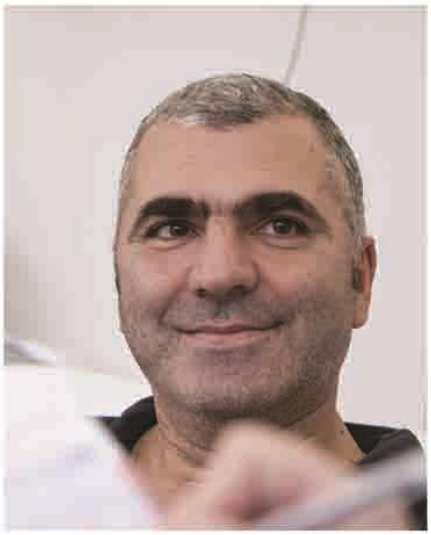
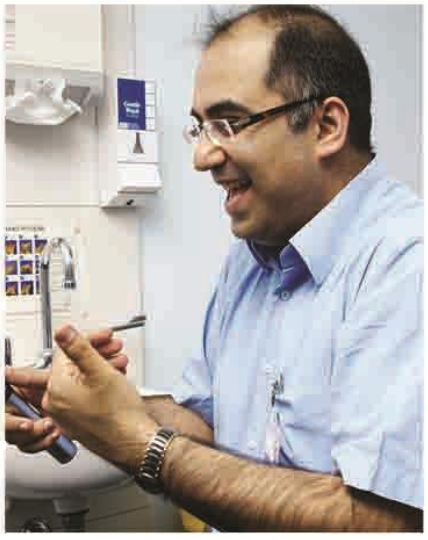
NHS
Commissioning Board

Annual Report and Accounts 1 October 2012 to 31 March 2013





THE NHS CONSTITUTION
the NHS belongs to us all

NHS Commissioning Board

Report and Accounts 1 October 2012 to 31 March 2013

NHS Commissioning Board is known as NHS England

Presented to Parliament pursuant to Paragraph 6 (3) Schedule 15 of the National Health Service Act 2006

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Contents

CHAIR'S AND CHIEF EXECUTIVE'S FOREWARD

This report covers the six month period from 1 October 2012 to 31 March 2013, representing the first six months of the NHS Commissioning Board ("the Board"). This was a period of continued and unprecedented change driven by the Health and Social Care Act 2012. During this time, a significant step forward has been taken towards the transformation of the way we care for patients through the ongoing development of a new system that is clinically-led and focused on improving health outcomes for patients.

The NHS Commissioning Board was set up as an Executive Non-Departmental Public Body (ENDPB) on 1 October 2012, independent from day-to-day political management and focused relentlessly on improving the health of patients and local communities throughout England. Its predecessor body, The NHS Commissioning Board Special Health Authority, ceased its operations on 30 September 2012 and its assets and liabilities were transferred over to the Board at 1 October 2012. The Board is a going concern.

Creating this new commissioning system is undoubtedly a significant challenge. It provides us all with a remarkable opportunity to innovate and do things differently by focusing our efforts on outcomes rather than processes to achieve sustainable improvements in healthcare.

By working with our partners, the Board has continued with an ambitious programme of work to put in place robust processes and systems to secure the safe, successful transition to the new system, underpinned by the values and principles of the NHS Constitution.

Rapid and significant progress has been made over the past six months. This is testament to the vision, hard work and determination of the Board and its partners to seize the opportunity we have been given to allow clinical leaders the freedom to both innovate and transform health outcomes in their local communities.

The Board has worked closely with 211 emerging clinical commissioning groups (CCGs) to provide guidance and support that enabled them to commence operations from 1 April 2013.

In December 2012 the Board published Everyone Counts: Planning for Patients 2013/14. This set out the principles behind the planning of clinically-led commissioning aimed at providing the best possible outcomes for patients. This also helped to inform the development of the Business Plan for 2013/14 - 2015/16 aimed at Putting Patients First, which sets out the operating model for the Board and how the Board will drive up quality and value whilst securing the best outcomes for patients.

We continued to work with CCG leaders on the establishment of the NHS Commissioning Assembly, a forum that brings together all those leaders with responsibility for NHS commissioning decisions to create a shared leadership and vision for commissioning in England. Significant work has also gone into planning for the launch of a full leadership development programme for clinical leaders and in the creation of clinical senates and networks across England.

This report marks the end of the opening chapter in the transformation of the NHS. There remains much to do to build on the real progress and change already taking place throughout the country. The Board's Business Plan outlines in detail what we aim to achieve over the coming months.

This will only be possible with the continued support, involvement and commitment of colleagues and partners to truly transform the health outcomes of our patients.

Professor Malcolm Grant, Chair

Sir David Nicholson, Chief Executive

OVERVIEW

The NHS Commissioning Board Special Health Authority (the "Authority") was established in October 2011 under the NHS Act 2006 as an interim body to undertake all the necessary preparatory work for the successful establishment of the NHS Commissioning Board (the "Board") and the new commissioning architecture.

On 1 October 2012, the functions of the Board Authority transferred to the NHS Commissioning Board, which was formally established as an executive non-departmental public body (ENDPB) - a new independent organisation with executive powers and exceptional responsibilities.

The Board was in this period held to account for its performance by the Secretary of State for Health against four strategic objectives, relating to:

- transferring power to local organisations;
- establishing the commissioning landscape;
- developing specific commissioning and financial management capabilities; and
- developing excellent relationships.

The Board translated these into four operational objectives and worked to successfully ensure:

- appropriate infrastructure and resources were in place to enable the Commissioning Board to operate successfully upon its establishment as an ENDPB in October 2012;
- the Board's role and functions were agreed;
- the design of the Board was completed and agreed, including its business model and sub-national structures and how it will discharge its functions; and
- the Board's relationships and how it will work with its partners were developed and agreed.

The Board recognised it could not achieve its objectives in isolation and worked with clinicians, managers and a wide range of stakeholders to deliver its aims.

The Board is committed to openness and transparency. Four board meetings were held between 1 October 2012 and 31 March 2013. These meetings were held in public and live-streamed over the internet. Papers were published on the Board's website in advance of the meeting.
Further information on the Board, including board papers and publications, can be found on: www.england.nhs.uk.

From 1 April 2013, we adopted the name 'NHS England'. We want to be a champion of openness and transparency, and the new name will help us to connect with patients more easily and enable us to speak for the NHS, as the organisation responsible for allocating the budget and delivering on the objectives set out in the Mandate.

Equal opportunities and diversity

The Board is committed to providing equal opportunities for all staff. Our aim is to ensure that all staff are aware that any form of discrimination against people because of their gender, marital status, race, age, sexual orientation, religion, disability, part-time or fixed-term working, is prohibited within the Board, and to ensure that the Board abides by the statutory regulations regarding human rights and discrimination.

Staff involvement and wellbeing

The Board kept all members of staff informed about organisational, management and policy issues through regular staff briefings.

As, for the majority of the period, all staff other than the executive team were seconded from the Department of Health (DH) or NHS organisations, no sickness absence records were held by the Board. Records will be maintained from 1 April 2013 onwards.

Personal data incidents

During the period 1 October 2012 to 31 March 2013, the Board had no personal data incidents. Each person that is a member of the board confirms that, to the best of their knowledge:

a) there is no relevant audit information of which the Board's auditors are unaware; and

b) all possible steps have been taken to ensure that the Board's auditors are aware of any relevant information.

Six months accounts to 31 March 2013

The accounts have been prepared and issued by the Board, under directions given by the Secretary of State, with the approval of HM Treasury, in accordance with Schedule A1 (paragraph 15) of the NHS Act 2006. The accounts report the resources that have been used by the Board to deliver its objectives. These annual accounts have been prepared in accordance with the guidance set out in the Government Financial Reporting Manual (FReM) 2012/13.

ABOUT THE COMMISSIONING BOARD

The Board

The board of directors at the Commissioning Board consists of a non-executive chair, a chief executive, six non-executive directors, and three executive directors:

Chair, Professor Malcolm Grant

Chief Executive, Sir David Nicholson

Non-Executive Director, Lord Victor Adebowale

Non-Executive Director, Margaret Casely-Hayford

Non-Executive Director, Ciaran Devane

Non-Executive Director, Dame Moira Gibb

Non-Executive Director, Naguib Kheraj

Non-Executive Director, Ed Smith

Chief Financial Officer, Paul Baumann

Chief Nursing Officer, Jane Cummings

National Medical Director, Sir Bruce Keogh

The Executive Team

During the six month period covered by the accounts the executive team comprised:

Chief Executive, Sir David Nicholson

Chief Financial Officer, Paul Baumann

Chief Nursing Officer, Jane Cummings

Chief Operating Officer and Deputy Chief Executive, Ian Dalton (until 30 April 2013)

National Director: Transformation, Jim Easton (until 31 January 2013)

National Director: Commissioning Development, Dame Barbara Hakin

National Director for Patients and Information, Tim Kelsey

National Medical Director, Sir Bruce Keogh

National Director: Policy, Bill McCarthy

National Director: Human Resources, Jo-Anne Wass

On 21 May 2013 Sir David Nicholson announced he would be retiring on 31 March 2014.

Directors' Interests

The table below sets out the Director's declared interests to ensure that the work of the Board is conducted in an open and transparent manner and that any conflicts of interest are dealt with in accordance with the Standards of Business Policy.

Directors	Declared interests
Professor Malcolm Grant Chair	President and Provost, University College London Board member, University College London partners Board member, Higher Education Funding Council for England
Sir David Nicholson Chief Executive	NHS Chief Executive (until 31 March 2013) Honorary Fellow, Royal College of General Practitioners Honorary Fellow, Royal College of Physicians Senior Fellow, University of Birmingham, Health Service Management Wife is Chief Executive, Birmingham Children's Hospital
Lord Victor Adebowale Non-executive director	Chief executive Officer and Company Secretary, Turning Point Non-Executive director – Three Sixty Action Ltd Non-Executive director – Tomahawk Ltd Director, Leadership in Mind Ltd Chair, Vision Development Board member, English Touring Theatre Commissioner, UK Commission for Employment and Skills
Margaret Casely-Hayford Non-executive director	Director, British Retail Consortium Secretary, Buy.Com Limited Secretary, Cavendish Trustees Limited Secretary, Herbert Parkinson Limited Secretary, JLP Scotland Limited Secretary, Jon Lewis Car Finance Limited Secretary, John Lewis Delivery Limited Secretary, John Lewis Foundation Secretary, John Lewis Partnership Pensions Trust Secretary, John Lewis Partnerships plc Secretary, John Lewis Partnerships Services Limited Secretary, John Lewis Partnership Trust Limited Secretary, John Lewis plc Secretary, John Lewis Properties plc Secretary, John Lewis PT Holdings Limited Secretary, Jonelle Jewellery Limited Secretary, Jonelle Limited Secretary, JSL Custodian Trustee Limited Seretary, Leckford Estate Limited Secretary, Park One Management Limited Secretary, Peter Jones Limited Secretary, The Odney estate Limited Secretary, Waitrose Limited Secretary, De Facto 1123 Limited
Ciaran Devane Non-executive director	Chief Executive, Macmillan Cancer Support

Directors	Declared interests
Dame Moira Gibb Non-executive director	Non-executive director, UK Statistics Authority Chair, Social Work Reform Board
Naguib Kheraj Non-executive director	Employee, Barclays Bank (until 31 March 2013) Member, Investment Committee of Wellcome Trust Brother is general practitioner Sister in law is Interim Medical Director, National Clinical Assessment Service
Ed Smith Non-executive director	Pro Chancellor and Chair of Council, University of Birmingham
Paul Baumann Chief Financial Officer	None
Jane Cummings Chief Nursing Officer	Trustee, Over the Wall (charity)
Sir Bruce Keogh National Medical Director	Fellow, Royal College of Surgeons in England (previous Member of Council) Fellow, Royal College of Surgeons of Edinburgh – King James IV Professor Honorary Fellow, Royal College of Surgeons in Ireland Honorary fellow, American College of Surgeons Honorary Fellow, Royal College of Anaesthetists Honorary Fellow, Royal College of General Practitioners Honorary Member and Past Secretary General, European Association for Cardiothoracic Surgery Member and Past President, Society for Cardiothoracic Surgery in Great Britain and Ireland Honorary Member, British Society of Interventional Radiology Honorary Member, Faculty of Medical Management and Leadership Council, British Heart Foundation Vice-Patron, The Poppy Factory
Ian Dalton Chief Operating Officer and Deputy Chief Executive	None
Jim Easton National Director - Transformation	None
Dame Barbara Hakin National Director: Commissioning Development	Family member is employee of PWC
Tim Kelsey National Director: Patients and Information	Trustee, Nuffield Trust Partner is a Director of ZPB, a health strategy company
Bill McCarthy National Director: Policy	Member, Council of University of York Board, Hull York Medical School Wife is employee of the Refuge Council and an ante-natal teacher

Directors	Declared interests
Jo-Anne Wass National Director: Human Resources	Husband was undertaking an IMAS assignment to the Commissioning Board, substantive employee of NHS East Midlands until 31 March 2013. From 1 April 2013 an employee of NHS England.

Who we are

The Board operates from two central support offices based in Leeds and London, with four Regional offices for the North, Midlands and East, South and London. There are a further 27 area offices spread across the whole of England. We have authorised 211 Clinical Commissioning Groups (CCGs).

The Regional offices provide clinical and professional leadership, co-ordinate planning, operational management, emergency preparedness, and undertake direct commissioning functions and processes within a single operating model.

The Area teams are responsible for commissioning high quality primary care services, supporting and developing CCGs, assessing and assuring performance, direct and specialised commissioning, managing and cultivating local partnerships and stakeholder relationships, including representation on health and wellbeing boards.

The 211 CCGs are at the heart of the new commissioning arrangements and will focus on delivering better outcomes and responding to the needs and wishes of their local community.

In addition, we act as the host organisation for:

- All Commissioning Support Units;
- NHS Leadership Academy;
- NHS Improving Quality;
- NHS Sustainable Development Unit;
- Strategic Clinical Networks; and
- Clinical Senates.

Next steps

The Board took on its full powers on 1 April 2013. Our Business Plan for 2013/14 – 2015/16: 'Putting patients first' sets out how we will work to support the NHS commissioning system to put patients at the centre of care and deliver improved outcomes for all. The plan establishes an 11-point scorecard to measure progress we are making in relation to our objectives. We will be accountable both to the public and to our board for the improvements we are making in each area.

OUR MANAGEMENT COMMENTARY

Background

The financial statements contained within this report have been prepared in accordance with the direction given by the Secretary of State for Health under the NHS Act 2006 and in a format instructed by the Department of Health (DH) with the approval of HM Treasury.

Our accounts for the period 1 October 2012 to 31 March 2013 have been prepared under International Financial Reporting Standards (IFRS) and comprise a Statement of Comprehensive Net Expenditure, a Statement of Financial Position, a Statement of Changes in Taxpayers' Equity, a Statement of Cash Flows and all with related notes.

The Board was established on 1 October 2012 along with the supporting commissioning architecture as outlined in the NHS Health and Social Care Act 2012. During the period from October 2012 to March 2013, the vast majority of the Board's expenditure related to the reimbursement of seconded staff from DH and a number of NHS organisations.

Financial performance

The DH sets stringent financial targets against which we are expected to deliver. For the full year 2012/13 the NHS commissioning Board Special Health Authority (the "Authority") and the Board received one full allocation for the year and we were required to maintain our expenditure within certain key funding limits:

- revenue expenditure within a limit of £81.7m.

For the period 1 April 2012 to 30 September 2012 the NHS Commissioning Board Special Health Authority spent £18.2m and for the period 1 October 2012 to 31 March 2013 the Board spent £43.4m In total for both periods expenditure was £61.6m, which represents an underspend of £20.1m.

The Authority accounts to 30 September 2012 included assets of £6.5m and liabilities of £12.6m, with net liabilities of £6.1m. In accordance with the Financial Reporting Manual we have recognised a loss on transfer by absorption of £6.1 m in the Board's Statement of Comprehensive Net Expenditure to bring the net liability into our accounts. The Board also recognised a gain on transfer by absorption of £0.1m relating to intangible assets transferred from the National Patients Safety Agency. The net loss on absorption was £6.0m.

The Board's full statutory powers became effective on 1 April 2013 with an associated budget of £95.6bn. Certain assets and liabilities relating to those operating activities hitherto performed by other NHS organisations are being transferred to the Board with effect from 1 April 2013. The value of these assets and liabilities is being determined by an assurance process, which will be completed in 2013/2014.

As part of the transition arrangements, we were required to make payments on behalf of Clinical Commissioning Groups of £13.2m before 1 April 2013 to ensure funding was available from 1 April 2013. The DH will provide funding for these payments, which are reflected in the accounts as

agency payments. As such, our accounts include £13.2m in an overdraft and a corresponding receivable from the DH of £13.2m.

Our Statement of Financial Position, therefore, shows a negative general fund balance of £14.8m. This has arisen due to cash not being drawn down against our cash limit until April 2013. These funds have subsequently been drawn down and there are no going concern issues.

In addition to the above, we are required to comply with the Better Payments Practice Code, which requires non-NHS trade creditors to be paid within 30 days or agreed terms. Our performance against this target for the six months to 31 March 2013 is as follows:

Non-NHS trade creditors	**Number**	**Value £000**
Total non-NHS trade invoices paid	3,868	45,924
Total non-NHS trade invoices paid within target	3,378	38,676
Percentage of non-NHS bills paid within target	**87%**	**84%**

Auditor

The Comptroller and Auditor General was appointed by statute to audit the Board. The audit fee for the period ended 31 March 2013 of £29,500 is for the audit of these accounts.

Accounting Officer's disclosure to the auditors

As far as the Accounting Officer is aware, there is no relevant audit information of which our auditors are unaware and the Accounting Officer has taken all steps he ought to have taken to make himself aware of any relevant audit information and to establish that our auditors are aware of that information.

Principal risks and uncertainty

Effective risk management is a cornerstone of good governance and our framework of procedures and internal controls contribute to mitigating and controlling the risks we face.
Our Annual Governance Statement, included at page 23, provides further details of our risk management strategy and procedures.

REMUNERATION REPORT

The remuneration of the NHS Commissioning Board is set by the Remuneration and Terms of Service Committee on behalf of the Board in conjunction with the Department for Health (DH). The pay rates are in line with the Very Senior Manager (VSM) pay framework for Arm's Length Bodies (ALBs) and are subject to DH approval. The committee is chaired by the Chair of the Board, together with two Non-Executive Directors.

This report for the period ended 31 March 2013 is produced by the board. The Remuneration and Terms of Service Committee met 2 times during the period 1 October 2012 to 31 March 2013.

The Remuneration and Terms of Service Committee operates within a framework laid down by the DH. Its remit is to determine, on behalf of the Board, the terms of service, remuneration and other benefits of the Chief Executive, national directors and such other posts as are specifically designated by the Board to be within their remit, ensuring that relevant employees are fairly rewarded for their individual contributions to the organisation.

The committee also ensures that an effective system is in place that is properly administered, to monitor and evaluate the performance of relevant employees, including such assessments as may be required to determine their level of remuneration.

The remuneration of national directors is reviewed annually by the Remuneration and Terms of Service Committee, taking account of national awards, central guidance and other relevant factors. The remuneration of non-executive directors is determined by the Secretary of State for Health.

The Board, with the approval of the DH Remuneration Committee, operates the NHS VSM Pay Framework. This framework also provides access to an approved scheme for performance related payments which are paid in line with DH instructions.

Appointments

Non-executive directors are appointed by the Secretary of State for a term of either two and a half or four years.

The Chief Executive has a contract with the DH up to 31 March 2013 and is seconded to the Board.

All other national directors have NHS VSM contracts of employment, although some remained on secondment from their former organisations until 1 April 2013. There are no contractual clauses or other agreements for compensation in the event of early termination of office other than those provided by statutory requirements.

Emoluments of board members

The remuneration relating to all directors in post during the period 1 October 2012 to 31 March 2013 is detailed in the tables below. It identifies the salary, other payments and allowances and pension benefits applicable to both executives and non-executives. This information is subject to audit and has been audited by the Board's external auditors.

Non-Executive directors

The following table sets out details of payments made and appointment term details for the Chair and non-executive members:

	1 October 2012 – 31 March 2013				
Name and title	**Salary in £5k bands** **£000**	**Bonus payments in £5k bands** **£000**	**Benefits in kind** **(rounded to the nearest £100)**	**Date of appointment**	**Appointment ends**
Professor Malcolm Grant Chair	30-35 *	0	0	31 October 2011	30 October 2015
Lord Victor Adebowale Non-Executive Director	0-5	0	0	1 July 2012	31 December 2014
Margaret Casely – Hayford Non-Executive Director	0**	0	0	1 July 2012	30 June 2016
Ciaran Devane Non-Executive Director	0-5	0	0	1 January 2012	31 December 2015
Dame Moira Gibb Non-Executive Director	0-5	0	0	1 July 2012	31 December 2014
Mr Naguib Kheraj Non-Executive Director	0**	0	0	1 July 2012	30 June 2016
Ed Smith Non-Executive Director	10-15	0	0	9 November 2011	8 November 2015

* The Chair of the Board receives no direct remuneration for the appointment, but his employer, University College London (UCL) makes a recharge to the Board for the time Professor Grant devotes to the appointment (limited to the advertised remuneration for the appointment).

** Margaret Casely-Hayford and Naguib Kheraj have waived their entitlement to remuneration for their appointments.

Chief Executive and national directors

The following table sets out details of payments made and contract term details for the Chief Executive and national directors, as appropriate. All benefits in kind relate to the provision of a lease car. Other Remuneration for Ian Dalton relates to an uplift for the dual role he occupied and for Jim Easton it relates to a recruitment and retention premium.

		1 October 2012 – 31 March 2013				
Name	**Title**	**Salary in £5k bands £000**	**Other Remuneration in £5K bands £000**	**Bonus payments in £5k bands £000**	**Benefits in kind (to nearest £100)**	**Notes**
Sir David Nicholson	Chief Executive	40-45	0	0	0	On secondment from the Department of Health (DH). His total remuneration was £210,000-£215,000 and DH recharged for 40% of his time until 31 March 2013. Benefits in kind will be fully disclosed in the Department of Health resource account.
Ian Dalton	Chief Operating Officer/Deputy Chief Executive	100-105	0-5	5-10	0	Was on secondment from North East SHA until 31 March 2013. North East SHA recharged for his full salary. He left the position on 30 April 2013.
Professor Sir Bruce Keogh	National Medical Director	35-40	0	0	0	Was on secondment from the DH until 31 March 2013. His total remuneration was £190,000-£195,000 and DH recharged for 40% of his time. His substantive employer is University College London Hospitals NHS Foundation Trust (UCLH) and from 1 April 2013 he is seconded directly from UCLH.
Paul Baumann	Chief Financial Officer	100-105	0	0	0	Was on secondment from London SHA. London SHA recharged for his full salary until 31 March 2013 when he moved onto the Board's payroll.
Dame Barbara Hakin	National Director: Commissioning Development	105-110	0	0	0	Was on secondment from East Midlands SHA (EMSHA). EMSHA recharged for her salary.

		1 October 2012 – 31 March 2013				
Name	**Title**	**Salary in £5k bands £000**	**Other Remuneration in £5K bands £000**	**Bonus payments in £5k bands £000**	**Benefits in kind (to nearest £100)**	**Notes**
Bill McCarthy	National Director: Policy	85-90	0	5-10	1,100	Was on secondment from Yorkshire and the Humber SHA (Y&HSHA). Y&HSHA recharged for his full salary until 31 March 2013 when he moved onto the Board's payroll.
Jim Easton	National Director: Transformation	45-50	0-5	0	0	Was on secondment from South Central SHA. South Central SHA recharged for 80% of his time until 31 January 2013 when he left the position.
Tim Kelsey	National Director for Patients and Information	90-95	0	0	0	
Jo-Anne Wass	National Director: Human Resources	75-80	0	0	0	
Jane Cummings	Chief Nursing Officer	80-85	0	0	0	Was on secondment from the North West SHA. North West SHA recharged for 100% of her time until 1 April 2013 when she moved onto the Board's payroll.

For 2012/13 there is a requirement for all public sector bodies to disclose the ratio of top to median staff pay as part of the Remuneration Report. The disclosure should include the banded total remuneration of the highest paid director, the median total remuneration of the staff and the pay multiple (ratio) between the two. In 2012/13 the Board staff were employed on a secondment basis. Many staff were seconded on a part-time basis and some national directors worked on a part-time basis for the Board. It is therefore felt that it would not be appropriate to include this disclosure for 2012/13.

Pension benefits

The Chief Executive and National Directors are members of either the Civil Service or NHS pension schemes.

The figures included in the table below are the full year pension benefits for each employee rather than the amount attributable to their Board role.

Name and Title	Real Increase / (decrease) in pension at age 60 (bands of £2,500)	Real Increase / (decrease) in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31st March 2013 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31st March 2013 (bands of £5000)	Cash Equivalent Transfer Value at March 2013	Cash Equivalent Transfer Value at March 2012	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Sir David Nicholson Chief Executive (Note 1)	5-10	N/A	115-120	N/A	2,163	1,933	129
Ian Dalton Chief Operating Officer/Deputy Chief Executive	2.5-5	7.5-10	20-25	60-65	362	293	54
Professor Sir Bruce Keogh National Medical Director	(0-2.5)	(2.5-5)	75-80	230-235	1,748	1,645	17
Paul Baumann Chief Financial Officer	0-2.5	5.0-7.5	10-15	40-45	260	206	43
Dame Barbara Hakin National Director: Commissioning Development (Note 2)	(0-2.5)	(0-2.5)	75-80	215-220	0	1,665	n/a
Bill McCarthy National Director: Policy	(0-2.5)	(0-2.5)	60-65	190-195	1,129	1,055	19

Name and Title	Real Increase / (decrease) in pension at age 60 (bands of £2,500)	Real Increase / (decrease) in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31st March 2013 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31st March 2013 (bands of £5000)	Cash Equivalent Transfer Value at March 2013	Cash Equivalent Transfer Value at March 2012	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Jim Easton National Director: Transformation	0-2.5	0-2.5	45-50	135-140	791	728	25
Tim Kelsey National Director: Patients and Information (Note 3)	0-2.5	N/A	0-5	N/A	32	N/A	N/A
Jo-Anne Wass National Director: Human Resources	2.5-5	12.5-15	45-50	140-145	748	623	93
Jane Cummings Chief Nursing Officer	10-15	35-40	65-70	205-210	1,260	965	245

Notes:

1. The section of the Civil Service pension to which David Nicholson belongs, has no lump sum.
2. No Cash Equivalent Transfer Value is shown as this normal retirement age for the scheme has been passed
3. Tim Kelsey joined the NHS Pension Scheme in July 2012 so there are no prior year figures or increases shown. As all new joiners to the NHS Pension Scheme are now enrolled to the 2008 section there is no lump sum shown

All pension related increases are the full year increases.

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

Cash Equivalent Transfer Value (CETV)

The right hand side of the above disclosures relating to pension benefits shows the staff member's cash equivalent transfer value accrued at the beginning and end of the reporting period and the increase in cash equivalent transfer value effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

A cash equivalent transfer value is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the staff member's accrued benefits and any contingent spouse's pension payable from the scheme. A cash equivalent transfer value is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity, to which disclosure applies. The cash equivalent transfer value figures, and from 2003/04 the other pension details, include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the National Health Service Pension Scheme/Principal Civil Service Pension Scheme arrangements and for which, the Civil Superannuation Vote has received a transfer payment commensurate to the additional pension liabilities being assumed. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

Cash equivalent transfer values are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries, as advised by the actuary to the Principal Civil Service Pension Scheme.

The real increase in the value of the CETV

This takes account of the increase in accrued pension due to inflation and contributions paid by the officer and is calculated using common market valuation factors for the start and end of the period.

Sir David Nicholson

Chief Executive

NHS Commissioning Board

18 June 2013

Financial Statements
6 months to 31 March 2013

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

The Accounting Officer for the DH has appointed the Chief Executive of the NHS Commissioning Board (the Board) as the Accounting Officer. As Chief Executive and Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible, in accordance with the responsibilities set out in HM Treasury's *Managing Public Money* and as assigned to me in the Accounting Officer Memorandum.

Under the Health and Social Care Act 2012 and directions made thereunder by the Secretary of State with the approval of Treasury, we are required to prepare a statement of accounts for each financial year in the form, and on the basis, determined by the Secretary of State, with the approval of Treasury. The accounts are prepared on an accruals basis and must give a true and fair view of our state of affairs at the year end and of its net resource outturn, recognised gains and losses and cash flows for the financial year. As Accounting Officer, I have responsibility for ensuring the preparation of our accounts and the transmission of them to the Comptroller and Auditor General.

In preparing the accounts, I am required to:

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and applied suitable accounting policies on a consistent basis;

- make judgements and estimates on a reasonable basis;

- state whether applicable accounting standards have been followed and disclosed and explained any material departures in the financial statements; and

- prepare the financial statements on a going concern basis.

My relevant responsibilities as Accounting Officer, including responsibility for the propriety and regularity of the public funds and assets vested in the Board, and for the keeping of proper records, are set out in *Managing Public Money* issued by the Treasury.

ANNUAL GOVERNANCE STATEMENT

Introduction

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 under provisions enacted in the Health & Social Care Act 2012 which amended the NHS Act 2006.

The NHS CB inherited a range of functions, duties and responsibilities from the NHS Commissioning Board Authority, a Special Health Authority, which ceased to exist on 30 September 2012.

The six month period from 1 October 2012 was one of completing the wider work to establish the new commissioning system in England and preparing for 1 April 2013 when the NHS CB took on its full statutory powers as part of the new system.

As would be expected, the transitional nature of the NHS CB during the period meant a lot of the governance arrangements a mature organisation would have in place were being developed and implemented through the period.

In addition, with the taking on of its full statutory powers on 1 April 2013 NHS CB transformed from a £60m organisation to a £95.6bn organisation, requiring significantly different governance processes.

As this report covers the six month reporting period, to 31 March 2013, and the period to the signing of the statement it describes governance arrangements in place during the period to 31 March 2013 as well as those that have been established to deal with the larger organisation, and which are now starting to bed in.

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS CB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS CB is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS CB Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the NHS CB, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. An appropriate system of internal control for an organisation the size and nature of the NHS CB has been in place for the six months ended 31 March 2013 and up to the date of approval of the annual report and accounts.

The governance framework

The NHS CB Board comprises the Chair, six Non-executive Members and four Executive Members. The four Executive Members are: the Chief Executive; the National Medical Director; the Chief Nursing Officer; and the Chief Financial Officer.

The Chief Operating Officer, National Director: Commissioning Development, National Director: Human Resources, National Director: Patients & Information and National Director: Policy attend Board meetings but are not voting members of the Board.

Until 30 April 2013 Ian Dalton was also Deputy Chief Executive. From 1 May 2013 Barbara Hakin has been Acting Deputy Chief Executive, pending the appointment of a permanent replacement.

Standing Orders provide for the appointment of a Vice-Chair and, from April 2013, the appointment of a Senior Independent Director. No appointments have yet been made to these roles, but a Non-executive Director is nominated to chair the Board in the absence of the Chair or in the event of a conflict of interests declared by him.

Board members bring a range of complementary skills and experience in areas such as finance, governance and health policy. All Non-executive Member appointments, and the appointment of the Chair, are made by the Secretary of State for Health taking account of the skill sets already represented on the Board and recognising where gaps could be filled.

The role of the Board is to:

- Set the overall strategic direction of the NHS CB, within the context of NHS priorities;
- Monitor performance against objectives;
- Provide effective financial stewardship;
- Ensure high standards of corporate governance and personal conduct; and,
- Promote effective dialogue between the NHS CB and the communities it serves.

The Board undertakes a proportion of its work through Committees and Sub-committees. Each Committee and Sub-committee has a set of terms of reference, which have been formally adopted by the Board. Committee and Sub-committee Chairs present their approved minutes to the Board meeting following their approval, together with a summary of any meetings that have occurred, but for which approved minutes are not yet available.

Also from 1 April 2013, a standing item on all Committee and Sub-committee agendas is the identification of matters discussed that should specifically be drawn to the attention of the Board. Any identified items are recorded in the Committee/Sub-committee Chairman's written report to the Board.

As part of refreshing its Corporate Governance Framework, ready for the NHS CB taking on its full statutory powers, the Board reviewed its Committee and Sub-committee structure and agreed to a number of changes and new Committees from April 2013.

Audit Committee

The Committee was in operation throughout the six month period, and has continued to operate since the period end.

The objective of the Committee is:

- To provide assurance to the Board and me through an independent and objective view of internal control.

The Committee delivers its Objective by:

- Overseeing internal and external audit services;
- Reviewing financial and information systems, monitoring the integrity of the financial statements and reviewing significant financial reporting judgements;
- Providing oversight of the establishment and maintenance of an effective system of assurance on risk management and internal control, across the whole of the NHS CB's activities, that supports achievement of the NHS CB's objectives;
- Monitoring compliance with Standing Orders and Standing Financial Instructions;
- Obtaining assurance that the NHS CB has adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work;
- Reviewing schedules of losses and compensations and making recommendations to the Board;
- Reviewing the work of other Committees, and other significant assurance providers or functions, which can provide relevant assurances; and,
- Requesting and reviewing reports and positive assurances from directors and managers on overall arrangements for governance, risk management and internal control.

The NHS CB, and thus the Committee, fulfils a dual role with regard to the activities of the NHS CB itself and its oversight of the wider NHS commissioning system. While the governance of individual CCGs is a matter for their respective Boards and Audit Committees, the NHS CB Audit Committee will, in future, seek assurance that the NHS CB's oversight and management of the commissioning system is effective in securing delivery of NHS strategic objectives and in eliminating or mitigating strategic, financial and operational risks.

The Committee is composed entirely of Non-executive Members, as follows:

- Ed Smith (Chair);
- Naguib Kheraj; and,
- Moira Gibb.

All the Committee members were in post for the full six month period, and remain in post.

The Committee's main activities through the period have been:

- Monitoring the financial closure process for the first six months of 2012-13 for the NHS Commissioning Board Authority, including reviewing and recommending to the Board for approval key documents, including the annual report, annual accounts and governance statement;
- Monitoring the financial year end process for the second six months of 2012-13, including reviewing and recommending to the Board for approval key documents, including the annual report, annual accounts and governance statement;
- Receiving an assessment of financial transition risks and assurance over delivery;
- Monitoring delivery of the internal audit plan for the six month period;
- Receiving the Head of Internal Audit Opinion on the system of internal control within the NHS CB;
- The re-tender of the Internal Audit and Counter Fraud contracts; and,
- Receiving and considering other reports from NHS CB management in accordance with its terms of reference.

The Audit Committee identified progress on transition and the significant risks associated with it as matters requiring the attention of the Board. The progress was informed by work which was carried out by Deloitte and a report from external audit, which highlighted particular risks in the areas of management reporting, finance processes, direct commissioning, budgets and property services. The Committee also discussed risks associated with the transfer of assets and liabilities to successor bodies.

These risks were being managed by the executive, and the Board was asked to endorse additional resource for these high priority work streams and more generally to support the finance transition work programme. No other matters were specifically drawn to the Board's attention other than the assurances and recommendations as part of the annual report and accounts process.

The Committee is due to undertake an assessment of its operation and effectiveness using the self-assessment checklist for Audit Committees produced by National Audit Office. Any issues that are identified will be turned into an action plan for the Committee over the ensuing period.

The Committee has established a work plan for the year forward, which is reviewed and updated at each meeting of the Committee.

Remuneration and Terms of Service Committee

The Committee was in operation throughout the six month period, and has continued to operate since the period end.

The objectives of the Committee are to:

- Approve the appropriate remuneration and terms of service for the Chief Executive, Directors and other Very Senior Managers;
- Consider other issues in relation to all staff employed by the NHS CB; and,
- Adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors and senior staff whilst remaining cost effective.

The Committee delivers its Objective by:

- With regard to the Chief Executive, Directors and other Very Senior Managers, setting all aspects of salary (including any performance-related elements, bonuses);
- Provisions for other benefits, including pensions and cars;
- Arrangements for termination of employment and other contractual terms (decisions requiring dismissal shall be referred to the Board);
- Ensuring that Employees are fairly rewarded for their individual contribution to the NHS CB – having proper regard to the NHS CB's circumstances and performance and to the provisions of any national arrangements for such staff;
- Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate, advising on and overseeing appropriate contractual arrangements for such staff. This applies to all NHS CB staff;
- Proper calculation and scrutiny of any special payments;
- Approval of human resources policies and procedures for all NHS CB staff; and,
- Provision of guidance and benchmarking for Clinical Commissioning Groups on pay issues as appropriate.

Membership is:

- Malcolm Grant, Chair (Chair);
- Ed Smith, Non-executive Member;
- Ciaran Devane, Non-executive Member.

The Committee's main activities through the year have been:

- Reviewing the performance of the Executive Team, both individually and collectively;
- Approving the terms of service and remuneration offer to the Chief Executive, Directors and other Very Senior Managers;
- Approving a number of redundancy proposals and severance arrangements; and
- Reviewing and approving HR policies and gaining assurance on their implementation.

The Committee did not identify any matters that needed specifically drawing to the attention of the Board.

Trust & Charitable Funds Committee

Standing Orders provide for the establishment of a Trust & Charitable Funds Committee should the need arise. The need did not arise during the period, and hence no Committee was established.

Finance & Procurement Committee

The Committee was in operation throughout the six month period.

In April 2013 the Committee's functions were split between the Finance & Investment Committee and Procurement Controls Committee and the Committee disbanded.

The objective of the Committee was:

- To approve expenditure on activities relating to the NHS CB's functions, as set out in the NHS Act 2006 (as amended), and the Health and Social Care Act 2012 utilising, where appropriate, the delegated financial limits set out in the Standing Financial Instructions for members in attendance (the Committee has no delegated budgetary authority of its own).

The Committee delivered its Objective by:

- Approving business cases for the procurement of goods and services (including professional services);
- Reviewing all significant business cases for expenditure prior to their submission to the Department of Health;
- Reviewing all assignments which fall within the Office of Government Commerce (OGC) definition of consultancy on a rolling basis every three months and agreeing any proposal to prolong a professional services agreement beyond nine months, before it is submitted for approval by the Minister for the Cabinet Office/Chief Secretary to the Treasury; and,
- Approving the quarterly forecast of spending to be provided by the NHS CB to the Department of Health.

Membership was:

- David Nicholson, Chief Executive (Chair);
- Ed Smith, Non-executive Member;
- Paul Baumann, Chief Financial Officer;
- Bill McCarthy, National Director: Policy; and,
- Jo-Anne Wass, National Director: Human Resources.

Clinical Commissioning Group Authorisation Sub-committee

The Committee was in operation throughout the six month period and continues to operate.

The objective of the Committee is:

- To approve the authorisation of Clinical Commissioning Groups (CCGs) with or without conditions.

The Committee delivers its Objective by:

- Receiving assurance and providing assurance to the Board on the quality and rigour of both the overall assessment arrangements supporting the authorisation process and the deliberations of the moderation and conditions panels;
- Considering the recommendations of the moderation and conditions panels;
- Receiving assurance and providing assurance to the Board on the quality and rigour of the authorisation process;
- Making the decision whether to authorise the aspiring CCGs in each wave;
- Communicating immediately after the meeting the outcome of its deliberations to all applicant CCGs in the form of a decision letter; and,
- Considering and approving or rejecting requests for removal of a condition.

Membership was:

- Victor Adebowale, Non-executive Member (Chair);
- Ciaran Devane, Non-executive Member;
- Naguib Kheraj, Non-executive Member;
- Paul Baumann, Chief Financial Officer;
- Ian Dalton, Chief Operating Officer; and,
- Barbara Hakin, National Director: Commissioning Development.
- Bruce Keogh, National Medical Director

Finance & Investment Committee

At its April 2013 meeting the Board approved the establishment of a Finance & Investment Committee. The Committee first met on 10 June 2013.

The objective of the Committee is:

- To scrutinise financial planning and performance for the NHS CB and wider NHS commissioning sector, reviewing areas of concern, and reporting to the Board as appropriate.

The Committee delivers its Objective by:

- Reviewing and approving the financial policy framework for the commissioning sector which supports delivery of the NHS CB's strategic objectives;
- Reviewing and agreeing changes to individual elements of the financial policy framework for the commissioning sector (for example allocations or Payment by Results policy);
- Monitoring the in-year financial performance of the commissioning sector;
- Considering the NHS CB's medium term financial strategy, in relation to both revenue and capital, and making recommendations to the Board;
- Reviewing and recommending the overall annual revenue and capital budgets to the Board for approval, and then monitoring spend during the year;
- Reviewing and assessing business cases for:
    - Capital expenditure across the commissioning sector;
    - Commissioning commitments which underpin the revenue implications of a third party investing capital, or entering into a lease commitment (for example commissioner support to a PFI scheme);
    - Financial aspects and investment requirements of reconfiguration proposals;
    - NHS CB income generation;
    - NHS CB leases or managed service agreements whether accounted as revenue or capital; and,
    - NHS CB expenditure to be financed by borrowing, however sourced;
    - but not:
    - NHS CB revenue expenditure, which is considered by the Procurement Control Committee;
- Reviewing all business cases for expenditure (as above) that require Department of Health or Cabinet Office approval, prior to their submission to the Department of Health;
- Approving business cases (as above) on behalf of the Board in the context of the NHS CB's agreed budget and within the delegated limits approved by the Board as part of the scheme of delegation or recommending business cases above delegated limits to the Board for approval;
- Considering and approving NHS CB financial policies; and,
- Reviewing other substantial issues of financial policy and delivery and making recommendations to the Board.

Membership is:

- Moira Gibb, Non-executive Member (Chair);
- Ed Smith, Non-executive Member;
- Paul Baumann, Chief Financial Officer;
- Bill McCarthy, National Director: Policy; and
- Barbara Hakin, Interim Chief Operating Officer.

Procurement Controls Committee

At its April 2013 meeting the Board approved the establishment of a Procurement Controls Committee.

The objective of the Committee is:

- To approve expenditure on activities relating to the NHS CB's functions, as set out in the NHS Act 2006 (as amended), and the Health and Social Care Act 2012 utilising, where appropriate, the delegated financial limits set out in the Standing Financial Instructions for members in attendance (the Committee has no delegated budgetary authority of its own).

The Committee delivers its Objective by:

- Reviewing and assessing business cases for NHS CB revenue expenditure at all stages (strategic outline case, outline business case, full business case and post control reports) for compliance with national guidance, legislation and best practice, but not business cases for:
    - Capital expenditure across the commissioning sector;
    - Commissioning commitments which underpin the revenue implications of a third party investing capital, or entering into a lease commitment (for example commissioner support to a PFI scheme);
    - Financial aspects and investment requirements of reconfiguration proposals;
    - NHS CB income generation;
    - NHS CB leases or managed service agreements whether accounted as revenue or capital; and,
    - NHS CB expenditure to be financed by borrowing, however sourced.
    - which are considered by the Finance & Investment Committee
- Approving business cases for the procurement of goods and services (including professional services);
- Reviewing all business cases for expenditure that require Department of Health or Cabinet Office approval (excluding those considered by Finance & Investment Committee), prior to their submission to the Department of Health;
- Reviewing all assignments which fall within the Office of Government Commerce (OGC) definition of consultancy on a rolling basis every three months and agreeing any proposal to

prolong a professional services agreement beyond nine months, before it is submitted for approval by the Minister for the Cabinet Office/Chief Secretary to the Treasury; and,

- Reviewing and approving the quarterly forecast of spending to be provided by the NHS CB to the Department of Health.

Membership is:

- David Nicholson, Chief Executive (Chair)
- Paul Baumann, Chief Financial Officer;
- Ed Smith, Non-executive Member;
- Bill McCarthy, National Director: Policy; and,
- Jo-Anne Wass, National Director: Human Resources.

Commissioning Support Committee

At its April 2013 meeting the Board approved the establishment of a Commissioning Support Committee, following shadow running during the period. The Committee has not yet met in the new financial year.

The objective of the Committee is:

- To oversee assurance and development of Commissioning Support Units.

The Committee delivers its Objective by:

- Overseeing assurance of CSUs, ensuring that:
    - All aspects of employment, finance, legal and corporate functions are properly delegated;
    - They are fit for purpose to deliver high quality services; and,
    - They are fit for purpose to make the transition to stand alone.
- Overseeing development of CSUs, ensuring that:
    - They continuously improve in their ability to deliver high quality, cost effective services; and,
    - They develop independence in line with the Board's market strategy for all commissioning support services and its externalisation strategy for NHS CSUs.

Membership is:

- Moira Gibb, Non-executive Member (Chair);
- Ed Smith, Non-executive Member;
- Margaret Caseley-Hayford, Non-executive Member;
- Paul Baumann, Chief Financial Officer;
- Jo-Anne Wass, National Director: Human Resources;

- Tim Kelsey, National Director: Patients & Information;
- Rosamond Roughton, Interim National Director: Commissioning Development;
- Andrew Kenworthy, Director of CSU Transition Programme;
- Bob Ricketts, Director of Commissioning Support Strategy & Market Development.

Directly Commissioned Services Committee

At its April 2013 meeting the Board approved the establishment of a Directly Commissioned Services Committee. The Committee has not yet met.

The objectives of the Committee are:

- To oversee the implementation of the direct commissioning strategic priorities as agreed by the Board and to contribute to the development of strategic priorities; and,
- To provide assurance to the Board that the strategic priorities are being delivered.
- The Committee delivers its Objectives by:
- Delivering leadership and direction to the implementation of the single operating models outlined in the following documents:
    - Securing Excellence in Specialised Commissioning;
    - Primary Care;
    - Offender Health;
    - Sexual Assault Referral Centre;
    - Services for Armed Forces and their Families;
    - Dental Services; and,
    - Public Health Services as contained in the Section 7a Agreement.
- Ensuring that direct commissioning is patient focused and clinically led and to oversee the role and work of the Clinical Priorities Advisory Group on behalf of the Board;
- Driving the improvement of standards and outcomes and the reduction of variation and inequalities for services commissioning directly by the NHS CB;
- Providing assurance to the Quality & Clinical Risk Committee that there are robust systems and processes in place for monitoring and assuring the quality of directly commissioned services and for driving continuous quality improvement;
- Ensuring that the services commissioned by the NHS CB are exemplary in their approach to public and patient involvement;
- Delivery of the business plan objectives for all areas of direct commissioning; and,
- Providing leadership to the integration of direct commissioning activities with those services commissioning by Clinical Commissioning Groups and Local Authorities.

Membership is:

- Two Non-executive Members (to be appointed, with one to Chair);
- Barbara Hakin, Interim Chief Operating Officer;
- Paul Baumann, Chief Financial Officer;
- Tim Kelsey, National Director: Patients & Information;
- Bruce Keogh, National Medical Director;
- Jane Cummings, Chief Nursing Officer;
- Ann Sutton, Director of Commissioning (Corporate)
- Anne Rainsberry, Regional Director – London;
- Paul Watson, Regional Director – Midlands & East;
- Richard Barker, Regional Director – North ; and,
- Andrea Young, Regional Director – South.

Quality & Clinical Risk Committee

At its April 2013 meeting the Board approved the establishment of a Quality & Clinical Risk Committee. The Committee has not yet met.

The objective of the Committee is:

- To assure the Board that robust systems and processes are in place to enable NHS CB to:
    - Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,
    - Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions.

The Committee delivers its Objective by:

- In respect of NHS CB's duty as to continuous quality improvement, the Committee will seek assurance that:
    - Commissioners have access to and are having regard to evidence based standards and other guidance describing what constitutes high quality care across the comprehensive service;
    - Commissioners have access to the necessary comparative information to support measurement of the quality of and outcomes from commissioned services;
    - The power of transparency in driving quality improvement is being fully harnessed through putting in place mechanisms for publishing information relating to the quality of commissioned services;
    - Financial levers and incentives are effectively aligned and deployed to drive continuous quality improvement;

  - Robust mechanisms are in place for monitoring and supporting the uptake of the latest innovations and technologies through the commissioning process; and,
  - The clinical and non-clinical leadership of the commissioning system is sufficiently focussed on quality and has the necessary skills to lead efforts across the system to drive continuous quality improvement.
- In respect of NHS CB's function as a direct commissioner (primary care services, certain specialised services, military and offender health services), the Committee will seek assurance that there are robust systems and processes in place for monitoring and assuring the quality of these services and for driving continuous quality improvement;
- In respect of NHS CB's function of holding the local system of commissioning to account, the Committee will seek assurance that robust systems and processes are in place for assuring that clinical commissioning groups are meeting their statutory duties with regards to quality (duty as to continuous quality improvement and duty to support improvements in the quality of primary care) and that they have robust systems and processes in place for assuring themselves of the quality of the services that they have commissioned;
- In respect of NHS CB's wider system leadership role for quality, the Committee will seek assurance that robust systems and processes are in place for:
  - Providing timely and accurate clinical advice to the system;
  - Sharing and receiving information and intelligence with regards to quality from other relevant parts of the system; and,
  - Ensuring the effective operation of Quality Surveillance Groups across the country.
- The Committee will also seek assurance that the NHS CB has robust systems and processes in place for discharging those specific functions which directly relate to managing quality and clinical risk, including:
  - The revalidation of doctors;
  - Managing the national performers list, which is intended to assure the suitability of all primary care doctors, dentists and ophthalmic practitioners who undertake NHS primary care services in England; and,
  - Having robust systems in place to collect and analyse information relating to the safety of services provided by the health service, to provide advice and guidance to such persons as it considers appropriate, and to monitor the effectiveness of the advice and guidance given.

Membership is to be confirmed.

The risk and control framework

Risk management is embedded in the activity of the NHS CB through:

- The Risk Management Strategy and supporting policies and procedures;
- The Committee structures described earlier in this report;
- Management processes (e.g. using a risk-based approach to help prioritise the expenditure);
- The Board's Assurance Framework;
- Risk management skills training including both clinical risk assessments of various types and the mandatory and statutory training programme; and,
- Building a counter fraud culture.

The key elements of the NHS CB's Risk Management Strategy are designed to identify and control risks whether strategic, financial, reputational or relating to compliance, health and safety or clinical safety. The original Risk Management Strategy was reviewed and refreshed in April 2013.

The NHS CB employs a standardised methodology in the application of risk grading criteria, which helps to ensure a consistent approach to the prioritisation of risks and the effective targeting of resources. As a result risk management is an important element of the NHS CB's Business Planning processes.

The NHS CB has adopted a bottom up approach to the generation of its risk register with each Directorate, Regional Team, Area Team, CSU and hosted body preparing its own risk register. This is supplemented by the identification of strategic risks at NHS CB level e.g. through the identification of key risks in the NHS CB Business Plan. These are transitional arrangements which will be developed into a risk management process across the new organisation.

During 2012-13 each of the Directorates has continued to undertake regular reviews of their risks. The Risk Management Strategy sets the framework for the escalation of risk. Risks must be supported by a time framed action plan. The process outlined in the Risk Management Strategy requires regular review of individual risk assessments.

The PMO support the Directorates by providing specialist advice on identifying and assessing risks and work with them to facilitate risk mitigation plans through training, education and other individual support.

In addition, the Board agrees the strategic risks that relate to its principal objectives. This forms the Assurance Framework and has been embedded into the NHS CB. It is based on the NHS CB's corporate objectives as agreed by the Board and is a high level document covering all the NHS CB's functions, which is reviewed and, if necessary, updated at each Board meeting.

The Assurance Framework for 2012-13 covered risks to the following objectives:

- Safe transfer of functions from current organisations to a new commissioning system of an NHS Commissioning Board, Clinical Commissioning Groups and commissioning support organisations;

- Safe transfer of emergency preparedness, resilience and response responsibilities at all levels;
- Establishment of the NHS CB with the full set of legal powers required to deliver its functions;
- Adequate resourcing of the NHS CB to enable it to carry out its functions, with people transferred from existing organisations in accordance with the People Transition Policy;
- Full coverage across England by established Clinical Commissioning Groups, with the majority fully authorised;
- Creation of commissioning support services, with robust oversight arrangements, providing high quality support to the NHS CB and Clinical Commissioning Groups;
- Agreement of a mandate, which provides the freedom and resources to deliver its full set of functions;
- Delivery of a new finance spine and continuity of Family Health service payments;
- Agreement of operating plans focused on delivering the NHS Outcomes Framework, the NHS Constitution, any other requirements that flow from the mandate and statutory requirements for:
    - Fully or partially authorised Clinical Commissioning groups; and
    - All services that will be commissioned directly by the Board;
- Establishment of partnership agreements which capture the way the NHS CB will co-operate and collaborate with external partners to deliver its statutory functions, consistent with its organisational objectives;
- Positive feedback from partners on the NHS CB's values, behaviours and whether it is delivering on its commitments;
- Ability to demonstrate that patients, the public and their representatives have participated in, and the NHS CB has responded to their views on, the establishment of the NHS CB; and,
- Delivery of an organisational development strategy and plan, providing interventions designed to create a high performing, healthy organisation where people want to work and with whom others want to do business.

Specific risks relating to the 2012-13 Assurance Framework were identified in the following areas:

- Meeting the system wide objective of ensuring that all staff in sender organisations had clarity about their future employment by December 2012;
- Populating the NHS CB organisational structure by March 2013;
- Securing a sustainable operating structure within the Operations Directorate;
- Full development of the commissioning support system by April 2013;
- Securing sufficiently strong stakeholder engagement during the design process to ensure support and rigour in the design;
- Putting in place effective and co-ordinated finance and information flows through the new system;

- Creating clarity on resource allocations to Clinical Commissioning Groups and the NHS CB in time to enable effective planning for 2013-14;
- Ensuring capacity in the Clinical Commissioning Group authorisation process sufficient to secure robust outcomes;
- Creating effective partnership agreements and embedding the values and behaviours within them leading to well aligned relationships and support for the NHS CB in carrying out its core business and statutory functions;
- Securing feedback from partners which indicates that partnership agreements are fully embedded within the NHS CB and priority partners, resulting in robust partnerships that are able to deliver the objectives of the NHS CB and sustain its reputation;
- Demonstrating that the NHS CB has responded to and acted on people's views and experiences; and,
- Implementing the Organisational Development Strategy in a timely and effective manner, thus laying the foundations to create a single organisation with a single culture and shared sense of purpose.

A number of gaps in controls and/or assurance were identified in reviewing and agreeing the Assurance Framework. These have been monitored as appropriate within the Committee structure.

Appropriate mitigations were identified and implemented by management, with Board agendas during the six month period being structured around the key risks and issues affecting the transition to full powers in April 2013.

Within this overall approach, finance transition risks in particular have been managed through programme structures established by the executive, complemented by independent assurance provided by Deloitte LLP in a series of reports to the Audit Committee. The fourteen work streams which make up this programme were managed in collaboration with DH colleagues and subject to a full mutual assurance process to ensure delivery, manage interdependencies and mitigate risks. These risks and the related action plans were also discussed at regular meetings with the National Audit Office as external auditors of the NHS CB.

The Board is aware of the importance of maintaining high standards of information governance and securing the confidentiality of patients' information. It ensures delivery of this objective via the Senior Information Risk Officer who will chair the Information Governance Committee, once established. The Senior Information Risk Officer is supported by an Information Governance Manager and the NHS CB has a range of policies, procedures and training material to make sure that information governance principles are well known by all staff and embedded into everyday practice across the NHS CB. The Board has appointed the National Director: Policy as the Senior Information Risk Officer.

The NHS CB Integrated Intelligence Tool has been developed to provide consistent, up to date information to support NHS CB's analysis, oversight, decision making and risk management through a single accessible, easy-to-use tool. The Integrated Intelligence Tool is an interactive dashboard which brings together about 100 indicators so that Officers can view them at national, regional, local, and organisational levels, and through different lenses.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure that we comply with all employer obligations contained within the Scheme regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that the NHS CB complies with all of its obligations under equality, diversity and human rights legislation.

Capacity to handle risk

The NHS CB is committed to providing high quality services in a safe and secure environment. The NHS CB offers leadership on risk management through a clear Risk Management Strategy. This is currently being reviewed to ensure that it covers the wider range of risks facing the NHS CB as it takes up its full responsibilities.

As Chief Executive I have overall responsibility for risk. Day to day responsibility for risk management processes is delegated to the National Director: Policy with National Directors taking responsibility for specific risk areas as follows:

National Director: Policy

- Health & Safety
- Information Governance

National Director: Human Resources

- Workforce
- Equality & Diversity

Chief Financial Officer

- Financial

The NHS CB employs a range of specialists to lead on the implementation of risk management strategies. These include the Social and Corporate Responsibility Manager, the Health and Safety Advisor and specialists in information governance, business continuity and emergency planning.

The responsibility for risk management is identified across all levels in the NHS CB; from Board members, through National Directors to all managers and staff. As indicated above, named National Directors have specific responsibilities and accountability for risk, and these are laid out in the Risk Management Strategy, which was reviewed in April 2013.

The Executive Risk Management Group met bi-weekly through the six month period, chaired by the Director of Corporate Development and reported to the Executive Team via the National Director: Policy.

Following a review of risk management arrangements in April and May 2013 a Risk Management Group has been established as a sub-group of the Executive Team. Its membership includes the National Director for every Directorate, together with specialists with specific expertise in risk management. The Risk Management Group receives reports and monitors action plans from the subgroups covering the main areas of risk identified above. The Risk Management Group reports to the Quality & Clinical Risk Committee and Audit Committee, as necessary.

Staff and management responsibilities for risk are clearly identified within the Risk Management Strategy, covering both clinical and non-clinical risks. Staff are trained appropriately within that framework, the key elements being the use of root cause analysis techniques for the investigation of serious incidents and the identification, preparation and evaluation of risks for the risk register. Training and education of staff in good practice in managing risks of all kinds is provided both in house from the NHS CB's specialist advisory team for risk and safety and from external providers, such as fire safety. A range of formal training sessions on matters relating to risk is co-ordinated centrally.

The NHS CB is committed to learning from good practice, and works closely with its internal auditors and external specialist bodies.

Review of economy, efficiency and effectiveness of the use of resources

The NHS CB, as with all other publicly funded bodies, faces significant financial challenges over the coming years. These pressures apply both to the NHS CB's own activities and to its role as provider of funds - via Clinical Commissioning groups and through its direct commissioning units - into the health system.

As part of the Government's control of expenditure the NHS CB is subject to expenditure controls in the same way as other Arms' Length Bodies. As a consequence business cases have had to be completed and approved before spending could occur in a range of areas. Initial approval is given by the Finance & Procurement Committee (since 1 April 2013 the Procurement Controls Committee or Finance & Investment Committee depending on the area of spend), and for spend above certain thresholds or in certain categories approval has also had to be sought from the Department of Health. In some cases approval is also needed from the Cabinet Office or HM Treasury.

In building staff structures across the NHS CB standard structures have been defined for comparable teams operating in different areas, which ensures consistency of pay between posts.

In delivering its responsibilities across the wider commissioning system the NHS CB has issued guidance on allocations and running cost allowances. In addition the system has continued obligations under the QIPP programme to deliver savings in future years.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and executive managers within the NHS CB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of internal audit's work. The Head of Internal Audit Opinion for the six months was significant assurance.

Managers within the NHS CB who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the NHS CB achieving its principal objectives has been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee and the Board. A plan to address weaknesses and ensure continuous improvement of the system is in place.

In light of the Harris Review, NHS England has reviewed all of the statutory duties and powers conferred upon the organisation by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and other associated legislative and regulatory amendments. As a result, I can confirm that we are clear about the legislative requirements associated with each of the statutory functions for which NHS England is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead National Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of our statutory duties.

There have been no departures from the Corporate Governance Code during this period.

The following information highlights some of the key methods that the Board uses to be assured that its system of internal control is effective.

The Board

Board agendas during the six month period were structured around the key risks and issues affecting the transition to full powers in April 2013. The Board has reviewed the governance framework to ensure it is fit for purpose post April 2013, and approved a new framework, new Committee and Sub-committee structures and refreshed and enhanced Standing Orders, Standing Financial Instructions and Scheme of Delegation.

The Audit Committee

The Annual Internal Audit Plan, as approved by the Audit Committee, enables the Board to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. The Committee has reviewed internal and external audit reports, and reviewed progress on meeting the requirements of the Assurance Framework.

The Quality & Clinical Risk Committee

The Board identified the need to establish a Quality & Clinical Risk Committee, post April 2013, to provide assurance to the Board and Audit Committee that there are adequate controls in place to ensure the NHS CB is delivering its statutory and non-statutory clinical duties and responsibilities.

National Directors

National Directors have clear responsibilities for risk management within their areas of control. They also have corporate responsibility as Board members.

Internal Audit

During the six month period the NHS CB used West Yorkshire Audit Consortium as providers of internal audit services. The contract and associated Quality Plan specify that the delivery of the internal audit function will continue to be in compliance with the Government Internal Audit Standards and those of the Institute of Internal Auditors (UK).

The internal audit plan continued the work started in the first six months of 2012-13, and focussed on core financial systems, human resources and payroll implementation and Pre-employment checks, with the aim of providing assurance over the implementation and operation of new systems.

In a number of areas the controls tested in operation were not fully developed and/or had not operated over the full period being tested. In these cases internal audit reviewed alternative, mitigating, controls that had been established, to assure itself as to the overall control environment.

During the six month period Internal Audit issued two limited assurance audit reports as follows:

- Complaints; and,
- HR Pre-employment Checks.

The audit of complaints identified issues with:

- No policy and supporting procedures;
- Identifying an appropriate level of resourcing to handle complaints in future;
- Equal access (particularly multi-lingual, hearing impairment and visual impairment);
- The handling of patient identifiable data;
- Ineffective communication with stakeholders;
- Lack of guidance over the handling of complaints inherited at 1 April 2013; and,
- A lack of monitoring and reporting arrangements.

The audit of HR pre-employment checks identified issues with:

- Assessing the requirement for professional registration, a qualification and/or a CRB check;
- Monitoring of the issue of offer letters;
- Reconciliation of off ESR reconciliations to the number of ESR records;
- The receipt of acceptances of offers from candidates; and,
- The completion of pre-employment checks within agreed timescales.

In some cases the issues identified by Internal Audit confirmed areas already identified for improvement by management, but some new issues were also identified. In the context of the six

month accounts, with their limited scope of activity, I am confident that despite these issues sufficient assurance is available, and this is reflected in the Significant Assurance opinion issued by the Head of internal audit.

Action plans have been put in place to address all the issues identified, and follow up reviews will be undertaken in 2013-14 to confirm the improvements have been actioned in full.

Conclusion

The six months to 31 March 2013 have been a period of preparation for the largest structural change in the NHS in its history. The NHS CB, as a new organisation, has been managing the risks associated with establishing the new commissioning system across the NHS as well as the risks arising from the transformation in the functions of the NHS CB from an £80m organisation in start-up to a £95.6bn organisation at the core of a brand new commissioning system.

As would be expected with a change of this scale there have been significant challenges. Where gaps in capacity, capability or action plans have been identified, mitigation plans have been developed, and the related improvements have either been delivered or are on track to be delivered.

In this context, with the exception of the internal control issues that I have outlined in this statement, my review confirms that the NHS Commissioning Board has built, and continues to work on embedding, a generally sound system of internal controls, that should support the achievement of its policies, aims and objectives, and also that all control issues identified have been or are being addressed.

Sir David Nicholson

Chief Executive

NHS Commissioning Board

18 June 2013

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSES OF PARLIAMENT

I certify that I have audited the financial statements of the NHS Commissioning Board for the period ended 31 March 2013 under the Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to examine, certify and report on the financial statements in accordance with the Health and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff 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 NHS Commissioning Board's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Commissioning Board; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by

Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the NHS Commissioning Board's affairs as at 31 March 2013 and of the net operating cost for the period then ended; and

- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012; and
- the information given in the Management Commentary for the period for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or

- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

21 June 2013

Statement of comprehensive net expenditure

For the period 1 October 2012 to 31 March 2013

	Notes	For the 6 month period to 31 Mar 2013
		£000
Staff costs	3.1	11,850
Non-staff costs	3.2	31,709
Less income	3.3	(208)
Net operating costs for the financial period		**43,351**
Net loss on transfers by absorption	11	**5,963**
Total comprehensive net expenditure for the period		**49,314**

Statement of Financial Position at 31 March 2013

	Notes	31 March 2013 £000
Non Current Assets		
Property, plant & equipment	4.1	3,509
Intangible assets	4.2	116
Total non-current assets		**3,625**
Current Assets		
Trade and other receivables	4.3	15,897
Other current assets	4.3	5
Total current assets		**15,902**
Current Liabilities		
Trade and other payables	4.4	(9,476)
Provisions	4.6	(31)
Other liabilities	4.4	(24,834)
Total current liabilities		**(34,341)**
Non-current assets less net current liabilities		**(14,814)**
Assets Less Liabilities:		**(14,814)**
Taxpayers' Equity		
General Fund		(14,814)
Total Taxpayers' Equity:		**(14,814)**

The notes on pages 51 to 71 form part of these accounts.
The financial statements on pages 47 to 50 were approved by the Board's Audit Committee on 17June 2013 and signed on its behalf by

Chief Executive: Sir David Nicholson Date: 18 June 2013

Statement of Changes in Taxpayers' Equity

For the 6 month period ended 31 March 2013

	General Fund	Total Reserves
	£000	£000
Balance at 1 October 2012	0	**0**
Changes in taxpayers' equity for 2012-13		
Total net expenditure for the year	(49,314)	**(49,314)**
Total recognised income and expense for 2012-13	(49,314)	**(49,314)**
Grant in aid	34,500	**34,500**
Balance at 31 March 2013	(14,814)	**(14,814)**

A negative fund has arisen because expenditure has been accounted for (via accruals) for which the cash was drawn down after the period end and there is therefore no going concern or liquidity risk. Cash is only drawn down as required.

Statement of Cash Flows for the 6 month period ended 31 March 2013

	Notes	For the 6 month period to 31 Mar 2013
		£000
Cash flows from operating activities		
Net operating costs		**(43,351)**
Other cash flow adjustments		**168**
Movement in working capital	5.1	**3,040**
Movement due to transfers by absorption	11	**(12,617)**
Net cash (outflow) from operating activities		**(52,760)**
Cash flows from investing activities		
Purchase of property, plant and equipment		**(1,471)**
Net cash (outflow) from investing activities		**(1,471)**
Cash flows from financing activities		
Grant in Aid		**34,500**
Cash transferred under absorption	11	**6,125**
Net financing		**40,625**
Net (decrease) in cash and cash equivalents		**(13,606)**
Cash and cash equivalents at the beginning of the period		**0**
Cash and cash equivalents at the end of the period		**(13,606)**

The notes on pages 51 to 71 form part of these accounts.

NOTES TO THE ACCOUNTS

1. Accounting policies

The financial statements have been prepared in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS Commissioning Board ("the Board") for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

1.1 Accounting conventions

The financial statements are prepared under the historical cost convention, modified to account for the revaluation of fixed assets at their value to the Board by reference to current costs. This is in accordance with directions issued by the Secretary of State for Health and approved by Treasury. Executive Non Departmental Public Bodies are not required to provide a reconciliation between current cost and historical cost surplus and deficits.

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 Board'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.

Accounting for staff costs and remuneration

The Board and Department of Health (DH) staff have a role in establishing the Board. DH staff are accounted for in the DH Resource Account. Other staff costs are accounted for in these financial statements.

As set out in the Remuneration Report, the Chief Executive and directors costs charged to the Board are based on the time spent working for the Board.

1.2 Income and funding

The main source of funding for the Board is a Parliamentary grant from the DH. The Board is required to maintain expenditure within this allocation. The DH also approves a cash limit for the period. The Board is required to draw down cash in accordance with this limit. Cash drawn down is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received.

1.3 Taxation

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

1.4 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 three 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.

1.5 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 that govern the way each individual case is handled.

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

1.6 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 where their costs are charged to the Board. 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 Board commits itself to the retirement, regardless of the method of payment.

1.7 Provisions

The Board provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

1.8 Financial instruments

Financial assets

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

Financial assets are initially recognised at fair value

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset. At the Statement of Financial Position date, the Board 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 Operating Cost Statement 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 Operating Cost Statement 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.

Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Board 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.

Financial liabilities at fair value through profit and loss

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

Other financial liabilities

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

1.9 Going Concern

The financial statements have been prepared on a going concern basis.

1.10 Property, Plant & Equipment

(a) Capitalisation

Property, plant & equipment is capitalised if it is capable of being used for more than one year and where items:
- individually have a cost equal to or greater than £5,000; or
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

(b) Valuation

The Board had no assets in the land & buildings category during the accounting period. The carrying value of existing assets 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.

1.11 Intangible Assets

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 amortised historic cost to reflect the opposite effects of development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged on a straight line basis to write off the costs or valuation of tangible and intangible non-current assets, less any residual value, over their estimated useful lives. The 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 or, where shorter, the lease term. Useful economic lives for assets included in the accounts are:

- Information technology: 2 - 4 years
- Software licenses: 3 years

At each Statement of Financial Position date, the Board 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.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the Statement of Comprehensive Net 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 the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

2.1 Revenue Resource Limit

	For the 6 month period to 31 Mar 2013
	£000
Net operating costs for the financial year	**43,351**
Revenue Resource Limit *	**63,535**
Under spend against Revenue Resource Limit	**20,184**

* The NHS Commissioning Board Authority and the NHS Commissioning Board received one allocation for the 2012-13 financial year of £81,748,000. The above is the amount of resource allocated by the Department of Health, less the amount used by the NHS Commissioning Board Special Health Authority to 30 September 2012 of £18,213,000.

2.2 Capital Resource Limit

	For the 6 month period to 31 Mar 2013
	£000
Gross Capital Expenditure	**3,235**
Capital Resource Limit *	**7,338**
Under/(over) spend against Capital Resource Limit	**4,103**

* The NHS Commissioning Board Authority and the NHS Commissioning Board received one allocation for the 2012-13 financial year of £7,750,000. The above is the amount of resource allocated by the Department of Health, less the amount used by the NHS Commissioning Board Special Health Authority to 30 September 2012 of £412,000.

2.3 Under/ (over)spend against Cash Limit	For the 6 month period to 31 Mar 2013
	£000
Total Charge to Cash Limit *	**34,500**
Cash Limit	**70,759**
Under/(over) spend against Cash Limit	**36,259**

* The NHS Commissioning Board Authority and the NHS Commissioning Board received one allocation for the 2012-13 financial year of £82,259,000. The above is the amount of resource allocated by the Department of Health, less the amount used by the NHS Commissioning Board Special Health Authority to 30 September 2012 of £11,500,000.

3.1 Staff numbers and related costs

Executive members and staff costs:

	Permanently employed £000	Other £000	For the 6 month period to 31 Mar 2013 £000
Salaries and wages	1,721	9,743	**11,464**
Social security costs	171	0	**171**
Employer contributions to NHS Pensions	215	0	**215**
Total	**2,107**	**9,743**	**11,850**

	Permanently employed Number	Other Number	Total Number
Total	**45**	**242**	**287**

Other Salaries and Wages costs relate to the cost (including social security and pension costs) of employees seconded from other NHS organisations and the Department of Health.

3.2 Non-Staff costs

	For the 6 month period to 31 Mar 2013
	£000
The expenses of the Board were as follows:	
Non-executive members' remuneration	**60**
Supplies and services – general	**25,498**
Consultancy services	**888**
Establishment	**1,270**
Transport (business travel)	**1,056**
Premises	**1,463**
Depreciation	**114**
Amortisation on intangible assets	**23**
Audit fees statutory audit	**30**
Other auditor remuneration	**58**
Legal fees	**73**
Education, training and conferences	**1,102**
Hospitality	**17**
Insurance	**4**
Redundancy	**53**
Total non-staff costs	**31,709**

3.3 Operating Income

	For the 6 month period to 31 Mar 2013
	£000
Sale of Goods and Services	**208**
Total Operating Income	**208**

3.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme (NHSPS). 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, 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's assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Commissioning Board of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

Details of the benefits payable under the NHSPS can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and an IAS26 accounting valuation every year. An outline of these follows:

a) 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme liabilities. Up to 31 March 2009, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2009, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) IAS 26 Accounting valuation

In accordance with IAS 26, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2009 is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2009 with summary global member and accounting data.

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

Scheme provisions prior to 31 March 2008

The Scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. A lump sum normally equivalent to three years pension is payable on retirement.

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. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

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, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die 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 income and expenditure account at the time the organisation commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

Principal Civil Service Pension Scheme (PCSPS)

The Principal Civil Service Pension Scheme (PCSPS) is an unfunded multi-employer defined benefit scheme. As such, the NHS Commissioning Board is unable to identify its share of the underlying assets and liabilities. The scheme actuary valued the scheme as at 31 March 2007. Details can be found in the Annual Report and Accounts of the Cabinet Office: Civil Superannuation www.civilservice.gov.uk/pensions.

The Scheme Actuary reviews employer contributions usually every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2012-13 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employer contributions are age-related and range from 3% to 12%.

Employers also match employee contributions up to 3% of pensionable pay.

From 1 April 2012, most members of the various PCSPS arrangements have paid extra contributions towards their pensions.

4.1 Property, Plant & Equipment

	Information technology	Total
	£000	£000
Cost or Valuation at 1 October 2012	0	**0**
Additions - purchased	3,233	**3,233**
Transfers under absorption accounting	390	**390**
Gross cost at 31 March 2013	**3,623**	**3,623**
Accumulated depreciation at 1 October 2012	0	**0**
Charged during the year	(114)	**(114)**
Accumulated depreciation at 31 March 2013	**(114)**	**(114)**
Net book value at 1 October 2012	0	0
Net book value at 31 March 2013	**3,509**	**3,509**

4.2 Intangible Assets

	Software Licenses	Total
	£000	£000
Cost or Valuation at 1 October 2012	0	**0**
Transfers under absorption accounting	139	**139**
Gross cost at 31 March 2013	**139**	**139**
Accumulated amortisation at 1 October 2012	0	**0**
Charged during the year	(23)	**(23)**
Accumulated depreciation at 31 March 2013	**(23)**	**(23)**
Net book value at 1 October 2012	0	0
Net book value at 31 March 2013	**116**	**116**

4.3 Receivables

	31 March 2013 £000
Trade receivables	**14,103**
Other receivables	**1,794**
Trade and other receivables	**15,897**
Other prepayments	**5**
Total current receivables	**15,902**

4.4 Trade payables and other current liabilities

	31 March 2013 £000
Trade payables - revenue	**8,895**
Trade payables - capital	**429**
Other payables	**152**
Bank overdraft (note 4.5)	**13,606**
Other taxation and social security	**192**
Accruals and deferred income	**11,036**
Trade and other payables	**34,310**

4.5 Cash and Cash equivalents

	2012-13 £000
Balance at 1 October 2012	**0**
Net change in the year	**(13,606)**
Balance at 31 March 2013	**(13,606)**

Comprising:

	31 March 2013 £000
Bank overdraft	**(13,606)**
Cash and cash equivalents as in Statement of cash flows	**(13,606)**

4.6 Provisions

	2012-13 £000
Balance at 1 October 2012	**0**
Net change in the year	**31**
Balance at 31 March 2013	**31**

4.7 Capital Commitments

Contracted capital commitments at 31 March 2013 for which no provision has been made in these financial statements total £1.3m.

4.8 Events after the reporting period

The full statutory powers of the Board became effective on 1 April 2013 with an associated budget for 2013/14 of £95.6bn. Certain assets and liabilities relating to those operating activities hitherto performed by other NHS organisations are being transferred to the Board with effect from 1 April 2013. The value of these assets and liabilities is being determined by an assurance process, which will be completed during 2013/14.

5.1 Movements in working capital

	2012-13 £000
(Increase) in receivables within one year	**(15,902)**
Increase in payables within one year	**34,310**
(Increase) in capital payables and accruals	**(1,762)**
(Increase) in bank overdraft	**(13,606)**
Total	**3,040**

5.2 Analysis of changes in net cash or equivalents

	As at 1 October 2012 £000	Cash flows £000	As at 31 March 2013 £000
Bank overdraft	0	(13,606)	**(13,606)**
Total	**0**	**(13,606)**	**(13,606)**

6. Related party transactions

The Board is a body corporate established by order of the Secretary of State for Health. The DH is regarded as a related party. During the period the Board had a number of material transactions with DH and with other entities for which the DH is regarded as the parent department including strategic health authorities, primary care trusts and NHS trusts.

7. 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 Board are met primarily through Parliamentary funding, financial instruments play a more limited role in creating risk than 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 Board's expected purchase and usage requirements and the Board is therefore exposed to little credit, liquidity or market risk.

Currency risk

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

Interest rate risk

All of the Board's financial assets and financial liabilities carry nil or fixed rates of interest. The Board is not, therefore, exposed to significant interest-rate risk.

Credit risk

Because the majority of the Board's income comes from funds voted by Parliament and from other NHS bodies the Board has low exposure to credit risk.

Liquidity risk

The Board's net operating costs are financed from resources voted annually by Parliament. The Board largely finances its capital expenditure from funds made available from Government under an agreed capital resource limit. The Board is not, therefore, exposed to significant liquidity risks.

7.1 Financial Assets

	Loans and receivables	Total
	31 March 2013 £000	**31 March 2013 £000**
Trade receivables	14,103	**14,103**
Other receivables	1,794	**1,794**
Other financial assets	5	**5**
Total at 31 March 2013	**15,902**	**15,902**

7.2 Financial Liabilities

	Other	Total
	31 March 2013 £000	**31 March 2013 £000**
Trade Payables	9,324	**9,324**
Other payables	152	**152**
Borrowings	13,606	**13,606**
Other financial liabilities	11,228	**11,228**
Total at 31 March 2013	**34,310**	**34,310**

7.3 Maturity of financial liabilities

	31 March 2013 £000
In one year or less	34,310
Total	**34,310**

7.4 Fair values

Fair values of financial assets and liabilities do not differ from the carrying amounts.

8. Intra-government balances

	Receivables amounts falling due within one year	Payables amounts falling due within one year
	£000	**£000**
Balances with other central government bodies	15,726	**8,929**
Balances with NHS and Foundation Trusts	45	**988**
Balances with bodies external to government	131	**24,393**
At 31 March 2013	**15,902**	**34,310**

9. Early adoption of IFRSs, amendments and interpretations

The Board has not adopted any IFRSs, amendments or interpretations early.

IFRS's, amendments and interpretations in issue but not yet effective, or adopted

IAS 8, "Accounting policies, changes in accounting estimates and errors", requires disclosures in respect of new IFRSs, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period.

The following have not been adopted early by the Board:

- IFRS 7 "Financial Instruments": disclosures amendment to allow for better comparisons between financial statements. The effective date is for accounting periods beginning on or after 1 January 2013.

- IFRS 9 "Financial Instruments": new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2015.

- IFRS 13 "Fair Value Measurement": IFRS 13 applies when other IFRSs require or permit fair value measurements. The new requirements are effective for accounting periods beginning on or after 1 January 2013.

- IAS 1 "Presentation of Financial Statements": Amendment to the existing standard to improve disclosures to users of the accounts. The effective date is for accounting periods beginning on or after 1 June 2012.

- IAS 19 "Employee Benefits": the amendments will improve the recognition and disclosure requirements for defined benefit plans and modify the accounting for termination benefits. The new requirements are effective for accounting periods beginning on or after 1 January 2013.

- IAS 32 "Offsetting Financial Assets and Financial Liabilities": amendments to clarify the application of offsetting requirements. The amendments are effective for accounting periods beginning on or after 1 January 2014.

None of these new or amended standards and interpretations are likely to be applicable or are anticipated to have future material impact on the financial statements of the Board.

10. Other financial commitments

The Board has entered into a number of contracts. The most significant is a contract with NHS Shared Business Services for the provision of an accounting system and services. The contract commenced on 29 March 2012 for a period of six years with a break clause after four years. The total cost of the contract for the initial four years is £64.1m. There is a remaining commitment of £46.1m.

	2012/13
	£000
Amount payable within one year	**15,867**
Amount payable after one year but within five years	**30,760**
Total	**46,627**

11. Impact on the financial statements of Absorption accounting

The NHS Commissioning Board became a legal entity on 1 October 2012. In accordance with the Financial Reporting Manual, the net gain/loss from operations transferring to the Commissioning Board are brought into these accounts in year and opening balances are not restated. On 1 October 2012, the following balances were therefore transferred to the NHS Commissioning Board from the NHS Commissioning Board Authority (CBA) and National Patient Safety Agency (NPSA):

		£000
Transfer of Property Plant and Equipment (CBA)		**390**
Transfer of software licenses (NPSA)		**139**
Transfer of cash and cash equivalents (CBA)		**6,125**
Transfer of receivables (CBA)	6	
Transfer of trade and other payables (CBA)	(12,623)	
Transfer of net liabilities		**(12,617)**
Net loss on transfers by absorption		**(5,963)**

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