Newcastle Primary Care Trust

2012-13 Annual Report and Accounts

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Newcastle Primary Care Trust

2012-13 Annual Report

NEWCASTLE PRIMARY CARE TRUST

2012-13 ANNUAL REPORT

1 About us

Newcastle Primary Care Trust (PCT) was established in 2001 with responsibility for providing a wide range of community health services and commissioning healthcare for the city's 273,000 residents. Since then the organisation has undergone a number of significant changes.

First, in 2006 we developed a shared management team with North Tyneside PCT and Northumberland Care Trust and two years later our community health services were integrated with those at North Tyneside PCT.

The next major change happened on 1 April 2011, in line with the national policy 'transforming community services', when we transferred 1,644 staff who worked in the community to provide healthcare or health services, such as district nurses and health visitors, to Newcastle upon Tyne Hospitals NHS Foundation Trust.

At this point we became a commissioning organisation only, with our staff based at our headquarters at Bevan House, Newcastle Great Park.

However, the biggest change for the PCT was heralded in July 2010 when the government published its White Paper 'Equity and excellence: liberating the NHS'.

This signalled a fundamental shift for NHS commissioning with the abolition of PCTs, the establishment of clinical commissioning groups (CCGs) and the transfer of our public health improvement responsibilities to local authorities, from 1 April 2013.

The Health and Social Care Bill gained royal assent in March 2012 which meant that from 1 April 2013 CCGs became responsible for making sure that the right local health services are planned and commissioned to meet the healthcare needs of local people.

We worked closely with the two Newcastle CCGs, NHS Newcastle West CCG and NHS Newcastle North and East CCG to support them in taking on their new responsibilities and more recently with the North of England Commissioning Support Unit (NECS), which provides support services for the CCGs.

We also worked closely with Newcastle City Council, and the Association of North East Councils (ANEC) to ensure a smooth transfer of responsibilities for public health and with the emerging Cumbria, Northumberland and Tyne & Wear Area Team of NHS England in relation to other functions that transferred there from our PCT.

We were one of 12 primary care organisations (PCO) in the North East, organised for several years into four PCO clusters. We worked with the North East Strategic Health Authority, which was our link to the Department of Health.

We worked closely with our main providers of healthcare and health services who are GPs and other independent contractors, Newcastle upon Tyne Hospitals NHS Foundation Trust, Northumberland, Tyne and Wear NHS Foundation Trust and North East Ambulance Service NHS Foundation Trust. We also had close links with Newcastle City Council and the community and voluntary sector in the city.

This annual report and accounts is the last to be published by Newcastle PCT, for future information for NHS commissioning information for Newcastle upon Tyne post April 1, 2013, please go to:

www.newcastlewestccg.nhs.uk

www.newcastlenorthandeastccg.nhs.uk

or seek information from the Cumbria, Northumberland, Tyne & Wear Area Team of NHS England by visiting www.england.nhs.uk

For information on public health, visit www.newcastle.gov.uk

2 Overview of the year

During 2012-13 our focus was very much on supporting the new NHS organisations, particularly NHS Newcastle North and East and NHS Newcastle West CCGs and NECS through a stringent authorisation process as they have prepared to take on new responsibilities. We also had to remain focused on making sure that our day to day work commitments were delivered as well as preparing for an efficient close down of the PCT.

As a result many of our staff worked between organisations and it was only since the autumn that there was more certainty about where they would be working in the future.

Against this background it is important to say how proud we were at the way our staff conducted themselves during such a prolonged period of change and uncertainty. They remained committed to making sure that it was business as usual and did their very best not to be distracted by concerns about their own futures, remaining dedicated to the job at hand. As such we tackled some big challenges in year and approached the year-end knowing that we would meet our statutory obligations.

Patients were foremost in our work, underpinned by robust clinical and financial management which gave our best possible start to the CCGs.

We also tackled some challenging issues during the year. Working closely with the two acute foundation trusts, we achieved an enviable position in relation to waiting time targets, but we had had a relatively small number of long waiters, in orthodontics, complex orthopaedics and trauma. We all recognised that patients rightly want their treatment as quickly as possible and we were pleased that significant progress was made towards eliminating these long waits.

The NHS in Newcastle continued to perform well on reducing healthcare acquired infections but meeting the target had become difficult as it takes only a small number of cases to threaten this. It is a credit to all concerned that despite such challenging targets, improvements continued.

As part of our many efforts to reduce avoidable attendances at accident and emergency (A&E) departments we worked closely with both of the universities in Newcastle to encourage students to register with a GP at the same time as they registered for their course. We did this by attending the course registration events and providing students with information to help them to make an informed choice about which practice to register with. This not only gave young people, many of whom are new to the city, better access to healthcare but it helped to avoid inappropriate and costly attendances at A&E departments.

In terms of other activities during the year, our staff and the NHS in general rose to the challenges presented by the Olympics. There was successful planning to ensure that many thousands of people could enjoy the games at St James's Park and the torch relay through the city centre. Over this period it was absolutely essential that we had excellent emergency planning arrangements in place and also that we took steps to make sure that visitors to the city knew how to access NHS services should this be necessary.

Throughout the year we supported activity to encourage pregnant women to have whooping cough vaccinations to protect their newborn babies. We also reminded parents to protect their children from measles by making sure they had two doses of the MMR vaccination. This activity followed a rise in cases of whooping cough and measles throughout the country.

We supported activity across the region to encourage members of the public in the at risk groups to have their flu vaccination and get flu safe. We also raised awareness of Catch it, Bin it, Kill it, and encouraged people to promote good hand hygiene to prevent infections spreading such as flu and the common cold.

With the help of community pharmacies we also publicised a convenient scheme for many patients to get their flu vaccination by simply walking into selected pharmacies across Newcastle, North Tyneside and Northumberland. This local enhanced service contract with community pharmacy was introduced in 2011 to help the working age population who found it more accessible to attend a pharmacy. The

scheme proved to be popular and we extended it to those over 65 who were at risk of flu.

The Think Pharmacy First (TPF) minor ailments community pharmacy scheme continued to be popular with patients. TPF offered patients who qualify for free prescriptions, due to low income, the choice of going straight to their pharmacist for a consultation, advice, and if appropriate, treatment. An added benefit was that GPs had more time to see those patients with more complex health needs.

We ensured ongoing publicity for the TPF scheme throughout the year, including hay fever in spring, head lice in September and coughs and colds in the winter. TPF was also publicised alongside our ongoing Choose Well campaign. This used a colour coded thermometer to actively promote the best use of services and helped direct the public to which is the best urgent care service to use for different conditions.

A huge amount of planning also took place to prepare for the implementation of NHS 111 on 1 April 2013. This was a nationally driven initiative which was piloted in a number of areas around the country, including County Durham, and aimed to make sure that members of the public requiring urgent healthcare received it more quickly and efficiently. We were aware that when they become ill, people can sometimes be confused over which service to access and we hoped that NHS 111 would be of great benefit to them.

Following the transfer of the majority of our community services to Newcastle upon Tyne Hospitals NHS Foundation Trust on 1 April 2011, there were still a small number of residual services for which we needed to find new management arrangements. These included the Grainger Medical Practice in Benwell, which following a procurement exercise is now managed by Care UK and the interpreting services for which a procurement exercise was also completed.

Work continued to progress the development of West One, a new NHS centre in Benwell, new facilities that we know are much awaited by the local community.

In January and February we engaged patients from the Gateway practice in Walker to help them find a new GP practice. This followed a mutual decision by Malling Health which managed the practice that was established two years ago and the PCT to disperse the patient list. This followed Lord Darzi’s review of the NHS which led to an increase in GP practices in some towns and cities, including Newcastle. Although the practice was providing high quality healthcare, despite vigorous efforts, it had not managed to recruit to its patient list as expected. Consequently the list size was less than 700 which made it the smallest GP practice across the North of Tyne. There were several GP practices in the vicinity that patients could choose to register with.

In February, the publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC set out almost 300 recommendations that all NHS organisations needed to consider in moving forward. Meeting these

recommendations and ensuring the highest possible levels of quality and safety will be a priority for the new NHS organisations in the future and the work required will build on actions taken following the report published after the first Mid Staffordshire inquiry.

All in all, we can be proud of what we have achieved in the past 12 years over the life of Newcastle PCT. We handed over to new organisations a legacy of performance against key targets to improve health and health care for the people of Newcastle.

We recognised that none of this would have been possible without the commitment and expertise of our own staff and those in other NHS bodies across the city. We were very grateful for the working relationships that we enjoyed with our key partners including Newcastle City Council and the community and voluntary sector and last but not least with the public who we have served.

3 Improving performance

2012-13 was both a challenging and successful year with a focus on maintaining and improving upon previous waiting times across a range of clinical pathways. There was particular focus on reducing the number of patients waiting for consultant led services.

Throughout the year high standards were consistently maintained relating to waiting times for cancer diagnosis and treatment.

Significant reductions in the numbers of health care acquired infections were achieved by close collaborative working across the health economy. The number of reported MRSA and C.Diff cases, which are types of bacterial infection that are resistant to a number of widely used antibiotics, were reduced compared to previous years.

The North East Ambulance Service NHS Foundation Trust responded within the eight minute target for urgent and life threatening emergencies.

Areas which were of concern and where the expected levels of performance were not achieved relate to the smoking cessation initiative and offering and delivering the number of health checks to the eligible population. A significant amount of work was achieved in these areas and will continue to be areas of focus in the forthcoming year.

4 Supporting the transition process

Over the last year more clarity was gained concerning the transition process to new NHS organisations, meaning that we started to make progress over where different functions of the PCT would go in the future.

A significant amount of work took place to support the city's two clinical commissioning groups. During the year the CCGs received advice from the NHS Commissioning Board on how their new organisations should be named which prompted the name changes from Newcastle Bridges CCG and Tyne Health CCG to NHS Newcastle West CCG and NHS Newcastle North and East CCG, to reflect the geographical areas each body has statutory responsibility for.

The lead GP chairs for each were also formally appointed as Dr Guy Pilkington for NHS Newcastle West CCG and Dr Relton Cummings for NHS Newcastle North and East CCG.

We worked closely with them on their authorisation process to ensure they were in a good position to be formally established as CCGs in their own right and take on new responsibilities under the Health and Social Care Act 2012.

A major aspect of this process included independent consideration of key policies and documents produced by the CCGs, followed by a panel visit which took place during November 2012 to explore their readiness to take on their new responsibilities.

Another element of this authorisation was a 360°stakeholder survey where key partners were identified and asked to take part in a survey, allowing the future NHS Commissioning Board to assess whether the relationships the CCGs have forged during transition with partners are likely to provide sufficient basis for effective commissioning. During the year both CCGs undertook activity to seek the public's views on health commissioning intentions and how health services should be shaped for the future.

The development of robust mechanisms for patient and public involvement was an important part of the authorisation process and as outlined later in the Planning for Better Services section, the CCGs have carried out specific activities to involve particular communities of interest.

On a more on-going basis both CCGs are undertaking various ways to involve stakeholders, patients and Newcastle's vibrant voluntary and community sector in their commissioning plans.

They have an active role in the city's Health and Wellbeing Board, they also attend the health and wellbeing overview and scrutiny committee, and take part in community and voluntary sector forums. Both CCGs have specific plans for the future which they developed through authorisation and have CCG wide patient forums with lay representatives who champion patient and public involvement in the work of the CCG.

Further developments took place for the two Newcastle CCGs working closely with NHS Gateshead CCG, and they agreed to have shared management arrangements with what became known as the Newcastle and Gateshead CCG Alliance. Key

appointments were made to the management team including former NHS North of Tyne directors Mark Adams as accountable officer (designate) and Joe Corrigan as chief finance officer (designate).

Also, a former consultant surgeon at Gateshead Hospitals NHS Foundation Trust, Mr Bill Cunliffe was appointed as secondary care specialist on the joint CCGs board and Gateshead GP and former NHS North of Tyne deputy medical director Dr Neil Morris was appointed as medical director.

During November and December recruitment took place for lay members of the CCG boards who provide strategic overview for each organisation, similar to that provided by non-executive directors. Michael Burke was appointed governance lay member (designate) for NHS Newcastle North and East CCG and Oliver Wood took up the patient public involvement lay member (designate) role.

Mandy Taylor was appointed NHS Newcastle West CCG's patient public involvement lay member (designate) and Jeff Hurst as the governance lay member (designate) role.

In February 2013 both CCGs received official notification from the NHS Commissioning Board that they had the go ahead to be become fully authorised as clinical commissioning groups for the city.

The North of England Commissioning Support Unit (NECS), the organisation that provides commissioning support and business services for local CCGs developed over the year and went from strength to strength as it secured contracts to support NHS Cumbria CCG as well as providing at scale services to CCGs and commissioning support units (CSUs) across the North East, Cumbria, West Yorkshire and North Yorkshire and Humber.

Under the leadership of managing director (designate) Stephen Childs, NECS passed various checkpoints on the road to authorisation and received extremely positive reviews by the NHS Commissioning Board, achieving the highest cumulative score of any CSU in the country.

During the year significant efforts were made to ensure staff were informed about changes happening including regular chief executive-led staff meetings, regular staff bulletins and updates.

From September 2012 onwards more clarity was gained over new receiving NHS organisations staffing structures and local staff engagement took place giving colleagues the opportunity to feedback on local CCG and commissioning support structures. Some changes were made as a result of this engagement and it also helped staff understand how new organisations would work in partnership in the future.

Meanwhile a national HR transition process and time frame was published meaning that a North East partnership board was established with staff side, union representatives and management to help support a smooth process and staff scrutiny over the matching of staff to jobs, recruitment and transfer where appropriate to new bodies. This was in addition to our ongoing engagement with the NHS North of Tyne staff side.

In December, the NHS Commissioning Board area team structures for Cumbria, Northumberland, Tyne & Wear and for Durham, Darlington and Tees were published.

The structures were based on proposed structures that were consulted on and agreed with national staff trades union representatives.

Senior members of the area team were appointed under the interim directorship of our Chief Executive Chris Reed and it was agreed that the two local area teams across the North East would continue to maintain a single commissioning structure for primary care which is hosted by the Durham, Darlington and Tees area team. In January 2013, John Lawlor, formerly a PCT Chief Executive in West Yorkshire who also had executive level experience of working in NHS trusts, was appointed as the area team lead director.

Cumbria, Northumberland, Tyne & Wear hosted the specialised services commissioning team who commissioned those low volume but high cost NHS services for the North East and Cumbria.

In terms of the transfer of public health responsibilities our public health staff under the leadership of director of public health for Newcastle Dr Fu Meng Khaw, moved to Newcastle Civic Centre in January 2013, where they worked closely with the Council's management team as the local authority took on new responsibilities for commissioning public health.

During the year more details on the national public health body Public Health England (PHE) emerged and they became the expert voice for public health from April 2013.

5 Planning for better services

A locality delivery plan was jointly developed by the two CCGs working closely with us at NHS North of Tyne and focused on tackling health inequalities and improving the wellbeing of people living across the city.

Schemes in the plan included reducing waste from medicines and changing patients to drugs that were equally effective but cheaper for the NHS to buy and GPs working

more closely with care homes across the city to reduce the number of old people being taken into hospital.

An example of one of the schemes involved training up GP and practice staff to be better able to assess patients with chronic obstructive pulmonary disease (COPD), previously known as emphysema.

COPD accounted for a high number of unplanned admissions into hospital in Newcastle – around 1000 per year. Both CCGs' plans looked at how this number could be significantly reduced if patients were regularly assessed by health staff in the community both when their condition was stable and when they were having problems breathing. It was anticipated that this could reduce the number of hospital admissions for people with COPD by 20 per cent in the next five years.

Other objectives set out in their plan included improving 24-hour monitoring of blood pressure for local people to assess whether they were suffering from the condition. Other key priorities included improving education for newly diagnosed people with diabetes. This meant reducing waiting times for patients to learn how to manage their condition better, improved specialist foot care provision as well as enhanced access to retinal screening.

Older people's healthcare, in particular looking at falls services and the integration of care to prevent hospital admissions were just some of the areas of joint work being developed.

All of these plans were subject to increased local clinical and stakeholder involvement in decisions about how services should be accessed, provided and designed for patients, moving towards commissioning with a health outcomes focus. They were reviewed by the patient forums and were subject to the input of the community and voluntary sector.

Over the year both CCGs undertook specific public engagement activities to ensure that local stakeholders were involved in shaping the local commissioning intentions to plan and purchase health care and health services for the population of the city. In the west, the CCG built upon work they had led on the previous year when they hosted a conference to look at particular issues of health commissioning around the black and minority ethnic communities of which there were high populations in that area of the city.

Newcastle North and East led a conference for the city in September 2012 looking at the issues stakeholders felt were important in delivering healthcare to an aging population and what this would mean to the commissioning of older people's services.

Working closely with partners in social care and the city's Health and Wellbeing Board, over 70 people attended from organisations interested in older people.

The outputs from the conference were worked into the 2013-14 commissioning plans for both CCGs.

6 Communicating with our staff

Clearly for our staff a major concern was where they would be employed post 1 April 2013, so it was very important for us to have a regular flow of information to ensure they were as up to date as possible about the HR process.

By the end of January 2013, most staff had transferred to either one of the CCGs, North of England Commissioning Support (NECS which is the commissioning support unit), the Area Team, Public Health or the NHS Commissioning Board.

This was an unsettling period of time for commissioning staff. We made significant efforts to ensure that we keep staff as up to date as possible. We knew that our staff network closely with peers and colleagues in other parts of the region's NHS so we co-ordinated key announcements with other PCTs in the region to ensure, where we could, that all staff received information at the same time and on a fair and equal basis. We did this through regular staff transition bulletins, regular staff meetings led by our chief executive as well as drop in sessions for staff to speak to our Chief Executive.

Consultation on the structures and job descriptions for NECS and the CCGs took place with staff and staffside representatives and they were encouraged to feedback any comments. A series of workshops were held by both NECS and the CCGs which staff were supported to attend.

We valued the input from staff side throughout this process.

7 Staff involvement in the community

Despite the uncertainty for their futures, our staff continued to be involved in supporting their local communities and campaigning for issues they felt strongly about. Rather than send Christmas cards to each other staff decided to donate money to St Oswald's Hospice, which provides specialist care for local adults, young people and children. They also took part in Cancer Research UK's Race for Life. Other staff continue to volunteer for their local communities in various ways including the scout and guide movement.

8 Preparing for emergencies

The NHS Operating Framework identified emergency preparedness as a high priority and required PCTs to maintain and test arrangements to deliver an effective response to threats and hazards. In addition, PCTs were designed as 'category one'

responders under the Civil Contingencies Act 2004 and therefore had a statutory duty to prepare plans for responding to emergencies and major incidents which may have affected their local area. From April this responsibility transferred over to Cumbria, Northumberland, Tyne and Wear Area Team.

Over the past twelve months we continued to work closely with NHS colleagues and other partner agencies to ensure that these plans were robust and that they took account of local risks and national policy. This was supported by a number of training events and regular multi agency exercises to test our plans and highlight any issues to be addressed.

Preparation work to ensure that the NHS was prepared for the Olympics 2012 paid off as Newcastle was one of the host cities for football. Nine matches were held at St James's Park last July and August and as expected there was a large influx of visitors to the region. The Olympic Torch Relay also travelled through the north of Tyne area over two days last June. Steps were taken to minimise disruption to health services during that time.

The Choose Well campaign message was also stepped up and plans were in place to ensure visitors to the city had good access to information on how to use local urgent care services – in particular to help minimise impact on A&E at Newcastle's Royal Victoria Infirmary which is close to St James's Park and also inappropriate calls to 999. Activity included placing all Choose Well information in all city hotels, briefing hotel senior staff, Choose Well and public health messages incorporated into Olympics social media and Choose Well TV adverts were displayed on outdoor screens during screening of matches.

9 Ensuring safety of personal information

We remained committed to safeguarding personal information about patients, service users and staff, by embedding information governance (IG) into everything we did.

Our approach brought together all the legal rules, guidance and best practice that applied to recording and handling personal information, underpinned the provision of high quality services and ensured that we didn't cause unnecessary anxiety or distress to individuals due to lost or inaccurate data.

Our staff worked hard to complete their IG annual training and continued to show a high level of understanding and competency during spot checks and within their normal working practices. This meant patients and service users were reassured not only about the confidentiality of their personal information, but that the right information was available to healthcare professionals for their treatment needs.

Our commitment wasn't restricted to our own activities – we expected all our partner and sub-contractor organisations to maintain confidentiality and security of personal information too, by proving as part of the contracting process that they also adopted and maintained good and consistent IG practice.

The importance of good IG practice was never been greater, as the NHS prepared for the biggest change to healthcare delivery in its 65 year history. We worked closely with our partners and successor organisations to ensure that policies, procedures and working practices were fit for purpose for a smooth transition moving forward to the challenges ahead.

During 2012-13, the following data loss incidents were reported:

SUMMARY OF SERIOUS UNTOWARD INCIDENTS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2012-13				
Date of incident (month)	**Nature of incident**	**Nature of data involved**	**Number of people potentially affected**	**Notification steps**
No incidents were reported during the year				
Further action taken	Not applicable			

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2012-13		
Category	**Nature of incident**	**Total**
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	1
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	4
V	Other (e.g. loss of ID badge)	10

10 Patient Safety

10.1 Serious incidents

A serious incident requiring investigation is an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm;
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- A 'Never Event' as defined by the National Patient Safety Agency. These are largely very serious, preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

In 2012-13, 313 serious incidents were received into the national NHS reporting system for such incidents (StEIS). The total number of SIs reported during this period together with incident grading by provider (sector) was:

Total Numbers of SIs reported

Quarter	Grade	NHSD	Indep Contract	NHS NoT	NHCFT	NEAS	NuTHFT	NTW	Totals
Q1	0	0	0	0	0	0	0	0	**0**
	1	0	1	3	35	1	**6**	20	**66**
	2	0	1	1	0	0	3	3	**8**
	Totals	**0**	**2**	**4**	**35**	**1**	**9**	**23**	**74**
Q2	0	0	0	0	0	0	0	0	**0**
	1	0	2	2	27	1	13	24	**69**
	2	0	0	2	1	0	0	1	**4**
	Totals	**0**	**2**	**4**	**28**	**1**	**13**	**25**	**73**
Q3	0	0	0	0	0	0	0	0	**0**
	1	0	5	2	31	6	17	21	**82**
	2	0	0	4	1	0	0	0	**5**
	Totals	**0**	**5**	**6**	**32**	**6**	**17**	**21**	**87**
Q4	0	0	0	0	0	0	0	0	**0**
	1	1	1	0	20	8	23	24	**77**
	2	0	0	0	0	0	1	1	**2**
	Totals	**1**	**1**	**0**	**20**	**8**	**24**	**25**	**79**
	Totals per Trust	**1**	**10**	**14**	**115**	**16**	**63**	**94**	**313**

Explanation of Grades

Grade 0: Notification is only necessary if it is unclear as to whether a serious incident has occurred. If within three working days it is found not to be a serious incident, it can be downgraded. If a serious incident has occurred it will be regraded as a grade 1 or 2.

Grade 1: Examples include mental health – deaths in the community, avoidable or unexplained death, mental health – attempted suicides as inpatients, ambulance services missing target for arrival resulting in death or severe harm to patient.

Grade 2: Examples include maternal deaths, inpatient suicides (including following absconsion), child protection, adult safeguarding, Never Events, accusation of physical misconduct or harm.

Explanation of abbreviations

NHSD:	Northern Doctors Out of Hours Service
Indep Contract	Independent Contractors
NHS NoT:	NHS North of Tyne
NHCFT:	Northumbria Health Care NHS Foundation Trust
NEAS:	North East Ambulance Service NHS Foundation Trust
NuTHFT:	Newcastle Upon Tyne Hospitals NHS Foundation Trust
NTW:	Northumberland Tyne & Wear NHS Foundation Trust

243 serious incidents remained open on StEIS for future management by designated CCGs according to GP registration of the patient involved in the incident:

CCG	Number of SIs open	Rationales
Northumberland	**82**	Patients registered with GPs in Northumberland
Newcastle Alliance	**83**	Patients registered with GPs in Newcastle
North Tyneside	**40**	Patients registered with GPs in North Tyneside
Out of Area	**23**	NuTH, NEAS & NTW patients
Unknown	**15**	Unable to identify GP – continue to pursue
Total	**243**	

However three Trust were specialty / tertiary centres, that treated patients ‘out of area’, from across the region and in some cases nationally. These were Newcastle upon Tyne Hospitals NHS Foundation Trust, North East Ambulance Service NHS Foundation Trust and the mental health services at Northumberland Tyne & Wear NHS Foundation Trust.. 23 incidents related to ‘out of area’ patients at these tertiary centres and agreement was reached that these will be allocated to CCGs locally to ensure completeness of the SI investigation. Similarly, some incidents awaited allocation pending confirmation of the host CCG.

Monthly reports of serious incident activity were provided to individual Clinical Commissioning Groups from December 2012 thereby ensuring as continuity post 31 March.

In respect of Never Events, six were reported for the same period:

- Three were Grade 2 events and one Grade 1 event as reported by NuTH.
- Two Grade 2 events were reported by NHCFT.

For each Never Event a 'root cause analysis' was undertaken and a detailed action plan, with specific milestones agreed with the PCT's patient safety team. The Board received assurance that appropriate actions were fully implemented through formal reporting prior to closure of the incident on StIES.

10.2 North East Ambulance Service NHS Foundation Trust (NEAS) handover breaches

On 1st December NEAS implemented a policy that included addressing handover delays in excess of two hours at Accident and Emergency (A&E) Departments. This was undertaken with support from the Strategic Health Authority (SHA) as a strategy to investigate the anecdotal reports of prolonged waiting times encountered by ambulance crews trying to hand-over patients at A&E Departments and the consequent impacts on NEAS' performance targets.

Although the incidents weren't attributable to NEAS, they were asked to record any handover breaches onto StEIS. NHS North of Tyne maintained an overview of the numbers and locations of incidents and ensured that the other regional PCTs were kept abreast of the situation via regular updates and sharing of information.

In December 2012 and January 2013, 127 breaches were reported in total, primarily involving University Hospitals North Durham (UHND) and James Cook University Hospital (JCUH). One handover breach reported in January involved North Tyneside General Hospital. NEAS continued to report the numbers of breaches reported to them in order to triangulate information received by the various PCTs. In February, seven breaches were reported with 1 handover breach involving Queen Elizabeth Hospital in Gateshead.

10.3 Stop the Clock

'Stop the Clock' was a national initiative introduced to suspend response times for those incidents subject to external factors such as those awaiting verdicts from H.M. Coroner. These incidents were historically kept open until a verdict was achieved; this could have caused a considerable delay and a decision was made to declare such incidents to the SHA and cease counting the mandatory response times. The

clock was restarted once a verdict was delivered. There remains 'clock stops' on 10 incidents

10.4 Safeguarding

The Continuing Health Care and Intensive Case Review Teams continued to undertake quality assurance visits to nursing and residential care homes, both proactively and in response to Care Quality Commission concerns / alerts. There was regular attendance by NoT's Continuing Healthcare Team at the CQC's monthly and quarterly three-way information-sharing meetings and this was effective in updating and disseminating information to patient safety and safeguarding Leads.

There were 35 establishments and 16 individuals subject to regular inspection / support and / or QA visits provided by these two teams with support from additional PCT clinical staff. Several establishments were subject to intensive remedial action and remained closed to admissions. The Stop the Clock mechanism was applicable to one organisation in view of an on-going investigation.

Since the vertical integration of community services, the pathways for reporting child-related safeguarding incidents required clarification and collaborative working. The majority of non-accidental injuries were highlighted to North of Tyne via the Designated Safeguarding Nurses and were reflected back to the Trusts involved for reporting as serious incidents.

11 Looking after the environment

The PCT's Sustainability Strategy and Management Plan identified the following challenging outcomes:

- 10% reduction in energy and carbon by 2015
- Adopt a sustainable procurement model
- A reduction in staff travel emissions by 2015
- A 25% reduction in metered water consumption by 2020
- Recycle 50% of waste by 2015
- All new buildings to achieve a high environmental classification
- Awareness and training for all staff
- Develop Partnerships and Networks to support sustainable development
- Carbon reduction principles to be embedded in organisational policies

It is a requirement that Government bodies report their energy use and carbon emissions in a consistent way so that comparisons can be made between different public sector bodies.

There were significant improvements in carbon reduction across the whole of the PCT Careful temperature management of buildings led to a reduction in gas usage and the introduction of solar panels at many of the PCT's sites has had an impact on mains electricity usage while also generating income from Feed in Tariffs within the National Grid. In addition water usage is now more accurately measured and reported in line with the requirements of Government Sustainability Reporting which will provide a more robust basis for management in the future.

Energy Use and Carbon Emissions 2012/13

Area	Brief	Non-Financial Information	Financial Information
Greenhouse Gas Emissions	Scope 1 Direct emissions	602 tCO_2e 3,274,500kWh	£ 101,569
	Scope 2 Indirect emissions	739 tCO_2e 1,410,800kWh	£ 264,776
	Scope 3 Official Business Travel	44 tCO_2e	£51,891
Waste minimisation and management	Total waste arising	242.62 Te	£44,861
	Waste sent to landfill	230.42 Te	£41,261
	Waste recycled /reused	12.20 Te	£3,600
	Hazardous waste treatment	N/A	N/A
	Waste incinerated (no energy recovery)	N/A	N/A
Finite resources	Water usage	40,780m^3	£ 43,365

Units of measurement
tCO_2e tonnes of CO_2 equivalent
kWh kilo Watt hours
Te tonnes equivalent

Explanation of Categories

Scope 1: Direct emissions from sources owned or controlled by the PCT e.g. emissions from boilers, fugitive emissions from air conditioning units, etc.

Scope 2: Indirect emissions from energy consumed which was supplied by another party e.g. electricity supplied in buildings, etc

Scope 3: Emissions that related to paid/reimbursed official business travel.

12 Managing finance and risk

Integrated governance was the tenet to effective management of both clinical and financial risk. To this end and as part of the corporate governance structure an Integrated Governance Committee operated that was chaired by a non-executive director; who reported to audit committee at least quarterly. The focus of the Integrated Governance Committee was review and assurance on the Corporate Risk Register and Assurance Framework.

The Audit Committee was a sub committee of the Board that provided a means of independent and objective review of governance control systems, financial systems, financial information and compliance with law, guidance and codes of conduct. Membership of the Committee was entirely non-executive and it met at least bi-monthly with meetings being preceded by a private meeting with committee members and auditors only (i.e. without executive officers attendance). Reporting was direct to the Board and matters highlighted by the Audit Chair's briefing to the Board for 2012/13 made particular reference to the development of CCGs and continuing health care funding pressures which arose from the requirement for a provision for restitution cases. This provision of £2,600,000 (current & non current) related to an estimate of compensation costs for individuals who met appropriate continuing healthcare criteria and had previously borne the cost of nursing in private care as a direct personal expense, or where (following nursing assessment) individuals may be deemed retrospectively to have met the national criteria for free nursing care. There was, and remains a high degree of uncertainty inherent both in anticipating claims and in assessing the likelihood of success and eventual financial outcome. A contingent liability of £20,540,000 relating to continuing health care compensation claims was reported.

The internal audit service further supported the audit committee by evaluating and reporting on the effectiveness and adherence to the systems of internal controls that PCT had in place.

To support CCGs in their development to authorisation, the Board in May 2011, approved arrangements for the CCGs to be committees with delegated budgets, that reported to the Board. This arrangement was underpinned by NHS North of Tyne transitional framework with regular CCG meetings throughout the year as the means of Board assurance on CCG performance and financial stewardship.

13 Financial review and summary financial statements

This report contains summarised financial statements. Anyone who wishes to have a full understanding of our organisation's financial position and performance can get a full set of 2012-13 annual accounts free of charge from:

Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

13.1 Statutory financial duties

Newcastle PCT met all of its statutory duties for the 2012-2013 financial year with the following financial performance against these duties:

To keep spending within the revenue resource limit

The revenue surplus of £1,105,000 represented an underspend of 0.21% against the final revenue resource limit of £534,691,000.

To keep expenditure within the capital resource limit

The capital surplus of £118,000 represented an underspend of 6.46% against the final Capital Resource Limit of £1,826,000.

To keep cash outgoings within the cash limit

The year end cash balance was £24,000 against a cash limit of £532,095,000.

To ensure full cost recovery for provider (community) services

Community services for Newcastle PCT were fully commissioned, primarily from Newcastle Upon Tyne Hospitals Foundation Trust. As a consequence there were no hosted community services to demonstrate full cost recovery in 2012-13.

13.2 Financial performance

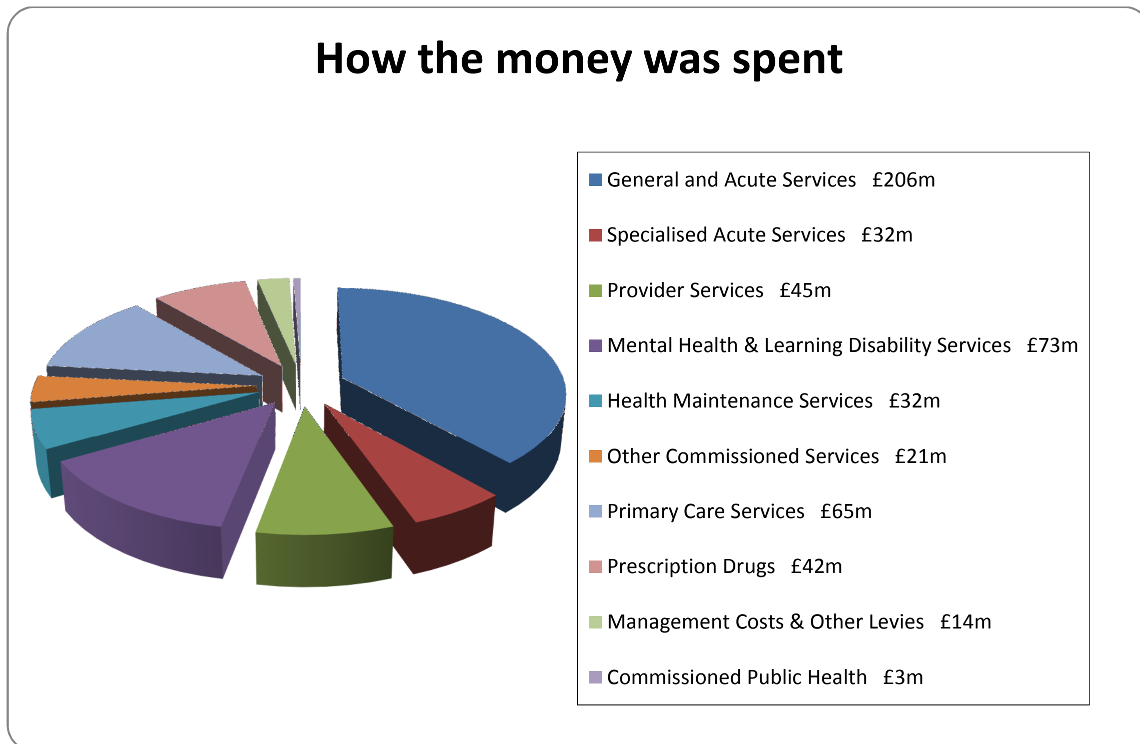
Newcastle PCT board approved a balanced budget for 2012-2013 before the start of the financial year and as part of a five year financial strategy.

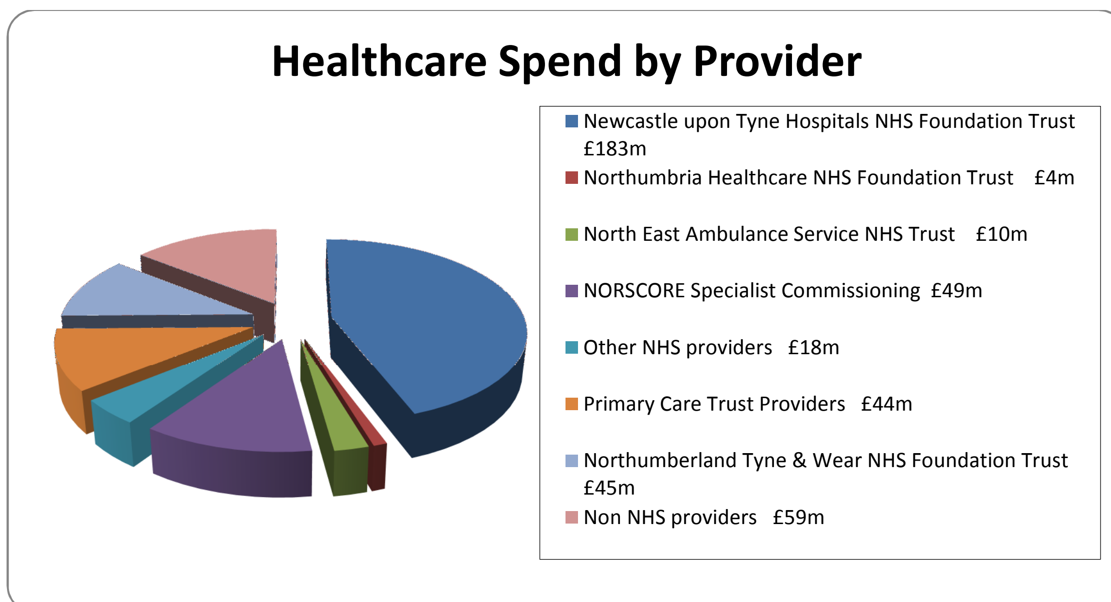
As part of wider financial management across the NHS, the PCT was required to achieve a revenue surplus, as with all of the primary care organisations in NHS North East.

As noted the surplus achieved was £1,105,000 despite facing a number of in-year cost pressures. Most notable, where expenditure was significantly above budgeted levels, was:

- £9.3m on continuing and funded nursing care.

Net expenditure in 2012-13 totalled £534m and was applied in the following way:





13.3 Key financial performance indicators

Revenue resource limit

The PCT's performance for 2012-13 is as follows:

Revenue resource limit	2012-13 £000	2011-12 £000
Total net operating cost plus (gain)/loss on transfers by absorption for the financial year	**533,586**	525,234
Final revenue resource limit for year	**534,691**	525,548
Underspend against revenue resource limit	**1,105**	314

Capital resource limit

The PCT is required to keep within its capital resource limit

Capital resource limit	2012-13 £000	2011-12 £000
Gross capital expenditure	**1,858**	2,461
Asset disposals	**(150)**	0
Charge against the capital resource limit	**1,708**	2,461
Capital resource limit	**1,826**	2,463
Underspend against capital resource limit	**118**	2

Management of cash

Statement of cash flows for the year ended 31 March	2012-13 £000	2011-12 £000
Cash flows from operating activities		
Net operating cost before interest	**(533,510)**	(525,077)
Other cashflow adjustments	**6,249**	1,930
Movements in working capital	**(1,654)**	(1,576)
Provisions utilised	**(116)**	(58)
Interest paid	**(179)**	(181)
Net cash outflow from operating activities	**(529,210)**	(524,962)
Cash flows from investing activities		
Payments to purchase property, plant and equipment	**(2,801)**	(2,012)
Payments to purchase intangible assets	**(191)**	(147)
Proceeds of disposal of PPE & intangible assets	**150**	0
Interest received	**24**	24
Net cash outflow from investing activities	**(2,818)**	(2,135)
Net cash outflow before financing	**(532,028)**	(527,097)
Cash flows from financing activities		
Net parliamentary funding	**532,095**	527,129
Capital element of payments in respect of finance leases and LIFT	**(52)**	(48)
Net cash inflow from financing	**532,043**	527,081
Net increase / (decrease) in cash	**15**	(16)
Cash at the beginning of the financial year	**9**	25
Cash at the end of the financial year	**24**	9

Better payment practice code

There was a further financial obligation under the Better Practice Payment Code to pay 95 percent of creditors within 30 days of invoicing or receipt of invoice or goods, whichever was the later. Overall performance for the year was that 98.62% of correctly addressed and undisputed invoices were paid within the required 30 days as a percentage of the total value of invoices paid and 94.27% as a percentage of the total number of invoices paid in the year.

Better Payment Practice Code	**2012-13**	**2012-13**	2011-12	2011-12
	Number	**£000**	Number	£000
Non-NHS creditors				
Total bills paid in the year	**14,301**	**92,814**	13,265	87,748
Total bills paid within target	**13,400**	**88,522**	12,336	82,869
Percentage of bills paid within target	**93.70%**	**95.38%**	93.00%	94.44%
NHS creditors				
Total bills paid in the year	**2,654**	**357,015**	2,167	356,818
Total bills paid within target	**2,584**	**355,115**	2,046	354,796
Percentage of bills paid within target	**97.36%**	**99.47%**	94.42%	99.43%

Running costs

In order to prepare for the new system of GP Commissioning PCTs were required to report their running costs. The broad definition of running costs was that it would include any cost incurred that was not a direct payment for the provision of healthcare or healthcare related services. The point to note is that the total cost was divided by the weighted population to give a cost per weighted population for the organisation.

Running costs	**2012-13**	2011-12
Running costs (including Public Health) (£000)	**11,631**	11,022
Weighted population (number)*	**295,852**	295,852
Management cost per head of weighted population (£)	**39.3**	37.3

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

Analysis of secondary care expenditure

Secondary health care expenditure by category was as follows:

Purchase of hospital and community health services by care group	2012-13 £000	2012-13 %	2011-12 £000	2011-12 %
Learning difficulties	**2,769**	**0.7**	3,499	0.9
Mental illness	**69,892**	**17.1**	70,875	17.8
Maternity	**4,888**	**1.2**	4,905	1.2
General & acute	**222,918**	**54.6**	216,461	54.5
Accident & emergency	**12,289**	**3.0**	11,793	3.0
Community health services	**86,709**	**21.2**	80,040	20.2
Other contractual	**9,133**	**2.2**	9,647	2.4
Total expenditure	**408,598**	**100**	397,220	100

Audit arrangements

The PCT is subject to both internal and external audit. The external auditors, appointed by the Audit Commission, are Deloitte LLP, and their report on the PCT's summary financial statements is shown on page 33. The costs of external audit, together with comparable figures for 2011/12 are shown below:

Audit Costs	2012-13 £000	2011-12 £000
Accounts	**99**	154

Summary financial statements

Statement of Comprehensive Net Expenditure for the year ended 31 March	**2012-13 £000**	2011-12 £000
Commissioning		
Gross operating costs	**560,798**	554,245
Less: miscellaneous income	**(27,288)**	(29,168)
Commissioning net operating costs	**533,510**	525,077
Net operating costs before interest	**533,510**	525,077
Interest receivable	**(24)**	(24)
Other Losses	**(79)**	0
Interest payable	**179**	181
Net operating cost for the financial year	**533,586**	525,234

Statement of changes in taxpayers' equity for the year ended 31 March 2013	**General Fund £000**	**Revaluation Reserve £000**	**Total £000**
Balance at 1 April 2012	**(16,020)**	**4,324**	**(11,696)**
Net operating cost for the year	**(533,586)**		**(533,586)**
Net loss on revaluation of property, plant and equipment		**(79)**	**(79)**
Impairments		**(379)**	**(379)**
Transfers between reserves			
Total recognised income and expense for 2012-13	**(533,586)**	**(458)**	**(534,044)**
Net parliamentary funding	**532,095**		**532,095**
Balance at 31 March 2013	**(17,511)**	**3,866**	**(13,645)**

Statement of changes in taxpayers' equity for the year ended 31 March 2012	General Fund £000	Revaluation Reserve £000	Total £000
Balance at 1 April 2011	(17,915)	4,210	(13,705)
Net operating cost for the year	(525,234)		(525,234)
Net gain on revaluation of property, plant and equipment		206	206
Impairments		(92)	(92)
Total recognised income and expense for 2011-12	(525,234)	114	(525,120)
Net parliamentary funding	527,129		527,129
Balance at 31 March 2012	(16,020)	4,324	(11,696)

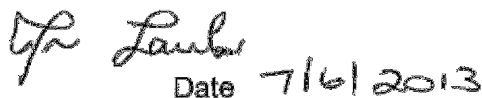
Statement of financial position as at 31 March	2012-13 £000	2011-12 £000
Non-current assets		
Property, plant and equipment	**20,837**	23,252
Intangible assets	**252**	167
Other financial assets	**168**	168
Total non-current assets	**21,257**	23,587
Current assets		
Trade and other receivables	**6,715**	11,390
Cash and cash equivalents	**24**	9
Non-current assets classified "Held for Sale"	**150**	**150**
Total current assets	**6,889**	11,549
Total assets	**28,146**	35,136
Current liabilities		
Trade and other payables	**(35,045)**	(41,832)
Other liabilities	**(222)**	(139)
Provisions	**(1,309)**	0
Borrowings	**(54)**	(51)
Total current liabilities	**(36,630)**	(42,022)
Non-current assets plus/less net current assets/liabilities	**(8,484)**	(6,886)
Non-current liabilities		
Provisions	**(1,385)**	(220)
Borrowings	**(2,462)**	(2,517)
Other liabilities	**(1,314)**	(2,073)
Total non-current liabilities	**(5,161)**	(4,810)
Total assets employed	**(13,645)**	(11,696)
Financed by:		
Taxpayers' Equity		
General fund	**(17,511)**	(16,020)
Revaluation reserve	**3,866**	4,324
Total Taxpayers' Equity	**(13,645)**	(11,696)

The 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 a Signing Officer.

John Lawlor

Signing Officer



Date 7/6/2013

13.4 Remuneration and terms of service committee

The salaries of the chief executive, executive directors and very senior managers were determined in accordance with arrangements set down by the Department of Health. The actual remuneration was decided by the joint remuneration and terms of service (RATS) committee. This was an integrated committee comprised of the chair and nominated non-executive directors of NHS North of Tyne.

The following non-executive directors sat on this committee over the past year:

Ms G Tiller, chair

Ms J Henderson

Mr N Bradbury

Ms D Jones

Ms P Denham

Mr N Barker

Mr D Willis

Ms M Coyle

Ms S Stokes White

There were no inflationary pay uplifts awarded in 2012-13 to senior managers in line with the recommendations set out by the Department of Health. Staff earning £21,000 or less received a flat uplift of £250. Other pay awards were consistent with the pay review bodies' recommendations.

The very senior managers' (VSM) was determined by the NHS pay framework for very senior managers. The scheme provided for an annual inflationary uplift and a bonus element based upon performance in the preceding year

In accordance with this NHS pay framework, no inflationary uplift was awarded for 2012-13. Performance related bonuses were restricted to no more than 25% of qualifying very senior managers, i.e. two executive officers, with the approval of the North East Strategic Health Authority in accordance guidance issued by the NHS Chief Executive.

The recipients of performance related bonuses in 2012-13 that equated to 5% of their salaries were Mr C Reed, Chief Executive and Mr M Adams, Director of Commissioning, being consistent with the DH guidance.

13.5 Remuneration report

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

The banded remuneration of the highest paid director in Newcastle PCT in the financial year 2012-13 was £175k to £180k (2011-12, £175k to £180k). In 2012-13, no employee received remuneration in excess of the total remuneration of the highest paid director.

In 2012-13, no employee received remuneration in excess of the highest paid director.

The cost to Newcastle of the highest paid director due to the North of Tyne cluster arrangement in the financial year 2012-13 was £60k to £65k (2011-12, £60k to £65k) This was 1.4 times (2011-12, 1.6) the median remuneration of the workforce, which was £42.6k (2011-12 £37.4k).

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

Additional notes

- All benefits in kind relate to the taxable benefits resulting from a lease car.
- Mike Guy held a joint post with County Durham PCT.
- The Chief Executive and Directors worked on a cluster basis across NHS North of Tyne.

Reporting of compensation schemes – exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Lees than £10,000	0	0	0
£10,001-£25,000	1	0	1
£25,001-£50,000	1	0	1
£50,001-£100,000	1	0	1
£100,001 - £150,000	4	0	4
£150,001 - £200,000	1	0	1
>£200,000	1	0	1
Total number of exit packages by type	**9**	**0**	**9**
Total cost	**£1,088,778**	**0**	**£1,088,778**

No special payments were made in relation to exit packages.

The staff for whom exit packages were paid in 2012-13 were employed by Newcastle Primary Care Trust as part of a shared management structure. The costs of their employment and redundancy were recharged by Newcastle PCT to North Tyneside PCT and the Northumberland Care Trust on a weighted capitation basis. North Tyneside's share of the redundancy costs was £285,913 and Northumberland's share was £427,345.

There were six staff for whom exit packages were paid in 2011-12 (four compulsory and two other departures). The total cost of these packages was £529,000.

Newcastle PCT remuneration report

		2012-13							
		Total salary (bands of £5,000)	Other remuneration (bands of £5,000)	Bonus payments (bands of £5,000)	Benefits in kind (rounded to nearest £00)	PCT share of salary (bands of £5,000)	PCT share of other remuneration (bands of £5,000)	PCT share of bonus payments (bands of £5,000)	PCT share of benefits in kind (rounded to nearest £00)
Name	**Title**	£000	£000	£000	£00	£000	£000	£000	£00
Chris Reed	Chief executive	175 - 180	345 - 350	5 - 10	19	60 - 65	115 - 120	0 - 5	7
Ian Davison	Director of informatics and project management	100 - 105	0	0	0	35 - 40	0	0	0
Joe Corrigan	Director of finance and estates	115 - 120	0	0	0	40 - 45	0	0	0
Mark Adams	Director of commissioning	115 - 120	0	5 - 10	0	40 - 45	0	0 - 5	0
Mike Guy	Medical director	150 - 155	0	0	105	25 - 30	0	0	18
Pauline Fryer	Board secretary/head of corporate affairs	90 - 95	180 - 185	0	28	30 - 35	60 - 65	0	10
Rachel Chapman	Director of public engagement and communications	85 - 90	100 - 105	0	0	30 - 35	35 - 40	0	0
Sue Gordon	Executive director of public health	105 - 110	0	0	0	35 - 40	0	0	0
Lesley Young-Murphy	Interim Director of Community Care and Organisational Development	95 - 100	0	0	1	30 - 35	0	0	0
Gina Tiller	Chair	35 - 40	0	0	0	35 - 40	0	0	0
Deborah Jones	Non-executive director	5 - 10	0	0	0	5 - 10	0	0	0
Pamela Denham	Non-executive director	5 - 10	0	0	0	5 - 10	0	0	0

Newcastle PCT remuneration report (continued)

		2012-13						
		RI in Pension at age 60 (bands of £2,500)	**RI in Lump Sum at age 60 (bands of £2,500)**	**Total accrued Pension at age 60 at 31 March 2013 (bands of £5,000)**	**Lump Sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)**	**CETV at 31 March 2013**	**CETV at 31 March 2012**	**RI in CETV**
Name	**Title**	£000	£000	£000	£000	£000	£000	£000
Chris Reed	Chief executive	(0 - 2.5)	(5 - 7.5)	80 - 85	245 - 250	1811	1716	6
Ian Davison	Director of informatics and project management	0 - 2.5	0 - 2.5	10 - 15	35 - 40	207	181	17
Joe Corrigan	Director of finance and estates	(0 - 2.5)	(0 - 2.5)	35 - 40	110 - 115	624	584	9
Mark Adams	Director of commissioning	0 - 2.5	0 - 2.5	20 - 25	60 - 65	372	337	17
Mike Guy	Medical director	0	0	0	0	0	0	0
Pauline Fryer	Board secretary/head of corporate affairs	(0 - 2.5)	(2.5 - 5)	40 - 45	120 - 125	0	820	(863)
Rachel Chapman	Director of public engagement and communications	0 - 2.5	0 - 2.5	10 - 15	40 - 45	334	301	17
Sue Gordon	Executive director of public health	(0 - 2.5)	(0 - 2.5)	40 - 45	125 - 130	845	795	8
Lesley Young-Murphy	Interim Director of Community Care and Organisational Development	0 - 2.5	2.5 - 5	15 - 20	50 - 55	322	278	29
Gina Tiller	Chair	0	0	0	0	0	0	0
Deborah Jones	Non-executive director	0	0	0	0	0	0	0
Pamela Denham	Non-executive director	0	0	0	0	0	0	0

INDEPENDENT AUDITORS' REPORT TO THE DIRECTORS OF NEWCASTLE PCT

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the revenue resource limit note, the capital resource limit note, the management of cash note, the better payment practice code note, the running costs note, the staff sickness note, the analysis of expenditure note, the audit arrangements note, Statement of Changes in Taxpayers' Equity and the Statement of Financial Position and the Statement of Comprehensive Net Expenditure.

This report is made solely to the Board of Directors of Newcastle PCT in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report.

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

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

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of Newcastle PCT for the year ended 31 March 2013.

Paul Thomson ACA, Engagement Lead,
For and on behalf of Deloitte LLP
Appointed Auditor
Newcastle, UK,
7 June 2013

Department
of Health

Newcastle Primary Care Trust

2012-13 Accounts

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Newcastle Primary Care Trust

2012-13 Accounts

Newcastle Primary Care Trust

Accounts for the period 1st April 2012 to 31st March 2013

NATIONAL HEALTH SERVICE ACT 2006
DIRECTIONS BY THE SECRETARY OF STATE FOR HEALTH IN RESPECT OF PRIMARY CARE TRUSTS' ACCOUNTS

The Secretary of State for Health gives the following Directions, with the approval of the Treasury, in exercise of powers conferred on him by sections 272(7) and (8) and 273(1) and (4) of, and paragraph 3(1) of Schedule 15 to, the National Health Service Act 2006[1]:

Application and interpretation

1. -(1) These Directions apply to Primary Care Trusts in England and the accounts of such bodies for the financial year ending 31st March 2013.
(2) In these Directions:
"The Accounts" means the accounts of a Primary Care Trust for the financial year;
"the current financial year" means the financial year ending 31st March 2013;
"the Primary Care Trust" means the Primary Care Trust in question.

Form of Accounts
2.-(1) The Accounts submitted under paragraph 5 of Schedule 15 to the 2006 Act must show, and give a true and fair view of, the Primary Care Trust's gains and losses, cash flows and financial state at the end of the current financial year.
(2) The Accounts must meet the accounting requirements of the NHS Manual for Accounts in force for the current financial year, which shall be agreed with the Treasury.

Statement of Responsibilities
3.-The statement of responsibilities in respect of the Accounts must be signed and dated by the an individual designated by the Department of Health's permanent secretary for the purpose.

Revocation
4. The directions given by the Secretary of State in respect of the form of accounts of Primary Care Trusts for the financial years prior to the current financial year are revoked.

Signed by authority of the Secretary of State for Health
Member of the Senior Civil Service, Department of Health

27 March 2013

[1] 2006 c.41.

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST

The Department of Health's Accounting Officer designates the Signing Officer of the accounts of PCTs in England, an officer of the Department of Health, to discharge the following responsibilities for the Department, to ensure that for the year ended 31 March 2013:

- there were effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money was achieved from the resources available to the primary care trust;
- the expenditure and income of the primary care trust had been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems were 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, I have properly discharged the above responsibilities, as designated Signing Officer and through experience in my role as Signing Officer until 31 March 2013.

Signed..Designated Signing Officer

Name: John Lawlor

Date 7/6/2013

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

Primary Care Trusts as NHS bodies are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the primary care trust and the net operating cost, recognised gains and losses and cash flows for the year. From 1 April 2013 responsibility for finalising the accounts falls to the Secretary of State. Formal accountability lies with the Department of Health's Accounting Officer, and her letter of 28 March 2013 designated the Signing Officer and Finance Signing Officer, to discharge the following responsibilities for the Department in preparing 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.
- ensure that the PCT kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.
- have taken reasonable steps for the prevention and detection of fraud and other irregularities.

The Signing Officer and the Finance Signing Officer confirm to the best of their knowledge and belief, they have complied with the above requirements in preparing the accounts.

By order of the Permanent Secretary.

7/6/2013 Date .... Signing Officer

7/6/13 Date .... Finance Signing Officer

NEWCASTLE PRIMARY CARE TRUST
ANNUAL GOVERNANCE STATEMENT 2012/13

This statement was prepared as part of the 2012/13 annual accounts for Newcastle Primary Care Trust (PCT).

Introduction

The NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health, required the Signing Officer for Newcastle Primary Care Trust to provide assurance about the stewardship of this organisation. The Signing Officer for Newcastle Primary Care Trust until 28th March 2013 was Mr Chris Reed, Chief Executive. From this date, and, with the approval of the Joint Board of North of Tyne Primary Care Trusts on 26th March 2013, the Signing Officer status passed to Mr John Lawlor, National Commissioning Board Area Team Director for Cumbria, Northumberland, Tyne and Wear. Mr Lawlor will sign the accounts of the PCT.

1. Scope of Responsibility

It was the responsibility of the Chief Executive as Signing Officer, supported by other executive directors, to make and implement operational decisions to run the business day-to-day within the strategy agreed by the Board and to maintain a sound system of internal control that supported the achievement of the organisation's aims and objectives. The Chief Executive was also personally responsible for the safeguarding of public funds and the organisation's assets as set out in the Signing Officer Memorandum.

2. The Governance Framework of the Organisation

The governance framework comprised the systems and processes by which the organisation was controlled. It enabled the organisation to monitor the achievement of its strategic objectives and to consider whether those objectives had led to the delivery of appropriate, cost effective services.

2.1.1 The Role of the Board

The Board was accountable for internal control.

The Board set the strategy and oversaw its implementation by the management team. The ultimate focus of the organisation was long-term health and well-being, with a requirement to deliver on short-term objectives, congruent with the longer terms aims of Newcastle PCT as detailed in the strategic plan.

In setting the strategy and agreeing the corporate objectives, the Board was mindful of its wider obligations and considered the impact of engagement with its various stakeholders and partners. In monitoring the implementation of the strategy, the Board aimed to ensure that it maintained an effective system of internal control and that the management team maintained an effective risk management and oversight process so that the strategy was delivered in a controlled and sustainable way, particularly in financially challenging times.

The Board approved Standing Orders and Standing Financial Instructions which provided the corporate governance framework within which the Board and management team operated, including the key matters and decisions reserved only for the Board and those delegated to members of the management team. The NHS North of Tyne website was closed subsequent to the abolition of PCTs on 31st March 2013. It is anticipated that the Department of Health will continue to provide on-line access to Standing Orders, Standing Financial Instructions and Scheme of Delegation and other corporate PCT legacy documents.

2.1.2 How the Board Operated

It was the prime responsibility of the Chair to provide leadership to the Board to ensure that it satisfied its legal and regulatory responsibilities. The Board met bi-monthly in public, in accordance with the Public Bodies (Admission to Meetings) Act 1960. The agenda was set by the Chair in consultation with the Chief Executive and the Board Secretary. The meetings were conducted and business transacted in accordance with Standing Orders including the availability of papers five days in advance of the meeting to provide advance disclosure of relevant information to Board members and the public. At each meeting any members of the public in attendance were invited to make any relevant representations to the Board.

An Annual General Meeting used to be held in public to present the Annual Report and Annual Accounts and to provide the opportunity for representations to be made to the Board by the public. As the PCT was abolished on 31 March 2013, there will not be an Annual General meeting to present this year's accounts but it is expected that these will be published in June 2013 once they have been reviewed by the auditor and signed off by the Department of Health Audit subcommittee. (Non-executive directors from the North of Tyne PCO cluster were members of this committee).

The non-executive directors were independent of management. Their role was to advise and constructively challenge management and to monitor the success of the management team in delivering the agreed strategy within the risk appetite and control framework set by the Board. The Board considered that it was legally compliant in terms of discharge of its statutory duties.

2.1.3 Delegation of Responsibilities

The Chief Executive, Chris Reed, was the North of Tyne PCO's Signing Officer for almost the whole of the year. Following approval by the Board at its final meeting on 26th March 2013, the Signing Officer role moved to Mr John Lawlor, the NHS Commissioning Board's Area Team Director, on 28th March. The NHS had asked for this change to ensure that beyond 31st March 2013 there was a named Signing Officer for each PCT to deal with corporate close-down matters that could not be completed sooner, including for example the signing of the PCT accounts.

Specific responsibilities were delegated by the Signing Officer to designated executive directors and the Board Secretary:

- Medical Director was the executive director for risk management and governance and for professional performance assessment of medical staff and independent contractors;
- Board nurse led risk management related to patient safety and professional performance of non medical clinical staff;
- Director of Finance led the management of risk associated with finance, estates and health and safety;
- Director of Commissioning led the management of risk associated with commissioning, planning, contracting, performance and patient safety;
- Director of Informatics & Project Management led the management of risks associated with IM&T, project management and information governance;
- Board Secretary / Head of Corporate Affairs led on the implementation of corporate governance and assurance systems, supported by the corporate risk & assurance manager.

2.2 Board Sub Committees

As part of the governance arrangements set out in the Standing Orders there were a number of sub-committees of the Board with specific designated responsibilities and terms of reference.

Membership of the Board and all sub committees is shown in Appendix A.

2.2.1 Audit Committee

This was a non-executive committee of the Board which provided a means of independent and objective review of governance control systems, financial systems, financial information and compliance with law, guidance and codes of conduct. Membership of the Committee was entirely non-executive. The Audit Chair was a Fellow of the Chartered Institute of Global Management Accountants and one other NED member was a CCAB registered professional. Executive directors and other staff were in attendance as appropriate.

The audit committee provided a written report to Board members after each meeting. These reports typically summarised the main agenda items at each meeting, including the reports of internal audit, external audit, counter fraud, Director of Finance and the Integrated Governance Committee. Matters highlighted by the Audit Chair's briefing to the Board in 2012/13 included information on work done to support the development of CCGs and issues around continuing health care funding.

The internal audit service supported the audit committee by evaluating and reporting on the effectiveness and adherence to the systems of internal controls that Newcastle PCT had in place. The audit committee was also supported by external audit, to provide assurances on the work of the internal audit service and on the organisation's financial management and end of year accounts. The external auditor in 2012/13 was Deloitte LLP, appointed by the Audit Commission. They were required to operate to international accounting standards and to comply with the auditing code of practice. The Committee and the Board were assured that Deloitte LLP had adequate policies and safeguards in place to ensure auditor objectivity and independence were maintained.

The external auditor previously provided the Board with an Annual Audit letter, which would in other years would have been made available on the NHS North of Tyne website. Following the abolition of PCTs, it is anticipated that the DH will be making arrangements to have External Audit reports available publicly once published.

The Audit Committee met at least bi-monthly and the meetings were preceded with a private meeting with committee members, internal and external audit (i.e. without executive officers present).

2.2.2 Integrated Governance Committee

This Committee ensured that there were appropriate mechanisms in place to manage risk and corporate and clinical governance and that these were operating in an effective way. The committee was also responsible for ensuring that there were effective arrangements in place for meeting statutory and mandatory requirements and adhering to national guidance in respect of governance.

The integrated governance committee was chaired by a non-executive director; and its chair reported to audit committee at least quarterly.

2.2.3 Remuneration and Terms of Service Committee

This Committee advised the Board on appropriate remuneration and terms of service for the chief executive, executive directors and other very senior managers. Membership of the Committee was entirely non-executive.

Executive and non-executive remuneration was set within national policy and guidelines. For the chair and non-executive directors (including the co-opted non-executive director), remuneration and terms of service were determined nationally and confirmed in individual letters of appointment by the Appointments Commission. There was no performance related element of pay for non-executive directors under their national terms and conditions of service.

Remuneration for the chief executive and executive directors was directed by the Department of Health (DH) and set out in the Very Senior Manager (VSM) pay framework, available on line.

The Remuneration and Terms of Service Committee existed to recommend to the Board and Strategic Health Authority (SHA) any awards of discretionary aspects of pay and conditions for staff, in accordance with DH guidance. The VSM pay framework limited the element of pay that was performance related and final approval of any award to the Chief Executive or an Executive Director rested with the SHA as the 'parent' organisation. The committee also scrutinised and determined redundancy arrangements for staff displaced as a result of the abolition of Primary Care Organisations and the transition to new management arrangements. For VSM staff the committee's decisions were also overseen by the SHA.

2.2.4 Estates Committee

This sub-committee had the delegated authority for decision making in relation to estate developments and acquisitions and disposals to the value of £3m, provided the capital had been made available within the capital resource limit and also monitored progress against the statutory target for the capital resource limit. The committee was chaired by a non-executive director.

2.2.5 Newcastle North and East and Newcastle West Clinical Commissioning Groups

In May 2011 the Joint Board approved arrangements for the Clinical Commissioning Groups (CCGs) to be committees that reported to the Board, to support them on their development path to authorisation. This arrangement was underpinned by NHS North of Tyne transitional assurance framework as the main means of the CCGs reporting to the Joint Board. In order to support this regular assurance meetings were held with the CCGs to monitor their performance throughout the year. These meetings replaced the financial sub group where in other circumstances a finance sub group would have been required.

2.2.6 Non-Executive membership was a key feature of all of the sub committees, thereby ensuring objective challenge and review of the management team and their actions.

3 Board Effectiveness and Assessment of Compliance with Corporate Governance Codes

3.1 Board Composition

The members of the Board had a wide range of skills and experience as required to govern effectively, particularly given the complex NHS environment.

The NHS North of Tyne Board was chaired by Gina Tiller and comprised eight non-executive members (including a co-opted member), six Executive Directors and the Chief Executive, Chris Reed. The other members of the Board, who were not executive directors, included the Board Secretary and the three locality Directors of Public Health. The CCG Chairs attended the Board. The names of all Board members are given in appendix A, and an annual record of attendance for each Board member at Board meetings in 2012-13 was maintained.

The Board Chair and non-executive Directors were appointed to the Board by the Appointments Commission, in accordance with the Commission's national policies and procedures for its appointments to public bodies. The Chair and the non-executive Directors were appointed with pre-determined lengths of tenure and subject to annual appraisal. Executive Directors were recruited in accordance with the organisation's recruitment policy and procedure, which was supported by Equal Opportunities best practice and independent assessment/advice.

For all directors, external interests were declared at least annually and held in a register. These interests were further declared and noted ahead of Board or Committee meetings to ensure probity and independence in the business to be transacted.

The effective performance of the Board and its Committees was a fundamental component of the success of Newcastle PCT. The Board undertook a self-assessment of its effectiveness and performance in March 2012. The evaluation was co-ordinated and directed by the Board Chair, with the support of the Board Secretary. A questionnaire covering the main areas of assessment set out in the UK Governance Code formed the basis of the workshop session. The Board identified some key learning points and concluded that there was a sound governance framework in place and identified strong evidence of business practices compliant with the UK Corporate Governance Code, 2010 to which all best practice refers. The Board was satisfied that is had complied with the UK Corporate Governance Code.

3.2 Commitment and Development

During the course of this reporting period the Board met formally a total of six times, usually bi-monthly. In addition it also met informally, as necessary to discuss specific topic areas.

The register of interests and noted attendance at Board/committee meetings provided assurance of personal capacity of each individual to fulfil a Board role, whether Executive or non-Executive.

All directors were appraised annually and had a personal development plan which incorporated both mandatory and other training needs as identified at the time. Further peer support and networking was provided by access to NHS Confederation training and learning events.

4 Accountability

4.1 Risk Management and Internal Control

The Board considered that it had an effective risk management approach in place as demonstrated by the risk management arrangements set out below.

The risk management arrangements within Newcastle PCT and across NHS North of Tyne were developed through, and with the full involvement of, the board, audit and integrated governance committees. Board level leadership and responsibility for risk management was clearly defined in the North of Tyne risk management strategy and there were clear lines of accountability for managing risk throughout the organisation.

The Chief Executive had overall responsibility for risk management and reported directly to the board. The Integrated Governance Committee which had a non-executive membership, including a non-executive Chair, also supported the Board in overseeing risk management.

NHS North of Tyne supported an open and honest approach to risk and incident reporting with the overriding emphasis on solving and learning from problems and not attributing blame. All staff had access to the risk management strategy (NHS North of Tyne risk management strategy NoT CG05, January 2011), and were actively encouraged to report incidents, accidents and near misses via the incident reporting system. Risk management awareness training was included in the staff induction and mandatory training programme.

The risk management strategy detailed the systems and structures for managing risks including aims and objectives and the commitment to the implementation of risk management systems throughout the organisation. The strategy was supported by other policies that addressed specific areas of risk, e.g. incident reporting, health and safety, infection control and information governance. Copies were furnished to the Department of Health as part of preparation for organisational close down.

The risk management strategy outlined:

- the roles and responsibilities of the Board and Committees in respect of risk management
- the roles and responsibilities of officers for elements of risk management
- access to specialist advice
- the risk management process in place within the organisation, including the systematic identification, assessment, evaluation and control of risks via mechanisms such as the Board assurance framework and the corporate risk register

- a description of risk management terms to ensure common understanding and full guidance on the risk analysis matrix for the grading of risk priority.

Risk identification was achieved primarily through the following processes:

- clinical and non clinical risk assessment
- complaints management
- claims management
- performance and finance & contracting monitoring and reports
- incident reporting including serious and untoward incidents
- audits (both internal and those carried out by external bodies).

4.2 Risk Assurance Framework and Risk Registers

The two main features of the risk management process were the assurance frameworks and risk registers. Board members and senior managers were actively involved in establishing and maintaining an assurance framework and its links to risk registers. A system was established within the organisation that aimed to provide a thorough overview of risks. The purpose was to ensure that risks were identified and managed at the appropriate level and to provide a mechanism of escalation through the tiers that alerted the integrated governance committees, the joint audit committee and the board of very high risks. Directorate risk registers existed and any very significant corporate risks arising out of these were included in the corporate risk register.

During 2012-13 the assurance framework was in place and monitored by the Integrated Governance Committee. The assurance framework covered all of the organisation's main activities including financial, clinical and organisational activities and identified the principal objectives and targets that the organisation was striving to achieve and the risks to the achievement of these targets. It identified and examined the system of internal control in place to manage risks and the review and assurance mechanisms which related to the effectiveness of the system of internal control. It was developed during the NHS reforms implementation work with transition risks identified.

Regular reports were made to the Integrated Governance Committee and any significant issues were reported to the Board. The risk assurance framework and the corporate risk register were reviewed at least annually by the Audit Committee and the Board. The framework identified actions that needed to be taken to address gaps in control and assurance and a small number were identified. Each action had an identified lead and was monitored throughout the year by the Integrated Governance Committee. The framework was last updated and reviewed by the committee in February 2013.

5. Performance against National Priorities

The national priorities were set out in the NHS Operating Framework 2012-13 Performance against targets was closely monitored by the Executive Commissioning Team, using a detailed planning checklist. Exceptions were highlighted and action plans to address any underperformance were prepared and actioned. Where necessary, a recovery plan was put in place.

Performance against targets was reported to the Strategic Health Authority on a quarterly basis. Performance was reported to the Board at each meeting.

Within all the PCTs in North of Tyne the waiting times for access to consultant led services had improved, focus continued throughout the year within certain specialties to achieve the 18 weeks waiting time thresholds. These include Trauma and Orthopaedics, Neurosurgery and Orthodontics.

Newcastle PCT failed to achieve their smoking cession and health check targets. All the other targets as set out in the NHS Operating Framework 2011-12 were achieved.

6. Significant Issues in 2012-13

Throughout the year Newcastle PCT identified and managed a range of risks, both strategic and operational. None of the risks were identified as 'very high' but some were identified as 'high.'

The Chair of the Integrated Governance Committee (IGC) provided a quarterly report to the Audit Committee. All high and very high risks as identified in the corporate risk register were included in that report, along with details of mitigating actions. Emerging risks as identified were also reported. The report also referred to formal assurances received by the IGC.

The risks highlighted by the Chair of IGC in the quarterly reports to the Audit Committee in 2012/13 included delivering efficiencies, information governance risks, and adequate risk assessment and management of services sourced from third parties. These issues are all referred to in the 'significant issues' section, below.

The significant issues for 2012/13 as identified and considered by the IGC, Audit Committee and Board are noted below.

6.1 Continuing Healthcare

Continuing Healthcare (CHC) refers to a package of continuing care arranged and funded by the NHS. The arrangements for assessment and funding were governed by a national framework and case law. The increase in the number and the cost of continuing healthcare and complex packages of care continued to be an area of significant risk for Newcastle, North Tyneside PCTs and Northumberland Care Trust in the reporting period 2012-2013.

There was significant working with local authority partners across North of Tyne to further develop and agree shared policies and operational processes in order to enhance and expedite decision making for patients and assure the quality of care packages. The introduction of an IT software solution enhanced documentation and process control in relation to assessment, decision making and on-going case management. It provided a source of data triangulation for safeguarding as well as financial processes.

There was an increase in the number of patients receiving Funded Nursing Care and Continuing Healthcare which was reflective of the aging populations North of Tyne.

The updated internal audit report in March 2013 identified that there was significant assurance on the controls in place around the assessment of individuals for CHC and organisational decision making and assurance systems in place for the management of the financial risks of CHC.

There was a national campaign this year encouraging patients and relatives, who felt that they had a retrospective claim in respect of CHC, to initiate such a claim before the opportunity to do so closed on 31st March 2013. This resulted in more than 950 claims which will take many months to process in line with the national framework.

The risks associated with CHC remained assessed as high and this will continue to receive close attention into the 2013/2014 financial year by Clinical Commissioning Group receiving organisations. The risks associated with CHC were identified as one of the top risks in the Quality Handover document which was an appendix of the Corporate Handover document.

6.2 North East Ambulance Service Foundation Trust (NEAS)

It was widely reported over winter months that ambulances were struggling to pick up and drop off patients at the busiest of times, particularly when the receiving emergency hospitals and their emergency departments were coping with very high numbers of presenting patients. This was examined in some detail by commissioners and providers, culminating in a workshop in February 2013 for leaders from all key NHS organisations to set an agenda for improvements for the future. GPs remained concerned on behalf of their patients and GP led Clinical Commissioning Groups picked up the commissioning of these services from 1st April 2013. Improvements in response and drop off times for NEAS remained problematic. The Board was assured that this was understood at the highest levels in both the new and existing NHS organisations and that this will be taken forward.

6.3 Health Strategy, Delivery of Efficiencies and Achievement of Financial Balance

The financial context continued to be challenging. The Board remained committed to delivering the vision of improving the equality, quantity and quality of life for the population served. Given the marginal growth rate of finance, the achievement of this health strategy was dependent on resources being released from efficiency measures and improving the quality of care to ensure the health systems delivered better value for money. The drive to deliver efficiencies continued to sit at the heart of the strategy; without this focus it would not have been possible to release the resources needed to continue the momentum of improvement.

Realising savings via investment in quality, innovation, productivity and prevention programme (QIPP) was embedded in the Integrated Operational and Strategic Plan (ISOP) and the associated Local Delivery Plans. Across the whole health economy, the focus was on taking waste out of the delivery systems and to develop care closer to home and deliver improvement to health and wellbeing and to the quality of services. This was dependent on resources released through efficiencies. The need to deliver a total of £58.9m in efficiencies in 2012-13 across North of Tyne presented a significant challenge.

In addition to the Director of Finance Reports to the Board throughout the year, financial performance was monitored through performance reviews with CCGs as sub committees of the Board. Newcastle PCT successfully achieved financial break even and executed all of its other statutory financial duties during 2012-13. The accounts will be signed off by the Area Team Director, John Lawlor, who is the PCT's Signing Officer for residual corporate close-down matters.

The need for financial efficiencies will continue to be challenging going forward and the Chief Executive was confident that Newcastle CCGs and the NHS Commissioning Board Area Team were sighted on the challenge ahead. Handover meetings to brief them directly on material matters had taken place and the notes of these meetings formed part of another agenda item for the Joint Board's final meeting.

6.4 Delivering System Reform

Throughout 2012-13 Newcastle PCT prepared for the system reform as signalled in the Health and Social Care Bill. The changes include the transfer of all PCT responsibilities to new bodies, including the Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board, ready for the abolition of Primary Care Trusts in April 2013.

During 2012-13 the risks identified with these changes included maintaining the balance between retaining control to meet the PCT's statutory responsibilities and corporate objectives, whilst developing and empowering the emerging CCGs and other developing organisations. The development and implementation of a single ISOP was key to managing these risks. The ISOP brought together all the key requirements for the NHS accountability arrangements across the areas of quality, resources and reform. Progress against plan was monitored closely and reported to the Board.

In addition regular performance monitoring meetings were held with each of the CCGs, giving them the opportunity to develop their mechanisms for managing the system whilst the PCT remained accountable.

Preparations were also made to ensure a smooth transfer of responsibilities on 31 March 2013:

Handover Document

A high level corporate handover document was prepared. It was intended to signpost the key risks, issues and areas of concern that new NHS organisations needed to be aware as they assumed responsibility for the discharge of their functions. It was approximately ten pages in length. Its preparation was the responsibility of the Board Secretary and Head of Corporate Affairs.

A Quality Handover Document was also developed over the last few months. The document was designed to meet the information needs of the successor bodies and to pass on legacy issues essential to the continuation and development of high quality commissioning. It was prepared in accordance with the guidance provided by the National Quality Board *'How to maintain quality during the transition: preparing for handover' (May 2012)*. The Medical Director and Board Nurse were responsible for this document.

The handover document, in full, became a public document once signed off by the Board at the final Board meeting of the primary care organisation in March 2013.

PCO Transfer Schemes

All PCO assets and liabilities which were not discharged formed part of a Transfer Scheme, a legal document which confirmed the transfer of all assets and liabilities to receiver organisations. Essentially the asset or liability followed the destination of the statutory function. There was also a Transfer Scheme for staff transfers to each of the receiver organisations.

In accordance with relevant guidance, the Chief Executive signed off the Template for Sender Assurance for the Newcastle PCT Draft Transfer Scheme, on the basis of the information provided in Annex 3 and Annex A, submitted to the Handover and Closedown Team on 22 February 2013. This identified property which was intended to transfer to receiver organisations and which was identified in Schedule 2 of the transfer scheme on the effective date of transfer.

Handover Meeting

Formal handover meetings took place with each of the receiving organisations. The meetings covered the headline information being handed over and agreed specific arrangements for those areas which needed more in depth discussions.

6.5 Adult Safeguarding

6.5.1 Safeguarding

A number of adult safeguarding issues were raised in 2012-13 in relation to nursing homes and specialist hospital placements. Newcastle PCT worked in partnership with local authorities to ensure the safety of patient care in those establishments involved, closing to admission where appropriate, closely monitoring residents and working closely with providers to ensure that an action plan was delivered. In addition to organisational concerns, individual concerns continued to be managed in line with local adult safeguarding policies with the local authorities as lead agency.

6.5.2 Winterbourne

North of Tyne worked with local authorities and Specialist commissioning to develop an action plan in response to the Winterbourne Concordat (2012). They were committed to working collaboratively with all their partners to ensure the commissioning and quality assurance of safe and sustainable care for people in Newcastle, North Tyneside and Northumberland with learning disabilities or autism who also had behaviours that challenged or mental health conditions. The initial key milestone involving the identification of patient registers was completed in line with the 31st March 2013 deadline and responsibility for taking forward the health actions within the plan was transferred to the Clinical Commissioning Groups with input from specialist Commissioning in the Area Teams.

6.6 Procurement Challenges

As a commissioning organisation, Newcastle PCT were required to market test services, in line with national guidance.

The procurement of diabetic retinopathy screening services was challenged in February 2012 by an unsuccessful bidder. This challenge was referred to the courts, and the award of the contract had to be suspended. However, on application by the PCT the courts gave permission for the contract suspension to be lifted and consequently the PCT awarded the contract to the successful bidder. The unsuccessful bidder later withdrew their challenge.

6.7 Information Governance and Data Security

Newcastle PCT had strong systems of information governance in place, overseen by the Information Governance Committee which reported into the Integrated Governance Committee. During 2012-13 there were no significant lapses of data security and consequently none that needed reporting to the information commissioner.

6.8 Fraud Awareness and Anti Bribery

Newcastle PCT were supported by the Local Counter Fraud Specialist (LCFS), who reported to the Audit Committee. Fraud awareness was reported as good. There were no significant fraud issues to report in 2012-13.

The PCT stated their commitment to the Anti-Bribery Act 2010, which came into force in July 2011. They did not have any bribery issues to report in 2012-13.

6.9 Independent Inquiry into Care Provided by mid Staffordshire NHS Foundation Trust January 2005 - March 2009

The Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC) published in February 2010, made 18 recommendations, 5 of which were directly relevant to commissioning organisations. A second report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013) stated that "People must always come before numbers", and that the quality and safety of patient care must always be at the forefront of board discussions and decisions. Foremost, the report urged all commissioning, service provision, regulatory and ancillary organisations in healthcare to consider the findings and recommendations of the report and decide how to apply them to their own work.

At its March 2013 meeting, the Board of NHS North of Tyne considered the report findings together with receiving assurance that the recommendations from the February 2010 report had been completed. Given the changes to commissioning in the NHS and the abolition of the Primary Care Trusts and Care Trust in NHS North of Tyne, the Board received assurance that required actions with evidence of ongoing improvement was part of formal handover arrangements to receiving organisations in the new NHS commissioning system.

7. Stakeholders

The Board identified stakeholders and partner organisations that were critical to the achievement of its strategic aims.

The public engagement and communications team worked closely with colleagues across all directorates and supported clinical commissioning groups (CCGs) to make sure that statutory obligations were met around involvement and consultation. This also involved closely working with and responding to any queries from local MPs, overview and scrutiny committees, local involvement networks (LINks) and the emerging local Healthwatch, health and well-being boards, local authorities and many community groups, as well as other NHS partners.

During 2012-13 a wide range of activities were undertaken which helped to inform the annual planning process, including engagement on commissioning intentions of both CCGs with patient and community forums, and specific targeted events with key stakeholders, such as a conference to look at the direction of travel for health and social care services for the aging population of Newcastle.

A range of projects were supported to improve health and healthcare. This included gathering patient experience and feedback to inform service specifications for procurements, such as those for the Any Qualified Provider initiative and the GP out of hours service. Information was provided for patients to inform them about service developments and any changes to ensure access was maintained and choice was promoted in line with the NHS Constitution.

In all efforts the PCT were aware of the need to make sure that they reached particular communities of interest. They also targeted specific groups to work in partnership on particular projects and engagement, always striving to maintain a two-way dialogue. Lay representatives were appointed to each CCG board to champion patient and public involvement and to authorise publication of a detailed communications strategy and action plan. Representatives of CCGs and the public engagement and communications team worked with a range of key stakeholders to ensure links between the new structures and community groups moved forward past April 2013. The Board identified stakeholders and partner organisations that were critical to the achievement of its strategic aims. As Newcastle PCT and NHS North of Tyne were public bodies they did not have shareholder accountability.

The Chief Executive was confident that the Annual Governance statement described a system and approach which remained robust from 1st April 2012 to 31st March 2013.

John Lawlor, Signing Officer
7th June 2013

Appendix A
Committee Membership from 1 January 2012

	Audit	Remuneration	Integrated Governance	Estates	Finance	Public Experience (nominated lead)	Equality and Diversity (nominated lead)
Gina Tiller		*✓		*✓			
Jacqui Henderson		✓			✓		
Mary Coyle		✓					
Dave Willis	*✓	✓	✓		*✓		
Neil Bradbury		✓		✓			✓
Neil Barker	✓	✓		✓			
Pamela Denham		✓	✓			✓	
Debbie Jones	✓	✓	*✓				
Sheila Stokes White	✓	✓			✓		

***Committee Chair**

All Non Executive Directors were members of the Remuneration Committee, however there was a minimum attendance of two at each Committee

FOREWORD TO THE ACCOUNTS

Newcastle Primary Care Trust

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

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	**15,468**	16,909
Other costs	5.1	**545,330**	537,336
Income	4	**(27,288)**	(29,168)
Net Operating Costs Before Interest		**533,510**	525,077
Investment income	9	**(24)**	(24)
Other (Gains)/Losses	10	**(79)**	0
Finance costs	11	**179**	181
Net Operating Costs for the Financial Year		**533,586**	525,234
Of which:			
Administration Costs			
Gross employee benefits	7.1	**12,101**	12,700
Other costs	5.1	**8,226**	7,959
Income	4	**(8,916)**	(9,946)
Net Administration Costs Before Interest		**11,411**	10,713
Investment income	9	**(24)**	(24)
Finance costs	11	**179**	181
Net Administration Costs for the Financial Year		**11,566**	10,870
Programme Expenditure			
Gross employee benefits	7.1	**3,367**	4,209
Other costs	5.1	**537,104**	529,377
Income	4	**(18,372)**	(19,222)
Net Programme Expenditure Before Interest		**522,099**	514,364
Other (Gains)	10	**(79)**	0
Net Programme Expenditure for the Financial Year		**522,020**	514,364

Other Comprehensive Net Expenditure	**2012-13 £000**	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**379**	92
Net (gain) on revaluation of property, plant & equipment	**0**	(206)
Net loss on Assets Held for Sale	**79**	0
Total Comprehensive Net Expenditure for the Year*	**534,044**	525,120

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 22 to 60 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current Assets:			
Property, plant and equipment	12	**20,837**	23,252
Intangible assets	13	**252**	167
Other financial assets	21	**168**	168
Total Non-current Assets		**21,257**	**23,587**
Current Assets:			
Trade and other receivables	19	**6,715**	11,390
Cash and cash equivalents	23	**24**	9
Total Current Assets		**6,739**	11,399
Non-current assets held for sale	24	**150**	150
Total Current Assets		**6,889**	11,549
Total Assets		**28,146**	35,136
Current Liabilities			
Trade and other payables	25	**(35,045)**	(41,832)
Other liabilities	26	**(222)**	(139)
Provisions	32	**(1,309)**	0
Borrowings	27	**(54)**	(51)
Total Current Liabilities		**(36,630)**	**(42,022)**
Non-current Assets less Net Current Assets/Liabilities		**(8,484)**	(6,886)
Non-current Liabilities			
Other Liabilities	28	**(1,314)**	(2,073)
Provisions	32	**(1,385)**	(220)
Borrowings	27	**(2,462)**	(2,517)
Total Non-current Liabilities		**(5,161)**	(4,810)
Total Assets Employed:		**(13,645)**	(11,696)
Financed by Taxpayers' Equity:			
General fund		(17,511)	(16,020)
Revaluation reserve		3,866	4,324
Total Taxpayers' Equity:		**(13,645)**	(11,696)

The notes on pages 22 to 60 form part of this account.

The financial statements on pages 18 to 21 were reviewed by the North of Tyne Audit Committee on 3rd June 2013 and sigr
on its behalf by the Signing Officer John Lawlor

Signing Officer: Date: 7/6/13

Statement of Changes In Taxpayers Equity for the Year Ended 31 March 2013

	General fund	Revaluation Reserve	Total Reserves
	£000	£000	£000
Balance at 1 April 2012	**(16,020)**	**4,324**	**(11,696)**
Changes in Taxpayers' Equity for 2012-13			
Net Operating Cost for the year	**(533,586)**	**0**	**(533,586)**
Net (loss) on Revaluation of Property, Plant and Equipment	**0**	**(79)**	**(79)**
Impairments	**0**	**(379)**	**(379)**
Total Recognised Income and Expense for 2012-13	**(533,586)**	**(458)**	**(534,044)**
Net Parliamentary Funding	**532,095**	**0**	**532,095**
Balance at 31 March 2013	**(17,511)**	**3,866**	**(13,645)**
Balance at 1 April 2011	(17,915)	4,210	(13,705)
Changes in Taxpayers' Equity for 2011-12			
Net Operating Cost for the year	(525,234)	0	(525,234)
Net Gain on Revaluation of Property, Plant and Equipment	0	206	206
Impairments	0	(92)	(92)
Total Recognised Income and Expense for 2011-12	(525,234)	114	(525,120)
Net Parliamentary Funding	527,129	0	527,129
Balance at 31 March 2012	(16,020)	4,324	(11,696)

Statement of Cash Flows for the Year Ended 31 March 2013

	NOTE	**2012-13 £000**	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(533,510)**	(525,077)
Depreciation and Amortisation	12.1, 12.2/13.1, 13.2	**1,481**	1,216
Impairments and Reversals	12.1, 12.2/14/24	**2,178**	734
Interest Paid	11	**(179)**	(181)
Decrease/(Increase) in Trade and Other Receivables	19.1	**5,298**	(4,713)
(Decrease)/Increase in Trade and Other Payables	25	**(6,276)**	1,748
(Increase)/Decrease in Other Current Liabilities	26	**(676)**	1,389
Provisions Utilised	32	**(116)**	(58)
Increase/(Decrease) in Provisions	32	**2,590**	(20)
Net Cash Inflow/(Outflow) from Operating Activities		**(529,210)**	(524,962)
Cash Flows from Investing Activities			
Interest Received		**24**	24
(Payments) for Property, Plant and Equipment	12.1, 12.2	**(2,801)**	(2,012)
(Payments) for Intangible Assets	13.1	**(191)**	(147)
Proceeds of Disposal of Assets Held for Sale (PPE)	24	**150**	0
Net Cash (Outflow) from Investing Activities		**(2,818)**	(2,135)
Net Cash (Outflow) Before Financing		**(532,028)**	(527,097)
Cash Flows from Financing Activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP LIFT		**(52)**	(48)
Net Parliamentary Funding	3.4	**532,095**	527,129
Net Cash Inflow from Financing Activities		**532,043**	527,081
Net Increase/(Decrease) in Cash and Cash Equivalents	23	**15**	(16)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	23	**9**	25
Cash and Cash Equivalents (and Bank Overdraft) at Year End	23/36.1	**24**	9

1. Accounting Policies

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

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

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) Transactions

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

Acquisitions and Discontinued Operations

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

Critical Accounting Judgements and Key Sources of Estimation Uncertainty

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

Critical Judgements in Applying Accounting Policies

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

Critical judgements in relation to continuing health care provision and contingent liability are detailed in note 32 and 33.

Key Sources of Estimation Uncertainty

The critical judgements made by the PCT's management principally relate to estimations (see below) that management has made in the process of applying the entity's accounting policies, that have the most significant effect on the amounts recognised in the financial statements.

Within the carrying values attributed to non - current assets of the PCT, Land and Buildings with a value of £18,268k have been valued by the Valuation Office Agency in accordance with the requirements of IFRS. In both 2012/13 and 2011/12 there has been a high level of volatility in both property markets and construction costs, which is continuing. The revised valuations have resulted in a revenue charge for impairments of £2,178k, and net reductions in the overall carrying value of previously revalued assets of £458k recognised through the Revaluation Reserve. General economic conditions will continue to affect these values, and improvement may lead to a partial or complete reversal of current impairments.

1. Accounting Policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Care Trust Designation

Newcastle PCT is not designated as a Care Trust under s45 of the Health and Social Care Act 2001.

1.4 Pooled Budgets

The PCT has not entered into pooled budgets with Local Authorities.

1.5 Taxation

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

1.6 Administration and Programme Costs

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

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

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

1. Accounting Policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

Subsequent Expenditure

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

1. Accounting Policies (continued)

1.8 Intangible Assets

Recognition

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

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

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

Measurement

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

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

1.9 Depreciation, Amortisation and Impairments

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

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

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

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

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

1. Accounting Policies (continued)

1.10 Donated Assets

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

1.11 Government Grants

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

1.12 Non-current Assets Held for Sale

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

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

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

1.13 Inventories

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

1.14 Cash and Cash Equivalents

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

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

1.15 Losses and Special Payments

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

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

1.16 Clinical Negligence Costs

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

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

1. Accounting Policies (continued)

1.17 Employee Benefits

Short-term Employee Benefits

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

Retirement Benefit Costs

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

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

1.18 Research and Development

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

1.19 Other Expenses

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

1.20 Grant Making

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

1. Accounting Policies (continued)

1.21 Contingencies

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

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

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

1.22 Leases

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

The PCT as Lessee

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

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

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

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

The PCT as Lessor

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

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

1.23 Provisions

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

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

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

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

1. Accounting Policies (continued)

1.24 Financial Instruments

Financial Assets

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

Financial assets are initially recognised at fair value.

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

Loans and Receivables

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

Fair value is determined by reference to quoted market prices where possible.

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

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

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

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

1. Accounting Policies (continued)

Financial Liabilities

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

Financial liabilities are initially recognised at fair value.

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

1.25 NHS LIFT Transactions

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

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

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

a) Services Received

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

b) LIFT Assets, Liabilities, and Finance Costs

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

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

1. Accounting Policies (continued)

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

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

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

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

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

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

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

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

1.26 Going concern

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Newcastle PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 42 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. Revaluations of £458k and impairments of £2,178k have been recognised in the period, such transactions being routine within the annual cycle of activity. No disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

1.27 Events after the Reporting Period

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

NHS Newcastle North and East Clinical Commissioning Group (CCG) and NHS Newcastle West CCG who will commission healthcare services on behalf of the patients in Newcastle excluding those provided by GP practices and those classed as specialised or public health services.

NHS England who will commission specialised services and primary care services from GPs, dentists, pharmacists and opticians.

Newcastle City Council who will commission public heath services.

1. Accounting Policies (continued)

1.28 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

With effect from 1 April 2011, the Primary Care Trust has ceased to act as a Provider of Services and all activities that were previously reported as a separate segment were transferred to NHS provider organisations. Accordingly the PCT has only one main activity and segmental accounts do not apply.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13	2011-12
	£000	£000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**533,586**	525,234
Revenue Resource Limit	**534,691**	525,548
Underspend against Revenue Resource Limit (RRL)	**1,105**	314

3.2 Capital Resource Limit

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

	2012-13	2011-12
	£000	£000
Capital Resource Limit	**1,826**	2,463
Charge to Capital Resource Limit	**1,708**	2,461
Underspend against CRL	**118**	**2**

3.3 Provider Full Cost Recovery Duty

The PCT acted only as a commissioner of services in 2012-13.

3.4 Under/(Over)spend against Cash Limit

	2012-13	2011-12
	£000	£000
Total Charge to Cash Limit	**532,095**	527,129
Cash Limit	**532,095**	527,129
Under/(Over)spend against Cash Limit	**0**	**0**

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

	2012-13
	£000
Total cash received from DH (Gross)	**465,336**
Sub Total: Net Advances	**465,336**
Plus: cost of Dentistry Schemes (central charge to cash limits)	**13,520**
Plus: drugs reimbursement (central charge to cash limits)	**53,239**
Parliamentary Funding Credited to General Fund	**532,095**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	3,633	0	3,633	3,501
Prescription Charge income	3,066	0	3,066	2,958
Strategic Health Authorities	3,517	0	3,517	3,597
NHS Foundation Trusts	3,841	57	3,784	3,911
Primary Care Trusts - Other	2,524	1,888	636	5,844
Recoveries in respect of employee benefits	7,790	6,880	910	6,850
Local Authorities	0	0	0	615
Education, Training and Research	118	0	118	79
Other Non-NHS Patient Care Services	1,877	24	1,853	1,434
Charitable and Other Contributions to Expenditure	0	0	0	133
Other revenue	922	67	855	246
Total miscellaneous revenue	27,288	8,916	18,372	29,168

5. Operating Costs

5.1 Analysis of Operating Costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	**49,468**	**0**	**49,468**	38,893
Non-Healthcare	**2,343**	**2,083**	**260**	1,506
Total	**51,811**	**2,083**	**49,728**	40,399
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**861**	**0**	**861**	6,477
Goods and services (other, excl Trusts, FT and PCT))	**330**	**27**	**303**	599
Total	**1,191**	**27**	**1,164**	7,076
Goods and Services from Foundation Trusts	**307,149**	**613**	**306,536**	305,728
Purchase of Healthcare from Non-NHS bodies	**52,350**	**0**	**52,350**	46,275
Expenditure on Drugs Action Teams	**2,951**	**0**	**2,951**	2,592
Contractor Led GDS & PDS (excluding employee benefits)	**18,373**	**0**	**18,373**	19,932
Chair, Non-executive Directors & PEC remuneration	**92**	**92**	**0**	68
Consultancy Services	**8**	**8**	**0**	92
Prescribing Costs	**43,028**	**0**	**43,028**	44,881
G/PMS, APMS and PCTMS (excluding employee benefits)	**37,948**	**0**	**37,948**	37,701
Pharmaceutical Services	**7,494**	**0**	**7,494**	8,430
New Pharmacy Contract	**7,159**	**0**	**7,159**	6,285
General Ophthalmic Services	**3,058**	**0**	**3,058**	3,064
Supplies and Services - Clinical	**270**	**1**	**269**	626
Supplies and Services - General	**628**	**76**	**552**	951
Establishment	**2,096**	**1,378**	**718**	1,853
Transport	**86**	**54**	**32**	118
Premises	**5,932**	**877**	**5,055**	5,597
Impairments & Reversals of Property, plant and equipment	**2,178**	**0**	**2,178**	734
Depreciation	**1,375**	**1,375**	**0**	1,160
Amortisation	**106**	**106**	**0**	56
Impairment of Receivables	**(81)**	**0**	**(81)**	23
Research and Development Expenditure	**315**	**67**	**248**	369
Audit Fees	**99**	**99**	**0**	154
Clinical Negligence Costs	**20**	**20**	**0**	78
Education and Training	**2,013**	**176**	**1,837**	2,174
Other	**(2,319)**	**1,174**	**(3,493)**	920
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**545,330**	**8,226**	**537,104**	537,336
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**802**	**797**	**5**	792
Other Employee Benefits	**14,666**	**11,304**	**3,362**	16,117
Total Employee BenefitsCharged to SOCNE	**15,468**	**12,101**	**3,367**	16,909
Total Operating Costs	**560,798**	**20,327**	**540,471**	554,245

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,631**	**11,123**	**508**
Weighted population (number in units)*	**295,852**	**295,852**	**295,852**
Running costs per head of population (£ per head)	**39.31**	**37.59**	**1.72**
PCT Running Costs 2011-12			
Running costs (£000s)	11,022	10,265	757
Weighted population (number in units)	295,852	295,852	295,852
Running costs per head of population (£ per head)	37.26	34.70	2.56

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

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

5.2 Analysis of Operating Expenditure by Expenditure Classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	**37,948**	37,701
Prescribing Costs	**43,028**	44,881
Contractor led GDS & PDS	**18,373**	19,932
General Ophthalmic Services	**3,058**	3,064
Pharmaceutical Services	**7,494**	8,430
New Pharmacy Contract	**7,159**	6,285
Total Primary Healthcare purchased	**117,060**	120,293
Purchase of Secondary Healthcare		
Learning Difficulties	**2,769**	3,499
Mental Illness	**69,892**	70,875
Maternity	**4,888**	4,905
General and Acute	**222,918**	216,461
Accident and Emergency	**12,289**	11,793
Community Health Services	**86,709**	80,040
Other Contractual	**9,133**	9,647
Total Secondary Healthcare Purchased	**408,598**	397,220
Total Healthcare Purchased by PCT	**525,658**	517,513
Healthcare from NHS FTs included above	**307,688**	299,718

6. Operating Leases

The PCT's significant operating leases do not have contingent rents and are based on standard commercial terms free of any onerous restrictions.

The PCT leases 12 buildings for terms ranging from 2 to 27 years.

In addition the PCT leases cars and office equipment under short term operating leases.

Newcastle PCT, under General Medical Services (GMS) Premises directions, reimburses GP Contractors for the costs incurred in providing premises suitable for the delivery of GMS services: under IFRIC4, "Determining whether an arrangement contains a lease," the PCT has determined that the substance of those reimbursements should be recognised as operating leases but as there is no defined term in the GMS arrangements it is not possible to analyse future obligations over financial years.

6.1 PCT as Lessee

			2012-13	2011-12
	Buildings	**Other**	**Total**	
	£000	**£000**	**£000**	£000
Payments Recognised as an Expense				
Minimum lease payments			**3,310**	3,133
Total			**3,310**	3,133
Payable:				
No later than one year	**3,221**	**34**	**3,255**	2,857
Between one and five years	**11,305**	**34**	**11,339**	11,014
After five years	**22,452**	**0**	**22,452**	21,285
Total	**36,978**	**68**	**37,046**	35,156
Total future sublease payments expected to be received			**4,107**	5,042

6.2 PCT as Lessor

There are no leasing arrangements whereby the PCT acts as lessor other than GP subleases (referred to in note 6.1 above) in PCT premises which are reimbursable by the PCT as commissioning costs.

7. Employee Benefits and Staff Numbers

7.1 Employee Benefits

	2012-13			Permanently Employed			Other		
	Total	Admin	Programme	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits - Gross Expenditure									
Salaries and wages	**12,446**	**10,294**	**2,152**	**10,219**	**8,824**	**1,395**	**2,227**	**1,470**	**757**
Social security costs	**739**	**638**	**101**	**739**	**638**	**101**	**0**	**0**	**0**
Employer Contributions to NHS BSA - Pensions Division	**1,354**	**1,169**	**185**	**1,354**	**1,169**	**185**	**0**	**0**	**0**
Termination benefits	**1,089**	**0**	**1,089**	**0**	**0**	**0**	**1,089**	**0**	**1,089**
Total Employee Benefits	**15,628**	**12,101**	**3,527**	**12,312**	**10,631**	**1,681**	**3,316**	**1,470**	**1,846**
Less recoveries in respect of employee benefits (table below)	**(7,790)**	**(6,880)**	**(910)**	**(6,580)**	**(6,383)**	**(197)**	**(1,210)**	**(497)**	**(713)**
Total - Net Employee Benefits Including Capitalised Costs	**7,838**	**5,221**	**2,617**	**5,732**	**4,248**	**1,484**	**2,106**	**973**	**1,133**
Employee costs capitalised	**160**	**0**	**160**	**0**	**0**	**0**	**160**	**0**	**160**
Gross Employee Benefits Excluding Capitalised Costs	**15,468**	**12,101**	**3,367**	**12,312**	**10,631**	**1,681**	**3,156**	**1,470**	**1,686**
Recognised As:									
Commissioning employee benefits	**15,468**			**12,312**			**3,156**		
Gross Employee Benefits Excluding Capitalised Costs	**15,468**			**12,312**			**3,156**		

	2012-13			Permanently Employed			Other		
	Total	Admin	Programme	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits - Revenue									
Salaries and wages	**5,958**	**5,795**	**163**	**5,461**	**5,298**	**163**	**497**	**497**	**0**
Social Security costs	**395**	**383**	**12**	**395**	**383**	**12**	**0**	**0**	**0**
Employer Contributions to NHS BSA - Pensions Division	**724**	**702**	**22**	**724**	**702**	**22**	**0**	**0**	**0**
Termination Benefits	**713**	**0**	**713**	**0**	**0**	**0**	**713**	**0**	**713**
TOTAL Excluding Capitalised Costs	**7,790**	**6,880**	**910**	**6,580**	**6,383**	**197**	**1,210**	**497**	**713**

Employee Benefits - Prior- Year

	Total	Permanently Employed	Other
	£000	£000	£000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	13,986	12,279	1,707
Social security costs	888	888	0
Employer Contributions to NHS BSA - Pensions Division	1,627	1,627	0
Termination benefits	529	529	0
Total Gross Employee Benefits	17,030	15,323	1,707
Less recoveries in respect of employee benefits	(6,850)	(6,359)	(491)
Total - Net Employee Benefits Including Capitalised Costs	10,180	8,964	1,216
Employee Costs Capitalised	121	0	121
Gross Employee Benefits Excluding Capitalised Costs	16,909	15,323	1,586
Recognised As:			
Commissioning employee benefits	16,909		
Gross Employee Benefits Excluding Capitalised Costs	16,909		

7.2 Staff Numbers

	2012-13			2011-12		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Average Staff Numbers						
Medical and dental	**10**	**6**	**4**	14	12	2
Administration and estates	**273**	**238**	**35**	303	266	37
Healthcare assistants and other support staff	**1**	**1**	**0**	5	5	0
Nursing, midwifery and health visiting staff	**5**	**5**	**0**	21	21	0
Nursing, midwifery and health visiting learners	**3**	**3**	**0**	0	0	0
Scientific, therapeutic and technical staff	**0**	**0**	**0**	31	31	0
TOTAL	**292**	**253**	**39**	374	335	39
Of the above - staff engaged on capital projects	**3**	**0**	**3**	1	0	1

7.3 Staff Sickness Absence and Ill Health Retirements

	2012-13	2011-12
	Number	Number
Total Days Lost	**1,580**	1,860
Total Staff Years	**227**	250
Average working Days Lost	**6.96**	7.44

The figures for sickness absence are based on the calendar year 2012 and converted to the "Cabinet Office" measurement base to ensure consistency of reporting across the Department of Health.

There were no early retirements on the grounds of ill health in either 2011-12 or 2012-13

There were no additional pensions liabilities in either 2011-12 or 2012-13

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	**0**	**0**	**0**	1	0	1
£10,001-£25,000	**1**	**0**	**1**	1	0	1
£25,001-£50,000	**1**	**0**	**1**	1	1	2
£50,001-£100,000	**1**	**0**	**1**	1	0	1
£100,001 - £150,000	**4**	**0**	**4**	0	0	0
£150,001 - £200,000	**1**	**0**	**1**	0	0	0
>£200,000	**1**	**0**	**1**	0	1	1
Total number of exit packages by type (total cost	**9**	**0**	**9**	4	2	6
	£	**£**	**£**	£	£	£
Total Resource cost	**1,088,778**	**0**	**1,088,778**	140,000	389,000	529,000

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

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

The staff for whom exit packages were paid in 2012/13 were employed by Newcastle Primary Care Trust as part of a shared management structure. The costs of their employment and redundancy were recharged by Newcastle PCT to North Tyneside PCT and the Northumberland Care Trust on a weighted capitation basis. North Tyneside's share of the redundancy costs was £285,913 and Northumberland's share was £427,345.

7.5 Pension Costs

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

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

a) Accounting Valuation

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

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

b) Full Actuarial (Funding) Valuation

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

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

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

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

c) Scheme Provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of Compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**14,301**	**92,814**	13,265	87,748
Total Non-NHS Trade Invoices Paid Within Target	**13,400**	**88,522**	12,336	82,869
Percentage of NHS Trade Invoices Paid Within Target	**93.70%**	**95.38%**	93.00%	94.44%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,654**	**357,015**	2,167	356,818
Total NHS Trade Invoices Paid Within Target	**2,584**	**355,115**	2,046	354,796
Percentage of NHS Trade Invoices Paid Within Target	**97.36%**	**99.47%**	94.42%	99.43%

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

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

There were no amounts included in finance costs from claims made under this legislation nor compensation paid to cover debt recovery costs under this legislation.

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: loan interest receivable	24	24	0	24
Total investment income	24	24	0	24

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain on disposal of assets held for sale	79	0	79	0
Total	79	0	79	0

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under LIFT contracts:				
- main finance cost	179	179	0	181
Total	179	179	0	181

12.1 Property, Plant and Equipment

	Land	Buildings Excluding Dwellings	Assets Under Construction and Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
2012-13								
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or Valuation:								
At 1 April 2012	2,484	21,926	714	1,720	120	4,236	794	31,994
Additions Purchased	0	1,155	0	0	0	512	0	1,667
Reclassifications	0	678	(714)	4	0	0	32	0
Reclassifications as Held for Sale	0	(150)	0	0	0	0	0	(150)
Impairments/Negative Indexation	(72)	(307)	0	0	0	0	0	(379)
Reversal of Impairments	0	0	0	0	0	0	0	0
At 31 March 2013	2,412	23,302	0	1,724	120	4,748	826	33,132
Depreciation								
At 1 April 2012	28	4,825	0	947	52	2,474	416	8,742
Impairments	75	2,103	0	0	0	0	0	2,178
Charged During the Year	0	415	0	146	68	682	64	1,375
At 31 March 2013	103	7,343	0	1,093	120	3,156	480	12,295
Net Book Value at 31 March 2013	2,309	15,959	0	631	0	1,592	346	20,837
Purchased	2,309	15,959	0	631	0	1,592	346	20,837
Total at 31 March 2013	2,309	15,959	0	631	0	1,592	346	20,837
Asset financing:								
Owned	2,309	13,059	0	631	0	1,592	346	17,937
On-SOFP LIFT Contracts	0	2,900	0	0	0	0	0	2,900
Total at 31 March 2013	2,309	15,959	0	631	0	1,592	346	20,837

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings Excluding Dwellings	Assets Under Construction and Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	942	3,382	0	0	0	0	0	4,324
Movements	(151)	(307)	0	0	0	0	0	(458)
At 31 March 2013	791	3,075	0	0	0	0	0	3,866

The movement in the revaluation reserve mainly related to Molineux Street, Newcastle.

There were no additions to Assets Under Construction in 2012-13.

In line with guidance issued by the Department of Health, the assets represented by the above values will transfer at book value to a number of public sector bodies. Land and buildings will transfer primarily to NHS Property Services and the remaining assets will transfer to those organisations receiving the services to which they are aligned.

12.2 Property, Plant and Equipment

2011-12	Land	Buildings Excluding dwellings	Assets Under Construction and Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost orValuation:								
At 1 April 2011	2,500	20,238	714	1,682	120	3,644	668	29,566
Additions - purchased	0	1,557	0	38	0	593	126	2,314
Reclassifications	(9)	10	0	0	0	(1)	0	0
Revaluation & Indexation Gains	75	131	0	0	0	0	0	206
Impairments	(82)	(10)	0	0	0	0	0	(92)
At 31 March 2012	2,484	21,926	714	1,720	120	4,236	794	31,994
Depreciation								
At 1 April 2011	0	3,692	0	796	35	1,961	364	6,848
Impairments	28	706	0	0	0	0	0	734
Charged During the Year	0	427	0	151	17	513	52	1,160
At 31 March 2012	28	4,825	0	947	52	2,474	416	8,742
Net Book Value at 31 March 2012	2,456	17,101	714	773	68	1,762	378	23,252
Purchased	2,456	17,101	714	773	68	1,762	378	23,252
At 31 March 2012	2,456	17,101	714	773	68	1,762	378	23,252
Asset financing:								
Owned	2,456	14,025	714	773	68	1,762	378	20,176
On-SOFP LIFT contracts	0	3,076	0	0	0	0	0	3,076
At 31 March 2012	2,456	17,101	714	773	68	1,762	378	23,252

12.3 Property, Plant and Equipment
No assets were donated during the year.

Land and operational property assets were revalued to fair value (existing use/depreciated replacement cost of modern equivalent asset) as at 31 March 2013 by the Valuation Office Agency in accordance with Policy.

Surplus assets have been valued at Market value.
The basis of valuation is the same as for the preceding year.

Asset lives for each class of asset are:

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings excl Dwellings	4	68
Plant & Machinery	4	10
Transport Equipment	0	0
Information Technology	4	5
Furniture and Fittings	6	13

There have been no significant changes of asset lives/residual values.

No compensation from third parties has been received in respect of assets impaired. Where necessary the Department of Health provides resource cover for market impairments.

Where assets have previously been impaired for reasons of market volatility and to the extent that the impairment was charged to Operating Expenditure, reversal of the impairment is also recognised through net expenditure, as shown in note 5.

No property is held at existing use value where that value is materially different from its open market value.

13.1 Intangible Non-current Assets

2012-13	Software Purchased	Development Expenditure	Total
	£000	£000	£000
Cost or Valuation			
At 1 April 2012	420	121	541
Additions - purchased	0	191	191
At 31 March 2013	420	312	732
Amortisation			
At 1 April 2012	364	10	374
Charged during the year	39	67	106
At 31 March 2013	403	77	480
Net Book Value at 31 March 2013	17	235	252
Net Book Value at 31 March 2013 comprises			
Purchased	17	235	252
Total at 31 March 2013	17	235	252

There are no revaluation reserve balances for intangible non-current assets.

Development expenditure primarily relates to the development of the Reporting Analysis and Intelligence Delivering Results (RAIDR) system.

In line with guidance issued by the Department of Health, the assets represented by the above values will transfer at book value to those organisations receiving the services to which they are aligned.

13.2 Intangible Non-current Assets

	Software Purchased	Development Expenditure	Total
2011-12			
	£000	£000	£000
Cost or Valuation			
At 1 April 2011	394	0	394
Additions - purchased	26	121	147
At 31 March 2012	420	121	541
Amortisation			
At 1 April 2011	318	0	318
Charged during the year	46	10	56
At 31 March 2012	364	10	374
Net Book Value at 31 March 2012	56	111	167
Net Book Value at 31 March 2012 comprises			
Purchased	56	111	167
Total at 31 March 2012	56	111	167

13.3 Intangible Non-current Assets

The Intangible Assets of the PCT include computer applications software licences.
These assets are not subject to revaluation as they have short economic lives.
The Fair values are estimated by amortising the assets over the shorter of the licence period and period of use: the values shown at the end of each financial period represent cost less accumulated amortisation.

The original cost or valuation of these assets is shown in note 13.1.

The PCT has no internally generated Intangible Assets.

No Intangible Assets have been acquired by government grant.

The PCT does not hold control any significant Intangible Assets not recognised as such because they fail to meet the recognition criteria of IAS 38.

Asset lives for each class of asset are:

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	4	4
Development Expenditure	3	3

14. Analysis of Impairments and Reversals Recognised in 2012-13

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment Impairments and Reversals Taken to SoCNE			
Changes in market price	2,178	0	2,178
Total Charged to Annually Managed Expenditure	2,178	0	2,178
Property, Plant and Equipment Impairments and Reversals Charged to the Revaluation Reserve			
Changes in market price	379	0	0
Total Impairments for PPE Charged to Reserves	379	0	0
Total Impairments of Property, Plant and Equipment	2,557	0	2,178
Non-current Assets Held for Sale - Impairments and Reversals Charged to SoCNE.			
Changes in market price	0	0	0
Total Charged to Annually Managed Expenditure	0	0	0
Total Impairments of Non-current Assets Held for Sale	0	0	0
Total Impairments Charged to Revaluation Reserve	379	0	
Total Impairments Charged to SoCNE - AME	2,178	0	2,178
Overall Total Impairments	2,557	0	2,178

All of the impairment cost recognised in these accounts has arisen from the revaluation conducted by the Valuation office agency as at 31 March 2013 for value in use for Land and Buildings in accordance with Policy.

Impairments charged to the revaluation reserve do not impact on programme or administration costs.

15 Investment Property

The PCT holds no investment property.

16 Commitments

16.1 Capital Commitments

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

	31 March 2013	31 March 2012
	£000	£000
Property, plant and equipment	**0**	740
Total	**0**	740

16.2 Other Financial Commitments

The PCT has not entered into non-cancellable contracts (which are not leases or LIFT contracts or other service concession arrangements).

17 Intra-Government and Other Balances

	Current Receivables £000s	**Current Payables £000s**
Balances with other Central Government Bodies	**5,064**	**1,520**
Balances with Local Authorities	**0**	**3,751**
Balances with NHS Trusts and Foundation Trusts	**523**	**7,467**
Balances with bodies external to government	**1,128**	**26,058**
At 31 March 2013	**6,715**	**38,796**
prior period:		
Balances with other Central Government Bodies	9,196	1,197
Balances with Local Authorities	0	13,082
Balances with NHS Trusts and Foundation Trusts	476	10,289
Balances with bodies external to government	1,718	17,264
At 31 March 2012	11,390	41,832

18 Inventories

The PCT held no inventories in either 2012-13 or 2011-12.

19.1 Trade and Other Receivables

	Current	
	31 March 2013	31 March 2012
	£000	£000
NHS receivables - revenue	**4,666**	9,672
NHS receivables - capital	**623**	0
Non-NHS receivables - revenue	**616**	500
Non-NHS prepayments and accrued income	**427**	796
Provision for the impairment of receivables	**(5)**	(106)
VAT	**298**	493
Other receivables	**90**	35
Total	**6,715**	11,390

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

Other receivables that are neither past due nor impaired are assumed to be recoverable in full.

No financial assets that would otherwise be past due or impaired, have had terms renegotiated.

19.2 Receivables Past their Due Date but not Impaired

	31 March 2013	31 March 2012
	£000	£000
By up to three months	**87**	518
By three to six months	**56**	142
By more than six months	**120**	0
Total	**263**	660

The PCT does not hold collateral for receivables.

19.3 Provision for Impairment of Receivables

	2012-13	2011-12
	£000	£000
Balance at 1 April 2012	**(106)**	(88)
Amount written off during the year	**20**	5
Amount recovered during the year	**81**	0
(Increase)/decrease in receivables impaired	**0**	(23)
Balance at 31 March 2013	**(5)**	(106)

Non NHS Receivables are assumed to be liable to impairment when recovery is delayed by more than 90 days beyond normal terms or where the PCT becomes aware of specific adverse circumstances affecting the debtor.

20 NHS LIFT Investments

	Share Capital £000	Total £000
Balance at 1 April 2012	**168**	**168**
Balance at 31 March 2013	**168**	**168**
Balance at 1 April 2011	168	168
Balance at 31 March 2012	168	168

21 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**168**	168
Total Other Financial Assets - Non Current	**168**	168

22 Other Current Assets

The PCT held no other current assets during 2012-13 or 2011-12.

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**9**	25
Net change in year	**15**	(16)
Closing balance	**24**	9
Made up of		
Cash with Government Banking Service	**24**	8
Cash in hand	**0**	**1**
Cash and Cash Equivalents as in Statement of Financial Position	**24**	9
Cash and Cash Equivalents as in Statement of Cash Flows	**24**	9

24 Non-current Assets Held for Sale

	Land	Buildings,Excl. Dwellings	Total
	£000	£000	£000
Balance at 1 April 2012	**0**	**150**	**150**
Plus assets classified as held for sale in the year	**0**	**150**	**150**
Less assets sold in the year	**0**	**(150)**	**(150)**
Plus reversal of impairment of assets held for sale	**79**	**0**	**79**
Revaluation	**(79)**	**0**	**(79)**
Balance at 31 March 2013	**0**	**150**	**150**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**
			0
Balance at 1 April 2011	0	150	150
Balance at 31 March 2012	0	150	150

25 Trade and Other Payables

	Current	
	31 March 2013	31 March 2012
	£000	£000
Interest payable	**0**	0
NHS payables - revenue	**7,567**	10,947
NHS payables - capital	**26**	0
NHS accruals and deferred income	**1,394**	539
Family Health Services (FHS) payables	**10,221**	11,974
Non-NHS payables - revenue	**10,420**	12,310
Non-NHS payables - capital	**63**	600
Non_NHS accruals and deferred income	**4,648**	4,455
Social security costs	**127**	0
Tax	**152**	0
Other	**427**	1,007
Total	**35,045**	41,832

26 Other Liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Lease incentives	**222**	139	**1,314**	2,073
Total	**222**	139	**1,314**	2,073
Total other liabilities (current and non-current)	**1,536**	2,212		

27 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
LIFT liabilities:				
Main liability	**54**	51	**2,462**	2,517
Total	**54**	51	**2,462**	2,517
Total other liabilities (current and non-current)	**2,516**	**2,568**		

Borrowings/Loans - Payment of Principal Falling Due in:

	Other	**Total**
	£000s	**£000s**
0 - 1 Years	**54**	**54**
1 - 2 Years	**58**	**58**
2 - 5 Years	**132**	**132**
Over 5 Years	**2,272**	**2,272**
TOTAL	**2,516**	**2,516**

28 Other Financial Liabilities
The PCT did not have other financial liabilities during 2012-13 or 2011-12.

29 Deferred Income
The PCT did not have deferred income other than the lease incentives referred to in note 26 in either 2012-13 or 2011-12.

30 Finance Lease Obligations
The PCT does not have Finance Lease obligations, other than the LIFT Schemes referred to in note 34.

	31 March 2013	31 March 2012
Finance Leases as Lessee	**£000**	£000
Contingent Rents recognised as an expense.	**(61)**	(50)

31 Finance Lease Receivables as Lessor
The PCT holds no finance leases as lessor.

32 Provisions

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s
		Comprising:				
Balance at 1 April 2012	**220**	**10**	**93**	**20**	**0**	**97**
Arising During the Year	**2,600**	**0**	**0**	**0**	**2,600**	**0**
Utilised During the Year	**(116)**	**(10)**	**(9)**	**0**	**0**	**(97)**
Reversed Unused	**(10)**	**0**	**0**	**(10)**	**0**	**0**
Balance at 31 March 2013	**2,694**	**0**	**84**	**10**	**2,600**	**0**
Expected Timing of Cash Flows:						
No Later than One Year	**1,309**	**0**	**9**	**0**	**1,300**	**0**
Later than One Year and not later than Five Years	**1,355**	**0**	**45**	**10**	**1,300**	**0**
Later than Five Years	**30**	**0**	**30**	**0**	**0**	**0**
Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:						
As at 31 March 2013	**3**					
As at 31 March 2012	0					

The provisions relating to pensions for former directors and other staff are as advised by the NHS pensions agency and represent the future capitalised values of early retirement costs against which regular quarterly payments of actual pension are recharged.
Legal claims include estimates for specific cases notified by the NHSLA.
The continuing care provision £2.6m (current & non current) relates to an estimate of compensation costs for individuals who meet appropriate continuing healthcare criteria and have previously borne the cost of nursing in private care as a direct personal expense, or where (following nursing assessment) individuals may be deemed retrospectively to meet national criteria for free nursing care. There is a high degree of uncertainty inherent both in anticipating claims and in assessing the likelihood and eventual financial outcome.

33 Contingencies

34 LIFT - Additional Information

Charges to Operating Expenditure and Future Commitments in respect of on and off SOFP LIFT	**31 March 2013**	31 March 2012
	£000	£000
34.1 Total Charge to Operating Expenses In Year - OFF SOFP LIFT	**473**	456
Service element of on SOFP LIFT charged to operating expenses in year	**217**	220
Total	**690**	676

	31 March 2013	31 March 2012
	£000	£000
Payments Committed to in respect of off SOFP LIFT and the Service Element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	**643**	676
Later than One Year, No Later than Five Years	**2,570**	2,703
Later than Five Years	**8,354**	9,414
Total	**11,567**	12,793

	31 March 2013	31 March 2012
	£000	£000
Estimated capital value of project - off SOFP LIFT	**2,132**	2,132

34.2 Imputed "Finance Lease" Obligations for on SOFP LIFT Contracts Due	**31 March 2013**	31 March 2012
	£000	£000
No Later than One Year	**229**	230
Later than One Year, No Later than Five Years	**850**	883
Later than Five Years	**4,001**	4,198
Subtotal	**5,080**	5,311
Less: Interest Element	**(2,564)**	(2,743)
Total	**2,516**	2,568

35 Impact of IFRS Treatment - 2012-13

	Total	**Admin**	**Programme**
	£000	**£000**	**£000**
Revenue Costs of IFRS: Arrangements Reported on SoFP under IFRIC12 (e.g LIFT)			
Depreciation charges	**61**	**61**	**0**
Interest Expense	**178**	**178**	**0**
Other Expenditure	**322**	**0**	**322**
Total IFRS Expenditure (IFRIC12)	**561**	**239**	**322**
Revenue consequences of LIFT schemes under UK GAAP / ESA95 (net of any sublease income)	**(467)**	**0**	**(467)**
Net IFRS Change (IFRIC12)	**94**	**239**	**(145)**

36 Financial Instruments

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

Currency Risk

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

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

Credit Risk

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

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

36.1 Financial Assets	**Loans and Receivables**	**Available For Sale**	**Total**
	£000	**£000**	**£000**
Receivables - NHS	**5,289**	**0**	**5,289**
Receivables - non-NHS	**611**	**0**	**611**
Cash at bank and in hand	**24**	**0**	**24**
Other financial assets	**388**	**150**	**538**
Total at 31 March 2013	**6,312**	**150**	**6,462**
Receivables - NHS	9,672	0	9,672
Receivables - non-NHS	394	0	394
Cash at bank and in hand	9	0	9
Other financial assets	528	0	528
Total at 31 March 2012	10,603	0	10,603

36.2 Financial Liabilities	**Other than at 'Fair Value Through Profit and Loss'**	**Total**
	£000	**£000**
NHS payables	**8,987**	**8,987**
Non-NHS payables	**26,058**	**26,058**
LIFT & finance lease obligations	**2,516**	**2,516**
Other financial liabilities	**1,536**	**1,536**
Total at 31 March 2013	**39,097**	**39,097**
NHS payables	11,508	11,508
Non-NHS payables	25,891	25,891
Other borrowings	2,212	2,212
LIFT & finance lease obligations	2,568	2,568
Other financial liabilities	4,433	4,433
Total at 31 March 2012	46,612	46,612

37 Related Party Transactions

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Newcastle PCT except as shown below:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
Chris Reed (Chief Executive) Wife was Chief Executive of NHS South of Tyne & Wear, and an Interim Director of the National Commissioning Board - Cumbria area	**1,511,833**	**279,038**	**246,104**	**4,671**
Pamela Denham (Board Member) Chair of Age UK Newcastle and Partner of Community Ventures of the Community Foundation - Tyne & Wear	**141,864.00**	**0**	**56,089.00**	**0**
Deborah Jones (Board Member) Newcastle University	**130,365**	**0**	**0**	**0**
Neil Barker (Board Member) NNT LIFT Company (FUNDCO1) Limited	**2,519,074**	**0**	**36,882**	**0**
Related Party Transactions 2011/12				
Chris Reed (Chief Executive) Wife was Chief Executive of Gateshead, South Tyneside and Sunderland PCTs. Son worked for Sunderland PCT.	1,855,390	333,094	599,121	11,097
Pamela Denham (Board Member) Age UK Newcastle and Newcastle University	269,885	1,597	0	0
Deborah Jones (Board Member) Newcastle University	114,032	1,597	0	0

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

Strategic Health Authorities
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Newcastle City Council in respect of property cost and Continuing Health Care services.

38 Losses and Special Payments

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

	Total Value of Cases £s	Total Number of Cases
Total Special Payments	**10,000**	**1**
Total Losses and Special Payments	**10,000**	**1**

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	280,342	2
Special payments - PCT management costs	16,462	2
Total Losses	280,342	2
Total Special Payments	16,462	2
Total Losses and Special Payments	296,804	4

Details of cases individually over £250,000

There was one instance of a fruitless payment of £278,784 in 2011-12. This related to obligations to LIFT arising from revision of the West One scheme following Clinical Commissioning Group support for a revised scheme and the late withdrawal of a GP practice post Stage 1 Business Case approval by the SHA. The PCT carries these obligations under the LIFT Strategic Partnership Agreement and any additional cost recovery for works undertaken in the new scheme will be credited against this payment.

39 Third party Assets

The PCT held no third party assets in either 2012-13 or 2011-12.

40 Pooled Budget

Newcastle PCT did not have any pooled budget arrangements with Local Authorities in either 2012-13 or 2011-12.

41 Cashflows Relating to Exceptional Items

There were no exceptional cash flows during the period ended 31 March 2013 or 31 March 2012.

42 Events After the end of the Reporting Period

There have been no adjusting or non-adjusting events after the reporting period.

The main functions carried out by Newcastle Primary Care Trust in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

NHS Newcastle North and East Clinical Commissioning Group (CCG) and NHS Newcastle West CCG who will commission healthcare services on behalf of the patients in Newcastle excluding those provided by GP practices and those classed as specialised or public health services.

NHS England who will commission specialised services and primary care services from GPs, dentists, pharmacists and opticians.

Newcastle City Council who will commission public heath services.

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

We have audited the financial statements of Newcastle PCT for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 42. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

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

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

Respective responsibilities of the Signing Officer and Finance Signing Officer, and auditors

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

Scope of the audit of the financial statements

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

apparent material misstatements or inconsistencies we consider the implications for our report.

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects

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

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

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

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

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 Newcastle PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Paul Thomson ACA (Engagement Lead),
on behalf of Deloitte LLP,
Appointed Auditor,
One Trinity Gardens,
Broad Chare,
Newcastle-upon-Tyne,
NE1 2HF

7 June 2013