Department of Health

NHS

Havering Primary Care Trust

2012-13 Annual Report and Accounts

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Havering Primary Care Trust

2012-13 Annual Report

NHS

North East London and the City

Havering Primary Care Trust

Annual report 2012/13

Creating a healthier future

Contents

1 Foreword

2012/13 was a year to remember for north east London and the City. This was the year of the Olympics and Paralympics, when north east London was the centre of world attention. Thousands of visitors came to east London and many local people and NHS staff were able to take part in the opening or closing ceremonies or work as volunteers.

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

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

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

The overarching purpose of primary care trust 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 think of current services and what they wanted us to develop.

We then looked at the different ways those needs could be met, and we enter into contracts with a range of organisations to provide services for people in Havering. 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 Barking, Havering and Redbridge University Hospital 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 North 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 met 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 Havering 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, Newham, Redbridge, Tower Hamlets 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 due to Mr Akram being unavailable.

Non-Executive Directors (NEDs)

There were seven Non-Executive Directors, including the chair above, appointed across the seven primary care trusts. The Vice-Chair is a member of all seven statutory Boards as is the Audit Chair. The NEDS were:

- Frances Pennell-Buck, Vice-Chair from 1 April 2012 to 31 March 2013
- Kash Pandya as 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, some 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
- 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 CCG chair, and the director of public health.

For NHS Havering these were:
Dr Atul Aggarwal, Havering Clinical Commissioning Group chair, 1 April 2012 to 31 March 2013
Dr Jane Moore, Director of Public Health, 1 April 2012 to 12 May 2012
Dr Lesley Mountford, Director of Public Health, 13 May 2012 31 March 2013

Audit Committee arrangements

The audit committee was made up of three non-executive directors or associate non-executive directors, Kash Pandya as Chair, Charles Beaumont and Mariette Davis. The chair of the PCT was not a member of the committee.

Within the cluster arrangements each PCT retained a separate audit committee function but these met together through 2012/13, with the membership shown above.

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

Declarations of Interest

All Board members declared any interests which might be relevant and material to their NHS responsibilities. This included 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 were stored in an Interests Register and detailed below. Where there is no entry, this means there were no relevant declared interests.

Register of interests 2012/13

Name	Role	Organisation	Nature of interest
Kash Pandya	Non Executive Director & 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
		Citizens Advice Bureau	Adviser
		Barking & Dagenham CCG Redbridge CCG	Lay Member Lay Member
Dr Atul Aggarwal	Chair – Havering CCG	Maylands Surgery	GP Partner
		Essex General Practice Services	Director
		Essex Medicare LLP	Partner
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
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	Husband providing coaching support
		London Borough of Newham	Husband providing project support.
		Outlook care	Husband is Non Executive Director

Name	Role	Organisation	Nature of interest
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 Trust	Partner Governor
John Lock	Non Executive Director	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, WF 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. Related party transactions took place with London South Bank University, with income of £194,000.

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 bodies 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** (CCGs), which give GPs and other clinicians responsibility for using resources to secure high-quality services for local people.

NHS Havering 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. Havering Clinical Commissioning Group is chaired by Dr Atul Aggarwal and its Chief Officer is Conor Burke**.**

The boards of the PCTs in Outer North East London 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 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 will also be required to provide a small number of mandatory services, including:

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

6 Our performance

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

Last year we met national standards in the following areas:

Barking, Havering and Redbridge University Hospital Trust;

- met all requirements that patients are treated in hospital within 18 weeks of referral
- achieved national standards for cancer care
- met the standards for ensuring hospital patients were assessed for Venous thromboembolism risk on admission.

North East London NHS Foundation Trust;

- met its 18 week referral requirements for its children's, adult and specialist services

Some of targets were not met:

Barking, Havering and Redbridge University Hospital Trust:

- failed to meet the A&E four hour wait standard
- failed to meet the ambulance handover standards
- failed to meet requirements on limiting cases of MRSA
- exceeded the national standards for the number of cases of C difficile contracted by hospital patients.

The Care Quality Commission issued two reports on A&E and maternity services at Barking, Havering and Redbridge University Hospitals NHS Trust in February 2013. This followed unannounced visits made to the trust during November and December 2012.

The CQC's A&E report highlights that urgent action is needed to improve the quality of care. Inspectors found some poor care, unacceptable practices and waits. Our response outlines the work we are undertaking with the Trust and partners to improve the standard of care.

The CQC's maternity report shows that services have significantly improved and the trust is now meeting all standards of care, safety and staffing. The opening of the Barking Birthing Centre and the Queen's Birth Centre provides additional capacity and choice of birth environment for women with low-risk pregnancies.

For public health, over the last 10 years, all -cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen.

Priorities in Havering include early detection of cancer to improve 1 year survival, tackling childhood obesity, and falls and fracture prevention.

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 has moved. 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.

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 in NHS North East London and the City, 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

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:

- The redevelopment of St George's Hospital in Hornchurch. This consultation, which was due to close on 12 May 2013, has been led by NHS Havering Clinical Commissioning Group
- Emergency Dental Care

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 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 have 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 2013.

Consultation with staff and staffside representatives took place on structures for the commissioning support unit (CSU) 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 provided a variety of learning experiences including masterclasses which allowed staff to explore the wider health economy and the new developments of 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 2,993 days lost. This was with a full-time equivalent of 265 members of staff. The average number of working days lost was 11.3. This was a sickness rate average of 5.0% across the calendar year.

'Two Tick' 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 potential 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 provided a stand-alone 'health kiosk' which 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 h created a sense of 'belonging together' within a transient organisation.

Equality objectives

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

Off payroll engagements

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	3.00
No that have since come onto the organisation's payroll	0.00
No. that since been re-negotiated/re-engaged to include contractual clauses allowing the (organisation) to seek assurance as to their tax obligations	0.00
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	0.00
No that have come to an end	3.00
Total FTE	3.00

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

	FTE
No. of new engagements	9.00
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	9.00
Of which:	
No. for whom assurance has been accepted and received	0.00
No. for whom assurance has been accepted and not received	9.00
No that have been terminated as a result of assurance not being received	0.00
Total	9.00

We have defined "off payroll engagements" to mean that it relates to interim staff who have occupied substantive roles.

9 Taking care of the environment

NHS organisations have a responsibility for the environment. We were 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 was our commitment and registration to the good corporate citizen model. This required NHS trusts to explore their environmental credentials, identify any deficiencies and plan for future improvements. It also allowed benchmarking between trusts. We investigated, took action and monitored sustainability issues with the goal of reducing the carbon footprint. This brings financial as well as environmental benefits.

Havering PCT had an approved sustainability action plan. This set out desired outcomes and helped in the development of a plan for sustainable health. Some sample outcomes are set out below across the eleven headings:

Energy and carbon management
Encourage all staff to take responsibility for energy consumption and carbon reduction, including dissemination of the climate change staff survey findings.
Procurement
Consider local procurement, whole lifecycle costs and the environmental impact of financial decisions, in preparation for the use of carbon as a currency.
Water
Measure and monitor water costs and consumption, including the results in an annual report.
Waste
Monitor and manage the quantity and cost of all waste streams and set trajectories to monitor, manage and reduce them over time.
Commissioning
Routinely mandate providers through service specifications to consider and minimise carbon impact of their service delivery proposals
Designing the built environment
Ensure that buildings are designed to promote sustainable behaviours in staff, patients and visitors, and are adaptable to support change towards low carbon patient pathways.
Role of partnerships and networks
Ensure that we use leverage within local partnerships and performance frameworks to promote carbon reduction.
Governance
Complete the good corporate citizen assessment model and produce an action plan with clear milestones to measure, monitor and reduce direct carbon emissions.
Investment
Develop carbon literacy and embed carbon reduction in financial mechanisms.
Green information technology programme
Reduce power consumption and paper usage and increase use of recycled paper and toners for printers.

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 was 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 talked earlier in this report 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 NHS Havering was given a revenue resource limit of £449.634 million from the Department of Health.

We spent the money on services as follows:

Acute hospital care	54%
Non-acute	21%
Prescribing and primary care	19%
Corporate and other costs	6%

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

- **Cash limit** Our cash limits were £436.186 million (for revenue) and £2.425 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 £449.634 million and achieved a surplus of £4.104 million.
- **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 £2.425 million. The PCT has spent £1.160 million in the year for the achievement of the capital programme.

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. We paid 89% of non-NHS invoices (84% by value) and 87% of NHS invoices (91% 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 were 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 are required to have a remuneration committee to oversee the pay, terms and conditions of service of senior managers.

The main function of the committee is 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 are included that were 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, were 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, were 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 were 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 agreed 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 Havering PCT in the year 2012/13 was £24,147.69 (2011/2012 = £34,654.13). This was 2.41 times (2011/2012 = 3.60) the median remuneration of the workforce, which was £10,036.66 (2011/2012 = £9,635.21). The reason for the variances between 2011/2012 and 2012/2013 is that the highest paid director salary is now spread across seven PCTs (For 2011/2012 this was 4 PCTs) in the North East London Cluster.

The highest paid director's salary is based upon the estimated cost to Havering PCT. Some staff who are not recharged across the sector (seven PCTS) cost Havering PCT more than the highest paid director only due to the fact that they have not been recharged across all 7 PCTs. As a result 37 staff cost Havering 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 Havering PCT compared to the highest paid director as only being shown as the element of cost the PCT is charged for that directors service

Havering 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 Havering 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)

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 Havering 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: Havering 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 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 these 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.

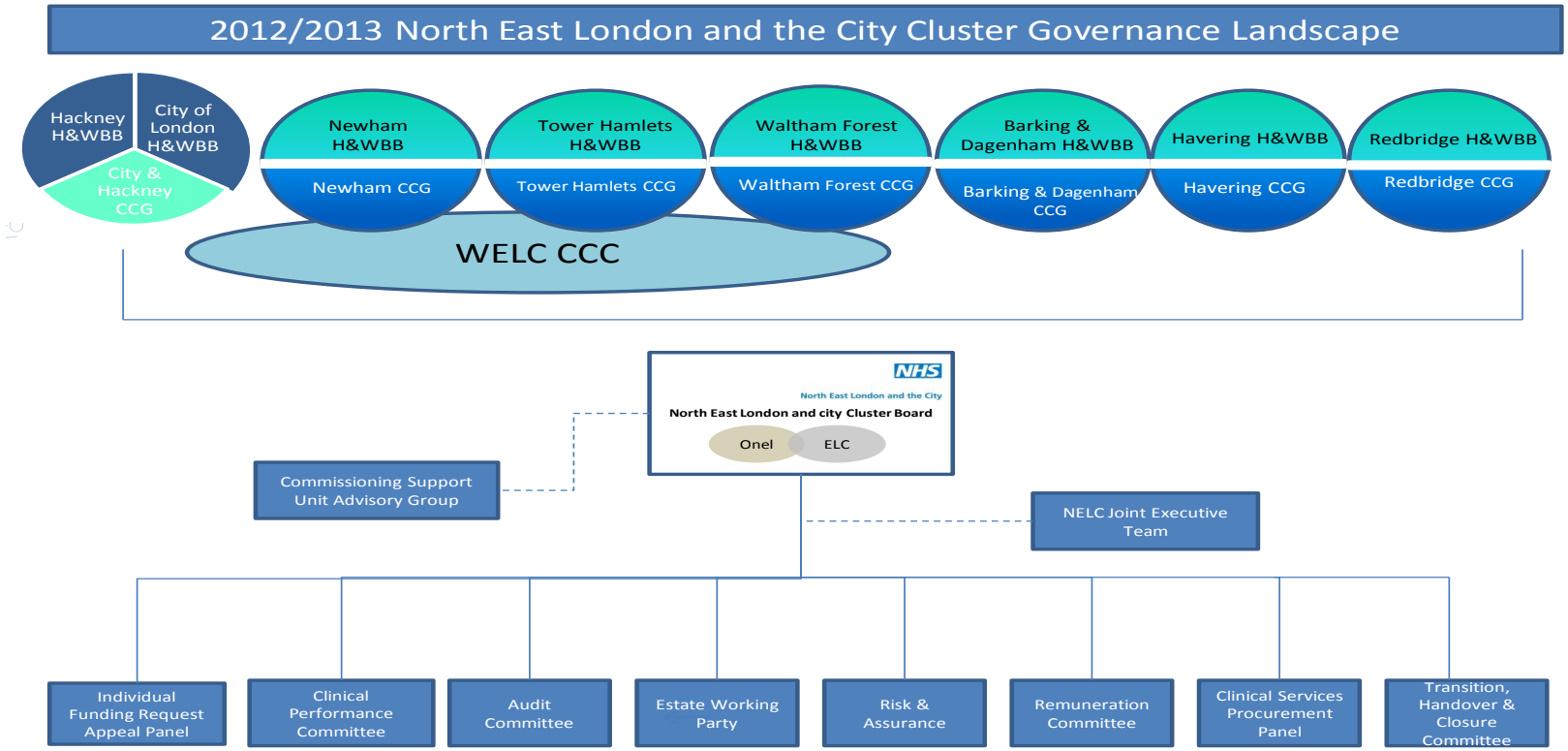
2. The governance framework of the organisation

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 City committee structure



Agreed April 2012

The Cluster Board for North East London and the City has 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 has been 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 has enabled the Cluster to conduct its business during a period of significant change in the NHS. It has 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 has been supported by a number of committees as evidenced in the structure diagram. These committees have been 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 has ensured that a wide range of non-executive knowledge and experience was retained and used in the assurance process.

The Audit Committee has met on a bi-monthly basis through to September 2012 and then met monthly from October 2012 to March to strengthen assurance. It has been quorate on each occasion. It has considered internally and externally audit reports along with updates from the counter-fraud officer. It has 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 has 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 has been 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 has been 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 have 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 amd 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, transferred their functions, both statutory and non statutory to 47 other organisations. The process for making this transfer was 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 Chairs 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 organisations' 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:

- The 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 draws on the best practice elements of ISO31000 and therefore embraces the concept of enterprise and integrated risk management in ensuring achievement of best outcomes. The Risk Management Strategy sets 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.

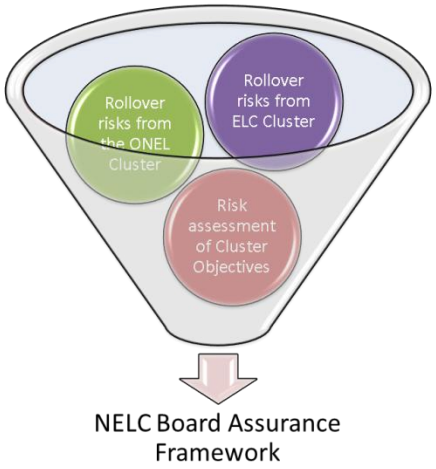


Figure 1 showing the 2 main processes that led to the creation of the NELC Board Assurance Framework

Supplementing this “top down” process of risk identification was the 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 both 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 Havering PCT identified during 2012/13, which populated the Board Assurance Framework (BAF) 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.					

1.8	Maintaining an effective and proactive quality assurance framework during periods of transition for both the provider and commissioner landscape across all provider groups					
2.1	Progress in quality improvement is not achieved in the timeframe set out and inability to sustain quality and safety of maternity services at BHRUT in the context of CIP and requirement to operate					
2.2	Failure to meet emergency care access standards at BHRUT/Queens Hospital adversely impacting on service users and other organisations					
2.3	Failure to deliver BHRUT 2012/13 financial plan – deficit reduced in line with plan to maximum £40m. Dependent on £23m CIP delivery and 10.3 commissioner QIPP delivery					
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 (BAF) 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 & Assurance committee. This Committee has undertaken a "deep dive" challenge into particular areas of risks, for example quality and safety and has held individual directors to account for the risks associated with their areas of responsibility.

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

The Framework is consistent with the template promulgated by the Department of Health and explicitly maps objectives against pertinent risks, controls and assurances. It also describes 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.
- Elevated levels of legionella bacteria found in sections of the water system at St. George's Hospital in Hornchurch.
- 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 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
- Patient accommodation on the St George's site was vacated in November 2012
- 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 has 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 had responsibility for the development and maintenance of the system of internal control provided 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 it's quality of commissioned services described in the Department of Health's Operating Framework and delivered through the Risk and 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 Havering PCT has a generally sound system of internal controls that support the achievement of its policies, aims and objectives and that

those control issues have been or are being addressed.

- The Audit Committee provides 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 have 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 outer north east London 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 INTERNALCONTROL AT HAVERING 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 one area of weakness, where a RED rated report was 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;*
- *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.

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 point raised above regarding the failings in information governance identified. We would also anticipate reference to issues identified elsewhere in the Cluster concerning Continuing Care where considered relevant to the PCT. These were in relation to:

- how evidence on the eligibility of Continuing Care patients could not be provided through the submission of checklists and Decision Support Tools prior to invoices being paid to continuing care providers; and
- the inability to provide sufficient evidence to demonstrate that care reviews were being consistently undertaken for all patients within three months of them being deemed eligible for continuing care funding.

RSM Tenon Limited

16 Independent auditor's report (external)

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

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

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

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

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the PCT's affairs as at 31 March 2013 and of its net operating costs for the year then ended; and

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

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion

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

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

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

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

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

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

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

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

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

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

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

considered, whether all aspects of the PCT's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

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

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

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

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

Kevin Lowe, Engagement Lead

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

4 June 2013

17 External auditor's costs

Havering PCT's external auditor is PricewaterhouseCoopers LLP. They were paid £155,866 (inclusive of VAT) in 2012/13 to carry out the statutory audit. In 2011/12 the fees were £259,776.

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

Havering Primary Care Trust

2012-13 Accounts

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Havering Primary Care Trust

2012-13 Accounts

CONTENTS Page Number

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 Havering 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

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 **Havering** 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 **Havering** 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

FOREWORD TO THE FINANCIAL STATEMENTS

HAVERING PRIMARY CARE TRUST

The financial statements for the year ended 31st March 2013 have been prepared by the Havering 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:-

Becketts House
2-14 Ilford Hill
Ilford
Essex
IG1 2QX

Statement of Comprehensive Net Expenditure for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**7,144**	10,899
Other costs	5.1	**450,509**	432,059
Income	4	**(13,508)**	(14,455)
Net operating costs before interest		**444,145**	428,503
Investment income	9	**(17)**	(80)
Finance costs	10	**1,402**	1,393
Net operating costs for the financial year		**445,530**	429,816
Of which:			
Administration Costs			
Gross employee benefits	7.1	**5,815**	8,867
Other costs	5.1	**3,527**	3,933
Income	4	**(148)**	(2,899)
Net administration costs before interest		**9,194**	9,901
Investment income	9	**-**	-
Finance costs	10	**-**	-
Net administration costs for the financial year		**9,194**	9,901
Programme Expenditure			
Gross employee benefits	7.1	**1,329**	2,032
Other costs	5.1	**446,982**	428,126
Income	4	**(13,360)**	(11,556)
Net programme expenditure before interest		**434,951**	418,602
Investment income	9	**(17)**	(80)
Finance costs	10	**1,402**	1,393
Net programme expenditure for the financial year		**436,336**	419,915

Other Comprehensive Net Expenditure		2012-13 £000	2011-12 £000
Impairments and reversals put to the revaluation reserve	11	**3,772**	2,943
Net (gain) on revaluation of property, plant and equipment	11	**(1,521)**	(121)
Total comprehensive net expenditure for the year		**447,781**	432,638

This statement summarises, on an accruals basis, the net operating costs of the PCT.

The financial statements have been prepared on a going concern basis. Please refer to note 1.1 for additional disclosure.

Statement of Financial Position as at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	11	**51,043**	63,411
Intangible assets	12	**72**	767
Other financial assets	17	**331**	339
Total non-current assets		**51,446**	64,517
Current assets:			
Inventories	15	**-**	1
Trade and other receivables	16	**4,292**	4,995
Cash and cash equivalents	18	**26**	19
Total current assets		**4,318**	5,015
Total assets		**55,764**	69,532
Current liabilities			
Trade and other payables	19	**(25,759)**	(36,458)
Provisions	21	**(10,344)**	(2,182)
Borrowings	20	**(42)**	(23)
Total current liabilities		**(36,145)**	(38,663)
Non-current assets less net current liabilities		**19,619**	30,869
Non-current liabilities			
Trade and other payables	19	(790)	(838)
Provisions	21	(481)	(2,472)
Borrowings	20	(11,131)	(11,172)
Total non-current liabilities		**(12,402)**	(14,482)
Total Assets Employed:		**7,217**	16,387
Financed by taxpayers' equity:			
General fund		(6,751)	(46)
Revaluation reserve		13,968	16,433
Total taxpayers' equity:		**7,217**	16,387

As a NHS Primary Care Trust no interest can be received in relation to balances held within its bank accounts.

The notes on pages 5 to 44 are an integral part of these financial statements.

The financial statements have been prepared on a going concern basis. Please refer to note 1.1 for additional disclosure.

The financial statements on pages 1 to 44 were authorised for issue by the board of directors on 4th June 2013 and were signed on its behalf by:-

Designated Signing Officer:
Peter Coates (CBE)

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

	Note	General fund	Revaluation reserve	Total reserves
		£000	£000	£000
Changes in taxpayers' equity for 2012-13				
Balance at 1 April 2012		**(46)**	**16,433**	**16,387**
Net operating cost for the year		(445,530)	-	**(445,530)**
Net gain on revaluation of property, plant, equipment	11	-	1,521	**1,521**
Impairments and reversals	11	-	(3,772)	**(3,772)**
Transfers between reserves		214	(214)	**-**
Total recognised income and expense for 2012-13		**(445,316)**	**(2,465)**	**(447,781)**
Net Parliamentary funding	3	438,611	-	**438,611**
Balance at 31 March 2013		**(6,751)**	**13,968**	**7,217**
Changes in taxpayers' equity for 2011-12				
Balance at 1 April 2011		**5,328**	**19,255**	**24,583**
Net operating cost for the year		(429,816)	-	(429,816)
Net gain on revaluation of property, plant and equipment		-	121	121
Impairments and reversals.		-	(2,943)	(2,943)
Total recognised income and expense for 2011-12		(429,816)	(2,822)	(432,638)
Net Parliamentary funding		424,442	-	424,442
Balance at 31 March 2012		**(46)**	**16,433**	**16,387**

The general fund reflects the cumulative surplus/deficit made arising each year from the Statement of Comprehensive Net Expenditure. The PCT's Parliamentary funding is also accounted for in this reserve. This balance cannot be released back to the Statement of Comprehensive Net Expenditure.

The revaluation reserve reflects movements in the value of property, plant and equipment as set out in the respective accounting policies for each asset category. The revaluation reserve balance relating to each asset is released to the general fund on disposal of that asset.

A transfer between the revaluation reserve and general fund has taken place for an amount of £214,000 in respect of assets which carried a revaluation reserve balance which was no longer required.

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		**(444,145)**	(428,503)
Depreciation and amortisation	5.1	**1,715**	2,543
Impairments and reversals	13	**10,257**	4,857
Interest paid	10	**(1,376)**	(1,323)
Decrease in inventories	15	**1**	236
Decrease in trade and other receivables		**703**	4,494
Decrease in trade and other payables		**(10,571)**	(2,312)
Provisions utilised	21	**(2,247)**	(4,326)
Increase in provisions	21	**8,392**	1,560
Net cash outflow from operating activities		**(437,271)**	(422,774)
Cash flows from investing activities			
Interest received	9	**17**	80
Payments for property, plant and equipment		**(1,336)**	(1,608)
Payments for intangible assets		**-**	(123)
Loans repaid in respect of LIFT		**8**	23
Net cash outflow from investing activities		**(1,311)**	(1,628)
Net cash outflow before financing		**(438,582)**	(424,402)
Cash flows from financing activities			
Capital element of payments in respect of finance leases and on-SoFP LIFT		**(22)**	(56)
Net Parliamentary Funding		**438,611**	424,442
Net cash inflow from financing activities		**438,589**	424,386
Net increase/(decrease) in cash and cash equivalents		**7**	(16)
Cash and cash equivalents at beginning of the period	18	**19**	35
Cash and cash equivalents at year end		**26**	19

This statement provides information on the PCT's liquidity viability and financial adaptability.

The notes on pages 5 to 44 are an integral part of these financial statements.

Notes to the financial statements

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.

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.

Going Concern

The financial statements have been prepared on a going concern basis.

On 19 January 2011 the Government announced its intention to abolish PCT's and transfer their functions into new organisations within the umbrella of the Department of Health. On the 27th March 2012 the Health and Social Care Bill received Royal Assent.

This transfer of services is to come into effect from 1st April 2013.

After the closure it is proposed that all the PCTs functions will continue either with Commissioning Support Organisations, Clinical Commissioning Groups, National Commissioning Board or Local Authorities. Estates functions are due to be transferred to NHS Property Services Limited. Ultimate control will still reside with the Department of Health.

At the point of closure it is proposed that the PCT, in its current legal form, will be abolished. Please refer to note 30 for additional disclosure.

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 judgments, 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.

Notes to the financial statements

Critical judgements in applying accounting policies

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

LIFT schemes

The PCT has recognised, under IFRIC 12, the need to account for a Local Improvement Finance Trust (LIFT) scheme at Harold Hill, Cranham and South Hornchurch as a service concession arrangement. The indications of a service concession include the provision of a healthcare service, control over the services and control over the asset at the end of the lease. The leases for these three schemes satisfy these conditions. Previously each 25 year lease was treated as an operating lease under UK GAAP. Each lease is now treated as a finance lease and the assets are included within property, plant and equipment, with a corresponding liability also recognised on the Statement of Financial Position (SoFP).

Continuing Care Provision

Under IAS 37 the PCT has recognised the need to provide for an amount of £9,680,757 in respect of continuing care claims based upon the following judgements:-

- Where claims have been received with no dates as to which the period claim related an assumption of 52 weeks was used as a prudent estimate.
- The provision was based upon a payout of £700 per week based upon the national London Procurement LPP Pan London Price.
- A percentage of 36% was assumed against the potential total liability. Where by 30% was informed by the Independant review panels conducted by NHSL on a sample basis plus an element which the PCT felt needed to cover the PCT's demographic population.

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.

Non-current asset valuations

During the financial year the District Valuation Office conducted an interim asset valuation review of all land and buildings held by the PCT. A valuation report has been prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as these terms are consistent with the requirements of HM Treasury, the National Health Service and Department of Health.

Public sector bodies including the NHS are required to apply the revaluation model set out in IAS 16 and value their capital assets to fair value. Fair value is defined in IAS16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. The fair value of land and buildings is usually determined from market-based evidence by appraisal undertaken by professionally qualified valuers.

The interim asset valuation was undertaken in February and March 2013 as at the prospective valuation date of 31st March 2013, an agreed departure from the RICS Valuation Standards.

The age and remaining lives of buildings and their component parts have been assessed as at the valuation date.

Quality outcome framework (QOF)

The liability for the QOF payment as part of the GP contract is based on the Quality Management and Analysis System giving the PCT objective feedback on quality of care delivered to patients. It shows how well the practice is performing measured against national achievement targets. Through the QOF, general practices are rewarded financially for aspects of the quality of care they provide.

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 place and it's legal obligations.

Notes to the financial statements

Prescribing and pharmacy liabilities
The Department of Health actions monthly cash charges to the PCT for prescribing and pharmacy contracts. These are issued approximately six weeks in arrears. The PCT uses a forecast provided by the NHS Business Authority to estimate the full year expenditure.

Outer North East London (ONEL) Recharges
A proportion of the pay and non pay costs incurred in year by the PCT have been recharged to Redbridge PCT, Waltham Forest PCT and Barking and Dagenham PCT. These three organisations, along with the PCT, operate within a cluster arrangement including having a shared management team, along with a number of functions. Shared costs incurred by the other three ONEL PCTs have also been recharged to the PCT.

Costs which are specific to the running of each PCT are not recharged and remain as costs within each specific PCT's statement of comprehensive net expenditure. Shared payroll costs are recharged across ONEL based upon the estimated proportion of the contribution made by each employee to the ONEL PCTs. Shared non pay costs are also recharged on this basis as it is considered a reasonable proxy of the relative share of expenditure.

Pay recharges are shown net within the statement of comprehensive net expenditure. Non pay and agency payroll cost items are shown net of related income.

1.2 Revenue and Funding
The main source of funding for the PCT is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the general fund of the PCT. 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 PCT. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work and includes recharges to other PCTs. 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.

Refer to note 4 for analysis.

1.3 Pooled budgets
The PCT has entered into a pooled budget arrangement with London Borough of Havering Local Authority. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for learning disabilities activities.
The pool is hosted by London Borough of Havering Local Authority. In 2010/11 as commissioner of healthcare services, the PCT made contributions to the pool, which were then used to purchase healthcare services. The PCT accounted for its share of the assets, liabilities, income and expenditure of the pool in accordance with the pooled budget agreement.

In 2011/12 the pooled budget was transferred in its interiority to the London Borough of Havering Local Authority. As such £7,269,000 was deducted from the PCT's baseline revenue resource limit at the beginning of the year and passed straight to the local authority. This deduction is now made recurrently before the initial baseline revenue resource limit is passed to the PCT.

Refer to note 28 for further disclosure.

Notes to the financial statements

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

1.5 Administration and Programme Costs
HM 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 of Health has defined "admin and programme" in terms of running costs.

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

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

Refer to note 5.1 for further disclosure.

1.6 Capital Charges
As per the HM Treasury guidance for 2012/13 cost of capital charges and credits have been removed entirely from the PCT's reported financial position. As a result an amount of £412,000 (2011/12 £716,000) has been removed from the resource limit and not charged to the statement of comprehensive net expenditure.

The cost of capital charge is calculated at 3.5% of the net of average assets less liabilities, except for donated assets and cash balances with the Government Banking Services.

1.7 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.

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.

Land and buildings are measured subsequently at fair value. Plant and equipment is stated at historical cost less depreciation.

Notes to the financial statements

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

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

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

As a result of a downward valuation of land and buildings the PCT has incurred an impairment of £9,306,000 (£4,857,000 2011/12) which was charged to the statement of comprehensive net expenditure and £3,772,000 was charged to the revaluation reserve (£2,943,000 2011/12) in relation to several buildings owned by the PCT, further disclosure of this matter can be found at note 11.

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 ready for use.

Until 31st March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1st 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.

Increases in the carrying amount on revaluation of land and buildings are credited to revaluation reserve in taxpayers equity.

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.

1.8 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;

Notes to the financial statements

- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- 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), as a proxy for fair value. Internally-developed software is held at amortised historic cost to reflect the opposing effects of increases in development costs and technological advances.

Amortised replacement costs (modern equivalent assets basis) is indexed for relevant price increases, as a proxy for fair value.

Refer to note 12 for additional disclosure.

1.9 Depreciation, amortisation and impairments
Freehold land, properties under construction and assets held for sale are not depreciated.

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

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

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

A transfer is requried from the revaluation reserve to retained earnings of an amount representing the lower of the impairment charged and the balance for the asset in the revaluation reserve.

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, if their carrying amount is to be recovered principally through a sale transaction rather than continuing use. Fair value is open market value including alternative uses.

Notes to the financial statements

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

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

1.11 Inventories
Inventories are valued at the lower of cost and net realisable value. Cost is determined using the first-in first-out. Net realisable value is the estimated selling price in the ordinary course of business less applicable variable selling expenses. This is considered to be a reasonable approximation to fair value due to the high turnover of inventories. Refer to note 15 for additional disclosure.

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.

1.13 Losses and Special Payments
Losses and special payments are items that Government 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).

Losses and special payments are compiled on an accruals basis excluding any provisions in relations to such payments. Refer to note 27 for additional disclosure.

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 21.

Any provision in respect of clinical negligence claims are included within the accounts of the NHSLA and do not form part of the PCT's accounts.

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 year is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following year.

Notes to the financial statements

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.

Termination benefits
Termination benefits are payable when employment is terminated by the PCT before the normal retirement date, or whenever an employee accepts voluntary redundancy in exchange for these benefits. The PCT recognises termination benefits when it is demonstrably committed to a termination when the entity has a detailed formal plan to terminate the employment of current employees without possibility of withdrawal. In the case of an offer made to encourage voluntary redundancy, the termination benefits are measured based on the number of employees expected to accept the offer. Benefits falling due more than 12 months after the end of the reporting period are

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

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

1.18 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. Refer to note 22 for additional disclosure

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

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

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

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

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

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

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

1.20 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. Provisions are measured at the present value of the expenditures expected to be required to settle the obligation using a pre tax rate that reflects current market assessments of the time value of money and the risks specific to the obligation (being HM Treasury's discount rate of 2.2% (2.8% in respect of early staff departures) in real terms). The increase in provision due to passage of time is recognised as interest expensed.

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.

Provisions for restructuring costs are recognised when the PCT has a present legal or constructive obligation as a result of past events; it is probable that an outflow of resources are required to settle the obligation; and the amount has been reliably estimated. 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. Refer to note 21 for additional disclosure.

1.21 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. Refer to note 25 for additional disclosure.

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.

Notes to the financial statements

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.

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

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

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

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

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

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

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or 'other financial liabilities'. The PCT only has financial liabilities categorised as 'other financial liabilities'.

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

1.22 NHS LIFT transactions
HM Treasury has determined that government bodies shall account for infrastructure LIFT 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 LIFT asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

Notes to the financial statements

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the LIFT asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Refer to note 23 for additional disclosure.

a) Services received

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

b) LIFT assets, liabilities, and finance costs

The LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the PCT's approach for each relevant class of asset in accordance with the principles of IAS 16. These assets have been revalued as at 31st March 2013.
A LIFT liability is recognised at the same time as the asset is recognised. It is measured initially at the same amount as the fair value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

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

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

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

c) Lifecycle replacement

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

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

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

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

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

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

1.23 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

Segment	Acute	Non Acute	Prescribing and Primary Care	Corporate	Total
	2012/13 £000	2012/13 £000	2012/13 £000	2012/13 £000	2012/13 £000
Actual net expenditure	239,524	94,892	86,595	24,519	445,530
Revenue Resource Limit	234,391	83,211	93,957	38,075	449,634
Surplus/(Deficit)	(5,133)	(11,681)	7,362	13,556	4,104
	2011/12 £000	2011/12 £000	2011/12 £000	2011/12 £000	2011/12 £000
Actual net expenditure	234,742	86,423	87,934	20,717	429,816
Revenue Resource Limit	234,789	83,793	92,334	19,773	430,689
Surplus/(Deficit)	47	(2,630)	4,400	(944)	873

Included within the segments are material spend as follows:-	2012-13 £000	2011-12 £000
Prescribing and Primary Care Segment		
Prescribing Costs	34,805	37,585
G/PMS, APMS and PCTMS (excluding employee benefits)	33,636	34,025
Acute Segment		
Goods and services from NHS Trusts	190,135	190,782
Non Acute Segment		
Purchase of Healthcare from Non-NHS Bodies	43,091	32,723
Corporate Segment		
Depreciation	1,533	2,140
Amortisation	182	403
Impairments and Reversals of Property, plant and equipment	9,803	4,857

Note: Total Operating Segments reconcile to Net Operating Cost as shown in note 3.1

The Chief Operating Decision Maker (CODM) is considered to be the Board, which evaluates performance of the organisation based on net expenditure of the segments. The statement of financial position, and cash flow statements are not reported on a segmental basis. The activities of the reportable segments are as follows:

Acute
Acute has the largest budget and accounted for 54% of total expenditure in 2012/13 (2011/12 55%). Secondary Care Services are commissioned from NHS Trusts, Foundation Trusts and the Independent Sector. Barking Havering and Redbridge University Hospitals NHS Trust is the main provider of services totalling £147m (2011/12 £145m), followed by Barts and the London NHS Trust at £29m (2011/12 £23m).

Non Acute
Non Acute commissioning includes adult community services and nursing care from the private sector. Non acute services are largely commissioned from Local Authorities and nursing homes. Non acute commissioning also includes mental health. North East London NHS Foundation Trust (NELFT) is the PCT's largest provider of mental health services. Expenditure with NELFT was £59m in 2012/13 (£59m 2011/12).

Prescribing and Primary Care
The PCT commissions medical services from a number of GPs and dentists. It also takes responsibility for pharmacy services. Contracts with GP Practices totalled £34m in 2012/13 (£34m 2011/12) and Prescribing Costs £35m in 2012/13 (£38m 2011/12) as included in Note 5.1.

Corporate
The Corporate function facilitates all areas of Pay and Non Pay expenditure to provide the services within 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	**445,530**	429,816
Revenue Resource Limit	**449,634**	430,689
Underspend Against Revenue Resource Limit (RRL)	4,104	873

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**2,425**	1,715
Charge to Capital Resource Limit	**1,160**	1,705
Underspend Against Capital Resource Limit (CRL)	**1,265**	10

3.3 Underspend against cash limit

	2012-13 £000	2011-12 £000
Total charge to cash limit	**438,611**	424,442
Cash limit	**438,611**	424,442
Under/(Over)spend Against Cash Limit	**-**	-

3.4 Reconciliation of cash drawings to parliamentary funding

	2012-13 £000	2011-12 £000
Total cash received from DH (Gross)	388,845	373,579
Plus: cost of dentistry schemes (central charge to cash limits)	9,168	9,237
Plus: drugs reimbursement (central charge to cash limits)	40,598	41,626
Parliamentary funding credited to general fund	**438,611**	424,442

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**3,219**	-	3,219	3,062
Prescription charge income	**2,017**	-	2,017	1,903
Strategic health authorities	**-**	-	-	324
NHS Trusts	**216**	48	168	168
NHS Foundation Trusts	**3,564**	1	3,563	2,021
Primary Care Trusts - Other	**2,387**	11	2,376	1,788
Recoveries in respect of employee benefits	**-**	-	-	2,805
Local Authorities	**68**	68	-	197
Education, training and research	**1,396**	-	1,396	1,065
Rental revenue from operating leases	**25**	-	25	25
Other revenue	**616**	20	596	1,097
Total miscellaneous revenue	**13,508**	**148**	**13,360**	**14,455**

Admin income is income incurred that is not directly attributable to the provision of healthcare or healthcare services.

Income shown in this note does not include cash received from the Department of Health and drawn down directly into the bank account of the PCT and credited to the General Fund.

As per the manual for accounts the overarching principle is that transactions should be accounted for in accordance with accounting standards, with all treatments having been agreed by both parties. Generally, this means revenue income and expenditure should be recorded gross unless the transaction is of a non-trading nature and an organisation is deemed to be acting solely as an agent and does not gain any economic benefit from the transaction. Therefore recoveries in respect of employee benefits are shown on a net basis as disclosed within note 1.1. Only the element of the salary relating to the PCT has been recorded as expenditure as in substance the employee works for both organisations and the recharge is merely an administrative arrangement. This is in contrast to last financial year where pay recharges were shown gross.

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	**19,318**	-	19,318	21,076
Non-Healthcare	**591**	156	435	117
Total	**19,909**	**156**	**19,753**	**21,193**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**190,135**	6	190,129	190,782
Goods and services (other, excl Trusts, FT and PCT))	**799**	-	799	943
Total	**190,934**	**6**	**190,928**	**191,725**
Goods and services from Foundation Trusts	**78,775**	58	78,717	75,810
Purchase of healthcare from Non-NHS bodies	**43,091**	-	43,091	32,723
Expenditure on drugs action teams	**1,020**	-	1,020	1,126
Non-GMS services from GPs	**1,156**	-	1,156	993
Contractor led GDS & PDS (excluding employee benefits)	**12,718**	-	12,718	12,462
Chair, non-executive directors & PEC remuneration	**35**	35	-	81
Consultancy Services	**84**	80	4	184
Prescribing costs	**34,805**	-	34,805	37,585
G/PMS, APMS and PCTMS (excluding employee benefits)	**33,636**	-	33,636	34,025
Pharmaceutical services	**-**	-	-	88
New pharmacy contract	**8,882**	-	8,882	7,009
General ophthalmic services	**2,043**	-	2,043	2,011
Supplies and services - clinical	**630**	116	514	903
Supplies and services - general	**1,702**	1,353	349	1,654
Establishment	**856**	505	351	781
Premises	**3,946**	90	3,856	2,337
Impairments & reversals of property, plant and equipment	**9,803**	-	9,803	4,857
Depreciation	**1,533**	-	1,533	2,140
Amortisation	**182**	-	182	403
Impairment & reversals intangible non-current assets	**454**	-	454	-
Impairment of receivables	**57**	57	-	(113)
Audit fees	**92**	92	-	242
Education and training	**70**	70	-	92
Other	**4,096**	909	3,187	1,748
Total operating costs charged to statement of comprehensive net expenditure	**450,509**	**3,527**	**446,982**	**432,059**
Employee benefits (excluding capitalised costs)				
PCT officer board members	**280**	280	-	378
Other employee benefits	**6,864**	5,535	1,329	10,521
Total employee benefits charged to SOCNE	**7,144**	**5,815**	**1,329**	**10,899**
Total operating costs	**457,653**	**9,342**	**448,311**	**442,958**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**9,496**	8,013	1,483
Weighted population (number in units)	**250,327**	250,327	250,327
Running costs per head of population (£ per head)	**37.93**	**32.01**	**5.92**
PCT Running Costs 2011-12			
Running costs (£000s)	**10,109**	8,732	1,377
Weighted population (number in units)	**250,327**	250,327	250,327
Running costs per head of population (£ per head)	**40.38**	**34.88**	**5.50**

Running costs are costs incurred by an NHS Organisation which are not directly linked to patient treatment or well being.

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

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	33,636	34,025
Prescribing costs	34,805	37,585
Contractor led GDS & PDS	12,718	12,462
General ophthalmic services	2,043	2,011
Pharmaceutical services	-	88
New pharmacy contract	8,882	7,009
Non-GMS Services from GPs	1,156	993
Total Primary Healthcare purchased	**93,240**	94,173
Purchase of Secondary Healthcare		
Learning Difficulties	1,385	1,339
Mental Illness	33,025	35,057
Maternity	10,029	10,441
General and Acute	222,056	217,692
Accident and emergency	6,831	6,735
Community Health Services	57,959	49,592
Other Contractual	7	107
Total Secondary Healthcare Purchased	**331,292**	320,963
Total Healthcare Purchased by PCT	**424,532**	**415,136**
Healthcare from NHS FTs included above	78,775	75,810

The expenditure shown above analyses the PCT's total expenditure on patient treatment for its own residents. Figures are net of any income recovery from other NHS organisations where the PCT acts as lead commissioner.

No expenditure is shown for self-provided secondary healthcare in 2012/13. The services are provided under partnership agreements with London Borough of Havering, who is the lead partner and are therefore not treated as provider.

6. Operating Leases

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**25**	25
Total	**25**	25
Receivable:		
No later than one year	**25**	25
Between one and five years	**104**	103
After five years	**348**	374
Total	**477**	502

The PCT entered into an operating lease agreement with Newlands Pharmacies on 17th November 2009 as a lessor of office space within the Harold Hill LIFT building. The building is being used as a pharmacy. The annual rental income to the PCT is £25,000. The lease is due to expire on 16th September 2030 with rental reviews taking place on the renewal day of 17th November in the years 2013, 2017, 2021, 2025 and 2029 based upon current RPI at the review date. For the purposes of the note above the PCT has assumed 3.5% increase per rental review date.

Havering PCT also received £1,000,000 from Newlands Pharmacy in relation to a lease premium which was paid on commencement of the lease. This amount is to be released over the period of the lease to the statement of comprehensive net expenditure. This amount is not recognised within the rent receivable amounts above.

General Medical Services (GMS)
The GMS contract entered in to by the PCT with GP's includes conditions relating to the use of GP premises under IFRIC 4, Determining whether an arrangement contains a lease.

The PCT has determined that those conditions are operating leases. As the GMS contract does not contain defined terms, it is not possible to analyse the financial impact of the arrangements over future financial years. The premises costs include the GMS payments in the statement of comprehensive net expenditure for 2012/13 of £2,548,099 (£2,699,396 2011/12).

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									
Salaries and wages	**6,050**	5,465	585	**1,328**	867	461	**4,722**	4,598	124
Social security costs	**244**	159	85	**244**	159	85	**-**	-	-
Employer Contributions to NHS pensions scheme	**293**	191	102	**293**	191	102	**-**	-	-
Termination benefits	**557**	-	557	**557**	-	557	**-**	-	-
Total employee benefits	**7,144**	**5,815**	**1,329**	**2,422**	**1,217**	**1,205**	**4,722**	**4,598**	**124**
Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**7,144**	**5,815**	**1,329**	**2,422**	**1,217**	**1,205**	**4,722**	**4,598**	**124**

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits 2011-12			
Salaries and wages	**8,486**	3,758	4,728
Social security costs	**692**	692	-
Employer Contributions to NHS pensions scheme	**767**	767	-
Termination benefits	**954**	954	-
Total gross employee benefits	**10,899**	**6,171**	**4,728**
Less recoveries in respect of employee benefits	**(2,805)**	(2,805)	-
Total - net employee benefits including capitalised costs	**8,094**	**3,366**	**4,728**
Employee costs capitalised	**-**	-	-
Gross employee benefits excluding capitalised costs	**10,899**	**6,171**	**4,728**

As per the manual for accounts the overarching principle is that transactions should be accounted for in accordance with accounting standards, with all treatments having been agreed by both parties. Generally, this means revenue income and expenditure should be recorded gross unless the transaction is of a non-trading nature and an organisation is deemed to be acting solely as an agent and does not gain any economic benefit from the transaction. Therefore employee benefits are shown on a net basis as disclosed within note 1.1. Only the element of the salary relating to the PCT has been recorded as expenditure as in substance the employee works for both organisations and the recharge is merely an administrative arrangement. This is in contrast to last financial year where pay recharges were shown gross.

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	1	1	-	2	2	-
Administration and estates	104	29	75	122	39	83
Nursing, midwifery and health visiting staff	7	2	5	6	3	3
Scientific, therapeutic and technical staff	1	1	-	5	4	1
Other	-	-	-	-	-	-
TOTAL	113	33	80	135	48	87

7.3 Staff sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	2,993	17,320
Total Staff Years	265	1,345
Average working Days Lost	11.29	12.88

The figures included above are based upon the calendar year 2012 due to timing difficulties with financial year data. The Department of Health considers the above figures to be a reasonable proxy for financial year equivalents.

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

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
Less than £10,000	-	-	-	2	1	3
£10,001-£25,000	-	-	-	3	6	9
£25,001-£50,000	1	-	1	6	5	11
£50,001-£100,000	-	-	-	4	3	7
£100,001 - £150,000	-	-	-	2	-	2
£150,001 - £200,000	-	-	-	3	-	3
>£200,000	-	-	-	2	1	3
Total number of exit packages by type (total cost	1	-	1	22	16	38
	£000s	£000s	£000s	£000s	£000s	£000s
Total resource cost	37	-	37	1,952	752	2,704

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

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

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	15,591	54,495	15,812	48,400
Total Non-NHS Trade Invoices Paid Within Target	13,809	45,546	12,335	33,319
Percentage of Non-NHS Trade Invoices Paid Within Target	88.57%	83.58%	78.01%	68.84%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,662	311,249	3,662	301,231
Total NHS Trade Invoices Paid Within Target	3,183	282,925	3,019	284,490
Percentage of NHS Trade Invoices Paid Within Target	86.92%	90.90%	82.44%	94.44%

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

9. Investment income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
LIFT: loan interest receivable	17	-	17	80
Total investment income	17	-	17	80

10. Finance costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest on obligations under LIFT contracts:				
- main finance cost	1,085	-	1,085	1,086
- contingent finance cost	291	-	291	237
Total interest expense	1,376	-	1,376	1,323
Provisions - unwinding of discount	26		26	70
Total	1,402	-	1,402	1,393

11.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation:						
At 1 April 2012	**30,481**	**31,208**	**1,786**	**532**	**3,378**	**67,385**
Additions purchased	-	1,101	-	-	59	**1,160**
Reclassifications	-	208	-	-	-	**208**
Disposals other than for sale	-	-	(1,588)	(75)	(2,433)	**(4,096)**
Upward revaluation/positive indexation	1,102	419	-	-	-	**1,521**
Impairments/negative indexation	(2,073)	(1,699)	-	-	-	**(3,772)**
At 31 March 2013	**29,510**	**31,237**	**198**	**457**	**1,004**	**62,406**
Depreciation						
At 1 April 2012	-	-	**1,457**	**426**	**2,091**	**3,974**
Reclassifications	-	149	-	-	-	**149**
Disposals other than for sale	-	-	(1,588)	(75)	(2,433)	**(4,096)**
Impairments	171	9,196	172	-	325	**9,864**
Reversal of impairments	-	(61)	-	-	-	**(61)**
Charged during the year	-	1,062	94	40	337	**1,533**
At 31 March 2013	**171**	**10,346**	**135**	**391**	**320**	**11,363**
Net Book Value at 31 March 2013	**29,339**	**20,891**	**63**	**66**	**684**	**51,043**
Purchased	29,339	20,891	63	66	684	**51,043**
Total at 31 March 2013	**29,339**	**20,891**	**63**	**66**	**684**	**51,043**
Asset financing:						
Owned	26,401	12,772	63	66	684	**39,986**
On-SOFP Lift contracts	2,938	8,119	-	-	-	**11,057**
Total at 31 March 2013	**29,339**	**20,891**	**63**	**66**	**684**	**51,043**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Plant & machinery	Transport equipment	Information technology	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**12,533**	**3,790**	**97**	**13**	**-**	**16,433**
Net gain on property plant and equipment	(973)	(1,382)	(97)	(13)	-	**(2,465)**
At 31 March 2013	**11,560**	**2,408**	**-**	**-**	**-**	**13,968**

11.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation:						
At 1 April 2011	**32,721**	**53,867**	**1,773**	**526**	**3,007**	**91,894**
Additions - purchased	-	1,192	13	6	371	**1,582**
Revaluation & indexation gains	-	121	-	-	-	**121**
Impairments	(2,240)	(703)	-	-	-	**(2,943)**
Cumulative dep netted off cost following revaluation	-	(23,269)	-	-	-	**(23,269)**
At 31 March 2012	**30,481**	**31,208**	**1,786**	**532**	**3,378**	**67,385**
Depreciation						
At 1 April 2011	-	**17,198**	**1,179**	**386**	**1,483**	**20,246**
Impairments	-	4,857	-	-	-	**4,857**
Charged during the year	-	1,214	278	40	608	**2,140**
Cumulative dep netted off cost following revaluation	-	(23,269)	-	-	-	**(23,269)**
At 31 March 2012	-	-	**1,457**	**426**	**2,091**	**3,974**
Net Book Value at 31 March 2012	**30,481**	**31,208**	**329**	**106**	**1,287**	**63,411**
Purchased	30,481	31,208	329	106	1,287	**63,411**
At 31 March 2012	**30,481**	**31,208**	**329**	**106**	**1,287**	**63,411**
Asset financing:						
Owned	25,953	22,310	329	106	1,287	**49,985**
On-SOFP Lift contracts	4,528	8,898	-	-	-	**13,426**
At 31 March 2012	**30,481**	**31,208**	**329**	**106**	**1,287**	**63,411**

11.3 Property, plant and equipment

Of the net book value at 31 March 2013, £26,400,800 (2011/12 £25,953,000) related to land valued at open market value and £12,772,000 (2011/12 £22,310,000) related to buildings excluding dwellings valued at Modern Equivalent Asset Value which were owned by the PCT. £2,938,200 related to land at open market value and £8,118,992 related to buildings, installations and fittings valued at open market value which were not owned by the PCT but came under its LIFT Co arrangement.

During the financial year a revaluation of all properties, including those owned and those included under the LIFT Co arrangement, was undertaken to value assets as at 31 March 2013. This is in line with the accounting policies of the PCT. An independent valuation report has been produced by the District Valuation office which has been prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as these terms are consistent with the requirements of HM Treasury, the National Health Service and Department of Health.

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

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

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

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

"the Market Value on the assumption that the property is sold as part of the continuing enterprise in occupation" (effectively EUV); or

"the Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the traditional understanding of Market Value).

The Department of Health has indicated that for NHS assets it requires the former assumption to be applied for operational assets.

The valuation has had the following impact on land:-

	Increase in Value	Impairment charge to revaluation reserve	Impairment charge to the statement of comprehensive net expenditure	Total
	£000	£000	£000	£000
St Georges Hospital	500	-	-	500
Victoria Centre	55	-	-	55
Elm Park Clinic	70	-	-	70
Rainham Clinic	26	-	-	26
Romford Clinic	-	(408)	(171)	(579)
Collier Row Clinic	-	(15)	-	(15)
Harold Wood Clinic	54	-	-	54
26 Gubbins Lane	174	-	-	174
Harold Hill Lift Building	50	-	-	50
Cranham Lift Building	10	-	-	10
South Hornchurch Lift Building	-	(1,650)	-	(1,650)
Harold Wood Polysystem, London South Bank University, Long Term Conditions Centre	163	-	-	163
	1,102	(2,073)	(171)	(1,142)

11.3 Property, plant and equipment (cont'd)

The valuation has had the following impact on Buildings:-

	Increase in Value	Impairment charge to revaluation reserve	Impairment/(reversal) charge to the statement of comprehensive net expenditure	Total
	£000	£000	£000	£000
St Georges Hospital (Several Buildings)	-	(692)	(8,783)	(9,475)
Victoria Centre	2	(44)	(59)	(101)
Elm Park Clinic	-	(15)	-	(15)
Rainham Clinic	-	(93)	-	(93)
Romford Clinic (Several Buildings)	179	(176)	-	3
Collier Row Clinic	-	(137)	-	(137)
Harold Wood Clinic	-	(101)	-	(101)
26 Gubbins Lane	37	-	-	37
Harold Hill Lift Building	-	(441)	-	(441)
Cranham Lift Building	-	-	(83)	(83)
South Hornchurch Lift Building	-	-	(119)	(119)
Harold Wood Polysystem	-	-	(152)	(152)
London South Bank University	174	-	-	174
Long Term Conditions Centre	27	-	61	88
	419	(1,699)	(9,135)	(10,415)

Where a piece of land or building has increased in value the amount has been charged against the revaluation reserve. Those pieces of land or buildings which have decreased in value have firstly been offset by balances within the revaluation reserve for those specific assets which totalled £3,772,186, and any further decrease in value has been charged to the statement of comprehensive net expenditure as an impairment, which totals £9,307,000. Where an impairment charge arose in 2011/12 for a specific property due to a value decrease, and then subsequently the property increased in value in 2012/13 a reversal of impairment was charged to the statement of comprehensive net expenditure. For more information on this impairment please refer to note 13.

During 2012/13 a decision was made by the Board to close the St Georges Hospital site. The site has been valued at market value which totalled £16,000,000 in relation to land.

As disclosed within note 1.1 the Health and Social Care Bill obtained royal ascent and as a result all closing balances within the statement of financial position will be transferred to a successor organisation. Therefore during 2012/13 a full non current asset physical verification exercise took place. As a result a number of pieces of equipment were deemed to be obsolete or had no further economic benefit to the organisation. These items have been removed form the asset register of the PCT and been disposed of accordingly. Those items removed from the asset register will not be transferred to a successor organisation.

The non current asset physical verification exercise had the following impact:-

	Impairment/(reversal) charge to the statement of comprehensive net expenditure
	£000
Plant and machinery	172
Information Technology	325
	497

As part of the non current physical verification exercise a number of items which had a £nil net book value were removed from the asset register due to the items being obsolete or having no further economic value. These totalled:-

	£000
Plant and machinery	1,588
Transport	75
Information Technology	2,433
	4,096

The amounts above had no financial impact on the PCT's financial position.

11.3 Property, plant and equipment (cont'd)

Economic Lives of Property, Plant and Equipment:-

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings excluding dwellings	5	50
Plant and machinery	-	7
Transport equipment	-	7
Information technology	-	5
Furniture and fittings	-	5

Open Market Value of tangible non-current assets	Land	Buildings excl. dwellings	Total
	£000s	£000s	£000s
Open market value at 31 March 2013	29,339	20,891	50,230
Open market value at 31 March 2012	30,481	31,208	61,689

12.1 Intangible non-current assets

2012-13	Software purchased £000	Total £000
At 1 April 2012	**1,985**	**1,985**
Reclassifications	(208)	**(208)**
Disposals other than by sale	(1,696)	**(1,696)**
At 31 March 2013	**81**	**81**
Amortisation		
At 1 April 2012	**1,218**	**1,218**
Reclassifications	(149)	**(149)**
Disposals other than by sale	(1,696)	**(1,696)**
Impairments charged to operating expenses	454	**454**
Charged during the year	182	**182**
At 31 March 2013	**9**	**9**
Net book value at 31 March 2013	**72**	**72**
Net book value at 31 March 2013 comprises		
Purchased	72	**72**
Total at 31 March 2013	**72**	**72**

All assets relate to patient database software and have a finite useful life and are amortised over five years on a straight line basis.

12.2 Intangible non-current assets

2011-12	Software purchased £000	Total £000
At 1 April 2011	**1,862**	**1,862**
Additions - purchased	123	**123**
At 31 March 2012	**1,985**	**1,985**
Amortisation		
At 1 April 2011	**815**	**815**
Charged during the year	403	**403**
At 31 March 2012	**1,218**	**1,218**
Net book value at 31 March 2012	**767**	**767**
Net book value at 31 March 2012 comprises		
Purchased	767	**767**
Total at 31 March 2012	**767**	**767**

12.3 Intangible non-current assets

As disclosed in note 11.3 the non current asset physical verification had the following impact on intangible non- current assets

	Impairment/(reversal) charge to the statement of comprehensive net expenditure
	£000
Software Purchased	454

As part of the non current physical verification exercise a number of items which had a £nil net book value were removed from the asset register due to the items being obsolete or having no further economic value. These totalled:-

	£000
Software Purchased	1,696

The amount above had no financial impact on the PCT's financial position.

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			
Loss or damage resulting from normal operations	45	-	45
Total charged to Departmental Expenditure Limit	**45**	**-**	**45**
Unforeseen obsolescence	452	-	452
Changes in market price	9,306	-	9,306
Total charged to Annually Managed Expenditure	**9,758**	**-**	**9,758**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	3,772	-	-
Total impairments for PPE charged to reserves	**3,772**	**-**	**-**
Total Impairments of Property, Plant and Equipment	**13,575**	**-**	**9,803**
Unforeseen obsolescence	454	-	454
Total charged to Annually Managed Expenditure	**454**	**-**	**454**
Total Impairments of Intangibles	**454**	**-**	**454**
Total Impairments charged to Revaluation Reserve	3,772	-	-
Total Impairments charged to SoCNE - DEL	45	-	45
Total Impairments charged to SoCNE - AME	10,212	-	10,212
Overall Total Impairments	**14,029**	**-**	**10,257**

As part of the 31st March 2013 valuation carried out by the District Valuation Office an impairment charge of £9,306,000 was charged to the statement of comprehensive net expenditure for several of the PCT's properties. £8,783,853 was in respect of the St Georges Hospital Site. This site was closed as disclosed within note 11.3. The remaining impairment charge of £523,000 was due to the way in which buildings are valued as explained in the accounting policies of these accounts at note 1.7. The breakdown for this can be seen at note 11.3.

As part of the non current physical verification exercise £951,000 was charged to the statement of comprehensive net expenditure in relation to non current assets being lost or damaged through normal operations or due to unforeseen obsolescence. Further disclosure of these amounts can be found within note 11.3 and 12.3.

£10,212,000 of the total impairment charge is deemed to be part of annually managed expenditure and therefore full funding has been received from the Department of Health into the PCT's Revenue Resource Limit to offset this impairment charge in the year. £44,779 of the total impairment charge is deemed to be part of departmental expenditure limit and therefore funding must come from the PCT's current Revenue Resource Limit.

Impairment charged to the revaluation reserve in the year relates to those land and buildings which decreased in value due to the District Valuation Office report. Those land and buildings which were reduced in value were offset by specific balances held within the revaluation reserve for each individual asset. Amounts for £2,072,750 and £1,699,000 were charged to the revaluation reserve for land and buildings respectively.

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.

14 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	144	-	2,562	-
Balances with local authorities	-	-	934	-
Balances with NHS bodies outside the departmental group	-	-	-	-
Balances with NHS Trusts and Foundation Trusts	559	-	4,198	-
Balances with Public Corporations and Trading Funds	-	-	-	-
Balances with bodies external to government	-	-	-	-
At 31 March 2013	**703**	**-**	**7,694**	**-**
prior period:				
Balances with other central government bodies	2,444	-	2,522	-
Balances with local authorities	167	-	959	-
Balances with NHS Trusts and Foundation Trusts	1,499	-	15,537	-
Balances with bodies external to government	885	-	17,440	838
At 31 March 2012	**4,995**	**-**	**36,458**	**838**

15 Inventories

	Other £000	Total £000
Balance at 1 April 2012	1	1
Inventories recognised as an expense in the period	(1)	(1)
Balance at 31 March 2013	-	-

Due to the closure of St Georges Hospital, no heavy oil inventory remains.

16.1 Trade and other receivables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	**703**	3,202
NHS prepayments and accrued income	**-**	563
Non-NHS receivables - revenue	**338**	260
Non-NHS prepayments and accrued income	**3,113**	792
Provision for the impairment of receivables	**(57)**	-
VAT	**195**	178
Total	**4,292**	4,995

Trade and other receivables are stated at their fair values.

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

16.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**157**	138
By three to six months	**-**	781
By more than six months	**13**	338
Total	**170**	1,257

16.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**-**	(314)
Amount written off during the year	**-**	201
Amount recovered during the year	**-**	113
(Increase)/decrease in receivables impaired	**(57)**	-
Balance at 31 March 2013	**(57)**	**-**

17 NHS LIFT investments

	Loan £000
Balance at 1 April 2012	**339**
Loan repayments	**(8)**
Balance at 31 March 2013	**331**
Balance at 1 April 2011	362
Loan repayments	(23)
Balance at 31 March 2012	**339**

IAS 39 defines a financial instrument as a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. In order to comply with IAS requirements all necessary steps have been taken by the PCT to identify and review basic short-term financial instruments, the value of which have generally remained unchanged by the adoption of these standards. Much consideration has been given to checking whether longer-term or more complex financial instrument accounting arrangements have changed. The measurement and recognition of the LIFT Co investment at cost is deemed to be a reasonable approximation of fair value.

18 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**19**	35
Net change in year	**7**	(16)
Closing balance	**26**	19
Made up of		
Cash with Government Banking Service	26	19
Cash and cash equivalents as in statement of financial position	**26**	19
Cash and cash equivalents as in statement of cash flows	**26**	19
Patients' money held by the PCT, not included above.	-	-

19 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
NHS payables - revenue	**4,380**	5,209	-	-
NHS accruals and deferred income	**2,380**	12,754	-	-
Family Health Services (FHS) payables	**10,544**	11,045	-	-
Non-NHS payables - revenue	**4,071**	3,548	-	-
Non-NHS payables - capital	**-**	176	-	-
Non NHS accruals and deferred income	**4,197**	3,490	-	-
Tax	**138**	185	-	-
Other	49	51	790	838
Total	**25,759**	36,458	**790**	838
Total payables (current and non-current)	**26,549**	**37,296**		

Other current and non current payables are made up of the remaining amount in respect of the lease premium received from Newlands Pharmacy as disclosed within note 6.

20 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
LIFT liabilities:				
Main liability	**42**	23	**11,131**	11,172
Total	**42**	**23**	**11,131**	**11,172**
Total other liabilities (current and non-current)	**11,173**	**11,195**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	Other £000s	Total £000s
0 - 1 Years	-	42	**42**
1 - 2 Years	-	170	**170**
2 - 5 Years	-	99	**99**
Over 5 Years	-	10,862	**10,862**
TOTAL	-	**11,173**	**11,173**

21 Provisions for other liabilities and charges

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**4,654**	133	1,837	14	786	1,789	95
Arising during the Year	**9,460**	-	20	-	8,895	25	520
Utilised during the Year	**(2,247)**	(133)	(1,868)	(14)	-	(232)	-
Reversed unused	**(1,068)**	-	-	-	-	(1,068)	-
Unwinding of discount	**26**	-	11	-	-	15	-
Change in discount Rate	-	-	-	-	-	-	-
Transferred (to)/from other public sector bodies	-	-	-	-	-	-	-
Balance at 31 March 2013	**10,825**	-	-	-	**9,681**	**529**	**615**
Expected Timing of Cash Flows:							
No Later than One Year	**10,344**	-	-	-	**9,681**	**48**	**615**
Later than One Year and not later than Five Years	**80**	-	-	-	-	**80**	-
Later than Five Years	**401**	-	-	-	-	**401**	-

Provisions for pensions include both pensions of the PCT and the preceding organisation Barking, Havering and Brentwood Health Authority for staff who have taken early retirement or have retired through ill health, the cost of which the PCT is responsible for. In addition the PCT is notified of provision amounts from NHS Trusts and Foundation Trusts under "Back to Back" arrangements. These provisions are recognised on a discounted basis (using a discount rate of 2.8%) due to the long period over which the provision is held. The amounts are also adjusted for inflation annually using rates advised by the Department of Health. Provisions values are reviewed to ensure accuracy. The provision is based on actual payments made to members of the scheme, with life expectancy reviewed periodically.

In April 2012 the Department of Health announced deadlines for individuals (or their representatives) who wanted to request an assessment for NHS continuing healthcare for periods of care between 1st April 2004 and 31st March 2012. With the process still continuing to assess claims for the period 1st April 2004 - 31st March 2011 from the previous deadline of 30 September 2012, the review of the claims for the second deadline has not yet commenced. This announcement related to previously unassessed periods of care, where there is evidence to suggest an assessment should have been conducted. As a result of this deadline the PCT has reviewed the number of claims made and in line with IAS 37 has made a provision of £9,680,757. The continuing care team will continue to review all claims made against the organisation and in cases where the provision is not required, the amount will be released to the statement of comprehensive net expenditure.

Likewise given the subjective nature and process of assessing claims for the period 1st April to 31st March 2011 there is a possibility of further costs arising that cannot be fully qualified.

Due to the abolishment of PCT's the Department of Health has advised PCT's to clear as many long term provisions as possible prior to the 31st March 2013. As a result the PCT utilised £1,427,728 in relation to "Back to Back" provisions, £765,798 in respect of early retirement provisions. £52,998 of utilised provisions was in respect of the NHS Business Services Authority Injury Benefit Scheme for which a long term provision is still to be carried over to a successor organisation.

At the 31st March 2013 a review of staff who have not found a substantive role within a new public sector organisation was completed. These staff will potentially be made redundant. As a result an additional provision of £519,628 has been made in respect of redundancy costs. This amount represents the expected element of staff redundancies associated with Havering PCT as part of the Outer North East London Sector as at the statement of financial position date. If staff subsequenlty find an alternative role within a public organisation no redundancy payment will be made and the provision will be released to the statement of comprehensive net expenditure.

An amount of £1,028,484 in relation to Practice Based Commissioning savings has been released to the statement of comprehensive net expenditure. A revised accrual of £812,915 in respect of this scheme has subsequently been included within the PCT's total current payables.

The value of provisions carried forward is a close estimate of actual cost expected.

21 Provisions for other liabilities and charges (continued)

Other provisions comprise the following:-

	£000
Injury benefit	498
NHSLA	31
	529

£30,965 is included within provisions for the NHSLA at 31st March 2013 in respect of liabilities to third parties provision of the PCT (31st March 2012 £28,375)

22 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Other	**(8)**	(1,668)
Net Value of Contingent Liabilities	**(8)**	(1,668)

In accordance with IAS 37 the PCT recognises a contingent liability in regards to Liabilities to Third Parties Scheme (LTPS) and Practice Based Commissioning savings schemes.

There are currently eight cases ongoing at the statement of financial position date in relation to LTPS for which a provision of £30,965 (2011/12 £28,375) has been included within provisions. A contingent liability of £8,494 (2011/12 £13,625) exists due to the uncertainty of these cases, as the liability depends on the outcome of the litigation which is at present is uncertain.

It is not anticipated that any material liabilities will arise from the contingent liabilities other than those provided for in note 21.

23.1 NHS LIFT schemes off-statement of financial position

The PCT has no NHS LIFT Schemes which are deemed to be off-statement of financial position

23.2 NHS LIFT schemes on-statement of financial position

The PCT currently has three LIFT (Local Improvement Finance Trust) Schemes which involves the PCT procuring the design, building, financing and operation of healthcare faculties to the Barking & Havering LIFT Company (No. 1) Limited for the benefit of Havering residents. The three schemes in question are Harold Hill, Cranham and South Hornchurch which operate under the same contractual arrangements as a lease plus agreement. The LIFT Co acquires the site and builds the medical faculty with an option available to the PCT to purchase the asset. The term of the arrangement is 25 years over which a finance charge and lease rental is incurred. Contract payments are increased year on year based on RPI. Further to this the basis of the liabilities for the future are computed using the universal model prescribed by the Department of Health and are therefore subject to possible changes as some assumptions have been made around data input such as asset useful economic lives and elements surrounding component accounting. As all three schemes fall within the scope of a service concession they have been accounted for under IFRIC 12. The assets are therefore accounted for as on statement of financial position.

Imputed "finance lease" obligations for on SoFP LIFT Contracts due	**Cranham**	**St Hornchurch**	**Harold Hill**	**31 March 2013**	31 March 2012
	£000	**£000**	**£000**	**£000**	£000
No later than one year	249	314	560	**1,123**	1,107
Later than one year, no later than five years	1,023	1,286	2,230	**4,539**	4,566
Later than five years	5,195	7,627	10,627	**23,449**	24,544
Subtotal	**6,467**	**9,227**	**13,417**	**29,111**	30,217
Less: Interest element	**(3,817)**	**(5,871)**	**(8,250)**	**(17,938)**	(19,022)
Total	**2,650**	**3,356**	**5,167**	**11,173**	11,195

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013**	31 March 2012
	£000	£000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**-**	-
Service element of on SOFP LIFT charged to operating expenses in year	**347**	351
Total	**347**	351

	31 March 2013	31 March 2012
	£000	£000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	**1,747**	1,701
Later than One Year, No Later than Five Years	**7,332**	7,060
Later than Five Years	**25,989**	27,178
Total	**35,068**	35,939

The lease plus arrangement for the three schemes states that the PCT has an option to purchase the LIFT assets at the end of the 25 year period at an adjusted market price. This price effectively measures the difference between the actual open market value at the end of the contract and the residual value of the asset. As the purchase option prices for all three schemes are considerably lower than the fair value and residual value as per the LIFT Co model, a decision has been made by the PCT to exercise the option to purchase the asset at the end of the term. This decision is further supported by the specialist nature of the building and how it meets the health needs of the local community.

The nature and extent of the LIFT Co arrangement is that of a Lease Plus Agreement (LPA) entered into by both Barking and Havering LIFT Company and the PCT in respect of specific buildings in which the floor plan and space and configuration of the buildings for Harold Hill, Cranham and South Hornchurch have been determined and costed at the financial close. All three LIFT LPA schemes are over a period of 25 years in which a base contract price has been set for the above at £652,899, £297,873 and £374,717 per annum respectively. These base contract price figures are then uplifted by the retail price index from the inception of the lease, up to the conclusion of these lease terms to arrive at a nominal contract price for each year of the lease.

Under this joint arrangement, this affords the PCT the rights, and not the option to expect the provision of services in the maintenance of the three LIFT schemes involving planned improvements and replacement programmes for e.g. lifecycle costs. Any failure on the part of the Barking LIFT Company to provide such services will contravene not only the relevant legislation, and regulations, but will give rise to a reduction in the lease plus payments where evidence of a landlord event of default has occurred.

In addition to the above, all three LIFT contracts offer the PCT the option and not the obligation to purchase either all or some of the schemes at a price at the end of the term subject to adjustments to the actual open market value as stipulated by schedule 14 of the LPA contracts. Linked in with this option, is the granting to the PCT if it so wishes, a pre-emption right to purchase the above three schemes in line with schedule 14 of the Lease plus agreement. Similarly the PCT has the option and not the obligation to purchase as a result of any forced sale of shares of either the three schemes above in line with Schedule 14 of the contract. Lastly, the contract affords the PCT in the event of a landlord event of default for e.g. Barking Lift Company failing to achieve actual completion dates or abandoning works, the PCT can terminate the lease in its entirety by notice in writing having immediate effect subject to the provisions of the funder's direct agreement.

24 Impact of IFRS treatment - 2012-13

	Total	Admin	Programme
	£000	£000	£000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. LIFT/PFI)			
Depreciation charges	**183**	-	183
Interest expense	**1,085**	-	1,085
Other expenditure	**638**	-	638
Total IFRS Expenditure (IFRIC12)	**1,906**	-	**1,906**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(1,722)**	-	(1,722)
Net IFRS change (IFRIC12)	**184**	-	**184**

25 Financial Instruments

Financial risk management
IFRS 7 Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks and entity faces in undertaking these activities.

The PCT is not exposed to significant financial risk factors arising from financial instruments. The main source of funding for PCT's are allocations (Parliamentary Funding) from the Department of Health within an approved cash limit. Other income principally comprises fees and charges for services provided to external customers, the majority of whom are within the NHS boundary. The way in which the PCT is financed, and its role as healthcare commissioner and provider, determines that it is not exposed to the degree of financial risk faced by business entities. Financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the PCT in undertaking its activities.

Market Risk
Market Risk is the possibility that financial risk might arise as a result of changes in such measures as interest rates and stock market movements. The PCT's transactions are all undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no significant investments other than short term bank deposits. Other than cash balance, the PCT's financial assets and liabilities carry no fixed rates of interest and the PCT's income and operating cash flows are consequently independent of changes in market interest rates.

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

Credit Risk

Credit risk is the possibility that other parties might fail to pay amounts due to the PCT. Credit risk arises from deposits with banks as well as credit exposures to the PCT's debtors. The PCT does not operate with surplus cash as this is drawn down from the Department of Health when needed for use. As the PCT does not hold any investments other than necessary cash it is not exposed to interest rate risk. The PCT's cash assets are held within the Government banking service only. The PCT's net operating costs are incurred largely under annual service level agreements with local trusts and foundation trusts.

Liquidity Risk

Liquidity risk is the possibility that the PCT may not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding for an adequate amount of committed credit facilities. The PCT must draw down cash from its annual allocation when needed and it must not exceed this limit.

25 Financial Instruments continued

25.1 Financial Assets

	Loans and receivables	Total
	£000	£000
Receivables - NHS	703	703
Receivables - non-NHS	281	281
Cash at bank and in hand	26	26
Other financial assets	3,113	3,113
Total at 31 March 2013	**4,123**	**4,123**
Receivables - NHS	3,765	3,765
Receivables - non-NHS	260	260
Cash at bank and in hand	19	19
Other financial assets	792	792
Total at 31 March 2012	4,836	4,836

25.2 Financial Liabilities

	Other £000	Total £000
NHS payables	6,760	**6,760**
Non-NHS payables	8,268	**8,268**
LIFT Liabilities	11,173	**11,173**
Total at 31 March 2013	**26,201**	**26,201**
NHS payables	17,963	17,963
Non-NHS payables	7,214	7,214
LIFT Liabilities	11,195	11,195
Total at 31 March 2012	36,372	36,372

26 Related party transactions

The Department of Health is regarded as a related party. During the year the PCT has had a significant number of material transactions with the Department of Health, and with other entities for which the Department of Health is regarded as the parent entity. These transactions are in relation to the provision of healthcare services and these entities are listed below. This note includes all significant transactions with other NHS organisations.

	2012-13		2011-12	
	Payments to related party £000	Receipts from related party £000	Payments to related party £000	Receipts from related party £000
Barking Havering & Redbridge NHS University Trust	147,411	168	145,144	168
Tower Hamlets Primary Care Trust	84	2	62	2
North East London NHS Foundation Trust	58,694	3,559	60,488	2,020
Barking & Dagenham Primary Care Trust	434	145	11,159	1,575
London Ambulance Service NHS Trust	6,891	-	6,781	-
Redbridge Primary Care Trust	522	214	2,332	1,221
South West Essex Primary Care Trust	-	359	4	352
Barts Health NHS Trust	29,074	-	23,263	-
Waltham Forest Primary Care Trust	13	139	1,022	1,339
Croydon Primary Care Trust	14,681	-	10,859	-
City & Hackney Primary Care Trust	4,096	1,505	-	-

	2012-13		2011-12	
	Amounts Owed to related party £000	Amounts due from related party £000	Amounts Owed to related party £000	Amounts due from related party £000
Barking Havering & Redbridge NHS University Trust	1,672	-	10,678	581
Tower Hamlets Primary Care Trust	-	-	6	-
North East London NHS Foundation Trust	587	-	829	462
Barking & Dagenham Primary Care Trust	171	32	897	823
London Ambulance Service NHS Trust	-	20	35	-
Redbridge Primary Care Trust	267	29	1,071	466
South West Essex Primary Care Trust	-	64	-	116
Barts Health NHS Trust	723	-	170	7
Waltham Forest Primary Care Trust	-	-	279	580
Croydon Primary Care Trust	418	-	106	-
City & Hackney Primary Care Trust	-	-	-	-

In addition the PCT has entered into a number of transactions with other Government departments and other central and local Government bodies in relation to the provision of healthcare services. Most of these transactions have been with the London Borough of Havering Local Authority and London Borough of Waltham Forest Local Authority in respect of joint enterprises.

	2012-13		2011-12	
	Payments to related party £000's	Receipts from related party £000's	Payments to related party £000's	Receipts from related party £000's
London Borough of Havering	6,062	68	6,356	197

	2012-13		2011-12	
	Amounts Owed to related party £000's	Amounts due from related party £000's	Amounts Owed to related party £000's	Amounts due from related party £000's
London Borough of Havering	934	-	930	58
London Borough of Waltham Forest	-	-	-	109

26 Related party transactions (cont'd)

Other entities are considered to be a related party if Havering Primary Care Trust can:

*have direct or indirect control of the other party

*have influence over the financial and operational policies of the other party; or the parties are subject to common control or influence from the same source.

The below individuals declared interests which related to the full financial year for the PCT unless stated.

Name	Position in sector	Name of organisation where interest held	Position held/interest held
Afzal Akram	Deputy Chair	London Borough of Waltham Forest	Elected Councillor and Cabinet Member
Lesley Buckland	Non Executive	Age Concern Havering	Trustee
Ken Aswani	Medical Director	Allum Medical Centre	Partner
Ken Aswani	Medical Director	NHJ Alliance	Member
Ken Aswani	Medical Director	RCGP	Member

The transactions are listed below in relation to interest declared above.

	2012-13		2011-12	
	Payments to Related Party £000's	Receipts from Related Party £000's	Payments to Related Party £000's	Receipts from Related Party £000's
London South Bank University	-	194	-	194
Age Concern Havering (Charity)	557	-	436	-

27 Losses and special payments

The total number of losses cases in 2012-13 was nil, involving a total loss of £nil (2011-12 nil cases and £nil).

The total number of special payments in 2012-13 was nil, involving a total of £nil (2011-12 nil cases and £nil).

28 Learning Disability pooled budget

Havering PCT has a pooled budget arrangement with the London Borough of Havering Local Authority. The London Borough of Havering Local Authority is the host.

The PCT's shares of the income and expenditure handled by the pooled budget in the financial year were:

	2012-13 £000	2011-12 £000
Income	-	-
Expenditure	-	-

In 2011/12 the pooled budget was transferred in its interiority to the London Borough of Havering Local Authority. As such £7,269,000 was deducted from the PCT's baseline revenue resource limit at the beginning of the year and passed straight to the local authority.

29 Independent Sector Treatment Centre

The PCT operates an Independent Sector Treatment Centre in partnership with PHG (North East London) Ltd, The Secretary of State for Health, Barking and Dagenham PCT, Redbridge PCT, Waltham Forest PCT and Barking, Havering and Redbridge Hospitals NHS Trust. Barking and Dagenham PCT hold these premises within their accounts at a value of £4,288,435 for Buildings and receive funding from the Department of Health in relation to capital charges incurred on this property.

The contract in respect of this service expired on 31st December 2011 and a new contract was awarded to PHG (North East London) Ltd. The current contract is due to expire on 31st December 2014.

Each party to the ISTC agreement made payments to PHG (North East London) Ltd throughout the year. Havering PCT made payments of £6,594,598 in 2012/13 (2011/12 £2,110,878).

30 Events after the end of the reporting period

The main functions carried out by Havering 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. Havering 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, Havering Clinical Commissioning Group, North East London NHS 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.

The assets and liabilities of the PCT/SHA were transferred to successor bodies on 1 April 2013 as follows:

	Balances held by PCT as 31st March 2013 £000s	Department of Health £000s	Clinical Commissioning Groups £000s	Commissioning Board £000s	NHS Foundation Trusts £000s	NHS Property Services £000s	Community Health Partnerships £000s
Non-Current assets							
Property, Plant and Equipment	51,043	16,000	35	241	4,115	19,595	11,057
Intangible Assets	72	-	-	-	72	-	-
Other Financial Assets	331	-	-	-	-	-	331
Total Non Current Assets	51,446	16,000	35	241	4,187	19,595	11,388
Current Assets							
Trade and Other Receivables	4,292	4,236	-	56	-	-	-
Cash and Cash Equivalents	26	26	-	-	-	-	-
Sub Total Current Assets	4,318	4,262	-	56	-	-	-
Non-Current Assets Held For Sale	-	-	-	-	-	-	-
Total Current Assets	4,318	4,262	-	56	-	-	-
Total Assets	55,764	20,262	35	297	4,187	19,595	11,388
Current Liabilities	-	-	-	-	-	-	-
Trade and Other Payables	(25,759)	(18,385)	(7,325)	-	-	-	(49)
Provisions	(10,344)	(664)	(9,680)	-	-	-	-
Borrowings	(42)	-	-	-	-	-	(42)
Total Current Liabilities	(36,145)	(19,049)	(17,005)	-	-	-	(91)
Net current assets/(liabilities)	(31,827)	(14,787)	(17,005)	56	-	-	(91)
Total assets less current liabilities	19,619	1,213	(16,970)	297	4,187	19,595	11,297
Non-current liabilities							
Trade and Other Payables	(790)	-	-	-	-	-	(790)
Provisions	(481)	(481)	-	-	-	-	-
Borrowings	(11,131)	-	-	-	-	-	(11,131)
Total Non-Current Liabilities	(12,402)	(481)	-	-	-	-	(11,921)
Total Assets Employed	7,217	732	(16,970)	297	4,187	19,595	(624)
Taxpayers Equity							
General Fund	(6,751)	(8,768)	(16,970)	297	2,677	17,516	(1,503)
Revaluation Reserve	13,968	9,500	-	-	1,510	2,079	879
Total	7,217	732	(16,970)	297	4,187	19,595	(624)

14 Annual governance statement

Name of organisation: Havering 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 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 these 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.

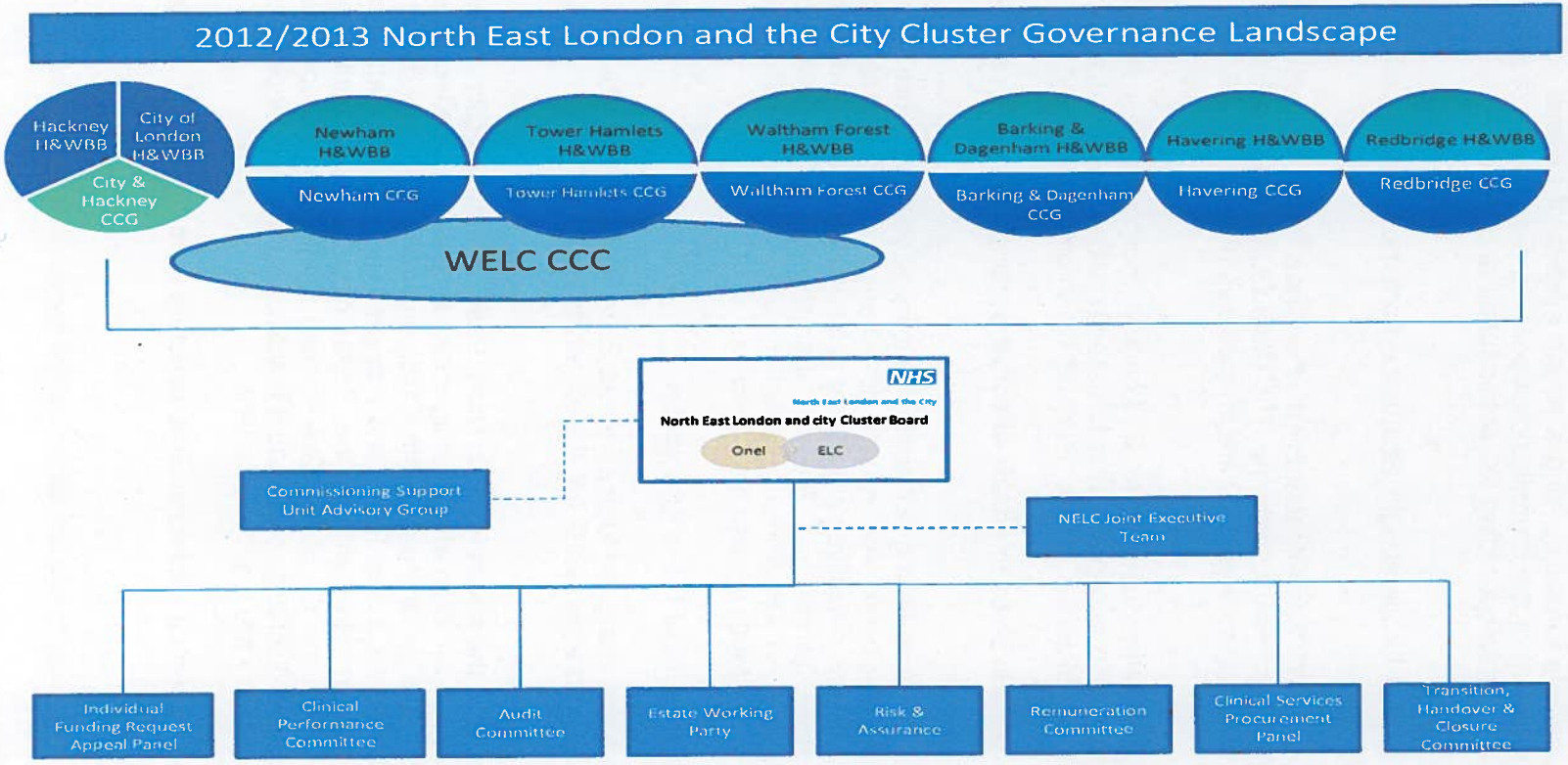
2. The governance framework of the organisation

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 City committee structure



Agreed April 2012

The Cluster Board for North East London and the City has 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 has been 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 has enabled the Cluster to conduct its business during a period of significant change in the NHS. It has 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 has been supported by a number of committees as evidenced in the structure diagram. These committees have been 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 has ensured that a wide range of non-executive knowledge and experience was retained and used in the assurance process.

The Audit Committee has met on a bi-monthly basis through to September 2012 and then met monthly from October 2012 to March to strengthen assurance. It has been quorate on each occasion. It has considered internally and externally audit reports along with updates from the counter-fraud officer. It has 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 has 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 has been 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 has been 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 have 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 amd 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, transferred their functions, both statutory and non statutory to 47 other organisations. The process for making this transfer was 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 Chairs 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 organisations' 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:

- The 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 draws on the best practice elements of ISO31000 and therefore embraces the concept of enterprise and integrated risk management in ensuring achievement of best outcomes. The Risk Management Strategy sets 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.

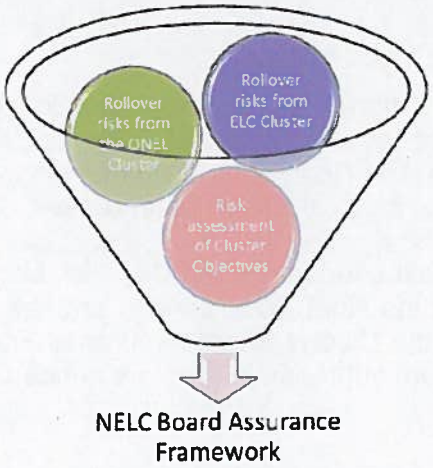


Figure 1 showing the 2 main processes that led to the creation of the NELC Board Assurance Framework

Supplementing this "top down" process of risk identification was the 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 both 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 Havering PCT identified during 2012/13 which populated the Board Assurance Framework (BAF) 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.					

1.8	Maintaining an effective and proactive quality assurance framework during periods of transition for both the provider and commissioner landscape across all provider groups					
2.1	Progress in quality improvement is not achieved in the timeframe set out and inability to sustain quality and safety of maternity services at BHRUT in the context of CIP and requirement to operate					
2.2	Failure to meet emergency care access standards at BHRUT/Queens Hospital adversely impacting on service users and other organisations					
2.3	Failure to deliver BHRUT 2012/13 financial plan – deficit reduced in line with plan to maximum £40m. Dependent on £23m CIP delivery and 10.3 commissioner QIPP delivery					
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 (BAF) 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 & Assurance committee. This Committee has undertaken a "deep dive" challenge into particular areas of risks, for example quality and safety and has held individual directors to account for the risks associated with their areas of responsibility.

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

The Framework is consistent with the template promulgated by the Department of Health and explicitly maps objectives against pertinent risks, controls and assurances. It also describes 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.
- Elevated levels of legionella bacteria found in sections of the water system at St. George's Hospital in Hornchurch.
- 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 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
- Patient accommodation on the St George's site was vacated in November 2012
- 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 has 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 had responsibility for the development and maintenance of the system of internal control provided 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 it's quality of commissioned services described in the Department of Health's Operating Framework and delivered through the Risk and 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 Havering PCT has a generally sound system of internal controls that support the achievement of its policies, aims and objectives and that

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 have 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 outer north east London CCGs.

Peter Coates, CBE
Designated Signing Officer

16 Independent auditor's report (external)

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

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

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

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

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the PCT's affairs as at 31 March 2013 and of its net operating costs for the year then ended; and

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

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion

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

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

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

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

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

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

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

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

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

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

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

considered, whether all aspects of the PCT's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

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

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

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

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

Kevin Lowe, Engagement Lead

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

4 June 2013

17 External auditor's costs

Havering PCT's external auditor is PricewaterhouseCoopers LLP. They were paid £155,866 (inclusive of VAT) in 2012/13 to carry out the statutory audit. In 2011/12 the fees were £259,776.