

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

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: loan interest receivable	116	0	116	118
Subtotal	116	0	116	118
Total investment income	116	0	116	118

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)	(288)	0	(288)	(25)
Total	(288)	0	(288)	(25)

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under LIFT contracts:				
- main finance cost	1,928	1,928	0	1,463
- contingent finance cost	736	736	0	226
Total interest expense	2,664	2,664	0	1,689
Other finance costs	0	0	0	11
Provisions - unwinding of discount	442		442	29
Total	3,106	2,664	442	1,729

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	20,741	54,508	0	5,714	3,817	340	5,269	48	90,437
Additions of Assets Under Construction				1,880					1,880
Additions Purchased	0	3,620	0		49	0	16	26	3,711
Additions Leased	0	5,245	0		0	0	0	0	5,245
Reclassifications	0	5,476	0	(5,713)	(258)	0	206	289	0
Disposals other than for sale	0	(3,119)	0	0	(30)	0	(193)	0	(3,342)
Upward revaluation/positive indexation	400	45	0	0	0	0	0	0	445
Impairments/negative indexation	0	(2,221)	0	0	0	0	0	0	(2,221)
At 31 March 2013	21,141	63,554	0	1,881	3,578	340	5,298	363	96,155
Depreciation									
At 1 April 2012	104	2,111	0	0	2,033	237	3,150	18	7,653
Disposals other than for sale	0	(3,119)	0		(29)	0	(167)	0	(3,315)
Impairments	0	1,599	0	0	15	0	79	0	1,693
Charged During the Year	52	2,593	0		492	26	1,024	47	4,234
At 31 March 2013	156	3,184	0	0	2,511	263	4,086	65	10,265
Net Book Value at 31 March 2013	20,985	60,370	0	1,881	1,067	77	1,212	298	85,890
Purchased	20,985	60,312	0	1,881	1,125	77	1,212	298	85,890
Total at 31 March 2013	20,985	60,312	0	1,881	1,125	77	1,212	298	85,890
Asset financing:									
Owned	20,010	42,852	0	1,829	1,125	77	957	298	67,148
Held on finance lease	0	0	0	52	0	0	255	0	307
On-SOFP PFI contracts	975	17,460	0	0	0	0	0	0	18,435
Total at 31 March 2013	20,985	60,312	0	1,881	1,125	77	1,212	298	85,890

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	11,199	3,313	0	0	0	73	0	0	14,585
Movements (specify)	400	(2,281)	0	0	0	0	0	0	(1,881)
At 31 March 2013	11,599	1,032	0	0	0	73	0	0	12,704

Additions to Assets Under Construction in 2012-13

	£000
Buildings excl Dwellings	1,709
Plant & Machinery	171
Balance as at YTD	1,880

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**20,741**	**55,107**	**0**	**3,159**	**4,683**	**340**	**5,527**	**420**	**89,977**
Additions - purchased	0	252	0	5,217	159	0	329	0	**5,957**
Reclassifications	0	2,558	0	(2,662)	104	0	0	0	**0**
Disposals other than by sale	0	0	0	0	(1,129)	0	(587)	(372)	**(2,088)**
Revaluation & indexation gains	0	28	0	0	0	0	0	0	**28**
Impairments	0	(1,311)	0	0	0	0	0	0	**(1,311)**
Cumulative dep netted off cost following revaluatic	0	(2,126)	0	0	0	0	0	0	**(2,126)**
At 31 March 2012	**20,741**	**54,508**	**0**	**5,714**	**3,817**	**340**	**5,269**	**48**	**90,437**
Depreciation									
At 1 April 2011	**52**	**1,396**	**0**		**2,820**	**193**	**2,788**	**383**	**7,632**
Disposals other than for sale	0	0	0		(1,113)	0	(578)	(372)	**(2,063)**
Impairments	0	25	0	0	0	0	0	0	**25**
Charged During the Year	52	2,816	0		326	44	940	7	**4,185**
Cumulative dep netted off cost following revaluatic	0	(2,126)	0	0	0	0	0	0	**(2,126)**
At 31 March 2012	**104**	**2,111**	**0**	**0**	**2,033**	**237**	**3,150**	**18**	**7,653**
Net Book Value at 31 March 2012	**20,637**	**52,397**	**0**	**5,714**	**1,784**	**103**	**2,119**	**30**	**82,784**
Purchased	20,637	52,397	0	5,714	1,700	103	2,119	30	**82,700**
Government Granted	0	0	0	0	84	0	0	0	**84**
At 31 March 2012	**20,637**	**52,397**	**0**	**5,714**	**1,784**	**103**	**2,119**	**30**	**82,784**
Asset financing:									
Owned	19,609	39,342	0	5,714	1,784	103	1,736	30	**68,318**
Held on finance lease	0	0	0	0	0	0	383	0	**383**
On-SOFP PFI contracts	1,028	13,055	0	0	0	0	0	0	**14,083**
At 31 March 2012	**20,637**	**52,397**	**0**	**5,714**	**1,784**	**103**	**2,119**	**30**	**82,784**

12.3 Property, plant and equipment

All of the land and building assets of the PCT have been valued to fair value as defined in IAS 16, the amount an asset could be exchanged between knowlegeable and willing parties in an arm's length transaction, by the District Valuer at 31st March 2013. The fair value of land and buildings is the Market Value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This equates to Existing Use Value in the IRCs Standards.

The valuation of the building assets owned by the PCT has been impaired as a result of the valuations undertaken by the Valuation Office. The impairment has been taken to the revaluation reserve for each asset and any remaining balance has been charged to the Operating Cost Statement.

To comply with IFRS the valuations are reveiwed on an annual basis.

The remaining economic useful lives of each class of asset, at the Statement of Financial Position date were:

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings exc Dwellings	12	37
Plant and Machinery	2	22
Transport Equipment	3	7
Information Technology	1	5
Furniture and Fittings	3	8

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Unforeseen obsolescence	1,693		1,693
Total charged to Annually Managed Expenditure	**1,693**		**1,693**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	2,221		
Total impairments for PPE charged to reserves	**2,221**		
Total Impairments of Property, Plant and Equipment	**3,914**	**0**	**1,693**
Total Impairments charged to Revaluation Reserve	2,221		
Total Impairments charged to SoCNE - AME	1,693		1,693
Overall Total Impairments	**3,914**	**0**	**1,693**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0

14 Commitments

14.1 Capital commitments

The PCT had not entered into capital commitments at the date of the statement of financial position.

14.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements). The payments to which the trust is committed are as follows

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**1,775**	4,347
Later than one year and not later than five year	**9,155**	8,433
Later than five years	**5,393**	7,891
Total	**16,323**	20,671

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	8,138	0	3,253	0
Balances with Local Authorities	0	0	2,665	0
Balances with NHS Trusts and Foundation Trusts	210	0	16,346	0
Balances with bodies external to government	1,500	0	28,827	0
At 31 March 2013	**9,848**	**0**	**51,091**	**0**
prior period:				
Balances with other Central Government Bodies	3,995	0	1,562	0
Balances with Local Authorities	0	0	21	0
Balances with NHS Trusts and Foundation Trusts	2,965	0	10,238	0
Balances with bodies external to government	3,776	0	34,057	0
At 31 March 2012	**10,736**	**0**	**45,878**	**0**

16 Inventories

	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000
Balance at 1 April 2012	**0**	**12**	**0**	**0**	**0**	**0**	**12**
Inventories recognised as an expense in the period	0	(12)	0	0	0	0	(12)
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**

17.1 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	**7,642**	6,363	**0**	0
NHS prepayments and accrued income	**34**	597	**0**	0
Non-NHS receivables - revenue	**687**	309	**0**	0
Non-NHS prepayments and accrued income	**946**	4,119	**0**	0
Provision for the impairment of receivables	**(150)**	(1,102)	**0**	0
VAT	**672**	446	**0**	0
Other receivables	**17**	4	**0**	0
Total	**9,848**	10,736	**0**	0
Total current and non current	**9,848**	10,736		
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

17.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**1**	1,253
By three to six months	**0**	24
By more than six months	**0**	123
Total	**1**	1,400

17.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(1,102)**	(134)
Amount written off during the year	**84**	8
Amount recovered during the year	**1,169**	0
(Increase)/decrease in receivables impaired	**(301)**	(976)
Balance at 31 March 2013	**(150)**	(1,102)

18 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**417**	**0**	**417**
Additions	**209**	**0**	**209**
Loan repayments	**(13)**	**0**	**(13)**
Loans repayable within 12 months	**(4)**	**0**	**(4)**
Balance at 31 March 2013	**609**	**0**	**609**
Balance at 1 April 2011	0	373	373
Disposals	373	(373)	0
Loan repayments	(10)	0	(10)
Revaluations	66	0	66
Loans repayable within 12 months	(12)	0	(12)
Balance at 31 March 2012	**417**	**0**	**417**

19.1 Other financial assets - Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	12	0
Other Movements	3	12
Closing balance 31 March	**15**	12

19.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**417**	373
Additions	192	417
Transferred to current financial assets	(15)	0
Disposals	0	(373)
Total Other Financial Assets - Non Current	**594**	417

20 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**55**	0
Net change in year	**4,734**	64
Closing balance	**4,789**	64
Made up of		
Cash with Government Banking Service	**4,798**	55
Cash and cash equivalents as in statement of financial position	**4,798**	55
Cash and cash equivalents as in statement of cash flows	**4,798**	55
Patients' money held by the PCT, not included above	**0**	0

21 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	**7,611**	3,396	**0**	0
NHS accruals and deferred income	**11,405**	8,394	**0**	0
Family Health Services (FHS) payables	**11,636**	15,524		
Non-NHS payables - revenue	**7,525**	8,314	**0**	0
Non-NHS payables - capital	**1,233**	1,792	**0**	0
Non_NHS accruals and deferred income	**11,097**	8,356	**0**	0
Social security costs	**583**	0		
Payments received on account	**1**	0	**0**	0
Other	0	102	0	0
Total	**51,091**	45,878	**0**	0
Total payables (current and non-current)	**51,091**	**45,878**		

22 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
LIFT liabilities:				
Main liability	**515**	445	**20,014**	15,354
Finance lease liabilities	**153**	123	**0**	127
Total	**668**	**568**	**20,014**	**15,481**
Total other liabilities (current and non-current)	**20,682**	**16,049**		

23 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at1 April 2012	**170**	0	**0**	0
Deferred income addition	**0**	170	**0**	0
Transfer of deferred income	**(170)**	0	**0**	0
Current deferred Income at 31 March 2013	**0**	170	**0**	0
Total other liabilities (current and non-current)	**0**	**170**		

24 Finance lease obligations

Amounts payable under finance leases (Other)	Minimum lease payments		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**153**	132	**153**	127
Between one and five years	**0**	132	**0**	123
Less future finance charges	**0**	(14)		
Present value of minimum lease payments	**153**	250	**153**	250
Included in:				
Current borrowings			**153**	127
Non-current borrowings			**0**	123
			153	250

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	**5,320**	341	1,714	314	0	0	0	0	2,951	0
Arising During the Year	**983**	0	0	23	0	932	0	0	28	0
Utilised During the Year	**(2,471)**	(368)	(1,926)	(10)	0	0	0	0	(167)	0
Reversed Unused	**(512)**	(58)	(145)	(230)	0	0	0	0	(79)	0
Unwinding of Discount	**442**	85	357	0	0	0	0	0	0	0
Balance at 31 March 2013	**3,762**	**0**	**0**	**97**	**0**	**932**	**0**	**0**	**2,733**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**1,568**	**0**	**0**	**97**	**0**	**932**	**0**	**0**	**539**	**0**
Later than Five Years	**2,194**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2,194**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	16
As at 31 March 2012	0

Provisions for legal claims are based the projected possiblity of a case occuring and the PCT incuring a loss as provided by external solicitors. Based on estimations provided it is expected the cases will complete in the following year. Further details of these provisions are provided in the accounting policies note 1.22.

Retrospective Continuing Care Claim Provision for the repayment of nursing care and interest is an estimate of the number successful claims at the average cost of the claims. It is expected review and payment of costs will be completed in the following year. Further details of these provisions are provided in the accounting policies note 1.22.

Other includes provisions for rental provisions, onerous leases, and dilapidations. Dilapidations are assumed to occur at the end of the lease, other provisions are assumed to be ulitised in the following year. Further details of these provisions are provided in the accounting policies note 1.22.

There is no expected reimbursements for any of the provisions.

26 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Other	**0**	(10)
Net Value of Contingent Liabilities	**0**	(10)

Unquantified

In April 2012, the Department of Health announced the deadline of 31 March 2013 for individuals to request an assessment of eligibility for NHS Continuing Healthcare funding, for cases during the period 1 April 2011 – 31 March 2012. With the process still continuing to assess claims for the period 1 April 2004 – 31 March 2011 from the previous deadline of 30 September 2012, the review of the claims for the second dead-line has not yet commenced. Therefore estimates are yet not available to quantify the contingent liability.

27 LIFT - additional information

Under the LIFT framework the PCT has entered into agreements under which the East London LIFT Company constructs new primary care centres and then leases them back to the PCT under a standard 25 year Lease Plus Agreement (LPA) or Land Retention Agreement (LRA). The East London LIFT Company is responsible for full maintenance and lifecycle costs throughout the term of the LPA. The PCT is contractually bound to pay the East London LIFT Company a fixed, index-linked, annual charge which does not fluctuate according to the usage of the asset. Under the LPA the contract makes provision for penalties that are incurred by the East London LIFT Company to ensure that agreed standards and requirements for services are complied with.

In 2012-13 the PCT entered into agreements with the East London LIFT Company for the Newby Place Health Centre at Newby Place under a LPA. The contract is due to expire in 2037.

Under IFRIC 12, the assets are treated as assets of the PCT. The substance of the contract is that the PCT has a finance lease and payments comprise two elements – imputed finance lease charges and service charges. There is an option to purchase in the LPAs which is not expected to be exercised.

Total finance lease obligations for on-Statement of Financial Position PFI/NHS LIFT contracts due, over the life of the schemes are:

Charges to operating expenditure and future commitments in respect of on SOFP LIFT	**31 March 2013 £000**	31 March 2012 £000
Service element of on SOFP LIFT charged to operating expenses in year	**245**	177
Total	**245**	177

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	**270**	181
Later than One Year, No Later than Five Years	**1,165**	785
Later than Five Years	**6,263**	3,966
Total	**7,698**	4,932

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013 £000**	31 March 2012 £000
No Later than One Year	**2,807**	2,058
Later than One Year, No Later than Five Years	**11,799**	8,413
Later than Five Years	**53,214**	37,473
Subtotal	**67,820**	47,944
Less: Interest Element	**(47,292)**	(32,145)
Total	**20,528**	15,799

28 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.

28.1 Financial Assets	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives			**0**
Receivables - NHS	7,676		**7,676**
Receivables - non-NHS	1,049		**1,049**
Cash at bank and in hand	4,798		**4,798**
Other financial assets	626	0	**626**
Total at 31 March 2013	**14,149**	**0**	**14,149**
Embedded derivatives			0
Receivables - NHS	5,861		5,861
Receivables - non-NHS	309		309
Cash at bank and in hand	64		64
Other financial assets	458	0	458
Total at 31 March 2012	6,692	0	6,692

28.2 Financial Liabilities	Other £000	Total £000
Embedded derivatives		**0**
NHS payables	19,025	**19,025**
Non-NHS payables	31,491	**31,491**
PFI & finance lease obligations	20,682	**20,682**
Other financial liabilities	1	**1**
Total at 31 March 2013	**71,199**	**71,199**
Embedded derivatives		0
NHS payables	11,791	11,791
Non-NHS payables	33,817	33,817
PFI & finance lease obligations	16,049	16,049
Other financial liabilities	101	101
Total at 31 March 2012	61,758	61,758

29 Related party transactions

Details of related party transactions* are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Homerton Hospital- Lesley Mountford	4,903,092		295,865	

*Related Party transactions are with individuals or with organisations individuals have significant influence.

The Department of Health is regarded as a related party. During the year 2012-13 the PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

English Strategic Health Authorities
London Strategic Health Authority

English NHS Foundation Trusts
East London NHS Foundation Trust
University College London NHS Foundation Trust
Homerton University Hospital NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
Guys And St Thomas NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Non Contracted Activity (NCA) Accruals and unassigned part-completed episodes
Basildon And Thurrock Univ Hosp NHS Foundation Trust
Chelsea And Westminster Hospital NHS Foundation Trust
Kings College Hospital NHS Foundation Trust
Royal Free London NHS Foundation Trust
Central And North West London MH NHS Foundation Trust
Camden And Islington NHS Foundation Trust
Royal Brompton And Harefield NHS Foundation Trust
North East London NHS Foundation Trust
The Royal Marsden Hospital NHS Foundation Trust

English NHS Trusts
Barts Health NHS Trust
London Ambulance Service NHS Trust
Imperial College Healthcare NHS Trust
The Royal National Orthopaedic Hospital NHS Trust
Barking, Havering And Redbridge University Hospitals NHS Trust
The Lewisham Healthcare NHS Trust
Whittington Hospital NHS Trust
Barnet, Enfield And Haringey Mental Health NHS Trust
South London Healthcare NHS Trust
Central London Community Healthcare NHS Trust
North West London Hospitals NHS Trust
Mid Essex Hospital Services NHS Trust
St Georges Healthcare NHS Trust
North Middlesex University Hospital NHS Trust

English Primary Care Trusts
Croydon PCT
City And Hackney Teaching PCT

Other English RAB Authorities
NHS Litigation Authority

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Tower Hamlets Local Authority.

30 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
Special payments - PCT management costs	450	1
Total losses	0	0
Total special payments	450	1
Total losses and special payments	450	1

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
Special payments - PCT management costs	0	0
Total losses	0	0
Total special payments	0	0
Total losses and special payments	0	0

31 Events after the end of the reporting period

The main functions carried out byTower Hamlets PCT in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

NHS England, will commission Primary Care Services from a number of GPs, Dentists, Pharmacists and Optomotrists and Secondary Specialist Care Services from the NHS Trusts, Foundation Trusts and the Independent Sector. Tower Hamlets Clinical Commissioning Group, will commission Secondary Care Services (excluding Specialist Care Services) from the NHS Trusts, Foundation Trusts and the Independent Sector. NHS Property Services Ltd, will provide management services of the NHS Estates.

Property, Plant and Equipment assets have transferred to NHS Property Services Ltd, NHS England, Tower Hamlets Clinical Commissioning Group, NHS Barts Health Trust and East London Foundation Trust on 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCTs' books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.

The schedule below shows the summary analysis of the financial value of assets and liabilities transferred to receiving bodies of the PCT.

		Entities receiving assets and liabilities following the PCT's/SHAs closure								
The assets and liabilities of the PCT/SHA were transferred to successor bodies on 1 April 2013 as follows:	**Balances held by the PCT at 31 March 2013**	**Department of Health**	**Clinical Commissioning Groups**	**Commissioning Board**	**NHS Foundation Trusts**	**NHS Trusts**	**Department of Health ALBs**	**NHS Property Services**	**Community Health Partnerships**	**Other** *Local Authority*
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Non-current assets:										
Property, plant and equipment	85,890	0	156	1,437	0	51,772	0	14,090	18,435	0
Other financial assets	594	0	0	0	0	0	0	0	594	0
Total non-current assets	**86,484**	**0**	**156**	**1,437**	**0**	**51,772**	**0**	**14,090**	**19,029**	**0**
Current assets:										
Trade and other receivables	9,848	8,889	0	510	0	0	0	243	203	3
Other financial assets	15	0	0	0	0	0	0	0	15	0
Cash and cash equivalents	4,798	4,798	0	0	0	0	0	0	0	0
Total current assets	**14,661**	**13,687**	**0**	**510**	**0**	**0**	**0**	**243**	**218**	**3**
Non-current assets held for sale	0	0	0	0	0	0	0	0	0	0
Total current assets	**14,661**	**13,687**	**0**	**510**	**0**	**0**	**0**	**243**	**218**	**3**
Total assets	**101,145**	**13,687**	**156**	**1,947**	**0**	**51,772**	**0**	**14,333**	**19,247**	**3**
Current liabilities										
Trade and other payables	(51,091)	(41,077)	(6,407)	(3,608)	0	0	0	0	0	0
Provisions	(1,568)	(97)	(932)	(477)	0	0	0	(62)	0	0
Borrowings	(668)	0	(153)	0	0	0	0	0	(515)	0
Total current liabilities	**(53,327)**	**(41,174)**	**(7,492)**	**(4,085)**	**0**	**0**	**0**	**(62)**	**(515)**	**0**
Non-current assets plus/less net current assets/liabilities	**47,818**	**(27,487)**	**(7,336)**	**(2,138)**	**0**	**51,772**	**0**	**14,271**	**18,732**	**3**
Non-current liabilities										
Provisions	(2,194)	0	0	0	0	(860)	0	(1,317)	(17)	0
Borrowings	(20,014)	0	0	0	0	0	0	0	(20,014)	0
Total non-current liabilities	**(22,208)**	**0**	**0**	**0**	**0**	**(860)**	**0**	**(1,317)**	**(20,031)**	**0**
Total Assets Employed:	**25,610**	**(27,487)**	**(7,336)**	**(2,138)**	**0**	**50,912**	**0**	**12,954**	**(1,299)**	**3**
Financed by taxpayers' equity:										
General fund	12,906	(27,487)	(7,336)	(2,138)	0	40,142	0	11,306	(1,585)	3
Revaluation reserve	12,704	0	0	0	0	10,770	0	1,648	286	0
Total taxpayers' equity:	**25,610**	**(27,487)**	**(7,336)**	**(2,138)**	**0**	**50,912**	**0**	**12,954**	**(1,299)**	**3**

As at 22 May 2013, Trade and other receivables has reduced by £8,107k from £9,848k to £1,741k. Trade and other payables has reduced from £51,091k to £25,179k a reduction of £25,911k.

Details of the assets and liabilities transferring to successor bodies is not within the scope of the Auditor's report and is provided for information only

14 Annual governance statement

Name of organisation: Tower Hamlets Primary Care Trust

1. Scope of responsibility

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

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

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

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

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

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

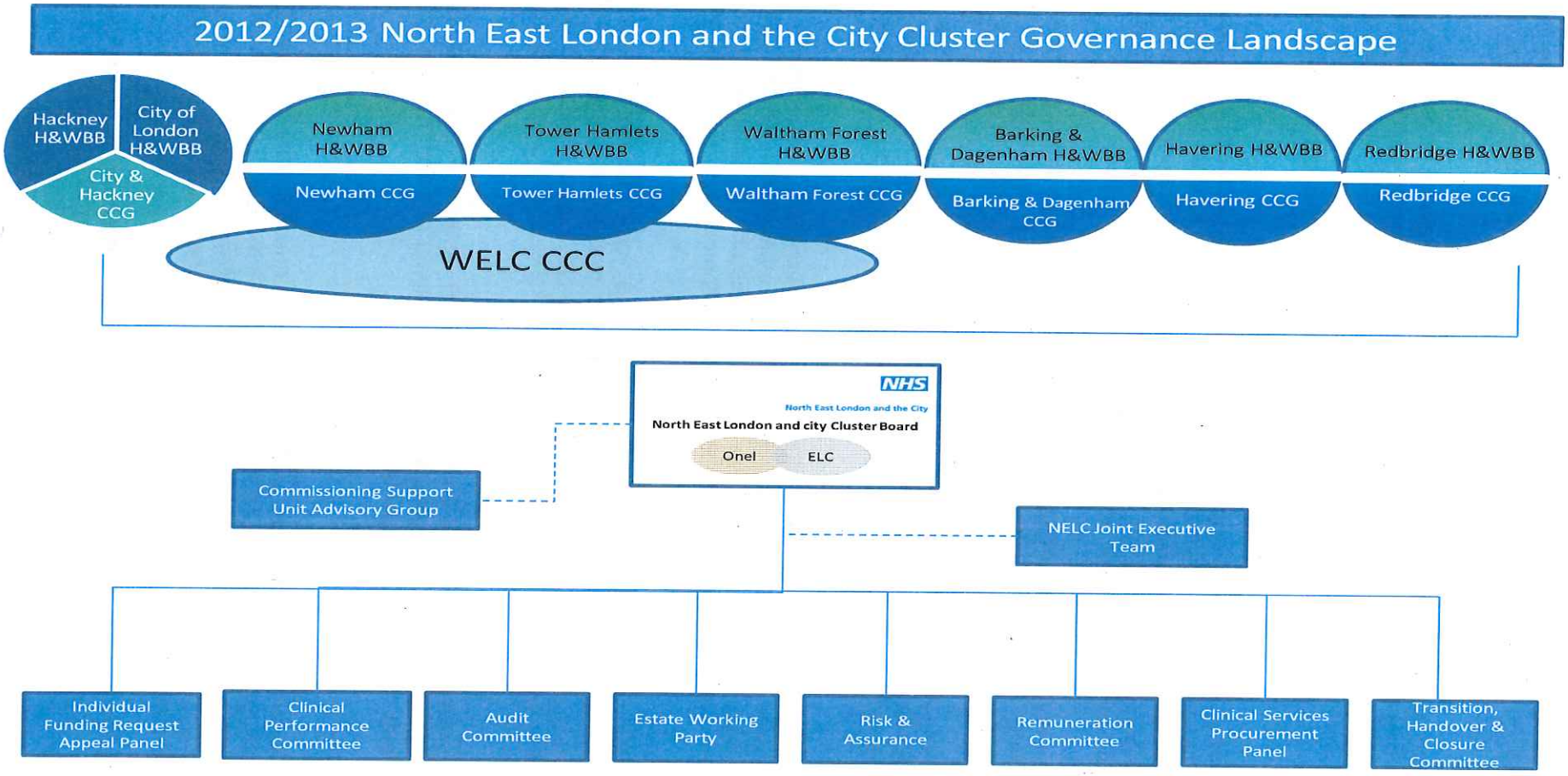
2. The governance framework of the organisation

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

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

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

NHS North East London and the City committee structure



Agreed April 2012

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

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

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

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

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

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

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

3. Board effectiveness

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

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

- that the members individually and collectively understand what is expected of them

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

4. Assurance

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

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

5. Risk assessment

5.1 Risk management strategy

The Cluster governance structure was designed to ensure that there was a balance between having robust governance arrangements for the organisation and being able to deliver an effective end state.
The risks to the achievement of the Cluster's Corporate Objectives were identified through the process detailed in the North East London and the City Risk Management Strategy. This document was created following a review of the risk management strategies for:

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

Elements of best practices from these documents in terms of: risk definitions, identification processes, templates and risk matrix were taken out and combined to create the NHS North East London and the City Risk Management Strategy. This was approved by the Board at its May 2012 meeting.

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

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

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

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

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

5.2 Risk identification

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

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

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

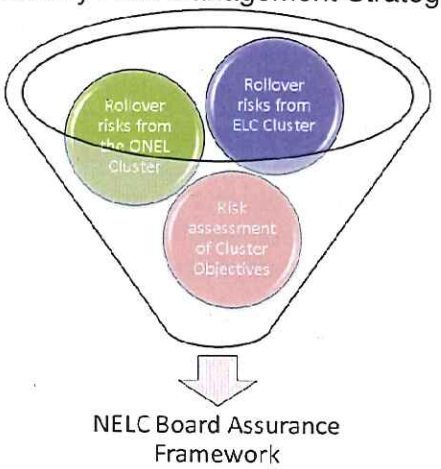


Figure 1 showing the 2 main processes that led to the creation of the NELC Board Assurance Framework

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

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

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

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

5.3 Accountability for risks

Individual Directors were held accountable for the risks associated with their Directorates. The Board Assurance Framework and Corporate Risk Register were refreshed quarterly through meetings with the Directorate risk leads. Once reviewed and revised the documents were reported to the following bodies:

- Transition, Handover and Closure Committee
  This Committee retained oversight for all the risks pertaining to Transition, Handover and Closure. It met on a monthly basis from November 2012

- Risk and Assurance Committee
  This Committee reviews both the Board Assurance Framework and Corporate Risk Register in its entirety at least once a quarter to provide probity of the documents and thus the risks facing the organisation.
  This Committee also had the power to request "Deep Dives" to provide assurance to the Board that the Cluster has effective systems of internal control in relation to risk management and governance. The Committee held one deep dive on the issue of "quality and handover to the CCGs". It met bi-monthly.

- Audit Committee
  The Audit Committee was responsible for reviewing the effectiveness of the internal control and risk management systems and received reports from management on the effectiveness of the risk systems that the Cluster had established.

- Cluster Board
  The Board received the Board Assurance Framework once a quarter to ensure that the Board retained oversight of all the risks to the achievement of the Corporate Objectives and allow Board members to challenge executives on areas of weak control, assurance or high risk rating.

5.4 Board Assurance Framework 2012/13

Key risks for Tower Hamlets PCT identified during 2012/13 which populated the Board Assurance Framework for 2012/13 and how their risk rating changed over the financial year are summarised below:

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

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

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

The assessment of risks has been undertaken in accordance with the Cluster's risk strategy and Board Assurance Framework. This includes a risk scoring and escalation process that ensures as far as is practicably possible that there is consistency of applied risk ratings

across the organisation. In depth scrutiny of the BAF has been undertaken by the Risk and Assurance committee. This Committee has undertaken a "deep dive" challenge into particular areas of risks, for example quality & safety and has held individual directors to account for the risks associated with their areas of responsibility.

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

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

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

5.5 Corporate Risk Register

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

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

These corporate risks have been managed as follows:

- The delivery team for Transition, Handover and Closure have put in place relationship managers to ensure there was effective communication with receiving organisations. Regular bulletins have been issued to staff and public communication statements issued in the local press and on website
- A finance closedown team has been put in place to manage "wind up" effectively
- Remedial action was taken to ensure compliance with Information Governance Toolkit by 31 March 2013. Lessons learn from the deficiencies have been passed on the CCGs and the CSU to inform their Information Governance Toolkit compliance for 2013/14

5.6 The Risk and control framework

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

A rolling review of the Assurance Framework for 2012/2013, carried out by the PCT's internal auditors, RSM Tenon and Parkhill has demonstrated that there is an effective system of internal control to manage the principal risks identified by the organisation.

However it was noted that there is scope for some improvement when articulating the mechanisms that provide assurances that the controls put in place to manage risks are indeed effective. The specific issues that have been highlighted for improvement are listed below:

i. Information Governance
ii. Continuing Care

6 Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.
For 2012 / 13 the Head of Internal Audit has advised me that based on the work undertaken in 2012/13, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

However, he has issued an Information Governance report with a RED opinion rating whilst at the same time noting that we are drawing up a response to the recommendations made which we expect to mitigate any gaps in controls identified moving forwards.
Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

- The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by other sources including;
- Scrutiny from our external auditors
- Information Governance Assurance tool kit compliance submission
- The Cluster's internal monitoring and review process for its quality of commissioned services described in the Department of Health's Operating Framework and delivered through the Risk & Assurance Committee
- Reports by Internal and External Audit and the results of Patient and Staff Surveys
- Annual Care Quality Commission (CQC) assessment for safeguarding children
- Local Safeguarding Children Board (LSCB) annual report
- Robust incident and complaints monitoring processes, ensuring compliance with national Serious Incident reporting.
- NHS London's review of the plans to support the 2012/13 QIPP programme and consequential financial impacts at both PCT and Outer North East London levels
- Assurance on fraud and potential fraud is provided through the work of the local counter fraud officer who provides updates, communications and training on all appropriate counter fraud issues to PCT staff and emerging CCG pathfinder organisations.
- My review confirms that Tower Hamlets PCT had a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.
- The Audit Committee provided the Board with an independent and objective view of arrangements for internal financial control within the PCT, ensuring that the Internal Audit service complies with mandatory auditing standards including the review of all fundamental financial systems.
- The Board and Executive Directors managed and reviewed their principal risks through their Performance reviews both with NHS London and the cluster's

Operating Plan and the Business Planning process and their contribution to the development of the Assurance Framework.

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

Significant Issues

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

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

Peter Coates, CBE
Designated Signing Officer

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