Department of Health

NHS

North East Strategic Health Authority

2012-13 Annual Report and Accounts

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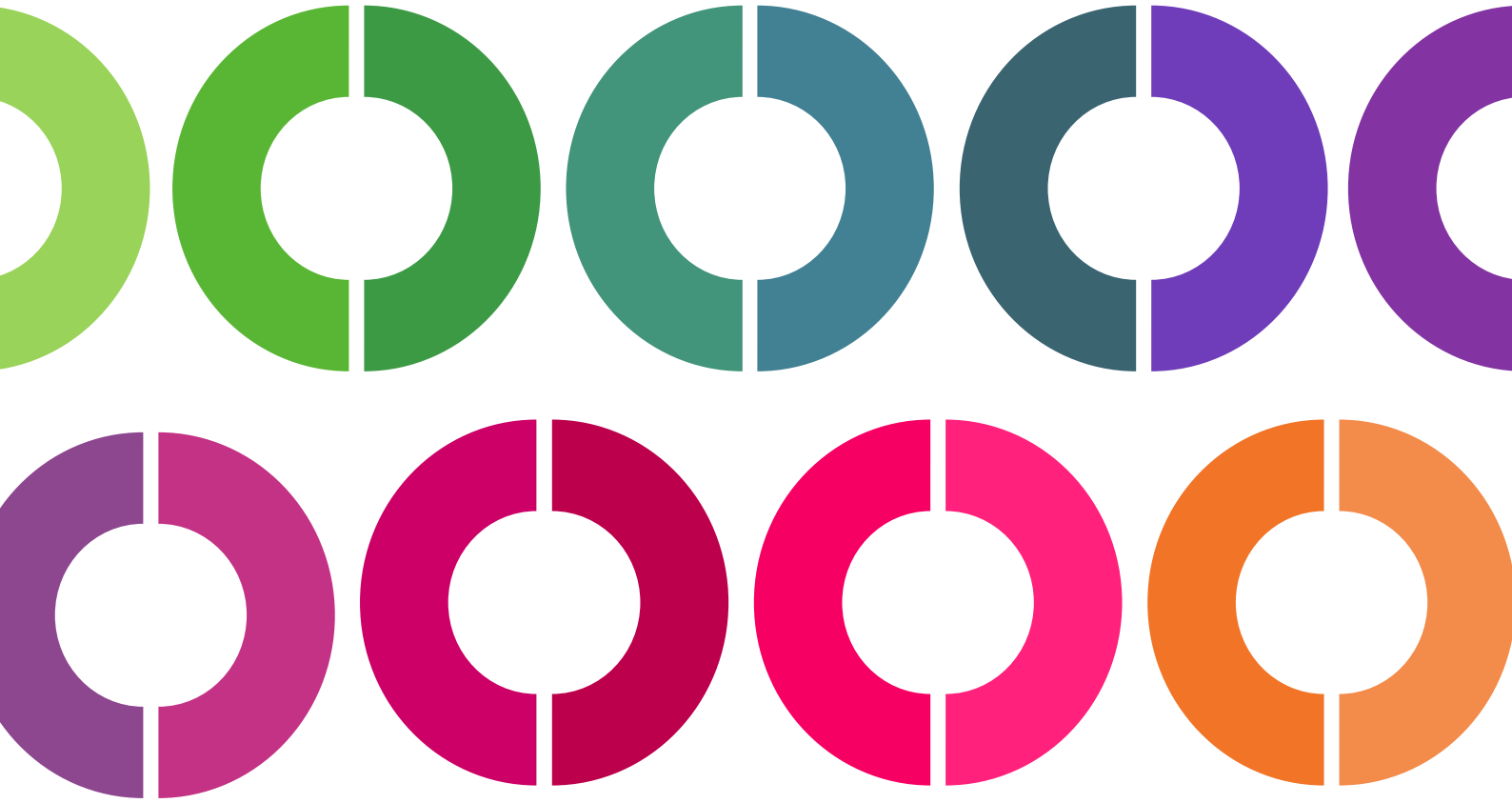
North East Strategic Health Authority

2012-13 Annual Report

NHS
North East



ANNUAL REPORT
AND FINANCIAL STATEMENTS

2012/2013

North East Strategic Health Authority
Part of NHS North of England

Foreword from the Chair and Chief Executive

This final annual report of the three strategic health authorities (SHAs) that make up NHS North of England is an opportunity to reflect – not just over the past year, but over the whole period of the SHAs – and acknowledge the contribution we have made towards improving health and healthcare for people who live in the North of England.

NHS North East, NHS North West and NHS Yorkshire and the Humber came into being in 2006 as a result of mergers of eight smaller SHAs established in 2002. During this time we have taken the NHS through a period of growth and development in the earlier years, but also through more financial and service pressures in the last three years.

Our stewardship of the NHS through the years of our tenure has hopefully lived up to the expectations of a good farmer – another generation of caring for land! Our land was the NHS and we weathered most of the storms and tried not to let the thistles grow under our feet. We have worked it hard and sought to get the best value we could. We have also grown ideas, encouraged innovation and introduced new technology to increase productivity and efficiency. We have overseen the governance and professional standards that continuously improved the environment for our patients and endeavour to protect them from avoidable harm.

Now we hand over to the new organisations that will manage the future NHS.

Our successor bodies will continue to face the challenges of ensuring the NHS stays relevant and trusted so it is able to serve an ageing population against the rising costs of treatments and constant increases in the number of people with long-term conditions.

We hand over during the most radical period of transition the NHS has seen since its inception in 1948. A transition to a new NHS that will be ever more patient-focused and clinically-led, with its success measured by outcomes.

I feel we have achieved so much it would be invidious to pick out too many examples. Put simply, what we have done is put the people first and work with the resources given to us to create as much health and as many good health services as we could:

- We have supported the development of our providers to be amongst the best hospitals, mental health services, community teams and general practices in the country.
- We have driven health improvement and tackled health inequalities – including world class innovations like Fresh, the North East Office for Tobacco Control, the Our Life public engagement social enterprise in the North West and the award-winning Altogether Better community health champions model in Yorkshire and the Humber.
- We have encouraged the research and delivery of technical innovations across the North from telemedicine in prisons to early adoption of new cancer drugs…

…and so much more.

All this success is due to the hard work and commitment of our staff. We are genuinely grateful to everyone who has worked in the SHAs and in the NHS organisation across the North in a particularly challenging time. Staff who, despite great uncertainties in their own futures, have unfailingly shown their dedication to delivering excellence to patients and health improvements for our population.

This year has very much been a year of transition, preparing to move from old structures to the new organisations that will continue to implement the changes to the NHS set out in the Health and Social Care bill 2010.

We wish our successors all the best for the future and pass the baton to them to take the NHS in the North of England forward for the benefit of those who use it.

Kathryn Riddle
Chair
NHS North of England

Professor Stephen Singleton OBE
Interim Chief Executive
NHS North of England

Strategic priorities and progress

About NHS North of England

On 3 October 2011, the three strategic health authorities across the north of England – NHS North East, NHS North West and NHS Yorkshire and the Humber – were placed under a single management framework and began to work together as NHS North of England – one of four strategic health authority 'clusters' across England.

NHS North of England's area includes 126 NHS organisations and 50 local authorities, with over 380,000 NHS staff providing health and social care to over 14.7 million people, with a NHS budget of £26 billion. Its overall aim has been to ensure the delivery of safe, high quality services with excellent patient experience and strong clinical outcomes during organisational changes in the NHS.

As part of NHS North of England, the three statutory strategic health authority bodies remained in place until the end of March 2013, with NHS North East continuing to be responsible for the performance and development of the NHS across the region.

This annual report outlines the work of NHS North East, as part of NHS North of England, during 2012/13.

NHS changes under the Health and Social Care Bill 2010

The strategic health authority has continued to lead a huge amount of work under the transition programme, which began in March 2011, to coordinate the implementation of NHS changes taking place under the Health and Social Care Bill 2010.

Working together with chief executives from primary care trusts, NHS foundation trusts, local authorities, clinical commissioning groups and the NHS Commissioning Board, a lot of our work this year has focussed on a detailed transition plan for the north east, to ensure smooth and effective handover of functions and work to successor organisations.

This work has covered the functions below, as well as the corporate transition of the strategic health authority and primary care trust clusters:

- Maintaining and improving the quality of health outcomes
- Developing the NHS workforce
- Provider development
- Public health services
- Commissioning arrangements
- Support for local authorities to establish health and wellbeing boards

Governance of the transition programme – which was a shared programme across the three strategic health authorities in the NHS North of England cluster – was through the transition programme board, which provided on going assurance to the NHS North of England chief executive that transition was on track, with all risks and issues actively managed.

The transition programme board

The detailed work of the transition programme was to ensure that functions, information and assets which were the responsibility of the three strategic health authorities (SHAs) making up NHS North of England, were either transferred successfully to the appropriate new organisation, or brought to satisfactory conclusion by 31 March 2013. The transition board coordinated and oversaw, on behalf of NHS North of England, the development and implementation of transition and closedown plans, to ensure the appropriate systems, processes and assurances were in place to support the SHA cluster through the final year of its operation to successful organisational closure.

The SHAs also continued to exercise oversight and assurance over the handover and closure programmes of PCTs across the north of England up until 31 March 2013.

The transition programme board which oversaw this work consisted of senior representatives from eleven specialist work streams:

- Workforce education and training
- Corporate affairs
- Operations and performance
- Estates
- Human resources
- Chief nurse and quality and safety
- Informatics
- Finance
- Public health
- Commissioning development
- Provider development

Programme assurance was provided through completion of a monthly report, completed by PCT transition leads and SHA cluster work stream leads and reviewed by the programme board. This allowed the programme board to identify emerging risks and issues, and plan mitigating actions at a regional and local level. The transition director reported on the overall progress of the programme to the SHA cluster board.

NHS Commissioning Board

The NHS Commissioning Board (NHS CB) is part of the government's vision to modernise the health service with the key aim of securing the best possible health outcomes for all patients.

Formally established as an independent body on 1 October 2012, the NHS CB takes up its full statutory duties and responsibilities on 1 April 2013. It will operate as a single organisation and will develop relationships with clinical commissioning groups through teams of staff working at a more local level – in area teams - as well as through four regional offices for England, with the northern office based in Leeds.

There are two local area teams responsible for the geography of the North East (and Cumbria):

- Cumbria, Northumberland, Tyne and Wear
- Durham, Darlington and Tees

Cumbria, Northumberland, Tyne and Wear area team will lead specialised commissioning and clinical networks for the north east and Cumbria

Durham, Darlington and Tees area team will take lead on primary care and offender health services for the north east and Cumbria.

Transfer of clinical contracts

In late November 2011, the Department of Health set out a national implementation plan for PCTs to prepare for the transition of NHS-funded healthcare contracts to successor organisations from 1 April 2013. This plan was based on a three stage approach:

1. Stock take – primary care trusts were asked to identify and reconcile all NHS-funded contracts and agreements held and record these in a national database. This phase was completed by March 2012.
2. Stabilise - undertake remedial actions to improve the controls, management and basic documentation of the contracts where identified from the risk assessments. This phase was completed by the end of September 2012.
3. Shift - this phase completed the operational and legal transfer (by means of formal transfer agreements) of contracting responsibilities from existing to future contracting authorities in the new structures. This phase concluded at 31 March 2013.

During 2012/13, the strategic health authority assured the progress of PCTs in preparing NHS-funded clinical contracts for transfer through monthly meetings with PCT contract leads and via the receipt of monthly written updates on PCT progress.

Commissioning development

During 2012/13, the development, assessment and authorisation of clinical commissioning groups (CCGs) was crucial to ensure the effective transfer of statutory responsibilities for commissioning from primary care trusts with effect from 1 April 2013.

By March 2013, twelve CCGs were in place to serve the north east.

The following CCGs will work to provide improved quality and health outcomes for NHS patients, as well as value for money for taxpayers:

- Northumberland CCG
- Newcastle North and East CCG
- Newcastle West CCG
- North Tyneside CCG
- Gateshead CCG
- South Tyneside CCG
- Sunderland CCG
- North Durham CCG
- Durham Dales, Easington and Sedgefield CCG
- Darlington CCG
- Hartlepool and Stockton-on-Tees CCG
- South Tees CCG

The expertise in CCGs is provided by clinicians from GP practices across the region and full details of running cost allowances are published at **http://www.commissioningboard.nhs.uk/2012/11/09/ccg-rca/**

Path to authorisation

To be established, and authorised by the NHS Commissioning Board, all CCGs were required to meet detailed consistent criteria. All authorised CCGs were assessed in terms of their geographical area, to ensure it is appropriate, fits with local authority working arrangements and able to serve the interests of the population well. They were required to submit written commissioning plans for 2012 to 2015, which were assessed by the strategic health authority, and were also responsible for leading the contracting process for 2012/13, whilst primary care trust clusters retained statutory accountability.

The authorisation process for CCGs was supported by a commissioning transition development work stream, which included a primary care trust cluster chief executive and representation from CCG members, primary care trust clusters, local authorities and the strategic health authority. This group was also responsible for ensuring a viable commissioning support unit was established to provide support services for CCGs across the region – see below.

In preparation for the transfer of services and contracts to new organisations that make up the healthcare system from April 2013, primary care trust clusters completed a stocktake of all existing contracts to ensure fitness for purpose before they were transferred to the NHS Commissioning Board, CCGs or local authorities.

All twelve CCGs in the north east progressed through the national authorisation process in four waves. As part of this:

- No CCGs in the North East applied in wave 1 (July 2012)
- Five North East CCGs submitted documentary evidence for authorisation in wave 2 (September 2012) and site visits were held in October/November 2012 by an authorisation panel:

  NHS Northumberland CCG

  NHS Sunderland CCG

  NHS Durham Dales Easington and Sedgefield CCG

  NHS Hartlepool and Stockton-on-Tees CCG

  NHS South Tees CCG

- Five CCGs in wave 3 of the authorisation process submitted documentary evidence in October 2012 and site visits were held in November 2012 by an authorisation panel:

  NHS Newcastle West CCG

  NHS Newcastle North and East CCG

  NHS Gateshead CCG

  NHS North Tyneside CCG

  NHS South Tyneside CCG

- Two CCGs in wave 3 of the authorisation process submitted documentary evidence in November 2012 and site visits were held in December 2012 by an authorisation panel:

  NHS North Durham CCG

  NHS Darlington CCG

Clinical Commissioning Group development events

The strategic health authority led a successful programme of engagement events throughout 2012/13 to support the development of emerging north east CCGs, including:

- In April 2012, representatives from the emerging CCGs came together with public health specialists to discuss the ways in which public health practitioners could support CCG commissioning for improved public health outcomes.
- In May 2012, emerging CCGs met to agree whether they would negotiate contracts for 2012/13 with NHS providers individually or on a collaborative basis.
- In September 2012, the strategic health authority hosted a workshop to help CCGs further understand their statutory duties for patient safety and safeguarding from April 2013.
- In November 2012, CCGs agreed the collaborative arrangements that would be put in place for contracting with non-NHS providers in 2013-14.

From 1 April 2013 the NHS Commissioning Board assumes responsibility for the ongoing development of CCGs.

Clinical Commissioning Group Forum

The Northern Clinical Commissioning Group Forum (NCCGF), comprising CCGs in the north east of England, Cumbria and Hambleton, Richmondshire and Whitby, was established in October 2012. The forum meets for one full day each month to facilitate and support the new NHS commissioning environment across the north east and Cumbria. The NCCGF is arranged in two separate and distinct parts, business and development, and the CCGs work collaboratively through the NCCGF where it makes sense to do so.

Commissioning support unit

Support services for the process of commissioning, and how they will be provided, were a key part of the authorisation process for clinical commissioning groups. These services can be provided in house by CCG employed staff or can be commissioned from a separate provider.

The North East Commissioning Support Unit (NECS) has been established to provide services at a local level to CCGs, as well as providing some support functions across a larger geographical area.

NECS has progressed through a number of checkpoints and is currently hosted by the NHS Commissioning Board. The unit delivers a number of work streams on a national and local level and is mainly staffed by people who worked previously in local primary care trusts and the strategic health authority.

Quality, Innovation, Productivity and Prevention (QIPP)

QIPP is a large scale transformational programme involving NHS staff, clinicians, patients and the voluntary sector in improving quality of care whilst making efficiency savings of up to £20 billion nationally by 2014/15. For the north east this represents £859 million between 2010/11 and 2014/15.

Gains from these quality and efficiency improvements are reinvested in frontline care and services, to benefit patients by providing more care closer to home, supporting the development of new treatments and technologies, increasing focus on prevention as well as meeting pressures placed on the NHS by an aging population.

During 2012/13, the strategic health authority has continued to drive forward the QIPP programme. The strategic health authority supported both primary care trust clusters and emerging clinical commissioning groups in developing local QIPP plans and CCGs are fully engaged and committed to leading on delivery from April 2013 onwards, when assurance around QIPP will transfer to the NHS National Commissioning Board local area teams and regional office.

Significant progress has been made over the past year and the north east continues to be amongst the strongest performers nationally.

Clinical networks

Clinical networks have an important role to support both commissioners and providers of healthcare in improving patient outcomes and experiences.

In July 2012, the NHS Commissioning Board published *The Way Forward* which confirmed key aspects of a new model, including the creation of four new strategic clinical networks for:

- Cancer
- Cardiovascular, diabetes and renal
- Mental health, dementia and neurological conditions
- Maternity and child health

The document also confirmed that the future geographical footprint to be covered by networks within the north east should incorporate the north east, north Cumbria and the Hambleton and Richmondshire part of North Yorkshire, which has a number of patients who receive treatment in Teesside.

In preparation for this enhanced role (which will formally commence in April 2013), the eight clinical innovation teams in the north east, that were previously tasked with taking forward implementation of the regional *Our Vision, Our Future* have started to migrate to new functions, some as clinical networks, others as cross-cutting improvement programmes.

Since May 2012, these eight groups have been working collaboratively with 13 other existing clinical networks under the banner of ‘Clinical Networks Northern England’ – the title of the new integrated structure that will provide future support and coordination across the full

range of networks.

Leaders from all networks have worked together on a programme to develop a new operating model in discussion with new and existing partners including foundation trusts, clinical commissioning groups and the north east commissioning support unit.

These complex discussions have been extremely positive, with a shared desire to ensure that we focus networks' activities on the most important issues that will have maximum impact in terms of improvement.

New groups called 'clinical senates' are also being developed to provide expert clinical opinion, advice and recommendations about issues or proposed changes which are particularly complex, sensitive or are likely to have a potentially significant impact.

In addition to all of this planning for future change, 2012/13 has been another year of major improvements and innovations spearheaded by networks.

The Learning Disability Network devised and promoted an extremely successful campaign - *PWLD (People with Learning Disabilities)* - which aimed to increase awareness amongst staff about how they can further improve experience, outcomes and safety for patients with learning disabilities. This has significantly strengthened the focus of acute hospitals on ensuring that they are able to provide the right services and a personalised approach in caring for people with learning disabilities and has also created a huge interest from staff who are anxious to promote a more sensitive and individual approach.

Deciding Right is a north east wide initiative - the first in the UK - to integrate the principles of making advance care decisions for all ages. It brings together advance care planning, the Mental Capacity Act, cardiopulmonary resuscitation decisions and emergency healthcare plans. Written by health and social care professionals, *Deciding Right* identifies the triggers for making care decisions in advance, complying with both current national legislation and the latest national guidelines. At its core is the principle of shared decision making to ensure that care decisions are centred on the individual and minimise the likelihood of unnecessary or unwanted treatment.

These and other examples of the work of clinical networks can be accessed at **http://www.cnne.org.uk/**

Public health

As part of the NHS reforms, a new national organisation called Public Health England has been established to provide a more coherent and consistent approach to public health work.

Responsibility for direct provision of services and support to improve the health and wellbeing of local populations has now switched from the NHS to local authorities.

A north east programme board, chaired by the regional director of public health, worked through the year to ensure it was a smooth transition under the key areas of:

- Workforce
- Communications and engagement
- Information and intelligence
- Health improvement
- Local transition planning
- Maintaining services
- Local Public Health England

Formal handover of responsibilities to all 12 local authorities in the region took place over a number of months to ensure learning, expertise and experience were shared across organisations.

Each local authority now employs their own director of public health and locally placed teams and services continue to focus on transforming the historically poor health of the north east into the best in the country over the course of a generation.

Access to services

New health service facilities

The NHS in the north east continues to develop world class facilities for patients and staff. Detailed information about significant developments to hospital and community health facilities is available on the websites of individual NHS organisations in the region.

NHS 111 service

The NHS 111 number is being rolled out further across the region, to provide a single point of telephone advice for non-emergency NHS services.

The service is provided by North East Ambulance Service NHS Foundation Trust, working in partnership with Northern Doctors Urgent Care (a local GP out of hours provider) and will soon be available to residents across the north east, when people in South of Tyne and Wear, North of Tyne and Tees areas access the number from early 2013.

Calls to NHS 111 are free and the service is available 24 hours a day, 365 days a year. Calls are handled by a team of highly trained advisers, supported by experienced clinicians, who make sure patients are directed to the right service first time. This may include dispatching an ambulance if one is needed, referring patients to other services within the NHS, or providing information and advice over the phone.

North East NHS armed forces forum

Improving health services for servicemen and women is central to the work of the north east NHS armed forces forum, which brings the military, health, social care and voluntary services together, to support collective decision making about the healthcare needs of armed service veterans.

In June 2012, the forum launched a new mental health service for veterans in the north east, the Veterans' Wellbeing Assessment and Liaison Service (VWALS). VWALS provides a single point of access for veterans who need mental health support, carrying out assessments to determine which local NHS services, social care organisations and charities are best placed to provide the help they need.

The forum has also commissioned a training programme for healthcare staff in the region to raise awareness about the issues that veterans can face. This is expected to begin in March 2013. Work is also well underway on the production of the north east 'Life Force' booklet which, in addition to highlighting the problems that veterans face, will provide details of the support services that are available in the region.

Cancer drugs fund

During 2012/13, the new national cancer drugs fund saw a further £11 million made available to patients in the north east. The North of England Cancer Drug Approval Group (NECDAG) manages the fund on behalf of the strategic health authority.

NECDAG is made up of senior clinicians and NHS managers who are involved in the care of cancer patients and ensures a consistent approach to how cancer drugs are prescribed across the north east. The group makes clinically led policy decisions on the best use of the funding and any patients wishing to access the fund must speak to their consultant.

The government set up the cancer drugs fund to allow individual patients to receive treatments that they have been unable to access through usual local funding arrangements by primary care trusts.

NHS continuing healthcare reviews

NHS continuing healthcare is a package of nursing care arranged and funded solely by the NHS, and provided over an extended period of time to help with physical or mental health needs that are a result of disability, accident or illness.

Primary care trusts are responsible for deciding who is eligible for continuing healthcare funding which can be provided in a variety of settings including care homes, nursing homes, hospices or in the person's own home.

Sometimes families may disagree with primary care trust decisions on whether they are eligible for continuing healthcare funding. In such cases the strategic health authority sets up independent review panels (IRPs) to consider decisions made.

Wherever possible, the strategic health authority works with primary care trusts to resolve disputes at a local level. There was a reduction in the number of IRPs held in the north east during 2012/13, with a total of 10 during the year.

North east IRPs follow a national operational policy to ensure consistency and the sharing of best practice on assessment processes.

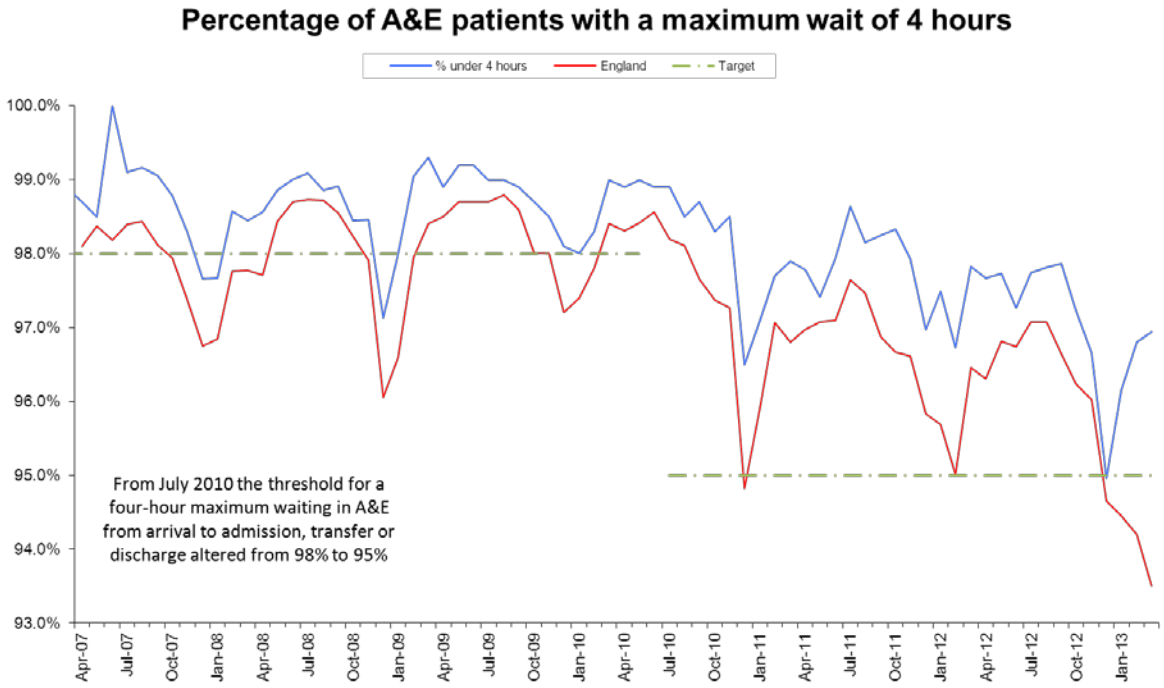
From April 2014, patients receiving continuing healthcare from the NHS will have the right to ask for a personal health budget, which will provide greater choice and say over their care.

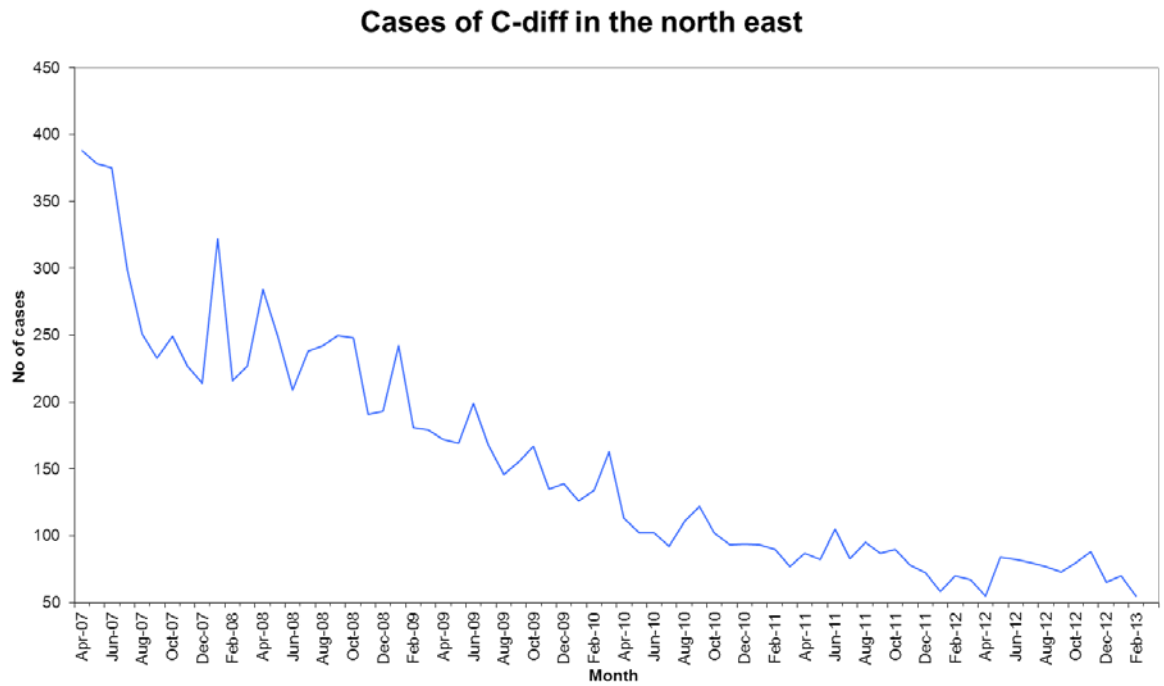
The strategic health authority is working closely with local commissioners to help with the transition to personal health budgets, building on skills and experiences gained following pilots that have taken place.

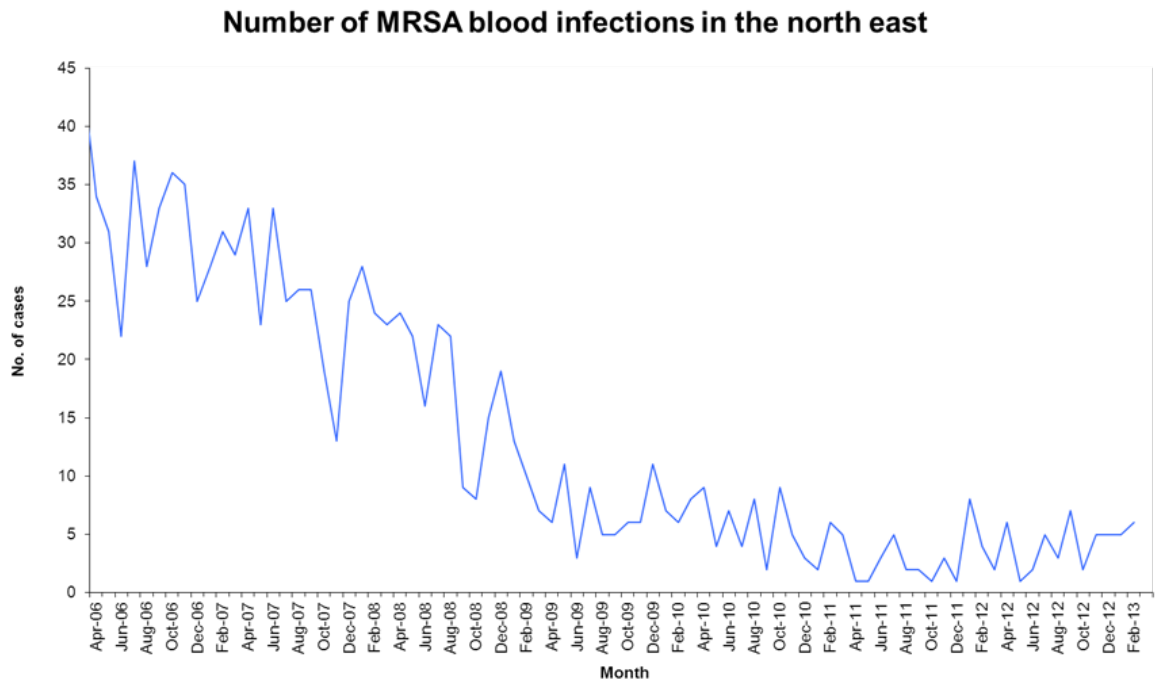
Work has taken place with NHS North West and NHS Yorkshire and the Humber to develop one continuing healthcare team as part of NHS North of England, in preparation for handover to the NHS Commissioning Board.

Performance against key standards

The government has made clear that patients can continue to expect shorter waiting times and the north east NHS continues to perform very well against all national standards.






Number of MRSA blood infections in the north east
No. of cases
45
40
35
30
25
20
15
10
5
0
Apr-06
Jun-06
Aug-06
Oct-06
Dec-06
Feb-07
Apr-07
Jun-07
Aug-07
Oct-07
Dec-07
Feb-08
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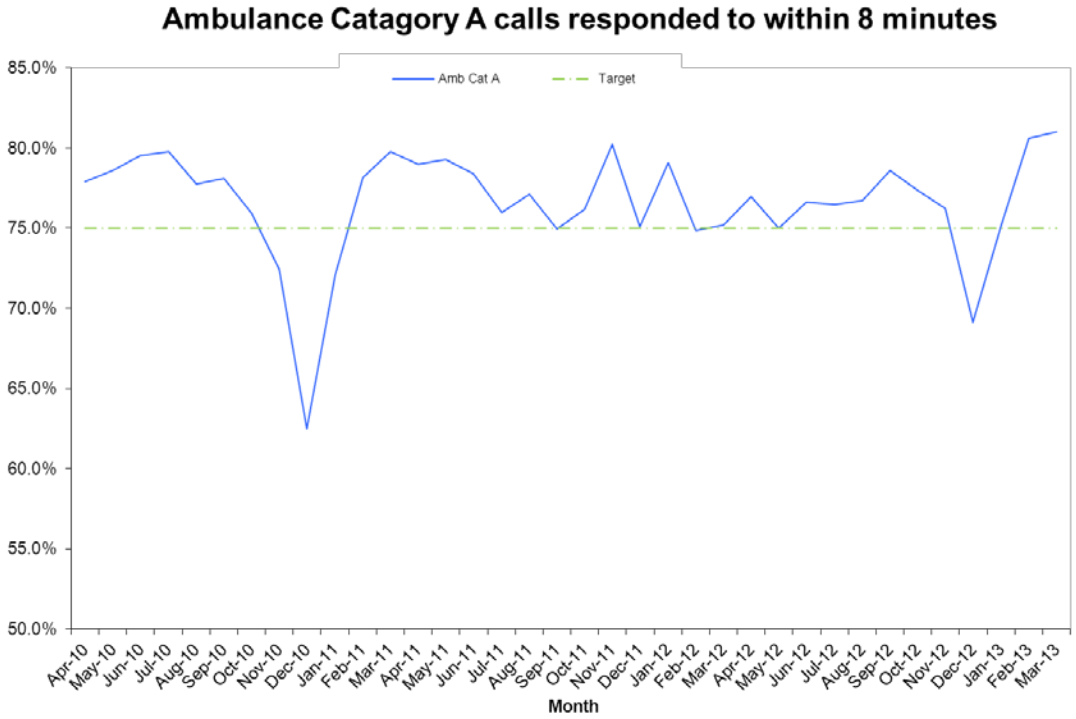
Feb-13
Month


Ambulance Catagory A calls responded to within 8 minutes
Amb Cat A
Target
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
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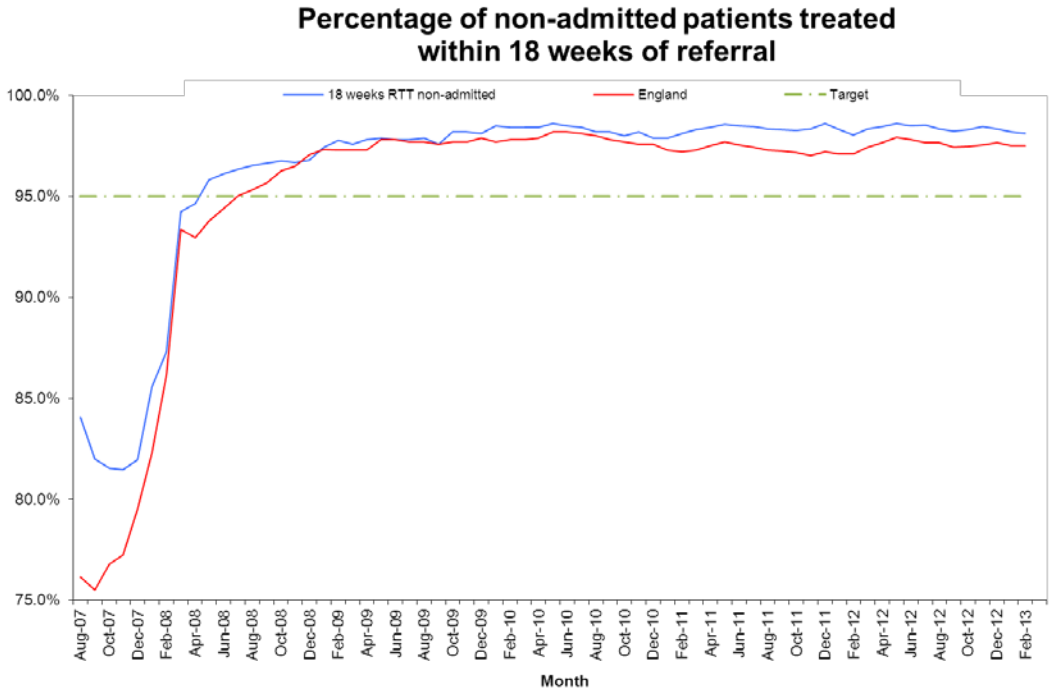
Percentage of non-admitted patients treated within 18 weeks of referral
18 weeks RTT non-admitted
England
Target
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
Aug-07
Oct-07
Dec-07
Feb-08
Apr-08
Jun-08
Aug-08
Oct-08
Dec-08
Feb-09
Apr-09
Jun-09
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Oct-09
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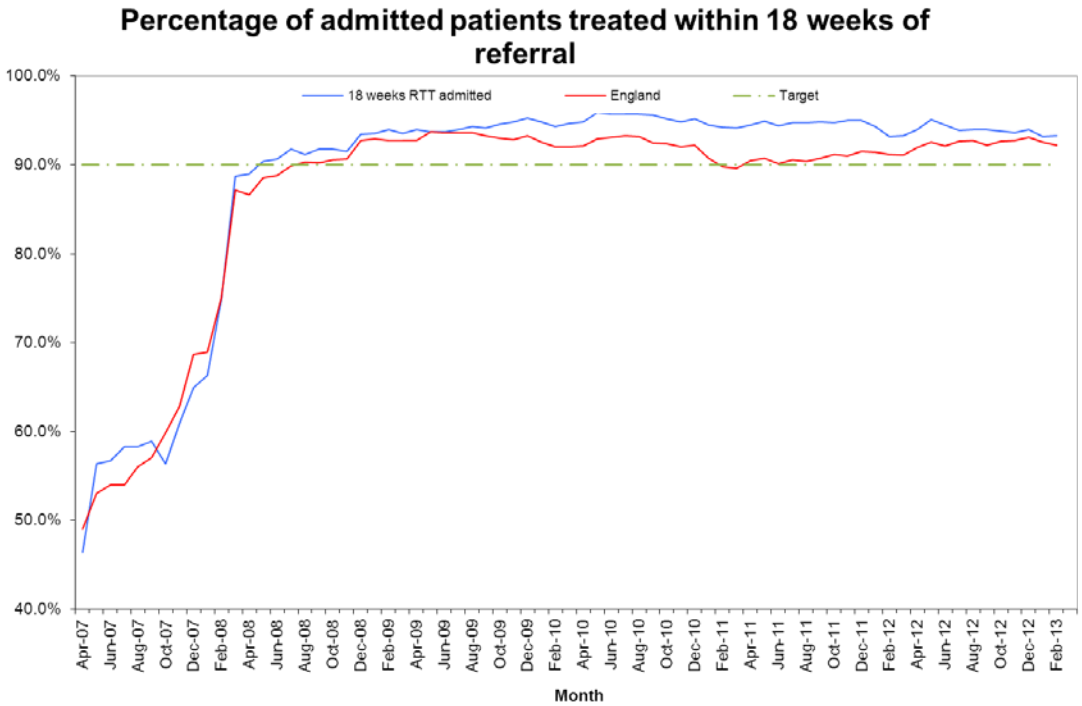
Feb-13
Month


Percentage of admitted patients treated within 18 weeks of referral
18 weeks RTT admitted
England
Target
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
Apr-07
Jun-07
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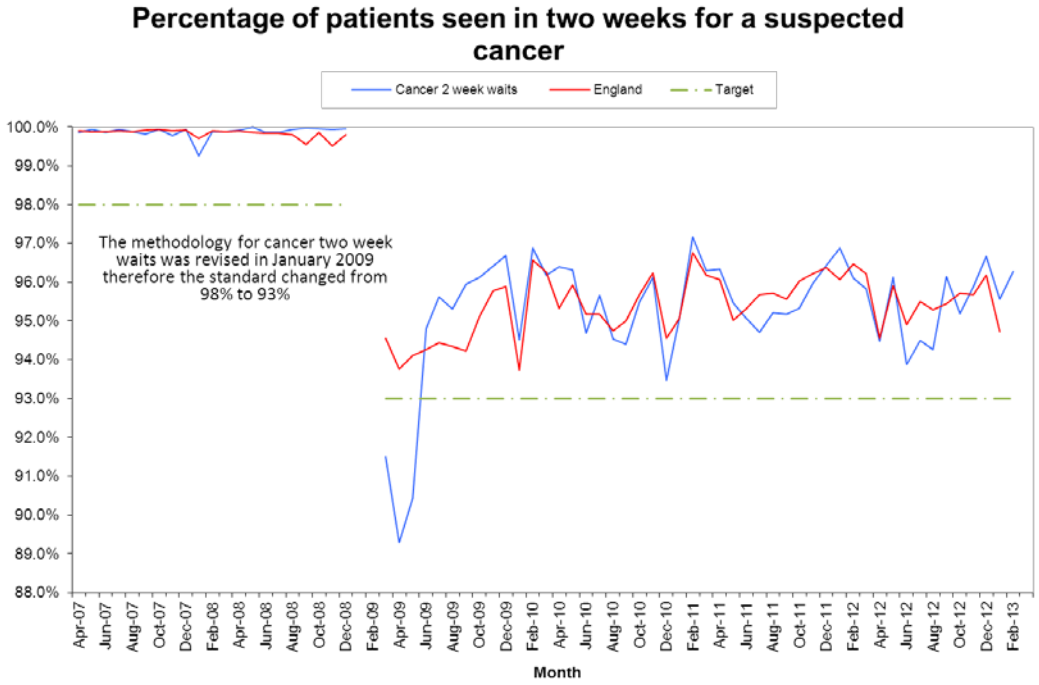
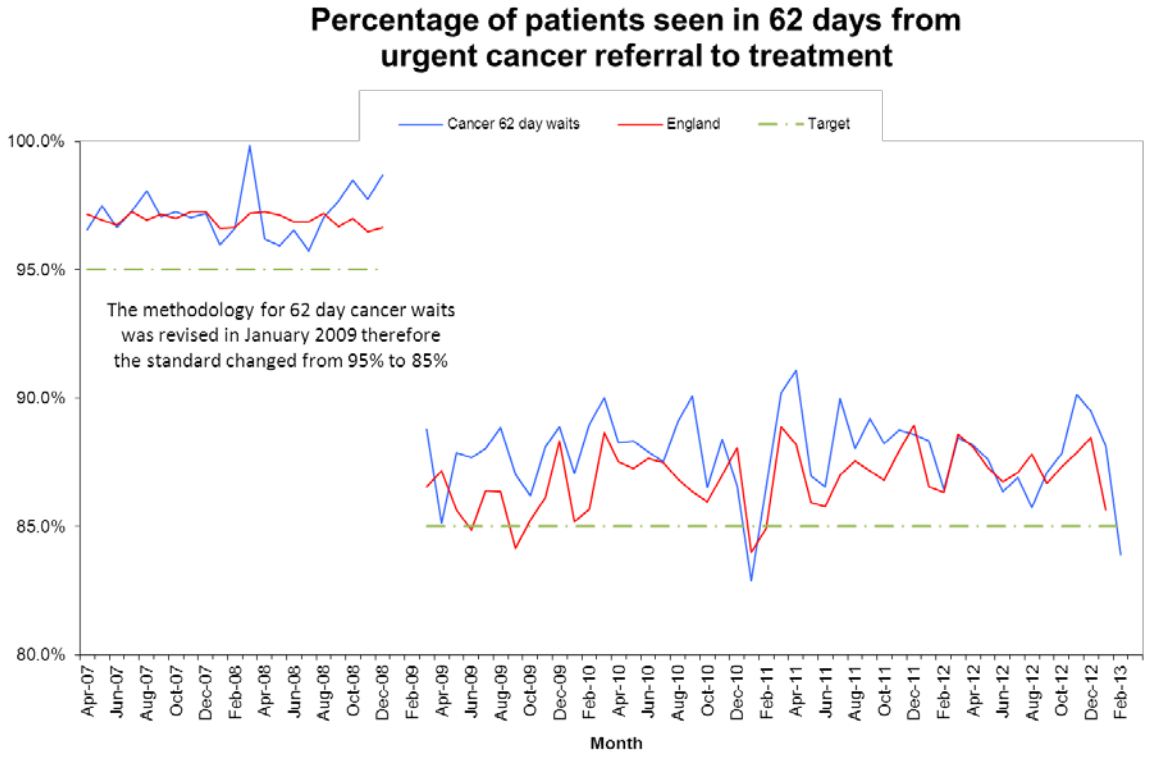

Percentage of patients seen in two weeks for a suspected cancer
Cancer 2 week waits
England
Target
100.0%
99.0%
98.0%
97.0%
96.0%
95.0%
94.0%
93.0%
92.0%
91.0%
90.0%
89.0%
88.0%
The methodology for cancer two week waits was revised in January 2009 therefore the standard changed from 98% to 93%
Apr-07 Jun-07 Aug-07 Oct-07 Dec-07 Feb-08 Apr-08 Jun-08 Aug-08 Oct-08 Dec-08 Feb-09 Apr-09 Jun-09 Aug-09 Oct-09 Dec-09 Feb-10 Apr-10 Jun-10 Aug-10 Oct-10 Dec-10 Feb-11 Apr-11 Jun-11 Aug-11 Oct-11 Dec-11 Feb-12 Apr-12 Jun-12 Aug-12 Oct-12 Dec-12 Feb-13
Month


Percentage of patients seen in 62 days from urgent cancer referral to treatment
Cancer 62 day waits
England
Target
100.0%
95.0%
90.0%
85.0%
80.0%
The methodology for 62 day cancer waits was revised in January 2009 therefore the standard changed from 95% to 85%
Apr-07 Jun-07 Aug-07 Oct-07 Dec-07 Feb-08 Apr-08 Jun-08 Aug-08 Oct-08 Dec-08 Feb-09 Apr-09 Jun-09 Aug-09 Oct-09 Dec-09 Feb-10 Apr-10 Jun-10 Aug-10 Oct-10 Dec-10 Feb-11 Apr-11 Jun-11 Aug-11 Oct-11 Dec-11 Feb-12 Apr-12 Jun-12 Aug-12 Oct-12 Dec-12 Feb-13
Month

Quality and patient safety

The region's NHS has a strong track record in providing safe and effective care with robust systems to minimise risk. Extensive work has taken place over recent years to embed a positive culture of patient safety and continuous improvement – which had a focus and impetus provided by the region's *Safer care north east* three year strategy, celebrated at a regional summit in March 2012.

In order to ensure a legacy for *Safer Care North East,* in the new NHS structure, the strategic health authority's nursing and patient safety team secured funding from the Health Foundation and our workforce development team to deliver a further two year strategy based on a regional 'cultural audit' of patient safety. This work will be taken forward across the north east, hosted by Northumbria Healthcare NHS Foundation Trust.

Known as *Investing in Behaviours,* the project will support a coordinated approach for organisations to learn from one another across the region to bring about any necessary cultural change and ensure high quality and consistent training is provided to address a range of 'human factors' which support the safest possible care. Significant work has already been carried out in implementing and embedding human factors training into all organisations in the region. But there is a need to go further faster and this project will facilitate that. It will also ensure that the NHS learns lessons from experts who work in other 'high risk' industries or environments, about how organisational culture affects all safety issues.

In support of this, a workbook and e-learning pack have been published as a free resource for all NHS organisations nationally.

Monitoring quality

Over the last ten years, there have been big improvements in how we monitor quality and safety of NHS services. We now have a system for collecting and reviewing information that shows the progress hospitals are making to improve patient care.

This 'quality dashboard' looks at mortality rate, the number of falls that patients have in hospitals, the number of pressure ulcers experienced and the level of viruses such as MRSA and CDiff. Patients and staff are also asked if they would recommend their hospital to others. Collectively, this information provides an overall picture of whether the care patients receive is as good as we would want it to be.

The 'safety thermometer'

As well as reporting on patient outcomes through the quality dashboard, hospitals are taking part in the national 'safety thermometer' initiative. This looks in more detail at a number of areas, including falls, infections linked to catheters and the number of VTE (a type of blood clot) that patients experience.

All organisations are required to report this information and latest figures show positive performance for hospitals across the north east, with all four measures below the national average and catheter acquired urinary tract infections significantly below the national average.

Safety thermometer information is used alongside other indicators to give an overall picture of a hospital's performance so we can spot quickly when standards are not as high as we expect; and share good practice so that quality of care continues to improve for everyone.

Dementia

Dementia is a significant challenge and a key priority for the NHS, with an estimated 25 per cent of acute beds occupied by people with dementia. When people with dementia come into acute care their length of stay is longer than people without dementia and they are vulnerable to potentially avoidable complications like dehydration and falls, and often experience delays in leaving hospital.

The strategic health authority held a regional dementia event in December 2012, which built on a conference held earlier in the year, with the clear aim of ensuring that by March 2013 every hospital in the north east will have committed to becoming a dementia friendly hospital, working in partnership with their local Dementia Action Alliance. The focus is on improving five key areas:

1. The environment in which care is given
2. The knowledge, skills and attitudes of the workforce
3. The ability to identify and assess cognitive impairment
4. The ability to support people with dementia to be discharged back home
5. The use of a person centred care plan which involves families and carers.

By making improvements in these areas we can reduce readmission rates, prevent falls and reduce the mortality of people with dementia in acute care.

Reducing preventable infections

Reducing healthcare associated infections remains a priority and the strategic health authority has continued to support local organisations in efforts to further reduce rates.

Across hospitals in the north east, there was a 41.8 per cent reduction in C.Difficile and healthcare related infections (79 down to 46 cases). There was a 100 per cent increase in reported MRSA bacteraemia, with a total of 14 cases reported against seven reported over the same period in 2011/12.

Work has been carried out by nurse directors from primary care trusts within the region to reduce infections. This has included:

- A targeted hand hygiene campaign, developed with patient and user involvement.
- A specific 'Clostridium Difficile root cause analysis tool', being trialled across several community areas.

- A review of support and training provided to care homes regarding effective infection prevention and control.
- A review of antibiotic prescribing and a scoping exercise to support better prescribing in acute and community settings

Learning lessons from serious incidents

Serious incidents requiring investigation

All NHS providers are required to report serious incidents requiring investigation, in accordance with guidance provided by the National Patient Safety Agency.

During 2012/13, there was a 60 per cent overall increase in serious incidents reported by service providers across the north east (1397 against 872 for the same period in the previous year), although there continues to be a significant decline in the number of these incidents reported as Grade 2 (most serious).

Safety experts would say that an increase in overall reported incidents is an indication of a positive safety culture. Moreover, when examining the percentage of the most serious incidents (Grade 2) measured against the total number of incidents reported (Grades 1 and 0) the marked downward trend from 30.9% (2009/10) to 23.2% (2010/11) to 15.9% (2011/12) and 6.34% (2012/13) suggests that healthcare within the region is getting safer.

All serious incidents requiring investigation are managed by the local commissioners of services, to encourage correct governance, learning and outcomes.

Independent investigations

Independent investigations are held when a person who has been receiving mental health services commits a serious offence such as murder or manslaughter.

During 2012/13, one new independent investigation was commissioned by the strategic health authority, bringing the total number of investigations currently in progress in the north east to eight. One independent investigation was also published during the year and is available from **www.northeast.nhs.uk**.

Safeguarding adults and children

Safeguarding adults

The strategic health authority works closely with regional and national colleagues to develop safe systems for the care of vulnerable adults. Preliminary findings of the Francis Report have galvanised the North East Safeguarding Network and directed further safeguarding work.

Over the past year in the north east, work has been carried out to:

- Identify a measurement tool for pressure ulcers, where the cause of the ulcer is seen to be a safeguarding issue. This tool has been shared across the country and the north east region is acknowledged as leading in this field of work.
- Provide training on supervision for safeguarding staff and provide an accredited course in leadership.
- Develop an established protocol for the care of vulnerable adults whose care is commissioned from outside the local area.
- Review all safeguarding structures and staffing.
- Share learning from the findings of Adult Safeguarding Board reviews and incidents

Safeguarding children

A professional network for designated doctors and nurses, who have lead responsibility for safeguarding children, has met since 2006 and continues to provide opportunities to share learning from serious incidents, undertake joint work and co-ordinate regional training where appropriate.

Information technology supporting healthcare

Information and communications technology (ICT) offers wide ranging opportunities for improved productivity and efficiency within the NHS. In 2012/13, the SHA continued to support local NHS organisations in identifying where ICT solutions and innovative technologies can help improve patient experience and outcomes.

NHS summary care record

Summary care records (SCRs) help ensure patients benefit from faster and safer treatment in emergencies. SCRs provide electronic access to a patient's allergies, medications and adverse reactions to medicines for healthcare staff treating them in hospitals, walk-in centres and out of hours settings.

The provision of emergency care records for north east patients achieved significant milestones in 2012/13. More than 1.8 million patients now have a summary care record, with the notable progress being delivered in NHS North of Tyne and NHS County Durham and Darlington – where over 85 per cent of the respective local populations have a SCR.

Highlights during the year also include the use of summary care records at St Oswald's Hospice in Newcastle and St Theresa's Hospice in Darlington.

Use of the records to improve patient care was also launched by Northumbria Healthcare NHS Foundation Trust and Newcastle upon Tyne Hospitals Foundation Trust, in addition to over 80 of the region's GP practices and 12 north east urgent care centres. Models of enhanced SCRs for end of life care and for people with learning disabilities were also developed by north east informatics staff, with implementation of the ground-breaking new functions due to start during 2013.

The SHA is also working closely with all healthcare providers to enable access to the summary care record in urgent and emergency care settings.

Strategic solutions

Health informatics and, more generally, information and communications technologies (ICT) offers many opportunities for improved productivity and efficiency within the NHS. In 2012/13 the SHA continued to support local NHS organisations to identify where ICT solutions and innovative technologies could help improve patient experience and outcomes.

We have worked closely with emerging clinical commissioning groups, clinical networks, local provider organisations and patient groups to ensure informatics and ICT solutions continue to support large scale service transformation in the future; ensuring a smooth transition of those essential skills and resources to the new healthcare system.

Significant progress has been made in the past year to roll out a vast array of electronic and digital solutions, including shared care records in GP, child health, hospice, urgent care and community settings, this has built upon previous successes such as, electronic image sharing. Solutions have been developed to enable the electronic sharing of information between care providers, patients and carers to improve care for particularly vulnerable patients (and their families and carers) such as those with learning disabilities, dementia or at the end of life.

Initiatives to enable electronic prescribing between GPs and community pharmacies have commenced. Information tools such as clinical dashboards are providing real time information to clinicians and service managers in order to monitor, manage and target care have been established in urgent care and mental health settings.

Information governance

With the reorganisation of NHS structures, most work in relation to information governance during 2012/13 has been to support the closedown of strategic health authorities and primary care trusts, and to ensure new emerging organisations are aware of responsibilities in relation to information governance.

In particular, it has been essential to ensure that any organisational changes do not impact on the security and confidentiality of SHA information and to ensure that records and information are available to functions as they move into new organisational structures, ensuring business continuity.

One area of work to support this has been to ensure that all paper and electronic records held within strategic health authorities and primary health trusts have been reviewed to identify whether they are still needed, ensuring all necessary information is transferred to new organisations.

Another key area has been to ensure that all staff have carried out information governance training, so that all confidential information continues to be handled appropriately during the closedown process and to ensure risks to this information are minimised.

Information breaches

Within the strategic health authority, there were 16 reported information breaches during 2012/13. The majority of these were internal and none of these incidents were classed as high level serious untoward incidents.

Clear processes are also in place to ensure that any incidents involving data loss or information breaches that occur in local NHS organisations are handled correctly and that lessons learned from these are shared to ensure the risks of such incidents happening again are minimised.

Summary of personal data related incidents in 2012/13

Category	Nature of incident	Total
One	**Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises**	**0**
Two	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
Three	**Insecure disposal of inadequately protected electronic equipment, devices or paper documents**	**0**
Four	Unauthorised disclosure	13
Five	**Other**	**3**

Workforce development

Education, training and development

The strategic health authority is responsible for commissioning NHS education and training on behalf of local healthcare providers and is committed to delivering quality improvements and value for money.

During 2012/13, we continued to work with local healthcare providers and higher education providers to ensure that education commissioned for the NHS was of the highest quality.

In May 2012, the new Nursing and Midwifery degree programmes at both Teesside and Northumbria Universities were successfully validated by the Nursing and Midwifery Council. The outcomes from the validations were very positive and the programmes gained approval for five years with only minor amendments. The programmes also gained many commendations; in particular, both universities were commended for their effective partnership working with local health care providers and the strategic health authority

During 2012/13, 1,781 new students entered non-medical training programmes which will lead to qualification as nurses, midwives, allied health professionals and healthcare scientists.

The Northern Deanery – the organisation responsible for training doctors in the region – had 3,194 doctors and dentists within its training programmes which included 1,758 doctors in specialty training, 805 doctors in foundation training, 503 general practitioners and 128 dentists.

The increasingly effective joint working between local health care providers, in the coordination of the education and training of their workforces, is also demonstrated in their agreement to establish sub-regional panels to select which vocational support staff from across the region should be supported centrally to be seconded to undertake pre-registration programmes at the universities. The establishment of the panels will ensure that it is the best vocational support staff from across the region who are seconded; linked to these secondments, the SHA has recently redesigned and improved the functionality of its student database ensuring that the data that it holds is accurate and meets both our current and future workforce needs.

The strategic health authority has a comprehensive and robust contract and quality performance system through which it continually assesses and monitors the quality of the education and training delivered by higher education institutions and trusts. Large quantities of performance and quality data is systematically collected and analysed and through the effective implementation of this process we are able to assure that the non-medical pre-registration education and training commissioned is of a high standard with a focus on continuous quality improvement. During 2012, we developed, piloted and implemented a Quarterly Return System (QRS) to standardise the collection of data from higher education.

Continuing Professional Development (CPD)

The CPD two-tier model was introduced in 2010 with the intention of increasing provider-led education and training as well as ensuring quality and increased value for money. We are now in the third year of the model and it continues to be well received by providers.

A 2012 survey of providers reported that 100 per cent of respondents said that their trust had felt engaged with the process, 90 per cent said that the CPD process had made investment decisions more transparent and 90 per cent agreed that trust's discussions with the universities about the CPD portfolio had been effective.

Throughout the year, 7,859 non-medical staff carried out CPD on 238 shared courses across the region.

The next phase is to evaluate the impact of CPD on service delivery and to review whether access to CPD can be widened to all organisations providing NHS care.

Health visitors

The strategic health authority has continued to work in partnership with NHS organisations to increase the number of health visitors in post to help meet the national government target of 4,200 extra health visitors by 2015. In the region, the number of health visitors has increased by 28, giving a total of 606 health visitors in the local NHS.

In September, our regional health visitor awards recognised the: best newly qualified health visitor, outstanding individual contribution award, family nominated award, team innovation award and lifetime achievement award. The event was a huge success and celebrated the achievements of health visitors and the health visiting service across the region.

Medical training

The General Medical Council's national training survey of all doctors in training demonstrated the high quality of medical training being delivered in the region. The Northern Deanery ranked first of all English deaneries for 'overall trainee satisfaction' and scored higher than average on many other aspects of training.

Northern Deanery trainee doctor survey

The 2012 trainee doctor survey achieved the highest response rate in the survey's six year history at 87.6 per cent. The 2012 survey results are a testimony to the commitment of clinical colleagues and trainees across the region.

Six of the 13 indicator scores where the Northern Deanery scored top marks are:

- 90.12 per cent - highest score for clinical supervision in whole UK
- 90.05 per cent - highest score for educational supervision in the whole of UK
- 86.10 per cent - highest induction score in the whole of UK
- 77.29 per cent - highest score for feedback in whole of UK
- 81.97 per cent - highest score for adequate experience indicator
- 81.77 per cent - most satisfying deanery (overall trainee satisfaction) in England, Wales and Northern Ireland, for the second year running (80.97 per cent in 2011).

The fill-rate for recruitment in the Northern Deanery in 2012 has seen some increases:

- Foundation at 98 per cent
- Primary care at 100 per cent
- Specialty training at 93 per cent.

Dental training

Looking towards developing the workforce of the future, the deanery has developed and delivered courses in extended skills in dental nursing and from 2013 will deliver a comprehensive continued professional development programme to hygienists and therapists. In 2012, a total of 8,224 delegates attended dental training courses.

Partnerships in education and learning

For those staff working on Agenda for Change bands 1 to 4, the strategic health authority has continued to support development in line with service needs and improvements.

During the year, approximately £2 million was invested for the delivery of workplace learning and other vocational qualifications through the School for Vocational Education. Working in partnership with the Skills Funding Agency attracted an additional £1 million in support of all levels of apprenticeship training.

Ofsted report

The 2012 Ofsted inspection resulted in an overall 'good' rating. Ofsted's report stated that teaching provided is excellent and partnerships 'outstanding'. In order to continue positive progress, we held a workshop for foundation trust contract managers to look at ongoing areas for improvement.

Apprenticeships

In February 2013, the strategic health authority hosted the NHS North East apprenticeships awards, which saw over 100 people attending and 21 NHS apprentices receive awards for outstanding dedication, hard work and enthusiasm.

Workforce planning

Work has continued with regional partners on the implementation of the workforce modernisation agenda, including implementing the Department of Health's modernising nursing (MNC), allied health professionals (MAHP) and scientific careers (MSC) work programmes. This has included appointing dedicated leads for each work programme to ensure the appropriate interface with the wider NHS reflects the needs and requirements of local organisations, and also to ensure that University courses deliver training programmes which meet the needs of the future NHS workforce.

The SHA has continued to encourage the sharing of best practice to support employers in their endeavours to reduce sickness absence. All employers are committed to developing positive staff health and wellbeing for the benefit of their workforce and patients. We have seen a reduction in sickness absence rates across the north east from an average of 4.52 in 2011/2012 to an average of 4.43 in 2012/13.

Quality of education and training

The Northern Deanery Quality Team produced the Deanery's first 'Good Practice in Medical Education' publication which is a celebration of successes in the postgraduate medication education across the region and which also aims to promote the sharing of good practice and excellence in education and training.

The trusts, postgraduate schools, the lead employer trust and colleagues within the Deanery reported their notable practices in medical education, all of which should ultimately improve patient safety. The publication includes 44 examples of innovative good practice.

Multi Professional Education and Training (MPET)

During 2012/13, the SHA continued to plan full utilisation of the multi professional education and training allocation (£261million) in line with previous years. This will result in no MPET financial reserve for the transfer to Local Education and Training Boards from 1 April 2013.

National guidance issued during the year enabled strategic health authorities to develop transition plans for the implementation of consistent tariffs for undergraduate medical and non-medical placements. A working group of north east foundation trust representatives developed this during 2012/13 to recommend a tariff transition plan to the shadow NHS North East LETB.

In October 2012, the LETB agreed a tariff transition plan with the support of all north east foundation trust chief executives.

Workforce transition

During 2012/2013 work continued on the transition of workforce, education and training to new, provider-led, local education and training boards (LETBs). The changes aim to establish a new framework for workforce planning to ensure high quality education that supports safe and high quality care.

In September 2011, an interim management board for the LETB was established as a formal sub-committee of the SHA board. The interim management board led on formulating the new LETB's vision, mission, values and priorities:

Mission

- To ensure security of supply of a competent, compassionate and caring workforce to provide excellent quality of health and patient care.

Vision

- Excellence in education and training for safe and effective healthcare.

Values

- Ensure security of supply of the workforce; Lead a safe transition to new financial arrangements for NHS education and training; Determine the approaches to funding, education and training for NHS providers as appropriate;

- Support providers of NHS services to produce reliable five-year workforce plans (and ten-year plans for medical staff); Develop and maintain the five-year workforce skills and development strategy that commands the confidence of partners and stakeholders; Enables an equal and diverse workforce.

Authorisation criteria

Authorisation enables LETB governing bodies to be formally established as part of Health Education England and to take on education and training functions in accordance with agreed criteria. This provides Health Education England with assurance that each LETB can make effective decisions in a way that engages with all relevant stakeholders to ensure security of supply of the workforce; in addition to having appropriate governance arrangements to support this and deal with conflicts of interest should they arise. Over 190 pieces of evidence demonstrating collaborative work in the region to support education and training were successfully reviewed against the six domains below:

- Vision and leadership
- Meaningful engagement
- Good governance
- Financial control
- Organisational capability
- Outcome-led improvement

On 28 March 2013, Health Education England, the local education and training board for the north east, was officially authorised, subject to two conditions.

Apprenticeships and workplace learning

During the year, approximately £1 million was invested in apprenticeships and workplace learning through the joint investment framework (JIF), with a further £1 million from the Skills Funding Agency. This supported 419 new apprentices and 182 new national vocational qualification (NVQ) learners.

7. Communications and engagement

London 2012 – Olympic legacy

The London 2012 Olympic Games offered a fantastic opportunity to create a lasting legacy of better health, in particular through using the profile of the games to increase awareness of and participation in physical activity.

As part of the regional Workforce Workfit programme led by the strategic health authority as our contribution to Olympic legacy, we have supported over 10,000 people across the region to become more active and participate in regular physical exercise, mainly through a programme of work-based, employee-led activity.

Media relations

During the year, the strategic health authority continued to work with local, regional, national and specialist media to raise the profile of the NHS in the north east, enhance the reputation of NHS services and create a better understanding of changes occurring in the NHS under transition to new structures.

Between April 2012 and March 2013, the SHA handled 100 reactive media enquiries and issued 44 proactive news releases.

Alongside print and broadcast media, the SHA social media profile continued to grow through platforms such as Facebook, Twitter and YouTube, which are increasingly used to engage and involve online audiences with latest developments and up to date service information.

NHS North East has over 6000 followers on Twitter and over 300 fans on Facebook.

Parliamentary liaison

The SHA provides the NHS business unit with timely and accurate parliamentary briefings about the development and performance of the NHS in the north east. This includes local context and information for parliamentary questions, adjournment debates and correspondence from MPs to health ministers. We also work closely with local NHS organisations to arrange ministerial visits to the region.

The volume and types of correspondence during the year comprised:

Private office cases - 16
Written correspondence from a MP to the secretary of state or another minister

Treat official/departmental emails - 10
A letter or email from a member of the public to the prime minister, secretary of state or a health minister.

Parliamentary questions - 200
Questions by MPs in parliament which require a written or verbal response.

Adjournment debates - 4
Involving different questions from a number of MPs on a single topic. Questions could relate to constituency issues or matters of public concern and detailed briefing is provided to cover local health issues.

Ministerial visits - 3
The SHA works with local NHS organisations to provide suggestions for visits and liaises with the local NHS and the Department of Health regarding timings, briefings and media relations.

Campaigns

Throughout the year, the strategic health authority coordinated a number of high profile public awareness campaigns.

As in previous years, this included the coordination of a region wide flu communications campaign to encourage an increase in vaccination rates amongst ‘at risk’ groups. This incorporated a programme of advertising, public relations and promotional activity, in addition to regular to GP bulletins, and information sharing with local authority partners and other stakeholders to ensure consistent, coordinated messages.

Corporate accountability, governance and finance

Planning for emergencies

Work has continued to ensure the region's NHS is prepared for, and has the ability to respond to, major incidents and any other pressures in the system.

As part of transition to the new NHS structures, a key piece of work has been to develop Emergency Planning Resilience and Response (EPRR) within the forming Local Health Resilience Partnerships (LHRP) and new NHS local area teams in the region. This was balanced with the requirement to maintain a response capability within the strategic health authority and primary care trusts until 31 March 2013.

In November 2012, the first of four national emergency planning exercises took place in Cleveland to test the command structures being developed within the Durham, Darlington and Tees local area team. A incident response plan was developed to support the exercise, bringing together the roles and responsibilities of key individuals and also of the emerging organisation. This plan was amended to reflect lessons learnt and rolled out across the country to assist with the development of emergency planning by other NHS local area teams.

During the year, we saw the Olympic torch track its way through the region and a significant amount of planning was carried out to ensure minimum impact on services as it travelled past a number of NHS organisations. Olympic football matches at St James Park in Newcastle were well planned for by all emergency services and the links for use of NHS services in the region were well prepared, should the need have arisen.

Human resources

Supporting staff through transition

The strategic health authority put a number of measures in place to support staff throughout the transition period, to ensure they were equipped with skills and knowledge for the future, as well as jobs they do today. Throughout 2012/13 an HR support service has delivered a number of staff training workshops including career planning, CV and application form preparation, job hunting and interview skills.

Staff involvement

Throughout transition, the staff partnership network has continued to meet regularly with nominated representatives from different teams including human resources, senior management and communications, coming together to discuss and consult on key employee issues.

Outputs from the staff partnership network are shared openly with the wider staff via email updates and regular staff meetings.

Staff sickness absence

The following figures for staff sickness absence are for the calendar year 1 January 2012 to 31 December 2012.

- Total days lost 1,533
- Total staff (wte) 211
- Average working days lost 7.3

Staff turnover at the strategic health authority for 1 January 2012 to 31 December 2012 was 13.11 per cent.

The strategic health authority's sickness absence rate for 1 January 2012 to 31 December 2012 was on average 3.3 per cent.

Sustainability report

Sustainability issues are considered as part of the strategic health authority's risk management process and a regional sustainability lead is actively involved in sharing opportunities for collaborative working and best practice.

The NHS Sustainable Development Unit encourages all NHS organisations to produce a report outlining information on energy consumption, waste, operating expenditure, carbon emissions and water usage, as well as corporate actions with regard to sustainability management. The standard reporting template to record this information is designed for NHS trusts and is therefore not applicable for the strategic health authority.

The following information, however, has been recorded for 2012/13:

• Recycled waste	20.204kg
• Floor area	4,003 m2
• Electric tariff	Green/renewable
• Business travel expenditure	£831, 429

Freedom of information

The Freedom of Information Act gives all members of the public the right to request access to information held by public authorities and aims to promote a culture of openness, transparency and accountability.

Between April 2012 and March 2013, 125 Freedom of Information Act requests were received and responded to, compared to 183 for 2011/12. All requests and responses are published on the strategic health authority's website.

Handling complaints

The NHS (complaints) regulations outline the process for complaints about NHS services. There are two stages to the complaints procedure; local resolution, followed by an independent review. Complaints should first be made to the complaints manager at the hospital, GP or dental practice where the care or treatment took place. The complaint will be investigated and a full written response provided. If the complaint cannot be resolved locally, it can be taken to the second stage by contacting the Parliamentary and Health Service Ombudsman on 0345 015 4033.

When looking into complaints raised by individuals, NHS organisations should be committed to the *Principles of Good Complaint Handling* published by the Parliamentary and Health Service Ombudsman.

A full set of the principles, together with supporting information, can be accessed via the following link:

http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-complaint-handling-full

Free, independent help, advice and support, including interpreter services are available from the Independent Complaints Advocacy Service (ICAS) on 0808 802 3000 (for ICAS in Yorkshire) or by visiting their website at **www.carersfederation.co.uk**

The North of England Strategic Health Authority Cluster Board

From 3 October 2011, Yorkshire and the Humber Strategic Health Authority, North East Strategic Health Authority, and North West Strategic Health Authority came together under a single management framework, working together as NHS North of England.

This section introduces the members of the North of England SHA Cluster Board and lists their declared interests.

From 1 April 2012 to 31 March 2013, the North of England SHA Cluster Board met on six occasions in both public and private sessions. Private board sessions ensure information of a confidential nature, within the terms of the exemptions permitted by the Freedom of Information Act 2000, can be discussed without compromising the proper and effective operation of the organisation.

Agendas and minutes of the public sessions of the board meetings can be found at **www.northeast.nhs.uk**

Non-executive directors - declared interests

Kathryn Riddle - Chairman
Kathryn is Pro Vice Chancellor and Chairman of the Council of the University of Sheffield. She is also a Justice of the Peace, a Deputy Lieutenant of South Yorkshire and an Honorary Colonel.

Sir Peter Carr CBE – Vice Chairman (to 31 May 2012)
Sir Peter is the Chair and Director of Premier Waste Management Ltd, Company Secretary and Director of Corchester Towers Ltd and, until early 2012, was Chair and Director of Durham County Waste Management Ltd.

Sally Cheshire – Vice Chairman
Sally is an Authority member and Audit Chair of the Human Fertilisation and Embryology Authority (HFEA, a non-departmental body of the DH). She is also the Audit Chair of the Health Research Authority (from July 2012).

Professor Peter Fidler CBE
Prof. Fidler is a Non-Executive Director of Codeworks and Chief Executive/Vice Chancellor of the University of Sunderland.

Alan Foster
Alan has no declared interests.

Sarah Harkness
Sarah is Chair of the SHA's Independent Investigations Committee (a standing committee of the SHA Board) and is a member of the Council and Audit Committee of the University of Sheffield. She is also a Non-Executive Director and Chair of the Audit Committee of the NHS Trust Development Authority (from 28 September 2012) and a non-executive director of JRI Orthopaedics Ltd.

Professor Oliver James
Prof. James is a Non-Executive Chair of e-Therapeutics PLC and Chair of Samoures Investment Trust, Jersey. He is also Chair of the Sir James Knott Trust.

Ian Walker
Ian is the Managing Director of Rotary Electrical Services and Chairman of Rotary Engineering UK Ltd. He is also a member of the Court of the University of Sheffield and is Chairman of the SHA's Audit Committee.

Executive Directors – declared interests

Ian Dalton CBE – Chief Executive (to September 2012)
Ian has no declared interests.

Richard Barker – Chief Operating Officer
Richard has no declared interests.

Jane Cummings – Director of Nursing / Chief Nurse (to May 2012)
Jane is a Trustee of 'Over the Wall' charity.

Gill Harris – Chief Nurse (from May 2012)
Gill has no declared interests.

Mark Ogden – Deputy Chief Executive / Director of Finance (to June 2012)
Mark is a member of The Financial Skills Partnership Advisory Group.

Jane Tomkinson – Director of Finance (from June 2012)
Jane has no declared interests.

Professor Stephen Singleton OBE – Medical Director and Interim Chief Executive (from October 2012)
Professor Singleton is the Chair of Trustees, Children's Foundation and a group member of Slaters' Bridge Group

Directors – declared interests

Elaine Darbyshire – Director of Communications and Corporate Affairs
Elaine is a Trustee of St. Ann's Hospice, Manchester and Trustee of 'Greatsport', Manchester. She is also Director of Our Life.

Tim Gilpin – Director of Workforce and Education
Tim is a Non-Executive Director of After Adoption Yorkshire

Professor Paul Johnstone – Cluster Director of Public Health
Paul's post is a joint position spanning the Department of Health and strategic health authority. He is a trustee of a charity called North-to-North Partnership. Paul's wife is a part-time partner for a small consultancy which provides management and leadership support for GPs and primary care professionals.

Committees of the board

Audit committee

The Audit Committee was responsible for making sure that the SHA ran in a clear and open way and that we identified and managed significant risks across the NHS. It also made sure that the SHA acted in line with relevant regulations, codes of conduct or any other relevant guidance.

The committee members were:

Chairman

- Mr Ian Walker

Non-executive directors

- Prof. Peter Fidler CBE
- Mr Alan Foster
- Mrs Sarah Harkness

Remuneration and terms of service committee

Details of this committee are contained in the remuneration report.

Patient Safety Committee

The Patient Safety Committee had oversight of the SHA's functions in relation to patient safety, with specific reference to:

- The commissioning and publication of independent investigations under HSG(94)27
- Oversight of other serious incidents
- Section 12 accountabilities
- Local Supervising Authority for Midwives

Local Education and Training Board (LETBE)

The purpose of the North East LETB is to:

- Identify and agree local priorities for education and training to ensure security of supply of the skills and people providing health and public health services across the North East
- Plan and commission education and training on behalf of the North East in the interests of sustainable, high-quality provision and health improvement
- Improve the quality of education and training for the future and current NHS workforce
- Develop effective partnerships and facilitate collaboration between key stakeholders
- Be a forum for developing the whole health and public health workforce
- Implement local financial governance assurance and delegated responsibility for the LETB Multi-Professional Education and Training (MPET) budget within the agreed HEE financial framework
- Drive improvements in service quality and safety

Auditors

We were required to have internal auditors appointed by the board, and external auditors, appointed by the Audit Commission.

The internal auditors were:

Northumbria Internal Audit and Counter Fraud Service
Unit 7/8
Silver Fox Way
Cobalt Business Park
Newcastle NE27 0QJ

The external auditor was:-

Mark Kirkham
Director
Mazars LLP
The Rivergreen Centre
Aykley Heads
Durham DH1 5TS

The cost of the work performed by the external auditor for 2012/13 was £105,000 inc VAT and was for audit services being the statutory audit and services carried out in relation to the statutory audit e.g. reports to the Department of Health.

Managing our finances

The 2012/13 accounts have been prepared using the government's resource accounting method, which measures the amount we spent against the limit approved by the Department of Health. Our operating costs – or expenditure – amounted to £284.2m, which was £63.7m less than the approved limit.

The surplus relates mainly to PCT bankings (£32.9m) and under spendings on hosted and other specific budgets.

The performance of the authority can be summarised as follows:

	2012/13 £million	2011/12 £million
Approved resource limit	347.9	346.8
Net operating costs	284.2	287.5
Operational financial balance	63.7	59.3

Running costs

From 2011/12, strategic health authorities are required to report their running costs. Running costs are any costs incurred which are not direct payments for the provision of healthcare or healthcare related services. Full details of running costs are given with summary financial statements on pages 62-70.

The cost of pay rises for board and senior managers was limited within the organisation to 0%.

Full details of the directors' salaries and pensions are also given within the remuneration report on pages 71-80.

Better payment practice code

The Department of Health requires health organisations to comply with the confederation of British Industry's Better Payment Practice Code to pay all creditors (both NHS and non-NHS) within 30 days of receiving goods or a valid invoice (whichever is the later) unless other payment terms have been agreed.

During the year we paid 99.0% of invoices by number, representing 99.7% by value, within 30 days. Details of compliance with the code are included in the summary financial statements on pages 62-70.

Pension liabilities

Accounting Policy Note 7.5 on page 22 of the full accounts explains how pension liabilities are treated in the accounts.

Details of directors' pension benefits can be found in the table on page 77-78.

International Financial Reporting Standards (IFRS)

The decision to move from United Kingdom Generally Accepted Accounting Practice (UK GAAP) to IFRS for the production of accounts in central government departments and other public sector bodies was announced in the Budget Statement of March 2007.

The 2012/13 accounts and the 2011/12 comparators have been prepared using IFRS.

Financial information

The following extracts are a summary of the full accounts which can be obtained without charge from:-

Department of Health
79 Whitehall
London
SW1A

Statement of the accounting officer's responsibilities

The Secretary of State has directed that the chief executive should be the accountable officer to the authority. The relevant responsibilities of accountable officers are set out in the accountable officers memorandum issued by the Department of Health. These include ensuring that:

- 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 authority
- The expenditure and income of the authority 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
- 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, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Professor Stephen Singleton OBE
Interim Chief Executive
29 May 2013

Annual Governance Statement

1. Scope of responsibility

This section broadly describes my responsibilities as Accountable Officer of the Authority, including maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding public funds.

1.1 During 2012/13 North East Strategic Health Authority continued to operate as a statutory body within the NHS North of England cluster, which included Yorkshire and the Humber and North West SHAs under a single management structure. This was the final year of `clustering` prior to the structural changes in the NHS becoming operational on 1 April 2013, at which time North East SHA will cease to exist. As Interim Chief Executive, appointed from October 2012, I have responsibility for the accounting and governance arrangements across the cluster including North East SHA during this final year.

1.2 The accounting and governance arrangements in operation across the cluster have been in operation since the creation of the NHS North of England Board in October 2011. These arrangements were put in place to reflect the need for continuity and stability during a period of significant change, and also to reflect the continuing statutory nature and responsibilities of the three SHAs, whilst operating within a single common set of objectives and priorities.

1.3 The Board is accountable for internal control and as Accountable Officer and Interim Chief Executive of the SHA, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum with the Department of Health.

1.4 In addition to my responsibility for the Strategic Health Authority, I am accountable for the performance of PCTs in the North East, including providing strategic leadership to the health community, ensuring that all parts of the NHS work together and with partner organisations such as Local Authorities, and driving the achievement of agreed targets for health improvement and service delivery.

1.5 During this period of significant change in the NHS, I am also responsible for ensuring that arrangements are in place to identify and manage risks associated with the transition of services and organisations within NHS North of England to their new successor bodies. 2012/13 has been a particularly challenging year as final arrangements have been put in place to ensure the smooth closedown of existing organisations, whilst ensuring the development of new organisations and their operational readiness from 1 April 2013. This included taking forward the structural changes to deliver Clinical Commissioning Groups (CCGs) which will succeed PCTs, together with their Commissioning Support Units (CSUs), and also supporting the development of new national bodies including the NHS England, Public Health England and Health Education England.

1.6 As Interim Chief Executive, I have overall responsibility for risk management arrangements and I am supported in this role by a Senior Management Team made up of Executive and other Directors. The structure of the Senior Management Team means that all directors have a responsibility for risk management in their respective areas. These responsibilities are set out in the Authority's Risk Management Strategy and Responsibilities Statement.

1.7 Relationships with Chief Executives in all local health organisations in the North East are maintained via a forum which meets on a regular basis and this is mirrored by other Directors with their professional counterparts. The Authority performance manages Primary Care Trusts and in this context it seeks assurance that these organisations have also developed frameworks for the management of risk and Board assurance, which is of particular importance during this final year of transition.

2. The governance framework of the organisation

This section sets out the governance arrangements in place within the Authority and reflects the fact that the SHA continued to operate within a single management structure following the `clustering` of Strategic Health Authorities in 2011.

2.1 The non statutory NHS North of England cluster brings together the three Strategic Health Authorities of NHS North East, NHS North West and NHS Yorkshire and the Humber under a single Board and management structure, whilst recognising the three SHAs continued to function as statutory bodies to 31 March 2013.

2.2 There is a single committee structure across the three SHAs, including an Audit Committee which is the principal committee charged with governance arrangements. Other committees of the Board include Remuneration and Terms of Reference; Provider Development; Education and Training; and Patient Safety. Membership of these committees is drawn from the non-Executive Directors of the Board of NHS North of England.

During the year there were several changes to Board membership, some of which were as a result of the structural changes taking place in the NHS. Board membership and attendance is shown in

2.3 The Board`s 2012/13 Business Plan includes the key deliverables set out in the NHS Operating Framework and these were reflected as strategic objectives in the Board`s Risk and Assurance Framework, which is the main vehicle for monitoring and reporting progress and associated risks. During the year the Board received quarterly updates on progress toward achieving its strategic objectives in a `traffic light` risk rated format. During the first half of the year a number of objectives turned from green to amber, largely due to uncertainties around the transition programme and the emergence of financial pressures in some NHS organisations. However, as the year progressed and guidance and clarification regarding processes and procedures became clearer, this allowed these issues to be managed more effectively.

In addition, regular performance reports and updates from relevant Directors on key business areas within its broader strategic objectives were reported to each meeting of the Board, highlighting performance, risks and actions in managing the effective implementation of the business agenda. These reporting mechanisms provided the Board with assurance on the progress and performance in achieving its key objectives

2.4 The key risks associated with the achievement of the Board`s strategic objectives are set out in the Risk and Assurance Framework, which continued to be reviewed and updated during the year to ensure it continued to meet operational needs and was being effectively implemented during this final year of transition. The risk and control framework associated with the Transition programme is referred to in sections 3 and 4 below.

2.5 The Board has ultimate responsibility for ensuring that effective governance arrangements are in place across all three SHAs and assures itself through a range of sources that effective governance, internal control and risk management arrangements are in place and operating effectively.

The Board also has a responsibility to ensure compliance with its **statutory functions** and receives regular compliance report. The Board`s development session in January 2013 considered the latest report.

2.6 The Board operates within the Code of Conduct for NHS Boards which sets out the public service values that are at the heart of the National Health Service, and also the Code of Accountability for NHS Boards which sets out the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health. These Codes, together with the Department of Health requirement for all NHS organisations to have a Board Risk and Assurance Framework setting out strategic objectives and risks, form the code of governance within which the SHA conducts its business.

2.7 The **Audit Committee** plays a key role in ensuring the establishment and maintenance of an effective integrated system of governance, risk management and internal control that supports the achievement of the organisation`s objectives. The minutes of the Audit Committee are reported to the Board at which the Committee Chair highlights any significant issues.

The Audit Committee is supported in its work by internal and external auditors, who provide independent review of the systems and procedures and report regularly to Committee. In addition, each SHA has a Local Counter Fraud Specialist who undertakes an annual programme of work approved by Committee, which supports a zero tolerance approach to fraud and corruption.

The normal processes for **scrutinising and signing off the statutory accounts** which would normally be carried out by the Audit Committee of the SHA in May/June 2013 following the conclusion of work by the auditors, cannot be carried out by the existing Committee as the SHA will cease to be a statutory body on 31 March 2013. Alternative arrangements have therefore been put in place which include the continued responsibility of myself and the Director of Finance beyond 31 March 2013 to bring this process to a conclusion, together with the establishment of an Audit Committee which will meet (probably in June) specifically for this purpose as a sub-committee of the Department of Health`s Audit Committee, with membership drawn from the Non Executive Directors of the Board of NHS North of England to provide continuity.

As part of the closedown process, arrangements are in place for identifying financial balances to appropriate receiver organisations in accordance with Department of Health guidance and details of these will be included in the annual accounts.

There is also a formal **Transfer Scheme** in place which is a legal process coordinated by the Department of Health, which identifies everything (e.g. existing staff, assets, contracts, data etc) that is transferring to new receiving organisations.

Any ongoing risks or actions associated with functions transferring to new organisations are being identified and documented, and arrangements made for discussion and **handover** to successor bodies. An example of this is a Quality handover event held in February 2013, with attendees from SHAs and PCTs across the North of England meeting with Public Health England and the NHS Commissioning Board to discuss the handover of Quality issues and risks.

3. Risk assessment

This section describes the arrangements for assessing risk and how this is monitored and managed within the Authority.

3.1The Board is engaged in the development and review of the risks associated with the Authority`s strategic objectives included in the Risk and Assurance Framework and the

relevant controls in place to manage those risks.

Risks are initially formulated by the relevant lead Director and considered and approved by the Board.

3.2 All staff are encouraged to participate in risk management and familiarise themselves with the various policies, processes, procedures and training materials available through shared electronic files, including arrangements for raising risks on the risk register. Anti-fraud and corruption work is carried out by a dedicated Local Counter Fraud Specialist who reports regularly to the Audit Committee and communicates with all staff.

3.3 The Authority operates a `traffic light` risk assessment process whereby risks are rated green (low), amber (medium) or red (high). Risk rating is the combined result of scoring for probability and impact and the value of risk scores is amended during the year as a consequence of actions taken to mitigate or manage risks. Strategic risks and their ratings are reviewed regularly by the Board through the review of the Risk and Assurance Framework.

3.4 A particular risk has been **staff capacity/capability** during the latter part of the year as staff began to be appointed to new NHS organisations. Close attention has been paid to this with plans in place to manage the situation. Both old and new organisations recognised the importance of ensuring an accurate and timely financial closedown and handover and have cooperated on staffing issues to deliver a satisfactory outcome.

3.5 **Information governance** and data security continued to be an important area for the SHA during this final year of transition. The main focus of work during 2012/13 has been on preparing SHA information for appropriate handover and supporting the business needs of emerging organisations, ensuring capability and capacity to take on Information Governance functions moving forward, whilst minimising risk and maintaining data security. This focus has meant that less work has been able to be done on pursuing the Department of Health Information Governance Toolkit indicators, an approach which was agreed by both the Senior Management Team and Audit Committee.

There have been no reported serious lapses in data security during the year.

4. The risk and control framework

This section describes how the various risk control mechanisms work within the Authority and how these provide assurance to the Board that risks are being addressed and managed.

4.1 In accordance with the principles of good governance, the key focus for managing risk and assuring the Board that effective arrangements are in place, is the **Board Risk and Assurance Framework**, which identifies the strategic objectives of the Board, together with the associated risks to achieving those objectives and the control mechanisms in place to manage risk.

4.2 This is the main vehicle for managing risk associated with the delivery of the Board`s strategic objectives. This is a strategic management tool and is not designed to reflect every potential risk, but rather to focus on those risks which are most significant and could threaten the achievement of the Authority`s strategic objectives. In addition, a further element of the risk and assurance process are departmental **Operational Risk Registers**, which capture those lesser, transient or operational risks which, although not likely to impact on the achievement of the organisations` objectives, need to be addressed and managed as part of the ongoing evaluation and improvement of the risk and control environment.

The Framework continued to be reviewed and updated during the year to ensure it continued to reflect the key strategic objectives of the Board, and that actions were

identified and agreed with the appropriate Directors to address any gaps in control or assurance processes. Strategic and operational risk registers operate a `traffic light` risk rating system which readily identifies the risk status and these ratings are reviewed regularly and amended as appropriate.

4.3 There has been particular focus in 2012/13 on the systems and risks surrounding the **Transition Programme,** including the financial closure programme in this final year, to ensure a smooth handover to successor organisations when the three cluster SHAs are abolished on 31 March 2013. The key governance and risk mechanisms associated with this are set out below.

The NHS North of England Board has a number of processes in place across the three cluster SHAs to successfully manage the Transition into the new NHS landscape.

A cluster **Transition Board** was established at the beginning of the year and has continued to provide leadership and management of the overall transition programme throughout the year, across the main business areas of the cluster SHAs. This reports to the NHS North of England Board on a regular basis and is supported by a number of **work stream groups,** dealing with key business areas, which link to both local and national mechanisms for identifying risks, seeking guidance and reporting actions. A North of England **transition risk register** has been developed which captures the key local risks identified through these various mechanisms, together with actions to manage these, and is monitored by the Transition Board.

The Transition Board is also supported through the **financial transition assurance framework** which links to one of the work stream groups. This is a `traffic light` risk rated system which is both a local and national financial reporting mechanism. It captures the key financial work areas which need to be addressed, together with milestones, timeframes and risks, and provides monthly local intelligence on progress. The framework is monitored by the Transition Board and is reported at national level to the Department of Health. All North of England PCTs are also involved in this process.

In addition, to support financial closedown and the production of the annual accounts and effective handover to successor organisations, the three cluster SHAs have detailed local financial **closedown plans** which are embedded within the broader transition assurance framework and provide a check list of the detailed tasks, responsible persons and timeframes for successful closedown.

4.4The various mechanisms set out above with regard to the management of the Transition process and associated risks are embedded within NHS North of England risk management arrangements. The importance of the Transition process to the successful delivery of the structural changes in the NHS is reflected in the well defined and documented processes for identifying, monitoring, reporting and managing risk in this regard. The reporting mechanisms include the cluster Transition Board, the NHS North of England Board and the Department of Health.

The NHS North of England Board received monthly reports on the progress of transition arrangements, which provided assurance that appropriate systems were in place to manage the process.

4.5The practice of inviting Directors to attend Audit Committee during the year to discuss the key risks associated with their objectives has been continued during 2012/13 and helped to inform the overall risk management process and provide assurance.

4.6 Risks are operationally managed through the **Senior Management Team** and the **Assurance Group** and monitored by the Audit Committee. The Assurance Group, which comprised senior managers across the broad spread of business of the three cluster SHA`s in the North of England, supported the Senior Management Team and Audit

Committee in monitoring risk management arrangements, providing regular review and monitoring of the risk environment, including development, monitoring and review of the Risk and Assurance Framework and Operational Risk Registers.

4.7 Risks are identified in a number of ways, including: -

- Risk assessment of policies and procedures
- Risk assessment of operational procedures
- Risk scanning by the Senior Management Team
- Board reports
- Strategic risk register
- Operational risk registers
- Assurance Group (with cross cutting membership on Transition and IT groups)
- Internal and External Audit reports.
- Information issued by the Department of Health on risks affecting the whole NHS.
- Local Counter Fraud Specialist reports.
- Plans and processes supporting the Transition programme including the risk register.

4.8 The prevention of risk is addressed through policies, procedures, guidance documents and manuals which are designed to assist and support staff and which govern the routine operational business processes of the SHA. These together form the internal control environment within which risks are managed.

4.9 **Internal and External Audit** also play a key role in reviewing risk, assurance and control systems and reporting on their effectiveness to Audit Committee on a regular basis. The Audit Committee is involved in determining the SHA`s internal audit plan, based on a risk assessment which reflects the key objectives set out in the Risk and Assurance Framework and aimed at providing the Board with assurance on various aspects of the risk and control environment. For 2012/13, Committee agreed that the plan should remain flexible, based on a rolling assessment of the SHA`s core processes, to reflect the increased potential for risk arising during this final year of transition. The SHA also had an **anti-fraud** plan in place throughout the year to detect and deter fraud. The plan was based on criteria set by NHS Protect (the national counter fraud service) plus a local risk based assessment and was approved and monitored by the Audit Committee.

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

This section talks about the effectiveness of the risk management processes in place within the Authority and the sources which provide evidence that the various mechanisms are operating effectively.

5.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways.

5.2 The Head of Internal Audit provides me with a year-end `Opinion` statement on the overall arrangements for gaining assurance through the Board Risk and Assurance Framework and on the systems of internal control which are reviewed as part of the internal audit work programme. For 2012/13 the audit Opinion gave the Authority 'significant assurance' that there was a sound system of internal control in operation throughout the year.

5.3 External Auditors appointed by the Audit Commission also provide an independent review of the Authority`s Financial Statements and overall control environment. Their Annual Audit Letter to the Board in respect of North East SHA provided an `Unqualified Opinion` (clear) for 2011/12. Their Opinion for the current year will be reported after the year-end accounts have been audited and is expected in June 2013. The auditors also provide a statutory Value for Money Conclusion on the SHA`s arrangements for securing

economy, efficiency and effectiveness and for 2011/12 the SHA received an `Unqualified Conclusion` (clear) opinion. The Auditor`s report for 2012/13 will be reported after the financial year end.

5.4 The Department of Health carried out a 2012 mid-yearTransition Assurance Review of all SHA clusters to assess preparedness to manage the transition programme through to its final conclusion. The outcome was very positive and provided the Board and the Department of Health with assurance that NHS North of England had appropriate arrangements in place which were being managed effectively.

5.5 Executive managers and Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance, through monitoring and review of the risks and associated actions in respect of their areas of responsibility. Senior managers also represent their respective Directors on the Assurance Group which is responsible for the operational effectiveness of the risk and control environment.

The Risk and Assurance Framework itself, which is subject to regular review, provides me with evidence of the effectiveness of the control mechanisms that manage the risks to the organisation of achieving its principal objectives.

5.6 My review is also informed by:

(i) other sources of assurance as set out in the Risk and Assurance Framework.

(ii) Board agenda papers which are linked to the appropriate Board objective/s and carry a risk assessment and other control statements completed by the author provide the Board with assurance.

(iii) The Transition programme assurance processes that were in place.

(iv) The system of internal control within the SHA comprising a range of policies, procedures, codes of conduct, scheme of delegation etc. The key procedures are set out in the SHA cluster Corporate Governance Manual which was reviewed and amendments approved by the Board during the year and communicated to all staff. The SHA also has in place a Budget Manual, designed to direct and guide staff in operational matters and improve internal control and risk arrangements.

(v) The Audit Committee has a key role in the oversight of the Authority`s risk and control environment which is reflected in the Committee`s Terms of Reference agreed by the Board.

(vi) NHS Protect (which leads nationally on work to identify and tackle fraud and corruption across the health service) provides the Authority with assurance regarding its anti-fraud and corruption arrangements. A Qualitative Assessment of all NHS bodies is carried out annually and for 2011/12 (the latest available) this showed that North East SHA was performing well.

(vii) The cross directorate Assurance Group which supports the Senior Management Team and Audit Committee.

6. Significant Issues

In this section I am required to declare if any significant issues have arisen during the year which could have impacted on the achievement of the Authority`s objectives or resulted in the annual accounts being misstated.

There were no significant issues to report by the North East SHA.

Signature Officer

Signature.....  .....

Date.....29/05/13.....

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR NORTH EAST STRATEGIC HEALTH AUTHORITY

We have audited the financial statements of North East Strategic Health Authority 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 table of salaries and allowances of senior managers and related narrative notes on pages 73 to 75;
- the table of pension benefits of senior managers and related narrative notes on pages 76 and 77; and
- the pay multiples and related narrative notes on page 78.

This report is made solely to the Accountable Officer for North East Strategic Health Authority 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.

Respective responsibilities of the Signing Officer and auditors

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Authority's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Authority; 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 North East Strategic Health Authority 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 properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Authority, or an officer of the Authority, 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 Authority 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 in November 2012, We have considered the results of the following:

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities at the Authority; and
- our locally determined risk-based work on managing transition issues arising from the abolition of the Strategic Health Authority.

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

Certificate

We certify that we have completed the audit of the accounts of North East Strategic Health Authority in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Mark Kirkham CPFA ACA, Engagement Lead, for and on behalf of Mazars LLP

Chartered Accountants
The Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

5 June 2013

Summary financial statements for 1 April 2012 – 31 March 2013

Summary financial statements for 2012/ 2013
Statement of comprehensive net expenditure for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration costs and programme expenditure		
Employee benefits	13,362	13,921
Other costs	276,260	279,392
Income	(5,479)	(5,830)
Net operating costs before interest	**284,143**	**287,483**
Other (gains)/ losses	0	0
Finance costs	0	13
Net operating costs for the financial year	**284,143**	**287,496**
Of which:		
Administration costs		
Employee benefits	10,745	12,560
Other costs	14,823	13.493
Income	(3,781)	(3,801)
Net administration costs before interest	**21,787**	**22,252**
Other (gains)/ losses	0	0
Finance costs	0	13
Net administration costs for the financial year	**21,787**	**22,265**
Programme expenditure		
Employee benefits	2,617	1,361
Other costs	261,437	265,899
Income	(1,698)	(2,029)
Net programme costs before interest	**262,356**	**265,231**
Other (gains)/ losses	0	0
Finance costs	0	0
Net programme expenditure for the financial year	**262,356**	**265,231**
Revenue resource limit*	**348,771**	**346,815**

* Revenue resource limit is the final revenue resource limit approved by the Department of Health against which the strategic health authority performance is measured

Statement of financial position as at 31 March

	31 March 2013 £000	31 March 2012 £000
Non-current assets		
Property, plant and equipment	0	0
Total non-current assets	**0**	**0**
Current assets		
Trade and other receivables	1,443	2,381
Cash and cash equivalents	59	43
Total	**1,502**	**2,424**
Non-current assets held for sale	0	0
Total current assets	**1,502**	**2,424**
Total assets	**1,502**	**2,424**
Current liabilities		
Trade and other payables	(2,361)	(3,489)
Provisions	(881)	(1,228)
Total current liabilities	**(3,242)**	**(4,717)**
Non-current assets plus/ less current assets/ liabilities	**(1,740)**	**(2,293)**
Non-current liabilities		
Trade and other payables	(855)	(923)
Provisions	0	(444)
Total non-current liabilities	**(855)**	**(1,367)**
Total assets employed	**(2,595)**	**(3,660)**
Financed by:		
Taxpayers' equity		
General fund*	(2,595)	(3,660)
Total taxpayers' equity	**(2,595)**	**(3,660)**

* General fund represents the capital element and the cumulative income and expenditure position within the balance sheet.

Summary of financial statements for 2012/ 2013
Statement of changes in taxpayers' equity for the year ended 31 March 2013

	General fund £000
Balance at 1 April 2012	**(3,660)**
Changes in taxpayers' equity for 2012-13	
Net operating costs for the year	(284,143)
Total recognised income and expense for 2012-2013	**(284,143)**
Net parliamentary funding	285,208
Balance at 31 March 2013	**(2,595)**

Statement of changes in taxpayers' equity for the year ended 31 March 2012

	General fund £000
Balance at 1 April 2011	**(4,224)**
Changes in taxpayers' equity for 2011-12	
Net operating costs for the year	(287,496)
Total recognised income and expense for 2011-2012	**(287,496)**
Net parliamentary funding	288,060
Balance at 31 March 2012	**(3,660)**

Note: the SHA does not hold any other reserves other than the general fund disclosed above.

Summary financial statements for 2012/ 2013
Statement of cash flows for the year ended 31 March 2013

	2012-2013 £000	2011-2012 £000
Cash flows from operating activities		
Net operating costs before interest	(284,143)	(287,483)
Depreciation and amortisation	0	4
(Increase)/ decrease in trade and other receivables	938	(149)
(Increase) in trade and other payables	(1,196)	(1,049)
Provisions utilised	(1,162)	(397)
Decrease in provisions	371	1,011
Net cash (outflow) from operating activities	**(285,192)**	**(288,063)**
Cash flows from investing activities	**0**	**0**
Net cash (outflow) before financing	**(285,192)**	**(288,063)**
Cash flows from financing activities		
Net parliamentary funding	285,208	288,060
Net cash inflows from financing	**285,208**	**288,060**
Net increase/ (decrease) in cash and cash equivalents	**16**	**(3)**
Cash and cash equivalents (and bank overdrafts) at the beginning of the period	**43**	**46**
Cash and cash equivalents (and bank overdraft) at year end	**59**	**43**

Financial performance 2012/ 2013

	2012-2013 £000	2011-2012 £000
Total net operating costs for the financial year	284,143	287,496
Revenue resource limit	347,881	346,815
Under (over) spend against revenue resource limit	**63,738**	**59,319**
Operating revenue		
Fees and charges	3,578	1,762
Recoveries in respect of employee benefits	1,751	1,746
Other	150	2,322
Total operating revenue	**5,479**	**5,830**
Operating costs (excluding employee benefits)		
Chair and non-executive members' remuneration	88	85
Consultancy services	904	472
External contractors	70	55
Establishment expenses	3,187	3,036
Transport and moveable plant	1	0
Premises	2,462	2,435
Depreciation	0	4
Impairment of receivables	8	10
Auditors remuneration – audit fee	105	160
MPET	262,560	268,176
Other	6,875	4,959
Total operating costs (excluding employee benefits)	**276,260**	**279,392**
Employee benefits		
Employee benefits (excluding officer board members)	11,877	12,148
SHA officer board members	1,485	1,773
Total employee benefits	**13,362**	**13,921**
Total operating costs	**289,622**	**293,313**

Financial performance 2012/ 2013 contd.

Running costs 2012/13	SHA and MPET	Public Health	Total
Running costs (£000)	17,772	4,162	21,934
Weighted population (in units)	2,945,582	2,945,582	2,945,582
Running costs per head of population (£ per head)	6.0	1.4	7.4

Running costs 2011/12	SHA and MPET	Public Health	Total
Running costs (£000)	19,187	3,319	22,506
Weighted population (in units)	2,945,582	2,945,582	2,945,582
Running costs per head of population (£ per head)	6.5	1.1	7.6

Operating leases

	2012-2013 £000	2011-2012 £000
Payments recognised as an expense		
Minimum lease payments	1,185	1,252
Contingent rents	192	0
Total	**1,377**	**1,252**
Payable		
No later than a year	1,092	1,110
Between one and five years	248	1,797
After five years	0	0
Total	**1,340**	**2,907**

Employee benefits and numbers

	2012-2013 £000	2011-2012 £000
Employee benefits gross expenditure		
Salaries and wages	10,320	11,126
Social security costs	898	932
Employer contribution to NHS pensions scheme	1,145	1,210
Termination benefits	999	653
Total employee benefits gross expenditure	**13,362**	**13,921**
Less recoveries in respect of employee benefits (see below)	(1,751)	(1,746)
Net employee benefits	**11,611**	**12,175**
Employee benefits – income		
Salaries and wages	(1,403)	(1,430)
Social security costs	(151)	(139)
Employer contributions to NHS pensions scheme	(197)	(177)
Termination benefits	0	0
Total employee benefits income	**(1,751)**	**(1,746)**
Average number of employees during the year	196	211
Staff sickness absence		
Total days lost	1,533	1,397
Total staff	211	215
Average working days lost	7.3	6.5

Better payment practice code – measure of compliance

	Number	£000
Total non-NHS bills paid in the year	12,454	66,915
Total non-NHS bills paid within target	12,331	66,733
Percentage of non-NHS bills paid within target	**99.0%**	**99.7%**
Total NHS bills paid in the year	1,780	220,750
Total NHS bills paid within target	1,773	220,629
Percentage of NHS bills paid within target	**99.6%**	**99.9%**

The late payment of Commercial Debts (Interest) Act 1998

	£000
Amounts included within interest payable note 2.5 arising from claims made by small businesses under the legislation	0
Compensation paid to cover debt recovery costs under the legislation	0

Remuneration report

Membership of the remuneration and terms of service committee

For the period 1 April 2012 to 31 March 2013 membership of the committee comprised three non-executive directors, Sally Cheshire, Kathryn Riddle and Professor Oliver James. The Chief Executive and the Director of Workforce and Education also usually attend.

Policy on the remuneration of senior managers for current and future financial years

Since January 2006, Her Majesty's Treasury (HM Treasury) has required that all public sector pay proposals must be subject to approval through the new HM Treasury/Cabinet Office gateway, the Public Sector Pay Committee (PSPC). The Department of Health (DH) and HM Treasury have therefore produced a framework for senior managers in the NHS – very senior managers pay framework (VSM).

The framework is based on setting "spot rates" for Chief Executive (CE) salaries of strategic health authorities (SHAs) and primary care trusts (PCTs) within four bands determined by the size of the weighted population of the SHA. Yorkshire and the Humber SHA is categorised as band 2. In addition to the spot rate, there is local discretion to increase salaries to reflect either additional duties and/or to aid recruitment and retention, the latter being called recruitment and retention premia (RRP's). Salaries under this framework are first approved by the SHA's remuneration committee and subject to final approval by the Department of Health.

Performance assessment and performance related pay

North East Strategic Health Authority has agreed to follow the national pay framework for VSM which includes the possibility for an annual non-pensionable, non-consolidated one-off payment, dependant on performance.

Contract duration, notice periods and termination payments.

All directors of the SHA are on a permanent contract with either the SHA or their substantive employer. All directors with the exception of the Regional Director of Public Health are subject to the terms and conditions of service set out in the very senior managers pay policy. The Regional Director of Public Health is subject to arrangements determined by the Department of Health. There are no specific conditions relating to termination payments except that any decisions about termination payments are reserved to the Remuneration and Terms of Service Committee.

Service contracts

Details of the service contract for each senior manager who has served NHS North of England from 1 April 2012 to 31 March 2013:

Name	Start date	Notice period
Executive directors and directors		
Ian Dalton CBE	28/08/2007	6 months
Richard Barker	01/05/2009	6 months
Jane Cummings	01/11/2007	6 months
Mark Ogden	01/07/2006	6 months
Prof. Stephen Singleton OBE	01/07/2006	6 months
Tim Gilpin	02/10/2006	6 months
Prof. Paul Johnstone	Joint appointment with DH 01/07/2006	6 months
Elaine Darbyshire	02/03/2009	6 months
Jane Tomkinson	11.05.2011	6 months
Gill Harris	01/05/2012	6 months
Non-executive directors		
Kathryn Riddle*	01/07/2006	31/03/2013
Sir Peter Carr CBE*	01/07/2006	31/03/2013
Sally Cheshire*	01/09/2006	31/03/2013
Prof. Peter Fidler CBE*	01/07/2006	31/03/2013
Sarah Harkness*	01/12/2007	31/03/2013
Alan Foster*	01/07/2006	31/03/2013
Prof. Oliver James*	01/08/2007	31/03/2013
Ian Walker*	01/10/2006	31/03/2013

Notes:

* Appointed by the Appointments Commission

Provision of compensation for early termination

Not applicable.

Other details sufficient to determine the entity's liability in the event of early termination

Not applicable.

Any other significant awards made to past senior managers

There were no other significant awards made to past senior managers

Salary and pension entitlements of senior managers

Salaries and allowances 1 April 2012 – 31 March 2013

	2012/2013 (share of cluster costs to North East SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**
Executive directors and directors of NHS North of England									
Ian Dalton CBE[1] Chief Executive	20-25	5-10	0	60-65	15-20	0	75-80	0	0
Richard Barker Chief Operating Officer	45-50	0-5	0	140-145	10-15	0	140-145	5-10	0
Mark Ogden[2] Deputy Chief Exec/ Director of Finance	15-20	0-5	10	45-50	5-10	20	175-180	5-10	60
Jane Cummings[3] Director of Nursing/ Chief Nurse	0-5	0	0	10-15	0	0	135-140	5-10	0
Prof. Stephen Singleton OBE[4] Medical Director/ Interim Chief Executive	45-50	15-20	0	140-145	360-365	0	190-195	0	40

Notes

[1] Ian Dalton was part-time in the role of Chief Executive at NHS North of England and on a part-time IMAS placement at the NHS Commissioning Board. He left NHS North of England in September 2012.

[2] Mark Ogden left NHS North of England in June 2012

[3] Jane Cummings left NHS North of England in May 2012

[4] Prof. Stephen Singleton became Interim Chief Executive at NHS North of England in September 2012 in addition to his role as Cluster Medical Director. His other remuneration includes the redundancy payment £300-305k

Salaries and allowances 1 April 2012 – 31 March 2013 contd.

	2012/2013 (share of cluster costs to North East SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**
Executive directors and directors of NHS North of England contd.									
Tim Gilpin Director of Workforce and Education	45-50	0	0	145-150	280-285	86	130-135	0	84
Prof. Paul Johnstone Cluster Director of Public Health	30-35	25-30	0	90-95	80-85	0	85-90	80-85	0
Elaine Darbyshire Director of Communications and Corporate Affairs	35-40	0	10	115-120	0	20	115-120	0	20
Jane Tomkinson[5] Director of Finance	45-50	0	20	145-150	0	50	N/A	N/A	N/A
Gill Harris[6] Director of Nursing/ Chief Nurse	45-50	0	0	140-145	0	0	N/A	N/A	N/A

Notes:
[5] Jane Tomkinson took the position as Director of Finance for NHS North of England in June 2012
[6] Gill Harris joined NHS North of England in May 2012

Hosted Programme (Yorkshire and Humber SHA)

Name and title	£000	£000	£00	£000	£000	£00	£000	£000	
Julietta Patnick National Cancer Screening Director	0	0	0	105-110	0	39	105-110	0	39

Salaries and allowances 1 April 2012 – 31 March 2013 contd.

	2012/2013 (share of cluster costs to North East SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**
Non-executive directors of NHS North of England									
Kathryn Riddle Chair	20-25	0	0	60-65	0	0	55-60	0	0
Sir Peter Carr CBE[7] Vice Chair	5-10	0	0	25-30	0	0	40-45	0	0
Sally Cheshire Vice Chair	15-20	0	0	50-55	0	0	40-45	0	0
Prof. Peter Fidler CBE Non-executive director	0-5	0	0	5-10	0	0	10-15	0	0
Alan Foster Non-executive director	0-5	0	0	5-10	0	0	10-15	0	0
Sarah Harkness Non-executive director	0-5	0	0	5-10	0	0	5-10	0	0
Prof. Oliver James Non-executive director	0-5	0	0	5-10	0	0	5-10	0	0
Ian Walker Non-executive director	0-5	0	0	10-15	0	0	10-15	0	0

Notes

[7] Sir Peter Carr left NHS North of England in May 2012

NHS pension benefits 2012/13 – executive directors and directors of NHS North of England[1]

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase in cash equivalent transfer value £000
Ian Dalton CBE Chief Executive	2.5-5	7.5-10	20-25	60-65	362	293	54
Richard Barker Chief Operating Officer	0-2.5	2.5-5	50-55	155-160	961	866	50
Mark Ogden Deputy Chief Executive/ Director of Finance	0-2.5	2.5-5	40-45	120-125	814	685	23
Jane Cummings Director of Nursing/ Chief Nurse	0-2.5	2.5-5	65-70	205-210	1,260	965	20
Prof Stephen Singleton OBE Medical Director/ Interim Chief Executive	0-2.5	2.5-5	65-70	200-205	142	1,326	(1,253)
Tim Gilpin Director of Workforce and Education	2.5-5	10-12.5	55-60	175-180	1,274	1,107	77
Paul Johnstone[2] Cluster Director of Public Health	N/A refer to note 1						
Elaine Darbyshire Director of Communications and Corporate Affairs	0-2.5	0	5-10	0	95	70	22

Notes

[1] Non-executive members do not receive pensionable remuneration, therefore their names are not listed

[2] Prof. Paul Johnstone is a member of the senior civil service pension scheme

NHS pension benefits 2012/13 – executive directors and directors of NHS North of England contd.

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase in cash equivalent transfer value £000
Jane Tomkinson Director of Finance	2.5-5	7.5-10	50-55	150-155	929	812	75
Gill Harris Director of Nursing/ Chief Nurse	(0-2.5)	(2.5-5)	55-60	165-170	1,013	966	(3)
Julietta Patnick National Cancer Screening Director	-2.5	0-2.5	35-40	105-110	758	701	14

Salary and pension entitlements of senior managers of NHS North of England

The executive directors are members of the NHS pension scheme. The employer's contribution to the scheme was equivalent to 14% of their salary.

From 1 April 2012 Prof. Paul Johnstone was appointed as the cluster director for Public Health and is employed by the Department of Health. This is a joint appointment between NHS North of England and the Department of Health.

The benefits in kind for the senior managers relate to their lease cars and it is calculated on the taxable benefit of the lease car.

Contrary to the definition of the real increase in CETVs set out in the Manual for Accounts, common market valuation factors have not been used for the start and end of the period (as the most recent set of actuarial valuation factors, produced by the Government Actuary's Department (GAD) with effect from 8 December 2011, have been applied as at 31 March 2013).

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 midpoint of the remuneration band for the highest paid director in North East Strategic Health Authority in the financial year 2012-13 was £67,500 (2011-12 £127,500). This was the net salary charged to North East SHA following clustering arrangement recharges with Yorkshire and Humber SHA and North West SHA. This was 2.43 times (2011-12 4.48 times) the median remuneration of the workforce, which was £27,625 (2011-12 £28,470).

The reduction in the remuneration for the highest paid director is due to the clustering arrangements applying for the full year in 2012/13 while in 2011/12 the clustering arrangements commenced 1 October 2011.

The midpoint of the remuneration band for the highest paid employee in North East Strategic Health Authority in the financial year 2012-13 was £182,500 (2011-12 £172,500). This was 6.53 times (2011-12 6.06 times) the median remuneration of the workforce, which was £27,625 (2011-12 £28,470).

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

Total cost of exit packages agreed 2012 - 2013

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departure agreed	Total number of exit packages by cost band (total cost) £000
Less than £10,000	2	0	18
£10,001 - £25,000	6	0	81
£25,001 - £50,000	3	0	110
£50,001 - £100,000	2	0	168
£100,001 - £150,000	2	0	221
£150,001 - £200,000	0	0	0
> £200,001	1	0	401
Total number of exit packages by type (total cost)	**16**	**0**	**999**

Feedback and comments

Department of Health Richmond Hou se 79 Whitehall **London** SW1A 2NS

Department of Health

NHS

North East Strategic Health Authority

2012-13 Accounts

October 2013

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North East Strategic Health Authority

2012-13 Accounts

NATIONAL HEALTH SERVICE

ANNUAL ACCOUNTS 2012/2013

The Accounts of the North East Strategic Health Authority

FOREWORD

These accounts have been prepared by the North East Strategic Health Authority (NHS North East) under section 98(2) of the National Health Service Act 1977 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statutory background

The North East SHA is a public body and part of the National Health Service. It is a statutory body governed by Acts of Parliament and came into existence on the 1st July 2006 under Statutory Instrument 2006 No 1408. As a statutory body, the North East SHA has specific powers to act as a regulator, to contract in its own name, act as a corporate trustee, to fund projects jointly planned with and to make payments and grants to local authorities, voluntary organisations and other bodies.

On the 2nd October 2011 SHAs were organised under a clustering arrangement, where the North East SHA was clustered with the Yorkshire and the Humber SHA and the North West SHA and have been placed under a single management framework and work together as NHS North of England. Each SHA maintains its separate statutory responsibilities and reports on its own activities and resources.

Main functions of the Strategic Health Authority

The North East SHA secures the improvement in the physical and mental health of people in the North East through resources available to it.

This is done by:

- Creating a strategic framework to deliver the NHS Plan in their area.
- Securing annual performance agreements and performance management of Primary Care Trusts and NHS Trusts.
- Building capacity and supporting performance improvement across all their local health agencies.

Review of activities and performance against targets

The North East SHA, in line with other NHS bodies, operates resource based accounting. This expenditure is measured against a Resource Limit set by the Department of Health. The North East SHA has a statutory duty to contain expenditure within the Resource Limit and an administrative duty to achieve "Operating Financial Balance".

Better Payment Practice Code

The North East SHA is required to pay its non-NHS creditors in accordance with the Better Payments Practice Code. The target is to pay 95% of non-NHS creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. Of the total relevant non-NHS bills, 99% of bills, representing 99.7% by value, were paid within the target. The same target applies to NHS bodies. Of the total relevant NHS bills, 99.6% of bills representing 99.9% by value, were paid within target.

Names of Board Members
NHS North of England

Chairman
Kathryn Riddle

Vice Chairman
Sir Peter Carr, C.B.E, DL (1.4.12 - 30.6.12)
Sally Cheshire

Non-Executive Directors
Professor Peter Fidler, M.B.E, DL, DipTP, DipSoc, MRTPI
Alan Foster
Sarah Harkness
Professor Oliver James BA, MA, BM, BCh, FRCP, F.Acad.Med.Sci
Ian Walker

Chief Executive
Ian Dalton C.B.E (1.4.12-30.9.12)
Professor Stephen Singleton O.B.E (1.10.12 - 31.3.13)

Executive Directors

Richard Barker	Chief Operating Officer
Jane Cummings (1.4.12 - 30.4.12)	Chief Nurse
Gill Harris (1.5.12 - 31.3.13)	Chief Nurse
Mark Ogden (1.4.12 - 30.6.12)	Cluster Director of Finance / Deputy Chief Executive
Jane Tomkinson (1.7.12 - 31.3.13)	Cluster Director of Finance
Professor Stephen Singleton O.B.E	Cluster Medical Director
Professor Stephen Singleton O.B.E	Deputy Chief Executive (1.7.12 - 30.9.12)

Other Directors

Tim Gilpin	Cluster Director of Workforce and Education
Professor Paul Johnstone	Cluster Director of Public Health
Elaine Darbyshire	Director of Communications & Corporate Affairs

Details of salaries, allowances and pension benefits relating to the Non - Executive Directors are contained in the governace and finance section of the Strategic Health Authority's 2012/13 Annual Report.

Policy in respect of employees with disabilities

The North East SHA is committed to challenging discrimination, promoting equality and diversity, and respecting human rights in all we do. The NHS North East is committed to employing people with disabilities and to retaining existing employees if they become disabled. The NHS North East has once again been re-accredited for the Job Centre Plus, Department of Work and Pensions "two ticks" disability symbol, which is proof of the authority's commitment to employing people with disabilities.

Policy in respect of equality and diversity

The North East SHA is committed to meet the Public Sector Equality Duty in the Equality Act 2010, by treating all its employees, applicants for employment, service users, patients and sub-contractors equally regardless of their gender, marriage or civil partnership status, sexual orientation, colour, race, nationality, ethnic origin, religion or belief, including lack of belief, age, disability, gender re-assignment, sex, pregnancy and maternity, age, disability, part time work status or carers' responsibilities.

The North East SHA will continually review its policies and practices to ensure that there are no barriers to the achievement of this objective.

Name of the auditor and the cost of work performed during the year.
The auditor is Mr M Kirkham from Mazars LLP. The summary of the auditors' remuneration is shown below:

	2012/13	2011/12
	£000	£000
Audit fees	105	159

Signed:  **Date:** 29/05/13

Signing Officer

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**13,362**	13,921
Other costs	5.1	**276,260**	279,392
Income	4	**(5,479)**	(5,830)
Net operating costs before interest		**284,143**	287,483
Finance costs	11	**0**	13
Net operating costs for the financial year		**284,143**	287,496
Net operating costs and transfer gains/losses for the financial year		**284,143**	**287,496**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**10,745**	12,560
Other costs	5.1	**14,823**	13,493
Income	4	**(3,781)**	(3,801)
Net administration costs before interest		**21,787**	**22,252**
Finance costs	11	**0**	13
Net administration costs for the financial year		**21,787**	**22,265**
Programme Expenditure			
Gross employee benefits	7.1	**2,617**	1,361
Other costs	5.1	**261,437**	265,899
Income	4	**(1,698)**	(2,029)
Net programme expenditure before interest		**262,356**	265,231
Net programme expenditure for the financial year		**262,356**	265,231

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Total comprehensive net expenditure for the year*	**284,143**	**287,496**

*This is the sum of the rows above plus net operating costs for the financial year.
The notes on pages 7 to 30 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:	12	**0**	0
Current assets:			
Trade and other receivables	19	**1,443**	2,381
Cash and cash equivalents	22	**59**	43
Total current assets		**1,502**	2,424
Total assets		**1,502**	2,424
Current liabilities			
Trade and other payables	24	**(2,361)**	(3,489)
Provisions	31	**(881)**	(1,228)
Total current liabilities		**(3,242)**	(4,717)
Non-current assets plus/less net current assets/liabilities		**(1,740)**	(2,293)
Non-current liabilities			
Trade and other payables	24	**(855)**	(923)
Provisions	31	**0**	(444)
Total non-current liabilities		**(855)**	(1,367)
Total Assets Employed:		**(2,595)**	(3,660)
Financed by taxpayers' equity:			
General fund		**(2,595)**	(3,660)
Total taxpayers' equity:		**(2,595)**	(3,660)

The notes on pages 7 to 30 form part of this account.

The financial statements on pages 3 to 6 were approved by the Audit Committee on 29 May and signed on its behalf by

Signing Officer Date: 29/05/13

Statement of changes in taxpayers equity
For the year ended 31 March 2013

	General fund £000	Total reserves £000
Balance at 1 April 2012	**(3,660)**	**(3,660)**
Changes in taxpayers' equity for 2012-13		
Net operating cost plus (gain)/loss on transfers by absorption	**(284,143)**	**(284,143)**
Total recognised income and expense for 2012-13	**(284,143)**	**(284,143)**
Net Parliamentary funding	**285,208**	**285,208**
Balance at 31 March 2013	**(2,595)**	**(2,595)**
Changes in taxpayers' equity for 2011-12		
Balance at 1 April 2011	(4,224)	(4,224)
Net operating cost for the year	(287,496)	(287,496)
Total recognised income and expense for 2011-12	(287,496)	(287,496)
Net Parliamentary funding	288,060	288,060
Balance at 31 March 2012	(3,660)	(3,660)

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	**(284,143)**	(287,483)
Depreciation and Amortisation	**0**	4
(Increase)/Decrease in Trade and Other Receivables	**938**	(149)
(Decrease) in Trade and Other Payables	**(1,196)**	(1,049)
Provisions Utilised	**(1,162)**	(397)
Increase in Provisions	**371**	1,011
Net Cash (Outflow) from Operating Activities	**(285,192)**	(288,063)
Net cash (outflow) before financing	**(285,192)**	(288,063)
Cash flows from financing activities		
Net Parliamentary Funding	**285,208**	288,060
Net Cash Inflow from Financing Activities	**285,208**	288,060
Net increase in cash and cash equivalents	**16**	(3)
Cash and Cash Equivalents at Beginning of the Period	**43**	46
Cash and Cash Equivalents at year end	**59**	43

1. Accounting policies

Under the provisions of the Health and Social Care Act 2012, North East SHA was dissolved on 31 March 2013. The SHA's functions, assets and liabilities transferred to other public sector entities as outlined in Note 40 Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

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

The Secretary of State for Health has directed that the financial statements of SHAs shall meet the accounting requirements of the SHA Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 SHAs 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 SHA 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 SHA for the purpose of giving a true and fair view has been selected. The particular policies adopted by the SHA are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

The SHA 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 SHA exercises in-year budgetary control over the other entity.

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

In the application of the SHA'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 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.

The North East SHA entered into a lease agreement for its headquaters at Waterfront 4 during 2009/10. The lease does not transfer substantially all of the risks and rewards incidental to ownership. An assessment of this lease was undertaken in 2009/10 and it was judged an operating lease under IAS 17.

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

The North East SHA has used estimation techniques in calculating provisions within the accounts. No key assumptions concerning the future or any other sources of estimation are considered to be a significant risk that would cause a material adjustment to the carrying amount of assets and liabilities within the next financial year.

1. Accounting policies (continued)

1.2 Revenue and Funding

The main source of funding for the SHA is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the SHA. 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 SHA. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work. It includes both income appropriated-in-aid of the Vote and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income.

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

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

1.3 Taxation

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

1.4 Administration and Programme Costs

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

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

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

1.5 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the SHA;
- 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.

1.6 Intangible Assets

The North East SHA did not have any intangible assets in 2012-13 or in 2011-12.

1. Accounting policies (continued)

1.7 Depreciation, amortisation and impairments

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the SHA expects to obtain economic benefits or service potential from the asset. This is specific to the SHA 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 SHA 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.

1.8 Non-current assets held for sale

North East SHA does not hold any non-current assets held for sale.

1.9 Inventories

The North East SHA had no inventories in 2012-13 or in 2011-12.

1.10 Losses and Special Payments

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

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

1.11 Clinical Negligence Costs

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

The NHSLA operates a risk pooling scheme under which the SHA pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The total value of clinical negligence provisions carried by the NHSLA on behalf of the SHA is disclosed at Note 31.

1. Accounting policies (continued)

1.12 Employee benefits
Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

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

1.13 Research and Development

The North East SHA has no research and development activity.

1.14 Other expenses

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

1.15 Grant making

Under section 256 of the National Health Service Act 2006, the SHA 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 SHA has a present legal or constructive obligation which occurs when all of the conditions attached to the payment have been met. The SHA did not make any grants in 2012-13 or in 2011-12.

1.16 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amount are valued at fair value at the end of the reporting period. The SHA did not have any of these allowances in 2012-13 or in 2011-12.

1.17 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 SHA, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1. Accounting policies (continued)

1.18 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 SHA 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 SHA's net operating cost.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

The SHA as lessor

The North East SHA is not the lessor for any leases.

1.19 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.

1.20 Provisions

Provisions are recognised when the SHA has a present legal or constructive obligation as a result of a past event, it is probable that the SHA 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% in real terms (2.8% for employee early departure obligations).

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 SHA 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 SHA 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 arising 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)

1.21 Financial Instruments

Financial assets

Financial assets are recognised when the SHA 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 de-recognised 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 interest method.

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.

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 SHA 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 SHA 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 de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

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

Financial liabilities at fair value through profit and loss

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

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.

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

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

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

2 Operating segments

Within the overall resource allocation issued by the Department of Health, North East SHA receives a separate allocation for Multi-Professional Education & Training (MPET) for its activities in relation to planning and commissioning training and education on behalf of the NHS organisations in the region. The relative size and nature of this allocation means that expenditure relating to the MPET allocation is monitored separately from North East SHA's other budgets. North East SHA also acts as a statutory host body to a range of regional programmes. These hosted budgets have also been reported separately from its core allocation. North East SHA segments net assets between SHA core, Workforce and Hosted.

	SHA Core		Hosted		Workforce		Economy		Total	
	2012-13 £000	2011-12 £000	**2012-13 £000**	2011-12 £000	**2012-13 £000**	2011-12 £000	**2012-13 £000**	2011-12 £000	**2012-13 £000**	2011-12 £000
Net Expenditure	**12,770**	14,357	**10,306**	6,859	**261,067**	266,280	**0**	0	**284,143**	287,496
Revenue Resource Limit	**14,129**	14,376	**10,901**	8,520	**261,086**	266,314	**61,765**	57,605	**347,881**	346,815
Segment surplus/(deficit)	1,359	19	595	1,661	19	34	61,765	57,605	63,738	59,319
Surplus/(deficit) before interest	**1,359**	19	**595**	1,661	**19**	34	**61,765**	57,605	**63,738**	59,319
Net Assets:										
Segment net assets	**(1,527)**	(1,658)	**(637)**	**0**	**(431)**	(2,002)	**0**	0	**(2,595)**	(3,660)

Expenditure of £64,176k was incurred with Newcastle upon Tyne Hospitals Foundation Trust (2011-12, £63,584). This is included in the total Workforce expenditure of £261,067k (2011-12 £266,280k). This represents 22.6% of total net expenditure of £284,143k (2010-11 22% of £287,496k).

Analysis of Workforce Development net operating costs by category:-

	2012-13 £000	2011-12 £000
Non medical education & training levy	**88,781**	89,093
Non medical education & training spec.devs	**3,445**	7,313
Non medical education & training spec.inits	**2**	3
Multi professional education & training levy	**366**	302
Medical & dental education levy	**113,752**	114,157
Service increment for teaching levy	**54,318**	52,894
Admin	**1,364**	3,011
other	**532**	1,403
	262,560	268,176
less income	**(1,493)**	(1,896)
	261,067	266,280

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The SHA's performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**284,143**	287,496
Revenue Resource Limit	**347,881**	346,815
Underspend Against Revenue Resource Limit (RRL)	**63,738**	59,319

The North East Strategic Health Authority maintains a strategic reserve for transfers to and from PCTs which stood at £32,856k as at 31 March 2013. (£32,192k as at 31 March 2012).

3.2 Capital Resource Limit

The North East SHA did not have any capital expenditure in 2012-13 or in 2011-12.

3.3 Cash Limit

	2012-13 £000	2011-12 £000
The SHA's performance for the year ended 2012-13 is as follows:		
Total Charge to cash limit	**(285,208)**	(288,060)
Cash Limit	**298,233**	289,835
Underdraw Against Cash Limit (CL)	**13,025**	1,775

The North East Strategic Health Authority returned £13,025k cash to DH in March 2013.

4. Operating Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Fees & Charges	**3,578**	1,912	1,666	1,762
Recoveries in respect employee benefits	**1,751**	1,719	32	1,746
Other	**150**	150	0	2,322
Total operating revenue	**5,479**	**3,781**	**1,698**	5,830

5.1 Operating costs (excluding employee benefits)

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Chair and Non-executive directors remuneration	88	88	0	85
Consultancy Services	904	904	0	472
External contractors	70	70	0	55
Establishment expenses	3,187	3,187	0	3,036
Transport and moveable plant	1	1	0	0
Premises	2,462	2,462	0	2,435
Depreciation	0	0	0	4
Impairments and Reversals of Receivables	8	8	0	10
Auditors remuneration - audit fee	105	105	0	160
MPET	262,560	1,535	261,025	268,176
Other (free text note)	6,875	6,463	412	4,959
Total Operating Costs excl. Employee benefits	276,260	14,823	261,437	279,392

5.2 Gross Employee Benefits - excluding capitalised costs and income in respect of staff costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Employee Benefits (excluding officer board members)	11,877	9,260	2,617	12,148
SHA Officer Board members	1,485	1,485	0	1,773
Total Employee Benefits	13,362	10,745	2,617	13,921
TOTAL OPERATING COSTS	289,622	25,568	264,054	293,313

5.3 Running costs and Public Health expenditure

	2012-13 £000	2011-12 £000
Of " Total op costs" Running Costs	26,252	26,401
Of "Total op costs excl employee benefits": Public Health	3,459	2,395
Of "Employee Benefits": Public Health	1,018	1,453
Total Public Health expenditure	4,477	3,848
Of Operating Revenue: amount relating to Public Health Income from Outside the NHS/DH	314	529

Running Costs 2012-13

	SHA & MPET £000	Public Health £000	Total £000
Running costs (£000s)	17,772	4,162	21,934
Weighted population (number in units)	2,945,582	2,945,582	2,945,582
Running costs per head of population (£ per head)	6.0	1.4	7.4

Running Costs 2011-12

	SHA & MPET £000	Public Health £000	Total £000
Running costs (£000s)	19,187	3,319	22,506
Weighted population (number in units)	2,945,582	2,945,582	2,945,582
Running costs per head of population (£ per head)	6.5	1.1	7.6

5.4 Operating Costs
Other expenditure included:-

	2012-13	2011-12
	£000	£000
Innovation Funding	**1,932**	755
Improving Access to Psychological Therapies	**660**	
Fluoridation	**412**	386
Strategic Health Asset Planning and Evaluation Project	**400**	350
Public Health North East Hosted Projects	**378**	165
Provision for Legal Claims	**373**	339
Social Care hosted project		396
Dementia Mental Health Programme	**364**	
Investing in Behaviours Programme	**245**	
Mental Health (CSIP)	**242**	
Choice And Social Exclusion Funding For PSA 16 Projects		191
QIPP - Accademic Health Science Network	**185**	
Quality Assurance Reference Centre East Pennine Cytology Training Centre - SLA For Staffing 2010/11		165
Any Qualified Provider	**148**	125
Safer Care North East Hosted Projects		163
Respiratory Pilot Project		143

Establishment Expenses included:-	**2012-13**	2011-12
	£000	£000
Health Awareness Campaigns	**398**	646
Travel & Subsistence	**563**	497
Training Expenses	**496**	438
Legal & Professional Fees	**159**	760
Conferences & Seminars	**172**	221
Telephone Line Rental	**50**	149

5.5 Workforce Development Costs

	2012-13 £000	2011-12 £000
NHS bodies	**209,030**	214,487
Educational Institutions	**47,082**	48,444
Other	**6,448**	5,245
Total	**262,560**	**268,176**

NHS Bodies: this is the cost of training provided by NHS bodies including the SHA itself.

Educational Institutions: these are payments for training provided by education bodies outside the NHS such as Universities and colleges.

Other: This includes all other workforce expenses such as administration costs.

5.6 Analysis of payments to Educational Institutions

	2012-13 £000	2011-12 £000
Northumbria University		
Allied health professionals training	**3,088**	3,205
MADEL	**29**	25
nurse training	**17,808**	19,050
Scientists & technical training	**82**	101
other	**318**	257
	21,325	22,638
Newcastle University		
Allied health professionals training	**1,596**	1,581
MADEL	**1,100**	1,176
SIFT	**485**	898
Scientists & technical training	**548**	586
other	**235**	503
	3,964	4,744
University of Sunderland		
MADEL	**2**	3
nurse prescribing	**35**	0
Scientists & technical training	**277**	482
other	**366**	341
	680	826
Teesside University		
Allied health professionals training	**4,502**	4,373
nurse training	**13,339**	12,279
SIFT	**10**	0
Scientists & technical training	**1,187**	994
other	**312**	404
	19,350	18,050
Colleges	**1,763**	2,187
TOTAL	**47,082**	48,445

6. Operating Leases

Waterfront 4 (Core North East SHA and Workforce Headquarters). The 10 year lease commenced on 23 June 2009. There is a break clause at 23 June 2014. There is no option to purchase the building. The rent is to be reviewed on 24 April 2012 and on the fifth anniversary of the lease commencement, to the higher of open market rent or rent payable under the lease immediately prior to the rent review date. Assignment or disposal is only permitted with landlord's consent and structural alterations to the premises are prohibited. The building must only be used as office space. The lease will be transferred to NHS Property Services Ltd on 1 April 2013.

Bourne House (Workforce). The lease is for 10 years ending 28 February 2018. There is a break clause at 1 March 2013, equating to nine months notice. The SHA decided not to exercise the break option and no penalties were incurred. The rent is to be reviewed 1 March 2013, to the higher of open market rent or rents payable under the lease immediately prior to the rent review date. Assignment or underletting is only permitted with the landlords consent. The building must only be used as offices. the lease will be transferred to NHS Property Services Ltd on 1 april 2013.

Raynham House (QARC). The lease is for 10 years ending 15 June 2018. There is a break clause at 15 June 2013, requiring six months notice. The SHA decided not to exercise the break option and no penalties were incurred. The rent is to be reviewed 15 June 2013, to the higher of open market rent or rent payable under the lease immediately prior to the rent review date. Assignment or underletting is only permitted with the landlords consent. The building must only be used as offices. the lease will be transferred to NHS Property Services Ltd on 1 April 2013.

There are other arrangements which are not formal property leases but which are included here:-

Ebsworth Building (Workforce). An interim arrangement was agreed with Durham University to rent this property pending completion of the new building at the Wolfson Institute. The arrangement commenced 31 March 2010 and extends to 30 August 2012. The building is used by Tees Valley GP training scheme staff.

Education Centre, N Cumbria Acute Hospitals NHS Trust (Workforce). This is a licence arrangement which commenced on 1 October 2007. The arrangement requires six months notice to terminate the licence.

Northumbria University. The Northern Deanery have use of 2 permanent office spaces and teaching rooms as required. There is no specified notice period to terminate this agreement.

The contingent rents are recognised on the basis of the difference between the current annual charge and the original rent specified in the lease document.

6.1 SHA as lessee

	2012-13			2011-12
	Buildings £000	**Other £000**	**Total £000**	£000
Payments recognised as an expense				
Minimum lease payments	**1,097**	**88**	**1,185**	1,252
Contingent rents	**191**	**1**	**192**	0
Sub-lease payments	**0**	**0**	**0**	0
Total	**1,288**	**89**	**1,377**	1,252
Payable:				
No later than one year	**1,058**	**34**	**1,092**	1,110
Between one and five years	**223**	**25**	**248**	1,797
After five years	**0**	**0**	**0**	0
Total	**1,281**	**59**	**1,340**	2,907

6.2 SHA as lessor

The North East SHA had no leasing agreements in 2012-13 or in 2011-12 where the SHA is a lessor.

7. Employee benefits and staff numbers

7.1 Employee benefits

				Permanently employed				Other	
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits 2012-13 - gross expenditure									
Salaries and wages	10,320	9,015	1,305	8,428	7,123	1,305	1,892	1,892	0
Social security costs	898	768	130	898	768	130	0	0	0
Employer Contributions to NHS BSA - Pensions Division	1,145	962	183	1,145	962	183	0	0	0
Termination benefits	999	0	999	999	0	999	0	0	0
Total employee benefits	13,362	10,745	2,617	11,470	8,853	2,617	1,892	1,892	0
Less recoveries in respect of employee benefits (table below)	(1,751)	(1,719)	(32)	(1,751)	(1,719)	(32)	0	0	0
Total - Net Employee Benefits including capitalised costs	11,611	9,026	2,585	9,719	7,134	2,585	1,892	1,892	0

				Permanently employed		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits 2012-13 - income						
Salaries and wages	1,403	1,377	26	1,403	1,377	26
Social security costs	151	149	2	151	149	2
Employer Contributions to NHS BSA - Pensions Division	197	193	4	197	193	4
TOTAL excluding capitalised costs	1,751	1,719	32	1,751	1,719	32

Employee Benefits Prior Year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross expenditure 2011-12			
Salaries and wages	11,126	9,036	2,090
Social security costs	932	932	0
Employer Contributions to NHS BSA - Pensions Division	1,210	1,210	0
Termination benefits	653	653	0
Total employee benefits	13,921	11,831	2,090
Less recoveries in respect of employee benefits	(1,746)	(1,746)	0
Total - Net Employee Benefits including capitalised costs	12,175	10,085	2,090
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	13,921	11,831	2,090

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	196	185	11	211	188	23
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	1,533	1,397
Total Staff Years	211	215
Average working Days Lost	7.3	6.5

The North East SHA did not have any persons retired early on ill health grounds in 2012-13 or in 2011-12.

The North East SHA did not have any additional pensions liabilities accrued in 2012-13 or in 2011-12.

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	2	0	2	9	0	9
£10,001-£25,000	6	0	6	0	0	0
£25,001-£50,000	3	0	3	1	0	1
£50,001-£100,000	2	0	2	0	0	0
£100,001 - £150,000	2	0	2	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	1	0	1	0	2	2
Total number of exit packages by type (total cost)	**16**	**0**	**16**	**10**	**2**	**12**
	£	£	£	£	£	£
Total resource cost	**999,301**	**0**	**999,301**	81,000	572,000	653,000

***This note provides an analysis of exit packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the North East SHA has agreed early retirements, the additional costs are met by the North East SHA 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.**

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

In 2012-13 the Strategic Health Authority had 42 employees (39, 2011-12) who had opted out of the NHS Pension Scheme.

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	**12,454**	**66,915**	11,293	65,373
Total Non-NHS Trade Invoices Paid Within Target	**12,331**	**66,733**	11,115	65,100
Percentage of NHS Trade Invoices Paid Within Target	**99.01%**	**99.73%**	98.42%	99.58%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,780**	**220,750**	1,923	224,649
Total NHS Trade Invoices Paid Within Target	**1,773**	**220,629**	1,912	224,448
Percentage of NHS Trade Invoices Paid Within Target	**99.61%**	**99.95%**	99.43%	99.91%

The Better Payment Practice Code requires the SHA 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

The North East SHA had no charges for late payments of commercial debts in 2012-13 or in 2011-12.

9. Investment Income

The North East Strategic Health Authority had no investment income in 2012-13 or in 2011-12.

10. Other Gains and Losses

The North East Strategic Health Authority had no other gains and losses in 2012-13 or in 2011-12.

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Provisions - unwinding of discount	**0**	**0**	**0**	**13**
Total	**0**	**0**	**0**	**13**

12.1 Property, plant and equipment

2012-13	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation:			
At 1 April 2012	142	13	**155**
At 31 March 2013	**142**	**13**	**155**
Depreciation			
At 1 April 2012	142	13	**155**
At 31 March 2013	**142**	**13**	**155**
Net Book Value at 31 March 2013	0	0	0

12.2 Property, plant and equipment

2011-12	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation:			
At 1 April 2011	142	13	**155**
At 31 March 2012	**142**	**13**	**155**
Depreciation			
At 1 April 2011	138	13	**151**
Charged During the Year	4	0	**4**
At 31 March 2012	**142**	**13**	**155**
Net book value at 31 March 2012	**0**	**0**	**0**

Economic Lives of Non-Current Assets	**Min Life Years**	**Max Life Years**
Property, Plant and Equipment		
Buildings excluding Dwellings	60	60
Plant and Machinery	5	5
Information Technology	2	2
Furniture and Fittings	2	2

13. Intangible non-current assets

The North East SHA had no intangible non-current assets in 2012-13 or in 2011-12.

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

The North East SHA had no impairments in 2012-13 or in 2011-12.

15. Investment property

The North East SHA had no investment property in 2012-13 or in 2011-12.

16. Commitments

16.1 Capital commitments

The North East SHA had no capital commitments in 2012-13 or in 2011-12.

16.2 Other financial commitments

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

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**30**	29
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**30**	29

17. Intra-Government and other balances

	Current receivables £000	**Current payables £000**	**Non-current payables £000**
Balances with other Central Government Bodies	**546**	**278**	**0**
Balances with Local Authorities	**298**	**0**	**0**
Balances with NHS Trusts and Foundation Trusts	**281**	**718**	**0**
Balances with bodies external to government	**318**	**1,365**	**855**
At 31 March 2013	**1,443**	**2,361**	**855**
prior period:			
Balances with other Central Government Bodies	1,211	1,273	0
Balances with NHS Trusts and Foundation Trusts	961	915	0
Balances with bodies external to government	209	1,301	923
At 31 March 2012	**2,381**	**3,489**	**923**

18. Inventories

The North East SHA had no inventories in 2012-13 or in 2011-12.

19.1 Trade and other receivables

	Current 31 March 2013 £000	31 March 2012 £000
NHS Receivables - Revenue	**387**	1,154
NHS Prepayments and Accrued Income	**73**	829
Non NHS Trade Receivables - Revenue	**162**	80
Non-NHS Prepayments and Accrued Income	**618**	135
Provision for Impairments of Receivables	**(6)**	(41)
VAT	**209**	189
Other receivables	**0**	35
Total current and non current	**1,443**	2,381

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	3	0
By three to six months	0	0
By more than six months	0	0
Total	3	0

19.3 Provision for impairment of receivables

	2012-13 £000	31 March 2012 £000
Balance at 1 April 2012	(41)	(39)
Amount written off during the year	43	8
Amount recovered during the year	3	6
(Increase)/decrease in receivables impaired	(11)	(16)
Balance at 31 March 2013	(6)	(41)

The SHA regards non NHS debt which has been outstanding for greater than 90 days to be at risk of non payment. As such a provision for impairment is recognised.

20. Other financial assets

20.1 Other financial assets - current

The North East SHA had no other current assets in 2012-13 or in 2011-12.

20.2 Other financial Assets - non current

The North East SHA had no non current assets in 2012-13 or in 2011-12.

20.3 Other financal assets - Capital analysis

The North East SHA had no capital expenditure in 2012-13 or in 2011-12.

21. Other current assets

The North East SHA had no other current assets in 2012-13 or in 2011-12.

22. Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	43	46
Net change in year	16	(3)
Closing balance	59	43
Made up of		
Cash with Government Banking Service	59	43
Cash and cash equivalents as in statement of financial position	59	43
Cash and cash equivalents as in statement of cash flows	59	43

23. Non-current assets held for sale

The North East SHA had no non-current assets held for sale in 2012-13 or in 2011-12.

24. 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	**89**	719		
NHS Accruals and Deferred Income	**767**	1,401		
Non-NHS Trade Payables - Revenue	**424**	176		
Non-NHS Accruals and Deferred Income	**774**	1,192		
Social Security Costs	**3**	0		
Tax	**126**	0		
Other	**178**	1	**855**	923
Total	**2,361**	3,489	**855**	923
Total payables (current and non-current)	**3,216**	**4,412**		

North East SHA did not have any outstanding pensions contributions in 2011-12..

Other payables (non-current) include an adjustment of £67k in 2012-13 (£279k 2011-12) relating to the end of the reduced rent charges for Waterfront 4. The benefit of the reduced rent period is recognised as a reduction in rent expenditure on a straight line basis over the whole lease period. The adjustment of £67k represents the spreading of the rent expense over the full period of the lease under IFRS compared to UK GAAP.

25. Other liabilities

The North East SHA had no other liabilities in 2012-13 or in 2011-12.

26. Borrowings

The North East SHA had no borrowings in 2012-13 or in 2011-12.

27. Other financial liabilities

The North East SHA had no other financial liabilities in 2012-13 or in 2011-12.

28. Deferred income

	Current	
	31 March 2013 £000	31 March 2012 £000
Opening balance at 1 April 2012	**421**	412
Deferred income addition	**29**	421
Transfer of deferred income	**(421)**	(412)
Deferred Income at 31 March 2013	**29**	421
Total other liabilities (current and non-current)	**29**	**421**

29. Finance lease obligations

The North East SHA had no finance lease obligations in 2012-13 or in 2011-12.

30. Finance lease receivables as lessor

The North East SHA had no finance lease receivables as lessor in 2012-13 or in 2011-12.

31. Provisions

	Total £000s	Admin £000s	Programme £000s	Comprising: Pensions to Former Directors £000s	Legal Claims £000s	Restructuring £000s
Balance at 1 April 2012	**1,672**	952	720	451	501	720
Arising During the Year	**705**	571	134	0	571	134
Utilised During the Year	**(1,162)**	(503)	(659)	(370)	(133)	(659)
Reversed Unused	**(334)**	(279)	(55)	(81)	(198)	(55)
Balance at 31 March 2013	**881**	**741**	**140**	**0**	**741**	**140**
Expected Timing of Cash Flows:						
No Later than One Year	**881**	741	140	0	741	140

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000s
As at 31 March 2013	88,697
As at 31 March 2012	100,228

The provision for restructuring relates to terminations for employees on retention contracts which end after 31 March 2013.

The provision for legal claims reflects current legal advice regarding the number of outstanding claims and the probability of the sums awarded.

32. Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities	**(256)**	(215)
Net Value of Contingent Liabilities	**(256)**	(215)

The contingent liability relates to outstanding legal claims and has been determined on the basis of legal advice. It is a potential liability that is not provided for but is disclosed. The contingent liability of £256k represents the difference between the total value of the outstanding legal claims (£997k) and the expected value of payments (£741k in note 31) that legal advisors believe will have to be made.

Contingent Assets

The North East SHA had no contingent assets in 2012-13 or 2011-12.

33. Impact of IFRS treatment 2012-13

The North East SHA has no charges due to the impact of IFRS treatment in 2012-13 or in 2011-12.

34. 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 SHA 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 SHA's expected purchase and usage requirements and the SHA is therefore exposed to little credit, liquidity or market risk.

Currency risk

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

Interest rate risk

SHAs are not permitted to borrow. The SHA therefore has low exposure to interest-rate fluctuations

Credit Risk

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

Liquidity Risk

The SHA 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 SHA is not, therefore, exposed to significant liquidity risks.

34.1 Financial Assets

	Loans and receivables £000	Total £000
Receivables - NHS	546	**546**
Receivables - non-NHS	9	**9**
Cash at bank and in hand	59	**59**
Total at 31 March 2013	**614**	**614**
Receivables - NHS	1,983	1,983
Receivables - non-NHS	54	54
Cash at bank and in hand	43	43
Other financial assets	35	35
Total at 31 March 2012	2,115	2,115

34.2 Financial Liabilities

	Other £000	Total £000
NHS payables	870	**870**
Non-NHS payables	1,463	**1,463**
Other financial liabilities	1,736	**1,736**
Total at 31 March 2013	**4,069**	**4,069**
NHS payables	1,770	1,770
Non-NHS payables	1,297	1,297
Other financial liabilities	2,596	2,596
Total at 31 March 2012	5,663	5,663

35. Related party transactions

Details of related party transactions with individuals are as follows:

Organisation Name	Relationship	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party
		£	£	£
Premier Waste Management	Sir Peter Carr, CBE, DL	1,348		117
University of Sunderland & subsidiaries	Prof Peter Fidler, MBE, DL, DipTP, DipSoc, MRTP	674,638		
Newcastle University	Prof Oliver James BA, MA, BM, BCh, FRCP, F,Acad.Med.Sci	4,079,397	31,506	985
University of Sheffield	Kathryn Riddle/ Sarah Harkness/Ian Walker	90,720		

The Department of Health is regarded as a related party. During the year North East SHA 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. For example :

Strategic Health Authorities
NHS Foundation Trusts
NHS Trusts
NHS PCT's
NHS Litigation Authority
NHS Business Services Authority

In addition, the SHA has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:-

Northumbria University
Teesnap Ltd
HM Revenue and Customs
Newcastle University
NHS Pensions Agency
New College Durham
University of Sunderland

36. Losses and special payments

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

	Total Value of Cases	Total Number of Cases
	£	
Losses	45,349	8
Total losses and special payments	45,349	8

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

	Total Value of Cases	Total Number of Cases
	£	
Losses	12,844	14
Special payments	40,000	1
Total losses and special payments	52,844	15

37. Third party assets

The North East SHA had no third party assets in 2012-13 or in 2011-12.

38. Pooled budget

The North East SHA had no pooled budgets in 2012-13 or in 2011-12.

39. Cashflows relating to exceptional items

The North East SHA had no cash flows relating to exceptional items in 2012-13 or in 2011-12.

40. Events after the end of the reporting period

Following the Heath and Social Care Act (2012), the SHA was dissolved on the 31 March 2013. The main functions carried out by North East SHA in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

- Health Education England
- NHS England
- NHS Trust Development Authority
- Public Health England
- Health & Social Care Information Centre

The SHA has put processes in place throughout 2012/13 to ensure the safe discharge of services and ensure a smooth transition. This will ensure that the SHAs duty to commission high quality education services across the NHS, provide support and leadership to Trust which have yet to obtain Foundation status and all other statutory duties will continue to be discharged by the successor organisations.

The SHA has been actively involved in the national process in arranging the transfer of balances post 31 March 2013. All short term balances will be discharged during the first quarter of 2013/14 and any long term balances will adhere to national policy and be transferred to the successor organisation.

In addition to the transfer of funtions, the lease for Waterfront 4, as the principal place of business of the SHA, has transferred to NHS Property Services on 31 March 2013 and any related balance sheet items will also transfer on the same date.

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE STRATEGIC HEALTH AUTHORITY 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of Signing Officer for the final accounts of North East Strategic Health Authority 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 Strategic Health Authority;

- 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 Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed Janet .....

Date 29/05/13

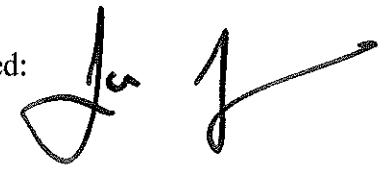
2012/13 ACCOUNTS FINANCE CERTIFICATE OF ASSURANCE TO THE DEPARTMENT OF HEALTH DIRECTOR GENERAL, STRATEGY FINANCE AND NHS

I am aware that as Signing Officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of North East Strategic Health Authority (SHA) in order to comply with the Department's 2012/13 accounts finalisation process.

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

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

Name: JANE TOMLINSON

Signed: 

Date: 29/05/13

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 North East Strategic Health Authority (SHA) 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 SHA:

- 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 SHA;
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the SHA;
- 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: S. J. SINGLETON

Signed: 

Date: 31. 5. 13

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR NORTH EAST STRATEGIC HEALTH AUTHORITY

We have audited the financial statements of North East Strategic Health Authority 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 table of salaries and allowances of senior managers and related narrative notes on pages 73 to 75;
- the table of pension benefits of senior managers and related narrative notes on pages 76 and 77; and
- the pay multiples and related narrative notes on page 78.

This report is made solely to the Accountable Officer for North East Strategic Health Authority 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.

Respective responsibilities of the Signing Officer and auditors

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Authority's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Authority; 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 North East Strategic Health Authority 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 properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Authority, or an officer of the Authority, 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 Authority 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 in November 2012, We have considered the results of the following:

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities at the Authority; and
- our locally determined risk-based work on managing transition issues arising from the abolition of the Strategic Health Authority.

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

Certificate

We certify that we have completed the audit of the accounts of North East Strategic Health Authority in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Mark Kirkham CPFA ACA, Engagement Lead, for and on behalf of Mazars LLP

Chartered Accountants
The Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

5 June 2013