Department of Health

NHS

Northumberland Care Trust

2012-13 Annual Report and Accounts

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Northumberland Care Trust

2012-13 Annual Report

NORTHUMBERLAND CARE TRUST

2012-13 ANNUAL REPORT

1 About us

Northumberland Care Trust (CT) was established in 2001 with responsibility for providing a wide range of community health services and commissioning healthcare for the county's 330,000 residents. Since then the organisation has undergone a number of significant changes.

First, in 2006 we developed a shared management team with Newcastle Primary Care Trust (PCT) and North Tyneside PCT.

The next major change happened on 1 April 2011, in line with the national policy 'transforming community services', when we transferred 1,701 staff who worked in the community to provide healthcare or health services, such as district nurses and health visitors, Northumbria Healthcare 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 Care Trust 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 primary care organisations and 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 NHS Northumberland Clinical Commissioning Group to support them in taking on their new responsibilities and more recently with the North of England Commissioning Support Unit (NECS), who provide support services for the CCGs.

We also worked closely with Northumberland County 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 the Care Trust.

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 were GPs and other independent contractors, Northumbria Healthcare NHS 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 Northumberland County Council and the community and voluntary sector in the county.

This annual report and accounts is the last to be published by Northumberland Care Trust, for future information for NHS commissioning information for Northumberland post April 1, 2013, please go to:

www.northumberlandccg.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.northumberland.gov.uk

2 Overview of the year

During 2012-13 our focus was very much on supporting the new NHS organisations, particularly NHS Northumberland CCG and NECS through a stringent authorisation process as they 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 Care Trust.

As a result many of our staff worked between organisations and it was only since the autumn that there was more certainty for individuals 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.

Meeting financial targets was a long-standing challenge in Northumberland but patients were foremost in our work, underpinned by robust clinical and financial management which gave our best possible start to the CCGs although financial challenges remained.

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

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

In terms of other activities during the year, our staff and the NHS in general rose to the challenges presented by the Olympics over the summer. There was successful planning to ensure that many thousands of people could enjoy the games at St James's Park and the torch relay which wound its way across the county to Newcastle. 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 area knew how to access NHS services should this be necessary.

Throughout the year we've supported activity to encourage pregnant women to have whooping cough vaccinations to protect their newborn babies. We've also reminded parents to protect their children from measles by making sure they have two doses of the MMR. 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 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 find it more accessible to attend a pharmacy. The scheme proved to be popular and we extended it to those over 65 who are at risk of flu.

The Think Pharmacy First (TPF) minor ailments community pharmacy scheme continued to be popular with patients. TPF offered patients who qualified 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 on-going Choose Well campaign. This used a colour coded thermometer to actively promote the best use of services and helped direct the public to which was the best urgent care service to use for different conditions.

On 1 August Northumbria Healthcare announced that following two incidents which gave cause for concern, it was suspending delivering and postnatal inpatient care at Berwick Maternity Unit pending a safety review. This was against a background of a declining number of deliveries at the unit – 13 during 2011-12 – which meant it was difficult for the midwives to practise and maintain their skills. We immediately began engagement with key groups in Berwick and commissioned some independent research to understand what was important to women at all stages of their maternity care. Following the publication of a safety review report by Northumbria Healthcare in November, which included two options for the future provision of midwifery-led services in Berwick we had a discussion at our joint board which resulted in us launching a statutory public consultation in December. During this process we were keen to hear the views of local people - and in particular young mothers and future mothers – about how local maternity services could be provided safely in Berwick.

A report was made to our joint board which met in public for the last time on 26 March 2013. The final decision rests with NHS Northumberland CCG who post 1 April became the statutory commissioners of local health services and healthcare for the county.

In January 2013 we worked closely with the Health Protection Agency, and the North East Primary Care Services Agency (NEPCSA) who managed contracts with GPs, dentists, opticians and pharmacists on our behalf, to recall 28 patients who were treated by one dentist at the Genix Dental Practice in Alnwick. This followed concerns that a dentist was not working to the highest levels of infection control.

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.

We were very pleased to have organised a ‘topping out’ ceremony which marked the completion of the building structure of Morpeth’s new £18m flagship health centre which was due to open its doors to treat patients in spring 2013. This accommodates two of the town’s GP practices Greystroke and Gas House Lane – along with integrated working with Morpeth’s third GP practice, Wellway, as well as services provided by local foundation trusts. Patients were involved every step of the way

since the public consultation for this development in 2007 and it was very pleasing to see the discussions we had with the public and what was important to them coming to fruition through a modern state of the art health centre.

Over the year we also invested another £5 million across Northumberland to improve old health centre buildings. Work took place on health centres in Haltwhistle, Bedlington, Guidepost and Broomhill meaning that both patients and health staff benefited from much improved surroundings.

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 new NHS organisations in the future and the work required will build upon actions taken following the report published after the first Mid Staffordshire inquiry.

All in all, as we approached abolition, we were proud of what we had achieved in the past 12 years during the life of Northumberland Care Trust. We handed over to new organisations a legacy of performance against key targets to improve health and health care for the people of Northumberland.

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 county. We were also very grateful for the working relationships that we had enjoyed with our key partners including Northumberland County Council and the community and voluntary sector and last but not least with the public who we 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 the 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, was reduced compared to recent years.

Offering and delivering the number of health checks to the eligible population was an area of focus and achievement. By the early detection of symptoms appropriate preventative treatment can be organised avoiding more complexities later in life.

Areas which were of concern and where the expected levels of performance were not achieved related to the North East Ambulance Service NHS Foundation Trust response times. Whilst there was a high priority to respond within the eight minutes expected time for urgent and life threatening emergencies, the 75% target was not achieved throughout the year.

The smoking cessation target was not achieved despite a significant amount of work being done in this area and will continue to be an area of focus in the forthcoming year.

4 Supporting the transition process

Over the last year more clarity was gained over the transition process to new NHS organisations meaning that we could start to make progress over where different functions of the Care Trust would go in the future.

A significant amount of work took place to support the emerging NHS Northumberland CCG.

The lead clinical Accountable Officer (designate) Dr Alistair Blair was formally appointed by the NHS Commissioning Board.

We worked closely with the NHS Northumberland CCG on their authorisation process to ensure they were in a good position to be formally established as a CCG in their own right and to 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 CCG, followed by a panel visit which took place during October 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 CCG has forged during transition with partners were likely to provide sufficient basis for effective commissioning.

Key appointments were made to the CCG management team including former strategic health authority head of primary care Julie Ross as chief operating officer (designate), and former NHS North of Tyne associate director of finance Rob Robertson as chief finance officer (designate).

During November and December recruitment took place for lay members of the CCG boards who provided strategic overview for each organisation, in a way like non-executive directors have done so in the past.

Jacqui Henderson CBE, formerly chair of Northumberland Care Trust, was appointed to the post of lay chair (designate), and Peter Atkinson, a retired prison governor, was appointed to the patient and public involvement lay governor (designate) role. Two highly experienced clinicians were also appointed to the governing body who were Dr Paul Crook as secondary specialist doctor and John Unsworth as the governing body nurse. Both provided expert advice and clinical leadership to the CCG.

Already there has been significant work done to engage with local people to understand their local issues and concerns. Northumberland CCG will be better positioned to continue to build on this work in the future and in particular ensure that there are plans in place to feed back to local people how their involvement has helped influence commissioning decisions.

From an active role in the county's Health and Wellbeing Board, the CCG also attended the health and wellbeing overview and scrutiny committee, and took part in community and voluntary sector forums. The CCG also had specific plans for the future which they developed through authorisation include plans to have CCG wide patient forums with lay representatives who champion patient and public involvement in the work of the CCG.

In February 2013 Northumberland CCG received official notification from the NHS Commissioning Board that it had the go ahead to be become fully authorised as the clinical commissioning group for Northumberland, an achievement of which everyone involved in supporting them thought their authorisation journey was very pleased and proud of.

The North of England Commissioning Support Unit (NECS), the organisation that provides commissioning support and business services for local clinical commissioning groups continued to develop 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 clinical commissioning groups 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 upon 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 was 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 commission 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 Northumberland Professor Sue Milner, moved to County Hall in Morpeth 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

During the year a plan which set out NHS Northumberland Clinical Commissioning Group's vision for the future was agreed and its main priority was to deliver patient focused, high quality services to help improve the health of residents in the county.

Called the Northumberland locality commissioning plan it spelt out NHS Northumberland CCG's intentions that it will look to develop further in the future.

Some of these intentions included focusing on driving up patient care using evidence based practice and integrated approaches as well as meeting the longer-term health needs of local people.

It also focused on providing healthcare closer to where people live to avoid unnecessary travelling to hospital and to create more support in the community for vulnerable and elderly people and for those with long term conditions to reduce avoidable hospital admissions.

Other commissioning intentions included developing an integrated prevention, identification and treatment drug and alcohol pathway. There was also a plan to introduce an early intervention programme for people with alcohol misuse problems and developing a community detox service, as well as looking at ways of identifying people at risk from obesity and proactively manage non-surgical weight loss.

Another scheme was helping patients suffering from stomach problems with a simple health test which checks for evidence of bowel inflammation.

The CCG made the stool sample test available for local patients who were suffering from bloating and chronic diarrhoea without weight loss.

These commissioning intentions were prioritised through public engagement during a series of events organised by the Northumberland Local Involvement Network (LINk) for local stakeholders (including the community and voluntary sector, partner and provider organisations, health scrutiny and local involvement networks) on behalf of the CCG.

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 kept staff as up to date as possible. We knew that our staff network worked 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, all staff received information at the same time and on a fair and equal basis. We achieved 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 continued to volunteer for their local communities in various ways such as 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

could affect their local area. From April this responsibility transferred over to Cumbria, Northumberland, Tyne and Wear Area Team.

Over the past 12 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, which impacted on the number of visitors to the county. 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, particularly in more rural areas.

The Choose Well campaign message was also stepped up and plans were in place to ensure visitors to the area had good access to information on how to use local urgent care services. Activity included Choose Well information in visitor locations, 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 could be 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 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 Care Trust'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 2012-2013

Area	Brief	Non-Financial Information	Financial Information
Greenhouse Gas Emissions	Scope 1 Direct emissions	595 tCO_2e	£117,329
		3,227,987kWh	
	Scope 2 Indirect emissions	274tCO_2e	£101,331
		522,653 kWh	
	Scope 3 Official Business Travel	tCO_2e	£59,052
Waste minimisation and management	Total waste arising	99.36 Te	£43,422
	Waste sent to landfill	96.50 Te	£41,833
	Waste recycled /reused	2.86 Te	£1,589
	Hazardous waste treatment	N/A	N/A
	Waste incinerated (no energy recovery)	N/A	N/A
Finite resources	Water usage	41308 m^3	£43,927

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 Care Trust 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 £3,400,000 (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 £30,840,000 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. This assurance meeting replaced the Finance Sub Group of the Care Trust as the means of additional financial overview.

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

Northumberland Care Trust 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 £257,000 represented an underspend of 0.04% against the final revenue resource limit of £591,945,000.

To keep expenditure within the capital resource limit

The capital surplus of £25,000 represented an underspend of 0.13% against the final Capital Resource Limit of £19,182,000.

To keep cash outgoings within the cash limit

The year end cash balance was £28,000 against a cash limit of £603,271,000.

To ensure full cost recovery for provider (community) services

Community services for Northumberland Care Trust were fully commissioned, primarily from Northumbria Healthcare Foundation Trust. As a consequence there were no hosted community services to demonstrate full cost recovery in 2012-13.

13.2 Financial performance

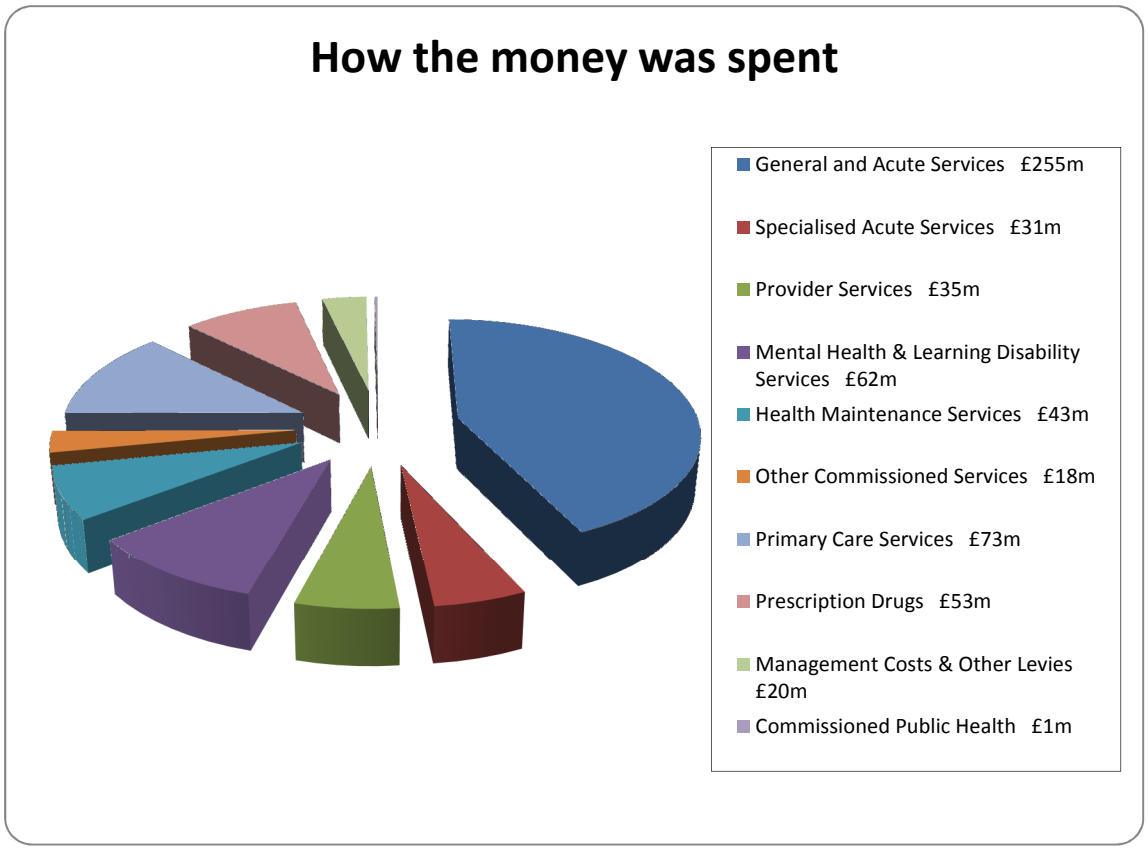
Northumberland Care Trust board approved a balanced budget for 2012-2013 before the start of the financial year and as part of a five year financial strategy.

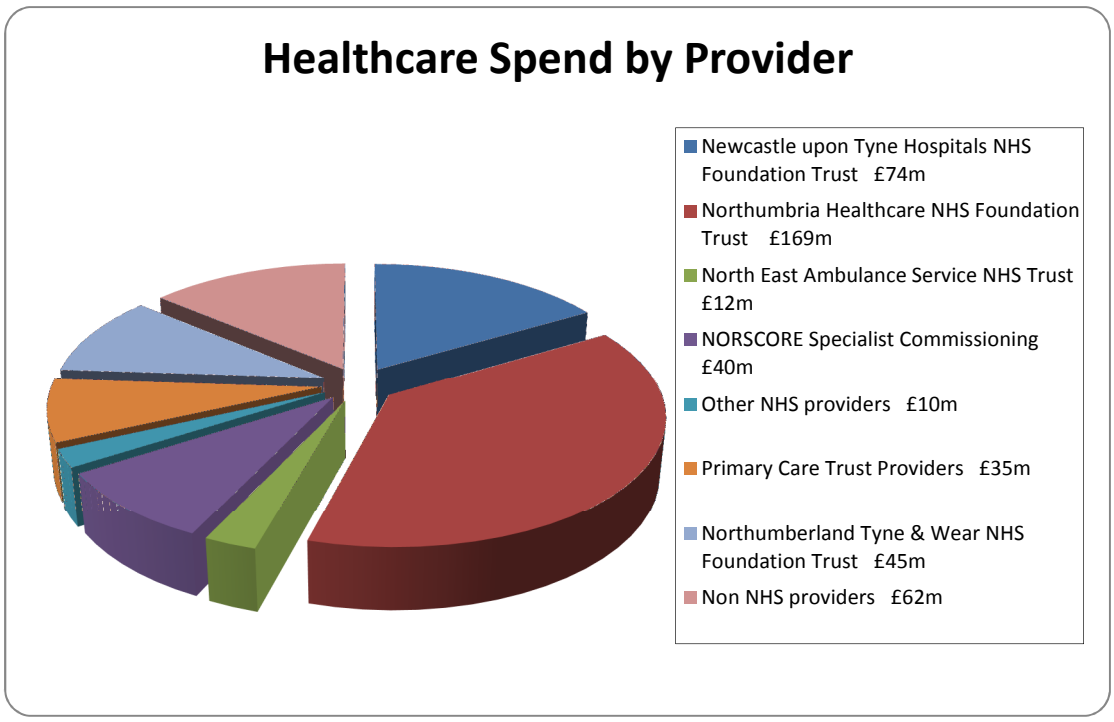
As part of wider financial management across the NHS, the PCT was required to achieve a revenue surplus, as with all of the primary care organisations in NHS North East.

As noted the surplus achieved was £257,000 despite facing a number of in-year cost pressures. Most notable, where expenditure was significantly above budgeted levels were:

- £9.0m on continuing and funded nursing care;
- £2.1m on a cost improvement programme.

Expenditure in 2012-13 totalled £592m and was applied in the following way:





13.3 Key financial performance indicators

Revenue resource limit

The Care Trust's performance for 2012-13 was as follows:

Revenue resource limit	2012-13 £000	2011-12 £000
Total net operating cost for the financial year	**591,688**	576,108
Final revenue resource limit for year	**591,945**	576,427
Underspend against revenue resource limit	**257**	319

Capital resource limit

The Care Trust was required to keep within its capital resource limit.

Capital resource limit	2012-13 £000	2011-12 £000
Gross capital expenditure	**19,157**	5,694
Asset disposals	**(0)**	(0)
Charge against the capital resource limit	**19,157**	5,694
Capital resource limit	**19,182**	5,708
Underspend against capital resource limit	**25**	14

Management of cash

Statement of cash flows for the year ended 31 March	**2012-13**	2011-12
	£000	£000
Cash flows from operating activities		
Net operating cost before interest	**(591,688)**	(576,108)
Other cashflow adjustments	**14,592**	2,451
Movements in working capital	**(7,064)**	5,420
Provisions utilised	**(280)**	(284)
Interest paid	**0**	0
Net cash outflow from operating activities	**(584,440)**	(568,521)
Cash flows from investing activities		
Payments to purchase property, plant and equipment	**(18,839)**	(5,855)
Payments to purchase intangible assets	**0**	(137)
Proceeds of disposals of assets held for sale	**0**	250
Net cash outflow from investing activities	**0**	(5,742)
Net cash outflow before financing	**(603,279)**	(574,263)
Cash flows from financing activities		
Net parliamentary funding	**603,271**	574,237
Net cash inflow from financing	**603,271**	574,237
Net increase / (decrease) in cash and cash equivalents	**(8)**	(26)
Cash at the beginning of the financial year	**36**	62
Cash at the end of the financial year	**28**	36

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 is the later. Overall performance for the year was that 98.79% of correctly addressed and undisputed invoices were paid within the required 30 days as a percentage of the total value of invoices paid and 95.72% as a percentage of the total number of invoices paid in the year.

Better Payment Practice Code	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS creditors				
Total bills paid in the year	**13,406**	**117,786**	8,596	113,541
Total bills paid within target	**12,844**	**113,638**	8,081	110,185
Percentage of bills paid within target	**95.81%**	**96.48%**	94.01%	97.04%
NHS creditors				
Total bills paid in the year	**2,273**	**404,325**	1,969	392,930
Total bills paid within target	**2,164**	**402,174**	1,826	388,805
Percentage of bills paid within target	**95.20%**	**99.47%**	92.74%	98.95%

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 included 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)	**10,078**	9,908
Weighted population (number)*	**336,634**	336,634
Management cost per head of weighted population (£)	**29.9**	29.4

* 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 expenditure

Purchase of hospital and community health services by care group	2012-13 £000	2012-13 %	2011-12 £000	2011-12 %
Learning difficulties	**2,620**	**0.6**	2,535	0.6
Mental illness	**50,937**	**11.6**	49,988	11.7
Maternity	**9,861**	**2.2**	9,696	2.3
General & acute	**255,367**	**58.1**	250,776	58.7
Accident & emergency	**21,520**	**4.9**	21,058	4.9
Community health services	**82,584**	**18.8**	48,376	11.3
Other contractual	**16,573**	**3.8**	45,131	10.6
	439,462	**100**	427,560	100

Audit arrangements

The Care Trust was subject to both internal and external audit. The external auditor, appointed by the Audit Commission, was Deloitte LLP, and their report on the Care Trust's summary financial statements is shown on page 32**.** The costs of external audit, together with comparable figures for 2011-12 are shown below:

Audit Costs	2012-13 £000	2011-12 £000
Accounts	**135**	187

Summary financial statements

Statement of Comprehensive Net Expenditure for the year ended 31 March	2012-13 £000	2011-12 £000
Commissioning		
Gross operating costs	**605,383**	590,689
Less: miscellaneous income	**(13,695)**	(14,581)
Commissioning net operating costs	**591,688**	576,108
Net operating costs before interest	**591,688**	576,108
Net operating cost for the financial year	**591,688**	576,108

Statement of changes in taxpayers' equity for the year ended 31 March 2013	General Fund £000	Revaluation Reserve £000	Other Reserves £000	Total £000
Balance at 1 April 2012	**(3,334)**	**3,036**	**(49)**	**(347)**
Net operating cost for the year	**(591,688)**	**0**	**0**	**(591,688)**
Net gain on revaluation of property, plant and equipment	**0**	**1,373**	**0**	**1,373**
Impairments	**0**	**(287)**	**0**	**(287)**
Reclassification adjustment on disposal of available for sale financial assets	**0**	**0**	**0**	**0**
Net gain/loss on pension	**0**	**0**	**0**	**0**
Total recognised income and expense for 2012-13	**(591,688)**	**1,086**	**0**	**(590,602)**
Net parliamentary funding	**603,271**	**0**	**0**	**603,271**
Balance at 31 March 2013	**8,249**	**4,122**	**(49)**	**12,322**

Statement of changes in taxpayers' equity for the year ended 31 March 2012	General Fund £000	Revaluation Reserve £000	Other reserves £000	Total £000
Balance at 1 April 2011	(1,538)	3,966	0	2,428
Net operating cost for the year	(576,108)	0	0	(576,108)
Net gain on revaluation of property, plant and equipment	0	73	0	73
Impairments	0	(928)	0	(928)
Reclassification adjustment on disposal of				
available for sale financial assets	75	(75)	0	0
Net gain/loss on pension	0	0	(49)	(49)
Total recognised income and expense for 2012-13	(576,033)	(930)	(49)	(577,012)
Net parliamentary funding	574,237	0	0	574,237
Balance at 31 March 2012	(3,334)	3,036	(49)	(347)

Statement of financial position as at 31 March	2012-13 £000	2011-12 £000
Non-current assets		
Property, plant and equipment	**30,299**	21,573
Intangible assets	**242**	126
Total non-current assets	**30,541**	21,699
Current assets		
Trade and other receivables	**6,684**	5,586
Cash and cash equivalents	**28**	36
Non-current assets classified "Held for Sale"	**270**	190
Total current assets	**6,982**	5,812
Total assets	**37,523**	27,511
Current liabilities		
Trade and other payables	**(21,592)**	(27,240)
Provisions	**(1,774)**	0
Total current liabilities	**(23,366)**	(27,240)
Total assets less current liabilities	**14,157**	271
Non-current liabilities		
Provisions	**(1,756)**	(539)
Trade and other payables	**(79)**	(79)
Total non-current liabilities	**(1,835)**	(618)
Total assets employed	**12,322**	(347)
Financed by:		
Taxpayers' Equity		
General fund	**8,249**	(3,334**)**
Revaluation reserve	**4,122**	3,036
Other reserves	**(49)**	(49)
Total Taxpayers' Equity	**12,322**	(347)

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 comprising 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 provides 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 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 Northumberland Care Trust 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.

The cost to Northumberland Care Trust of the highest paid director due to the North of Tyne cluster arrangement in the financial year 2012-13 was £70k to £75k (2011-12, £70k to £75k). This was 2.0 times (2011-12, 2.2) the median remuneration of the workforce, which was £35.6k (2011-12 £31.4k).

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 related 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

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 Northumberland Care Trust on a weighted capitation basis. Northumberland's share of the redundancy costs of nine people was £427,345. No exit packages were agreed for members of Northumberland Care Trust staff in 2011-12.

Northumberland Care Trust 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	70 - 75	135 - 140	0 - 5	8
Ian Davison	Director of informatics and project management	100 - 105	0	0	0	40 - 45	0	0	0
Joe Corrigan	Director of finance and estates	115 - 120	0	0	0	45 - 50	0	0	0
Mark Adams	Director of commissioning	115 - 120	0	5 - 10	0	45 - 50	0	0 - 5	0
Mike Guy	Medical director	150 - 155	0	0	105	30 - 35	0	0	21
Pauline Fryer	Board secretary/head of corporate affairs	90 - 95	180 - 185	0	28	35 - 40	70 - 75	0	11
Rachel Chapman	Director of public engagement and communications	85 - 90	100 - 105	0	0	30 - 35	40 - 45	0	0
Sue Gordon	Executive director of public health	105 - 110	0	0	0	40 - 45	0	0	0
Lesley Young-Murphy	Interim Director of Community Care and Organisational Development	95 - 100	0	0	1	35 - 40	0	0	1
Neil Bradbury	Non-executive director	5 - 10	0	0	0	5 - 10	0	0	0
Jacqui Henderson	Non-executive director	35 - 40	0	0	0	35 - 40	0	0	0
Sheila Stokes White	Non-executive director	5 - 10	0	0	0	5 - 10	0	0	0

Northumberland Care Trust remuneration report (continued)

		2012-13						
		Rl in Pension at age 60 (bands of £2,500)	**Rl 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**	**Rl 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	1,716	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
Neil Bradbury	Non-executive director	0	0	0	0	0	0	0
Jacqui Henderson	Non-executive director	0	0	0	0	0	0	0
Sheila Stokes White	Non-executive director	0	0	0	0	0	0	0

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF NORTHUMBERLAND CARE TRUST

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 Northumberland Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

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 Northumberland Care Trust for the year ended 31 March 2013.

David Wilkinson FCA, CF (Engagement Lead),
For and on behalf of Deloitte LLP,
Appointed Auditor,
Newcastle, UK,
7 June 2013

Department of Health

NHS

Northumberland Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Northumberland Care Trust

2012-13 Accounts

Northumberland 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

Andrew D Bangert

27 March 2013

[1] 2006 c.41.

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

The Department of Health's Accounting Officer designates the Signing Officer of the accounts of Care Trusts 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 Care Trust 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

NORTHUMBERLAND CARE TRUST
ANNUAL GOVERNANCE STATEMENT 2012/13

This statement was prepared as part of the 2012/13 annual accounts for Northumberland Care Trust .

Introduction

The NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health, required the Signing Officer for Northumberland Care Trust to provide assurance about the stewardship of this organisation. The Signing Officer for Northumberland Care Trust until 28th March 2013 was Mr Chris Reed, Chief Executive. From this date, to 31st March 2013, the Signing Officer status passed, with the approval of the Joint Board of North of Tyne Primary Care Trusts, to Mr John Lawlor, National Commissioning Board Area Team Director for Cumbria, Northumberland, Tyne and Wear. Mr Lawlor will sign the accounts of the Care Trust.

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 term aims of Northumberland Care Trust 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 Care Trust 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 the 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 and Care Trust to deal with corporate close-down matters that could not be completed sooner, including for example the signing of the PCT and Care Trust 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 to provide 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 Northumberland Care Trust 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 were 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 was 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 has 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 Northumberland Clinical Commissioning Group:

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 CCG reporting to the Joint Board. In order to support this, regular assurance meetings were held with the CCG to monitor its performance throughout the year.

These meetings replaced the finance sub group as a means of assuring the Board of appropriate financial management within the CCG and were attended by the Vice Chair and the Chair of the Audit Committee.

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 Northumberland Care Trust. 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 the personal capacity of each individual to fulfill 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 Northumberland Care Trust and across the 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 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 and were 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 and Care Trusts in North of Tyne the waiting times for access to consultant led services 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.

Ambulance response times within Northumberland were a major focus. A range of initiatives were ongoing to improve handover delays and GP urgent requests across the North East which impacted significantly upon the Northumberland performance.

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 the Care Trust 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. This was a standing agenda item for the Audit Committee.

There was significant working with the Care Trust's 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 in respect of the assessment, eligibility and financial management of individuals qualifying for CHC. This was supported by a written update in January 2012 and an internal audit report (NOT 1F05) which was presented to the Audit Committee on 16 March 2012 as part of the progress report.

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 across the North of Tyne cluster 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 be 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, to develop care closer to home and to deliver improvements to health and wellbeing and to improve 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 to both commissioners and providers and collectively these savings were achieved in full.

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. Northumberland Care Trust 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 Care Trust'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 Northumberland CCG and the NHS Commissioning Board Area Team were sighted on the challenge ahead. Handover meetings to brief them directly on material matters took place and the notes of these meetings form part of another agenda item for the Joint Board's final meeting.

6.4 Funding for Rural Healthcare – Acton Shapiro Report

In December 2011, Northumberland Care Trust agreed to an order by consent from the High Court to consider afresh, a report with recommendations undertaken by Acton Shapiro on the funding for primary care in rural areas. This followed legal action brought on behalf of Friends of Bellingham.

The Acton Shapiro report recommended that the Care Trust should:

- Agree a process with the practices affected for the phasing out the current pattern of rurality and small practice payments;
- Use some of this 'pot' of funding to pay for further Enhanced services or commission individual services which are specifically designed for dispersed and isolated communities;
- Retain a small practice allowance but focus this on the very small practices i.e. under 3,000 patients and consider an enhancement for practices which are both very small and very rural;
- Consider introducing a one-off grant which rural practices can apply for to help them address some of the challenges of delivering healthcare in very rural areas.

The Board established a sub-committee to review these recommendations and at its May 2012 meeting, the Board accepted the first three recommendations of the report. It also accepted in principal the fourth recommendation and that further work in conjunction with the LMC would consider how to implement this recommendation. The Board noted that nascent Northumberland CCG was seeking to ask the Department of Health to better recognise the needs of rural populations in the allocation formula and the Board supported the CCG in this regard. The Board also concluded that non-recurring investment in infrastructure or equipment for use in rural areas could be made by NHS NoT which would be contingent upon overall affordability constraints.

6.5 Delivering System Reform

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

During 2012/13 the risks identified with these changes included maintaining the balance between retaining control to meet 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 Care Trust 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 of 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 had not been discharged formed part of a Transfer Scheme, a legal document to confirm 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 Northumberland Care Trust 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.

6.6 Adult Safeguarding

6.6.1 Safeguarding

A number of adult safeguarding issues were raised in 2012/13 in relation to nursing homes and specialist hospital placements. The Care Trust 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.

6.6.2 Winterbourne

North of Tyne worked with local authorities and Specialist commissioning to develop an action plan in response to the Winterbourne Concordat (2012). The Care Trust were committed to working collaboratively with all Care Trust 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.

6.7 Procurement Challenges

As a commissioning organisation, Northumberland Care Trust 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 Care Trust 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.

6.8 Information Governance and Data Security

The Care Trust 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.

6.9 Fraud Awareness and Anti Bribery

The Care Trust was 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 Care Trust 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.

7. 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.

8. 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 Northumberland.

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 promoted in line with the NHS Constitution.

In all of their efforts the Care Trust was 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 Northumberland Care Trust 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

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

Northumberland Care Trust

These Accounts for the year ended 31 March 2013 have been prepared by the Northumberland 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	**895**	587
Other costs	5.1	**604,488**	590,102
Income	4	**(13,695)**	(14,581)
Net Operating Costs for the Financial Year		**591,688**	576,108
Of which:			
Administration Costs			
Gross employee benefits	7.1	**109**	401
Other costs	5.1	**9,895**	9,347
Net Administration Costs for the Financial Year		**10,004**	9,748
Programme Expenditure			
Gross employee benefits	7.1	**786**	186
Other costs	5.1	**594,593**	580,755
Income	4	**(13,695)**	(14,581)
Net Programme Expenditure for the Financial Year		**581,684**	566,360

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**287**	928
Net (gain) on revaluation of property, plant & equipment	**(1,373)**	(73)
Net actuarial loss on pension schemes	**0**	49
Total Comprehensive Net Expenditure for the Year	**590,602**	577,012

The notes on pages 22 to 63 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	**30,299**	21,573
Intangible assets	13	**242**	126
Total Non-current Assets		**30,541**	21,699
Current Assets:			
Trade and other receivables	19	**6,684**	5,586
Cash and cash equivalents	23	**28**	36
Total Current Assets		**6,712**	5,622
Non-current assets held for sale	24	**270**	190
Total Current Assets		**6,982**	5,812
Total Assets		**37,523**	27,511
Current Liabilities			
Trade and other payables	25	**(21,592)**	(27,240)
Provisions	32	**(1,774)**	0
Total Current Liabilities		**(23,366)**	**(27,240)**
Non-current Assets less Net Current Assets/Liabilities		**14,157**	271
Non-current Liabilities			
Trade and other payables	25	**(79)**	(79)
Provisions	32	**(1,756)**	(539)
Total Non-current Liabilities		**(1,835)**	(618)
Total Assets Employed:		**12,322**	(347)
Financed by Taxpayers' Equity:			
General fund		**8,249**	(3,334)
Revaluation reserve		**4,122**	3,036
Other reserves		**(49)**	(49)
Total Taxpayers' Equity:		**12,322**	(347)

The notes on pages 22 to 63 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 signed on its behalf by the Signing Officer John Lawlor

Signing Officer: J Lawlor Date: 7/6/2013

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

	General Fund	Revaluation Reserve	Other Reserves	Total Reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(3,334)**	**3,036**	**(49)**	**(347)**
Changes in Taxpayers' Equity for 2012-13				
Net operating cost for the year	**(591,688)**	**0**	**0**	**(591,688)**
Net gain on revaluation of property, plant, equipment	**0**	**1,373**	**0**	**1,373**
Impairments	**0**	**(287)**	**0**	**(287)**
Total Recognised Income and Expense for 2012-13	**(591,688)**	**1,086**	**0**	**(590,602)**
Net Parliamentary funding	**603,271**	**0**	**0**	**603,271**
Balance at 31 March 2013	**8,249**	**4,122**	**(49)**	**12,322**
Balance at 1 April 2011	(1,538)	3,966	0	2,428
Changes in Taxpayers' Equity for 2011-12				
Net operating cost for the year	(576,108)	0	0	(576,108)
Net gain on Revaluation of Property, Plant and Equipment	0	73	0	73
Impairments	0	(928)	0	(928)
Net gain on disposal of available for sale financial assets	75	(75)	0	0
Net actuarial (loss) on pensions	0	0	(49)	(49)
Total Recognised Income and Expense for 2011-12	(576,033)	(930)	(49)	(577,012)
Net Parliamentary funding	574,237	0	0	574,237
Balance at 31 March 2012	(3,334)	3,036	(49)	(347)

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		**(591,688)**	(576,108)
Depreciation and Amortisation	12.1, 12.2/13.1, 13.2	**1,012**	757
Impairments and Reversals	12.1, 12.2/14/24	**10,309**	1,815
Decrease in Inventories		**0**	323
(Increase)/Decrease in Trade and Other Receivables	19.1	**(1,012)**	14,897
(Decrease) in Trade and Other Payables	25	**(6,052)**	(6,830)
(Increase)in Other Current Liabilities	26	**0**	(2,970)
Provisions Utilised	32	**(280)**	(284)
Increase/(Decrease) in Provisions	32	**3,271**	(121)
Net Cash (Outflow) from Operating Activities		**(584,440)**	(568,521)
Cash Flows from Investing Activities			
(Payments) for Property, Plant and Equipment	12.1, 12.2	**(18,646)**	(5,855)
(Payments) for Intangible Assets	13.1, 13.2	**(193)**	(137)
Proceeds of Disposal of Assets Held for Sale (PPE)	24	**0**	250
Net Cash (Outflow) from Investing Activities		**(18,839)**	(5,742)
Net Cash (Outflow) before Financing		**(603,279)**	(574,263)
Cash Flows from Financing Activities			
Net Parliamentary Funding	3.4	**603,271**	574,237
Net Cash Inflow from Financing Activities		**603,271**	574,237
Net (Decrease) in Cash and Cash Equivalents	23	**(8)**	(26)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	23	**36**	62
Cash and Cash Equivalents (and Bank Overdraft) at Year End	23/36.1	**28**	36

1. Accounting Policies

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

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

In accordance with the directed accounting policy from the Secretary of State, the Care Trust 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

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 Care Trust'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 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

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

Within the carrying values attributed to non-current assets of the Care Trust, Land and Buildings with a value of £28,702k have been valued by the Valuation Office Agency in accordance with the requirements of IFRS. The revised valuations have resulted in a revenue charge for impairments of £10,309k, of which approximately half is due to the completion of the new primary care centre at Morpeth. In addition there were increases in the carrying value of assets of £1,086k recognised through the Revaluation Reserve.

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

Northumberland Care Trust is a Primary Care Trust that is designated by the Secretary of State under s45 of the Health and Social Care Act 2001 as a Care Trust because of its joint activities with Northumberland County Council.
The Local Authority funds the Care Trust to undertake or commission Social Care activities on a delegated basis. The Care Trust accounts for the income from the Local Authority and the related expenditure. With effect from 1 April 2011, the joint activities have been transferred to the management of Northumbria Healthcare NHS Foundation Trust.

1.4 Pooled Budgets

Northumberland Care Trust has not entered into any pooled budgets.

1.5 Taxation

The Care Trust 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, Care Trusts therefore analyse and report revenue income and expenditure by "admin and programme"
For Care Trusts, 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 Care Trust;
- 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 Care Trust'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 CareTrust'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 Care Trust; 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 Care Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Care Trust 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 Care Trust 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 Care Trust'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 Care Trusts 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 Care Trusts.

The NHSLA operates a risk pooling scheme under which the Care Trust 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 Care Trust 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 Care Trust commits itself to the retirement, regardless of the method of payment.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Care Trust's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the ***General Fund*** *and reported on the Statement of Changes in Taxpayers' Equity* .

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 Care Trust 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 Care Trust 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 Care Trust 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 Care Trust 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 Care Trust'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 Care Trust as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Care Trust'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 Care Trust'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 Care Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Care Trust 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 Care Trust 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 Care Trust 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 Care Trust 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 Care Trust 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 Care Trust 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.

Other Financial Liabilities

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

1.25 Going Concern

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Northumberland CT was dissolved on 1st April 2013. The Care Trust'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. Revaluation increases of £1,086k and impairments of £10,309k 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.

1.26 Events After the Reporting Period

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

NHS Northumberland Clinical Commissioning Group (CCG) who will commission healthcare services on behalf of the patients in Northumberland 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.

Northumberland County Council who will commission public heath services.

1. Accounting Policies (continued)

1.27 Accounting Standards that Have Been Issued but Have Not Yet Been Adopted

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

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

2 Operating Segments

With effect from 1 April 2011, the 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 Care Trust 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 Care Trust's performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**591,688**	576,108
Revenue Resource Limit	**591,945**	576,427
Underspend Against Revenue Resource Limit (RRL)	**257**	319

3.2 Capital Resource Limit

	2012-13	2011-12
	£000	£000
The Care Trust is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**19,182**	5,708
Charge to Capital Resource Limit	**19,157**	5,694
Underspend Against CRL	**25**	14

3.3 Provider Full Cost Recovery Duty

The Care Trust acted only as a commissioner of services in 2012-13 and 2011-12.

3.4 Under/(Over)Spend Against Cash Limit

	2012-13	2011-12
	£000	£000
Total Charge to Cash Limit	**603,271**	574,237
Cash Limit	**603,271**	581,462
Under/(Over)Spend Against Cash Limit	**0**	7,225

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

	2012-13
	£000
Total cash received from DH (Gross)	**530,967**
Sub Total: Net Advances	**530,967**
Plus: cost of Dentistry Schemes (central charge to cash limits)	**12,549**
Plus: drugs reimbursement (central charge to cash limits)	**59,755**
Parliamentary Funding Credited to General Fund	**603,271**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Programme	2011-12
	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**4,565**	**4,565**	4,527
Prescription Charge income	**3,381**	**3,381**	3,214
Strategic Health Authorities	**2,915**	**2,915**	2,855
NHS Foundation Trusts	**1,319**	**1,319**	1,640
Primary Care Trusts - Other	**0**	**0**	602
Other Non-NHS Patient Care Services	**877**	**877**	1,594
Charitable and Other Contributions to Expenditure	**0**	**0**	10
Rental revenue from operating leases	**36**	**36**	115
Other revenue	**602**	**602**	24
Total miscellaneous revenue	**13,695**	**13,695**	14,581

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 PCTs				
Healthcare	**40,334**	**0**	**40,334**	33,016
Non-Healthcare	**7,312**	**6,854**	**458**	6,342
Total	**47,646**	**6,854**	**40,792**	39,358
Goods and Services from Other NHS Bodies Other than FTs				
Goods and services from NHS Trusts	**1,123**	**0**	**1,123**	8,297
Goods and services (other, excl Trusts, FT and PCT))	**59**	**18**	**41**	355
Total	**1,182**	**18**	**1,164**	8,652
Goods and Services from Foundation Trusts	**340,072**	**372**	**339,700**	336,519
Purchase of Healthcare from Non-NHS bodies	**61,538**	**0**	**61,538**	58,237
Expenditure on Drugs Action Teams	**1,396**	**0**	**1,396**	1,518
Contractor Led GDS & PDS (excluding employee benefits)	**17,751**	**0**	**17,751**	17,320
Chair, Non-executive Directors & PEC remuneration	**57**	**57**	**0**	67
Prescribing Costs	**52,838**	**0**	**52,838**	54,291
G/PMS, APMS and PCTMS (excluding employee benefits)	**46,436**	**0**	**46,436**	45,334
Pharmaceutical Services	**7,922**	**0**	**7,922**	8,020
New Pharmacy Contract	**7,756**	**0**	**7,756**	7,873
General Ophthalmic Services	**3,324**	**0**	**3,324**	3,397
Supplies and Services - Clinical	**94**	**0**	**94**	419
Supplies and Services - General	**63**	**0**	**63**	462
Establishment	**272**	**18**	**254**	280
Transport	**38**	**0**	**38**	11
Premises	**2,116**	**0**	**2,116**	1,264
Impairments & Reversals of Property, plant and equipment	**10,249**	**0**	**10,249**	1,815
Impairments and Reversals of non-current assets held for sale	**60**	**0**	**60**	0
Depreciation	**935**	**935**	**0**	744
Amortisation	**77**	**77**	**0**	13
Impairment of Receivables	**(63)**	**0**	**(63)**	123
Audit Fees	**135**	**135**	**0**	187
Clinical Negligence Costs	**92**	**92**	**0**	112
Education and Training	**2,290**	**0**	**2,290**	2,122
Grants for revenue purposes	**0**	**0**	**0**	120
Other	**212**	**1,337**	**(1,125)**	1,844
Total Operating Costs Charged to Statement of Comprehensive Net Expenditure	**604,488**	**9,895**	**594,593**	590,102
Employee Benefits (Excluding Capitalised Costs)				
Other Employee Benefits	**895**	**109**	**786**	587
Total Employee Benefits Charged to SOCNE	**895**	**109**	**786**	587
Total Operating Costs	**605,383**	**10,004**	**595,379**	590,689
Grants to Fund Revenue Expenditure				
To Local Authorities	**0**	**0**	**0**	120
Total Revenue Grants	**0**	**0**	**0**	120
Total Grants	**0**	**0**	**0**	120

	Total	Commissioning Services	Public Health
Care Trust Running Costs 2012-13			
Running costs (£000s)	**10,078**	**9,357**	**721**
Weighted population (number in units)*	**336,634**	**336,634**	**336,634**
Running costs per head of population (£ per head)	**29.9**	**27.8**	**2.1**
Care Trust Running Costs 2011-12			
Running costs (£000s)	9,908	9,135	773
Weighted population (number in units)	336,634	336,634	336,634
Running costs per head of population (£ per head)	29.4	27.1	2.3

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

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

5.2 Analysis of Operating Expenditure by Expenditure Classification	**2012-13** **£000**	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	**46,436**	45,334
Prescribing costs	**52,838**	54,291
Contractor led GDS & PDS	**17,751**	17,320
General Ophthalmic Services	**3,324**	3,397
Pharmaceutical services	**7,922**	8,020
New Pharmacy Contract	**7,756**	7,873
Total Primary Healthcare Purchased	**136,027**	136,235
Purchase of Secondary Healthcare		
Learning Difficulties	**2,620**	2,535
Mental Illness	**50,937**	49,988
Maternity	**9,861**	9,696
General and Acute	**255,367**	250,776
Accident and emergency	**21,520**	21,058
Community Health Services	**82,584**	48,376
Other Contractual	**16,573**	45,131
Total Secondary Healthcare Purchased	**439,462**	427,560
Grant Funding		
Grants for revenue purposes	**0**	120
Total Healthcare Purchased by Care Trust	**575,489**	563,915
Healthcare from NHS FTs included above	**339,578**	336,263

6. Operating Leases

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

The Care Trust leases 8 buildings for terms ranging from 1 to 20 years.

In addition the Care Trust leases cars under short term leases.

Northumberland Care Trust, 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 Care Trust 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 Care Trust as Lessee

		2012-13	2011-12
	Buildings	**Total**	
	£000	**£000**	£000
Payments Recognised as an Expense			
Minimum lease payments		**1,473**	1,556
Total		**1,473**	1,556
Payable:			
No later than one year	**1,366**	**1,366**	1,423
Between one and five years	**6,714**	**6,714**	6,760
After five years	**14,756**	**14,756**	15,540
Total	**22,836**	**22,836**	23,723
Total future sublease payments expected to be received		**0**	0

6.2 Care Trust as Lessor

	2012-13	2011-12
	£000	£000
Recognised as Income		
Rental Revenue	**36**	115
Total	**36**	115
Receivable:		
No later than one year	**36**	40
Total	**36**	40

7. Employee Benefits and Staff Numbers

7.1 Employee Benefits

2012-13							
				Permanently employed			Other
	Total	Admin	Programme	Total	Admin	Programme	Total	Programme
	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits - Gross Expenditure								
Salaries and wages	**937**	**90**	**847**	**686**	**90**	**596**	**251**	**251**
Social security costs	**50**	**7**	**43**	**50**	**7**	**43**	**0**	**0**
Employer Contributions to NHS BSA - Pensions Division	**91**	**12**	**79**	**91**	**12**	**79**	**0**	**0**
Total Employee Benefits	**1,078**	**109**	**969**	**827**	**109**	**718**	**251**	**251**
Total - Net Employee Benefits Including Capitalised Costs	**1,078**	**109**	**969**	**827**	**109**	**718**	**251**	**251**
Employee Costs Capitalised	**183**	**0**	**183**	**0**	**0**	**0**	**183**	**183**
Gross Employee Benefits Excluding Capitalised Costs	**895**	**109**	**786**	**827**	**109**	**718**	**68**	**68**
Recognised As:								
Commissioning employee benefits	**895**			**827**			**68**	
Gross Employee Benefits Excluding Capitalised Costs	**895**			**827**			**68**	

Employee Benefits - Prior Year

	Total	Permanently employed	Other
	£000	£000	£000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	628	465	163
Social security costs	34	34	0
Employer Contributions to NHS BSA - Pensions Division	62	62	0
Total Gross Employee Benefits	724	561	163
Total - Net Employee Benefits Including Capitalised Costs	724	561	163
Employee Costs Capitalised	137	0	137
Gross Employee Benefits Excluding Capitalised Costs	587	561	26
Recognised As:			
Commissioning employee benefits	587		
Gross Employee Benefits Excluding Capitalised Costs	587		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	**Permanently employed Number**	**Other Number**	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Administration and estates	**21**	**18**	**3**	20	19	1
Nursing, midwifery and health visiting staff	**5**	**5**	**0**	0	0	0
TOTAL	**26**	**23**	**3**	20	19	1
Of the above - staff engaged on capital projects	**3**	**0**	**3**	2	0	2

7.3 Staff Sickness Absence and Ill Health Retirements

	2012-13 Number	2011-12 Number
Total Days Lost	**596**	12,413
Total Staff Years	**38**	1,035
Average working Days Lost	**15.68**	11.99

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.

The figure for average working days lost during 2012-13 was calculated using a more appropriate methodology than the previous year and hence the change in 'days lost' and 'staff years' between the two years. The resulting figures for both years is however correct.

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**2**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**138**	83

7.4 Exit Packages Agreed During 2012-13

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 Northumberland Care Trust on a weighted capitation basis. Northumberland's share of the redundancy costs of nine people was £427,345. There were no exit packages paid in 2011-12.

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.

7.5d Pension costs - Local Government Pension Scheme

Social Care staff who transferred employment from Northumberland County Council have retained membership of the Local Government Pension Scheme.

Northumberland County Council Pension Fund

Introduction
The disclosures below relate to the funded liabilities within the Northumberland County Council Pension Fund (the "Fund") which is part of the Local Government Pension Scheme (the "LGPS"). The funded nature of the LGPS requires Northumberland Care Trust and its employees to pay contributions into the Fund, calculated at a level intended to balance the pensions liabilities with investment assets.

Northumberland Care Trust recognises gains and losses in full, immediately through Other Comprehensive Income and Expenditure.

In accordance with Financial Reporting Standards, disclosure of certain information concerning assets, liabilities, income and expenditure relating to pension schemes is required.

Contributions for the Accounting Period Ending 31 March 2014
Northumberland Care Trust is not expected to make any further regular contributions to the fund in the accounting period ending 31 March 2014. However contributions may be required in respect of any cessation deficit following the Care Trust's exit from the Fund.

Assumptions

The latest actuarial valuation of Northumberland Care Trust's liabilities took place as at 01 April 2011. Liabilities have been estimated by the independent qualified actuary on an actuarial basis using the projected unit credit method. The principal assumptions used by the actuary in updating the latest valuation of the Fund for IAS 19 purposes were:

Principal Financial Assumptions (% per annum)

	31/03/2013	31/03/2012	31/03/2011	31/03/2010	31/03/2009
Discount rate	**4.7**	4.8	5.4	5.5	6.5
RPI Inflation	**3.7**	3.6	3.7	3.9	3.6
CPI Inflation	**2.8**	2.6	2.8	n/a	n/a
Rate of increase to pensions in payment*	**2.8**	2.6	2.8	3.9	3.6
Rate of increase to deferred pensions	**2.8**	2.6	2.8	3.9	3.6
Rate of general increase in salaries **	**4.7**	5.1	5.2	5.4	5.1

* In excess of Guaranteed Minimum Pension increases in payment where appropriate.

** In addition, allowance is made for the same age related promotional salary scales as used at the actuarial valuation of the Employer's Liabilities as at 01 April 2011.

7.5d Pension Costs - Local Government Pension Scheme (Continued)

Mortality Assumptions

The mortality assumptions are based on the recent actual mortality experience of members within the Fund and allow for expected future mortality improvements.

Post retirement mortality (retirement in normal health)	**31/03/2013**	31/03/2012
Males		
Year of Birth base table	**Standard SAPS Normal Health All Amounts**	Standard SAPS Normal Health All Amounts
Rating to above base table * (years)	**0**	0
Scaling to above base table rates	**100%**	100%
Improvements to base table rates	**CMI_2009 with a long term rate of improvement of 1.25% p.a.**	CMI_2009 with a long term rate of improvement of 1.25% p.a.
Future lifetime from age 65 (aged 65 at accounting date)	**22.5**	22.4
Future lifetime from age 65 (aged 45 at accounting date)	**24.3**	24.2
Females		
Year of Birth base table	**Standard SAPS Normal Health All Amounts**	Standard SAPS Normal Health All Amounts
Rating to above base table * (years)	**0**	0
Scaling to above base table rates	**100%**	100%
Improvements to base table rates	**CMI_2009 with a long term rate of improvement of 1.25% p.a.**	CMI_2009 with a long term rate of improvement of 1.25% p.a.
Future lifetime from age 65 (aged 65 at accounting date)	**24.7**	24.5
Future lifetime from age 65 (aged 45 at accounting date)	**26.6**	26.5

** A rating of x years means that members of the Fund are assumed to follow the mortality pattern of the base table for an individual x years older than them. The ratings shown apply to normal health retirements.*

	31/03/2013	31/03/2012
Commutation	**Each member assumed to exchange 50% of the maximum amount permitted of their past service pension rights on retirement, for additional lump sum.**	Each member assumed to exchange 50% of the maximum amount permitted of their past service pension rights on retirement, for additional lump sum.
	Each member assumed to exchange 75% of the maximum amount permitted of their future service pension rights on retirement, for additional lump sum.	Each member assumed to exchange 75% of the maximum amount permitted of their future service pension rights on retirement, for additional lump sum.

7.5d Pension Costs - Local Government Pension Scheme (Continued)

Expected Return on Assets

The approximate split of assets for the Fund as a whole (based on data supplied by the Fund Administering Authority) is shown in the table below. Also shown are the assumed rates of return adopted by the Employer for the purposes of IAS 19.

	Long-term Expected Rate of Return at 31-Mar 2013 (% pa) *	**Asset Split at 31-Mar 2013 (%)**	Long-term Expected Rate of Return at 31-Mar 2012 (% pa) *	Asset Split at 31-Mar 2012 (%)	Long-term Expected Rate of Return at 01-Apr 2011 (% pa) *	Asset Split at 01-Apr 2011 (%)	Long-term Expected Rate of Return at 31-Mar 2010 (% pa) *	Asset Split at 31-Mar 2010 (%)	Long-term Expected Rate of Return at 31-Mar 2009 (% pa) *	Asset Split at 31-Mar 2009 (%)
Equities	**7.8**	**68.7**	8.1	69.6	8.4	68.3	8.0	70.5	7.0	67.4
Property	**7.3**	**4.4**	7.6	5.0	7.9	5.2	8.5	5.5	6.0	7.5
Government Bonds	**2.8**	**15.4**	3.1	14.0	4.4	18.2	4.5	15.3	4.0	17.9
Corporate Bonds	**3.8**	**10.1**	3.7	10.6	5.1	7.1	5.5	7.7	5.8	6.0
Cash	**0.9**	**0.8**	1.8	0.8	1.5	1.0	0.7	1.0	1.6	1.2
Other**	**7.8**	**0.6**	8.1	0.0	8.4	0.2	8.0	0.0	1.6	0.0
Total	**6.6**	**100.0**	6.9	100.0	7.3	100.0	7.2	100.0	6.3	100.0

** The overall expected rate of return on Fund assets is a weighted average of the individual expected rates of return on each asset class, and is shown in the bottom row of the above table.*

*** Other holdings may include hedge funds, currency holdings, asset allocation futures and other financial instruments. It is assumed these will get a return in line with equities.*

Description of the Basis Used to Determine Expected Return

Northumberland Care Trust employs a building block approach in determining the rate of return on Fund assets. Historical markets are studied and assets with higher volatility are assumed to generate higher returns consistent with widely accepted capital market principles. The assumed rate of return on each asset class is set out within this note. The overall expected rate of return on assets is then derived by aggregating the expected return for each asset class over the actual asset allocation for the Fund at 31 March 2013.

Reconciliation of Funded Status to Balance Sheet	**Value as at 31-Mar-13 £M's**	Value as at 31-Mar-12 £M's
Fair value of assets	**0.000**	0.353
Present value of funded defined benefit obligation	**0.008**	0.432
Pension liability recognised on the Statement of Financial Position	**(0.008)**	(0.079)

Analysis of the Profit and Loss Charge	**Period Ending 31-Mar-13 £M's**	Period Ending 31-Mar-12 £M's
Current service cost	**0.018**	0.017
Past service cost	**0.010**	0.000
Interest cost	**0.021**	0.019
Expected return on assets	**(0.025)**	(0.023)
Curtailment cost	**0.000**	0.000
Settlement cost	**(0.043)**	0.000
Expense recognised	**(0.019)**	0.013

Changes to the Present Value of Liabilities During the Accounting Period	**Period Ending 31-Mar-13 £M's**	Period Ending 31-Mar-12 £M's
Opening defined benefit obligation	**0.432**	0.348
Current service cost	**0.018**	0.017
Interest cost	**0.021**	0.019
Contributions by participants	**0.010**	0.006
Actuarial (gains) / losses on liabilities *	**0.003**	0.042
Net benefits paid out #	**0.000**	0.000
Past service cost	**0.010**	0.000
Business combinations	**0.000**	0.000
Curtailments	**0.000**	0.000
Settlements	**(0.486)**	0.000
Closing defined benefit obligation	**0.008**	0.432

** Includes changes to the actuarial assumptions.*

 # Consists of net cash-flow out of the Fund in respect of the employer, excluding contributions and any death in service lump sums paid, and including an approximate allowance for the expected cost of death in service lump sums.

7.5d Pension Costs - Local Government Pension Scheme (Continued)

Changes to the Fair Value of Assets During the Accounting Period	**Period Ending 31-Mar-13 £M's**	Period Ending 31-Mar-12 £M's
Opening fair value of assets	**0.353**	0.310
Expected return on assets	**0.025**	0.023
Actuarial gains / (losses) on assets	**0.026**	(0.007)
Contributions by the employer	**0.029**	0.021
Contributions by participants	**0.010**	0.006
Net benefits paid out #	**0.000**	0.000
Business Combinations	**0.000**	0.000
Settlements	**(0.443)**	0.000
Closing fair value of assets	**0.000**	0.353

 # Consists of net cash-flow out of the Fund in respect of the employer, excluding contributions and any death in service lump sums paid, and including an approximate allowance for the expected cost of death in service lump sums.

Actual Return on Assets	**Period Ending 31-Mar-13 £M's**	Period Ending 31-Mar-12 £M's
Expected return on assets	**0.025**	0.023
Actuarial gain / (loss) on assets	**0.026**	(0.007)
Actual return on assets	**0.051**	0.016

Analysis of Amounts Recognised in SOCITE	**Period Ending 31-Mar-13 £M's**	Period Ending 31-Mar-12 £M's	Period Ending 31-Mar-11 £M's	Period Ending 31-Mar-10 £M's	Period Ending 31-Mar-09 £M's	Period Ending 31-Mar-08 £M's	Period Ending 31-Mar-07 £M's
Total actuarial gains / (losses)	**0.023**	(0.049)	(0.62)	(0.06)	(5.20)	0.89	0.52

History of Experience Gains and Losses *	**Period Ending 31-Mar-13**	Period Ending 31-Mar-12
Experience Gains / (Losses) on Assets		
Amount (£M's)	0.026	(0.007)
Percentage of assets	N/A	(2.0%)
Experience Gains / (Losses) on Liabilities #		
Amount (£M's)	0.000	0.000
Percentage of the present value of the liabilities	0.0%	0.0%

**This history can be built up over time and need not be constructed retrospectively (and once complete will show the current period and previous four periods)*

 # This item consists of gains / (losses) in respect of liability experience only and excludes any change in liabilities in respect of changes to the actuarial assumptions used.

7.5e. Transfer of staff in membership of Local Government Pension Scheme

As part of the process of transferring all Provider Services to Northumberland Healthcare NHS Foundation Trust with effect from 1 April 2011, most of the Care Trust staff who were in membership of the Northumberland County Council Pension Scheme at that date were transferred to the Foundation Trust, which had (under has the terms of the Business Transfer Agreement) become an employer member of the Northumberland County Council Pension scheme.

Under the terms of the agreement the Foundation Trust continued in membership of the Northumberland County Council pension scheme, and took responsibility for the relevant underlying deficit of the scheme at that date. The liability for the pension fund deficit was calculated in accordance with IAS19 (i.e. the excess of actuarial liability for the staff transferred over the related share of scheme net assets) was valued by the Scheme actuary at £1.37M as at 31 March 2011, and the 2011-12 accounts were restated accordingly including the effect of £2.97M cash payable to the Foundation Trust in 2011/12 in connection with the Business Transfer agreement.

The historic accumulated actuarial deficit arising on the Care Trust's Pensions Reserve was transferred to General fund as at 31 March 2011.

Northumberland Care Trust ceased participation in the Fund on 31 March 2013. Northumberland County Council will be subsuming assets and the majority of the liabilities in respect of the Care Trust. However the Care Trust will be responsible for any cessation deficit arising in respect of service between 10 August 2009 and 31 March 2011 for one member who was not included in the original valuation of the Care Trust's liabilities, as the member had additional part time employment for which they were not enrolled in the Fund.

The member's record was subsequently recognised in the LGPS and the Care Trust paid all outstanding contributions due to the Fund in respect of this member in December 2012. This backdating of service has been included as a past service cost and, for pragmatic reasons, the figures have been set to equal the additional emploer contributions paid. However a deficit may exist to the extent that the contributions together with estimated investment returns to 31 March 2013 in respect of service completed with the Care Trust between 10 August 2009 and 31 March 2011, are not sufficient to cover the value of the member's benefits accrued during the same period at the cessation date of 31 March 2013.

The value of the assets available to fund the member's benefits have been subtracted from the value of the liabilities of the member's additional service with the Care Trust, to give an estimated cessation deficit of £0.008M. Northumberland Care Trust will be liable for this amount to the Fund in respect of the cessation deficit as at 31 March 2013.

From 1 April 2013, Northumberland Care Trust will no longer have any liability or assets in the Fund with the exception of the cessation deficit due to the Fund. An allowance has been made for a settlement of assets and liabilities in respect of the Care Trust at the accounting date, which shows the final balance sheet position to be nil assets and liabilities equal to the amount of the estimated cessation deficit.

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	**13,406**	**117,786**	8,596	113,541
Total Non-NHS Trade Invoices Paid Within Target	**12,844**	**113,638**	8,081	110,185
Percentage of NHS Trade Invoices Paid Within Target	**95.81%**	**96.48%**	94.01%	97.04%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,273**	**404,325**	1,969	392,930
Total NHS Trade Invoices Paid Within Target	**2,164**	**402,174**	1,826	388,805
Percentage of NHS Trade Invoices Paid Within Target	**95.20%**	**99.47%**	92.74%	98.95%

The Better Payment Practice Code requires the Care Trust 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

The Care Trust had no investment income in either 2012-13 or 2011-12.

10. Other Gains and Losses

The Care Trust has no gains/losses other than those arising on normal operating activities.

11. Finance Costs

The Care Trust has no Finance costs (interest payable or unwinding of discounts).

12.1 Property, Plant and Equipment

2012-13	Land	Buildings Excluding Dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or Valuation:									
At 1 April 2012	**5,958**	**11,633**	**704**	**6,909**	**840**	**146**	**4,213**	**626**	**31,029**
Additions Purchased	**0**	**18,558**	**0**	**0**	**0**	**0**	**406**	**0**	**18,964**
Reclassifications	**0**	**5,861**	**0**	**(5,861)**	**0**	**0**	**0**	**0**	**0**
Reclassifications as Held for Sale	**0**	**(140)**	**0**	**0**	**0**	**0**	**0**	**0**	**(140)**
Upward Revaluation/Positive Indexation	**1,131**	**222**	**20**	**0**	**0**	**0**	**0**	**0**	**1,373**
Impairments/Negative Indexation	**0**	**(287)**	**0**	**0**	**0**	**0**	**0**	**0**	**(287)**
At 31 March 2013	**7,089**	**35,847**	**724**	**1,048**	**840**	**146**	**4,619**	**626**	**50,939**
Depreciation									
At 1 April 2012	**249**	**3,938**	**159**	**1,048**	**496**	**100**	**3,268**	**198**	**9,456**
Impairments	**0**	**10,249**	**0**	**0**	**0**	**0**	**0**	**0**	**10,249**
Charged During the Year	**0**	**343**	**19**	**0**	**71**	**24**	**404**	**74**	**935**
At 31 March 2013	**249**	**14,530**	**178**	**1,048**	**567**	**124**	**3,672**	**272**	**20,640**
Net Book Value at 31 March 2013	**6,840**	**21,317**	**546**	**0**	**273**	**22**	**947**	**354**	**30,299**
Purchased	**6,840**	**21,317**	**546**	**0**	**273**	**22**	**947**	**354**	**30,299**
Total at 31 March 2013	**6,840**	**21,317**	**546**	**0**	**273**	**22**	**947**	**354**	**30,299**
Asset Financing:									
Owned	**6,840**	**21,317**	**546**	**0**	**273**	**22**	**947**	**354**	**30,299**
Total at 31 March 2013	**6,840**	**21,317**	**546**	**0**	**273**	**22**	**947**	**354**	**30,299**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings Excluding Dwellings	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	£000's
At 1 April 2012	**2,546**	**396**	**94**	**0**	**0**	**0**	**0**	**0**	**3,036**
Movements	**1,131**	**(65)**	**20**	**0**	**0**	**0**	**0**	**0**	**1,086**
At 31 March 2013	**3,677**	**331**	**114**	**0**	**0**	**0**	**0**	**0**	**4,122**

The movement in the revaluation reserve mainly related to an increase in respect of land on the Mount Morpeth and land and buildings at Oaklands Morpeth. The latter being offset by decreases in respect of Broomhill and Nursery Park Ashington.

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	Dwellings	Assets Under Construction and Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	6,847	13,208	701	522	797	146	3,574	292	**26,087**
Additions Purchased	0	780	35	3,976	43	0	639	334	**5,807**
Reclassifications	0	(2,411)	0	2,411	0	0	0	0	**0**
Reclassifications as Held for Sale	0	(10)	0	0	0	0	0	0	**(10)**
Upward revaluation/positive indexation	0	73	0	0	0	0	0	0	**73**
Impairments/negative indexation	(889)	(7)	(32)	0	0	0	0	0	**(928)**
At 31 March 2012	**5,958**	**11,633**	**704**	**6,909**	**840**	**146**	**4,213**	**626**	**31,029**
Depreciation									
At 1 April 2011, including land impairments	69	3,061	128	0	425	76	2,998	140	**6,897**
Impairments	180	574	13	1,048	0	0	0	0	**1,815**
Charged During the Year	0	303	18	0	71	24	270	58	**744**
At 31 March 2012	**249**	**3,938**	**159**	**1,048**	**496**	**100**	**3,268**	**198**	**9,456**
Net book value	5,709	7,695	545	5,861	344	46	945	428	**21,573**
Purchased	5,709	7,695	545	5,861	344	46	945	428	**21,573**
Total at 31 March 2012	**5,709**	**7,695**	**545**	**5,861**	**344**	**46**	**945**	**428**	**21,573**
Asset financing:									
Owned	5,709	7,695	545	5,861	344	46	945	428	**21,573**
Total	**5,709**	**7,695**	**545**	**5,861**	**344**	**46**	**945**	**428**	**21,573**

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 exc Dwellings	1	78
Dwellings	8	58
Plant & Machinery	4	10
Transport Equipment	5	5
Information Technology	4	5
Furniture and Fittings	4	10

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	**11**	**137**	**148**
Additions - purchased	**0**	**193**	**193**
At 31 March 2013	**11**	**330**	**341**
Amortisation			
At 1 April 2012	**10**	**12**	**22**
Charged during the year	**1**	**76**	**77**
At 31 March 2013	**11**	**88**	**99**
Net Book Value at 31 March 2013	**0**	**242**	**242**
Net Book Value at 31 March 2013 Comprises			
Purchased	**0**	**242**	**242**
Total at 31 March 2013	**0**	**242**	**242**

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

Development expenditure primarily relates to the development of the Reporting Analysis and Intelligence Delive

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	11	0	11
Additions - internally generated	0	137	137
At 31 March 2012	11	137	148
Amortisation			
At 1 April 2011	9	0	9
Charged during the year	1	12	13
At 31 March 2012	10	12	22
Net Book Value at 31 March 2012	1	125	126
Net Book Value at 31 March 2012 comprises			
Purchased	1	125	126
Total at 31 March 2012	1	125	126

13.3 Intangible Non-current Assets

The Intangible Assets of the Care Trust include computer applications software licences, and the capitalised development costs of certain Information systems projects.

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 Care Trust's Intangible Assets include internally generated developments and enhancements of Information systems and web services, that generate future economic benefits.

No intangible assets have been acquired by government grant.

The Care Trust 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		
Development Expenditure	3	3

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

	2012-13 Total	2012-13 Programme
	£000	£000
Property, Plant and Equipment Impairments and Reversals Taken to SoCNE		
Changes in market price	**10,249**	**10,249**
Total Charged to Annually Managed Expenditure	**10,249**	**10,249**
Property, Plant and Equipment Impairments and Reversals Charged to the Revaluation Reserve		
Changes in market price	**287**	**0**
Total Impairments for PPE Charged to Reserves	**287**	**0**
Total Impairments of Property, Plant and Equipment	**10,536**	**10,249**
Non-current Assets Held For Sale - Impairments and Reversals Charged to SoCNE.		
Changes in market price	**60**	**60**
Total Charged to Annually Managed Expenditure	**60**	**60**
Total Impairments of Non-current Assets Held For Sale	**60**	**60**
Total Impairments Charged to Revaluation Reserve	**287**	**0**
Total Impairments Charged to SoCNE - AME	**10,309**	**10,309**
Overall Total Impairments	**10,596**	**10,309**

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 Care Trust 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**	11,119
Total	**0**	11,119

16.2 Other Financial Commitments

The Care Trust 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	**Non-current Receivables £000s**	**Current Payables £000s**	**Non-current Payables £000s**
Balances with other Central Government Bodies	**4,239**	**0**	**964**	**0**
Balances with Local Authorities	**0**	**0**	**2**	**0**
Balances with NHS Trusts and Foundation Trusts	**1,740**	**0**	**4,502**	**0**
Balances with bodies external to government	**705**	**0**	**16,126**	**79**
At 31 March 2013	**6,684**	**0**	**21,594**	**79**
Prior Period:				
Balances with other Central Government Bodies	11	0	2,047	0
Balances with Local Authorities	0	0	9,126	0
Balances with NHS Trusts and Foundation Trusts	3,447	0	3,846	0
Balances with bodies external to government	2,128	0	12,300	0
At 31 March 2012	5,586	0	27,319	0

18. Inventories

The Care Trust held no inventories during 2012-13 or 2011-12.

19.1 Trade and Other Receivables

	Current	
	31 March 2013	31 March 2012
	£000	£000
NHS receivables - revenue	**5,443**	3,458
NHS receivables - capital	**86**	0
Non-NHS receivables - revenue	**524**	541
Non-NHS prepayments and accrued income	**207**	1,680
Provision for the impairment of receivables	**(48)**	(170)
VAT	**450**	56
Other receivables	**22**	21
Total	**6,684**	5,586

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	**168**	531
By three to six months	**17**	871
By more than six months	**129**	3
Total	**314**	1,405

The Care Trust does not hold collateral for receivables.

19.3 Provision for Impairment of Receivables

	2012-13	**2011-12**
	£000	**£000**
Balance at 1 April 2012	**(170)**	(53)
Amount written off during the year	**59**	6
Amount recovered during the year	**63**	0
(Increase)in receivables impaired	**0**	(123)
Balance at 31 March 2013	**(48)**	(170)

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 Care Trust becomes aware of specific adverse circumstances affecting the debtor.

20. NHS LIFT Investments

The Care Trust held no investment in NHS LIFT in either 2012-13 or 2011-12.

21. Other Financial Assets

The Care Trust held no other financial assets in either 2012-13 or 2011-12.

22. Other Current Assets

The Care Trust held no other current assets in either 2012-13 or 2011-12.

23. Cash and Cash Equivalents

	31 March 2013	31 March 2012
	£000	£000
Opening Balance	**36**	62
Net change in year	**(8)**	(26)
Closing Balance	**28**	36
Made Up Of		
Cash with Government Banking Service	**28**	11
Commercial banks	**0**	**25**
Cash and Cash Equivalents as in Statement of Financial Position	**28**	36
Cash and Cash Equivalents as in Statement of Cash Flows	**28**	36

24. Non-current Assets Held For Sale

	Land	Buildings, Excl. Dwellings	Total
	£000	£000	£000
Balance at 1 April 2012	**133**	**57**	**190**
Plus assets classified as held for sale in the year	**0**	**140**	**140**
Less impairment of assets held for sale	**0**	**(60)**	**(60)**
Balance at 31 March 2013	**133**	**137**	**270**
Liabilities Associated with Assets Held For sale at 31 March 2013	**0**	**0**	**0**
			0
Balance at 1 April 2011	133	297	430
Plus assets classified as held for sale in the year	0	10	10
Less assets sold in the year	0	(250)	(250)
Balance at 31 March 2012	133	57	190

Non Current Assets held for sale include redundant operational estate land and buildings where no opportunity presents for development: where market conditions permit sale is planned to take place within 12 months.

25. Trade and Other Payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS payables - revenue	**3,270**	4,786	**0**	0
NHS payables - capital	**380**	0	**0**	0
NHS accruals and deferred income	**1,816**	1,107	**0**	0
Family Health Services (FHS) payables	**9,258**	11,843	**0**	0
Non-NHS payables - revenue	**5,201**	4,255	**0**	0
Non-NHS payables - capital	**445**	421	**0**	0
Non_NHS accruals and deferred income	**847**	4,145	**0**	0
Social security costs	**283**	0	**0**	0
Other	**92**	683	**79**	79
Total	**21,592**	27,240	**79**	79
Total payables (current and non-current)	**21,671**	27,319		

26. Other Liabilities

There were no other liabilities during 2012-13 or 2011-12.

27. Borrowings

The Care Trust holds no Borrowings.

28. Other Financial Liabilities

The PCT did not have other financial liabilities except as disclosed in these accounts in either 2012-13 or 2011-12.

29. Deferred Income

	Current	
	31 March 2013	31 March 2012
	£000	£000
Opening balance at1 April 2012	**0**	198
Transfer of deferred income	**0**	(198)
Current deferred Income at 31 March 2013	**0**	0

30. Finance Lease Obligations

The Care Trust had no Finance lease obligations in either 2012-13 or 2011-12.

31. Finance Lease Receivables as Lessor

The Care Trust held no Finance leases as lessor in either 2012-13 or 2011-12.

32. Provisions

		Comprising:					
	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care [1] £000s	Equal Pay £000s	Other £000s
Balance at 1 April 2012	**539**	**10**	**133**	**66**	**0**	**180**	**150**
Arising During the Year	**3,400**	**0**	**0**	**0**	**3,400**	**0**	**0**
Utilised During the Year	**(280)**	**(10)**	**(42)**	**0**	**0**	**(79)**	**(149)**
Reversed Unused	**(129)**	**0**	**0**	**(53)**	**0**	**(76)**	**0**
Balance at 31 March 2013	**3,530**	**0**	**91**	**13**	**3,400**	**25**	**1**
Expected Timing of Cash Flows:							
No Later than One Year	**1,774**	**0**	**35**	**13**	**1,700**	**25**	**1**
Later than One Year and not later than Five Years	**1,756**	**0**	**56**	**0**	**1,700**	**0**	**0**
Later than Five Years	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	**30**
As at 31 March 2012	971

Provisions include an estimate of the probable cost of defending equal pay claims: as at 31 March 2013 the costs were estimated at £25,000 for defending the remaining four claims (2012 - 25 Claims) made by provider services staff. In the opinion of the Directors, the Care Trust will be successful in defending any claims that may eventually come to Court, and accordingly no provision is made for the value of the claims themselves.

The provisions relating to pensions for former directors and staff are as advised by the NHS pensions agency, and represent the future capitalised values of early retirement costs against which regular quarterly payment of pensions are recharged

Legal claims includes the estimates for specific cases notified by NHS LA.
The continuing care provision £3.4m (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

The Care Trust did not have any LIFT contracts in either 2012-13 or 2011-12.

35. Impact of IFRS Treatment - 2012-13

In the absence of LIFT or other finance lease arrangements, there are no impacts arising from the change from UK GAAP to IFRS.

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 Care Trust 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 Care Trust's expected purchase and usage requirements and the Care Trust is therefore exposed to little credit, liquidity or market list.

Currency Risk

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

Interest Rate Risk

Care Trusts are not permitted to borrow. The Care Trust therefore has low exposure to interest-rate fluctuations.

Credit Risk

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

Liquidity Risk

The Care Trust 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 Care Trust is not, therefore, exposed to significant liquidity risks.

36.1 Financial Assets	**Loans and receivables**	**Total**
	£000	**£000**
Receivables - NHS	**5,529**	**5,529**
Receivables - non-NHS	**476**	**476**
Cash at bank and in hand	**28**	**28**
Other financial assets	**472**	**472**
Total at 31 March 2013	**6,505**	**6,505**
Receivables - NHS	3,458	3,458
Receivables - non-NHS	371	371
Cash at bank and in hand	36	36
Other financial assets	718	718
Total at 31 March 2012	4,583	4,583

36.2 Financial Liabilities	**Other than at 'fair value through profit and loss'**	**Total**
	£000	**£000**
NHS payables	**5,466**	**5,466**
Non-NHS payables	**15,751**	**15,751**
Other financial liabilities	**454**	**454**
Total at 31 March 2013	**21,671**	**21,671**
NHS payables	5,893	5,893
Non-NHS payables	20,664	20,664
Other financial liabilities	762	762
Total at 31 March 2012	27,319	27,319

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 Northumberland Care Trust 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	**1,304,544**	**0**	**12,766**	**2,173,581**
Neil Barker (Board Member)				
NNT LIFT Company (FUNDCO1) Limited	**5,260,886**	**0**	**31,972**	**0**

Related Party Transactions 2011/12	Payments to Related Party	Receipts from Related Party	Amounts Owed to Related Party	Amounts Due from Related Party
Details of related party transactions with individuals are as follows:	£	£	£	£
Chris Reed (Chief Executive)				
Wife was Chief Executive of Gateshead,				
South Tyneside and Sunderland PCTs.				
Son worked for Sunderland PCT.	1,283,159	600,000	12,838	9,568
NNT LIFT Company (FUNDCO1) Limited	2,404,759	0	0	0

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

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

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**
Special payments - Care Trust management costs	**26,000**	**4**
Total Losses and Special Payments	**26,000**	**4**

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**
Special Payments - Care Trust Management Costs	3,400	1
Total Losses and Special Payments	3,400	1

39. Third Party Assets

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

40. Pooled Budget

Northumberland Care Trust did not have any pooled budget arrangements 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 Northumberland Care Trust in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

NHS Northumberland Clinical Commissioning Group (CCG) who will commission healthcare services on behalf of the patients in Northumberland 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.

Northumberland County Council who will commission public heath services.

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER FOR NORTHUMBERLAND CARE TRUST

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

Respective responsibilities of the Signing Officer and 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 Northumberland Care Trust as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects

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.

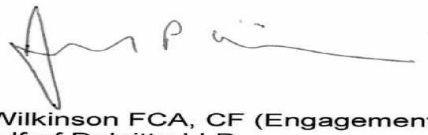
We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in November 2012. We have considered the results of the following:

- 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 Northumberland Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.



David Wilkinson FCA, CF (Engagement Lead),
on behalf of Deloitte LLP,
Appointed Auditor,
One Trinity Gardens,
Broad Chare,
Newcastle-upon-Tyne,
NE1 2HF

7 June 2013