Department of Health

NHS

Lewisham Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Lewisham Primary Care Trust

2012-13 Annual Report

Lewisham Primary Care Trust Annual Report 2012/13

NHS Lewisham
Cantilever House
Eltham Road
London
SE12 8RN

2. WELCOME

Welcome to the Lewisham Primary Care Trust (PCT) annual report for 2012/2013. This is our final annual report following the disestablishment of PCTs as part of the health service reforms set out in the Health and Social Care Act 2012. Despite the changes going on within the NHS, in Lewisham we have remained focused on improving local health and providing healthcare services that are innovative, responsive and of the highest quality to our local population.

As we look back over ten years of our PCT, we can be proud of the achievements and improvements that have been made to local health and healthcare services including: investment in new NHS facilities; integrated working with community, hospital and social care services; increase in life expectancy and quality of life; marked improvements in immunisation rates, safeguarding, breastfeeding, teenage pregnancy rates and chlamydia screening and the establishment of strong and effective partnerships.

Lewisham PCT was established in 2002 serving a very diverse population which is predominately young and mobile, with pockets of high deprivation and a range of significant health challenges. Over the last decade we have seen the successful separation of our community health services in 2009 when they transferred from the PCT to the local hospital to form Lewisham Healthcare NHS Trust; a reduction in our workforce in 2010 when we became part of the NHS South East London cluster of PCTs and in 2012 when a Trust Special Administrator (TSA) http://www.tsa.nhs.uk/ was appointed to review the finances of South London Healthcare NHS Trust and the sustainability of health services across south east London. This review and subsequent recommendations, approved by the Secretary of State for Health in January 2013 disappointed Lewisham clinicians, staff and residents, many of whom believe the reduction of emergency and maternity provision at the local hospital will have a detrimental impact on Lewisham residents. It is therefore critical that the incoming NHS Lewisham Clinical Commissioning Group ensures that the implementation of the recommendations are managed and delivered for the best interests of Lewisham people. An important element of these changes will be the provision of more integrated care in the community as set out in the South East London Community Based Care Strategy. http://www.tsa.nhs.uk/document/appendix-i-community-based-care-strategy-south-east-london

2012/13 has been a financially challenging year but by working effectively and collaboratively with our partners we have ensured that money has been spent wisely. We have met all our financial targets.

On 1 April 2013, responsibility for planning and buying (commissioning) most of the health care services for Lewisham residents moved to the NHS Lewisham Clinical Commissioning Group (LCCG). This group, led by local GPs has been working in shadow form for the last 18 months and has proved it is fit for purpose by completing the rigorous national authorisation process led by NHS England. http://www.england.nhs.uk/The challenges for the CCG are considerable as Lewisham continues to experience increasing demands on health services due to population increases, more people living with long term conditions and the implementation of the TSA recommendations.

We recognise that we have not been able to deliver success alone. We would like to take this opportunity to thank our staff both past and present, local clinicians, partners and the public, all of whom have contributed in our ambitious work to reduce health inequalities and improve the health and wellbeing of our local population.

Caroline Hewitt
Chair
Lewisham Primary Care Trust

Dr Helen Tattersfield
Chair
NHS Lewisham Clinical Commissioning Group

Andrew Kenworthy
Chief Executive
Lewisham Primary Care Trust

3. The PCT

Lewisham PCT was responsible for improving the health and wellbeing of people who lived in, worked in or visited Lewisham. These responsibilities included assessing local healthcare needs and planning and buying the services required to meet those needs (we call this 'commissioning'). Lewisham PCT was led by the PCT Board, which was made up of executive and non executive directors and clinicians.

During 2012/13 the PCT Board was supported by the Lewisham Clinical Commissioning Committee (shadow Clinical Commissioning Group Governing Body) which was made up of local GPs, PCT Board members and designate lay members. This committee took on the task of commissioning and delivering improvements to the health of Lewisham people and the quality of local health services.

By working with our partners in the local NHS including GPs, pharmacists, dentists, hospitals and mental health providers and other borough partners (such as Lewisham Council and local voluntary and community groups) we sought to protect and improve health and wellbeing and reduce health inequalities, ensuring everyone had equal access to healthcare services.

Together we offered the people of Lewisham a wide range of services to help them stay healthy, and to care for them when they fell ill and needed extra support. We aimed to deliver high quality services that gave our communities the right care at the right time, in the right place and that were easy for people to use.

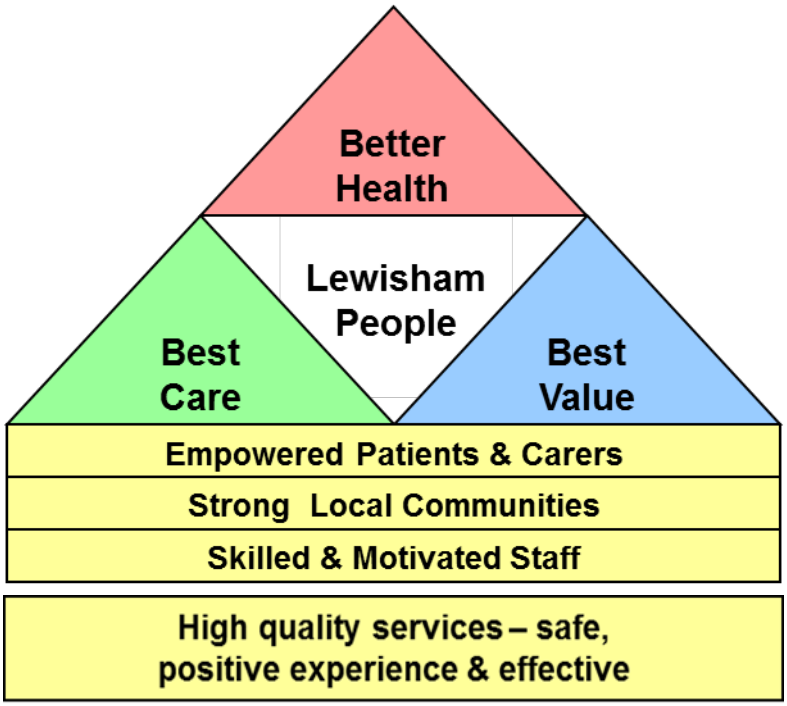
These services included:

- community services, provided through Lewisham Healthcare NHS Trust http://www.lewisham.nhs.uk/, such as district and school nursing, health visiting, specialist child health, therapy services and care for older people
- GPs, pharmacists, opticians and dentists
- hospital services through Lewisham Healthcare NHS Trust for inpatient, outpatient, day and emergency care. Some services were also commissioned from Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust mental health and substance misuse services from South London and Maudsley NHS Foundation Trust.

Our Vision and Goals

Our vision for commissioning in Lewisham was to improve the health of people living in the borough and where possible reduce health inequalities. This was achieved by co-operation between practices, community and primary care, secondary care, local authorities and the voluntary sector, patients and the public. This vision for improvement will be continued by the NHS Lewisham Clinical Commissioning Group.

Over the last 18 months the CCG has developed a five year strategic plan (2013/14 to 2017/18) building on the work Lewisham PCT has done in the past. The strategy aims to deliver the CCG's vision for improving health and reducing health inequalities in Lewisham. (see below)



The strategic plan identifies three key priorities for the next five years and shows how the CCG will work with commissioning partners, both within Lewisham and across the NHS in southeast London as a whole, to deliver quality services and better health for Lewisham people.

Our strategy is made up of:

- Our three priority health goals, to achieve Better Health healthy living for all; frail and vulnerable and people with Long Term Conditions.
- Our proposals to transform services, to achieve Best Care, includes the introduction of care plans for people with long term conditions, greater integration of health and social care services.
- Our financial strategy – 'Best Value' - by which we will ensure that our plans can be afforded within the resources we expect to get from the Government.

These areas have been agreed following:

- Feedback from local people and their experiences of health care services in Lewisham.
- Understanding the health needs of the population as set out in the Joint Strategic Needs Assessment (JSNA)
- Priority areas agreed by the Lewisham Health and Wellbeing Board..[1]

The CCG has developed a short summary of its strategic plan which is available on the CCG website at www.lewishamccg.nhs.uk.

.

[1] The Lewisham Health and Wellbeing Board is chaired by Sir Steve Bullock, Mayor of Lewisham and includes key partners from across health and social care in Lewisham. Visit http://www.lewishamjsna.org.uk/ for more information.

4. HEALTH AND WELLBEING IN LEWISHAM

Lewisham is an ethnically diverse inner London borough with high levels of deprivation, inequalities and unemployment. The population of about 270,000 people is relatively young, with one in four residents aged less than 19 years. The population aged 60 years and over represents one in seven people in the borough. This contrasts with England as a whole, where more than one in five people is over 60. Males comprise 49% and females 51%.

Lewisham is a 'Spearhead Authority' because it is in the worst 20 per cent of areas nationally for deprivation, life expectancy and premature deaths from cancer and cardiovascular disease, and is ranked the 31st most deprived borough in the country. It has a mobile population with estimates that as many as 20 per cent of people move in and out of the borough each year. All of these factors place a greater demand on health services and make delivering screening and immunisation programmes even more challenging.

Lewisham is the 15th most ethnically diverse local authority in England, and two out of every five residents are from a black and minority ethnic background. The largest BME groups are Black African and Black Caribbean: Black ethnic groups are estimated to comprise 30% of the total population of Lewisham.

For more information on health in Lewisham and the Joint Strategic Needs Assessment please visit www.lewishamjsna.org.uk

4.1 Health inequalities

While Life expectancy in Lewisham has been improving over the past decade, it remains below the London and England averages for both males (76.3 years) and females (81.3 years). For females the gap between life expectancy in Lewisham and that in England is narrowing, but for males it is not and that remains a challenge that we need to address, as are the considerable variations in life expectancy across Lewisham. The gap between the 10 per cent most deprived and the 10 per cent least deprived is 6.2 years for males and 3.3 years for females.

Disability free life expectancy at age 65 in Lewisham is not significantly different from that of London and England for either males or females. Within south east London, it is below that in Bromley for females, and not significantly different from those in the other boroughs. Disability free life expectancy at age 16 in Lewisham is not significantly different from that of London and England, or any of the other boroughs in south east London, for both sexes.

Compared with London as a whole, men and women in Lewisham are more likely to die prematurely from conditions which could be treated. We aim to reduce the numbers of such early deaths by prevention as well as treatment.

4.2 Improving health and wellbeing

In 2011 the Lewisham shadow Health and Wellbeing Board was established, chaired by Sir Steve Bullock, Mayor of Lewisham, and includes partners such as Lewisham Healthcare NHS Trust and Lewisham Council. The Board has used the joint strategic needs assessment (JSNA) process to develop a 10 year Health and Wellbeing Strategy 2012-2022 with the aim of ensuring that people in Lewisham are able to maintain the best possible health and wellbeing, receive the best possible care within resources available and maintain their

independence for as long as possible. . Nine priority outcomes have been developed which are closely aligned to those within the CCG's five year strategy. These are:

- Reduce update of smoking amongst children and young people and the numbers of people smoking.
- Reduce harm caused by alcohol.
- Promote healthy weight.
- Increase update of immunisation.
- Improve mental health and wellbeing.
- Improve sexual health
- Increase the number of people who survive colorectal, breast and lung cancers for one and five years.
- Delay and reduce the need for long term care and support
- Reduce the number of emergency admissions to hospital with chronic long term conditions.

For further information on Lewisham's Health and Wellbeing Strategy and the plans for delivering these priorities please visit www.lewishamjsna.org.uk

In Lewisham, there have been a number of improvements in health and wellbeing during 2012/13. These include:

- Greater immunisation coverage
- Increased numbers of referrals for physical activity and weight loss from the NHS Health Checks programme
- Increased numbers of people referred to alcohol services
- Fewer teenage conceptions

5. COMMISSIONING HEALTHCARE

5.1 Commissioning services

NHS Commissioning means planning, buying and monitoring the healthcare services that our residents need. As well as directly commissioning some services, the PCT also jointly commissioned a range of services with Lewisham Council. This approach will continue with NHS Lewisham Clinical Commissioning Group (CCG).

5.1.1 Hospital services

During 2012/13 Lewisham PCT commissioned care from three main hospital service providers: Lewisham Healthcare NHS Trust (http://www.lewisham.nhs.uk/) Guy's and St Thomas' NHS Foundation Trust (http://www.guysandstthomas.nhs.uk/Home.aspx) and King's College Hospital NHS Foundation Trust (http://www.kch.nhs.uk/), as well as a range of other providers across London and beyond. Commissioning hospital services was managed across south east London so that this work could be strengthened and enabled the best possible hospital care to be provided for local people.

Improvements in local hospital care over the last year included:

- A reduction in the number of patients waiting longer than 18 weeks between referral and treatment
- Improved staff engagement as reported in the NHS staff survey

Over the next three to five years, there will be a change in the organisation of hospitals and the way emergency, maternity and planned hospital services are provided in South East London

As a result of the recommendations of the Trust Special Administrator (TSA), the Secretary of State has agreed to the following changes to hospitals and services:

- South London Healthcare NHS Trust will no longer exist after October 2013 with each of its three hospitals planned to be taken over by a neighbouring hospital trust.
- Queen Elizabeth in Woolwich will merge with Lewisham Healthcare NHS Trust.
- Queen Mary's Hospital in Sidcup will be managed by Oxleas NHS Foundation Trust.
- Princess Royal in Bromley will be managed by King's College Hospital.
- Lewisham Hospital will retain a smaller A&E department to treat and admit patients with less serious conditions, with 24/7 senior emergency medical cover. It is estimated that up to 75% of the patients who currently use it will continue to do so
- Maternity Care – a SEL network of maternity units will be established with four obstetric led and a stand-alone maternity-led birthing centre at University Hospital Lewisham;
- Elective Services – a new 'elective centre' for non-complex operations is created at University Hospital Lewisham.

It is important to stress that these changes will take place over a period of time and nothing will change until alternative arrangements are in place. For the time being it is business as usual http://www.lewisham.nhs.uk/building_your_trust-1.aspx at Lewisham Hospital. More information is available at www.tsa.nhs.uk

5.1.2 Community health services

Community health services were commissioned from Lewisham Healthcare NHS Trust and included district and school nursing, health visiting, specialist child health, elderly care, sexual health services, foot care, health trainers, nutrition and dietetics advice and support, intermediate and respite care, and therapies such as speech and language therapy.

A south east London Community Based Care Strategy has been developed which sets out plans to develop more integrated community based care services for people in south east London.

5.1.3 Mental health and learning disability

Mental health

The main provider for mental health services in Lewisham is the South London and Maudsley NHS Foundation Trust (SLaM) http://www.slam.nhs.uk/.

In addition, the PCT also commissioned voluntary sector organisations to provide mental health services in the community. These included specific services for black African and black Caribbean people, lesbian gay bisexual and transgendered people, and an independent mental health advocacy service.

Learning disabilities

The majority of people with a learning disability used the mainstream mental health services provided by SLaM.

Improvements in mental health services over the last year include:

- I
- More support for people with dementia living in nursing homes
- Ensuring patients receive appropriate care in appropriate settings
- A more robust community care pathway
- More effective working across the primary and secondary care interface

5.1.4 Primary care services

A full range of primary care services were commissioned from general practitioners and other practice based staff, pharmacists, dentists and opticians.

During 2012/13 In Lewisham we had:

- 44 GP practices
- 35 dental practices
- 56 community pharmacies
- 20 opticians.

Improvements over the last year include:

- More children are fully immunised
- More patients are being prescribed the most clinically effective and cost effective medicines

From 1 April 2013 responsibility for commissioning GP, pharmacy, dental and optical care will move to NHS England (www.commissioningboard.nhs.uk)

5.1.5 Joint commissioning

Children's services were commissioned jointly with the London Borough of Lewisham Children and Young People directorate http://www.lewisham.gov.uk/Pages/default.aspx. Adult mental health and some other adult specialist services were also jointly commissioned with the council.

The Lewisham Joint Commissioning Unit was established as a recognised unit and a specific entity under a section 75 agreement between the council and Lewisham PCT, which aligned health and social care budgets under the management of the council. This included mental health, older adults, learning disabilities, physical disabilities, emerging client groups, and contracts and brokerage.

5.2 Ensuring high quality services

We were committed to ensuring that services we commissioned on behalf of our local population were safe, effective and of a high quality. Safety issues were reported at each board meeting and a number of systems were in place to support individual, team and corporate accountability. These included:

- quality alerts – this is an online tool used by GPs and other practice staff to raise concerns about the quality of service providers. Concerns were shared with the relevant providers to seek a solution and then discussed at regular quality meetings involving GPs and other healthcare providers

- assurance framework and risk register– this is a way of measuring the risks to our objectives and was constantly reviewed. Any high risks in relation to delivery of services were followed up with providers and reviewed by a board level quality and patient safety group

Our health care providers were held to account for quality issues through regular quality meetings. Each hospital also published quality accounts.

These measures of managing quality will continue with the CCG. In addition, in response to the Francis Report[2] published in February 2013, the government has launched plans to ensure that patients are always put first and people are treated with respect. The report sets out the need to develop the right culture of care within the NHS to ensure that there is no repetition of what happened at the Mid Staffordshire NHS Trust.

[2] The Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust

The CCG has established a formal group to review the impact of the recommendations in the Francis Report. Priorities include:

- Review the ways in which the CCG listens to patients and acts on what they are saying.
- Gain assurance from health providers that all recommendations from the Clinical Quality Review Groups are implemented.
- Intervene if there are any substandard or unsafe services.
- Review service data.

5.2.1 Serious Incidents

In 2012 / 2013 Lewisham HealthCare NHS Trust reported 113 Serious Incidents and South London and Maudsley reported 17. Serious incidents are always investigated to establish root causes and to ensure that actions are taken to prevent the incident occurring again. Full details of the quality of services provided by Lewisham hospital and South London and Maudsley are published in their annual Quality Accounts and are available on their websites (http://www.lewisham.nhs.uk/default.aspx) (http://www.slam.nhs.uk/)

6. IMPROVING QUALITY AND PERFORMANCE

6.1 Delivering our Quality, Innovation, Productivity and Prevention (QIPP) plans

Over the past year the NHS has faced significant financial pressures due to factors that increase the demand for and the cost of health services against a background of a much reduced rate of increase in NHS funding. In order to meet this challenge in Lewisham, clinical leaders have worked together across south east London and with local providers to to develop Quality, Innovation, Productivity, and Prevention (QIPP) projects for 2012/13. The aim of QIPP is to ensure that:

- Quality is improved.
- Innovation and evidence on what works well is used to redesign local services.
- Productivity and efficiency are increased.
- Prevention remains at the heart of what we plan to do.

The 2012/13 QIPP programme focused on increasing the level of integrated services and ensuring that services were accessible and met the health needs of local people. The CCG has received a monthly report on all the QIPP schemes to ensure they are making progress and on track.

Key achievements include:

COPD Pathway

This programme has been one of the truly 'integrated' successes for both Lewisham CGG and Lewisham Healthcare NHS Trust – encompassing primary, secondary and community care. A number of initiatives were introduced including: the introduction of key workers in all GP practices for patients with COPD, a consistent and well developed education programme (competency framework) to support key workers, investments to enable early supported discharge from hospital and triaging of all referrals.

In 2012/13 emergency admissions related to COPD reduced by 22% in comparison to 2011/12. Early review of the data suggests that this reduction has been for patients over 65 years. In addition, there is an indication that the COPD programme has also positively impacted on reducing emergency admissions for other respiratory conditions across all providers.
For patients this has meant a single point of access, a bespoke package of care for their condition and being treated in the most appropriate care setting.

Diabetes

A multi-disciplinary taskforce from the local health economy was established which developed the strategy for improving care for people with diabetes in Lewisham. There are a number of work streams and implementation plans have been developed with many being realised in 2013/14. However, the programme got off to an excellent start in 2012 with its first phase of 'getting basic right', which centred on improving care in primary care to enable patients to feel better supported in managing their own condition. The vision and strategy were developed in consultation with wider health economy, patients and the public. A further outcome of the work was the

establishment of a public/patient reference group and plans are in place to establish 'community champions' in partnership with Diabetes UK to support local people to manage their condition.

Heart Failure Pathway

A new pathway for Heart Failure was developed by a joint steering group with Lewisham Healthcare NHS Trust and Lewisham CCG. The pathway was supported by investments made by Lewisham CCG for a dedicated multidisciplinary team and was a direct response to the increase in the number of emergency admissions and readmissions for patients with this condition.

MSK (Musculo-skeletal) Pathway

A single point of access was developed in partnership with clinicians from Lewisham Healthcare NHS Trust and Lewisham CCG for all MSK referrals and the revised pathway went live in April 2012. Referrals are triaged to the most appropriate service.

Telehealth Pilot:

The Lewisham CCG in partnership with Lewisham Healthcare NHS Trust completed a 12 month pilot funded by the CCG. This innovative technology enabled 100 patients with COPD and Heart Failure to better self-manage their conditions by providing them with monitoring devices in their own home. The pilot involved community matrons and GPs working together to support patients. An evaluation of the pilot is currently being conducted by Public Health Lewisham. It is envisaged that the outcomes of the evaluation will inform future commissioning intentions.

Proactive Primary Care

Lewisham CCG completed a Proactive Primary Care feasibility study in 2012 with a local GP practice. Proactive Primary Care is essentially the use of routine telephone call follow-up with patients using motivational interviewing techniques. The idea is to support patients to self-manage through regular telephone contact initiated by the local GP practice. Lewisham CCG's feasibility study focussed on 70 patients aged between 45 and 65 years and was evaluated with the support of the London School of Economics.

Urgent Care:

Worked continued on refining services provided at the Urgent Care Centre, which is delivered in partnership with Lewisham Healthcare NHS Trust by local GPs located in the centre. In July 2012 our evaluation of the centre, which included user and staff feedback showed that patients were confident in the service, were seen by the most appropriate person and that many were aware of the Choose Well Campaign[3].

Mental Health:

Improvements in mental health included:

[3] The Choose Well Campaign encourages people to choose the most appropriate health service for their condition.

- the reconfiguration of Mental Health of Older Adults (MHOA) Continuing Healthcare with the closure of Granville Park. Over £800k was reinvested back into MHOA services.
- Continuation of the Lewisham forensic triage model for those requiring a hospital admission from prison. This has saved over £1.3m from commissioning budgets and diverted over 75% of people away from medium secure services. This therefore ensures that people are in the right place from both a clinical and risk perspective.
- Reduction in Adult Mental Health complex residential placements to ensure that people are in the right place at the right time via regular clinical review.

Medicines Management:

In 2012/13 the Lewisham CCG and Lewisham Healthcare NHS Trust medicines management and prescribing teams were successful in their collaborative approach in delivering a number of QIPP schemes, which focussed on reducing expenditure in prescribing by utilising the clinical specialist knowledge of primary and secondary care and the procurement advantages and formulary controls of secondary care. A medicines waste campaign was launched to encourage the public to use their medicines wisely.

End of Life Care

End of Life CQUINs (Commissioning for Quality and Innovation) were agreed with Lewisham Healthcare around three specific areas: Identification and registration of end of life care patients; Communication and Implementation of the Liverpool Care Pathway.

Processes and protocols to guide Community Nurses on the inclusion of patients on the End of Life Register have been developed and targets have been met for the number of nurses attending training on the Gold Standard Framework and Liverpool Care Pathway.

In February 2013, data from the current End of Life Care Electronic Register has been migrated to a new system called “Coordinate My Care”. (CMC). This system will be able to share information with all care providers including the NHS 111, London Ambulance Service and out of hours services.

The PEACE (Proactive Elderly Care Planning) document has been piloted on elderly care wards at UHL for patients being discharged to nursing homes who are likely to die within the next 12 months.

Following the success of the pilot with two Residential homes in 2010/11, St Christopher’s Hospice has been engaged to facilitate a programme aimed at improving Palliative care in care homes. All nine Residential Care Homes (RCHs) in Lewisham have passed the “Steps to Success” RCH programme for end of life care, and the number of residents enabled to die in the home (as opposed to hospital) has significantly increased.

6.2 Our performance

Performance for Lewisham People is reported as at Quarter 3, 2012/3 which is the latest validated data.

Achievements in 2012/13 include:

- Infection control– MRSA and CDifficile infections are half what they were at the same period last year at 2 and 24 respectively this year.
- All referral to treatment times within 18 weeks have met the Standards set for the NHS including those who have been referred and not yet treated (from May 2012 onwards). There are 23 patients who have been referred who have not yet been treated at the end of December. There is a plan to reduce this to zero by July 2013.
- All cancer waiting time standards have been met for the year to date, including being diagnosed and for those confirmed with cancer beginning treatment of various kinds.
- Child Immunisations for MMR at age 2 was substantially improved in 2011/2 and this has been sustained during the reporting year. The CCG Board is now focusing on to the pre school immunisations.
- A higher percentage of Lewisham people who need it are accessing Psychological Therapies. As a result the CCG will be focussing onreducing waiting times and an improvement in recovery rates for people who have been treated by the service.

There are some key challenges going forward to enable us to meet our key performance targets during 2012/13:

- While we are close to the planned number of people who have stopped smoking through NHS advice in the first three quarters of the year (1,076), Lewisham still need another 700in quarter four to meet the plan for the year.
- While Lewisham has 37 health visitors in place and has supplemented this with temporary staff, it will take another two years to deliver the planned increase in health visitors to 72 by 2015.

7. WORKING IN PARTNERSHIP

7.1 Developing Clinical Commissioning

Clinical commissioning in Lewisham has been led by the Lewisham Clinical Commissioning Committee which is chaired by local GP, Dr Helen Tattersfield, All 42 GP practices across the borough make up the membership of Lewisham Clinical Commissioning Group.

Since April 2012 the shadow CCG had delegated responsibility for all relevant commissioning budgets that fall within the remit of clinical commissioning groups (CCGs).

The areas of delegated responsibility covered:

- prescribing,and medicines management
- adult community health services, including adult nursing services and sexual and reproductive health
- planned care, including outpatients, diagnostics, inpatient care and continuing the existing work improving pathways of care
- unscheduled care including emergency admissions, A&E and Urgent Care Centre attendances
- services jointly commissioned through London Borough of Lewisham covering children and young people's services, adult mental health and other adult health client groups (under a section 75 arrangement).
- Lewisham Business Support Unit (BSU) operational budget.

A senior clinical director, GP, from the CCG leads on quality and safety and has attended the South East London Quality and Safety Sub Committee to provide oversight of provider quality assurance, attends the quality meeting between commissioners and Lewisham Healthcare and chairs a quarterly Lewisham based meeting focusing on improving key clinical pathways.

In January 2013, Lewisham CCG was authorised to take on its commissioning responsibilities by NHS England following an intense and rigorous authorisation process which was conducted with all CCGs across the country. The CCG formally took on these responsibilities as a statutory organisation on 1 April 2013. For more information on the authorisation process for CCGs please visit www.commissiongboard.nhs.uk.

7.2 Stakeholder Reference Group

Lewisham has contributed to the South East London stakeholder reference groups (SRG). The aim of the SRG is to improve and strengthen engagement across the local NHS and review the impact of any changes or plans on patient choice.

The SRGs aim to improve relationships with stakeholders and ensure they are kept informed of changes in the local NHS. They are made up of representatives from the local involvement networks (LINks), the voluntary sector, and council overview and scrutiny chairs and officers,

clinical commissioners, non executive directors and other representatives from NHS South East London. Local provider organisations are also invited.

Key achievements during 2012/13 include:

- reviewing of a range of engagement plans relating to different service improvements and developments
- co-ordinating responses to national developments and processes, including the engagement requirements for Any Qualified Provider and the Trust Special Administrator's report on South London Hospitals Trust (SLHT) and the NHS in South East London
- improving relationships between clinical specialities and organisations

The SRGs will continue during 2013/14 to enable the CCGs in south east London to work together on improving engagement with key stakeholders and local people.

7.3 Working together

We have a strong history of partnership working in Lewisham and we believe that health in the borough can only be improved by working effectively with partners and fully engaging clinicians to work with local communities and patients to co-design services for the future. Our key partners include local people and patients, clinical commissioners, Lewisham GP practices, independent contractors, Lewisham Healthcare NHS Trust, Lewisham Council, the voluntary and community sector, and Lewisham LINk.

We also work with neighbouring trusts and organisations on strategic programmes to improve health.

During 2012/13 working in partnership enabled us to:

- Undertake a review of diabetes care across Lewisham. A new vision has been developed together with a detailed plan of how improvements will be implemented.
- Delivery of the North Lewisham Plan which was developed to help reduce inequities in health in one of the most deprived parts of the borough – New Cross and Evelyn wards. The plan is made up of projects and initiatives that support the plan to help deliver improved health outcomes.

7.4 Healthier Communities Select Committee

We continue to work closely with the Lewisham Healthier Communities Select Committee on the local implementation of national NHS reforms and on plans and proposals for service change. For more information on the committee, please visit www.lewisham.gov.uk

7.5 Engaging with local people

The PCT has a long and successful track record of effective engagement with local people and this approach has been continued by the CCG. An engagement strategy setting out the principles and plans for effectively engaging with local groups, patients and the public was developed as part of the national authorisation process for CCGs. A Patient and Public Engagement Committee chaired by a GP co-ordinates engagement activity across the CCG working with health providers, Lewisham Council and Lewisham LINk (Local Involvement

Network). The group defines and approves workplans for engagement and makes sure key issues identified become an active part of commissioning plans and in year changes. The membership reflects the strong partnership approach in Lewisham.

The relationship with Lewisham LINk is positive and we have worked effectively on a range of joint initiatives to involve local people in health care planning. The LINk have developed an engagement database which records feedback from patients on their experiences of using local health services and provides rich and useful data for our engagement work. As part of the changes to the NHS, Lewisham Healthwatch will take over the responsibilities previously held by the LINk. For more information on the Lewisham Healthwatch please visit http://www.healthwatch.co.uk/directory/lewisham

We gather information on patient satisfaction from a huge range of sources including the NHS patient survey programme, surveys carried out by our local NHS providers, and our quality and complaints monitoring system. We are determined to learn from our local population about how we can jointly make a difference and improve patient experience.

We have a proven track record of listening to feedback from local people and using what they tell us to ensure that decisions we make about healthcare are underpinned by a clear understanding of public views, concerns and aspirations.

Knowing what people think about existing health services in Lewisham is also vital to helping us improve patient experience in the future.

Key achievements in 2012/13 include:

- A large scale survey to ask residents for their views on local health services which included presence at the Super Saturday event during the 2012 Olympics. Outputs from the survey were used to help inform development of the CCG priorities for the next five years.
- Several events with local people to ask for their view on development of our plans (ie older people diabetes, strategic priorities).
- Support to set up the Patient Participation Groups in practices with work to review how these have led to different improvements (for example accessing urgent appointments for GPs).

For further information on how to get involved in the work of the CCG please visit www.lewishamccg.nhs.uk or call Grainne Bellenie Engagement Manager on 020 3049 3204

7.6 Complaints and PALS (Patient Advice & Liaison Service)

The Patient Advice and Liaison Service (PALS) enables patients and carers to get information on their health services and give feedback on their experiences. The majority of these enquiries are handled through the local PALS helpline. During 2012/13 approximately 4,000 calls were received which is consistent with previous years involving information requests, general advice about local services, help to register with a local GP and accessing an appointment. Where enquiries need more than simple signposting or advice, patients are

offered individual support and guidance.

Anyone who is unhappy about the quality of service they receive can complain through the NHS complaints process. We take all complaints seriously, investigating them thoroughly and making it clear that a complaint will not affect the quality of care provided. Between April 2012 and February 2013 75 complaints were received. Most were responded to within 25 working days and those which took longer were agreed with complainants.

All NHS organisations are expected to have their own procedures for dealing with complaints. However, we also provide support to those wishing to make a complaint involving any of our independent contractors including GPs, dentists, opticians and pharmacists. Our complaints policy was updated in 2011 and is compliant with the 'Principles for Remedy' published by the Parliamentary and Health Service Ombudsman in 2009. If you wish to make a complaint about your NHS service, please visit www.lewishamccg.nhs.uk for more information.

7.7 The NHS Constitution

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

8. MAKING IT HAPPEN

8.1 Our staff

During 2012/13Lewisham PCT employed 50 members of staff within its Business Support Unity and 23 within its Public Health Department. This included staff working within the local CCG office and some based within the NHS South East London cluster providing services across south east London.Our staff have access to a training and development programme which is based on the training needs identified in personal development plans. The programme also includes mandatory training which ensures that all staff can work in a safe and effective way and are using best practice in particular around safeguarding and information governance. In March 2012 staff had access to the 'Piecing Together Change' programme designed specifically to help staff through the change process.

The sickness absence rate for Lewisham PCT staff was lower than the London target (2.45% for Lewisham against a London target of 3%). Sickness absence rates are monitored closely to ensure the right support is provided to staff who are absent due to sickness to enable appropriate and timely returns to work.

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

	2012-13 Number	2011-12 Number
Total Days Lost	**964**	**1,441**
Total Staff Years	**135**	**165**
Average working Days Lost	7.14	8.73

8.2 Communicating with staff

This year has been one of huge change and uncertainty for our staff as we have prepared for the dissolution of the PCT and creation of a new commissioning healthcare system. During periods of uncertainty good communication is even more important and a range of systems have been in place to provide clear information to staff and enable them to contribute and engage in developments.

These include:

- regular staff communication through a fortnightly update and monthly management brief
- monthly staff briefings with the opportunity for questions and feedback
- development of a special Transition update bulletin which focused on the key changes taking place across the health system and how this would impact on different staff groups.
- interactive staff road shows for updates on key organisational change such as the development of a commissioning support service
- Intranet and website.

Confidential email address for questions and answers. As part of our commitment to effective and productive conduct of employee relations the PCT was part of the NHS South East London joint partnership forum with staff side representatives. The purpose of the forum was to identify and facilitate workforce and employment business. This involved negotiation and consultation on policies and impending organisational changes. The forum met on a bimonthly basis and was committed to continuously improving the working lives, health and wellbeing of staff.

Effective communication remains to be just as important in the new commissioning healthcare system in 2013.

8.3 Equal Opportunities

As part of the development of the NHS South East London equality objectives for 2012/13, equality objectives were developed in order to strengthen our performance under the Public Sector Equality Duty (PSED) of the Equality Act 2010. These were aligned to the outcome of our Equality Delivery System (EDS) grading for staff and leadership, the EDS goals and outcomes, and our priorities for people transition.

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

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

The EDS aims to achieve positive cultural change in the NHS by creating an environment where services for patients and workplaces for staff are more equitable, diverse and that fairly represent the wider community.
The EDS enabled us to meet the aims of the Equality Act 2010 which is a legal requirement of all public organisations to take the necessary actions to achieve:

- elimination of unlawful discrimination
- advancement of equality of opportunity
- fostering of good relations between individuals and communities.

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

Achievements during 2012/13 include:

- Equality embedded into the new CCG organisations
- Joint Strategic Needs Assessments cover all the protected characteristics and key disadvantaged groups.
- Cluster-wide performance in the Learning Disability – Self Assessment Framework (LD-SAF) 2012 improved significantly, with central co-ordination and monitoring.
- All local NHS organisations complied with the Public Sector Equality Duty (PSED).
- Equality leads in place within the CCG.

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

8.6 Protecting your information

To provide the best possible healthcare services, NHS organisations collect sensitive and/or confidential information, often called Personal Identifiable Data (PID). The key elements of Information Governance set the standards to ensure that this information is dealt with legally, securely, efficiently and effectively. Throughout this year we have focused on the management and preparation of change in the NHS to ensure continuity of service and appropriate controls

around patient information. All our staff have undertaken Information Governance training and the CCG will continue to be committed to the standards set out by the Care Record Guarantee and the Information Governance Toolkit.

We continue to work hard to ensure the security of patient information and maintain appropriate access. We are reviewing current ways of working as well as support new innovations to ensure that appropriate controls and security are in place. Along with these changes we are keeping local patients informed about how their information is being used to deliver their healthcare and manage the NHS.

Areas of focus during 2012/13 include:

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

Arrangements were put in place for investigating any potential breach of our procedures or policies.

Statement on public information

Lewisham PCT complies with HM Treasury's guidance on setting charges for information in 'Managing Public Money' which can be read at http://www.hm-treasury.gov.uk/psr_mpm_index.htm

8.7 Serious incidents in relation to information governance

Staff are encouraged to report incidents and 'near miss' events so they can be investigated and so that we can reduce the risk of such incidents in future. We are also legally required to assess whether any incident constitutes a serious incident.

A serious incident is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service.

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

8.8 Risk Management

The NHS South East London approach to risk management and board assurance was in accordance with legislation and national and local guidance. It sought to embed recognised and developed best practice through a process of ongoing review and improvement whilst underpinning the production of the annual governance statement.

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

In Lewisham two new significant risks were identified for 2012/13:

- There is a risk that substantial changes to the healthcare system in Lewisham will lead to deterioration of service delivery caused by the outcome of the SLHT TSA leading to deterioration in financial and quality performance for Lewisham CCG.
- There is a risk that successful financial claims may be made against the PCT/CCG for retrospective continuing care funding reviews leading to unbudgeted expenditure

These risks were reported to the PCT Board and the Lewisham Shadow Governing Board in the PCT Board Assurance Framework and were managed within the routine risk management processes that are fully described in the Lewisham PCT 2012/13 Annual Governance Statement.

8.9 Emergency Preparedness, Resilience and Response

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

The highlight of 2012 was, of course, the London Olympic and Paralympic Games. Although the games did not take place in Lewisham, the effects of this global event were felt across London and considerable time and effort went into ensuring that south east London's health service was games-ready. A high-level senior coordinating committee planned and coordinated all providers, from the major acute trusts to small community pharmacies and nursing homes, to ensure everyone was prepared. The Cluster also worked closely with local authorities and Transport for London to ensure that staff and service users were aware of the possible impacts of the games and that disruption was kept to a minimum.

As we look to the future, the EPRR functions of the PCTs will transfer to NHS England who will take on the lead role for the emergency planning and response functions for London.

CCGs will continue to play an important role in EPRR with responsibilities under the Civil Contingencies Act and a focus on ensuring that South East London's health service remains robust in planning for, and managing surges in demand. They will also be required to assist NHS England in the event of a major incident. CCGs will additionally be represented on their local Borough Resilience Forum and the strategic body, the London Local Health Resilience Partnership.

A transition process has been underway since 2012 to ensure that these functions are handed over safely with assurance exercises conducted in 2013 prior to the handover culminating in Exercise Sentinel which took place in early February. The NHS England South Area EPRR team

will continue to work with all CCGs, providers and stakeholders in South East London to ensure that the NHS remains resilient in planning and response in the years to come.

8.10 Our Estate and sustainability

As part of the changes to the NHS, the NHS Property Services Ltd has been set up to maintain, manage and develop around 3,600 NHS facilities, from GP Practices to administrative buildings across the country.

In Lewisham, 2012/13 has been a year of further significant investment in the community estate, with investment to reduce backlog maintenance being the main priority. Funding was approved to address statutory, contractual and CQC identified priorities across Lewisham GP sites.

Business cases have been produced for the development of new GP premises for the Queens Road Practice and for the ICO Health Group (Boundfield Medical Centre, Chinbrook Practice, Downham Way Surgery and the Marvels Lane Surgery).

Considerable time has been given to arranging the transfer of the estate to community service providers, Community Health Partnerships (LIFT) or to NHS Property Services Ltd.

Environmental sustainability is an important NHS priority. During 2012/13 NHS South East London PCTs have concluded a number of property disposals for sites which did not meet healthcare requirements. This has seen older, less energy efficient stock sold. New buildings brought opened in the year have conformed to environmental requirements, providing better quality patient and staff environments as well as more efficient infrastructure.

9. GOVERNANCE

9.1 NHS South East London

On 1 April 2011, NHS South East London was established as a transitional organisation to take us through to 2013 and the implementation of the new healthcare system. NHS South East London consisted of a single shared corporate management team and six borough based business support units (BSUs). There was a single accountable officer (the Chief Executive), an executive team made up of the Chief Executive and four other directors (3 from 1 June 2012), a chief nurse and a medical director who worked with the managing directors of the six BSUs and the Chairs of the Local Clinical Commissioning Committees.

The joint boards were six individual PCT/care trust boards that worked together as one entity, undertaking the duties that are enshrined in law relating to the governance of primary care trusts and care trusts, but fulfilling them in a slightly different way. Certain mandatory positions on the boards, such as the chair and chief executive, were fulfilled by the same individual across all of the boards, while other positions are taken by local BSU managing directors and locally focused non executive directors. Fulfilling the same legal duties as trust boards have always had, the boards focused on developing strategies and priorities for the entirety of South East London, ensuring that the shadow clinical commissioning groups were fulfilling their duties, in accordance with what was delegated to them.

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

Name	**Position**
Caroline Hewitt	Chair, NHS South East London
Steven Corbishley	Non Executive Director
Andrew Kenworthy	Chief Executive NHS South East London Chief Executive NHS South East London (undertook a secondment from 4 September 2011)
Christina Craig	Interim Chief Executive NHS South East London (from 3 September 2012 as Interim CEO for NHS South East London)
Richard Chapman	Acting Director of Finance[2]
Malcolm Dennett	Interim Director of Finance (from 14 November 2012)
Alison Tonge	Interim Director of Finance (from 6

	August , to 15 November 2012)
Jane Schofield	Director of Operations and Joint Deputy Chief Executive
Gill Galliano	Director of Development and Joint Deputy Chief Executive (until 30 July 2012)
Donna Kinnair	Director of Nursing (until 1 October 2012)
Jane Clegg	Interim Director of Nursing (from 1 October 2012)
Sue Gallagher	Non Executive Director
Richard Gibbs	Non Executive Director
Graham Laylee	Non Executive Director
Rona Nicholson	Non Executive Director
Robert Park	Non Executive Director
David Whiting	Non Executive Director
Dr Helen Tattersfield	Chair, Lewisham Clinical Commissioning Group
Martin Wilkinson	Managing Director, Lewisham Business Support Unit
Dr Danny Ruta	Director of Public Health

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

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

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

9.2 Declaration of Lewisham Board members personal and financial interests – 2012/2013

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
Steven Corbishley	BT	A small number of shares of insignificant value	Nil
Susan Gallagher	Guys and St Thomas Charity	Trustee No remuneration paid	Self employed executive coach, facilitator and development consultant Husband a consultant oncologist at the Barts Health NHS Trust
	Guys and St Thomas Foundation Trust	Stakeholder governor	
Richard Gibbs	PHAST, a provider of public health consultancy to NHS bodies	Associate Consultant Value: None Materiality: Negligible since I avoid involvement with PHAST work in SE London	Nil
	Pembroke House, a charity helping deprived children in Walworth	Trustee No remuneration paid	
Caroline Hewitt	Withers LLP	Husband is partner in law firm whose clients include some NHS organisations. Remuneration: benefits from profit share	Nil
	VSO UK/VSO International	Member of Audit Committee No remuneration paid	
	Kings College Hospital Charity	Trustee No remuneration paid	
Graham Laylee	ECT Venues Ltd – from time to time provides conference rooms for NHS organisations.	Non Executive Director and small shareholder. Remuneration paid	Nil
Rona Nicholson	None	None	I am an Executive Director of Hanover Housing Association which operates in South East London and holds supporting people contracts with a number of Local Authorities
Robert Park	Cambridge House	Trustee No remuneration paid	Nil
David Whiting	Whiting & Birch Ltd	Director & Co Owner 50% shareholding	Occasional sales of books and journals to NHS bodies which are largely indirect and through agencies. Working

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
		Remuneration paid	relationship with academics and others who may be employed in the NHS, or undertake research in the NHS. Publishing activities on behalf of professional organisations and academic bodies (non in the UK).
Richard Chapman	None	None	Nil
Malcolm Dennett			
Alison Tonge (left)	None	None	Nil
Gill Galliano (left)	PCC CIC (Social Enterprise)	Trustee	Nil
Andrew Kenworthy	Diabetes UK Alzheimer's Society British Heart Foundation	Fund-raising for these organisations Wife – Consultancy business, training health professionals on cardio-vascular health and stroke for health communities/organisations across the UK	Nil
Christina Craig	None	None	Nil
Donna Kinnair	Royal College of Nursing Publications	Consultant Editor Expenses paid	Nil
	CWfI (Mouchell)	Board Member No remuneration paid	
	Walworth Academy	School Governor No remuneration paid	
Jane Clegg			
Jane Schofield	None	None	Nil
Helen Tattersfield	Oakview Family Practice	GP (proprietor) Remuneration paid Husband is business manager	Chair of Downham Nutrition Partnership, a charity promoting healthy eating and life style locally, for which I receive no payment
Martin Wilkinson	None	None	Nil

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
Danny Ruta	Guys and St. Thomas' Foundation Trust	Grant holder – grant to establish South East London Institute of Public Health	Nil
	Pro-active East London County Sports Partnership	Non Executive Director No remuneration paid	

9.3 Lewisham Clinical Commissioning Committee

The local clinical commissioning committees (LCCCs) were forerunners to the clinical commissioning groups (CCGs) which replaced PCTs and care trusts as the commissioners of local health services on 1 April 2013. This new clinically led body has been supported by Lewisham Business Support Unit to identify local healthcare needs and prioritise commissioning accordingly, providing a local focus to cluster wide strategies. They also undertook the duties of the professional executive committees (PECs) and provide oversight of local performance.

The Lewisham Clinical Commissioning Committee is chaired by Dr Helen Tattersfield and meets monthly in public. This committee is now the Governing Body for NHS Lewisham Clinical Commissioning Group which became the statutory organisation responsible for commissioning most of the healthcare services in Lewisham on 1 April 2013. The full membership is listed below:

Name	Title
Dr David Abraham	Senior Clinical Director
Aileen Buckton	Executive Director Community Services
Dr Judy Chen	Clinical Director
Prof Ami David MBE	Nurse Member
Dr Suparna Das	Secondary Care Doctor
Dr Hilary Entwistle	Clinical Director
Dr Arun Gupta	Clinical Director
Jennifer Gillard	Lewisham LINk Member
Dr Faruk Malik	Senior Clinical Director
Tony Read	Chief Financial Officer
Diana Robbins	Lay Member
Dr Marc Rowland	Clinical Director
Dr Danny Ruta	Director of Public Health
Dr Helen Tattersfield	Chair
Martin Wilkinson	Managing Director (Designate AO)
Ray Warburton	Vice Chair Lay Member

9.4 Joint Audit Committee

The Joint Audit Committee fulfilled the statutory audit functions required of PCTs and care trusts, ensuring that the governance and machinery of the cluster and the BSUs was functioning as it should. Its work programme included reviewing governance arrangements

(including information governance), assurance mechanisms including the work of internal and external audit, local counter fraud services, debt and waiver management, and reviewing the board assurance framework to make sure that corporate objectives and organisational risks are properly addressed. The Committee met four times a year and all meetings in 2012/13 were quorate.

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

9.5 **Integrated Governance Committee (IGC)**

The IGC had the following roles and responsibilities:-

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

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

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

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

9.6 Handover and Closure Committee

The Handover and Closure Committee oversaw all aspects of the Handover and Closure programme in the NHS in south east London leading up to the new NHS commissioning arrangements which came into force on the 1 April 2013. The Committee mets in private but provided its minutes to the Joint Boards. All meetings in 2012/13 were quorate.

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

9.7 Capital Strategy Group

The Capital Strategy Group oversaw all aspects of Capital Strategy, planning and progress in the NHS in south east London. The Group met in private but considered issues prior to their decision at public meetings of LCCCs or the Joint Boards. All meetings in 2012/13 were quorate.

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

9.8 Employment and Remuneration Committee

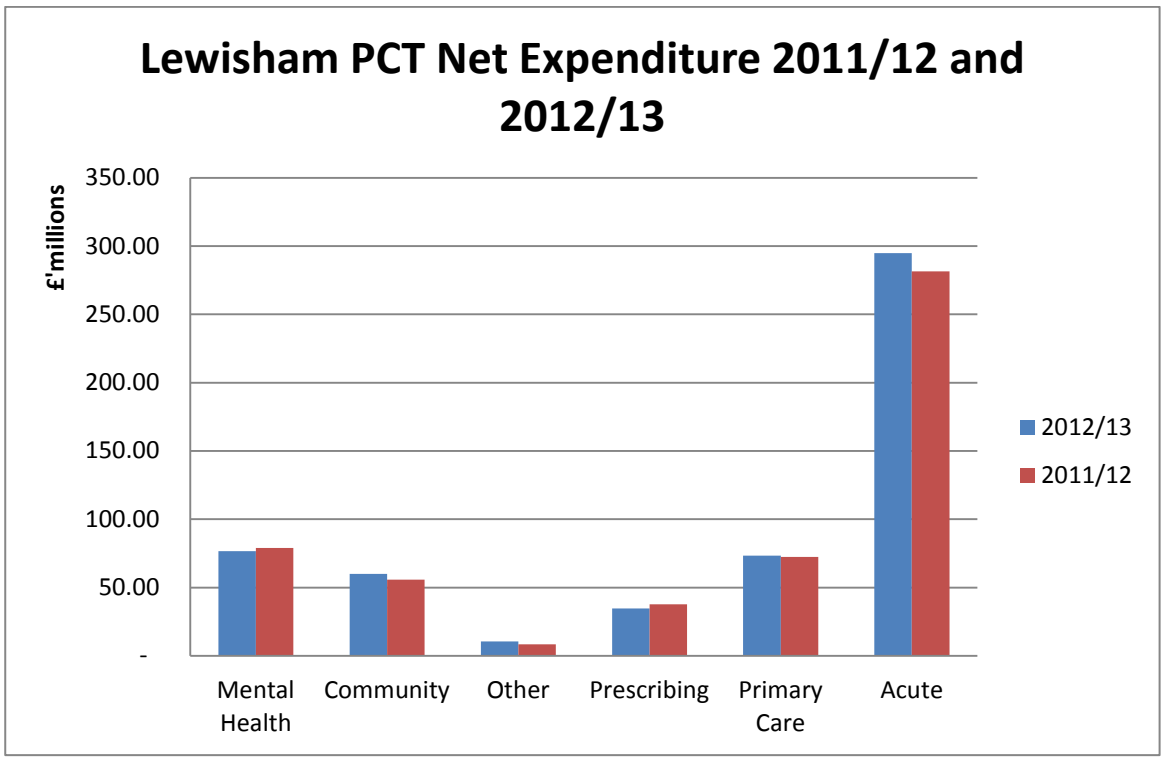
The Employment and Remuneration Committee met to consider the employment packages for those employees of the cluster whose remuneration falls outside the scope of Agenda for Change.

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

10. HOW WE SPENT YOUR MONEY

During 2012/13 we spent:

- **£442.0m on secondary and community healthcare** of which mental health £76.6m; general & acute £250.4m, maternity £22.6m, accident & emergency £21.9m, community £60m, learning difficulties £1.1m and other contractual £9.4m.
- **£106.3m on primary healthcare** of which, primary medical services £40.4m; prescribing £34.8m; dental services £18.0m; new pharmacy contract £9.5m; Pharmaceutical services £1.5m and ophthalmic contracts £2.1m.



11. REMUNERATION REPORT

11.1 Unaudited

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

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

11.2 Contract details

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

Name	Title	Start Date	End Date
Andrew Kenworthy * (to 4/9/2012)	Chief Executive, NHS SEL Cluster	03/10/2011	31/03/2013
Christina Craig *	Interim Chief Executive, NHS SEL Cluster	03/09/2012	31/03/2013
Gill Galliano	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	02/12/2002	30/06/2012
Richard Chapman *	Director of Finance, NHS SEL Cluster	01/11/2011	31/03/2013
Alison Tonge *	Interim Director of Finance, NHS SEL Cluster	06/08/2012	15/11/2012
Malcolm Dennett *	Interim Director of Finance, NHS SEL Cluster	14/11/2012	31/03/2013
Jane Schofield	Director of Operations, NHS SEL Cluster	01/04/2011	31/03/2013
Donna Kinnair	Director of Nursing, NHS SEL Cluster	12/02/2011	01/10/2012
Jane Clegg	Director of Nursing, NHS SEL Cluster	09/11/2012	31/03/2013
Caroline Hewitt	Chair, NHS SEL Cluster	01/04/2011	31/03/2013
Steven Corbishley	Non Executive Director, NHS SEL Cluster	01/04/2007	31/03/2013
Susan Gallagher	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Richard Gibbs	Non Executive Director, NHS SEL	01/04/2011	31/03/2013

	Cluster		
Graham Laylee	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Rona Nicholson	Non Executive Director, NHS SEL Cluster	01/04/2009	31/03/2013
Robert Park	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
David Whiting	Non Executive Director, NHS SEL Cluster	01/04/2007	31/03/2013
Dr Helen Tattersfield	Local Clinical Commissioning Committee Chair	01/08/2001	31/3/2013
Martin Wilkinson	Managing Director	01/04/2011	31/03/2013
Dr Danny Ruta	Director of Public Health	26/10/2009	31/03/2013

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

11.3 Senior Management cost sharing arrangements

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

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

Audited

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

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

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

		2012/13				2011/12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
Dr Helen Tattersfield	Local Clinical Commissioning Committee Chair	55-60				55-60			
Martin Wilkinson	Managing Director	90-95				90-95			
Dr Danny Ruta	Director of Public Health	100-105		5-10		90-95		5-10	

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

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

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

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	896	872	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	20-25	0	912	-912	
Richard Chapman	Director of Finance, NHS SEL Cluster	0-2.5	2.5-5	2.5-5	10-15	287	202	84	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	1157	1217	-60	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	5-10	10-15	565	500	65	
Martin Wilkinson	Managing Director	0-2.5	0-2.5	20-25	65-70	325	314	11	
Dr Danny Ruta	Director of Public Health	0-2.5	2.5-5.0	5-10	20-25	129	108	21	

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

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

Salaries and allowances

		2012/13				2011/12			
Name	Title	Salary (bands of £5,000	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
		£000	£000	£000	£00	£000	£000	£000	£00
Andrew Kenworthy (to 4.9.2012)	Chief Executive, NHS SEL Cluster	45-50				85-90			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					60-65			
Christina Craig (from 3.9.2012)	Interim Chief Executive, NHS SEL Cluster	150-155							
Gill Galliano (to 30.6.2012)	Director of Development, NHS SEL Cluster	30-35				125-130			
Jane Schofield	Director of Operations, NHS SEL Cluster	130-135	260-265			130-135			
Richard Chapman	Director of Finance, NHS SEL Cluster	110-115				65-70			
Alison Tonge (from 6.8.12 to 15.11.2012)	Interim Director of Finance, NHS SEL Cluster	80-85							
Malcolm Dennett (from 14.11.2012)	Interim Director of Finance, NHS SEL Cluster	70-75							
Donna Kinnair (to 1.10.2012)	Director of Nursing, NHS SEL Cluster	95-100	105-110			95-100			
Jane Clegg (from 9.11.2012)	Director of Nursing, NHS SEL Cluster	50-55							
Caroline Hewitt	Chair, NHS SEL Cluster	40-45				40-45			
Steven Corbishley	Non Executive Director, NHS SEL Cluster	Nil Remuneration				Nil Remuneration			
Susan Gallagher	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Richard Gibbs	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Graham Laylee	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Rona Nicholson	Non Executive Director, NHS SEL Cluster	Nil Remuneration				Nil Remuneration			
Robert Park	Non Executive Director, NHS SEL Cluster	5-10				5-10			
David Whiting	Non Executive Director, NHS SEL Cluster	10-15				10-15			

Lewisham PCT senior staff – these staff represent Lewisham PCT on Cluster Board.

Salaries and allowances

		2012/13				2011/12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
Dr Helen Tattersfield	Local Clinical Commissioning Committee Chair	55-60				55-60			
Martin Wilkinson	Managing Director	90-95				90-95			
Dr Danny Ruta	Director of Public Health	100-105		5-10		90-95		5-10	

Pension Benefits *(Total Pension entitlement)*

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	50-55	155-160	896	872	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	45-50	145-150	0	912	-912	
Richard Chapman	Director of Finance, NHS SEL Cluster	5-7.5	17.5-20	20-25	60-65	287	202	84	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	55-60	165-170	1157	1217	-60	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	25-30	85-90	565	500	65	
Martin Wilkinson	Managing Director	0-2.5	0-2.5	20-25	65-70	325	314	11	
Dr Danny Ruta	Director of Public Health	0-2.5	2.5-5.0	5-10	20-25	129	108	21	

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

11.6 Cash Equivalent Transfer Values

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

years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

11.7 Pay Multiples

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

The banded remuneration of the highest paid director in Lewisham PCT in the financial year 2012-13 was £102,500 (2011-12, £94,708). This was 2.72 times (2011-12 2.47 times) the median remuneration of the workforce, which was £37,714 (2011-12 £38,338)

In 2012-13, no (2011-12, one) employee received remuneration in excess of the highest paid director. Remuneration ranged from £638 to £100,622 (2011-12 £1,478 to £129,204).
Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind excluding severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The increase in the multiple between 2011-12 and 2012-13 is due to the changes in the salary of the highest paid director from £94,708 to £100,622 as well as the decrease in the median salary from £38,338 to £37,714.

11.8 Exit Packages

The PCT agreed one exit package during the year. The table provided below is also reported in the PCT's published accounts and is being reproduced here for completeness.

	2012-13			2011-12		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**0**	**0**	**0**	0	0	**0**
£10,001-£25,000	**1**	**0**	**1**	0	0	**0**
£25,001-£50,000	**2**	**0**	**2**	0	0	**0**
£50,001-£100,000	**2**	**0**	**2**	0	0	**0**
£100,001 - £150,000	**1**	**1**	**2**	0	0	**0**
Total number of exit packages by type (total cost	**6**	**1**	**7**	**0**	**0**	**0**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	**355,000**	**147,000**	**502,000**	0	0	0

11.9 Off Payroll Engagements – *(unaudited)*

Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012	Lewisham PCT
	No.
No. in place on 31 January 2012	**7**
of which	
No that have since come onto the organisation's payroll	0
of which	
No. that have since been re-negotiated/re-engaged, to include contractual clauses allowing the department to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the department to seek assurance as to their tax obligations	0
No. that have come to an end (**31st March 2013**)	7
Total	**7**

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

11.10 Related Party Transactions

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

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

	Services Received from Organisation	Payments to Related Party
		£
Dr Judy Chen-Rushy Green Group Practice	Primary Care	1,413,318
Dr Faruk Majid - Hilly Fields Medical Centre	Primary Care	1,279,780
Dr David Abraham - Morden Hill Surgery	Primary Care	958,561
Dr Helen Tattersfield - Oakview Family Practice	Primary Care	487,748
Dr Marc Rowland - Jenner Practice	Primary Care	1,351,435
Dr Arun Gupta - South Lewisham Group Practice	Primary Care	1,410,247
Dr Hilary Entwistle - Woolstone Medical Centre	Primary Care	769,448

The Department of Health, as Lewisham PCT's parent department, is regarded as a related party. During the year 2012/13, Lewisham Primary Care Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

		£000
Lewisham Healthcare NHS Trust	Acute	167,177
South London and Maudsley NHS Foundation Trust	Mental Health	66,304
Guys and St Thomas NHS Foundation Trust	Acute	59,765
Kings College Hospital NHS Foundation NHS Trust	Acute	44,215
London Borough of Lewisham	Learning disability and community healthcare	21,344

12. SUMMARY FINANCIAL STATEMENTS

LEWISHAM PCT SUMMARY FINANCIAL STATEMENTS 2012/13

These summary financial statements are a summary of the information in the PCT's full annual accounts for 2012/13. The summary financial statements might not contain sufficient information for a full understanding of the PCT's financial position and performance.
IFRSs are accounting standards issued by the International Accounting Standards Board (IASB). The term IFRS refers to the international equivalent to UK GAAP, the set of Generally Accepted Accounting Principles that includes accounting standards, interpretations, the IASB's framework and established accounting practice. The Chancellor's 2007 Budget announced that the accounts of central government departments and entities in the wider public sector will be produced using IFRS, as interpreted for the public sector in the IFRS-based Financial Reporting Manual (FReM). Central government, NHS Trusts, Primary Care Trusts and NHS Foundation Trusts all need to adopt IFRS and the annual accounts for government organisations and the NHS are to be prepared using IFRS standards.

12.1 PCT FINANCIAL PERFORMANCE 2012/2013

Statutory and other financial duties

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

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

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

Financial balance

PCTs have a statutory duty to keep expenditure within the resource limits set by the Department of Health for revenue and capital separately. The PCT's audited annual accounts show a surplus of £5.614m on revenue and £0.724m on capital.

	2012/13 Revenue £000	2012/13 Capital £000	2012/13 Total £000
Resource Limit	566,034	2,694	568,728
Net Operating Costs	560,503	1,970	562,473
Surplus / (Deficit)	**5,531**	**724**	**6,255**

All the Primary Care Trusts and Strategic Health Authorities were abolished from 1 April 2013. Under Department of Health year-end carry forward arrangements and guidance around financial planning for 2013/14, Lewisham PCT has been advised by DH to assume 68.9% as a carry forward resource in 2013/14 plans. Underspends against Capital Resource Limits are not carried forward. PCTs bid for capital resources on an annual basis.

Cash performance

The PCT has a statutory duty to remain within its set cash limit. There is a single cash limit covering both revenue and capital. The PCT drew down in full its 2011/12 cash limit of £561.779m. The Department of Health also sets a maximum year-end cash balance for PCTs of £50k. The PCT's cash balance as at 31st March 2013 was £21k.

	£000
Opening Cash balance 1 April 2012	1
Cash drawings including cash top sliced by DH	561,779
Cash Outgoings	561,759
Cash returned to DH	0
Closing cash balance 31 March 2013	**21**

Capital charges

Capital charges were introduced in the NHS in 1991 to increase awareness of the cost of owning assets. The amount payable is based on the actual opening and closing Balance Sheets for the year. There are two elements to this: depreciation of fixed assets and a charge of 3.5 per cent on net relevant assets. The Department of Health has revised the mechanism for charging capital charges interest since 2011/12. The PCT revenue resources for 2012/13 were increased by £35k for capital charges interest. Capital charges for Lewisham PCT for 2012/13 were as follows:

	£000
Depreciation	1,436
3.5% cost of capital charge on net relevant assets	48

Total	**1,484**

Public sector payment targets

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

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**6,773**	**42,061**	6,330	36,909
Total Non-NHS Trade Invoices Paid Within Target	**6,590**	**41,528**	6,034	36,367
Percentage of NHS Trade Invoices Paid Within Target	97.30%	98.73%	95.32%	98.53%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,159**	**429,799**	3,584	400,516
Total NHS Trade Invoices Paid Within Target	**4,079**	**416,316**	3,427	397,507
Percentage of NHS Trade Invoices Paid Within Target	98.08%	96.86%	95.62%	99.25%

Comparisons of 2012/13 annual accounts with previous years

1 Net operating costs

The overall growth in net operating costs of £13m (2.4%) since 2011/12 reflects the funding growth received by the PCT during 2012/13.

	2009/10	2010/11	2011/12	2012/13	Change from 2011/12	
	£m	£m	£m	£m	£m	%
Gross Operating Costs	520	546	561	575	14	2.5%
Including income of	10	14	13	14	1	7.6%
Net Operating						

Costs	510	532	548	**561**	**13**	**2.4%**

2 Non-Current Assets

Lewisham PCT's land and buildings have been revalued by the District Valuer as at 31 March 2013 by carrying out a full valuation exercise. This resulted in a net decrease in asset values of £0.58m. During the year the PCT incurred capital spend of £1.97m. The net reduction in non current assets of £1.582m reflects these transactions as well as the depreciation charges.

2009/10	2010/11	2011/12	2012/13	Change
£m	£m	£m	£m	£m
48.2	45.6	42.9	42.7	0.2

3 Net Current Liabilities

	2009/10	2010/11	2011/12	2012/13	Change
	£m	£m	£m	£m	£m
Current Assets	4.1	3.4	3.9	2.3	(1.6)
Current Liabilities	28.2	24.5	29.9	26.0	3.9
Net Current Liabilities	**24.1**	**21.1**	**26.0**	**23.7**	**2.3**

4 Taxpayers' equity

	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
General Fund	(6.5)	(6.6)	(9.7)	(8.4)	1.3
Revaluation Reserve	12.4	11.9	10.7	10.1	(0.6)
Total	**5.9**	**5.3**	**1.0**	**1.7**	**0.7**

5 Pensions

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

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(559,769)**	(546,815)
Depreciation and Amortisation	**1,436**	1,566
Impairments and Reversals	**187**	1,095
Interest Paid	**(761)**	(785)
Decrease/(Increase) in Trade and Other Receivables	**1,580**	(486)
(Decrease)/Increase in Trade and Other Payables	**(2,429)**	1,962
Provisions Utilised	**(1,573)**	(2,645)
Increase in Provisions	**2,338**	2,512
Net Cash Inflow/(Outflow) from Operating Activities	**(558,992)**	**(543,596)**
Cash flows from investing activities		
Interest Received	**27**	3
(Payments) for Property, Plant and Equipment	**(1,352)**	(784)
Net Cash Inflow/(Outflow) from Investing Activities	**(1,325)**	**(781)**
Net cash inflow/(outflow) before financing	**(560,317)**	**(544,377)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(1,442)**	(210)
Net Parliamentary Funding	**561,779**	544,587
Net Cash Inflow/(Outflow) from Financing Activities	**560,337**	**544,377**
Net increase/(decrease) in cash and cash equivalents	**20**	**0**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**1**	**1**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**21**	**1**

Statement of Financial Position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**42,433**	42,670
Intangible assets	**0**	0
investment property	**0**	0
Other financial assets	**246**	246
Trade and other receivables	**1**	1
Total non-current assets	**42,680**	42,917
Current assets:		
Inventories	**0**	0
Trade and other receivables	**2,279**	3,859
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**21**	1
Total current assets	**2,300**	3,860
Non-current assets held for sale	**0**	0
Total current assets	**2,300**	3,860
Total assets	**44,980**	46,777
Current liabilities		
Trade and other payables	**(23,856)**	(26,903)
Other liabilities	**0**	0
Provisions	**(1,967)**	(2,791)
Borrowings	**(231)**	(210)
Other financial liabilities	**0**	0
Total current liabilities	**(26,054)**	(29,904)
Non-current assets plus/less net current assets/liabilities	**18,927**	16,873
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(1,776)	(187)
Borrowings	(15,421)	(15,648)
Other financial liabilities	0	0
Total non-current liabilities	**(17,197)**	(15,835)
Total Assets Employed:	**1,730**	1,038
Financed by taxpayers' equity:		
General fund	(8,389)	(9,665)
Revaluation reserve	10,119	10,703
Total taxpayers' equity:	**1,730**	1,038

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	**12,605**	11,845
Other costs	**561,205**	548,679
Income	**(14,041)**	(13,709)
Net operating costs before interest	**559,769**	546,815
Investment income	**(27)**	(3)
Other (Gains)/Losses	**0**	0
Finance costs	**761**	791
Net operating costs for the financial year	**560,503**	547,603
Of which:		
Administration Costs		
Gross employee benefits	**9,127**	8,366
Other costs	**4,286**	5,299
Income	**(2,662)**	(1,397)
Net administration costs before interest	**10,751**	**12,268**
Investment income	**0**	0
Other (Gains)/Losses	**0**	0
Finance costs	**0**	0
Net administration costs for the financial year	**10,751**	**12,268**
Programme Expenditure		
Gross employee benefits	**3,478**	3,479
Other costs	**556,919**	543,380
Income	**(11,379)**	(12,312)
Net programme expenditure before interest	**549,018**	**534,547**
Investment income	**(27)**	(3)
Other (Gains)/Losses	**0**	0
Finance costs	**761**	791
Net programme expenditure for the financial year	**549,752**	**535,335**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,084**	1,260
Net (gain) on revaluation of property, plant & equipment	**(500)**	0
Net (gain) on revaluation of financial assets	**0**	(79)
Total comprehensive net expenditure for the year*	**561,087**	**548,784**

6 POST BALANCE SHEET EVENTS

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

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

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

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

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

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

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

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

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

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

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

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

7 Running costs

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

	2012/13	2011/12	Change
Running costs (£000s)	10,751	12,268	1,517
Weighted population (number)	297,390	297,390	-
Management cost per head of weighted population (£)	**36**	**41**	**13.9%**

The PCT measures its running costs according to the definitions provided by the Department of Health.
The PCT running costs for 2012/13 have been reduced by £1.5m (13.9%) in the year.

8 Audit

The PCT's external auditor is Grant Thornton. During the financial year 2012/13 £114k (including VAT) was paid in respect of carrying out the external audit of the PCT in accordance with the Code of Audit Practice.

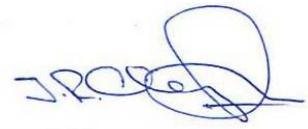
2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director General, Strategy Finance and NHS

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

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

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

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature: 

Date: 24 April 2013

2012/13 Accounts Certificate of Assurance to the Department of Health Director General, Strategy Finance and NHS

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

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

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

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

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

Name: Andrew Kenworthy

Signature:

Date: 24 April 2013

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

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Lewisham 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 31 May 2013

Carl Vincent
Director of Provider Finance and Finance Transition

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

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

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

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

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

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

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

Opinion

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

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

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

Carl Vincent
Director of Provider Finance and Finance Transition

Further Information

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

Tony Read
Chief Financial Officer, Lewisham CCG
Cantilever House
Eltham Road
London SE12 8RN
Tel 020 72063372
tonyread@lambethpct.nhs.uk

Department of Health

NHS

Lewisham Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Lewisham Primary Care Trust

2012-13 Accounts

Lewisham PCT
Annual Accounts

Year Ended 31st March 2013

FOREWORD TO THE ACCOUNTS

LEWISHAM PRIMARY CARE TRUST

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

1 Introduction

Lewisham Primary Care Trust (PCT) was established in April 2002 (Statutory Instrument 2002 No.1001). The PCT was responsible for improving health; for commissioning primary, community, hospital and other health services for the population registered with GP practices within the London Borough of Lewisham

Vision

Our vision for commissioning in Lewisham is to improve the health of people living in the borough and where possible reduce health inequalities. In delivering this vision we recognise the need to work in co-operation with Lewisham people, patients and their representatives, general practices, community and primary care providers, secondary care providers, local authorities and the voluntary sector. This vision for improvement will be continued by the NHS Lewisham Clinical Commissioning Group.

Until 2009 the PCT also provided community health services for Lewisham patients including community nursing, health visiting, school nursing, child and adult therapy services, specialist child health services, foot health services, podiatric surgery, elderly and intermediate care services, rapid response service, sickle cell services, reproductive and sexual health services. In 2009 the PCT transferred its community health services to Lewisham Healthcare NHS Trust.

Over 2010/11 the PCT worked with the six PCTs across South East London (Lambeth, Southwark, Lewisham, Bromley and Greenwich PCTs and Bexley Care Trust) to further develop collective arrangements to achieve improved value for money and to ensure ongoing delivery, to deliver the organisational change needed to deliver management cost savings requirements. A new NHS South East London Cluster arrangement was established from 1st April 2011 whereby, within individual PCT statutory arrangements, a range of roles and functions was delivered across the six PCTs. This is in line with national transition guidance following the publication of the Government's proposals for the NHS as set out in *Equity and Excellence: Liberating the NHS*. During 2012/13 NHS South East London cluster arrangement has been in place which brings together executive roles across the six South East London PCTs with a range of shared functions across the six boroughs and with borough Business Support Units supporting commissioning, the development of clinical commissioning and of health and wellbeing arrangements at a borough level. From 1st October 2012 the South London Commissioning Support Unit (SLCSU) operated in shadow form bringing together SE and SW London cluster teams across a range of support functions such as finance and acute commissioning.

Since 2011/12 clinical commissioning in Lewisham has been taken forward by the Lewisham Clinical Commissioning Committee, with specific delegated authority from the Lewisham PCT Board. Lewisham PCT has also worked with London Borough of Lewisham to develop shadow Health and Well Being arrangements to support the transition towards the transfer of responsibilities for public health and health improvement to local government from April 2013.

In 2012/13, the PCT employed 140 staff, of which 135 are permanently employed (average staff numbers). The total staff employed by Lewisham excludes staff employed by Lambeth PCT as host organisation of the cluster arrangements on behalf of South East London PCTs and Care Trust and from 1st October 2012 the South London Commissioning Support Unit.

The PCT has an established record of working with the NHS and other partners to achieve delivery of its objectives and secure value for money.

Acute hospital services are commissioned mainly from Lewisham Healthcare NHS Trust, Guy's & St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. Mental health services are commissioned mainly from South London and Maudsley NHS Foundation Trust, in conjunction with the London Borough of Lewisham. Along with King's College London, the three local NHS Foundation Trusts have worked in partnership to establish an Academic Health Sciences Centre, King's Health Partners, receiving Department of Health accreditation in March 2009.

The following pages set out the PCT's audited Annual Accounts for 2012/13.

Further copies of the PCT's 2012/13 Final Accounts and Annual Report can be obtained from:
Tony Read
NHS Lewisham Clinical Commissioning Group
Cantilever House, Eltham Road, London SE12 8RN
Telephone 0203 049 3833
e-mail: tonyread@nhs.net

2 Lewisham's Population and Local Health Issues

Overview

Lewisham is one of the thirteen inner London Boroughs. Stretching from the banks of the Thames in the north, to the borders of Bromley in the south, the 13.4 square miles of Lewisham encompass diverse communities, speaking over 170 languages. Lewisham is the 31st most deprived Local Authority in England. Relative to the rest of the country Lewisham's deprivation is increasing. The highest deprivation is particularly found in Evelyn ward in the North and Downham in the South and along the A2 corridor.

Lewisham's population of about 270,000 people is relatively young, with one in four residents aged under 19 years. Between 2010 and 2015 the population is expected to grow by a further 11,000, or 4%. The highest growth is expected in Evelyn and Lewisham Central wards, which form part of the Thames Gateway Zones of Change.

Lewisham is the 15th most ethnically diverse local authority in England, and two out of every five residents are from a black and minority ethnic background. The largest BME groups are Black African and Black Caribbean: Black ethnic groups are estimated to comprise 30% of the total population of Lewisham. In 2008/09, 60% of school children were from a black and minority ethnic background

Lewisham residents are more likely to experience poorer health and have greater need for health services. This, combined with its diverse ethnic and cultural mix, and a young population provides the PCT and its partners with unique challenges and opportunities for improving health and delivering health care at a community level. Reducing health inequalities is a core aim for the NHS and Local Authority.

Lewisham has a high level of health need. Life expectancy is lower and premature mortality is higher for a number of conditions including circulatory diseases, cancers, and respiratory conditions. There are other high levels of health needs in Lewisham such as long-term conditions (diabetes, cancer, coronary heart disease and respiratory diseases), mental health, sexual health, substance misuse and childhood obesity.

Lewisham's Joint Strategic Needs Assessment can be accessed at http://www.lewishamjsna.org.uk/

3 Lewisham PCT 2012/13 Performance against Statutory Financial Duties

In line with other NHS bodies, Lewisham PCT is required to prepare annual accounts on a resource accounting basis and is required by statute to meet certain financial duties to ensure that public funds are used appropriately.

These duties are:

(i) not to exceed its Revenue Resource Limit and Capital Resource Limit and its (combined revenue and capital) Cash Limit.

(ii) to absorb capital costs in full through a charge calculated at 3.5% of the average relevant net assets of the PCT.

(iii) to demonstrate full cost recovery on an accruals basis, in relation to provider functions. This is no longer applicable to Lewisham PCT following the transfer of Community Services to Lewisham Healthcare Trust in 2009.

In 2012/13 Lewisham PCT achieved in full its statutory financial duties as follows:

(i) Revenue and Capital Resource Limits and combined Cash Limit

Lewisham PCT underspent against its 2012/13 Revenue Resource Limit by £5.531 million (0.99%) (note 3.1) and by £0.724 million (26.87%) against its 2012/13 Capital Resource Limit (note 3.2).

Lewisham PCT drew down in full its 2012/13 Cash Limit and managed within the maximum cash balances determined by the Department of Health as at 31 March 2013.

The PCT has demonstrated financial balance without the need for the receipt of unplanned financial assistance. The following table shows the 2012/13 outturn position for Lewisham PCT against its 2012/13 Resource Limits:

	Revenue Resource Limit £000	Capital Resource Limit £000	Total £000
Resource Limit 2012/13	566,034	2,694	568,728
Charge against Resource Limit	(560,503)	(1,970)	(562,473)
Underspend	5,531	724	6,255
% Underspend	0.98%	26.87%	1.10%

Under the Department of Health year-end carry forward arrangements Revenue Resource Limits underspends or overspends reported at Month 12 2012/13 will be returned to CCGs and the NHS England (for direct commissioning) in 2013/14. Underspends against Capital Resource Limits are not carried forward. PCTs bid for capital resources on an annual basis.

(ii) Payment of Capital Charges

Lewisham PCT paid over in full capital charges to the Department of Health in respect of assets held by the PCT.

(iii) Provider Full Cost Recovery

Since 2010/11 this target is no longer applicable because Lewisham PCT did not directly provide patient services having transferred Community Health Services to Lewisham Healthcare NHS Trust in 2009.

International Financial Reporting Standards

International Financial Reporting Standards (IFRS) are accounting standards issued by the International Accounting Standards Board (IASB). The Chancellor's 2007 Budget announced that the accounts of central government departments and entities in the wider public sector will be produced using IFRS, as interpreted for the public sector in the IFRS-based Financial Reporting Manual (FReM). As a result, IFRS was implemented across the NHS from 2009/10 and is now fully embedded in the financial reporting framework.

4 Corporate Governance

The PCT has in place corporate governance arrangements that have been approved by the joint NHS SE London PCT Boards in 2011 and are set out in the *Corporate Governance and Accountability Framework* . This includes detailed Standing Orders and Standing Financial Instructions. During 2012/13 the Joint PCT Boards have kept its governance arrangements under review to ensure that they remain fit for purpose and have made a number of changes to the subcommittee structure.

There is an established Board Assurance Framework and supporting risk register in place as part of our regular integrated Performance and Reporting Framework built upon our annual business plan objectives.

5 The Health & Social Care Act 2012

The government published its White Paper, Equity and Excellence: Liberating the NHS in July 2010, setting out its long-term vision for the future of the NHS. The White Paper set out how the government intends to put patients at the heart of everything the NHS does, focus on continuously improving those things that really matter to patients - the quality and outcome of their healthcare and empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.

For PCTs the key implications include:

- Commissioning - the transfer of Commissioning responsibility from PCTs to Clinical Commissioning Groups and the NHS National Commissioning Board, leading to the abolition of Strategic Health Authorities (SHAs) and PCTs.

- Public Health and wellbeing: including the creation of a national Public Health service and the transfer of health improvement functions to local government.

- Resources: the government has restated its commitment to real terms increases in funds for health, to the need for the NHS to deliver £20 billion efficiency savings and the reduction in NHS management costs by 45 per cent over the next four years.

The Health and Social Care Bill was presented to Parliament in January 2011 and was passed in March 2012. The Department of Health has provided guidance on developments in managing the transition over the period of the implementation of the Bill. The criticality of ensuring day-to-day delivery of high standards of clinical care and the importance of ensuring that patients rights are met as set out in the NHS Constitution, including timeliness of diagnosis and treatment, have been reaffirmed.

6 Clinical Commissioning and CCG Authorisation

Over 2011/12 and 2012/13 the PCT continued to support the development of clinical commissioning through the Lewisham Clinical Commissioning Committee, working with local General Practices, communities and other partners. NHS Lewisham CCG has been fully authorised, as part of the national authorisation process, without conditions. The process included submission of evidence, including sign up of all Lewisham GP practices to the NHS Lewisham CCG Constitution, a site visit to demonstrate delivery on key competences and 119 criteria. The CCG operated in shadow form from January to March 2013 with the Lewisham Clinical Commissioning Committee operating as a formal sub-committee of South East London Cluster of PCTs throughout 2012/13. The Board was chaired by Dr Helen Tattersfield and included six other local GPs, Non Executive Directors, the Director of Public Health, the Managing Director of Lewisham Business Support Unit, the London Borough of Lewisham Director of Community Services . Lewisham LINk representatives were co-opted to the Committee and the Lewisham Local Medical Committee had observation status. The Lewisham Clinical commissioning Committee was supported by Lewisham Business Support Unit and staff based in the South East London Cluster of PCTs. Full delegation of budgets was achieved in 2011/12 with the delegation of acute budgets to the Lewisham Clinical Commissioning Committee in January 2012.

7 Trust Special Administrator (TSA) for South London Healthcare Trust

The PCT has long recognised the need to work with colleagues beyond Lewisham to ensure a health system best able to deliver best quality healthcare for Lambeth. We have therefore worked in collaboration with neighbouring PCTs and other NHS colleagues across a wide range of responsibilities. In January 2013 the Secretary of State published his decision on the future of South London Healthcare Trust (SLHT) following the recommendations of the Trust Special Administrator. This decision will affect health service configuration and provision across the whole of South East London. The recommendations notably include the dissolution of SLHT and changes to emergency and maternity services at Lewisham Hospital. The newly formed NHS Lewisham CCG will be working with partners and others across the system to ensure continuity of care and improved services across the whole of South East London, including for Lewisham patients. In particular NHS Lewisham CCG, working with other CCGs in South East London will be taking forward the implementation of the three year Community Based Care Strategy which seeks to ensure:

- support to help people manage their own health
- earlier intervention to prevent disease and better manage ill health; and
- community services to support people at home

8 Health Act Partnerships and Integrated Commissioning

During 2012/13 NHS Lewisham has continued to have joint commissioning arrangements (under Section 75 of the National Health Services Act 2006) with the London Borough of Lewisham for:

- Adult Mental Health Services
- Adult Services
- Children and Young Persons Services
- Integrated Community Equipment Store
- Delayed Discharges Arrangements
- Free Nursing Care

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

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

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

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

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

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

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

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

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

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

2012/13 Accounts Certificate of Assurance to the Department of Health Director General, Strategy Finance and NHS

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

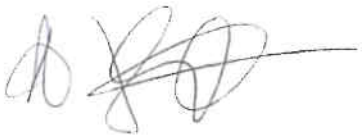
To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the PCT;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities
- 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
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Andrew Kenworthy
Accountable Officer 2012/13

Signature: 

Date: 24 April 2013

2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director Strategy Finance and NHS

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

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

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

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature:

Date: 24 April 2013

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

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

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

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

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

Respective responsibilities of the Signing Officer and auditor

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

Scope of the audit of the financial statements

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

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have

been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

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

We have undertaken our audit in accordance with the Code of Audit Practice and,

having regard to the guidance issued by the Audit Commission, we have considered the results of the following:

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

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

Certificate

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

S M. Exton

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

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

7 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**12,605**	11,845
Other costs	5.1	**561,205**	548,679
Income	4	**(14,041)**	(13,709)
Net operating costs before interest		**559,769**	546,815
Investment income	9	**(27)**	(3)
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**761**	791
Net operating costs for the financial year		**560,503**	547,603
Of which:			
Administration Costs			
Gross employee benefits	7.1	**9,127**	8,366
Other costs	5.1	**4,286**	5,299
Income	4	**(2,662)**	(1,397)
Net administration costs before interest		**10,751**	**12,268**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**10,751**	**12,268**
Programme Expenditure			
Gross employee benefits	7.1	**3,478**	3,479
Other costs	5.1	**556,919**	543,380
Income	4	**(11,379)**	(12,312)
Net programme expenditure before interest		**549,018**	**534,547**
Investment income	9	**(27)**	(3)
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**761**	791
Net programme expenditure for the financial year		**549,752**	**535,335**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,084**	1,260
Net (gain) on revaluation of property, plant & equipment	**(500)**	0
Net (gain) on revaluation of financial assets	**0**	(79)
Total comprehensive net expenditure for the year*	**561,087**	**548,784**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 14 to 52 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	42,433	42,670
Intangible assets	13	0	0
investment property	15	0	0
Other financial assets	21	246	246
Trade and other receivables	19	1	1
Total non-current assets		42,680	42,917
Current assets:			
Inventories	18	0	0
Trade and other receivables	19	2,279	3,859
Other financial assets	36	0	0
Other current assets	22	0	0
Cash and cash equivalents	23	21	1
Total current assets		2,300	3,860
Non-current assets held for sale	24	0	0
Total current assets		2,300	3,860
Total assets		44,980	46,777
Current liabilities			
Trade and other payables	25	(23,856)	(26,903)
Other liabilities	26,28	0	0
Provisions	32	(1,967)	(2,791)
Borrowings	27	(231)	(210)
Other financial liabilities	36.2	0	0
Total current liabilities		(26,054)	(29,904)
Non-current assets plus/less net current assets/liabilities		18,927	16,873
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(1,776)	(187)
Borrowings	27	(15,421)	(15,648)
Other financial liabilities	36.2	0	0
Total non-current liabilities		(17,197)	(15,835)
Total Assets Employed:		1,730	1,038
Financed by taxpayers' equity:			
General fund		(8,389)	(9,665)
Revaluation reserve		10,119	10,703
Other reserves		0	0
Total taxpayers' equity:		1,730	1,038

The notes on pages 14 to 51 form part of this account.

The financial statements on pages 10 to 13 were approved by the DH Audit Committee on 31 May 2013 and signed on its behalf by

Signed..... CVincent .....

Date..... 31/5/13

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

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

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**(9,665)**	**10,703**	**1,038**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(560,503)	0	**(560,503)**
Net gain on revaluation of property, plant, equipment	0	500	**500**
Impairments and reversals	0	(1,084)	**(1,084)**
Total recognised income and expense for 2012-13	**(560,503)**	**(584)**	**(561,087)**
Net Parliamentary funding	561,779	0	**561,779**
Balance at 31 March 2013	**(8,389)**	**10,119**	**1,730**
Balance at 1 April 2011	**(6,649)**	**11897**	**5,248**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(547,603)	0	(547,603)
Net Gain / (loss) on Revaluation of Financial Assets	0	79	79
Impairments and Reversals	0	(1,273)	(1,273)
Total recognised income and expense for 2011-12	(547,603)	(1,194)	(548,797)
Net Parliamentary funding	544,587	0	544,587
Balance at 31 March 2012	**(9,665)**	**10,703**	**1,038**

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	**(559,769)**	(546,815)
Depreciation and Amortisation	**1,436**	1,566
Impairments and Reversals	**187**	1,095
Interest Paid	**(761)**	(785)
Decrease/(Increase) in Trade and Other Receivables	**1,580**	(486)
(Decrease)/Increase in Trade and Other Payables	**(2,429)**	1,962
Provisions Utilised	**(1,573)**	(2,645)
Increase in Provisions	**2,338**	2,512
Net Cash Inflow/(Outflow) from Operating Activities	**(558,992)**	**(543,596)**
Cash flows from investing activities		
Interest Received	**27**	3
(Payments) for Property, Plant and Equipment	**(1,352)**	(784)
Net Cash Inflow/(Outflow) from Investing Activities	**(1,325)**	**(781)**
Net cash inflow/(outflow) before financing	**(560,317)**	**(544,377)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(1,442)**	(210)
Net Parliamentary Funding	**561,779**	544,587
Net Cash Inflow/(Outflow) from Financing Activities	**560,337**	**544,377**
Net increase/(decrease) in cash and cash equivalents	**20**	**0**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**1**	**1**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**21**	**1**

1. Accounting policies

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

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

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

As a consequence of the Health and Social Care Act 2012, Lewisham PCT will be dissolved on 31st March 2013. It's functions will be transferred to various new or existing public sector entities.

The Secretary of State has directed that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

As a result, the Board of Lewisham PCT have prepared these financial statements on a going concern basis.

1.1 Accounting Conventions

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

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

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.

Revenue recognition

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

Classification of property

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

1. Accounting policies (continued)

PFI and LIFT

The PCT's accounting policies regarding its PFI and LIFT scheme are disclosed in Note 1.26 to these financial statements. The PCT accounts for these assets under IFRIC 12 as a service concession and when the applicable elements of IAS 17 are met these are capitalised.

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

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

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

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

Provisions

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

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

Property, plant, and equipment

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

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

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

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

1. Accounting policies (continued)

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

Recoverability of NHS debtors

The PCT does not provide against amounts due from other NHS bodies and believes that these amounts are recoverable in full.

Provisions

The significant estimation uncertainties for the PCT's pension provisions are disclosed in Note 7.5

The PCT has no other material provisions. The PCT does not have any material estimation uncertainty over the completeness of its provisions. Contingent liabilities are disclosed in Note 1.21.

Property, plant, and equipment

The PCT's estimates regarding property, plant, and equipment used are disclosed in Note 1.7. They are annually reviewed by the PCT, using external specialist advice where appropriate. Where there is indication that the PCT's assets are impaired, the estimation technique used to calculate the level of impairment is to compare the current holding amount of the asset to the assets fair value as derived by a professional valuer and using a valuation basis suitable for the asset (normally open market value for alternative use). The difference is then accounted for in line with the applicable accounting standards.

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Care Trust Designation

Lewisham PCT has not been designated as a Care Trust.

1.4 Pooled budgets

The PCT has not entered into a pooled budget arrangement that meets with the criteria for disclosure.

1.5 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.

1.6 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)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.8 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the PCT's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential 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.

1.9 Depreciation, amortisation and impairments

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

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit 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)

1.10 Donated assets

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

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.11 Government grants

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

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.12 Non-current assets held for sale

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

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

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

1.13 Inventories

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

1.14 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.

1.15 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).

1.16 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)

1.17 Employee benefits

Short-term employee benefits

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

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

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.18 Research and Development

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

1.19 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.

1.20 Grant making

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

1. Accounting policies (continued)

1.21 Contingencies

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

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

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

1.22 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 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.

1.23 Foreign exchange

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

1.24 Provisions

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

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

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

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

1. Accounting policies (continued)

1.25 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

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

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

1.26 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

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

b) 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 cost in accordance with the principles of IAS 17. Subsequently, the assets are measured at cost, which is kept up to date in accordance with the PCT's approach for each relevant class of asset in accordance with the principles of IAS 16."

A LIFT liability is recognised at the same time as the LIFT assets are recognised. It is measured initially at the present value of the minimum lease payments 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.

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

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

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

2 Operating segments

The provider services transferred to Lewisham Healthcare NHS Trust in 2010-11, and therefore the PCT no longer has any separate operating segments.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		
Net operating cost plus (gain)/loss on transfers by absorption	**560,503**	547,603
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**566,034**	553,048
Under/(Over)spend Against Revenue Resource Limit (RRL)	5,531	5,445

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**2,694**	1,257
Charge to Capital Resource Limit	**1,970**	1,190
Underspend Against CRL	**724**	**67**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**561,779**	544,587
Cash Limit	**561,779**	544,587
Under/(Over)spend Against Cash Limit	**0**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	503,605
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**503,605**
Plus: cost of Dentistry Schemes (central charge to cash limits)	15,221
Plus: drugs reimbursement (central charge to cash limits)	42,953
Parliamentary funding credited to General Fund	**561,779**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**26**	0	26	0
Dental Charge income from Contractor-Led GDS & PDS	**2,741**	0	2,741	2,754
Prescription Charge income	**1,734**	0	1,734	2,001
Strategic Health Authorities	**423**	186	237	0
NHS Trusts	**3,100**	24	3,076	3,217
NHS Foundation Trusts	**304**	26	278	550
Primary Care Trusts - Other	**3,051**	2,379	672	2,578
Local Authorities	**119**	0	119	130
Education, Training and Research	**2,036**	0	2,036	1,851
Other revenue	**507**	47	460	628
Total miscellaneous revenue	**14,041**	**2,662**	**11,379**	**13,709**

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	**42,299**	0	42,299	32,200
Non-Healthcare	**994**	994	0	1,020
Total	**43,293**	**994**	**42,299**	**33,220**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**190,658**	10	190,648	181,595
Goods and services (other, excl Trusts, FT and PCT))	**47**	1	46	672
Total	**190,705**	**11**	**190,694**	**182,267**
Goods and Services from Foundation Trusts	**182,032**	625	181,407	184,477
Purchase of Healthcare from Non-NHS bodies	**27,395**	0	27,395	25,069
Contractor Led GDS & PDS (excluding employee benefits)	**18,142**	0	18,142	18,293
Chair, Non-executive Directors & PEC remuneration	**25**	25	0	28
Executive committee members costs	**338**	338	0	213
Consultancy Services	**199**	95	104	285
Prescribing Costs	**34,774**	0	34,774	37,696
G/PMS, APMS and PCTMS (excluding employee benefits)	**40,428**	65	40,363	40,500
Pharmaceutical Services	**1,529**	0	1,529	1,792
New Pharmacy Contract	**9,555**	0	9,555	9,977
General Ophthalmic Services	**2,067**	0	2,067	2,023
Supplies and Services - Clinical	**1,650**	0	1,650	1,600
Supplies and Services - General	**722**	0	722	919
Establishment	**1,129**	848	281	759
Transport	**64**	64	0	49
Premises	**3,754**	637	3,117	4,227
Impairments & Reversals of Property, plant and equipment	**187**	(58)	245	1,095
Depreciation	**1,436**	0	1,436	1,566
Impairment of Receivables	**(14)**	0	(14)	0
Audit Fees	**114**	114	0	175
Other Auditors Remuneration	**0**	0	0	78
Education and Training	**554**	142	412	563
Other	**1,127**	386	741	1,808
Total Operating costs charged to Statement of Comprehensive	**561,205**	**4,286**	**556,919**	**548,679**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**402**	402	0	366
Other Employee Benefits	**12,203**	8,725	3,478	11,479
Total Employee Benefits charged to SOCNE	**12,605**	**9,127**	**3,478**	**11,845**
Total Operating Costs	**573,810**	**13,413**	**560,397**	**560,524**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**10,751**	9,307	1,444
Weighted population (number in units)*	**297,390**	297,390	297,390
Running costs per head of population (£ per head)	**36**	**31**	**5**
PCT Running Costs 2011-12			
Running costs (£000s)	**12,268**	10,905	1,363
Weighted population (number in units)	**297,390**	297,390	297,390
Running costs per head of population (£ per head)	**41**	**36**	**5**

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula
Therefore, 2011-12 weighted populations have been used when 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	40,428	40,500
Prescribing costs	34,774	37,696
Contractor led GDS & PDS	18,010	18,147
General Ophthalmic Services	2,067	2,023
Pharmaceutical services	1,529	1,792
New Pharmacy Contract	9,549	9,977
Total Primary Healthcare purchased	**106,357**	110,135
Purchase of Secondary Healthcare		
Learning Difficulties	1,068	1,146
Mental Illness	76,605	78,973
Maternity	22,622	22,412
General and Acute	250,403	243,085
Accident and emergency	21,947	16,003
Community Health Services	59,949	55,760
Other Contractual	9,373	7,282
Total Secondary Healthcare Purchased	**441,967**	424,661
Total Healthcare Purchased by PCT	**548,324**	**534,796**
Healthcare from NHS FTs included above	180,724	183,572

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments	0	637	3	640	703
Contingent rents	0	129	0	129	103
Sub-lease payments	0	0	0	0	0
Total	0	766	3	769	806
Payable:					
No later than one year	0	0	714	714	717
Between one and five years	0	0	2,854	2,854	2,975
After five years	0	0	8,298	8,298	8,886
Total	0	0	11,866	11,866	12,578

Total future sublease payments expected to be received	0	0

The PCT has vehicle leasing arrangements mostly of 3 year duration. Also 5 properties under leasehold rental arrangements, the payments for these leases are included above.

The contingent rent relates to the Waldron LIFT scheme, the costs payable over the remaining 21 years total £8,157k

6.2 PCT as lessor

The PCT recharges Lewisham Healthcare NHS Trust under a Memorandum of Occupation for a range of overheads including accomodation of community health services in PCT property. All PCT property were transferred to other organisations on April 1, 2013 based on the Department of Health guidance on ownership arrangements for PCT property.

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
Employee Benefits - Gross Expenditure								
Salaries and wages	**11,174**	8,182	2,992	**8,365**	5,373	2,992	**2,809**	2,809
Social security costs	**598**	395	203	**598**	395	203	**0**	0
Employer Contributions to NHS BSA - Pensions Division	**833**	550	283	**833**	550	283	**0**	0
Total employee benefits	**12,605**	**9,127**	**3,478**	**9,796**	**6,318**	**3,478**	**2,809**	**2,809**
Less recoveries in respect of employee benefits (table below)	**0**	0	0	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**12,605**	**9,127**	**3,478**	**9,796**	**6,318**	**3,478**	**2,809**	**2,809**
Gross Employee Benefits excluding capitalised costs	**12,605**	**9,127**	**3,478**	**9,796**	**6,318**	**3,478**	**2,809**	**2,809**
Recognised as:								
Commissioning employee benefits	**12,605**			**9,796**			**2,809**	
Gross Employee Benefits excluding capitalised costs	**12,605**			**9,796**			**2,809**	

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**10,364**	7,001	3,363
Social security costs	**612**	612	0
Employer Contributions to NHS BSA - Pensions Division	**869**	869	0
Total gross employee benefits	**11,845**	**8,482**	**3,363**
Total - Net Employee Benefits including capitalised costs	**11,845**	**8,482**	**3,363**
Gross Employee Benefits excluding capitalised costs	**11,845**	**8,482**	**3,363**
Recognised as:			
Commissioning employee benefits	**11,845**		
Gross Employee Benefits excluding capitalised costs	**11,845**		

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	**8**	8	0	**9**	9	0
Administration and estates	**123**	118	5	**125**	119	6
Nursing, midwifery and health visiting staff	**3**	3	0	**3**	3	0
Scientific, therapeutic and technical staff	**6**	6	0	**6**	6	0
TOTAL	**140**	**135**	**5**	**143**	**137**	**6**

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	964	1,441
Total Staff Years	135	165
Average working Days Lost	7.14	8.73

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

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	0	0	0	0	0	0
£10,001-£25,000	1	0	1	0	0	0
£25,001-£50,000	2	0	2	0	0	0
£50,001-£100,000	2	0	2	0	0	0
£100,001 - £150,000	1	1	2	0	0	0
Total number of exit packages by type (total cost)	6	1	7	0	0	0
	£s	£s	£s	£s	£s	£s
Total resource cost	354,869	146,702	501,571	0	0	0

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

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

7.5 Pension costs

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

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	**6,773**	**42,061**	6,330	36,909
Total Non-NHS Trade Invoices Paid Within Target	**6,590**	**41,528**	6,034	36,367
Percentage of NHS Trade Invoices Paid Within Target	97.30%	98.73%	95.32%	98.53%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,159**	**429,799**	3,584	400,516
Total NHS Trade Invoices Paid Within Target	**4,079**	**416,316**	3,427	397,507
Percentage of NHS Trade Invoices Paid Within Target	98.08%	96.86%	95.62%	99.25%

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 Programme £000	2011-12 £000
Interest Income			
LIFT: loan interest receivable	27	27	3
Subtotal	27	27	3
Total investment income	27	27	3

10. Other Gains and Losses

Lewisham PCT had no other gains or losses for the years ended 31 March 2013 and 31 March 2012.

11. Finance Costs

	2012-13 Total £000	2012-13 Programme £000	2011-12 £000
Interest on obligations under LIFT contracts:			
- main finance cost	761	761	785
Total interest expense	761	761	785
Provisions - unwinding of discount	0	0	6
Total	761	761	791

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2012	**13,237**	**28,475**	**1,145**	**329**	**3,579**	**903**	**47,668**
Additions of Assets Under Construction	0	0	842	0	0	0	**842**
Additions Purchased	0	0		0	1,128	0	**1,128**
Reclassifications	0	558	(1,145)	0	587	0	**0**
Disposals other than for sale	(80)	(2,590)	0	0	0	0	**(2,670)**
Upward revaluation/positive indexation	0	500	0	0	0	0	**500**
Impairments/negative indexation	0	(1,084)	0	0	0	0	**(1,084)**
At 31 March 2013	**13,157**	**25,859**	**842**	**329**	**5,294**	**903**	**46,384**
Depreciation							
At 1 April 2012	**80**	**1,738**	**0**	**271**	**2,449**	**460**	**4,998**
Reclassifications	0	0		0	0	0	**0**
Disposals other than for sale	(80)	(2,590)	0	0	0	0	**(2,670)**
Impairments	0	245	0	0	0	0	**245**
Reversal of Impairments	0	(58)	0	0	0	0	**(58)**
Charged During the Year	0	665	0	52	646	73	**1,436**
At 31 March 2013	**0**	**0**	**0**	**323**	**3,095**	**533**	**3,951**
Net Book Value at 31 March 2013	**13,157**	**25,859**	**842**	**6**	**2,199**	**370**	**42,433**
Purchased	13,157	25,859	842	6	2,199	370	**42,433**
Total at 31 March 2013	**13,157**	**25,859**	**842**	**6**	**2,199**	**370**	**42,433**
Asset financing:							
Owned	11,287	13,368	842	6	2,199	370	**28,072**
On-SOFP PFI contracts	1,870	12,491	0	0	0	0	**14,361**
Total at 31 March 2013	**13,157**	**25,859**	**842**	**6**	**2,199**	**370**	**42,433**

Revaluation Reserve Balance for Property, Plant & Equipment	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**6,335**	**4,341**	**0**	**6**	**0**	**21**	**10,703**
Movements (specify)	0	(581)	0	(1)	0	(2)	**(584)**
At 31 March 2013	**6,335**	**3,760**	**0**	**5**	**0**	**19**	**10,119**

Property impairments of net £584k were charged to the Revaluation Reserve in respect of the DV revaluation of the PCT estate.

Additions to Assets Under Construction in 2012-13	£000
Buildings excl Dwellings	842
Balance as at YTD	**842**

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2011	**14,300**	**28,497**	**58**	**329**	**3,572**	**903**	**47,659**
Additions - purchased	0	38	1,145	0	7	0	**1,190**
Reclassifications	0	58	(58)	0	0	0	**0**
Revaluation & indexation gains	0	79	0	0	0	0	**79**
Impairments	(1,063)	(197)	0	0	0	0	**(1,260)**
At 31 March 2012	**13,237**	**28,475**	**1,145**	**329**	**3,579**	**903**	**47,668**
Depreciation							
At 1 April 2011	**0**	**0**		**214**	**1,735**	**388**	**2,337**
Impairments	80	1,015	0	0	0	0	**1,095**
Charged During the Year	0	723		57	714	72	**1,566**
At 31 March 2012	**80**	**1,738**	**0**	**271**	**2,449**	**460**	**4,998**
Net Book Value at 31 March 2012	**13,157**	**26,737**	**1,145**	**58**	**1,130**	**443**	**42,670**
Purchased	13,157	26,737	1,145	58	1,130	443	**42,670**
At 31 March 2012	**13,157**	**26,737**	**1,145**	**58**	**1,130**	**443**	**42,670**
Asset financing:							
Owned	11,287	15,692	1,145	58	1,130	443	**29,755**
On-SOFP PFI contracts	1,870	11,045	0	0	0	0	**12,915**
At 31 March 2012	**13,157**	**26,737**	**1,145**	**58**	**1,130**	**443**	**42,670**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	**£000's**
At 31 March 2011	7,398	4,472	0	6	0	21	**11,897**
Movements (specify)	(1,063)	(131)	0	0	0	0	**(1,194)**
At 31 March 2012	**6,335**	**4,341**	0	**6**	**0**	**21**	**10,703**

12.3 Property, plant and equipment

The PCT did not receive any donations in respect of property, plant and equipment.

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

An independent valuation was carried out in respect of the 1st April 2013 by the 'DVS Property Specialists for the public sector', the BCIS index has been used for the valuation of specialised assets. The age and remaining lives of buildings and their elements have been assessed as at the valuation date. It has been assumed that building elements will continue to be maintained normally over the period from the date of inspection to the valuation date and that there will be no untoward changes.

The valuation of each property is on the basis of Market Value subject to the following :
"the Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the traditional understanding of Market Value).

The Department of Health has indicated that for NHS assets it requires the above assumption to be applied for operational assets and that approach has been followed by the Valuer.

There has been no change of asset lives/residual values and thus no effect in the current and/or future years.

13 Intangible non-current assets

Lewisham PCT did not hold any Intangible non-current assets at 31 March 2013 and 31 March 2012.

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	187	(58)	245
Total charged to Departmental Expenditure Limit	**187**	**(58)**	**245**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	1,084	0	1,084
Total impairments for PPE charged to reserves	**1,084**	**0**	**1,084**
Total Impairments of Property, Plant and Equipment	**1,271**	**(58)**	**1,329**

Property impairments of £187k were taken to SoCNE in respect of the DV revaluation of the PCT estate, as there was insufficient balance within the revaluation reserve for these particular assets.

Property impairments of £1,084k were charged to the Revaluation reserve in respect of the DV revaluation of the PCT estate.

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Total Impairments charged to Revaluation Reserve	1,084	0	1,084
Total Impairments charged to SoCNE - DEL	187	(58)	245
Total Impairments charged to SoCNE - AME	0	0	0
Overall Total Impairments	**1,271**	**(58)**	**1,329**

15 Investment property

Lewisham PCT did not have any Investment Property at 31 March 2013 and 31 March 2012.

16 Commitments

16.1 Capital commitments

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

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

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	576	0	912	0
Balances with NHS Trusts and Foundation Trusts	644	0	6,319	0
At 31 March 2013	**1,220**	**0**	**7,231**	**0**
prior period:				
Balances with other Central Government Bodies	276	0	2,136	0
Balances with NHS Trusts and Foundation Trusts	1,236	0	5,582	0
Balances with bodies external to government	2,348	0	19,185	0
At 31 March 2012	**3,860**	**0**	**26,903**	**0**

18 Inventories

Lewisham PCT did not have any inventories at 31 March 2013 and 31 March 2012.

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	**1,220**	1,512	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**732**	177	**1**	1
Non-NHS prepayments and accrued income	**121**	2,218	**0**	0
Provision for the impairment of receivables	**(7)**	(21)	**0**	0
VAT	**213**	(33)	**0**	0
Total	**2,279**	3,859	**1**	1
Total current and non current	**2,280**	3,860		

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	**282**	1,133
By three to six months	**0**	2
By more than six months	**6**	5
Total	**288**	1,140

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(21)**	(21)
Decrease in receivables impaired	**14**	0
Balance at 31 March 2013	**(7)**	(21)

All debts written off are reported to the Audit Committee. NHS Shared Business Services provide the routine credit control service for the PCT, and refer to a debt collection agency where necessary. Invoices are written off only when they are deemed uncollectable, or enforcement costs would not be economic.

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**243**	**3**	**246**
Balance at 31 March 2013	**243**	**3**	**246**
Balance at 1 April 2011	322	3	325
Loan repayments	(79)	0	(79)
Balance at 31 March 2012	**243**	**3**	**246**

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**246**	325
Revaluation		(79)
Total Other Financial Assets - Non Current	**246**	246

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	**1**	0
Net change in year	**20**	0
Closing balance	**21**	0
Made up of		
Cash with Government Banking Service	**20**	1
Cash in hand	**1**	0
Cash and cash equivalents as in statement of financial position	**21**	1
Cash and cash equivalents as in statement of cash flows	**21**	1

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	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	**0**
Revaluation	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	**0**

Revaluation reserve balances in respect of non-current assets held for sale were:

At 31 March 2012	0
At 31 March 2013	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS payables - revenue	**2,624**	4,729	**0**	0
NHS payables - capital	**0**	618	**0**	0
NHS accruals and deferred income	**4,358**	1,960	**0**	0
Family Health Services (FHS) payables	**11,415**	13,953		
Non-NHS payables - revenue	**3,539**	3,621	**0**	0
Non_NHS accruals and deferred income	**1,645**	1,815	**0**	0
Social security costs	**106**	92		
Tax	**27**	115		
Payments received on account	**1**	0	**0**	0
Other	141	0	0	0
Total	**23,856**	26,903	**0**	0
Total payables (current and non-current)	**23,856**	**26,903**		

26 Other liabilities

Lewisham PCT had no other liabilities (current and non-current) at 31 March 2013 and 31 March 2012.

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
LIFT liabilities:				
Main liability	**231**	210	**15,421**	15,648
Total	**231**	**210**	**15,421**	**15,648**
Total other liabilities (current and non-current)	**15,652**	**15,858**		

28 Other financial liabilities

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Embedded Derivatives at Fair Value through SoCNE	**0**	0	**0**	0
Financial liabilities carried at fair value through SoCNE	**0**	0	**0**	0
Amortised Cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

29 Deferred income

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

30 Finance lease obligations

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

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

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

	31 March 2013 £000	31 March 2012 £000
Finance leases as lessee		
Future Sublease Payments Expected to be received	**0**	0
Contingent Rents Recognised as an Expense	**0**	0

31 Finance lease receivables as lessor

Amounts receivable under finance leases (buildings)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**-**	-
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectible lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	**0**	**0**	**0**
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Amounts receivable under finance leases (land)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**-**	-
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectible lease payments:	**0**	**0**	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	**0**	**0**	**0**
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Amounts receivable under finance leases (other)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**-**	-
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectible lease payments:	**0**	**0**	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	**0**	**0**	**0**
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Finance Leases (as a Lessor)	**31 March 2013 £000**	31 March 2012 £000
The unguaranteed residual value accruing to the PCT is	**0**	**0**
Accumulated allowance for uncollectible minimum lease payments receivable	**0**	**0**

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

32 Provisions

Comprising:

	Total £000s	Pensions Relating to Other Staff £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**2,978**	3	2,764	211	0
Arising During the Year	**2,338**	0	2,003	0	335
Utilised During the Year	**(1,573)**	(2)	(1,550)	(21)	0
Reversed Unused	**0**	0	0	0	0
Unwinding of Discount	**0**	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0
Balance at 31 March 2013	**3,743**	**1**	**3,217**	**190**	**335**
Expected Timing of Cash Flows:					
No Later than One Year	**1,967**	**0**	**1,608**	**24**	**335**
Later than One Year and not later than Five Years	**1,730**	**1**	**1,609**	**120**	**0**
Later than Five Years	**46**	**0**	**0**	**46**	**0**

Continuing Care Provisions

In March 2012 the Department of Health announced deadlines for individuals or their representatives to notify the relevant PCT if they believe there was a period of care between 1st April 2004 and 31st March 2012 where there is evidence that the individual should have been assessed for eligibility for NHS continuing healthcare (NHS CHC). This only applies to new cases ie where, the individual has not previously been assessed for NHS CHC during the identified period. The first deadline was the 30th September 2012 relating to claims between 1st April 2004 to 31st March 2011. The second deadline was 31st March 2013 relating to the period from 1st April 2011 to 31st March 2012. The PCT received a total of 95 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been ongoing through the year and a financial provision has been made based on estimates of the potential financial exposure using the latest information available at the time.

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	86
As at 31 March 2012	109

33 Contingencies

	31 March 2013 £000
Contingent liabilities	
Equal Pay	**0**
Other	**(2,680)**
Amounts Recoverable Against Contingent Liabilities	**0**
Net Value of Contingent Liabilities	**(2,680)**

The Contingent Liability relates to the balance of claims for the Continuing Healthcare costs estimate for which no provision has been made.

34 LIFT - additional information

The PCT entered into a 'Local Improvement Finance Trust' procurement arrangement in 2007 for Waldron Health Centre, it was fully operational from July 2007, and the lease expires in 2033. Payments are indexed on the basis of RPI.
The PCT is accounting for the lease on the assumption that it will exercise its right to purchase the asset at the end of the lease, or extend the lease. Under IFRIC 12 the asset is treated as an asset of the PCT, that the substance of the contract is that the PCT has a finance lease and payments comprise the two elements-imputed finance lease charges and service charges.

The PCT has no Off balance sheet PFI or LIFT schemes.

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013**	31 March 2012
	£000	£000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**194**	190
Total	**194**	190

	31 March 2013	31 March 2012
	£000	£000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	**199**	194
Later than One Year, No Later than Five Years	**849**	828
Later than Five Years	**4,045**	4,265
Total	**5,093**	5,287

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013**	31 March 2012
	£000	£000
No Later than One Year	**996**	981
Later than One Year, No Later than Five Years	**3,421**	3,759
Later than Five Years	**12,570**	13,227
Subtotal	**16,987**	17,967
Less: Interest Element	**(1,334)**	(2,109)
Total	**15,653**	15,858

35 Impact of IFRS treatment - 2012-13

	Total	Admin	Programme
	£000	£000	£000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)			
Depreciation charges	**214**	0	214
Interest Expense	**775**	0	775
Impairment charge - AME	**246**	0	246
Total IFRS Expenditure (IFRIC12)	**1,235**	**0**	**1,235**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(1,360)**	0	(1,360)
Net IFRS change (IFRIC12)	**(125)**	**0**	**(125)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12			
Capital expenditure 2012-13	0	0	0
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0	0	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	0	**0**
Receivables - NHS	0	220	0	**220**
Receivables - non-NHS	0	1,124	0	**1,124**
Cash at bank and in hand	0	20	0	**20**
Other financial assets	0	334	0	**334**
Total at 31 March 2013	**0**	**1,698**	**0**	**1,698**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	1,512	0	1,512
Receivables - non-NHS	0	177	0	177
Cash at bank and in hand	0	1	0	1
Other financial assets	0	243	3	246
Total at 31 March 2012	0	1,933	3	1,936

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	11,729	**11,729**
Non-NHS payables	0	16,577	**16,577**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	15,652	**15,652**
Total at 31 March 2013	**0**	**43,958**	**43,958**
Embedded derivatives	0	0	0
NHS payables	0	4,742	4,742
Non-NHS payables	0	2,273	2,273
Other borrowings	0	15,648	15,648
Total at 31 March 2012	**0**	22,663	22,663

37 Related party transactions

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

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

	Services Received from Organisation	Payments to Related Party £
Dr Judy Chen-Rushy Green Group Practice	Primary Care	1,413,318
Dr Faruk Majid - Hilly Fields Medical Centre	Primary Care	1,279,780
Dr David Abraham - Morden Hill Surgery	Primary Care	958,561
Dr Helen Tattersfield - Oakview Family Practice	Primary Care	487,748
Dr Marc Rowland - Jenner Practice	Primary Care	1,351,435
Dr Arun Gupta - South Lewisham Group Practice	Primary Care	1,410,247
Dr Hilary Entwistle - Woolstone Medical Centre	Primary Care	769,448

The Department of Health, as Lewisham PCT's parent department, is regarded as a related party. During the year 2012/13, Lewisham Primary Care Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

		£000
Lewisham Healthcare NHS Trust	Acute	167,177
South London and Maudsley NHS Foundation Trust	Mental Health	66,304
Guys and St Thomas NHS Foundation Trust	Acute	59,765
Kings College Hospital NHS Foundation NHS Trust	Acute	44,215
London Borough of Lewisham	Learning disability and community healthcare	21,344

2011/12	Services Received from Organisation	Payments to Related Party £
Dr Judy Chen-Rushy Green Group Practice	Primary Care	1,577,997
Dr Hilary Entwistle-Woolstone Medical Practice	Primary Care	946,738
Dr Faruk Majid - Hilly Fields Medical Centre	Primary Care	1,778,266
Dr David Abraham - Morden Hill Surgery	Primary Care	1,187,224

		£000
Lewisham Healthcare NHS Trust	Acute	157,126
South London and Maudsley NHS Foundation Trust	Mental Health	69,941
Guys and St Thomas NHS Foundation Trust	Acute	60,091
Kings College Hospital NHS Foundation NHS Trust	Acute	42,498
London Borough of Lewisham	Learning disability and community healthcare	16,871

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	4,919	3
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	4,919	3
Total special payments	0	0
Total losses and special payments	4,919	3

Lewisham PCT had no losses or special payments in 2011-12

Details of cases individually over £250,000	0	None

39 Third party assets

The PCT does not hold money on behalf of patients or any other parties.

40 Cashflows relating to exceptional items

The PCT did not receive any cashflow related to exceptional items during 2012-13. (2011-12 Nil)

41 Events after the end of the reporting period

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

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

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

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

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

41 Events after the end of the reporting period (Cont'd)

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

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

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

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

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

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

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

Lewisham Primary Care Trust

Annual Governance Statement 2012/2013
Organisation Code: 5LF

1. Scope of responsibility

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

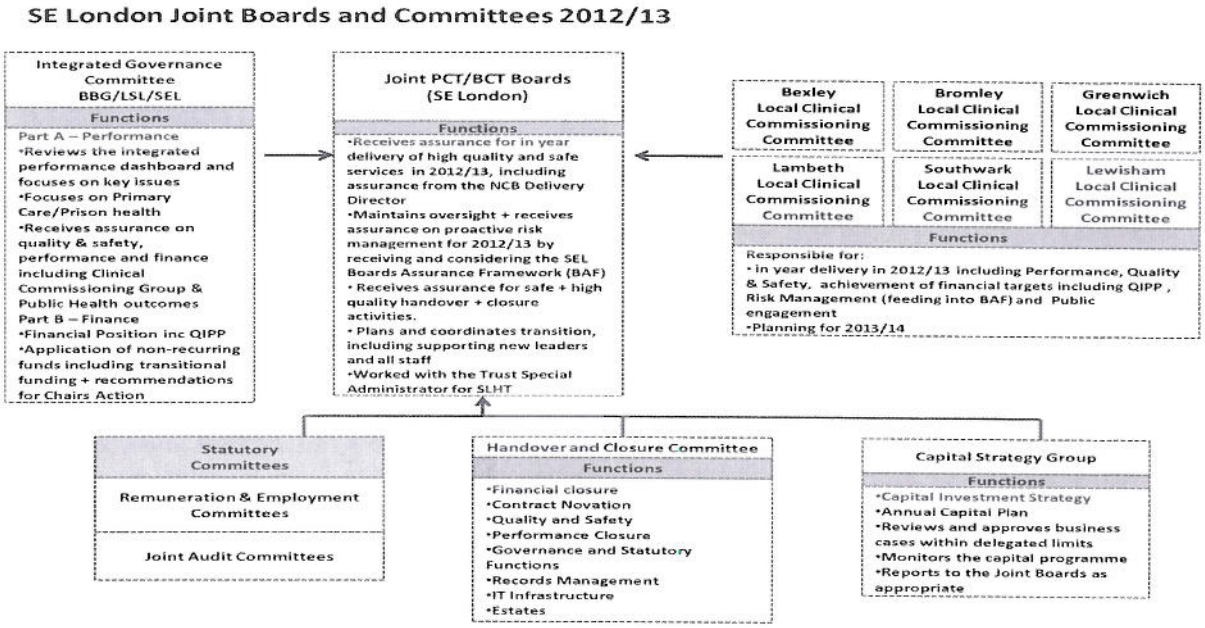
The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Lewisham PCT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control was in place in Lewisham PCT for the year ended 31 March 2013.

NHS South East London was established on 1 April 2011 and was a partnership of Bromley, Greenwich, Lambeth, Lewisham and Southwark Primary Care Trusts and Bexley Care Trust. This change was a first step towards delivering the Government's reforms to the NHS under the provisions of the Health and Social Care Act 2012 and which come into statutory force from 1 April 2013. Under the terms of the same Act Lewisham PCT and NHS South East London were disestablished on 31st March 2013. New commissioning organisations were created to commission health care services in Lewisham and these were principally NHS Lewisham Clinical Commissioning Group and NHS England. In this document NHS South East London is sometimes referred to as a "PCT Cluster" or "Cluster".

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

2. The governance framework of the organisation

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



Joint South East London PCT/Care Trust Boards

The Joint Boards were six individual PCT/Care Trust Boards that worked together as one entity, undertaking the duties that were enshrined in law relating to the governance of Primary Care Trusts and Care Trusts. Certain mandatory positions on the Boards, such as the Chair and Chief Executive, were fulfilled by the same individual across all of the Boards, while other positions were taken by local Primary Care Trust (PCT) Managing Directors and locally-focused non-executive directors. The Boards focused on developing strategies and priorities for the entirety of NHS South East London (NHS SEL) (including Lewisham), ensuring that the clinical commissioning committees were fulfilling their duties, in accordance with what was delegated to them.

- During 2012/13 the Joint Boards:
  - Implemented the revised Governance arrangements agreed on 26 January 2012 reflecting the new shadow Clinical Commissioning Group (CCG) arrangements in place from 1 October 2012
  - Agreed revised arrangements for managing conflicts of interest in NHS SEL
  - Adopted revised Corporate Governance Arrangements enacting the Transition
  - Reviewed and updated the Boards Assurance Framework at every Boards meeting.
  - Considered risk at every meeting and received assurance via an exception reporting arrangement, the format for which was considerably strengthened by the Boards during the year. This approach was supported through the delegation process whereby each borough Local Clinical Commissioning Committee (LCCC) reviewed risks relevant to their populations. The Joint Audit Committees (JAC) tested the system and process of assurance.
  - At each meeting received and considered reports on the following topics:

- Quality and Performance
- Finance
- Integrated Governance
- Local Clinical Commissioning Committees
- Transition and Handover & Closure including:
  - Clinical Commissioning Groups
  - The South London Commissioning Support Unit
- Individual matters reserved to the Joint Boards

The Joint Boards' Assurance Framework was publicly available on the NHS SEL website.

In 2012/13 the Boards met every two months, in public. All meetings were quorate for all Boards.

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

In the key areas of governance, there was a 100% satisfaction rating that governance arrangements enabled members to identify and, when necessary, declare potential conflicts of interest when conducting Board business. There was also a near unanimous satisfaction rating in the following areas (one member disagreed):

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

Overall, members were also satisfied that:

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

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

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

Notwithstanding the reflections detailed above, the Chair and Chief Executive believed that there had been no material departure from the Code of Conduct and Code of Accountability for NHS Boards and none has been suggested by other Board members

Lewisham Clinical Commissioning Committee (LCCC)

The Lewisham Clinical Commissioning Committee (LCCC) was a committee of the Lewisham PCT Board. During 2012/13 it assured the areas of commissioning responsibility that were delegated to the Lewisham Clinical Commissioning Group (CCG). The Lewisham CCG replaced the PCT as commissioner of local health services from April 2013 in line with new legislation. During 2012/13 the LCCC ensured that best practice governance was in place for Lewisham CCG as it became authorised as a statutory organisation. The clinically-led LCCC engaged with all 44 Lewisham GP practices covering four Lewisham localities and was supported by NHS Lewisham Business Support Unit and NHS South East London-wide shared teams to identify local healthcare needs and commission services for the population of Lewisham based on agreed strategic priorities. Over the past year the LCCC also undertook the duties of the Professional Executive Committee (PEC).

The LCCC provided a summary report to every Joint Board meeting including reporting on its delegated responsibilities. During 2012/13 the LCCC met monthly and all meetings were held in public. Full copies of the minutes are available on the archived NHS South East London public website[1].

Joint Audit Committees

- The Joint Audit Committees (JAC) fulfilled the statutory audit functions required of PCTs and Care Trusts, and ensured that the governance and machinery of the cluster and the PCTs/Care Trust was functioning as it should. Their work programme included reviewing governance arrangements (including Information Governance), assurance mechanisms including the work of internal and external audit, local counter fraud and security management services, debt and waiver management, and reviewing the Board Assurance Framework to make sure that corporate objectives and organisational risks were properly addressed.
- During 2012/13 the JAC considered all residual risks and Assurance Frameworks from the PCTs / Care Trust in SEL. The Committee reviewed the Assurance Framework at every meeting.
- The JAC considered each of the six individual PCTs/Care Trust Annual Accounts, Audit opinions, Annual Reports and Annual Governance Statements for 2011/12 at its meetings on the 9 and 30 May 2012. .
- On 9 January 2013 the JAC received and considered the Annual Audit Letters
- On 13 and 27 March 2013 the JAC considered each of the six individual PCTs/ Care Trust draft Annual Reports and Annual Governance Statements, along with the interim work on the 2012/13 Annual Accounts undertaken by internal and external audit. Year end documents will be finalised and approved post 31 March 2013 through the temporary mechanism being designed by the Department of Health.

---

1 http://www.webarchive.org.uk/wayback/archive/20130329030138/http:/www.selondon.nhs.uk/your_local_nhs/lewisham/local_clinical_commissioning_committee

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

Integrated Governance Committee (IGC)

The IGC had the following roles and responsibilities:-

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

Handover and Closure Committee

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

Capital Strategy Group

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

Joint Remuneration and Employment Committee

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

Assurance

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

Organisation	Assurance Level	Recommendations by Priority		
		High	Medium	Low*
Lewisham (Made/accepted)	Adequate	0	0	4/4
Summary of Audit	**Adequate**	**0**	**0**	**21/21**

3. Risk Assessment

3.1. Introduction

The Lewisham PCT approach to risk management and board assurance was in accordance with legislation, national and local guidance in force at the time. It sought to embed recognised and developed best practice through a process of ongoing review and improvement and underpinned the production of the Annual Governance Statement (AGS).

Through adopting the agreed NHS SEL approach to risk management and board assurance, Lewisham PCT believed that it had in place a sound governance structure and risk management arrangements to enable it deliver its objectives and thus serve its resident population.

The PCT systematically identified, at all levels, those risks that could affect these objectives and took every reasonable step to control risk. This included a process to monitor, and if necessary improve, how risks were being managed and demonstrate how this was occurring.

Lewisham PCT leadership team employed effective techniques for risk management, supported by good information systems, discussed and shared risk information amongst themselves and trained and supported all staff to an appropriate level of expertise.

Lewisham PCT also required that the organisations and people it commissioned to provide health services operated demonstrably effective risk management systems.

3.2. Purpose of risk management and board assurance

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

The PCTs in NHS SEL adopted the principles of the Australia/New Zealand Risk Management Standard (AS/NZS 4360:1999) in their approach to risk management. This is a generic model for identifying, prioritising and dealing with risks in any situation – at local or corporate level. It comprises definition, scope and consequence of risk. It provided an effective means of controlling and mitigating the risks associated with the delivery of commissioned services, the achievement of corporate objectives and any other aspect of health in NHS SEL.

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

3.3 Objectives

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

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

3.4. Description of terms and definitions

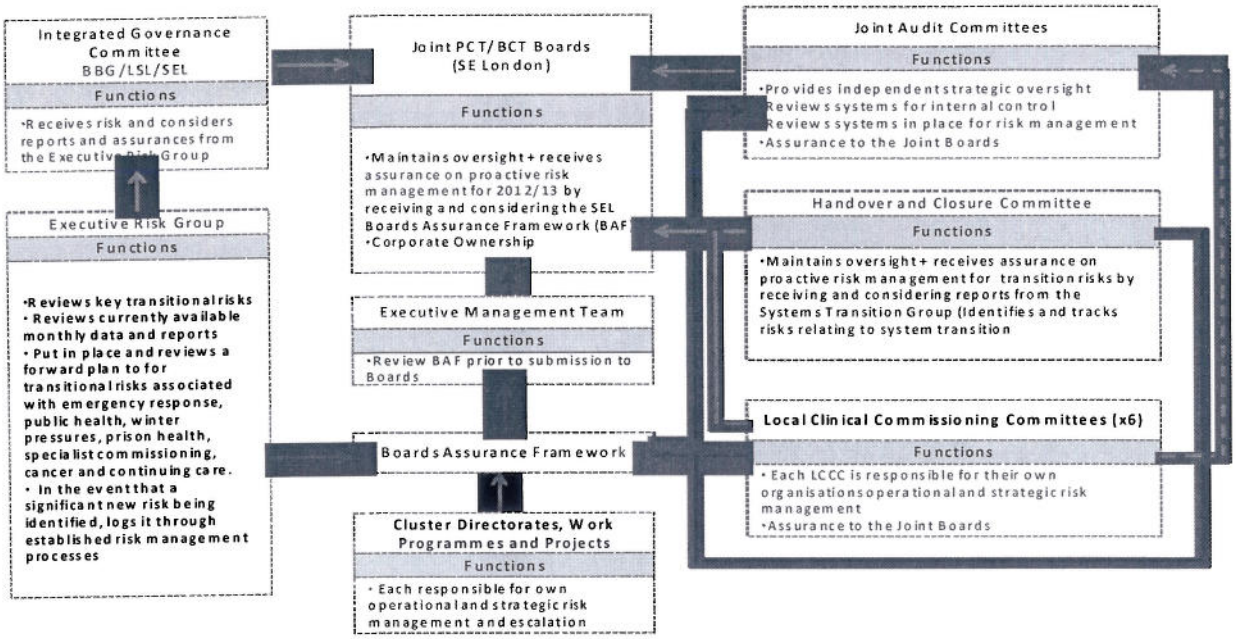
Risk management and assurance uses a number of terms and definitions that are necessary in order to communicate its meaning, interpretations and outcomes in a common way. The description of the terms, definitions and principles that the cluster worked to were set out in the joint NHS SEL Risk Management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

3.5. The risk management structure

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

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

SE London Risk Management Structure 2012/13



Additional information on the above groups follows:

Joint Boards (Corporate Ownership)

The Joint Boards owned the organisational objectives, risks to delivery and the assurance framework. It identified all its key significant risks and assured itself that they were being managed appropriately. Monitoring of the key risks was completed via the Joint Boards Assurance Framework. The Joint Boards needed to be satisfied that appropriate policies and strategies were in place and that systems were functioning effectively.

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

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

Joint Audit Committees (Assurance)

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

Local Clinical Commissioning Committees (Assurance)

Lewisham LCCC provided oversight, challenge and review of local issues, management response and interaction with cluster activities. The LCCC also reviewed locally specific risks and recommended their escalation to the JBAF in line with the principles contained within the NHS SEL Assurance Framework. The LCCC discussed risk at every meeting and considered, and acted on, its corporate risk register. This was a vital contribution to retaining local ownership and to escalating appropriate risks to the Joint Boards.

Executive Management Team (Management Adoption)

Fulfilled the corporate governance functions of a Risk Committee. It was responsible for co-ordinating and overseeing the development and implementation of the Policy & Strategy across the cluster. It oversaw the development of the Joint Boards Assurance Framework and the maintenance of appropriate local risk registers. On an alternate monthly basis it reviewed all significant risks on the JBAF prior to oversight by the Joint Boards, and new emerging risks that had escalated from the Directorates. The Committee monitored and ensured that the JBAF reflected all the key risks with particularly high residual scores and that it remained a dynamic document.

Assessed congruence and identification of any cross PCT issues. Ensured all strategic risks were identified, had been appropriately allocated and were being managed in accordance with NHS SEL policy. Made recommendations on escalation and commonality including identification of PCT specific risks (15 or above).

The Integrated Governance Committee (Management Adoption)

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

Executive Risk Group (Transition Risk Oversight)

In acknowledgement of the risks associated with the transitional period to March 31st 2013, the Joint Boards established an Executive Risk Group in November 2012. The Executive Risk Group brought together senior Executive Directors, including the Nursing and Medical Director, from the Cluster and the London office of the NHS Commissioning Board. The Executive Risk Group met every fortnight and systematically reviewed key risks as the transitional arrangements unfolded and as functions were handed on to the new shadow bodies. In addition to reviewing currently available monthly data and reports, the Executive Risk Group established a forward plan to review transitional risks associated with emergency response, public health, winter pressures, prison health, specialist commissioning, cancer and continuing care. The Executive Risk Group reported to the Integrated Governance Committee and, in the event that a significant new risk was identified through this process, it was logged in the normal way on the risk register.

PCT and Directorate Structures (Operational Management)

All directors had local risk management structures (in Lewisham this included aspects of capturing LCCC intelligence). All Directors and therefore their managers were responsible for; ensuring that appropriate and effective risk management processes were in place for each department / function within their scope of responsibility; compliance to the NHS SEL approach to risk management and board assurance; bringing to the attention of their director

/ department lead any significant risks that had been identified where local control measures are considered to be inadequate.

3.5.2 Risk reporting and management

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

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

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

3.5.3 Duties (roles & responsibilities)

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

- As signing officer delegated by the Department of Health's Accounting Officer I have taken assurance from the Accountable Officer during 2012-13 that he took overall Executive responsibility for ensuring that there was an effective risk management or assurance framework in place within the cluster, for meeting all statutory requirements, adhering to guidance issued by the Department of Health in respect of Governance. I was required to sign the Annual Governance Statement. The Accountable Officer was accountable to the Joint Boards.

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

  - Ensuring that appropriate and effective risk management processes were in place within their designated areas and scope of responsibility.
  - Ensuring all staff were made aware of the risks within their work environment and of their personal responsibilities.
  - Preparing specific Directorate/Departmental policies and guidelines to ensure all necessary risk assessments were carried out within their directorate/department in liaison with appropriate identified relevant advisors where necessary.
  - Implementing and monitoring any identified and appropriate risk management control measures within their functions and scope of responsibility.
  - Ensuring situations are addressed where significant risks had been identified and where local control measures were considered to be potentially inadequate,

Directors/ Directorate managers were responsible for bringing these risks to the attention of the Executive Management Team
- Ensuring that all staff were given the necessary information and training to enable them to undertake effective risk management practices.
- Ensuring that a Risk Register was maintained for their area of responsibility.

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

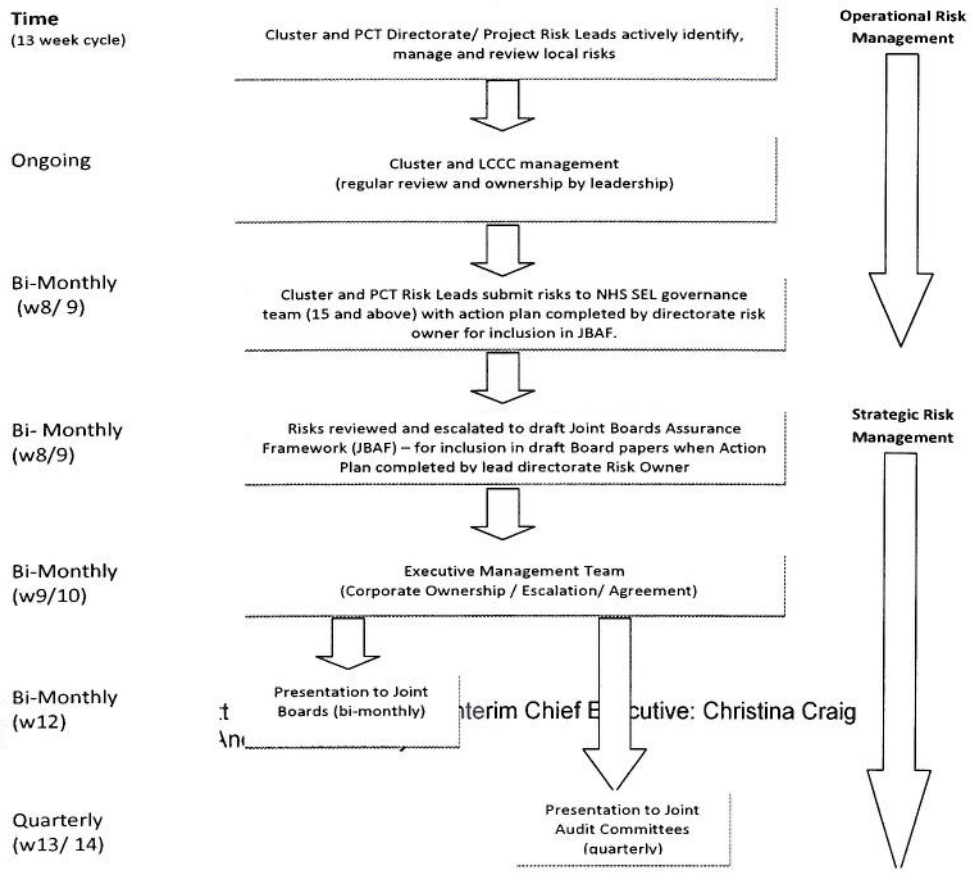
  - Reporting incidents/accidents and near misses using the agreed channels.
  - Complying with all cluster Rules, regulations, guidance and instructions to protect the health, safety and welfare of anyone affected by the Cluster's business.
  - Complying with all rules, regulations, guidance and instructions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

4. Risk reporting and risk ratings

4.1 Risk reporting process flow

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

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



4.2 Risk ratings

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

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

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

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

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

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

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

TOLERANCE THRESHOLD

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

4.3 Zero tolerance risks

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

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

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

5. Independent assurance

5. 1 Internal audit

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

5.2 NHS Litigation Authority (NHSLA)

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

6. Reviews and updates

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

7. New risks identified in the year 2012/13

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

ID	Work Stream	Date Raised	Risk Category	Risk Description	Initial Risk Score	Still on JBAF @ 31/03/13	Risk Score @ 31/3/13	PCT/ Care Trusts affected by Risk
ICT18	ICT	27/04/2012	Information Management and Technology	There is a risk that the amount of change to happen in 2012/13 due to changes in the NHS such as the closure of PCTs will lead to an undeliverable ICT workplan, leading to some change requirements not being met	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
E25	Governance (Approval)	01/05/2012	Governance	There is a risk that lack of clarity about the future of the Capital Strategy Group caused by internal review of corporate governance arrangements will lead to delays in reaching decisions on business cases for capital schemes, disposals etc	15	No: deescalated from JBAF or closed		All PCTs/ Care Trust
ICT25	ICT	18/05/2012	Information Management and Technology	There is a risk that the main data centre for the core ICT network covering LSLG is housed in Lower Marsh, whose lease ends on 28/9/12, leading to a significant clinical and financial risk if the lease is not extended	20	No: deescalated from JBAF or closed		All PCTs/ Care Trust
ICT28 (i)	ICT	02/07/2012	Information Management and Technology	There is a risk that proposed structures for the South London Commissioning Support Service are not fit for purpose and reduce ICT resources and capability at a time when increased resources are needed to meet organisational changes within South London	20	No: deescalated from JBAF or closed		All PCTs/ Care Trust

ID	Work Stream	Date Raised	Risk Category	Risk Description	Initial Risk Score	Still on JBAF @ 31/03/13	Risk Score @ 31/3/13	PCT/ Care Trusts affected by Risk
ICT28 (ii)	ICT	02/07/2012	Information Management and Technology	There is a risk that a number of staff will not have posts within SLCSS as of 01/10/12, leading to low morale, unclear line management and a lack of customer focus, leading to an increased risk of not meeting the needs of the business during the second half of 2012/13	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
IGR42	IG	19/08/2012	Legal & Compliance	There is a risk that successor organisations (the CSU) will not be set up to deal effectively or efficiently with information governance and information management caused by the levels of resource available and the complexity, pace and lack of clarity around transition leading to a failure to become authorised and embed efficient business processes	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
IGR50	IG	14/01/2013	Legal & Compliance	The NHS Commissioning Board is a new national organisation and as such it is likely that records management processes are not yet fully developed or embedded. Therefore there is a risk that records transferred to the NHS CB may not be fully managed in keeping with NHS requirements in the short term. Records cannot be transferred until assurances are received.	16	Yes	16	All PCTs/ Care Trust
JC07	Joint Commissioning	12/02/2013	Finance	There is a risk that successful financial claims may be made against the PCT/CCG for retrospective continuing care funding reviews leading to unbudgeted expenditure	12	Yes	16	Lewisham

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

Work Stream	Red
Information Governance	1
Joint Commissioning	1
Total	2

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

Zero Tolerance Risk
NHS Cluster
Lewisham

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

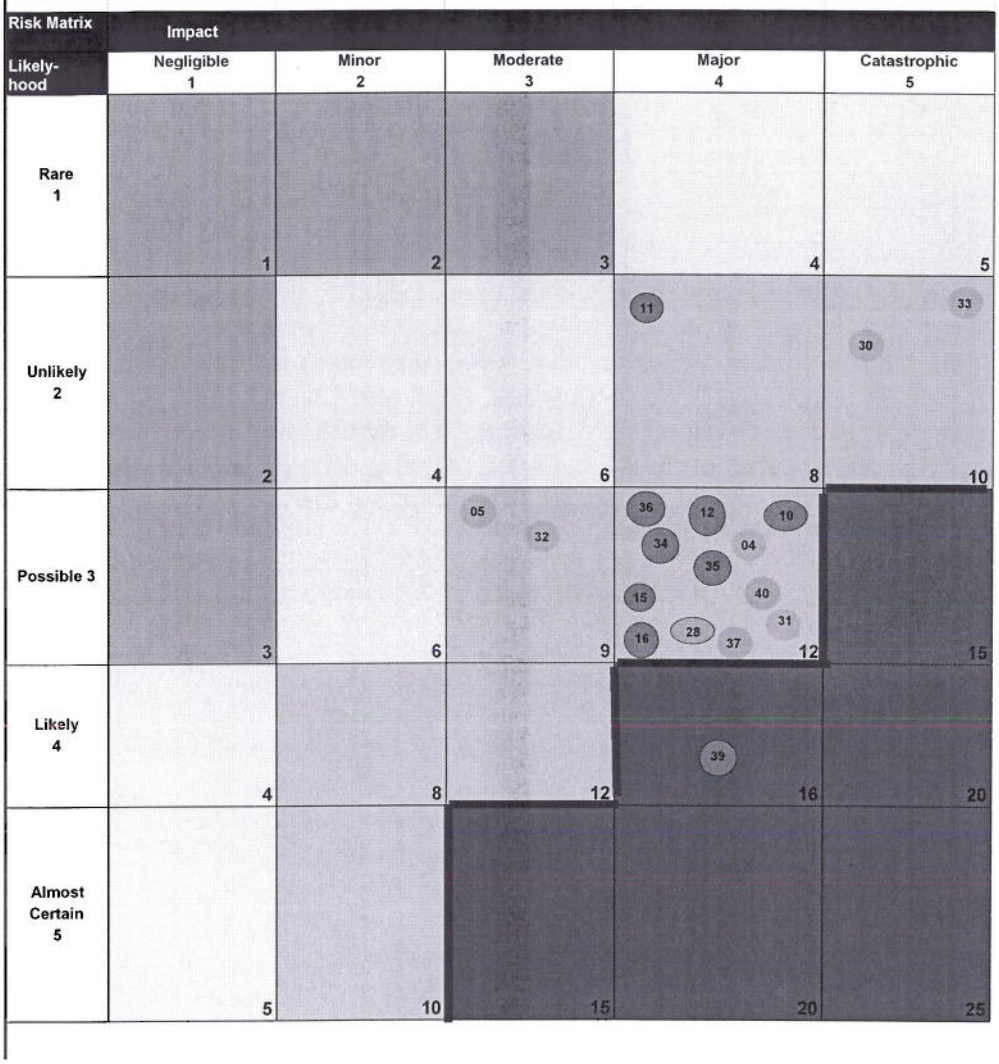
The common risk framework used across South East London evolved over the course of 2012 and 2013. It was informed by analysis and consideration by the Joint Boards, Boards Committees and local Business Support Units. During CCG preparation in 2012 and 2013 the Clinical Commissioning Groups gained greater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

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

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

The Heat Map below shows the distribution of all residual risks recorded by Lewisham and their movements during the year.

Lewisham Assurance Framework 2012/13 - Heat Map of Current Residual Risks



		Risk Description	Qtr 1 End	Qtr 2			Qtr 3			Qtr 4		
Corporate Objective 1: Improve health, quality and maintain safety of local NHS Services			June	July	August	Sept	Oct	Nov	Dec	January	February	March
CCG03	LA	Olympic Period impacting on services - **Zero Tolerance**	⇔	↓	⇔	Closed	Closed	Closed	Closed	Closed	Closed	Closed
CCG04	CMS	Failure to deliver Health & Wellbeing Goals	⇔	⇔	⇔	⇔	⇔	⇔	⇔	↑	⇔	⇔
CCG05	AB	Adult Safeguarding Arrangements - **Zero Tolerance**	⇔	↓	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
CCG30	AB	Safeguarding C&YP - **Zero Tolerance**				⇔	⇔	⇔	⇔	⇔	⇔	⇔
CCG31	MW	TSA Risk					**New Risk**	⇔	⇔	⇔	↑	⇔
CCG32	MW	111 Risk					**New Risk**	⇔	⇔	⇔	⇔	⇔
CCG33	AB	Children's Safeguarding Arrangements - **Zero Tolerance**							⇔	⇔	⇔	⇔
Corporate Objective 2: Sustain an effective grip on finance, performance and QIPP												
CCG10	TR	Insufficient risk reserve leading to CCG not being financially robust	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
CCG11	TR	Loss of financial skills and corporate memory - **Zero**	⇔	↓	⇔	⇔	⇔	⇔	⇔	↑	⇔	⇔
CCG12	GH	Quality and Safety Issues	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
CCG15	DR	Public Sector cuts caused by recession	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
CCG16	TR	Not achieving agreed access initiative performance levels for RTT	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
CCG34	TR	CSS Finance Risk							New Risk	⇔	⇔	⇔
CCG35	TR	Counter Fraud							New Risk	⇔	⇔	⇔
CCG36	TR	Bribery procedures							New Risk	⇔	⇔	⇔
CCG39	DC	Continuing Care Claims								**New Risk**	⇔	⇔
Corporate Objective 3: Proactively manage the transition to the new commissioning system												
CCG28	GH	CCG Failure to acknowledge CoI adequately	⇔	↓	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
CCG37	AB	Controlled Drug Agenda following transition.								**New Risk**	⇔	⇔
CCG40	AB	Controlled Drug Agenda following transition.									**New Risk**	⇔

8. Assurance

In October and November 2012 Internal Audit carried out a review of the BAF and Risk Management processes in each of the six Primary Care and Care Trusts in South East London.

Summary of Findings

"Good Practice

- Lewisham CCG has in place a risk management framework which identifies the need to monitor clinical, financial and corporate risks in line with NCB guidance. These risks have also been clearly identified within corporate risk registers and assurance frameworks. This ensures that both at governing body level and at a directorate level that a full scope of different types of risks that may affect the strategic and operational objectives of the CCG are identified and monitored.
- The CCG risk management framework outlines the roles and responsibilities for all parties with regards to risk management. Risk owners are clearly assigned risks and corresponding actions within corporate risk registers and assurance frameworks. This ensures that different parties and individuals and owners are accountable and have responsibility for identifying and monitoring specific risks and actions.
- Zero tolerance risks identified by the Cluster have been transferred accurately to the CCG corporate risk registers and frameworks and continue to be monitored in the latest iterations of CCG corporate risk registers. This signifies that the CCG has accepted the responsibility to identify and monitor high profile strategic risks, ensuring that these can be tracked at a local level.

"Areas for Improvement

- A recommendation was raised in 2011/12 about ensuring actions within risk registers fulfilled the SMART criteria. From this year's deep dive review of risks and actions in risk registers, although there has been improvement in ensuring that actions do fulfil the SMART criteria, there were still a number of high scoring risks with actions that did not fulfil the SMART criteria. The number of risks tested that did not fulfil the SMART criteria fell from 19 in 2011/12 to 2 this year."

Recommendations

No new recommendations were raised for Lewisham.

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

No incidents have been logged as Serious Incidents by Lewisham PCT during 2012/13

10. Significant Issues

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

Challenges during 2013/14

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

1. Delivering the transition

2013/14 will be a challenging year for Lewisham CCG, building on the success of its shadow running which commenced on 1 October 2012. We recognise the risks associated with the transition to new commissioning arrangements. We have robust plans in place supported by governance arrangements that will enable us to address the ongoing risks associated with transition whilst continuing to fulfil our statutory duty in 2013/14 of delivering the health and wellbeing needs of our local population.

2. Doing things differently

A significant amount of transformational change is needed across the local health economy in South East London and locally in Lewisham. Our commissioners are continuing to deliver service redesign schemes to maximise the benefits for patients. We have been working with our local providers to redesign services across many of our care pathways, including:

- GP initiated Outpatient Attendances
- Ensuring appropriate A&E attendances
- A new Diabetes Strategy
- Updating the COPD Pathway
- Updating the Heart Failure Pathway
- Developing a new MSK pathway
- Developing an Admission Avoidance Service:

.

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

3. Improving quality

We have set an ambitious productivity improvement targets for our health economy. Through our governance structures and processes we are monitoring and assuring execution of our plans on an ongoing basis, to ensure that we make savings without compromising the ongoing improvement of care quality, including outcomes across cancer, Referral to Treatment, A&E and waiting times. During 2013/14 we will further strengthen our quality processes by working collaboratively with our colleagues in the local health system to implement the recommendations resulting from the Francis Review. We will continue to listen to patients' views of the quality of local services and are working to

improve the way we engage with and listen to service users in all our commissioning activities.

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

Specific issues identified during 2012/13

We continue to work with our internal auditors to identify areas where our systems and processes for governance and internal control can be further strengthened. The work of Internal Audit during 2012/13 resulted in 5 high priority recommendations where improvements could be made to internal control systems and processes. These recommendations have been agreed by PCT Management and the resultant actions have been taken, or are in the process of being taken.

These covered:

Topic	NHS SEL Cluster	Lewisham
Conflicts of Interest	1	1
HR Staff Records	3	
General IT Controls		

Reconfiguration of Lewisham Hospital following the TSA Report into South London Healthcare NHS Trust

Lewisham Clinical Commissioning Committee faces a significant challenge after the Secretary of State for Health accepted the TSA's recommendations for the reconfiguration of Lewisham Healthcare NHS Trust. The LCCC recognises the need to respond effectively to the challenges faced by the NHS and will not shy away from difficult decisions. The Lewisham LCCC, in its new form as NHS Lewisham Clinical Commissioning Group, will maintain aspirations to improve patient care and health outcomes for Lewisham residents but remains unconvinced that the recommended changes will improve the quality of services for the vast majority of local people. NHS Lewisham CCG will be working with our membership, hospital providers and other local partners together with colleagues in neighbouring CCGs to ensure that any changes are well planned to the best advantage of Lewisham residents and local people are kept informed at all times. The CCG will continue to work with others to build on and further develop local services accessible to our local communities.

Learning lessons from Croydon

The Joint Audit Committees reviewed an NHS London checklist based on the Ernst & Young review of the experience at NHS Croydon. In addition, the Lewisham CCG Shadow Audit Committee reviewed the findings at its February meeting and planned to carry forward this learning into its behaviours and actions in the months ahead.

NHS Continuing Care

In March 2012 the Department of Health announced deadlines for individuals or their representatives to notify the relevant PCT if they believe there was a period of care between 1st April 2004 and 31st March 2012 where there is evidence that the individual should have been assessed for eligibility for NHS continuing healthcare (NHS CHC). This only applies to new cases ie where, the individual has not previously been assessed for NHS CHC during the identified period. The first deadline was the 30th September 2012 relating to claims between 1st April 2004 to 31st March 2011. The second deadline was 31st March 2013 relating to the period from 1st April 2011 to 31st March 2012. The PCT received a total of 95 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been ongoing through the year and a financial provision has been made based on estimates of the potential financial exposure using the latest information available at the time.

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

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

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

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

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

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

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

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

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

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