Department of Health

NHS

Harrow Primary Care Trust

2012-13 Annual Report and Accounts

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Harrow Primary Care Trust

2012-13 Annual Report

NHS Harrow

Annual Report for 2012/13

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Chair and Chief Executive NHS North West London joint statement

Welcome to the annual report for NHS Harrow covering the primary care trust's (PCT's) final year, from 1 April 2012 to 31 March 2013. This report reviews the work of the PCT and highlights what we achieved working closely with our partners.

NHS Harrow was part of a cluster of eight PCTs in North West London. The eight PCTs were Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster.

In April 2011, we re-organised the management of the eight PCTs into three sub clusters, each with a common management team: Brent and Harrow, Inner North West London (Hammersmith & Fulham, Kensington & Chelsea, and Westminster) and Outer North West London (Ealing, Hillingdon and Hounslow). This change helped to reduce management costs while maintaining a local focus.

In April 2012, we took this one step further, with further integration of the management of the PCTs. For the remainder of the year, we had a single senior team overseeing the work of all eight PCTs, with the PCT boards having the same members and meeting at the same time.

Together, these PCTs had responsibility to buy and oversee healthcare for the residents of their areas – nearly two million people in total across North West London. Their job was to work with GPs, other community based professionals and hospitals to improve healthcare for residents, and to make it easier to access services when they need them.

The challenge for the PCTs in 2012/13 was both to meet the ever increasing health demands of the populations they served while balancing their budgets. While the NHS's overall budget has been protected, demands and costs are increasing, so the task for the health service is to improve efficiency while maintaining high quality. To help us achieve this, with clinical colleagues across North West London, we developed 'Shaping a Healthier Future', a strategy to improve the quality of and access to services across North West London. To help develop these plans, the North West London PCTs worked with GPs, hospitals, community service providers, mental health trusts and local authorities. We also had an extensive programme of patient and public involvement in order to listen to and take into account people's views.

The year also saw a new organisational structure starting to be developed as a result of the reforms to healthcare commissioning contained in the Health and Social Care Act 2012. Through a carefully planned transition, we set up new GP-led clinical commissioning groups in shadow form. The eight clinical commissioning groups in North West London were authorised by the NHS England in 2012/13, which gave them the responsibility for the commissioning of many health care services in their areas from 1 April 2013.

The CCGs decided to manage themselves in two groups of four to best use their expertise and resources while maintaining a crucial local link. The PCTs supported the creation of the new organisations, providing support and guidance to develop the structures and systems, and to appoint and train staff.

We also created the North West London Commissioning Support Unit (NWL CSU) which was also authorised by the Department of Health to provide commissioning support services to the CCGs from April 2013.

The shadow CCGs started to lead the commissioning process from 1 October 2012, including contract negotiations for the provision of healthcare services from 2013/14 onwards. They also specified their commissioning support needs from the NWL CSU.

Since 1 April 2013, PCTs, along with strategic health authorities, no longer exist, and staff in the PCTs moved to the CCGs, NWL CSU, local authority public health teams or the NHS England. We worked closely with staff to make sure that the expertise that they held was not lost to the NHS. Most staff took on roles within the new system, and the NHS has thus fortunately retained much of the experience, skills and relationships developed during the life of the PCTs.

We would like to record our thanks to our many partners – GPs, patient representatives, other primary and community care providers, NHS Trusts, local authorities and voluntary sector organisations, for working with us so energetically to meet our shared aims.

Lastly, we would like to thank all the dedicated staff across the North West London PCTs who continued to work so hard through these major changes. The changes affected people personally but it is to their immense credit that they remained focused on ensuring that the very best healthcare possible is provided to residents in North West London.

Jeff Zitron
Chair NHS North West London
1 April 2012 – 31 March 2013

Anne Rainsberry
Chief Executive NHS North West London
1 April 2012 – 31 March 2013

Chair and Chief Officer NHS Harrow Clinical Commissioning Group joint statement

'Working together for a healthier Harrow' is how the year of 2012/13 can be best summed up for NHS Harrow and the organisations it worked with, and particularly with the new Harrow Clinical Commissioning Group.

It was the strong partnership between NHS Harrow with its local GPs and neighbouring clinical commissioning groups, NHS provider organisations, the local authority, the voluntary sector and with NHS North West London that enabled us to improve services for patients in 2012/13.

In the section on the year in focus in this report you can read about the many examples of how we have worked with our partners to improve services for patients. These include a new integrated care pilot which brings together GPs, social care representatives and secondary care consultants to provide the best care for people with long term conditions; a number of successful public health initiatives; and setting up primary care peer groups.

Delivering more services in a community setting was a key theme of the 'Shaping a healthier future' consultation to improve NHS services across North West London, including Harrow. There have understandably been concerns from local residents about the proposals, and we will continue to lobby hard to ensure we get the best possible services for Harrow.

We have made clear that changes to hospital services can only take place once there have been significant improvements to community based services. This work will be supported by a comprehensive out of hospital strategy, which will see services currently provided in hospital shifted into the community, to provide residents with more care in their homes and at convenient community settings including GP surgeries, children's centres and schools.

Our commitment to engage with patients and members of the public has been embedded with the start of patient workshops on service pathway redesign, the formalisation of our equality and engagement committee and the launch of Harrow CCG's website, which contains information on the work and decisions of the organisation. Harrow CCG will continue to seek further opportunities and initiatives in the coming year; engaging with all stakeholders to create a vibrant and effective healthcare landscape in Harrow.

The borough of Harrow is unique. We believe that to commission high quality services for the residents of Harrow, we need to work collaboratively with the other CCGs in North West London, particularly as the new Harrow Clinical Commissioning Group is a significantly smaller organisation compared to NHS Harrow.

The key aims of the Harrow CCG commissioning strategy for the next year are to:

- improve health and wellbeing in partnership with patients and wider community;

- ensure service provision is needs- led, sustainable and fair; and
- secure quality, cost-effective care delivered by the right person in the right place.

In 2012 we worked with the Brent, Ealing, and Hillingdon CCGs to create a joint federation which has enabled us to share a number of our staff costs, including the chief officer, chief financial officer and clinical governance roles without affecting our autonomy.

We also worked collaboratively with the four CCGs in inner North West London – West London, Central West London, Hammersmith & Fulham and Hounslow clinical commissioning groups. This allowed us the best opportunity to commission services with improved outcomes for the residents of Harrow, as well as sharing knowledge and best practice, and a joint Director of Strategy.

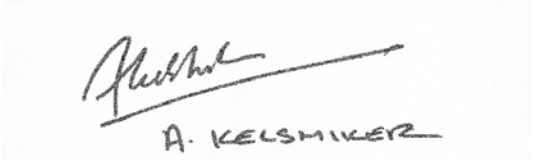
We are pleased to say that Harrow Clinical Commissioning Group was authorised with conditions by the National Commissioning Board (now called NHS England), which meant it was able to take on full statutory commissioning responsibilities from April 2013.

As part of the changes to the NHS in Harrow, all staff in NHS Harrow went through a restructuring process. Staff moved either to work in the clinical commissioning group, the new commissioning support unit, local authority public health teams, or in the new NHS England.

However, some staff were not able to secure a role and we supported these people to find alternative employment. Organisational restructuring is always a stressful process for everyone involved, and we would like to pay tribute to the hard work by all staff throughout the year, even though everyone's personal future was uncertain.

The progress and successes we have achieved in Harrow 2012/13 is a reflection of the high calibre of staff we were fortunate to have. We would like to pay tribute to clinical leads and management team for all their hard work and contribution which put Harrow CCG in a strong position to start its work a statutory body.

2012/13 was a challenging year and this year looks like it will be just as challenging. However, we are confident that a sustained focus on quality services and patient outcomes and the hard work undertaken by everyone in 2012/13, has built strong foundations on which to move forward.



Dr Amol Kelshiker
Chair and local GP
NHS Harrow Clinical Commissioning Group

Rob Larkman
Chief Officer
NHS Harrow Clinical Commissioning Group

The NHS in Harrow

NHS Harrow

NHS Harrow was established in 2002, and covered the same area as the London Borough of Harrow. It was dissolved, along with all primary care trusts, on 1 April 2013.

NHS Harrow commissioned all NHS services provided by GPs, pharmacists, prescriptions, dentists and opticians for the 237,000 residents in the borough. It also paid for hospital care on behalf of patients registered with Harrow GPs, care for mental health patients, and community services. It worked with local partners and the community to ensure that it provided the services residents needed and wanted in a joined-up way. It also worked with Harrow Council to help promote good health among residents and to support vulnerable people who were eligible for social care.

Changes to the NHS in Harrow

Major changes to the way primary and secondary care is commissioned across the NHS were introduced on 1 April 2013 as a result of the Government's Health and Social Care Act 2012.

The key changes to primary healthcare in Harrow were as follows.

Clinical Commissioning Groups

NHS Harrow was dissolved on 1 April 2013 and responsibility for the commissioning of acute, mental health and community NHS care in Harrow passed to NHS Harrow Clinical Commissioning Group. This gave GPs and other clinicians the responsibility for using resources to secure high quality services for their patients.

Harrow CCG's governing body is made up of GPs, a senior nurse, a secondary care doctor, practice manager, lay members and a chief officer and chief financial officer. Authorisation of Harrow CCG followed a rigorous assessment process by the NHS National Commissioning Board (now called NHS England) which ensured that the CCG was competent and effective and ready to take on the task of commissioning healthcare services.

Harrow CCG works collaboratively with three of its neighbouring CCGs - Brent, Ealing and Hillingdon CCG. Many of its providers are shared between the four CCGs and working together enables them to make decisions jointly where that makes sense and manage financial resources to address its patients' needs.

NHS England

NHS England took on many of the functions of the former primary care trusts for the commissioning of primary care health services, as well as some of the nationally-based functions previously undertaken by the Department of Health. This included

GP services, pharmaceutical and primary ophthalmic services, dental services and some other specialist services. It is a single national organisation with many of its functions carried out at a local level.

Public health

From April 2013 local authorities were given a new duty to improve the health of their population. To help Harrow Council fulfill this duty, the public health team that was previously based in NHS Harrow moved over to become part of the council. A national body, Public Health England, was established to protect and improve the nation's health and wellbeing, and to reduce health inequalities.

Commissioning support units

Commissioning Support Units provide a range of business functions designed to help clinical commissioning groups make better decisions for their patients and improve health services. North West London Commissioning Support Unit provides commissioning support to the eight CCGs in North West London, including Harrow CCG.

Healthwatch England

Harrow Local Involvement Networks (Harrow LINk), which used to look after the interests of users of publicly funded health and social care services, has been replaced by Healthwatch Harrow, part of Healthwatch England. Healthwatch England is the new, independent consumer champion for health and social care in England.

Health and wellbeing board

A new health and wellbeing board was established for Harrow that brought together the leaders of the local health and social care systems to work towards a common purpose to improve services and outcomes. The board members work together to develop a joint strategic needs assessment and joint health and wellbeing strategy for the borough. Integrating services, joint commissioning and pooling resources is central to translating the board's needs assessment and joint strategy into action.

The London Borough of Harrow

People in Harrow are, in general, healthier and live longer than the average for England and London. However, there are a number of underlying health issues that affect many of the population of the borough. People living in different social circumstances experience differences in their health and well being and in their life expectancy. Men in West Harrow can expect to live for five and a half years longer than men in Greenhill ward. However, although there are big variations in life expectancy, Harrow compares favourably to London as a whole.

Harrow's population of around 215,000 is projected to grow over the next ten years, with the greatest growth in the older age groups (45-59 and 60+). There is also a

predicted increase in numbers of children under 15 but a predicted reduction in the 15-44 age group.

More than half of Harrow's population is from black and minority ethnic groups, making Harrow one of the most ethnically diverse boroughs in the country. The largest group, after white, is Indian. There are huge inequalities in life expectancy within Harrow. Women in inner south Harrow can expect to live more than 10 years longer than women in Wealdstone.

Performance against national indicators

NHS Harrow has a statutory duty to report on the performance of a number of services against the national operating framework indicators for 2012/13.

In 2012/13 NHS Harrow met the following national indicators:

- Methicillin-resistant *Staphylococcus aureus* bacteraemia: reducing the number of outbreaks
- Clostridium difficile: reducing the number of outbreaks
- Ambulance response times: category A response within 8 minutes
- Ambulance response times: category A response within 19 minutes
- 18 weeks referral to treatment: admitted performance within 18 weeks
- 18 weeks referral to treatment: non-admitted performance within 18 weeks
- 18 weeks referral to treatment: incomplete pathways performance within 18 weeks
- Cancer two week wait – percentage seen within two weeks of an urgent GP referral for suspected cancer.
- Cancer 62 day wait percentage treated in 62 days from urgent GP referral for suspected cancer.

In 2012/13 NHS Harrow did not fully meet the following national indicator:

- Childhood immunisation levels continued to be a challenge for PCT's with performance slipping for 2011/12 levels. Action plans were agreed with providers and best practice shared across all of North West London PCTs.

Key highlights for 2012/13

Staff in NHS Harrow worked hard in 2012/13 to continue to develop the quality services that it provided. In this section are just a few that made a difference to patients and the public in the borough, and information on some of the methods used to engage with local people to make sure their views were taken into account.

Harrow's integrated care pilot scheme

The outer North West London integrated care pilot (ICP) began in April 2012, with the objective of improving outcomes for thousands of patients with complex needs.

During the year, the pilot focussed on patients over 75 years of age and also patients of any age with diabetes. By taking an integrated approach to their care, the scheme improved outcomes for patients, who all receive a primary care led care plans. Patients with complex conditions had their cases discussed and care plans agreed in multi-disciplinary case conferences.

Every one of the 35 GP practices in Harrow participated in the ICP work, which meant that the pilot was available in every locality across the borough. Multi-disciplinary groups were set up to match the existing six peer group localities established for the CCG, which were chaired by a Harrow GP.

Equality and engagement committee

Harrow CCG established an equality and engagement committee to provide oversight and assurance that the CCG had mechanisms in place to implement and act in accordance with the CCG's equality and diversity policy.

The committee had a role to seek assurance that arrangements were in place to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements. The committee was chaired by the CCG's lay member, whose portfolio covers equality and patient and public involvement, and membership includes GP clinical directors, the director of quality & safety, the stakeholder engagement officer and the local Harrow LINk representative.

The committee had responsibility for supporting equality via an effective and committed approach to engage all necessary parties who were directly or indirectly linked to the work of the CCG, ranging from patients and practices to voluntary organisations and other such associated social groups amongst Harrow's diverse and ethnically vibrant population. The Committee met monthly to cover areas including public engagement and communications, equality obligations, engagement with stakeholders and promoting borough-wide health initiatives championed by the CCG.

Quality, safety and clinical risk

The quality, safety and clinical risk committee had a key role to provide assurance to Harrow CCG on the quality of the services it commissioned. This included reviewing quality performance reports and identifying areas of concern. It also advised on the development of quality indicators including patient experience of existing and new services.

Next year the committee will build on its work by working with patients and patient groups to strengthen the ways in which patients' views and experiences are collected and used to improve care. It will also work with the commissioning support unit to improve the quality of reporting, the use of intelligence and the implementation of improvement. It also will also develop effective relationships with the area team of NHS England, the NHS Trust Development Authority and the Care Quality Commission to ensure effective information sharing and co-ordinated responses to concerns

Mental health

A number of improvements took place to modernise mental health services and shift settings of care from inpatient to community based mental health services and from secondary to primary care.

The placement efficiency project successfully repatriated people with mental health needs from out of borough placements into local placements which better met their needs, both improving the service provided to service users and achieving significant savings. A new joint mental health funding panel was set up with Harrow Council to ensure a clear, transparent and robust process for decision making regarding adult mental health funding requests.

Other key achievements include developing an attention deficit hyperactivity disorder (ADHD) pathway to provide cost effective access to assessment, diagnosis, treatment and review for people with symptoms of ADHD and those with an existing diagnosis. A new autism strategy was developed in partnership with the local authority to provide access to assessment and treatment to high functioning individuals with autism. Over the next year Harrow CCG plans to continue these initiatives and embed them in the new NHS system.

Children's services

In May 2012 an Ofsted/CQC inspection of safeguarding judged health services to be only adequate for safeguarding and inadequate in relation to delivering healthy outcomes for looked after children. This poor result led to a strong CCG focus on strengthening safeguarding arrangements and ensuring a strong base for delivering ongoing improvement.

Immediate actions in response to the inspection recommendations are now complete. Further work continues to ensure that improvements are not only embedded, but sustained and built upon, and that there is measurable evidence that these have resulted in better outcomes for children.

This has included strengthening the health pathway for looked after children, contributing to the development of a stronger local safeguarding children board with more robust monitoring arrangements for local services, and ensuring that records kept by health teams move from descriptive to analytical content and show evidence of improved risk awareness and reflective supervision. Additional resources have been committed by the CCG, including a new safeguarding nurse role to work across children and adult safeguarding.

Improving access to primary care

A locally strong healthcare system in Harrow must be sustained by consistently good primary care.

The transformation in how primary care services are configured allows projects such as the integrated care pilot to be successful. Six peer groups of GPs in Harrow were

created, with Harrow CCG clinical directors being chairs of each peer group. These were arranged on a geographical basis and allowed the practitioners in the respective peer group to meet as GP commissioners and collectively develop new ways of commissioning services as a collaborative, which previously would not have been possible.

The peer group system has been running in Harrow for just over a year, with well embedded communication between the CCG and member practices, along with an increase in collaboration and support between intra peer group practices. The peer group meetings invite healthcare providers on a regular basis to engage in discussion and outline areas for service improvements and patient experience. This is an unprecedented step in Harrow to ensure patients are consistently kept at the heart of primary care development.

Harrow CCG held monthly GP Forums for all 35 member practices to discuss, share and present information on primary care issues. Health partners and providers also presented their work streams and rolled out borough-wide schemes with the full participation of Harrow GPs.

Intermediate care and urgent care

There were a number of successes in service commissioning and delivery, marked by the implementation of new and innovative ways of working across complex pathways.

The short term assessment rehabilitation and re-ablement service reduced unnecessary hospital admissions through their rapid response service that worked within A&E and out in the community responding to GP requests for assessments. In addition, they helped reduce lengths of stay through their early supported discharge team, getting patients home with the support of therapists and specialist nurses.

Whilst the number of intermediate care beds for patients with a cognitive impairment as well as an intermediate care need have been reduced, services were developed to ensure the same throughput of patients. The service provided a more intensive therapy and intervention that facilitates early discharge.

The urgent care centre at Northwick Park Hospital became a 24/7 service in April 2012. It is now sees almost half of the patients presenting at the A&E department and has increased the level of acuity that it sees easing the pressure on the ED. Harrow CCG will work with the provider to make improvements to the patient pathway and the services patients receive at the UCC.

Continuing healthcare

The relationship between NHS Trusts and local authorities was a significant element in the delivery of a pathway-based approach for care services. Joint working between health and social care staff is a vital component of improving the lives of vulnerable adults and children.

During 2012/13, NHS Harrow worked with Harrow Council on a number of issues relating to continuing care, including:

- improving planning and commissioning of continuing healthcare through health and well-being boards;
- Improving standards and quality of continuing healthcare packages; and
- co-ordinating the provision of continuing healthcare so that health and social care services complement each other

Key achievements include:

- The development and implementation of a multi-agency decision-making process within children's services to ensure a robust, transparent and fair system.
- Reviews of high cost packages through assessments of individual needs analysis of current price and comparison to a 'fair market price'. This work has delivered efficiencies as well as improved quality of care.
- A seven day a week service where the continuing healthcare team complete nursing care assessments with rapid access to packages of care and spot purchasing of short term care packages.

Public health initiatives in Harrow

Harrow's public health team undertook a wide ranging programme of initiatives to improve public health in Harrow. Key achievements of the team were:

- Smoking: the number of people who stopped smoking in 2012/13 increased and is on track to meet their target of 903 people.
- Successful walk your way to health programme: The walks scheme had over 400 regular walkers taking part in eight regular weekly walks and two monthly walks across the borough. In addition, two GP surgeries and one neighbourhood resource centre established regular walks. There is also a Nordic Walking programme that started at the end of last year – this has been expanded and now includes monthly taster sessions. Three volunteer Nordic Walking instructors have been trained using funding obtained from the Mayor of London's Legacy Fund.
- Successful exercise on referral programme: Harrow GPs referred people with health issues to undertake an exercise programme available through the public health team. Between April 2012 and Jan 2013, 545 over-weight people with existing long term conditions were registered with the exercise on referral programme.
- Expert patient programme: Over the year the capacity of the programme was increased through the provision of additional facilitators and by increasing the number of programmes per year from two to six. One of the reasons for this increase was partnership work with the local job centre. The job centre staff discussed the programme with their clients who had long term condition to help them get back in to work. Over 50 per cent of referrals to the expert patient programme come through the job centre.

- Long term conditions: a peer mentoring and peer education programme was introduced to support self-management of diabetes. Sixteen diabetes champions from within the diverse communities of Harrow were recruited and trained. These people worked at promoting awareness of diabetes in order to facilitate early diagnosis.
- Learning disability: an action plan to improve the health of people with a learning disability was developed as a result of the Big Health Day in June 2012.
- 59 people with severe mental health problems who needed special support were helped to become more active. The programme gained recognition as being an example of inclusion and excellence and was awarded the Inspire Mark in association with the 2012 Olympics.

Stakeholder engagement

Harrow CCG actively engaged with the public and patients to ensure their voices were heard in shaping healthcare services.

Following the large-scale stakeholder event in June 2012, a community cardiology pathway workshop for service users was arranged in November 2012, and was attended by over 30 patients. The workshop enabled patients to review a new community pathway for cardiology, engage directly with clinicians and feedback their views to the CCG.

As a result of patient feedback, a number of service improvement measures were proposed, including access to the service via choose and book, more consistent delivery of post-operative care and faster access to diagnostics with results on the day where possible. Overall, the participants found the workshop as a very positive step towards the CCG ensuring there is 'no decision about me, without me'. Similar patient workshops are planned for future care redesign projects.

The CCG also launched its website www.harrowccg.nhs.uk to provide an on line presence for providing information on the work and decisions of the CCG.

Shaping a healthier future

The Shaping a Healthier Future programme across North West London aims to improve healthcare for the two million people living in the area.

It is led by the clinical commissioning groups and clinicians who have seen first-hand the health inequalities and changing needs in the area. NW London has a growing and ageing population and at present specialists are too thinly spread over too many sites and some facilities are inadequate.

The aim of the programme is to ensure that the right care is delivered in the right places. Clinicians believe that more investment needs to be made in local healthcare so that it is of a more consistently high standard.

The Shaping a Healthier Future vision is to:

- Bring care nearer to patients' homes so people are encouraged to access care earlier and more regularly to identify diseases so they can be more successfully treated and to better manage long term conditions;
- Concentrate complex services (including A&Es) in five major hospitals in order to ensure senior doctors can be present at evenings and weekends as well as during the day and to improve the safety and quality of services. Other sites would become local hospitals and elective hospitals, while specialist hospitals would remain largely as they are;
- Develop a more co-ordinated, seamless system that works better to keep people well and independent in the community, improves their quality of life and not just the quality of care they receive and relieve pressures on NHS services.

All nine current acute hospitals in North West London (Charing Cross Hospital, Chelsea and Westminster Hospital, Central Middlesex Hospital, Ealing Hospital, Hammersmith Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital) would continue to provide local hospital services, including a 24/7 urgent care centre (UCC) and outpatient and diagnostic services. These UCCs would be able to treat most illnesses and injuries that people go to hospital for. Those who do need to go to an A&E would generally dial 999 and an ambulance would take them to the nearest major hospital. On average this would take no more than six minutes longer than it does currently.

In determining which hospitals should become major hospitals, the programme assessed the options in great detail, looking at which would deliver the best clinical quality of care and access to care, whether they were affordable and could be delivered, and which would be best for research and education. This resulted in three options that were consulted on, including one preferred option.

Between 2 July and 8 October 2012, the programme ran a public consultation, attending over 200 meetings; arranging two road shows in all eight boroughs plus additional road shows in the neighbouring boroughs of Camden, Richmond and Wandsworth; sending over 73,000 consultation documents out to libraries, doctors' surgeries, pharmacies, hospitals, town halls; and taking part in three major public debates.

Clinicians and managers considered all consultation responses and reconsidered the proposals in light of all the issues and concerns. A number of changes were made to the proposals as a result of issues raised during the consultation. The final recommendations were discussed at a meeting of the Joint Committee of Primary Care Trusts (JCPCT) which represented the eight primary care trusts in North West London.

At this meeting the JCPCT unanimously agreed to give the go ahead to:

- investing over £190m more in out of hospital care to improve community facilities and the care provided by GPs and others across NW London.
- investing in five major hospitals at Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and West Middlesex.

- developing two hospitals – Central Middlesex and Hammersmith – as hospitals specialising in elective or planned care (for example, pre-planned procedures such as hip operations), as well as having a 24/7 urgent care centre.
- looking at further proposals for Ealing and Charing Cross hospitals, which were originally going to be local hospitals (also with urgent care centres) but may now have more services put into them, depending on further planning and costing work.

This is a large programme of change and final implementation will take between three – five years in total. Improvements to services outside hospital – such as GP and other local NHS facilities in the community – will happen first. The major changes to hospital will not happen until these community facilities have first been improved.

More detail can be found on the Shaping a Healthier Future website at www.healthiernorthwestlondon.nhs.uk

Compliments and complaints

Complaints are an important source of feedback on the quality of local health services. A national complaints process applies to all NHS organisations and seeks to provide complainants with an explanation and address their concerns The NHS always seeks to learn from complaints and improve procedures to prevent problems being repeated. The NHS complaints procedure adheres to the principles of remedy published by the Parliamentary and Health Service Ombudsman.

In 2011/12 NHS Harrow received a total of 74 complaints (compared to 65 in 2010/11). These related to primary care services including general practice, dentists, optometrists and pharmacists.

Informal complaints and concerns raised though the Patient Advice and Liaison Service were also a useful source of information on the quality of service local people receive from the NHS.

Emergency planning

The 2004 Civil Contingencies Act (CCA) provides the framework for national civil protection and emergency planning. It outlines the duties, roles and responsibilities required for local responders to deal with the efforts of serious emergencies and major incidents. Primary care trusts were defined as category one responders and are therefore responsible for complying with the six key elements of the CCA.

Emergency preparedness resilience and recovery was a cluster function in North West London, with the eight boroughs of Ealing, Hammersmith & Fulham, Westminster, Kensington & Chelsea, Hillingdon, Hounslow, Brent and Harrow served by a joint team. The team possessed a wealth of local knowledge developed over

many years of responding, planning and exercising with local responders in the health community and local authorities.

There were a number of major national events that the emergency planning team were involved in during 2012/13. The team were integral members of the planning in North West London for the Diamond Jubilee and the Olympics and Paralympic Games, ensuring and assuring that the health providers and commissioned services within the cluster could deliver all critical services should an incident happen.

The team also supported NHS North West London, community providers, mental health, acute trusts and the directly commissioned services to develop business continuity procedures. The on-call system was reviewed and revised and all staff participating in the on-call rota received training on the process that had been put in place. An extensive training programme was delivered to primary care, specifically in relation to hazardous materials. The team delivered various training sessions throughout the health community, tailored to meet individuals' needs, focusing on the organisation's ability to respond and recover should an incident occur. The emergency planning function transferred to NHS England early in 2013.

The legacy of the North West London emergency planning team is a comprehensive, detailed portfolio of emergency plans to support the response and recovery of the health community should an incident occur.

Taking care of our environment

A North West London-wide waste strategy was introduced which focused on increasing recycling rates, thus saving money by reducing the amount of waste being sent to landfill (ie saving on landfill tax). Throughout the year recycling was introduced to sites that had not previously had any, and recycling rates steadily improved.

Several initiatives throughout NW London were invested in, including the installation of more remotely monitored meter readers at health centre and clinic sites across the cluster, which allowed regular monitoring of electricity and gas consumption data. Anomalies are spotted more effectively and irregular usage investigated and managed. Energy efficient lighting was installed in some sites and wherever boiler replacement was carried out, they were replaced with the most energy efficient model possible.

A travel survey was conducted during the year to ascertain staff travel habits and included calculating the carbon footprint of individual staff which encouraged them to look at how they could change their travel arrangements. Cycle maintenance kits were provided at various sites where there were a high percentage of cyclists and these kits could be used for basic maintenance work.

New contract clauses were developed, including key performance indicators, to ensure that all provider contracts include sustainability as standard. Display energy certificates (DECs) were put in place in buildings where there is a legal requirement to display one.

Utility contracts were renegotiated within the Office of Government Commerce framework, thus providing stability for the next two years. New contracts included the purchase of some green energy as part of the commitment to carbon reduction.

Breaches of data protection

There was one breach of data protection reported by NHS Harrow in 2012/13. Patient identifiable data was sent via non secure email to both secure and non-secure email addresses**.** After a full investigation the following lessons for improvement were identified.

- Ensure all GPs, practice staff and provider staff have up to date information governance toolkit training.
- All staff should ensure that the person they send patient identifiable data to has a legitimate reason for receiving that data.
- All staff are mindful of the risk that documents they receive or send may have patient level data
- Staff working with and providing patient level data must use nhs.net email addresses in line with the PCT acceptable use of email policy
- 'Automatic' email addresses are deleted from systems
- Reconfiguration of spreadsheet data to ensure patient level data is produced separately from summary data and only shared on a need to know basis.
- CCG members are aware that when opening excel documents they need to look at all tabs before working with or sharing the document.
- Learning from the incident was flagged up at the practice manager and GP forums and shared with relevant providers

About our workforce

Following the introduction of a single management structure across the eight PCTs, an effective working partnership with staff trade unions was established. This helped to collectively address the challenges of working through the transition to nine separate organisations, as well as the transfer of public health teams to their respective local authorities, and the movement of other staff to other NHS organisations.

The cluster chief executive and her senior team held regular staff briefings across the PCTs to facilitate engagement and discussion with employees about the transition process. Dedicated newsletters and 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 coming into place in 2013.

A consultation with staff and staff side representatives took place on structures for the commissioning support unit (CSU) and CCGs, and on the matching and recruitment process for the CSU.

Staff were supported throughout the transition period, and given CV and interview training in order to fully prepare themselves for job interviews where they were not matched across to similar roles in the new organizations. Staff that were unable to secure roles in the new structures in NW London were encouraged and supported to find roles elsewhere either in other NHS organisations or more widely.

Equality and diversity and disabled employees

Equality is not solely a minority issue - it is important for everyone and directly or indirectly affects the whole population.

NHS Harrow served a diverse population and had a wide staff demographic. As a large employer and as a commissioner of services, it remained constantly committed to promoting diversity and equality by eliminating discrimination and complying fully with the statutory duties under the single equality scheme.

Staff sickness absence	2012/13	2011/12
Total days lost	1,523	3,029
Total staff years	238	3.75
Average working days lost	6.4	8.08

Note: These figures are based on calendar year and not financial year. Total Staff Years relates to the number of Whole Time Equivalents in post during the calendar year. The staff sickness figures are for the merged management structure for Brent and Harrow PCTs including staff on secondment.

The Treasury requires NHS bodies to publish information on off payroll engagements. Information on the off payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012 is not available to the PCT.

Information on all new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months is set out below, based on information collated by the Human Resources department at NHS North West London cluster.

Heading	FTE
No. of new engagements	1
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	1
Of which:	
No. for whom assurance has been accepted and received	1
No. for whom assurance has been accepted and not received	0
No that have been terminated as a result of assurance not being received	0
Total	1

Statement of the responsibilities of the signing officer of the primary care trust 2012/13 accounts

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

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

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

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

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

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

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

Signed.....

Date.....

Richard Douglas
Signing Officer

Annual governance statement

The annual governance statement is included with the full annual accounts which are available on the website of the Harrow Clinical Commissioning Group at www.harrow.nhs.uk .

Charging for information and principles of remedy

A statement that the entity has complied with Treasury's guidance on setting charges for information is required. This guidance is available as *Appendix 6.3 to Treasury's MPM.* In the unlikely event that an entity has not complied with this guidance (e.g. on commercial sensitivity grounds), the Department of Health should be consulted.

NHS bodies are required to include a reference in their annual reports to *Principles for Remedy* and state to what extent such principles have been adopted by the body and form part of its complaints handling procedure.

Summary financial statement

Primary care trusts were required to achieve three statutory financial duties. NHS Harrow's performance against each is summarised below:

- Revenue Resource Limit (RRL) – to contain revenue expenditure within the notified revenue resource limit of £372.4m. For 2012/13 the PCT achieved a surplus of £3.2m against the RRL.
- Capital Resource Limit (CRL) – to contain capital expenditure within the notified capital resource limit of £1.4m For 2012/13 the PCT achieved a surplus of £0.8m against the CRL.
- Cash Limit – to contain receipts and payments within the annual cash limit published by the Department of Health of £373.6m. Compared to its cash limit the PCT underspent by £6.6m

Achievement of the surplus against the revenue resource limit was only achieved with the £14.6m of planned support from NW London cluster. As a result the external auditors have issued a qualified VFM opinion as a result of lack of financial resilience.

Further details of the PCT's performance against its statutory and other financial duties are set out below in the summary financial statements.

Jonathan Wise
Director of Finance
23rd May 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**6,692**	5,160
Other costs	**371,493**	371,814
Income	**(11,072)**	(9,477)
Net operating costs before interest	**367,113**	367,497
Investment income	**(30)**	(11)
Other (Gains)/Losses	**0**	30
Finance costs	**2,125**	445
Net operating costs for the financial year	**369,208**	367,961
Transfers by absorption -(gains)	**0**	
Transfers by absorption - losses	**0**	
Net (gain)/loss on transfers by absorption	**0**	
Net Operating Costs for the Financial Year including absorption transfers	**369,208**	**367,961**
Of which:		
Administration Costs		
Gross employee benefits	**6,408**	5,160
Other costs	**7,003**	9,505
Income	**(2,331)**	(2,416)
Net administration costs before interest	**11,080**	**12,249**
Investment income	**(30)**	(11)
Other (Gains)/Losses	**0**	30
Finance costs	**331**	341
Net administration costs for the financial year	**11,381**	**12,609**
Programme Expenditure		
Gross employee benefits	**284**	0
Other costs	**364,490**	362,309
Income	**(8,741)**	(7,061)
Net programme expenditure before interest	**356,033**	**355,248**
Investment income	**0**	0
Other (Gains)/Losses	**0**	0
Finance costs	**1,794**	104
Net programme expenditure for the financial year	**357,827**	**355,352**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**337**	1,236
Net (gain) on revaluation of property, plant & equipment	**(287)**	(413)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**369,258**	**368,784**

Statement of Financial Position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**12,764**	12,706
Intangible assets	**0**	0
investment property	**0**	0
Other financial assets	**76**	79
Trade and other receivables	**0**	0
Total non-current assets	**12,840**	12,785
Current assets:		
Inventories	**0**	0
Trade and other receivables	**914**	2,202
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**666**	25
Total current assets	**1,580**	2,227
Non-current assets held for sale	**0**	0
Total current assets	**1,580**	2,227
Total assets	**14,420**	15,012
Current liabilities		
Trade and other payables	**(26,493)**	(32,339)
Other liabilities	**0**	0
Provisions	**(11,249)**	(449)
Borrowings	**(165)**	(166)
Other financial liabilities	**0**	0
Total current liabilities	**(37,907)**	(32,954)
Non-current assets plus/less net current assets/liabilities	**(23,487)**	(17,942)
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(81)	(3,165)
Borrowings	(4,853)	(5,019)
Other financial liabilities	0	0
Total non-current liabilities	**(4,934)**	(8,184)
Total Assets Employed:	**(28,421)**	(26,126)
Financed by taxpayers' equity:		
General fund	(35,030)	(32,785)
Revaluation reserve	6,609	6,659
Other reserves	0	0
Total taxpayers' equity:	**(28,421)**	(26,126)

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(367,113)**	(367,497)
Depreciation and Amortisation	**536**	2,054
Impairments and Reversals	**0**	298
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(331)**	(341)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**1,288**	2,108
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(5,633)**	6,595
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(5,155)**	(519)
Increase/(Decrease) in Provisions	**11,077**	376
Net Cash Inflow/(Outflow) from Operating Activities	**(365,331)**	**(356,926)**
Cash flows from investing activities		
Interest Received	**30**	11
(Payments) for Property, Plant and Equipment	**(857)**	(62)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	0
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**2**	2
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(825)**	**(49)**
Net cash inflow/(outflow) before financing	**(366,156)**	**(356,975)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(166)**	(154)
Net Parliamentary Funding	**366,963**	357,113
Capital Receipts Surrendered	**0**	0
Capital grants and other capital receipts	**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**366,797**	**356,959**
Net increase/(decrease) in cash and cash equivalents	**641**	**(16)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**25**	**41**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**666**	**25**

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(32,785)**	**6,659**	**0**	**(26,126)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(369,208)			**(369,208)**
Net gain on revaluation of property, plant, equipment		287		**287**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(337)		**(337)**
Movements in other reserves			0	**0**
Transfers between reserves*	0	0		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(369,208)**	**(50)**	**0**	**(369,258)**
Net Parliamentary funding	366,963			**366,963**
Balance at 31 March 2013	**(35,030)**	**6,609**	**0**	**(28,421)**
Balance at 1 April 2011	**(21,962)**	**7,484**	**0**	**(14,478)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(367,961)			(367,961)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		413		413
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		(1,236)		(1,236)
Movements in other reserves			0	0
Transfers between reserves*	25	(25)		0
Release of Reserves to Statement of Comprehensive Net Expenditure		23		23
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(367,936)	(825)	0	(368,761)
Net Parliamentary funding	357,113			357,113
Balance at 31 March 2012	**(32,785)**	**6,659**	**0**	**(26,126)**

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		367,961
Net operating cost plus (gain)/loss on transfers by absorption	**369,208**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**372,460**	368,111
Under/(Over)spend Against Revenue Resource Limit (RRL)	3,252	150

Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**1,445**	255
Charge to Capital Resource Limit	**644**	255
(Over)/Underspend Against CRL	**801**	**0**

Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**366,963**	357,113
Cash Limit	**373,593**	369,055
Under/(Over)spend Against Cash Limit	**6,630**	**11,942**

Reconciliation of Cash Drawings to Parliamentary Funding (current year)	2012-13 £000
Total cash received from DH (Gross)	324,600
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**324,600**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	7,458
Plus: drugs reimbursement (central charge to cash limits)	34,905
Parliamentary funding credited to General Fund	**366,963**

Audit arrangements

External audit services during 2012/13 were provided to NHS Harrow by Deloitte. Audit fees paid to the organisation's external auditors amounted to £90,000 plus VAT in respect of the following services:

Audit services (the statutory audit and related services) – £90,000.

Better payment practice code

This code requires the PCT to pay all valid invoices within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier. The extent of the PCT's compliance with the code is summarised below:

Measure of compliance	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**11,288**	**44,738**	10,643	37,036
Total Non-NHS Trade Invoices Paid Within Target	**10,719**	**43,689**	10,034	35,027
Percentage of Non NHS Trade Invoices Paid Within Target	94.96%	97.65%	94.28%	94.58%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,733**	**258,501**	3,977	251,336
Total NHS Trade Invoices Paid Within Target	**3,551**	**253,870**	3,751	250,462
Percentage of NHS Trade Invoices Paid Within Target	95.12%	98.21%	94.32%	99.65%

NHS Harrow is an approved signatory of the prompt payment code. This is a government initiative to tackle the issue of late payment in the UK. Approved signatories undertake to:

- pay suppliers on time; and
- give clear guidance to suppliers.

Related party transactions

During the year none of the board members or members of the key management staff or parties related to them has undertaken any material transactions with NHS Harrow. The following related party transactions were reported by the shadow clinical commissioning board that relate to NHS Harrow. The general medical services (GMS) payments shown below relates to services provided by the practice which the shadow clinical commissioning member is a partner rather than payments to shadow clinical commissioning members themselves. The payment is the total

paid to the practices as a whole before taking into account practice expenses in delivering services .

	Payments to Related Party	
	2012/13	**2011/12****
HARROW CLINICAL COMMISSIONING BOARD		
Dr A Kelshiker *	2,960,751	1,956,824
Dr D Patel *	532,368	374,301
Dr G Small *	1,715,584	1,535,552
Dr K Karia *	585,458	437,514
Dr K Rajani *	739,324	513,679
Dr L Gould *	1,351,162	943,983
Dr I Sayed ***		

* The practices which the above are partners held shares in Harmoni Ltd which was sold during 2012/13 to Care UK, and the above practices are no longer shareholders. They also hold shares in Harrow Health Ltd and both companies had dealings with Harrow PCT in 2012/13.

** The 2011/12 Figures relate to 9 months only (from July 2011).
*** Dr I Sayed commenced July 2012 and is a salaried GP with Harrow Health Ltd.

During 2012/13 Harmoni was awarded the tender to provide the NHS 111 service on behalf of Hounslow, Ealing, Brent and Harrow PCT's from March 2013. None of the GPs named above sat on the procurement panel. The tender approval was provided by the North West London Cluster Board.

Members of the cluster board with related party transactions include Sarah Cuthbert whose husband is a Partner in Deloitte. Deloitte are external auditors for Hillingdon and Harrow PCTs and also have worked on 'Shaping a Healthier Future' during the year. Mark Spencer held shares with Harmoni Ltd.

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

	Income	Expenditure	Receivables	Payables
A Primary Care Trusts	**£'000**	**£'000**	**£'000**	**£'000**
Brent PCT	143	130	58	237
Westminster PCT	311	2,214	0	231
Croydon PCT	-	21,454	0	99
B Trusts				
North West London Hospitals NHS Trust	100	99,183	63	359
Imperial College Hospitals NHS Trust	-	13,619	-	131
Barnet & Chase Farm Hospitals NHS Trust	-	6,026	-	46
Ealing Hospital Nhs trust	1,404	15,911	53	879
East And North Hertfordshire NHS trust	-	4,136		124
London Ambulance Services NHS Trust	-	5,817	-	8
West Hertfordshire Hospitals NHS Trust	-	3,248	-	60
B Foundation				
Central And North West London MH NHS Foundation Trust	323	23,737	297	1153
Moorfields Eye Hospital NHS Foundation Trust	-	5,823	-	415
Royal Brompton And Harefield NHS Foundation Trust	-	8,856	-	328
University College London NHS Foundation Trust	-	8,259	26	-
Royal Free Hospitals NHS Trust	-	5,105	4	-
D Others				
NHS London Strategic Health Authority	1,253	-		
E Local Councils				
Harrow London Borough Council	3,941	2,715	2634	324

Remuneration report

Membership of the remuneration and terms of services committee

Membership of the remuneration and terms of services committee was:

- Martin Roberts, Non-Executive Director (Chair)
- Jeff Zitron, Non-Executive Director
- Trish Longdon, Non-Executive Director
- Arif Kamal, Non-Executive Director

The committee advised the board on appropriate remuneration and terms of service for the chief executive and trust directors. The committee monitored and evaluated the performance of the chief executive, directors and individual officer members of the professional executive committee – having proper regard to the PCT's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

The committee reported the basis for its recommendations to the board which used the committee's report as the basis for its decisions on remuneration. However, the board remained accountable for taking final decisions on the remuneration and terms off service for the chief executive and trust

Directors

For directors' pay increases, the following factors were considered:

- current national market rates of comparable director posts;
- the individual performance of directors;
- internal comparators;
- changes to director portfolios;
- NHS pay awards for other staff groups;
- any national guidance relating to maximum pay bill increases;
- significant recruitment and/or retention issues; and
- the financial position of the PCT.

Performance measurement

Directors' performance was appraised on an annual basis by the chief executive. The chief executive's performance was appraised on an annual basis by the chief executive of the former strategic health authority, in this case NHS London.

Summary and explanation of policy on duration of contracts, and notice periods and termination payments

Senior managers were permanent employees of the PCT, and in the event of redundancy, they were subject to standard NHS severance packages.

Cluster Board

		2012/13		
		Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (bands of £1000) £000
Chair & Non Executives				
J Zitron	2	40-45		
T Longdon	2	10-15		
E Rantzen	2	10-15		
F Cass	2	10-15		
S Cuthbert	4	10-15		
A Kamal	3	5-10		
C Somani	3	10-15		
M Roberts	4	5-10		
Directors				
A Rainsberry: Chief Executive	1	165-170		
D Elkeles: Director of Strategy/Chief Officer designate, CWHH CCGs	2	120-125		
R Larkman: Chief Officer designate BEHH CCGs (from 1 October 2012)	6	70-75		
C Parker: Director of Finance, Hammersmith and Fulham, Hounslow, Kensington and Chelsea and Westminster PCTs (from 1 October 2012)	5	55-60		
D Slegg: Director of Finance (until 30 September 2012)	4	70-75		
J Wise: Director of Finance, Brent, Ealing, Harrow and Hillingdon PCTs (from 1 October 2012)	3	60-65		
S Weldon: Director of Commissioning and Performance (until 30 September 2012)	2	60-65		
M Spencer: Medical Director	2	85-90		
A Howe: Director of Public Health	3	120-125		
D Chaffer: Director of Nursing (until 30 June 2012)	2	30-35		
J Webster: Acting Director of Nursing (from 1 July 2012)	4	70-75		

The Cluster Board came into effect from 1st April 2012 and therefore there are no comparatives shown.

1 Employed by NHS London and no recharge of costs made to Cluster
2 Employed by Inner Cluster comprising Hammersmith & Fulham, Kensington & Chelsea and Westminster
3 Employed by Brent and Harrow PCT's
4 Employed by Outer Cluster comprising of Ealing, Hillingdon and Hounslow PCT's
5 Employed by NHS Islington and no recharge of costs made to Cluster
6 Employed by NHS Camden and recharged to Brent & Harrow PCT's

Senior managers' remuneration

NHS Harrow is required to disclose the relationship between the remuneration of the highest-paid director and the median remuneration of the organisation's workforce The calculation for the median remuneration does not include agency employees covering vacancy staff as this information is impracticable to retrieve.

The banded remuneration of the highest paid director in Harrow PCT in the financial year 2012-13 was £93,721 (2011-12, £93,721). This was 7.1 times (2011-12, 5.8) the median remuneration of the workforce, which was £13,228 (2011-12, £15,023).

In 2012/13, zero (2011/12, zero) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £5,093 to £88,180 (2011/12 £7,008-£85,853)

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

Cluster arrangements

The eight PCTs in North West London – NHS Brent, NHS Ealing, NHS Hammersmith & Fulham, NHS Harrow, NHS Hillingdon, NHS Kensington & Chelsea and NHS Westminster – operated collectively under a cluster arrangement from 1 April 2012 to 31 March 2013.

The costs of the shared posts remained with their employing PCT. The proportion of remuneration for NHS Harrow is set out below.

SALARIES AND ALLOWANCES		2012/13			2011/12		
Name and Title	Note	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (bands of £1000) £000	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (bands of £1000) £000
Non Executives							
Mr C Somani		0-5			0-5		
Mr A Kamal		0-5			0-5		
Executive Directors							
Mr R Larkman	1	50-55			50-55		
Mr J Wise		45-50			40-45		0-5
Dr A Howe		120-125			115-120		

1. On secondment from Camden PCT

Clinical commissioning group

The Health and Social Care Act 2012 sets out the new structures for the commissioning of NHS services. This saw primary care trusts dissolved on 1 April 2013 and replaced by GP-led clinical commissioning groups (CCGs).

There were eight CCGs created in North West London:

- NHS Brent CCG
- NHS Central London (Westminster) CCG
- NHS Ealing CCG
- NHS Hammersmith and Fulham CCG
- NHS Harrow CCG
- NHS Hillingdon CCG
- NHS Hounslow CCG
- NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

The NW London CCGs operated in shadow form from 1 October 2012, with the following responsibilities:

- ensure a rigorous assurance and reporting process during the shadow period from 1 October 2012 – 31 March 2013.
- agree governance that reflects new responsibilities.
- liberate CCGs to lead 13/14 commissioning round whilst providing effective support.
- support development of CCGs proactive risk management.
- fully align with national guidance - Nolan Principles.
- clarify accountability and responsibility – reflecting London changes.
- ensure CCGs governance is capable of receiving relevant PCTs Committee business.
- continue resource shift to enable CCGs capacity and capabilities.
- reduce complexity and avoid duplication – adding value not work.
- build on well developed arrangements to manage a safe and orderly transition and closure programme.

The membership of the shadow Harrow Clinical Commissioning board was as follows.

SALARIES AND ALLOWANCES		2012/13			2011/12		
Name and Title	Note	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (bands of £1000) £000	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (bands of £1000) £000
Non Executives							
Mr C Somani		0-5			0-5		
Mr G Zeidman		5-10			0-5		
Mr S Dighe		5-10			0-5		
Executive Directors							
Mr R Larkman	1	50-55			50-55		
Mr J Wise		45-50			40-45		0-5
Ms J Seghal from Aug 2011 Borough Director		90-95			55-60		
Ms T Sawtell - Borough Director from Jan 2011 - August 2011.					30-35		
Harrow CCB							
Dr K Karia		30-35			30-35		
Dr G Small		30-35			20-25		
Dr Amol Kelshiker		60-65			35-40		
Dr Lawrence Gould		30-35			30-35		
Dr Kanesh Rajani		35-40			30-35		
Dr D Patel		35-40			25-30		
Dr I Sayed	2	25-30			0		

1. On secondment from Camden PCT
2. Commenced 1st July 2012

Pension Benefits

Cluster Board

		Real Increase in pension at age 60 and related lump sum (bands of £2,500)		Total accrued pension at age 60 and related lump sum (bands of £5,000)		Cash Equivalent Transfer Value			
		Pension	Lump Sum	Pension	Lump Sum	at 31 March 2012	at 31 March 2013	Real increase	Employer's contribution to growth in CETV for the year
		£000	£000	£000	£000	£000	£000	£000	£000
A Rainsberry: Chief Executive	1	0	0	55-60	165-170	880	940	14	10
D Elkeles: Director of Strategy/Chief Officer designate, CWHH CCGs	2	0-2.5	2.5-5	20-25	60-65	242	281	27	19
R Larkman: Chief Officer designate BEHH CCGs (from 1 October 2012)	6	0-2.5	2.5-5	35-40	105-110	644	751	36	25
C Parker: Director of Finance, Hammersmith and Fulham, Hounslow, Kensington and Chelsea and Westminster PCTs (from 1 October 2012)	5	0-2.5	0-2.5	20-25	70-75	297	324	6	4
D Slegg: Director of Finance (until 30 September 2012)	4	2.5-5	5-10	65-70	195-200	1216	1439	80	56
J Wise: Director of Finance, Brent, Ealing, Harrow and Hillingdon PCTs (from 1 October 2012)	3	0-2.5	5-7.5	45-50	140-145	747	878	46	32
S Weldon: Director of Commissioning and Performance (until 30 September 2012)	2	0-2.5	2.5-5	20-25	70-75	309	378	26	19
M Spencer: Medical Director	2	0	0	50-55	155-160	948	1021	23	16
A Howe: Director of Public Health	3	0-2.5	2.5-5	25-30	85-90	453	519	42	30
D Chaffer: Director of Nursing (until 30 June 2012)	2	0-2.5	0-2.5	30-35	90-95	544	611	10	7
J Webster: Acting Director of Nursing (from 1 July 2012)	4	0-2.5	5-7.5	25-30	85-90	389	467	44	31

The pension costs of the shared posts remained with their employing PCT. The proportion of pension costs for NHS Harrow is set out below.

PENSION BENEFITS	Real Increase in pension at age 60 and related lump sum		Total accrued pension at age 60 and related lump sum		Cash Equivalent Transfer Value			
Name and Title	(bands of £2,500)		(bands of £5,000)					
	Pension	Lump Sum	Pension	Lump Sum	at 31 March 2012	at 31 March 2013	Real increase	Employer's contribution to
	£000	£000	£000	£000	£000	£000	£000	£000
Executive Directors								
Rob Larkman	0-2.5	2.5-5	10-15	40-45	244	285	28	19
Mr J Wise	0-2.5	2.5-5	15-20	50-55	284	334	35	25
Dr A Howe	0-2.5	2.5-5	25-30	85-90	453	519	42	30

The pension details for the Shadow Clinical Commissioning Board was as follows.

PENSION BENEFITS	Real Increase in pension at age 60 and related lump sum		Total accrued pension at age 60 and related lump sum		Cash Equivalent Transfer Value			
Name and Title	(bands of £2,500)		(bands of £5,000)					
	Pension	Lump Sum	Pension	Lump Sum	at 31 March 2012	at 31 March 2013	Real increase	Employer's contribution to
	£000	£000	£000	£000	£000	£000	£000	£000
Executive Directors								
Rob Larkman	0-2.5	2.5-5	10-15	40-45	244	285	28	19
Mr J Wise	0-2.5	2.5-5	15-20	50-55	284	334	35	25
Ms Javina Sehgal	0-2.5	0	5-10	0	58	80	18	13

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in other pension scheme or arrangement when a member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the

employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Exit packages

Department of Health Guidance required the exit package of an individual who works for more than one organisation to only appear in one set of accounts, therefore as Harrow does not have a payroll any exit packages relating to Harrow have been disclosed in Brent's Accounts

PCT running costs

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,711**	9,650	2,061
Weighted population (number in units)*	**200,605**	200,605	200,605
Running costs per head of population (£ per head)	**58**	**48**	**10**
PCT Running Costs 2011-12			
Running costs (£000s)	**12,843**	11,426	1,417
Weighted population (number in units)	**200,605**	200,605	200,605
Running costs per head of population (£ per head)	**64**	**57**	**7**

* 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

Independent auditor's statement

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER OF HARROW PRIMARY CARE TRUST

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and the notes on Financial Balance, Post Balance Sheet Events, Running Costs and Audit.

This report is made solely to the Accountable Officer for Harrow Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. Our audit work has been undertaken so that we might state to the Primary Care Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Primary Care Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

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

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

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

Opinion

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

Craig Wisdom (Engagement Lead)
for and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom

6 June 2013
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Contact details

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Department of Health

NHS

Harrow Primary Care Trust

2012-13 Accounts

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Harrow Primary Care Trust

2012-13 Accounts

Harrow Primary Care Trust
Governance Statement 2012-2013

1.	**Introduction**
	I am assured by the former Chief Executive of Harrow PCT (5K6) who was the Accountable Officer responsible for ensuring the proper stewardship of public funds and assets and who was accountable for the overall performance of the executive functions of the PCT, that the work of ensuring the discharge of obligations under Financial Directions was carried out in line with the requirements of the Accountable Officer Memorandum for PCT Chief Executives issued by the Department of Health. I am assured by the Accountable Officer that she has carried out her responsibilities which included ensuring the following: • management systems for safeguarding public funds and assets and assisting in the implementation of corporate governance have been properly maintained; • achievement of value for money with the resources available; • expenditure and income were properly accounted for; and • effective and sound financial management systems were in place. I am assured by the former Accountable Officer who was accountable to the Chair and Non-Executive members of the PCT Board for ensuring that its decisions were implemented, that the organisation worked effectively in accordance with Government policy and public service values, and maintained proper financial stewardship. Within the Standing Financial Instructions, it was acknowledged that the Chief Executive was ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the PCT Board met its obligation to perform its functions within the available financial resources. The former Chief Executive and Accountable Officer had overall executive responsibility for the PCT's activities and the achievement of its objectives; responsibility to the Chair and the PCT Board for ensuring that its financial obligations and targets were met and had overall responsibility for the PCT's system of internal control. The essence of that role as Accountable Officer was to ensure that the Trust carried out these functions in a way which ensured the proper stewardship of public money and assets. Effective and sound financial management and information are of fundamental importance. I am assured by the former the Accountable Officer that this occurred. The system of internal control has been in place at Harrow PCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts. With these assurances from the former Accountable Officer I have signed the Summarised Accounts of Health Bodies in England, and the Resource Accounts of the Department of Health. The Summarised Accounts are derived from the statutory accounts of the PCT. Together with the Director of Finance, the former Accountable Officer was responsible for ensuring that the accounts of the PCT were prepared under principles and in a format directed by the Secretary of State with the approval of the Treasury. Robust arrangements were put in place for the preparation and audit of the accounts of the PCT following closedown of North West London PCTs as statutory bodies. These arrangements are in line with Department of Health Guidance for financial closedown. A local delivery team was secured to prepare the accounts and a sub-committee of the Department of Health Audit and Risk Committee was established to review the accounts with retained non executive directors, the Director of Finance, the external and internal auditors and myself.

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

From April 2011, the PCT entered into a collaborative arrangement with other PCTs in North West London and has undergone significant structural and organisational change.

The "Cluster" of NHS North West London was formed from eight PCTs: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster. The Strategic Health Authority confirmed the "Cluster" was compliant with Primary Care Trust regulations and Primary Care Trust Cluster Implementation Guidance. The Strategic Health Authority reviewed the Corporate Governance Framework outlining the shared working arrangements that was agreed by the PCT Board in February 2011 and confirmed it as compliant with PCT regulations and PCT Cluster Implementation Guidance.

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

2. **Governance Framework – NHS North West London**

The PCT was part of a group of eight constituent PCTs which made up the NHS North West London Cluster which was the largest group of Primary Care Trusts in London with a population of 1.9 million and a budget of £3.4 billion which represented 24% of health expenditure in London. The eight PCTs that collaborated were: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster.

The governance arrangements from 1 April 2012 to 31 March 2013 changed from the previous year in line with the Department of Health guidance for PCT clustering. With effect from 1 April 2012 the eight PCTs' Board which was the NHS North West London Cluster Board have had a membership in common and have met in common, in practice operating as a single NWL Cluster Board. The eight PCTs continued to retain their statutory accountability for all duties, functions and responsibilities under NHS regulations and take decisions relating to individual PCTs where required by the relevant regulations. These arrangements were ratified at the Boards' meeting in common on 10 April 2012 and incorporated into a set of Standing Orders, Standing Financial Instructions and Scheme of Delegation. There was a single Accountable Officer for the eight PCTs, the Chief Executive Officer Dr Anne Rainsberry, and the Boards' Chairman was Jeff Zitron.

The following is the membership of the Cluster Board together with the attendance record at formal Board meetings:-

Seven Board meetings were held in the financial year 2012/13

Position	Name	Number of Board Meeting attended
Chairman	Jeff Zitron	**7/7**
Non-Executive Directors	Trish Longdon	**5/7**
	Elizabeth Rantzen	**6/7**
	Fergus Cass	**7/7**
	Sarah Cuthbert	**6/7**

	Arif Kamal	**7/7**
	Chandresh Somani	6/7
	Martin Roberts	6/7
Chief Executive	Anne Rainsberry	6/7
Director of Strategy/Chief Officer designate, CWHH CCGs	Daniel Elkeles	6/7
Chief Officer designate BEHH CCGs (from 1 October 2012)	Rob Larkman	2/3
Director of Finance, Hammersmith and Fulham, Hounslow, Kensington and Chelsea and Westminster PCTs (from 1 October 2012)	Clare Parker	3/3
Director of Finance (until 30 September 2012)	David Slegg	4/4
Director of Finance, Brent, Ealing, Harrow and Hillingdon PCTs (from 1 October 2012)	Jonathan Wise	3/3
Director of Commissioning and Performance (until 30 September 2012)	Simon Weldon	3/4
Medical Director	Mark Spencer	5/5

3. **Board Performance**

A survey of Board members was carried out at the end of 2011/12, which included positive feedback on the chairing and administration of the meetings. The main concerns expressed were over the quantity of business in the context of the rapid change underway in the NHS. During 2012/13 the Board kept its business and governance arrangements under constant review in response to these concerns. The Board supported the implementation of an Interim Operating Model and increasingly relied on the CCG Committee and its Sub Committees as they moved towards authorisation.

Training for Board members was carried out through Board Seminars and executive and non executive away days that were held on a regular basis. At these sessions members were briefed on areas relevant to the work of the PCTs which included interactive workshops for member participation into risk management (including a session on risk appetite), Shaping a Healthier Future and transition to the new NHS.

4. **Governance Framework**

The Cluster Board established the following committees between the eight PCTs:-

Joint Audit Committees
Joint Quality and Clinical Risk Committee
Joint Information Governance Committee
Joint Finance and Performance Committee
Joint Remuneration Committee
Joint Clinical Executive Committee
Joint Health and Safety Committee

The Cluster Board also established, in May 2012, a joint committee of the eight PCTs in North West London with Camden PCT, Richmond PCT and Wandsworth PCT to take decisions on Shaping a Healthier Future a programme set up to improve healthcare for the 1.9 million people in North West London.

	The PCT established the shadow Harrow Clinical Commissioning Group (CCG) Governing Body as a sub committee of the Cluster Board. In addition, the Cluster set up a number of supporting groups, including the following:- • Decision Making Group • Individual Funding Request (IFR) Group • Patient and Public Advisory Group Cluster Executive Team • Cluster Executive Team Terms of Reference were adopted by the Cluster Board for each of these Committees and Groups. In the light of the handover and transition to the new governance arrangements from April 2013 as determined by the Health and Social Care Act 2012, the Board has kept the Committees and their terms of reference under review during the year. From September the Governance Framework was supported by an Interim Operating Model of management designed to deliver in-year objectives and smooth transition to the new arrangements.
5.	**Committee Functions and Performance**
	The following is a summary of the Committee functions and performance: **Joint Audit Committee** The Committee was established in accordance with the guidance in the NHS Audit Handbook. It reviewed the financial management, governance, risk management and internal control in the PCTs and ensured they were adequate and effective. The Audit Committee met seven times during 2012/13 and at its initial meeting considered audit planning, priorities, working methods and the internal audit programme for the year. Regular reports were received on the overall financial position, risk management, counter fraud, internal and external audit and transition. The Committee paid particular attention to receiving assurance on the Joint Boards Assurance Framework, transition and handover and closure arrangements. In addition, the Committee received reports on IT, the Integrated Care Pilot and the review of recommendations from the NHS London report into NHS Croydon. At its final meeting the Committee agreed its Annual Report to the Board on its work during the year and reviewed the second draft of the Annual Governance Statement. **Joint Quality and Clinical Risk Committee** The Committee kept under review and required assurance on issues affecting the quality of services commissioned across NHS North West London, including patient safety, clinical effectiveness and patient experience. The Quality and Clinical Risk Committee met six times during 2012/13 and received regular reports on quality (quality exception reports), quality and clinical risk register, serious incidents and never events, revalidation, Organisational Health Intelligence reports, transition and handover and closure. The Committee paid particular attention to receiving assurance on action to improve clinical quality at Imperial College Healthcare NHS Trust and the handover and closure of quality and safety in accordance with the guidance issued by the National Quality Board. In addition, the Committee received reports on looked after children in Brent and Harrow, the "Savile" case and the Mid Staffordshire Inquiry. **Joint Information Governance Committee** The Joint Information Governance Committee was a standing group accountable to the North West London Cluster Executive Team. Its purpose was to support and drive the broader Information Governance ("IG") agenda and provide assurance that effective IG best practice mechanisms were in place within the North West London Cluster. The Information Governance Committee met eight times during 2012/13. Information governance risk was managed by reviewing progress towards IG toolkit submission reinforced by audit. Regular

reports were received on policies, the risk register, transition and records management.

Joint Finance and Performance Committee

The Committee undertook performance monitoring and oversight of Cluster-wide performance objectives to ensure that appropriate progress was made across NHS North West London. It ensured that progress was coordinated effectively and coherently between the Cluster (eight PCTs) and the eight Clinical Commissioning Groups (established as Committees of the relevant PCT) without unnecessary duplication. It supplemented the work of the Joint Audit Committee, which ensured that the statutory and regulatory requirements of the PCT functions were independently reviewed and assured. The Finance and Performance Committee met six times during 2012/13 and received regular reports on progress against finance and performance targets, risk register, transition and handover and closure. It paid particular attention to PCT Recovery Plans.

Joint Remuneration Committee

The Committee kept under review the remuneration and terms of service policy in NHS North West London and ensured that there was a consistent and fair approach to its application. The Remuneration Committee met 13 times during 2012/13 either in person or electronically in accordance with its terms of reference. The prime focus of its work was on employment and contractual issues relating to the transition to the new NHS with effect from 1 April 2013. The Committee considered a number of business cases for redundancy on grounds of organisational change and referred decisions to NHS London for ratification.

Joint Clinical Executive Committee

The Committee provided strong clinical leadership in developing a clinically robust and sustainable commissioning strategy, supporting the development of clinical commissioning, assuring clinical quality and leading communications with stakeholders. The Clinical Executive Committee met on a bi-monthly basis throughout the year. Its main focus of work was supporting emerging CCGs through the authorisation process and providing clinical input to the strategy *Shaping a Healthier Future in North West London.* The Committee also paid particular attention to the improvement of clinical care at Imperial College Healthcare NHS Trust and to the London Cancer Programme.

Joint Health & Safety Committee

The Committee kept under review and required assurance on issues affecting the health and safety requirements across NHS North West London Cluster. The Health and Safety Committee was established during the year and met six times during 2012/13. The focus of its work during the year was to assure itself that the PCT met its health and safety responsibilities, taking account of commissioned external reviews. It reviewed fire, health and safety and carbon reduction policies prior to endorsement by the Board. The Committee received regular reports on serious incidents, the risk register, implementation of mandatory training and premises assessment. It also received reports on the handover and closure of estates.

Harrow Clinical Commissioning Group Shadow Governing Body

The Committee undertook a range of functions on behalf of the PCT Board, including:-

a. commissioning functions for the practice patients of the members of the Group, and for those resident in the area of the emerging CCG who are not practice patients of any other emerging CCG for services commissioned on a practice patient basis; and commissions services required to be provided on an open access basis for all persons resident in the area of the emerging CCG
b. developed close links with the Borough of Harrow and participated in the development of

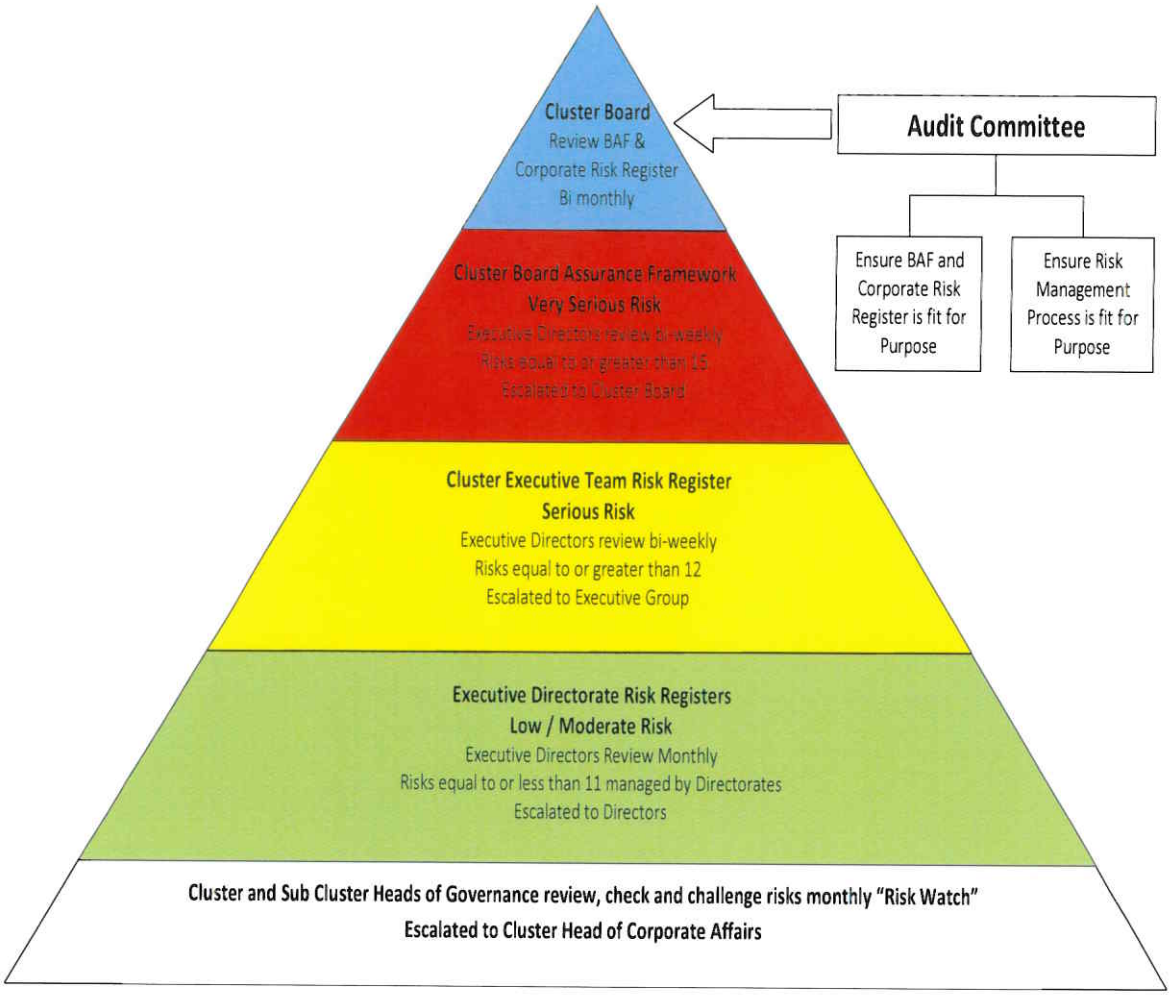
	joint strategic needs assessment for the borough and contributed to the Health and Well being board c. prepared the members of the Group for the submission of an application to the NHS Commissioning Board for Authorisation d. carried out such other functions as were required under the Accountability Agreement for the purpose of developing the competencies of a Clinical Commissioning Group. The Clinical Commissioning Group met regularly during 2012/13 and its prime focus was complying with national guidance in order to become authorised as a legal entity with effect from 1 April 2013. A substantial part of its work was the development of its constitution and governance arrangements, while at the same time discharging the commissioning responsibilities delegated to it by the Joint Boards. It set up its own Sub Committees to match key Cluster Committees in preparation for taking on its own statutory responsibilities with effect from April 2013. The CCG was authorised with conditions with effect from 1 April 2013 for which planned actions were in place for resolution..
6.	**Handover and Closure**
	The Board kept its arrangements under review throughout the year to ensure that it continued to address the following hierarchy of priorities in accordance with national guidance:- *1* Business as usual *2* Handover and Closure *3* Establishment of new arrangements The Board agreed to retain the existing committee structure but implemented an Interim Operating Model which ensured that there were clear accountability arrangements to secure in-year delivery and transition to the new system. The arrangements were formalised with changes to the membership of the Board with effect from 1 October 2012. Handover and closure was led by a Transition Director and supported by a Handover and Closure Operational Group (Star Chamber) comprising the leads of all the transition workstreams. Regular reports on progress on handover and closure were received at the Board, Audit Committee and Quality and Clinical Risk Committee. A Handover and Closure Risk Register was maintained and this fed into the Board Assurance Framework (BAF) in the same way as other risk registers. The BAF was shared with the emerging CCG, so that it could inform the development of the CCG's own risk management arrangements and BAF. The Board agreed in September that the Accountable Officer (designate) should review the CCG BAF and risk registers (including scrutiny of the BAF) and agreed that the CCG BAFs and Risk Registers would be reported to the relevant PCT Committee, so that assurance could be provided to the Board. The Audit Committee followed the development of the CCG BAFs and gained assurance that the emerging arrangements are likely to prove adequate and effective. At Joint Board and Committee level, the risk registers were made available to the CCGs so that they could determine their own risk management arrangements. The PCT adopted a practice of using handover certificates to formalise the handover of functions to successor bodies. The certificates included provision for the identification of outstanding issues and any risks which could impact on delivery in future if not adequately mitigated. These were designed to act as a trigger for discussion at handover meetings with receivers. This process gave the receiving organisation the information with which to assess risks against its own risk appetite and risk management strategy.
7.	**Framework for Financial Closedown**
	In accordance with national guidance, arrangements were put in place for financial closedown. This included:- • preparation and sign off of PCT accounts for 2012/13;

	• support for the completion of the Department's resource account; • transfer of closing balances to residual organisations; • management of local discharge of balances transferred to the Department; • management of payroll queries and other related payroll issues; and • handover of residual balances managed on behalf of the Department. The PCT Chief Executive and Director of Finance both secured posts in successor bodies but retained responsibility for financial closedown and the Accounts. Staff resources were secured to secure effective accounts preparation by means of agreement with successor organisations for staff who have secured employment and by means of staff appointments under the Retention and Exit Terms Scheme. In addition, staff resources were identified to transfer to, or be available to, the Legacy Management Office. For scrutiny and audit, existing arrangements for both internal and external audit encompassed the work associated with reviewing financial closedown and the completion of final accounts. All the Audit Committee members, whether they had roles in the new system or not, were asked and agreed to become members of an Audit Sub-Committee of the Department of Health Audit and Risk Committee to support the final accounts process.
8.	**Compliance with Corporate Governance Code**
	The Board of the PCT met in public and published Board Papers, agenda and minutes on their websites. The Board adhered to the "Nolan Principles" setting out the ways in which holders of Public Office behave in the discharge of their duties and as a guiding principle for decision making. The principles adopted by this Board are:- • Selflessness • Integrity • Objectivity • Accountability • Openness • Honesty • Leadership As a central part of the NHS the Board affirmed its commitment to the rights and values set out in the NHS Constitution and the seven key principles that guide the Board in all its actions:- • The NHS provides a comprehensive service available to all; • Access to NHS Services is based on clinical need, not an individual's ability to pay; • The NHS aspires to the highest standards of excellence and professionalism on the provision of high-quality care that is safe, effective and focussed on the patient experience; • NHS services must reflect the needs and preferences of patients, their families and carers; • The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population; • The NHS is committed to providing best value for taxpayer's money and the most cost-effective, fair and sustainable use of finite resources; • The NHS is accountable to the public, communities and patients that it serves.
9.	**Discharge of Statutory Functions**
	An integral part of transition was the reconciliation of the statutory functions of the PCT and their destination after the end of March 2013. The PCT used legal advice to establish the definitive list of statutory responsibilities and established a tracker to ensure that each function was transferred appropriately. In doing so, the PCT established that no irregularities were

	identified and assured itself that it was legally compliant. NHS continuing care issues were raised about the appropriate interpretation of the legislation in individual cases and the PCT followed the national process to review outstanding cases.
10.	**Risk and Control Framework**
	The following is a summary of the Cluster risk management strategy:- The Cluster Risk Management Strategy, agreed by the Cluster Board in November 2011, was embedded in the normal management processes and structures and encouraged by a culture of responsibility. The Risk Management Strategy promoted the philosophy of integrated governance and required all risk management to be systematic, robust and evident. It required that risk management processes were applied to business planning at all levels and that risk management issues be communicated to key stakeholders where necessary. The Strategy covered quality, clinical, organisational and financial risk, and identified the key management structures and processes defining objectives and responsibilities within the Cluster.. The principles of this Strategy were consistent with the Cluster key priorities – patient safety and staff management. Implementation of the Risk Management Strategy was co-ordinated and monitored by the Cluster Executive Team. The Strategy was supported by a NWL Risk Management Process which clearly described the processes that the Cluster had put into place in order to adequately manage risk. Since April 2012 there was a coherent and consistent approach across all 8 PCTs in the Cluster and in May the Board reviewed its appetite and tolerance for risks. The process ensured that the highest risks appeared on the Board Assurance Framework with a systematic approach to lower risks. The process ensured where risks were identified, there was a requirement for action to be taken to mitigate the risk. Where risks remained at a high level, they were subject to regular scrutiny by the Board, relevant Committee or the Executive Team, so that they received appropriate levels of management attention. During the course of 2012/13, in response to the exceptional challenges of transition, specific risk registers were maintained for specific risks, for example handover and closure and financial handover and closedown. The discipline of the strategy together with the training of staff ensured that the number of risks arising was kept to a minimum. The Strategy complied with best practice, NHS Litigation Authority and National Patient Safety guidance and the Department of Health requirements.
11.	**Risk Identification and Evaluation**
	The identification of new risks was a standing item on the agenda for the Cluster Board, its committees and key working groups from 2011. This ensured that each forum considered risk at the end of each meeting and was very effective in focusing attention on risk. The Cluster Executive Team work programmes captured all risks and issues within their risk logs (low scores) and dashboards which were then escalated to the appropriate risk register or log if scores reached the relevant threshold. Any risks identified or amended which reach thresholds for the Cluster tiered Risk Registers were passed to the Head of Corporate Affairs and duly considered, rated and assigned to an appropriate risk register and shared at a regular Heads of Governance meeting. They were then referred to the owner of the relevant risk register for additional controls and actions to mitigate the risk. The "5 x 5" matrix used when rating risks considered the impact of each risk in terms of in Injury/Safety, Legal or Financial, Performance/Service Interruption, Regulatory, or Adverse Publicity/Reputation. Each risk was then assigned to an appropriate register depending upon the score for its impact multiplied by the score for the likelihood of that occurring. Each rating was presented as a mitigated score based upon consideration of the controls in place. Actions were recommended to reduce the risk rating. The risk matrix included consideration of stakeholders in the assessment of impact of risks identified included among others such as: patients, the public, service users and the Department of Health. Controls for individual risks were only recorded where they were verified as making an active difference to reducing or

mitigating a risk. They had to have been verified as controls at an appropriate forum or by a recognised external/regulatory body. These were continually reviewed at the Head of Corporate Affairs, Head of Clinical Governance or Cluster Executive Team for Corporate or Directors' Risks; or by the designated lead for directorate risk registers with guidance and support from the Head of Corporate Affairs. All risks were triangulated with NHS London.

The following diagram highlights the Cluster process for stratification of risks:



12. **New Risks**

The Cluster operated an integrated Board Assurance Framework and Risk Register (as described above) based on the strategic objectives for the year. The BAF was reviewed at every Board meeting and was updated and revised as new risks were identified and existing risks were mitigated. 2012/13 presented challenges in meeting in-year delivery targets, ensuring effective handover and closure and establishing new organisations which are fit for purpose. The year included formal consultation on *Shaping a Healthier Future,* the strategy to secure improvements in health care across North West London. In that context, the most significant and enduring risks for 2012/13 are described below:-

Delivery of improvements in clinical quality and patient experience

In terms of delivering improvement in clinical quality and patient experience, high risks were associated with Imperial College Healthcare NHS Trust and North West London Hospitals NHS Trust. For Imperial there were risks associated with the sustainable delivery of the 18 week target and an inability to complete robust data validation of cancer pathways, leading to further

breaches of waiting standards. For North West London Hospitals the risks related to the achievement of the A & E 4 hour wait standard, poor performance in patient surveys and the level of consultant cover in maternity. The risks in both providers were of poor outcomes and poor patient experience. Trust action plans to address identified issues were subject to monitoring and review by the Quality and Clinical Risk Committee and Board and financial support provided where appropriate.

Support the development of the new commissioning and provider landscape

A key element of achieving improvements in quality in future was the implementation of the out of hospital strategies with transfer of care from acute to out of hospital settings. The risk of failure to achieve these objectives was identified as high throughout the year, with the potential impact on quality, financial stability and delays to the reconfiguration strategy. Action was coordinated across North West London between CCGs and supported by a strategy development team and a workforce transformation strategy. There was a rigorous assurance plan and detailed implementation plan for 2013/14 agreed by the Board.

On the same objective, there was also a risk of failure to meet the requirements of information governance frameworks with a resulting unsatisfactory audit and information governance toolkit. Action plans arising from the toolkit assessment were monitored regularly by the Information Governance Committee and additional resources were allocated to records management and information mapping in support. There was a systematic programme of records management to ensure effective transition to the new organisations.

Delivery of financial savings to achieve financial balance

Maintaining adequate and effective financial control and ensuring strong financial management, as well as delivering QIPP savings targets, represented a high risk. Key elements in managing the risk were the implementation of financial and commissioning strategies with strong controls exercised through contract management. The financial position was monitored on a regular basis by the Finance and Performance Committee and the Board with remedial action identified where necessary. A final review of risk rating took place in month nine as part of the draft closure of accounts.

13. **Performance Against NHS Operating Framework 2012/13**

Harrow PCT had a statutory duty to report on performance services against the national operating framework indicators for 2012/13.

In 2012/13 Harrow PCT met the following national indicators:

- Infection Control - MRSA bacteraemia and C. Difficile
- Ambulance quality - Category A response within 8 mins
- Ambulance quality - Category A response within 19 mins
- 18 weeks Referral to treatment time – admitted performance within 18 weeks
- 18 weeks Referral to treatment time - non-admitted performance within 18 weeks
- 18 weeks Referral to treatment time - incomplete pathways performance within 18 weeks
- Cancer 2 week wait – percentage seen within 2 weeks of an urgent GP referral for suspected cancer.
- Cancer 62 day wait percentage treated in 62 days from urgent GP referral for suspected cancer.

Harrow PCT did not fully meet the following indicators:

- Childhood immunisation levels continued to be a challenge for PCT's with performance slipping for 2011/12 levels. Action plans were agreed with providers and best practice

	shared across all of North West London PCTs.
14	**Lapses of Data Security**
	A lapse of data security was reported to the Information Commissioner. Patient identifiable data was sent via a non-secure e-mail to both secure and non-secure e-mail addresses. Following investigation a number of lessons for improvement were identified, including the need for up-to-date training, the use of appropriate e-mail accounts and adherence to good practice when handling patient identifiable information.
15	**Effectiveness of Risk Management and Internal Control**
	The key Board Committees regularly received and discussed their respective risk registers. The Audit Committee sought assurance that the BAF appropriately reflected the level of risk and incorporates mitigating action. Independent assurance on the effectiveness of risk management and internal control was provided through Internal Audit reviews of risk management, statutory duties and responsibilities and Cluster governance arrangements. The outcome of each of the audits was a green rating with a total of two low priority recommendations for which actions were been agreed. In summary, the Board could take substantial assurance that the controls upon which the organisation relied to manage these risk/areas were suitably designed, consistently applied and effective. A further audit on handover and closure was designed to provide independent assurance that the implementation of the process was effective. These specific audits were accompanied by a wider internal audit programme encompassing (amongst others) the following areas:- • Business continuity • Payroll and payroll feeder systems • Procurement • Clinical Commissioning Groups • QIPP • Continuing care • Performance Management • Information and Clinical Governance • Acute and non-acute commissioning and contract management • Transfers of estates and public health • Financial matters eg. creditors, general ledger, financial management, accounts receivable, cash and treasury The Board maintained an active programme of fraud prevention in accordance with the core activities required by NHS Protect. The PCT was compliant with the Secretary of State's Directions.
16	**Significant Issues**
	The external auditors issued a qualified opinion in regard to Value for Money (VfM) assessment connected to the PCT's underlying financial position. Although the PCT reported a surplus, this was after significant planned financial support. The PCT did not meet the Operating Framework of transferring a balanced financial position to Harrow CCG and the shortfall on QIPP plans against the PCT's agreed recovery plan increased the scale of the challenge for the CCG. The shadow CCG revised its three year recovery plan to address the underlying financial position in October 2012. An internal audit report on Continuing Care was undertaken during 2012/13 and was able to

	provide only partial assurance regarding the controls in place. In response to that report, local action plans were put in place to ensure that the issues identified in the audit report relating to 2012/13 were addressed.
17	**Head of Internal Audit Opinion**
	The purpose of the Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. The opinion is 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. Whilst we have not issued any RED rated reports we were only able to provide some (partial) assurance over* ***Continuing Care.*** *In particular we identified a backlog of assessments of patients having been undertaken which could have an impact both on quality of care and have financial implications. An agreed action plan is in place at borough level to be owned by the Clinical Commissioning Group moving forwards."*
18	**Conclusion**
	This statement was been discussed at the Audit Committee (19 January and 5 March 2013) and at the Cluster Board meeting (19 March 2013). It was also discussed at the sub committee of the Audit Committee of the Department of Health on the 8 May 2013 and approved at this committee on the 3rd June 2013. The views of the Committees and the Board have been taken into account in the preparation of this statement. Richard Douglas **6th June 2013**

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2013 have been prepared by NHS Harrow under section 98 (2) of the National Health service Act 1977 (as amended by section 24 (2) of the National Health Service and Community Care Act 1990) in the form which the Secretary of state has, with the approval of the Treasury directed.

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For the year ended 31 March 2013

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

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

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

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

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

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

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

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

Signed.....

Date.....6/6/13

Appendix 1

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 Harrow 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.

Accountable Officer	Director of Finance
Name: Anne Rainsberry	Jonathan Wise
Signed:	
Date: 24th May 2013	24/5/13

Appendix 2

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

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Harrow 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.

Accountable Officer

Name: Anne Rainsberry

Signed:

Date: 24th May 2013

Director of Finance

Jonathan Wise

24/5/13

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER FOR HARROW PCT

We have audited the financial statements of Harrow Primary Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 41. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

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

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

Respective responsibilities of the Signing Officer and auditors

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the 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 the financial resiliance of the PCT.

As a result, we have concluded that there is the following matter to report: In considering the PCT's arrangements for financial management, we identified that whilst the PCT can demonstrate that it has arrangements in place for monitoring financial management, these arrangements have not been effective in achieving the desired outcomes. In particular, the requirements of the PCT Operating Framework require PCTs, on dissolution, to transfer their responsibilities to the relevant CCG on 1 April 2013 in a position where the financial situation is in balance. Although the PCT did achieve the objective of not requiring additional sector support over and above the planned amount of £14.6 million in 2012/13, the underlying annual deficit implied for 2013/14 amounts to £5 million.

On the basis of this work, having regard to the guidance on the specified criteria published by the Audit Commission, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that in all significant respects Harrow PCT had in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013.

Certificate

We certify that we have completed the audit of the accounts of Harrow Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Craig Wisdom (Engagement Lead)
for and on behalf of Deloitte LLP
Appointed Auditor
St Albans, UK

6 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**6,692**	5,160
Other costs	5.1	**371,493**	371,814
Income	4	**(11,072)**	(9,477)
Net operating costs before interest		**367,113**	367,497
Investment income	9	**(30)**	(11)
Other (Gains)/Losses	10	**0**	30
Finance costs	11	**2,125**	445
Net operating costs for the financial year		**369,208**	367,961
Transfers by absorption -(gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**369,208**	**367,961**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**6,408**	5,160
Other costs	5.1	**7,003**	9,505
Income	4	**(2,331)**	(2,416)
Net administration costs before interest		**11,080**	**12,249**
Investment income	9	**(30)**	(11)
Other (Gains)/Losses	10	**0**	30
Finance costs	11	**331**	341
Net administration costs for the financial year		**11,381**	**12,609**
Programme Expenditure			
Gross employee benefits	7.1	**284**	0
Other costs	5.1	**364,490**	362,309
Income	4	**(8,741)**	(7,061)
Net programme expenditure before interest		**356,033**	**355,248**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**1,794**	104
Net programme expenditure for the financial year		**357,827**	**355,352**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**337**	1,236
Net (gain) on revaluation of property, plant & equipment	**(287)**	(413)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**369,258**	**368,784**

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**12,764**	12,706
Intangible assets	13	**0**	0
investment property	15	**0**	0
Other financial assets	21	**76**	79
Trade and other receivables	19	**0**	0
Total non-current assets		**12,840**	12,785
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**914**	2,202
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**666**	25
Total current assets		**1,580**	2,227
Non-current assets held for sale	24	**0**	0
Total current assets		**1,580**	2,227
Total assets		**14,420**	15,012
Current liabilities			
Trade and other payables	25	**(26,493)**	(32,339)
Other liabilities	26,28	**0**	0
Provisions	32	**(11,249)**	(449)
Borrowings	27	**(165)**	(166)
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(37,907)**	(32,954)
Non-current assets plus/less net current assets/liabilities		**(23,487)**	(17,942)
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(81)	(3,165)
Borrowings	27	(4,853)	(5,019)
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(4,934)**	(8,184)
Total Assets Employed:		**(28,421)**	(26,126)
Financed by taxpayers' equity:			
General fund		(35,030)	(32,785)
Revaluation reserve		6,609	6,659
Other reserves		0	0
Total taxpayers' equity:		**(28,421)**	(26,126)

The notes on pages 13 to 54 form part of this account.

The financial statements on pages 1-54 were approved by the North West London Audit Sub Committee of the Department of Health's Audit and Risk Committee on 3rd June 2013 and signed on its behalf by

Responsible Officer: Date: 6/6/13

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(32,785)**	**6,659**	**0**	**(26,126)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(369,208)			**(369,208)**
Net gain on revaluation of property, plant, equipment		287		**287**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(337)		**(337)**
Movements in other reserves			0	**0**
Transfers between reserves*	0	0		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(369,208)**	**(50)**	**0**	**(369,258)**
Net Parliamentary funding	366,963			**366,963**
Balance at 31 March 2013	**(35,030)**	**6,609**	**0**	**(28,421)**
Balance at 1 April 2011	**(21,962)**	**7,484**	**0**	**(14,478)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(367,961)			(367,961)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		413		413
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		(1,236)		(1,236)
Movements in other reserves			0	0
Transfers between reserves*	25	(25)		0
Release of Reserves to Statement of Comprehensive Net Expenditure		23		23
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(367,936)	(825)	0	(368,761)
Net Parliamentary funding	357,113			357,113
Balance at 31 March 2012	**(32,785)**	**6,659**	**0**	**(26,126)**

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(367,113)**	(367,497)
Depreciation and Amortisation	**536**	2,054
Impairments and Reversals	**0**	298
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(331)**	(341)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**1,288**	2,108
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(5,633)**	6,595
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(5,155)**	(519)
Increase/(Decrease) in Provisions	**11,077**	376
Net Cash Inflow/(Outflow) from Operating Activities	**(365,331)**	**(356,926)**
Cash flows from investing activities		
Interest Received	**30**	11
(Payments) for Property, Plant and Equipment	**(857)**	(62)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	0
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**2**	2
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(825)**	**(49)**
Net cash inflow/(outflow) before financing	**(366,156)**	**(356,975)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(166)**	(154)
Net Parliamentary Funding	**366,963**	357,113
Capital Receipts Surrendered	**0**	0
Capital grants and other capital receipts	**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**366,797**	**356,959**
Net increase/(decrease) in cash and cash equivalents	**641**	**(16)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**25**	**41**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**666**	**25**

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.

Under the provisions of the Health and Social Care Act 2012, Harrow PCT was dissolved on 31 March 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 42.1 Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The SOFP has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

Details of revaluations and impairments of Property, Plant and Equipment are included in note 1.6 and are considered routine within the annual cycle of activity whereby the District Valuation Office undertake a full revaluation every five years with annual desktop reviews.

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts. Such transfers fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE, and is disclosed separately from operating costs.

Acquisitions and Discontinued Operations

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

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

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

LIFT
The PCT has determined that the LIFT building under IFRS is treated as a Finance Lease. The Operating Cost Statement only reflects the service charge and Interest payment element of the rent. These values have been calculated using the Department of Health Model. The asset has been capitalised and a long term liability with the relevant party is shown in the accounts.

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

Asset Valuation
NHS Bodies are required to ensure that assets are carried at current cost using a suitable method selected by them. The Department of Health no longer issues indices therefore other indices which are widely recognised and in common use should be used instead. A full review was undertaken in April 2009 by the District Valuer of all land and buildings and as the PCT determined that there where no suitable indices available to reflect the closing valuation of its assets it therefore instructed the District Valuers to undertake a desktop review of its properties as at 31st March

The desktop review did not involve physical inspection of the sites but was instead based on the District Valuers knowledge of the local market.

The PCT has used the asset lives as determined by the District Valuer for each building in order to calculate depreciation. For more detailed notes on the depreciation policy see note 1.6

Prescription Pricing Authority
The Prescription Pricing Authority (PPA) currently provides us with details of the monthly expenditure incurred by Independent Contactors in respect of Pharmacy contract payments and drug costs. There is approximately a two to three month delay in notifying the PCT of its expenditure for a particular month. The PCT has therefore applied estimation techniques based on previous trends, expenditure profiles, forecasts from PPA and local knowledge from our Prescribing Advisors. This method has been used for many years and in previous years has not led to any material differences being identified.

Cost data has been received up to the end of January for drugs and up to the end of December for the Pharmacy

Dental Contract
Any under or over performance on the 2012/13 contract has been estimated based on current performance of the contract and also adjusted for the time lag as reported by Dental Payments Board. Actual data will be received at the end of June 2013.

Quality & Outcome Framework
Quality & Outcome Framework (QOF) Achievement for 2012/13 has been estimated on the basis of the current QMAS data which reports the clinical and part of the organisational achievements which represents 93% of the total. The final figure will be available once the GP Survey results are published on the 17th June 2013.

Recognition of Expenditure
The PCT has used various techniques to estimate the appropriate levels of income and expenditure to be included in the accounts. These include basing forecasts on actual expenditure incurred to date extrapolated to a full year, using internal databases (such as Continuing Care), local knowledge from managers and past experience has also been used to determine the appropriate levels of income and expenditure to be included. This method has been used for many years and in previous years has not led to any material differences being highlighted.

Flex & Freeze Data for Acute Contracts
Flex data is now known as monthly reconciliation data and freeze data as monthly post reconciliation data. As the terms imply there is a monthly closedown of the data. Post reconciliation data gets rolled into the next monthly reconciliation data. Trusts use the monthly reconciliation data to inform their monthly SLA Monitoring (SLAM) reports. The latest available SLAM information, Month 11 SLAM data available at the year of March, has been used for year-end accruals. In addition the accrual has been informed by the year-end Agreement of balances exercise and Trust's own accruals statements.

Brent Management Recharge to Harrow
All corporate costs are initially paid by Brent with an appropriate proportion recharged to Harrow. The recharge is based on actual costs for areas which are specific to one PCT (e.g. Public Health) and for shared departments (such as Finance) the split is based on the respective size (as measured by the Resource Limits). The split for 2012/13 has been determined at 62% for Brent and 38% for Harrow. An annual invoice to Harrow has been raised by Brent at the beginning of the year based on the budgeted amounts. In month 11 a full reconciliation of actual expenditure was undertaken and this resulted in no change therefore no further adjustments to this will be made.

Retrospective Claims for NHS Continuing Care Funding
On the 15th March 2012 the Department of Health announced deadlines for individuals to request an assessment of eligibility for NHS Continuing Healthcare Care funding, for cases during the period 1 April 2004 – 31 March 2012.

The deadline for notifying PCT's were as follows

Phase 1 Claim Period 1 April 2004 – 31 March 2011 a deadline of 30 September 2012
Phase 2 Claim Period 1 April 2011 – 31 March 2012 a deadline of 31 March 2013

Harrow PCT is still in the process of gathering all the necessary information to enable an assessment to take place therefore for these accounts both a provision and a contingent liability has been calculated using the following methodology.

Provision
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

For each of the two phases the total estimated liability has been calculated using:
a) an average length of claim based on a sample of both living and deceased claimants within each phase.
b) an average weekly nursing home cost based on a sample of the current nursing home costs.

To the total estimated liability the following has been applied
c) a standard interest rate
d) costs of undertaking the assessment.
e) for each phase a judgment on the likelihood of success.

Contingent Liability
A contingent liability has been shown representing the value of those judged to be likely to be unsuccessful in the provision calculation (i.e. if 60% likelihood has been applied to the total estimated liability then the balance of 40% has been shown as a contingent liability).

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT has entered into a pooled budget with London Borough of Harrow. Under the arrangement funds are pooled under S31 of the Health Act 1999 for community activities and a memorandum note to the accounts provides details of the joint income and expenditure.

The pool is hosted by London Borough of Harrow. As a commissioner of healthcare services, the PCT makes contributions to the pool, which are then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

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 an asset.

1.5 Administration and Programme Costs

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

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

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

1. Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. A full revaluation was undertaken by the District Valuers during 2009-2010. Indices are no longer provided therefore a desktop review of the carrying values was undertaken in March 2013 by the District Valuer. This has resulted in an upward movement of £287k on some of the values (this includes Alexandra Avenue £142k, Woodlands Hall £103k, as well as smaller increases on the other properties). There has also been impairments of £337k charged to the Revaluation Reserve (this relates to Belmont Building £232k, Caryl Thomas £104k).

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.7 Intangible Assets

Recognition

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

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

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

Measurement

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

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

1.8 Depreciation, amortisation and impairments

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

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

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

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

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1. Accounting policies (continued)

1.9 Cash and cash equivalents

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

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

1.10 Losses and Special Payments

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

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

1.11 Clinical Negligence Costs

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

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the PCT is disclosed at Note 32.

1. Accounting policies (continued)

1.12 Employee benefits

All salary costs including retirement benefits are initially paid by Brent and are recharged to Harrow through the Management Recharge (see note 1.1).

1.13 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. Accounting policies (continued)

1.14 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.

For the Continuing Care Contingent Liability see note 1.1

1.15 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.

1.16 Provisions

Provisions are recognised when the PCT has a present legal or constructive obligation as a result of a past event, it is probable that the PCT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% (2.8% in respect of early staff departures) in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the PCT has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the PCT has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

For the Continuing Care Provision see note 1.1

1. Accounting policies (continued)

1.17 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

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.

Fixed asset investments

£80 of shares in LiftCo are held as a Fixed asset investments are recorded at historic cost as they do not have a "quoted" market price nor an active market in which they could be traded..

1. Accounting policies (continued)

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

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

1.18 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

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

b) PFI and LIFT assets, liabilities, and finance costs

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

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

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement

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

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

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

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

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

Other assets contributed by the PCT to the operator

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

1. Accounting policies (continued)

1.19 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

1.20 Events after the Reporting Period

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

NHS England
Harrow Clinical Commissioning Group
London Borough of Harrow

Certain Land, Property, Plant & Equipment have transferred to NHS Property Services, NHS Trusts and Community Health Partnership on 31 March 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.The associated Borrowings and Revaluation Reserves have also transferred

Current Assets and Liabilties where the asset or liabilty will be discharged by 30th June 2013 will transfer to the Department of Health. Assets and Liabilities which will not be discharged by the 30th June 2013 will transfer with the function to the receivers above.

2 Operating segments

From 1st April 2011 Harrow Community Services previously an operating segment within Harrow PCT formed an Integrated Care Organisation with Ealing Hospital and the costs of the services transferred forms part of the Service Level Agreement with Ealing Hospital.

3. Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 2012-13 is as follows:	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year		367,961
Net operating cost plus (gain)/loss on transfers by absorption	**369,208**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**372,460**	368,111
Under/(Over)spend Against Revenue Resource Limit (RRL)	3,252	150

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	**1,445**	255
Charge to Capital Resource Limit	**644**	255
(Over)/Underspend Against CRL	**801**	**0**

3.3 Provider full cost recovery duty

From 1st April 2011 Harrow Community Services formally an operating segment within Harrow PCT formed an Integrated Care Organisation with Ealing Hospital and the costs of the services transferred forms part of the Service Level Agreement with Ealing Hospital.

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**366,963**	357,113
Cash Limit	**373,593**	369,055
Under/(Over)spend Against Cash Limit	**6,630**	**11,942**

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

	2012-13 £000
Total cash received from DH (Gross)	324,600
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**324,600**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	7,458
Plus: drugs reimbursement (central charge to cash limits)	34,905
Parliamentary funding credited to General Fund	**366,963**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	3
Dental Charge income from Contractor-Led GDS & PDS	**2,023**		2,023	1,998
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**1,875**		1,875	1,832
Strategic Health Authorities	**1,253**	0	1,253	1,346
NHS Trusts	**1,403**	1,334	69	1,569
NHS Foundation Trusts	**116**	0	116	26
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**956**	216	740	985
Primary Care Trusts - Lead Commissioning	**0**	0	0	0
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**0**	0	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**0**	0	0	0
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**2,719**	264	2,455	1,148
Patient Transport Services	**0**		0	0
Education, Training and Research	**0**	0	0	0
Non-NHS: Private Patients	**0**		0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**		0	0
NHS Injury Costs Recovery	**0**		0	0
Other Non-NHS Patient Care Services	**0**	0	0	0
Charitable and Other Contributions to Expenditure	**0**		0	0
Receipt of donated assets	**0**		0	0
Receipt of Government granted assets	**0**		0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**483**	483	0	429
Other revenue	**244**	34	210	141
Total miscellaneous revenue	**11,072**	**2,331**	**8,741**	**9,477**

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	**21,764**		21,764	15,247
Non-Healthcare	**1,866**	1,866	0	1,400
Total	**23,630**	**1,866**	**21,764**	**16,647**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**158,279**	0	158,279	171,108
Goods and services (other, excl Trusts, FT and PCT))	**502**	0	502	694
Total	**158,781**	**0**	**158,781**	**171,802**
Goods and Services from Foundation Trusts	**64,435**	0	64,435	56,403
Purchase of Healthcare from Non-NHS bodies	**31,012**		31,012	29,940
Social Care from Independent Providers	**0**		0	0
Expenditure on Drugs Action Teams	**0**		0	829
Non-GMS Services from GPs	**107**	0	107	236
Contractor Led GDS & PDS (excluding employee benefits)	**9,719**		9,719	9,411
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**0**		0	0
Chair, Non-executive Directors & PEC remuneration	**8**	8	0	46
Executive committee members costs	**302**	302	0	142
Consultancy Services	**978**	978	0	1,575
Prescribing Costs	**28,447**		28,447	30,721
G/PMS, APMS and PCTMS (excluding employee benefits)	**30,777**	0	30,777	30,572
Pharmaceutical Services	**45**		45	5
Local Pharmaceutical Services Pilots	**73**		73	288
New Pharmacy Contract	**8,559**		8,559	8,638
General Ophthalmic Services	**2,477**		2,477	2,543
Supplies and Services - Clinical	**121**	0	121	176
Supplies and Services - General	**261**	238	23	312
Establishment	**324**	290	34	671
Transport	**0**	0	0	24
Premises	**3,321**	2,370	951	2,907
Impairments & Reversals of Property, plant and equipment	**0**	0	0	298
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**536**	536	0	2,054
Amortisation	**0**	0	0	0
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**1,969**	0	1,969	64
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**98**	98	0	182
Other Auditors Remuneration	**0**	0	0	39
Clinical Negligence Costs	**0**	0	0	0
Education and Training	**1,343**	6	1,337	1,422
Grants for capital purposes	**0**	0	0	0
Grants for revenue purposes	**0**	0	0	220
Impairments and reversals for investment properties	**0**	0	0	0
Other	**4,170**	311	3,859	3,647
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**371,493**	**7,003**	**364,490**	**371,814**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	0
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**403**	403	0	366
Other Employee Benefits	**6,289**	6,005	284	4,794
Total Employee Benefits charged to SOCNE	**6,692**	**6,408**	**284**	**5,160**
Total Operating Costs	**378,185**	**13,411**	**364,774**	**376,974**

Harrow PCT is recharged by Brent PCT for three Executive members of the North West London Cluster Board. The majority of the NWL Cluster Board members are employed by Westminster PCT as the host. These costs are then recharged from Westminster PCT as part of the overall recharge we receive for the NWL Cluster and is charged against the 'Goods and Services from other PCTs' lines above and is £1,849k.

Any Non Executive Members of the Cluster Board employed by the PCT are shown on the 'Chair, Non Executive Directors and PEC Remuneration' line above.

	Total	Commissioning	Public Health Services
PCT Running Costs 2012-13			
Running costs (£000s)	**11,711**	9,650	2,061
Weighted population (number in units)*	**200,605**	200,605	200,605
Running costs per head of population (£ per head)	**58**	**48**	**10**
PCT Running Costs 2011-12			
Running costs (£000s)	**12,843**	11,426	1,417
Weighted population (number in units)	**200,605**	200,605	200,605
Running costs per head of population (£ per head)	**64**	**57**	**7**

* 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	30,777	30,571
Prescribing costs	28,447	30,721
Contractor led GDS & PDS	9,719	9,411
Trust led GDS & PDS	0	0
General Ophthalmic Services	2,476	2,543
Department of Health Initiative Funding	0	0
Pharmaceutical services	45	5
Local Pharmaceutical Services Pilots	73	288
New Pharmacy Contract	8,559	8,638
Non-GMS Services from GPs	107	236
Other	0	0
Total Primary Healthcare purchased	**80,203**	82,413
Purchase of Secondary Healthcare		
Learning Difficulties	5,023	6,464
Mental Illness	33,469	35,949
Maternity	14,129	13,583
General and Acute	177,592	169,522
Accident and emergency	6,262	12,598
Community Health Services	29,253	18,336
Other Contractual	11,328	16,209
Total Secondary Healthcare Purchased	**277,056**	272,661
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	220
Total Healthcare Purchased by PCT	**357,259**	**355,294**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	64,435	56,375

6. Operating Leases

Harrow PCT has also entered into certain financial arrangements involving the use of GP premises. Under:
IAS 17 Leases
SIC 27 Evaluating the substance of transactions involving the legal form of a lease
IFRIC 4 Determining whether an arrangement contains a lease

Harrow PCT has determined that those operating leases must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in the operating Cost Statement for 2012/13 is £1,895,676 (2011/12 £1,779,106) .

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**453**	489
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**453**	**489**
Payable:					
No later than one year	**0**	**453**	**0**	**453**	489
Between one and five years	**0**	**1,811**	**0**	**1,811**	1,737
After five years	**0**	**967**	**0**	**967**	1,572
Total	**0**	**3,231**	**0**	**3,231**	**3,798**
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

Harrow PCT has also entered into certain financial arrangements involving the renting of premises to GP's. Under:

IAS 17 Leases

SIC 27 Evaluating the substance of transactions involving the legal form of a lease

IFRIC 4 Determining whether an arrangement contains a lease

Harrow PCT has determined that those operating rentals must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. Also all PCT Estates will transfer on the 31st March 2013 to other organisations therefore only one years income has been shown.

In addition also from time to time individual rooms are hired out.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**483**	429
Contingent rents	**0**	0
Total	**483**	429
Receivable:		
No later than one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Total	**0**	0

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	**6,692**	6,408	284	**4,900**	4,900	0	**1,792**	1,508	284
Social security costs	**0**	0	0	**0**	0	0	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**0**	0	0	**0**	0	0	**0**	0	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Other post-employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination benefits	**0**	0	0	**0**	0	0	**0**	0	0
Total employee benefits	**6,692**	**6,408**	**284**	**4,900**	**4,900**	**0**	**1,792**	**1,508**	**284**
Less recoveries in respect of employee benefits (table below)	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**6,692**	**6,408**	**284**	**4,900**	**4,900**	**0**	**1,792**	**1,508**	**284**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**6,692**	**6,408**	**284**	**4,900**	**4,900**	**0**	**1,792**	**1,508**	**284**
Recognised as:									
Commissioning employee benefits	**6,692**			**4,900**			**1,792**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**6,692**			**4,900**			**1,792**		

This relates mainly to the recharge from Brent PCT

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 - Revenue									
Salaries and wages	**0**	0	0	**0**	0	0	**0**	0	0
Social Security costs	**0**	0	0	**0**	0	0	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**0**	0	0	**0**	0	0	**0**	0	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Other Post Employment Benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other Employment Benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination Benefits	**0**	0	0	**0**	0	0	**0**	0	0
TOTAL excluding capitalised costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**5,160**	4,604	556
Social security costs	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**0**	0	0
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**0**	0	0
Total gross employee benefits	**5,160**	**4,604**	**556**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**5,160**	**4,604**	**556**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**5,160**	**4,604**	**556**
Recognised as:			
Commissioning employee benefits	**5,160**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**5,160**		

7.2 Staff Numbers

2012-13				2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	**2**	2	0	**2**	2	0
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**98**	77	21	**86**	77	9
Healthcare assistants and other support staff	**3**	3	0	**1**	1	0
Nursing, midwifery and health visiting staff	**4**	4	0	**4**	4	0
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**4**	4	0	**4**	4	0
Social Care Staff	**0**	0	0	**0**	0	0
Other	**0**	0	0	**1**	1	0
TOTAL	**111**	**90**	**21**	**98**	**89**	**9**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	**1,523**	**3,029**
Total Staff Years	**238**	**375**
Average working Days Lost	6.40	8.08

Figures given are in calendar years.
Total Staff Years relates to the number of Whole Time Equivalents in post during the calendar year.
The staff sickness above is for the merged management structure for Brent and Harrow PCT including staff on secondment.

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

7.4 Exit Packages agreed during 2012-13

The Department of Health has issued guidance stating that PCT's should only report only those transactions it adminsters through its own payroll arrangements. Harrow PCT does not have a payroll (see note 1.1)

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**11,288**	**44,738**	10,643	37,036
Total Non-NHS Trade Invoices Paid Within Target	**10,719**	**43,689**	10,034	35,027
Percentage of Non NHS Trade Invoices Paid Within Target	94.96%	97.65%	94.28%	94.58%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,733**	**258,501**	3,977	251,336
Total NHS Trade Invoices Paid Within Target	**3,551**	**253,870**	3,751	250,462
Percentage of NHS Trade Invoices Paid Within Target	95.12%	98.21%	94.32%	99.65%

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

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

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

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	0	0	0	0
PFI finance lease revenue (contingent)	0	0	0	0
Other finance lease revenue	0	0	0	0
Subtotal	0	0	0	0
Interest Income				
LIFT: equity dividends receivable	20	20	0	0
LIFT: loan interest receivable	10	10	0	11
Bank interest	0	0	0	0
Other loans and receivables	0	0	0	0
Impaired financial assets	0	0	0	0
Other financial assets	0	0	0	0
Subtotal	30	30	0	11
Total investment income	30	30	0	11

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	0	0	(30)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0	0	0
Gain/(Loss) on disposal of Financial Assets - other than held for sale	0	0	0	0
Gain (Loss) on disposal of assets held for sale	0	0	0	0
Gain/(loss) on foreign exchange	0	0	0	0
Change in fair value of financial assets carried at fair value through the SoCNE	0	0	0	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	0	0	0	0
Change in fair value of investment property	0	0	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0	0	0
Total	0	0	0	(30)

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under PFI contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	331	331	0	341
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	331	331	0	341
Other finance costs	0	0	0	0
Provisions - unwinding of discount	1,794		1,794	104
Total	2,125	331	1,794	445

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	4,270	9,951	0	0	0	0	110	0	14,331
Additions of Assets Under Construction				0					0
Additions Purchased	0	644	0		0	0	0	0	644
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	0	0	0		0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	223	64	0	0	0	0	0	0	287
Impairments/negative indexation	0	(337)	0	0	0	0	0	0	(337)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	4,493	10,322	0	0	0	0	110	0	14,925
Depreciation									
At 1 April 2012	426	1,199	0	0	0	0	0	0	1,625
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	62	437	0		0	0	37	0	536
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	488	1,636	0	0	0	0	37	0	2,161
Net Book Value at 31 March 2013	4,005	8,686	0	0	0	0	73	0	12,764
Purchased	4,005	8,686	0	0	0	0	73	0	12,764
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	4,005	8,686	0	0	0	0	73	0	12,764
Asset financing:									
Owned	2,744	3,319	0	0	0	0	73	0	6,136
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	1,261	5,367	0	0	0	0	0	0	6,628
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	4,005	8,686	0	0	0	0	73	0	12,764

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	3,741	2,918	0	0	0	0	0	0	6,659
Movements (specify)	222	(272)	0	0	0	0	0	0	(50)
At 31 March 2013	3,963	2,646	0	0	0	0	0	0	6,609

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**5,005**	**9,785**	**0**	**0**	**820**	**0**	**2,701**	**1,955**	**20,266**
Additions - purchased	0	175	0	0	0	0	110	0	**285**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	30	0	0	0	0	0	(30)	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(30)	0	0	(741)	0	(2,701)	(1,925)	**(5,397)**
Revaluation & indexation gains	327	86	0	0	0	0	0	0	**413**
Impairments	(1,062)	(95)	0	0	(79)	0	0	0	**(1,236)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**4,270**	**9,951**	**0**	**0**	**0**	**0**	**110**	**0**	**14,331**
Depreciation									
At 1 April 2011	**80**	**728**	**0**		**400**	**0**	**2,514**	**918**	**4,640**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(741)	0	(2,701)	(1,925)	**(5,367)**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	288	10	0	0	0	0	0	0	**298**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	58	461	0		341	0	187	1,007	**2,054**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**426**	**1,199**	**0**	**0**	**0**	**0**	**0**	**0**	**1,625**
Net Book Value at 31 March 2012	**3,844**	**8,752**	**0**	**0**	**0**	**0**	**110**	**0**	**12,706**
Purchased	3,844	8,752	0	0	0	0	110	0	**12,706**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**3,844**	**8,752**	**0**	**0**	**0**	**0**	**110**	**0**	**12,706**
Asset financing:									
Owned	2,614	3,160	0	0	0	0	110	0	**5,884**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	1,230	5,592	0	0	0	0	0	0	**6,822**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**3,844**	**8,752**	**0**	**0**	**0**	**0**	**110**	**0**	**12,706**

12.3 Property, plant and equipment

Donated Assets
NHS Harrow does not have any donated assets

Property

Valuation Methodology

Land and Buildings were independently valued by the District Valuation Office during 2009/10 and they provided a valuation as at 1st April 2009 and in the case of the buildings the estimated remaining life (ranging from 8 to 88 years). NHS Harrow has depreciated all assets over their remaining life and has not assumed any residual value. They have subsequently undertaken a desktop review to update the values in 31st March 2011, 31st March 2012 and 31st March 2013.

The District Valuation Office valued the specialised properties adopting the modern equivalent assets approach methodology. For specialised operational assets, if there is no market-based evidence of fair value because of the specialised nature of the property and the item is rarely sold, except as part of a continuing business, fair value is estimated using a depreciated replacement cost approach subject to the assumption of continuing use.

Where depreciated replacement cost (DRC) has been used, it is confirmed that the valuer has had regard to the RICS Valuation Information Paper No. 10 *The Depreciated Replacement Cost (DRC) Method of Valuation for Financial Reporting,* as supplemented by Treasury guidance.

This method has been adopted for the following properties:
Alexander Avenue
Caryl Thonas Clinic
Belmont Health Centre

Properties which are not specialised have been valued on an Existing Use Value basis which has been done by adopting the comparable method. The properties valued on this basis are as follows:
Northwick Park Road
Elmwood

These properties are being used for clients with learning difficulties. It was seen from District Valuers inspections these properties are residential properties in residential locations. To value these they referred to sales of similar properties in the locality, and reflected where necessary the value of any adaptations and improvements which have been carried out.

Plant & Equipment

Operational equipment is carried at current value. Where assets are at low value, and/or have short useful economic lives, these are carried at depreciated historic cost as a proxy for current value. Equipment surplus to requirements is valued at net recoverable amount.
Plant & Equipment are depreciated at rates calculated to write them down to estimated residual value on a straight line basis over their estimated useful lives. The following lives are attributed:
Short life engineering plant and equipment - 5 years
Medium life engineering plant and equipment – 10 years
Long life engineering plant and equipment – 15 years
Vehicles – 7 years
Furniture – 10 years
IT equipment – 3 years
Soft furnishings – 7 years
Short life medical and other equipment – 5 years
Medium life medical equipment – 10 years
Long life medical equipment – 15 years
Mainframe-type IT installations – l8 years or as advised by IT at time of purchase

13.1 Intangible non-current assets

the PCT does not have any intangible assets

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	0	0
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Property, Plant and Equipment		
Buildings exc Dwellings	5	33
Dwellings	0	0
Plant & Machinery	0	0
Transport Equipment	0	0
Information Technology	2	2
Furniture and Fittings	0	0

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	337		
Total impairments for PPE charged to reserves	**337**		
Total Impairments of Property, Plant and Equipment	**337**	**0**	**0**
Intangible assets impairments and reversals charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Over-specification of assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	0		
Total impairments for Intangible Assets charged to Reserves	**0**		
Total Impairments of Intangibles	**0**	**0**	**0**
Financial Assets charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Loss as a result of catastrophe	0		0
Other	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Loss as a result of catastrophe	0		
Other	0		
TOTAL impairments for Financial Assets charged to reserves	**0**		
Total Impairments of Financial Assets	**0**	**0**	**0**

Non-current assets held for sale - impairments and reversals charged to SoCNE.

Loss or damage resulting from normal operations	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
Inventories - impairments and reversals charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0		0
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of Inventories	**0**	**0**	**0**
Investment Property impairments charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0		0
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total Investment Property impairments charged to SoCNE	**0**	**0**	**0**
Investment Property impairments and reversals charged to the Revaluation Reserve			
Loss or Damage Resulting from Normal Operations	0		
Over Specification of Assets	0		
Abandonment of Assets in the Course of Construction	0		
Unforeseen Obsolescence	0		
Loss as a Result of a Catastrophe	0		
Other (Free text note required)*	0		
Changes in Market Price	0		
TOTAL impairments for Investment Property charged to Reserves	**0**		
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	337		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	0		0
Overall Total Impairments	**337**	**0**	**0**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0
Donated and Gov Granted Assets, included above -			
PPE - Donated and Government Granted Asset Impairments: amount charged to SoCNE - DEL*	0	0	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SoCNE -AME*	0	0	0

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. A full revaluation was undertaken by the District Valuers during 2009-2010. Indices are no longer provided therefore a desktop review of the carrying values was undertaken in March 2013 by the District Valuer. There has been impairments of £337k charged to the Revaluation Reserve (this relates to Belmont Building £232k, Caryl Thomas Building £104k).

15 Investment property

The PCT does not have any investment property

16 Commitments

16.1 Capital commitments

The PCT does not have any capital commitments

16.2 Other financial commitments

The PCT does not have other financial commitments

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	172	0	707	0
Balances with Local Authorities	2,634	0	324	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	534	0	7,711	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	(2,426)	0	17,751	0
At 31 March 2013	**914**	**0**	**26,493**	**0**
prior period:				
Balances with other Central Government Bodies	1,317	0	398	0
Balances with Local Authorities	424	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,196	0	8,738	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	(735)	0	23,203	0
At 31 March 2012	**2,202**	**0**	**32,339**	**0**

18 Inventories

The PCT held no stock at the balance sheet date (2011/12 nil)

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**706**	2,346	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**2,928**	519	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**0**	0	**0**	0
Provision for the impairment of receivables	**(2,805)**	(836)	**0**	0
VAT	**85**	167	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	6	**0**	0
Total	**914**	2,202	**0**	0
Total current and non current	**914**	2,202		
Included above:				
Prepaid pensions contributions	**0**	0		

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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**50**	648
By three to six months	**0**	0
By more than six months	**0**	0
Total	**50**	648

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(836)**	(989)
Amount written off during the year	**0**	217
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(1,969)**	(64)
Balance at 31 March 2013	**(2,805)**	(836)

This is a provision for impairments based on managements judgement on the likelihood of debts being settled.

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**79**	**0**	**79**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**(3)**	**0**	**(3)**
Balance at 31 March 2013	**76**	**0**	**76**
Balance at 1 April 2011	84	0	84
Additions	0	0	0
Disposals	0	0	0
Loan repayments	(2)	0	(2)
Revaluations	0	0	0
Loans repayable within 12 months	(3)	0	(3)
Balance at 31 March 2012	**79**	**0**	**79**

21.1 Other financial assets - Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Other Movements	0	0
Closing balance 31 March	**0**	0

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**79**	84
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	(3)	(3)
Disposals	0	(2)
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**76**	79

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**(3)**	0

22 Other current assets

	31 March 2013 £000	31 March 2012 £000
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**25**	41
Net change in year	**641**	(16)
Closing balance	**666**	25
Made up of		
Cash with Government Banking Service	**666**	25
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**666**	25
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**666**	25
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

The PCT does not have any non-current assets for sale

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0		
NHS payables - revenue	**3,242**	6,369	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**5,176**	2,761	**0**	0
Family Health Services (FHS) payables	**0**	0		
Non-NHS payables - revenue	**1,507**	2,430	**0**	0
Non-NHS payables - capital	**10**	223	**0**	0
Non_NHS accruals and deferred income	**16,241**	20,522	**0**	0
Social security costs	**0**	0		
VAT	**0**	0	**0**	0
Tax	**0**	0		
Payments received on account	**0**	0	**0**	0
Other	317	34	0	0
Total	**26,493**	32,339	**0**	0
Total payables (current and non-current)	**26,493**	**32,339**		

26 Other liabilities

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

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**165**	166	**4,853**	5,019
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**165**	**166**	**4,853**	**5,019**
Total other liabilities (current and non-current)	**5,018**	**5,185**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	Other £000s	Total £000s
0 - 1 Years	0	165	**165**
1 - 2 Years	0	373	**373**
2 - 5 Years	0	556	**556**
Over 5 Years	0	3,924	**3,924**
TOTAL	**0**	**5,018**	**5,018**

28 Other financial liabilities

The PCT does not have any Other Financial Liabilities

29 Deferred income

The PCT does not have any Deferred Income

30 Finance lease obligations

The PCT does not have any Finance Leases

31 Finance lease receivables as lessor

The PCT does not have any Finance Leases

32 Provisions

		Comprising:								
	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**3,614**	0	3,573	41	0	0	0	0	0	0
Arising During the Year	**11,220**	0	3	4	0	11,213	0	0	0	0
Utilised During the Year	**(5,155)**	0	(5,139)	(16)	0	0	0	0	0	0
Reversed Unused	**(143)**	0	(143)	0	0	0	0	0	0	0
Unwinding of Discount	**1,794**	0	1,794	0	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0	0	0
Transferred (to)/from other Public Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**11,330**	**0**	**88**	**29**	**0**	**11,213**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**11,249**	**0**	**7**	**29**	**0**	**11,213**	**0**	**0**	**0**	**0**
Later than One Year and not later than Five Years	**26**	**0**	**26**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Later than Five Years	**55**	**0**	**55**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	50
As at 31 March 2012	7

£3k is included in pension relating to other staff in respect of the provisions of the NHS Litigation Authority at 31/3/2013 in respect of clinical negligence liabilities of the PCT (31/03/11 £16k). The remainder relates to Injury Benefits

The Continuing Care Provision is in respect of Retrospective claims see note 1.1

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**(7,514)**	(6)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(7,514)**	(6)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

Contingencies are as follows:
1. At the 31st March 2013 the PCT has a contingent liability of £2,375 (2011/12 £6,000) to the NHS Litigation Authority.

2. the £7,512k contingent liability is in respect or the retrospective continuing care outstanding claims (see note 1.1) as the final outcome and the resultant financial effects remain uncertain at the year end. The value reported is the worst case scenario.

34 LIFT - additional information

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013 £000**	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**426**	396
Total	**426**	396

Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.	**31 March 2013 £000**	31 March 2012 £000
LIFT Scheme Expiry Date:		
No Later than One Year	**426**	396
Later than One Year, No Later than Five Years	**1,704**	1,585
Later than Five Years	**5,963**	5,943
Total	**8,093**	7,924

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

	31 March 2013 £000	31 March 2012 £000
Estimated capital value of project - off SOFP LIFT	0	0
Value of Deferred Assets - off SOFP LIFT	0	0
Value of Residual Interest - off SOFP LIFT	0	0

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013 £000**	31 March 2012 £000
No Later than One Year	**486**	498
Later than One Year, No Later than Five Years	**1,904**	1,944
Later than Five Years	**6,431**	6,877
Subtotal	**8,821**	9,319
Less: Interest Element	**(3,803)**	(4,134)
Total	**5,018**	5,185

35 Impact of IFRS treatment - 2012-13

Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)	**Total £000**	Admin £000
Depreciation charges	**341**	341
Interest Expense	**331**	331
Impairment charge - AME	**0**	
Impairment charge - DEL	**0**	0
Other Expenditure	**426**	426
Revenue Receivable from subleasing	**0**	0
Total IFRS Expenditure (IFRIC12)	**1,098**	**1,098**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(923)**	(923)
Net IFRS change (IFRIC12)	**175**	**175**

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	0
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0

36 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit Risk

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

Liquidity Risk

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

36.1 Financial Assets

	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		706		**706**
Receivables - non-NHS		3,013		**3,013**
Cash at bank and in hand		666		**666**
Other financial assets	0	76	0	**76**
Total at 31 March 2013	**0**	**4,461**	**0**	**4,461**
Embedded derivatives	0			0
Receivables - NHS		2,346		2,346
Receivables - non-NHS		692		692
Cash at bank and in hand		25		25
Other financial assets	0	79	0	79
Total at 31 March 2012	0	3,142	0	3,142

36.2 Financial Liabilities

	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		8,418	**8,418**
Non-NHS payables		18,075	**18,075**
Other borrowings		0	**0**
PFI & finance lease obligations		5,018	**5,018**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**31,511**	**31,511**
Embedded derivatives	0		0
NHS payables		9,130	9,130
Non-NHS payables		23,175	23,175
Other borrowings		0	0
PFI & finance lease obligations		5,185	5,185
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	37,490	37,490

37 Related party transactions

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Harrow Primary Care Trust. The following related party transactions were reported by the Shadow Clinical Commissioning Board that relate to Harrow Primary Care Trust. The GMS payments shown below relates to services provided by the practice which the Shadow Clinical Commissioning member is a partner rather than payments to Shadow Clinical Commissioning members themselves. The payment is the total paid to the practices as a whole before taking into account practice expenses in delivering services.

	Payments to Related Party	
	2012/13	2011/12**
HARROW CLINICAL COMMISSIONING BOARD		
Dr A Kelshiker *	2,960,751	1,956,824
Dr D Patel *	532,368	374,301
Dr G Small *	1,715,584	1,535,552
Dr K Karia *	585,458	437,514
Dr K Rajani *	739,324	513,679
Dr L Gould *	1,351,162	943,983
Dr I Sayed ***		

* The practices which the above are partners held shares in Harmoni Ltd which was sold during 2012/13 to Care UK. TheThe practices which the above are partners held shares in Harmoni Ltd which was sold during 2012/13 to Care UK, and the above practices are no longer shareholders. They also hold shares in Harrow Health Ltd and both companies had dealings with Harrow PCT in 2012/13. Harrow Health Ltd and both companies had dealings with Harrow PCT in 2012/13.

** The 2011/12 Figures relate to 9 months only (from July 2011)

*** Dr I Sayed commenced July 2012 and is a salaried GP with Harrow Health Ltd

During 2012/13 Harmoni was awarded the tender to provide the 111 service on behalf of Hounslow, Ealing, Brent and Harrow PCT's from March 2013. None of the GPs named above sat on the procurement panel. The tender approval was provided by the North West London Cluster Board.

Members of the Cluster Board with related party transactions include Sarah Cuthbert whose husband is a Partner in Deloitte. Deloitte are external auditors for Hillingdon and Harrow PCTs and also have worked on 'Shaping a Healthier Future' during the year. Mark Spencer held shares with Harmoni Ltd.

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

	Income	Expenditure	Receivables	Payables
A Primary Care Trusts	**£'000**	**£'000**	**£'000**	**£'000**
Brent PCT	143	130	58	237
Westminster PCT	311	2,214	0	231
Croydon PCT	-	21,454	0	99
B Trusts				
North West London Hospitals NHS Trust	100	99,183	63	359
Imperial College Hospitals NHS Trust	-	13,619	-	131
Barnet & Chase Farm Hospitals NHS Trust	-	6,026	-	46
Ealing Hospital Nhs trust	1,404	15,911	53	879
East And North Hertfordshire NHS trust	-	4,136		124
London Ambulance Services NHS Trust	-	5,817	-	8
West Hertfordshire Hospitals NHS Trust	-	3,248	-	60
B Foundation				
Central And North West London MH NHS Foundation Trust	323	23,737	297	1153
Moorfields Eye Hospital NHS Foundation Trust	-	5,823	-	415
Royal Brompton And Harefield NHS Foundation Trust	-	8,856	-	328
University College London NHS Foundation Trust	-	8,259	26	-
Royal Free Hospitals NHS Trust	-	5,105	4	-
D Others				
NHS London Strategic Health Authority	1,253	-		
E Local Councils				
Harrow London Borough Council	3,941	2,715	2634	324

38 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

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

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

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

39 Third party assets

There are no third party assets

40 Cashflows relating to exceptional items

None

41 Events after the end of the reporting period

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

NHS England
Harrow Clinical Commissioning Group
London Borough of Harrow

Certain Land, Property, Plant & Equipment have transferred to NHS Property Services, NHS Trusts and Community Health Partnership on 31 March 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment. The associated Borrowings and Revaluation Reserves have also transferred

Current Assets and Liabilties where the asset or liabilty will be discharged by 30th June 2013 will transfer to the Department of Health. Assets and Liabilities which will not be discharged by the 30th June 2013 will transfer with the function to the receivers above.