NHS Blood and Transplant
Annual Report and Accounts 2012/13

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

Laid before the Scottish Parliament by the Scottish Ministers in pursuance of section 88 of the Scotland Act 1998

Ordered by the House of Commons to be printed 4 July 2013

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ANNUAL REPORT

The accounts for the year ending 31 March 2013 have been prepared as directed by the Secretary of State for Health in accordance with section 232 (Schedule 15, Paragraph 3) of the National Health Service Act 2006, and in a format as instructed by the Department of Health with the approval of Treasury.

The Nature and Purpose of NHSBT

NHS Blood and Transplant (NHSBT) is a Special Health Authority in England and Wales, with responsibilities across the United Kingdom for organ donation and transplantation. Our core purpose is to ***"save and improve lives"*** through the provision of a safe and reliable supply of blood components, solid organs, stem cells, tissues and related services to the NHS, and to the other UK Health Departments where directed.

NHSBT comprises the following group of strategic operating units, each with their own distinct supply chains, supported by common group services.

Blood Components covers the supply of red cells, platelets, plasma and related specialist products to NHS hospitals in England and North Wales. The cost of these products is recovered in the prices that are agreed annually through the National Commissioning Group for Blood. Around 7,000 units of whole blood are collected every day via a network of fixed sites and mobile blood collection teams. The blood is processed in five processing centres (two of which are also testing facilities) and distributed via a network of fifteen issue centres to over 200 NHS Trusts. NHSBT is also the operator of the International Blood Group Reference Laboratory.

Organ Donation and Transplantation (ODT). Three people die every day in the UK due to the lack of an organ for transplant. NHSBT is the UK "Organ Donation Organisation" that is working with all of the UK Health Services and hospitals throughout the UK in order to increase numbers on the Organ Donation Register, and to increase the numbers of deceased organs donated by 50% (from a 2007/08 baseline). The cost of these activities is directly funded by the UK Health Departments.

Diagnostic Services. These are highly specialised services that are provided via a national network of laboratories in support of blood transfusion and in the transplantation of organs, stem cells and tissues.

Tissues. NHSBT retrieves tissues (such as skin and bone) from deceased donors and processes these at its facility in Speke prior to storage and issue to NHS hospitals.

Stem Cell Services. NHSBT is the largest UK provider of haemopoietic stem cells for the treatment of blood cancers and operates the British Bone Marrow Registry and the NHS Cord Blood Bank. We additionally provide translational services to NHS, academic and commercial organisations seeking to take current and next generation stem cell therapies to the clinic.

Specialist Therapeutic Services (STS) provides a service for collecting stem cells, related immunotherapy products and serum for production of autologous tears. It also provides various apheresis based therapies such as phototherapy and plasma exchange.

Our activities in Diagnostic Services, Tissues, Stem Cells and STS are often collectively described as NHSBT's "Specialist Services". The cost of these activities is generally recovered in the prices of the products and services that are provided, with most prices agreed annually through the National Commissioning Group for Blood. In these areas, however, other providers exist, both within the NHS and the private sector. Competition is a developing feature in these segments and, as a consequence, there is an increasing trend for prices to be set on a commercial basis.

The operating units are identified separately within the NHSBT strategic plan and have distinct strategic objectives, targets and plans that are summarised below. The segmental reporting within these accounts (Note 2) reflects the strategic structure of NHSBT and identifies the income, contributions and allocation of overheads that are applied to each.

Strategic Objectives

Our strategic plan for the five years 2013 to 2018 is focused on:

- Continuing to modernise blood donation and providing a service that is responsive and attractive to our donors
- Improving our interfaces with NHS hospitals so that our services are as accessible and effective as possible
- Driving benefits through better integration and planning of the end to end blood supply chain from donor through to hospital blood banks
- Increasing the number of organ transplants in the UK through consolidating and building on the 50% growth in deceased organ donation that we achieved in April 2013 and launching and rolling out a new strategy to 2020
- Building on our unique skills and capabilities in tissues, stem cells, diagnostic and apheresis services to provide high quality and cost effective therapies to patients as a preferred national supplier to the NHS.

Our plans continue to be very ambitious and establish a series of very challenging objectives across each of our strategic operating units. Taken together our latest strategic plan represents an enormous challenge for NHSBT and requires a significant investment in "change" across the whole of the organisation, in systems, processes and leadership skills. The potential benefits are, however, significant for ensuring the ongoing safety and reliability of the critical products and services that we provide, generating more effective therapies for NHS patients and further improving the value for money to NHS hospitals.

Taking each of our strategic operating units in turn:

Blood Components: *Strategic Objective: To deliver a modern, world class blood service that provides a sustainable and dependable supply of blood components that meet all safety, quality, compliance and service standards, as effectively as possible.*

Our first concern will always be to provide a safe and dependable supply of blood components to hospitals, as well as providing a safe and attractive experience for our donors without whom our service would not exist.

We will continue to provide a service to our donors that is both a convenient and positive experience when donating whole blood or platelets. In doing so we will focus on donor satisfaction and monitor changes in the profile, values and expectations of our donor base to ensure that we can anticipate their needs and respond accordingly. We will underpin this by improving the environment in which our donors donate and introduce modern web based

processes that will allow them to book appointments and communicate more effectively with us.

We intend to further strengthen the interfaces with our customers, NHS hospitals, to ensure we continue to deliver our life saving products on time and in full without fail. We will develop improved processes that make NHSBT easy to do business with through the introduction of modern technology based systems. Ultimately we wish to be seen as "supplier of choice" to the NHS as opposed to one of necessity.

In conjunction with this, we will continue to modernise processes and systems throughout each stage of the blood supply chain, from the collection of blood to the processing, testing, issue and delivery of blood components to hospitals. We will work with hospitals to integrate the management of blood supply so that we can reduce overall wastage in the chain from donor to patient, and provide better intelligence on the usage of blood in hospitals and changes in the pattern of demand.

We will continue to be a highly cost effective supplier of blood and components to NHS hospitals and be able to demonstrate that we provide value for money. We have been significantly improving efficiencies across both our operational and support function and have delivered average real cash efficiency savings in excess of 3.5% p.a. over the period since 2007/08. As a result NHSBT is now achieving some of the highest productivity levels in the processing and testing of blood in the world. This is visible in the "headline" price for red cells, which has reduced from a high of £140/unit in 2008/09 to a price in 2012/13 of £123/unit (effectively saving in excess of £30m pa to the NHS). We have agreed a further reduction in cell prices to £122/unit for 2013/14.

Our actions are underpinned by strong collaboration with international blood services. In particular we will continue to use the intelligence that this provides to benchmark our performance against our international partners and will use this to identify further opportunities for improvement within NHSBT.

Organ Donation and Transplantation: *Strategic Objective: To increase deceased organ donation by 50% by 2013 and to sustain and improve thereafter. To work towards achieving self sufficiency in donation and transplantation across the UK, taking into account the changing donor pool. To change public behaviour with regard to organ donation, especially amongst black and minority ethnic (BAME) communities.*

The current strategy for Organ Donation and Transplantation derives from 2007/08 and is based on the recommendations of the Organ Donation Task Force (ODTF). Our resulting activities have largely been focused on establishing NHSBT as the Organ Donation Organisation for the UK, creating a supporting infrastructure and working with all of our stakeholders to improve the rate of deceased organ donation. Much of that work is now complete and we have been able to announce during April 2013 that the 50% growth in deceased organ donation that was proposed by the ODTF has now been achieved.

Despite this fantastic outcome, and the many lives saved and improved as a result, the UK still faces a shortage of donated organs. Over half a million people die each year in the UK but fewer than five thousand people each year die in circumstances or from conditions where they can become donors. As a result it remains the case that around three people die every day due to the lack of an available organ for transplant.

Although more people have agreed to donate organs over the last five years, this is because more people have been asked. The proportion of families who refuse to allow their relative's

organs to be used, sometimes even when they are told their relative wanted to be a donor, has not changed in most parts of the UK. Most people in the UK would take an organ from someone else, if they need one, but the majority have not signed up to be an organ donor. Those who do join the NHS Organ Donor Register (ODR) often do not tell their families, so families may feel unable to support their wish.

In response, during the latter part of 2012/13, we have been working extensively with clinicians across the UK Health Services, and all our other partners and stakeholders, to generate a new national strategy for organ donation and transplant through to 2020. Subject to approval by all of the UK Health Departments it is anticipated that the new strategy will be published by June 2013. The new strategy will build on the current success but will focus on the need to change public attitudes to organ donation and especially how the level of family consent can be improved.

As part of this we will work closely with all of the UK Health Departments to support the specific objectives and intentions of their national governments with regards to organ donation. In this regard the Welsh Government has made a bold move to introduce legislation to bring in a soft opt-out system for consent to organ donation by 2015. Under the new arrangements, people in Wales will have the choice of either registering a wish to be a donor (opting in); or not to be a donor (opting out). Those who do neither may be deemed to have given their consent to donation. The new system will be preceded by a two year communications campaign to ensure people living in Wales are aware of the new law and their choices. NHSBT will be working closely with the Welsh Government to support the introduction of the new legislation and the implementation of a new ODR that will probably be needed as a result.

Stem Cells: *Strategic Objective: To work in partnership with third sector organisations and the UK Health Services in the provision of an efficient and effective source of donor haemopoietic stem cells for the treatment of UK patients and to establish NHSBT as a prime partner for NHS, academic and commercial organisations seeking to take next generation stem cell therapies to the clinic.*

NHSBT directly supports around 50% of all haemopoietic stem cell (“bone marrow”) transplants in the NHS through collection, processing and cryopreservation of the donated stem cells. More than 400 patients each year in the UK, however, are denied access to a transplant, with around 200 lives lost due to the lack of a matched stem cell donor. This loss of life disproportionately affects black and ethnic minority patients because of the particular challenges in identifying suitable donors for members of these communities. In December 2010, the UK Stem Cell Strategic Forum set out a strategy for saving 200 lives per year through increasing the UK inventory of cord blood donations and by improving the performance of the UK based stem cell registries to match the best in the world. We will continue to work with the Anthony Nolan Charity, the UK Health Departments and other stakeholders to deliver the recommendations of the UK Stem Cell Strategic Forum and are committed to our part in establishing a UK cord blood inventory of 50,000 donations and maximising the donation of cords from BAME communities and the proportion of rare blood types.

In addition NHSBT intends to become a prime partner for the NHS, academic and commercial organisations seeking to take established cell therapies and next generation cellular and molecular therapies to the clinic. We will do this through leveraging our unique strengths in the provision of donor stem cells, expertise in specialist manufacturing, scientific skills, translational experience, regulatory expertise and distribution.

Tissues: *Strategic Objective: To be recognised by the NHS as the preferred supplier of high quality cost effective tissue allografts in England, Wales and Northern Ireland.*

NHSBT is the sole supplier of certain critical tissue products to the NHS that are ethically and transparently sourced from UK donors. NHSBT has the capability to provide bespoke services for unmet clinical needs that are not readily available commercially and can provide these products and services cost effectively to the NHS. We therefore aim to build on the capability of the Speke tissue bank and its highly capable and skilled team to promote and exploit these unique strengths across the NHS. We will increase the visibility and recognition of our services by NHS clinicians, and support these with high quality sales and marketing plans. As a result we will grow our revenue and generate a positive financial contribution which will be "re-cycled" into lower prices to hospitals and/or invested in developing an appropriate and sustainable new product pipeline. This will be supported by providing high quality care to donor families, ensuring that there is a consistent and ethically led approach to our relationships with donors of organs and tissues.

Diagnostic Services: *Strategic Objective: To ensure the clinically effective use of blood, organs and stem cells through the provision of high quality financially viable diagnostic services.*

NHSBT provides a range of highly specialised diagnostic services to NHS hospitals in support of blood transfusion and the transplantation of organs, tissues and stem cells. These services are delivered from a national network of laboratories managed by a highly skilled and dedicated workforce, supported by modern equipment and a national IT system.

The future shape and configuration of our services will, however, be impacted by significant changes in the external environment and especially:

- the modernisation and consolidation of pathology services across the NHS
- the entrance of private sector service providers to pathology services
- an increasing shortage of skilled staff in hospital blood transfusion laboratories
- the impact of mass throughput testing and DNA based technologies

In response we will build on our position in Histocompatability & Immunogenetics (H&I) as the UK's largest provider of these services. We will deliver an innovative, integrated and technologically enabled service which will save more patients' lives by ensuring they have access to precisely matched blood, stem cells and organs when needed. As a preferred national supplier we will utilise our scale to drive cost effectiveness and investment in developing tissue matching technologies.

In Red Cell Immunohaematology (RCI) we are currently developing a new strategy that is responsive to the threats described above. The new strategy will similarly focus on leveraging NHSBT's unique capability and national network in support of improving the quality and effectiveness of transfusion services across the NHS. As part of this it will consider opportunities for NHSBT to integrate its activities with those of hospitals and the emerging pathology networks.

Specialist Therapeutic Services: *Strategic Objective: To become the NHS preferred provider of high quality, cost effective therapeutic apheresis services.*

NHSBT has a long history of providing life-saving and life-enhancing therapeutic apheresis services within the NHS and now has the largest installed therapeutic apheresis equipment

base in the country. As a result Specialist Therapeutic Services (STS) provides treatment to over 1000 patients each year, through access to a portfolio of therapies across a range of clinical specialties using technology that exchanges, removes, or collects certain components within the blood. The service is delivered from six units that are based within NHS Trusts and operates an outpatient model for non-acute patient procedures.

In common with our other "specialist services" strategies above we will continue to build on our unique capability and national network with the objective of becoming the nationally preferred provider to the NHS. In support of this we will deploy high and consistent levels of nursing and medical experience and provide a responsive and flexible 7 day service to our customers.

As the only patient-facing service in NHSBT we place great emphasis on the quality of our service and the patient experience that we provide. In this we are assured by the numerous compliments received from hospitals and patients and the fact that the service has never received a formal complaint. We will continue to closely monitor patient experience and will routinely measure and respond to patient satisfaction.

Within our strategic plan we further identify a **"corporate"** strategy in support of our operating units which is: *To be the advocate for the voluntary donation of blood, organs and tissues; to champion a culture of sustainability across all of our activities; to develop organisational capacity, capability and processes in support of our objectives; to identify opportunities for effective collaboration across our Operating Divisions and support them with an effective programme of research and development and an efficient operating infrastructure.*

This reflects that NHSBT is one of the largest and most complex organisations of its type in the world. We require strong leadership and a broad range of skills and will continue to run a multi-level leadership development programme in support of our aims.

Our Research and Development (R&D) programme for blood components includes research into donor health, and the behavioural factors which lead people to donate, as well as continuing to investigate emerging infectious threats and the possibilities for screening and inactivation of such threats. In addition we will continue to invest in research which defines the optimal use of blood components and potential alternatives. In support of diagnostic services we will explore an appropriate portfolio of next generation diagnostics using genotyping and recombinant proteins. Our aim is to improve clinical outcomes, including alloimmunisation, by improved donor/patient matching, and increasing the availability of extended genotype blood stocks for hospitals.

In ODT we are developing an R&D programme intended to support our activities with hospital partners to assess novel methods for improving the quality and number of organs available for transplant. We will in particular look to support the development of ABO incompatible and antibody incompatible transplants. We will also continue to develop our strong research programme in Tissues including partnerships with academic partners to identify the next generation of products and services.

We will continue to engage with government and departmental plans for delivering back office functions through shared services and, in support of this, transferred the processing of our payroll to NHS Shared Business Services at the start of 2012/13. We operate a strong procurement function that was the first in the DH/NHS to be accredited by the Chartered Institute of Purchasing and Supply (CIPS). As a result we have very high levels of managed spend, either through utilising public sector frameworks or via formal tenders where a

framework is unavailable. We will continue to engage with the Department on shared service solutions for finance and accounting although, because NSHBT runs an efficient service and unique operational supply chains, an economic solution that provides the stock and warehousing functionality we require, has not been identified to date. It is not expected that this will lead to any change of service before the end of 2013/14.

Consistent with an organisation whose mission is to 'save and improve lives', we are committed to sustainable development and minimising wherever possible the impact of our operations on our environment. We believe that sustainability is an important value of our donors and that NHSBT should meet their expectations when they make their 'gift of life'. In support of this we have a comprehensive carbon management plan which commits us to reducing carbon emissions by 25% over the five years starting in 2009/10.

Management Commentary

Key Performance Headlines 2012/13

NHSBT is pleased to report that 2012/13 has been another very successful year.

Considering each of our operational areas in turn:

Blood Components

Stock levels and blood availability have continued to be resilient through 2012/13. In addition to the routine preparation for the expected winter pressures on blood stocks we were able to successfully build stocks in response to the impact of one-off events during 2012, most notably the Queen's Diamond Jubilee, the European football championship and the London Olympics. One of our key performance indicators is the number of times within the year that any blood group falls below a three day alert level for a consecutive period of three days or more. We are pleased to note that during 2012/13 there were no such instances (following zero instances in 2011/12).

With regard to the safety of blood there have been four confirmed cases of Transfusion Related Acute Lung Injury (TRALI) in 2012/13 (one case recorded in 2011/12). All four patients recovered and there were no failures in NHSBT safety measures that were identified as root causes. In addition there have been no confirmed reports of Transfusion Transmitted Infections (TTI) as a result of bacterial contamination in the year (and none since 2009). One of our strategic safety targets is to maintain the proportion of platelets issued to hospitals that are produced via component donation (apheresis) at 80%. The level of product issued from component donation production was above the target throughout the year, and finished the year at 86.5% (83.2% in 2011/12). We anticipate being able to continue delivering the 80% target during 2013/14.

We continue to focus on ensuring the highest standards of regulatory performance within our manufacturing and laboratory based activities. As a result of this we are pleased to note that during 2012/13 we have had only one instance of a "major" non compliance reported by our regulators, which is consistent with last year and much lower than historic levels. We already operate a "no criticals" approach to regulatory inspection and we are now extending this to become a "no majors" policy from 2013/14 onward.

Monitoring and management of the satisfaction levels of both our blood donors and our customers (NHS hospitals) is a critical part of our performance framework. Donor

satisfaction, measured as the percentage of donors scoring 9 out of 10 or higher for overall service, was at 68% and equal to the target for the year. We remain committed to improving our service to donors and this target will again be increased next year to 69%. The level of donor complaints (measured as complaints per million donations) has, however, been disappointing this year remaining well above the target of 3,800 and close to 4,800 (a significant increase on last year's level of 3,818). Waiting times and the availability of appointment slots at required times are the key reasons for the performance and we will address this by adjusting our schedules to correct the balance between appointments and slots for walk-in donors. Customer satisfaction measured as the percentage of customers scoring 9 out of 10 or higher for overall service, was at 68%, better than the target of 60% and significantly higher than the 59% recorded last year.

Despite strong and increasing performance levels in safety and quality NHSBT has been able to concurrently reduce the price of red cells to NHS hospitals from £140/unit in 2008/09 to £123/unit in 2012/13 whilst reporting year on year financial surpluses. Key to achieving our cost improvement plans has been the work to optimise processes in Blood Donation and the removal of excess capacity in the blood supply chain. The removal of capacity has resulted in a reduction from 12 manufacturing and 11 testing sites in 2008 to 5 and 2 respectively this year (with testing at Colindale closing in March 2013). As a result, processing productivity has risen by 62% and testing productivity by 67% since 2008/09 and now ranks amongst the most productive functions compared to other blood services across the world.

The key trend, with the largest impact on NHSBT during 2012/13, has been the sharp decline in red cell demand that we started to see in October 2012. Until that point demand had been consistent with previous years but then fell rapidly so that, by year end, demand was 2.7% lower than the forecast made in September 2012. NHSBT's costs are mostly fixed with consumables representing only a small proportion of the total. Reduction in demand is to be welcomed when this derives from better patient blood management but such a sharp decline can present operational difficulties, especially reducing resources in blood donation to match the reduced levels of activity. The decline has reduced the level of financial surplus in 2012/13 but, more importantly, it will put pressure on our ability to further reduce prices in 2013/14 and beyond.

Organ Donation and Transplantation

NHSBT is delighted to report that by April 2013 the level of deceased organ donation in the UK has grown by 50% versus a 2007/08 baseline (49.8% is the actual year end position). The aspiration to grow deceased organ donation by 50% within 5 years by 2013 came from the report of the ODTF that was published in January 2008. It is a fantastic achievement that this challenging vision has been achieved and results from the commitment and hard work of everybody that is involved in the donation pathway. The result reflects that there were 1,212 deceased donors in the UK in 2012/13 versus 809 in 2007/08 (and 1,087 in 2010/11). There were additionally 1,099 live donors in 2012/13 (1,094 last year).

As a result the total number of organ transplants (deceased and live) carried out in 2012/13 was 4,212 (3,960 last year) representing an increase of 30% above the 2007/08 baseline. The difference in the growth rate of transplantation versus donation reflects a higher proportion of donations following cardiac death as opposed to brain death (and hence a limitation to the number of organs that can be used), along with a general reduction in the quality (and hence number) of organs per donor as a result of donors tending to be older and with a higher body mass index. Having delivered on the aspiration of the ODTF to grow organ donation the new strategy for organ donation and transplantation will also identify

actions to improve the rate of transplantation growth through increasing the number of usable organs per donor.

During 2012/13, the implementation of the ODTF recommendations for which NHSBT is responsible has continued, and has resulted in:

- 19.5 million people registered on the Organ Donor Register (ca. 32% of the UK population) with another 1 million names having been added in the last year (versus 1.2 million added in 2011/12).
- Continued work on the Organ Donor Register to improve accuracy and resilience (in line with the recommendations put forward following the Review of the Organ Donation Register by Professor Sir Gordon Duff in October 2011).
- Completion of the development of an internet microsite, which communicates policies, best practices and statistics to professional audiences or members of the general public, who want greater and more detailed information and to make the working of ODT more transparent.
- Improved technology for clinicians using our Electronic Offering System (EOS) that provides them with web enabled devices that support the offering of organs for transplant and their decision whether to decline or accept an offer.

We have also worked closely with officials in the Welsh Health Department in support of proposed legislation in Wales for the implementation of a system of soft opt out for organ donation by 2015. All of the four UK Health Departments have agreed that a new organ donor register for the UK, that can support both opt-in and opt-out systems, will be required. We are therefore developing the plans in support of a new organ donor register so that this can be introduced in time to support the introduction of new legislation in Wales.

Despite these achievements, however, there remain around 8,000 people in the UK who are actively awaiting a transplant. In addition to those people on the 'active' waiting list, a further 2,000 people are on the 'suspended' list because they are too ill or unable to receive a transplant at present. Added together, this brings the total number needing an organ transplant in the UK to above 10,000.

Specialist Services

Activity in Specialist Services has been focused on continuing to improve the financial viability of individual service lines and developing the individual strategies of each.

The focus within Tissues has been to generate better visibility and recognition of our service across the NHS and to establish NHSBT as the preferred national provider of high quality, cost effective tissue allografts. In support of this product management skills have been introduced in order to develop our commercial management capability and generate improved sales, marketing and new product launch strategies. Although we are now much better placed to meet the demands of NHS hospitals and their patients we have seen a general decline in the level of demand for many of our products in the latter part of 2012/13. We have recently launched a Demineralised Bone Matrix (DBM) product into the NHS which should drive income growth in 2013/14 despite the adverse demand environment.

We continue to see demand growth in Diagnostics, Stem Cell Services and Special Therapeutic Services, although again, in some areas, we have observed a slow down in demand later in the year. Taken together, income from our specialist services was £54.3m in 2012/13, 5% higher than last year but lower than the levels we anticipated at the start of

the year. Lower demand growth will limit our ability to leverage our scale and our intent to hold, if not reduce, the cost (and hence the prices) of our products to NHS hospitals.

Customer satisfaction (measured as the percentage of customers scoring 9 out of 10 or higher for overall service) was better than target (62% vs 60%) for our Red Cell Reference services. The score for H&I services was significantly better than target (68% vs 60%) and also higher than the response that we received in the previous year (54.5%). We will continue to develop customer satisfaction measures for all of our services along with action plans to improve performance.

In addition we continue to support the recommendations of the UK Stem Cell Forum (UKSCF) that addressed the future of unrelated donor stem cell transplantation in the UK and reported in July 2010. This set out the underlying objective of saving 200 lives each year through increasing the UK inventory of cord blood donations and improving the performance of UK based stem cell registries, such as the British Bone Marrow Registry (BBMR). NHSBT is collaborating with the UK Health Services and the Anthony Nolan Charity to implement its recommendations. There were just over 2,000 cords banked during the year of which over 40% were from Black and Minority Ethnic (BAME) communities. Plans have been developed in conjunction with the DH, to increase the number of banked cords to 2,300 pa, while increasing BAME representation for the financial years 2013 - 15.

The NHS Cord Blood Bank now has 11,800 units with a Total Nucleated Count (TNC) of greater than $9x10^{8}$. Our intent is to increase the effectiveness of the bank through targeting collection of units with a TNC greater than $14x10^{8}$. By adopting this approach our units will become more likely to be selected and in doing so, we will be better placed to meet the needs of patients. We currently have 6,600 units of this standard. The UKSCF sought to have a UK inventory of 50,000 cord blood units by 2018 (with a high TNC level, defined as greater than $9x10^{8}$ for BAME donors and greater than $12x10^{8}$ for Caucasoid donors). The NHSBT target is to contribute a bank of 35,000 units towards the 50,000 target. At our planned collection levels we anticipate having a bank of higher TNC donations of 25,000 by the end of 2018, albeit with a much higher proportion of very high TNC (i.e. greater than $14x10^{8}$ for both BAME and Caucasoids). The outcome of these efforts may already be seen with the number of cord blood units issued in 2012/13 at 49 (versus 33 the previous year) and hence more lives saved and improved as a result.

NHSBT Corporate

Within “NHSBT Corporate” we generate and implement the strategies that are most appropriately driven at this level, rather than within the operating units. As part of this we have continued to develop programmes to support the development of our managers and improve our overall leadership capability. The key element of this is our SHINE talent and leadership development programme which encompasses all the ways NHSBT is supporting our staff to shine as tomorrow’s leaders.

During 2012/13 we have continued to implement our Carbon Management Plan that was generated in partnership with the Carbon Trust. The recently published CRC Performance League table, which ranks the relative performance of CRC Energy Efficiency Scheme participants, ranked NHSBT 6th out of more than 2,000 participants in the UK. This places NHSBT as the second highest performing body in the public sector and the highest performing DH/NHS organisation. Performance is being measured against NHSBT’s carbon emissions baseline and we expect to meet this year’s target of a cumulative 16% reduction from the 2009/10 baseline. Plans will continue to be developed to support the achievement of a targeted reduction of 25% carbon emissions over the 5 year period to 2014/15.

We continue to engage with opportunities to implement shared service solutions for our back office functions. At the start of the year the processing of our payroll was outsourced to NHS Shared Business Services (SBS). This has had only limited success due to a succession of basic process failures and high staff turnover within SBS. Financial savings have also been less than plan as a result of the need to put additional resources in place to ensure payroll accuracy and timeliness. Although we continue to explore opportunities for putting our finance and accounting processes into a shared services environment we have yet to identify a solution that will both provide lower costs and the stock managent functionality that our supply chains require. Our existing processes are highly efficient and integrated within an Oracle platform that provides the stock and warehousing functionality used by the blood supply chain. We continue to drive for automation and improvement and, as a measure of this, 70% of our procurement is now driven through formal purchase orders and 40% of these invoices are processed through Electronic Data Interchange. In addition we continually review the effectiveness of our corporate support functions and have redesigned the way we deliver our services in a number of areas. As a result we have reduced the cost of our corporate functions by £1.2m in 2012/13 equivalent to a 3.5% saving against the previous year.

Approved or Planned Future Developments

As part of our integrated planning, performance, risk management and assurance framework NHSBT is generating detailed strategies for each of its strategic operating units and updating these over an appropriate periodic cycle. Each plan sets out the strategic objective, broad action plans and targets that have been summarised in the section on strategic objectives above. In generating these plans NHSBT is aiming to improve the quality of its horizon scanning so that it can better capture and respond to the needs of our customers, patients and stakeholders, as well as anticipating significant changes in the external environment such as genomics, information technology and demographics.

We believe that our plan captures a balanced set of objectives designed to improve the safety, quality and efficiency of our services.

Within **Blood Components** our key projects include:

- Work on improving our services to donors, including the introduction of more modern web based forms of communication, along with improving overall productivity levels
- The development of new "order to cash" processes within our interfaces to NHS hospitals to support our intention to be their "supplier of choice"
- Development of processes in support of integrated blood stock management, building on data and learning from the three pilot schemes that are currently underway.
- Introduction of a Transport Management System to secure greater efficiency in our logistical processes and use of fleet

A key objective of the plan is to hold the significantly reduced prices of red cells that our recent activities have generated. We have committed to a further reduction of red cell prices to £122/unit in 2013/14 and our target is to at least hold this level over the next four years. In this regard our cost improvement plans have recently seen a major contribution from procurement savings from tenders that we have concluded in respect of blood packs and microbiology test kits (together generating savings of ca £5m pa commencing in 2013/14).

As indicated above, the achievement of our pricing targets will be impacted by the demand for red cells and the fall in demand that has taken place since October 2012. This

represents one of the largest short tem shifts in the demand trend that we have ever seen, and it is not yet clear whether this reflects a permanent change in demand levels. This provides further evidence for the need to integrate blood stocks management and provide better intelligence on the use of blood within hospitals and potential changes in demand. In the short term the impact of the significant procurement savings noted above has been a major factor in delivering a further price reduction in 2013/14 whilst also maintaining the financial capacity to fund our ongoing transformation plans.

In addition we will continue to work with the Welsh Government to support their intention to move to an All Wales Blood Service by 2016 (but with substantial progress expected to be made by 2014). Although the volumes of blood currently collected in, and supplied to, North Wales by NHSBT are relatively small this is not a trivial project and there are some complex service and logistical issues (across blood and supporting diagnostic services) that will require resolution by the Welsh Blood Service. The implementation will also put further pressure on NHSBT blood prices due to the removal of the volumes involved.

Within **Organ Donation and Transplantation** the primary focus during the early part of 2013/14 will be the finalisation of the new strategy and its adoption by all of our stakeholders. During the development of the new strategy the overall intent has been to work within existing funding levels. As the detailed plans that underpin the strategy emerge, however, this may result in initiatives that would require additional funding. This will be subject to agreement between all of the UK Health Departments as necessary.

In support of the new strategy we are again intending to seek authorisation to run national marketing campaigns in support of organ donation. In the last two years we have been unable to gain approval from the Cabinet Office for such campaigns, but continue to believe that they necessary if we are to change public attitudes to donation and improve the consent rate.

As indicated above the implementation of legislation for a soft opt-out system of organ donation in Wales is likely to require the development of a new organ donation register for the UK. The specification and costs for such a register have been identified and NHSBT will be accountable for its introduction and operation. At present the Welsh Government has plans in place to fund the investment in a new register, but is in discussion with the other UK Health Departments to discuss funding arrangements and seek contributions as appropriate.

We are also developing plans aimed at improving the ageing IT infrastructure that underpins organ donation and transplant and facilitates the application of the rules for the allocation of organ.

A common theme within all of our **Specialist Services** strategies is to exploit our unique national capabilities in support of safe and effective therapies for the NHS and its patients. As a result we expect to grow our income and, through improved scale, generate surpluses that can be reinvested back into reduced prices and/or new products/therapies. Hence much our activity is focused on developing our organisational capabilities and underpinning these with appropriate IT support (including electronic reporting of diagnostics results, support for customer relationship management and order to cash processes). With regard to new product launches, in Tissues, we are currently launching a new Demineralised Bone Matrix product (DBM) and will be following this up later in the year with the launch of Decellularised Dermis.

At the **NHSBT Corporate** level our major development is the planned reconfiguration of our estates footprint at Brentwood. The existing site at Brentwood is now oversized and will require significant investment in its fabric within the next few years. We are therefore looking at a scheme to re-provision the estate, to free up the existing site for sale, and decant

activities into lower cost and fit for purpose facilities in the area. Our initial proposals are being modified in response to the concerns of the hospitals that are served by the existing stock holding unit at Brentwood. Subject to gaining their support we would anticipate the project commencing around mid year. Elsewhere we are continuing to target investment in our Tooting and Birmingham sites in order to bring them up to an appropriate standard.

We will also continue to work with the Department of Health (DH) in order to identify an appropriate shared service solution for finance and accounting across the DH and its Arms Length Bodies.

Financial Review

NHS Blood and Transplant is a Special Health Authority and is treated as a Non Departmental Public Body (NDPB) under the Government Financial Reporting Manual (FReM).

NHSBT is therefore required to report on a net expenditure basis with grant-in-aid received from the Department of Health recognised in the general reserve. Although NHSBT is required to report on a net expenditure basis, the Board and management of NHSBT review NHSBT's financial performance on an income/expenditure basis, as this is more appropriate to the nature of NHSBT's activities. On this basis NHSBT generated an operating surplus of £2.7 million in 2012/13 (versus £4.3m in 2011/12).

Note 2 of the accounts reconciles the operating surplus as reported to the NHSBT Board to the net expenditure basis on which these accounts are prepared. The note further provides a segmental analysis of our financial performance that is consistent with the operating units defined by our strategies and the presentation of our management accounts.

The segmental analysis reports an operating deficit of £3.8 million for our specialist services (diagnostics, tissues, stem cell and specialist therapeutic services), offset by surpluses in blood components and organ donation and transplantation. The operating deficit in specialist services is an improvement on the deficit of £6.8 million in 2011/12 and is on target to remove this deficit by the end of 2013/14 . This represents significant progress given the deficit of approximately £22 million that existed in 2007/08, prior to when the deficit reduction plan was put in place.

In 2012/13 an initial allocation of £61.9 million revenue grant-in-aid was made. £55.2 million of this was allocated to Organ Donation with the balance supporting the activities of the International Blood Group Reference Laboratory and the development of the NHS Cord Blood Bank. During the year we were unable to gain approval for marketing activities in support of organ donation. As a result £1.5 million of grant-in-aid was returned to the Department of Health and the hence the total net amount of grant-in-aid is reported as £60.4 million in note 2 of the accounts (£53.7 million Organ Donation).

NHSBT receives the majority of its income from the recovery of costs through the pricing of blood components to NHS Hospitals. This income was £294.9 million in 2012/13 (£304.5m in 2011/12). Prices are set annually via a national commissioning process and are based on volume assumptions for the products provided in the year ahead. The reduction in income that was seen in the year reflects lower costs (and hence lower prices to hospitals) but mostly reflects the impact of the lower demand for red cells that was first observed in October 2012 and which has continued during the year.

NHSBT also receives income from the provision of diagnostics, tissues, stem cell and specialist therapeutic services amounting to £47.8 million in the year (£46.5m in 2011/12). This income also derives from prices agreed through the national commissioning process with NHS hospitals, although in areas such as tissues, we are increasingly exposed to commercial competition and hence prices are being set in response. Income is higher in the year as a result of increasing demand and the impact of our strategies to establish our services as national preferred providers to the NHS. Tissues income was flat year on year as despite our strategic objectives to grow the service we saw a fall in demand for skin, bone and tendon in the latter half of the year.

We also received contributions in the year of £8.5 million from devolved administrations in support of our UK wide activities in organ donation and transplantation (£7.0m in 2011/12) and £12.7 million of other income (£11.7m in 2011/12) for cost recovery in respect of other services we have provided.

For 2012/13 NHSBT was allocated capital funding of £7.5 million, all of which was spent. Much of this expenditure is incurred in the continual maintenance of manufacturing and laboratory facilities, and replacement of the manufacturing and testing equipment, and associated IT, that is used to support the operation of the blood and specialist services supply chains.

As shown on the Statement of Financial Position non-current assets have fallen from £168.0 million (2011/12) to £166.2 million (2012/13). The value of property assets have not been indexed during 2012/13 and a full valuation of these assets is planned for 2013/14.

The working capital position remains satisfactory with a ratio of total current assets to total current liabilities of 2.7:1 Current assets have slightly increased from £53.7 million (2011/12) to £54.1 million (2012/13). The overall result is a small decrease in total assets employed of £1.1 million.

Principles of Remedy

NHSBT is committed to providing quality responses to our customers' queries and concerns in line with 'Listening, Responding, and Improving', the Department of Health guidelines and supporting the Ombudsman's 'Principles of Remedy'. We actively seek feedback from our customers so that we can take steps to put things right when expectations and needs are not met, and we can understand where we need to improve. Complaints procedures are in line with the six principles that represent best practice published by the Parliamentary and Health Ombusman in 2010. Customers can complain in person, by phone to our Hospital or Donor Customer Services staff or in writing. Our contact details are published on complaint leaflets and on our websites.

Complaints are used in conjunction with hospital 'Trust Visit' reports to highlight areas for improvement. Over 400 Trust visits were completed during 2012/13. Service improvements initiated in response to complaints include the completed rollout of our online blood ordering system to 100% of hospitals where feedback is extremely positive. Electronic Reporting for Specialist Services was also requested by hospital staff during visits to reduce complaints associated with sample turnaround times. In response NHSBT has now delivered electronic reports via Sp-ICE (an electronic reporting system for Specialist Services) to over 60% of hospitals and our hospital satisfaction scores during 2013 are the highest ever with 71% of customers scoring us 9 or 10 out of ten for our service provision overall. During 2012/13, we received 431 contacts from hospital customers of which 292 (68%) were complaints and 139 (32%) were compliments.

The level of donor complaints this year has disappointingly been well above the target of 3,800 being closer to 4,800, a significant increase over last year's level of 3,816. Waiting times and the availability of appointment slots at the required times are the key reasons for donor complaints. We have addressed this with a project (RAIDE) to improve access to appointments throughout the session and to walk in slots from June 2013 onwards.

Our responses aim to address specific concerns and wherever possible are provided by front line managers who are closest to the issues. We want to apologise where service standards are not achieved, make the relevant improvement, or provide an acceptable explanation where this is not possible. All feedback is analysed and reported to management teams monthly to identify trends and remedial actions and independently checked by our Quality Managers. Work to develop a more detailed understanding of errors and incidents continues, so that we can improve our learning from these experiences. We are pursuing direct contact to resolve complaints and 58% of blood donor complaint issues were responded to by telephone during 2012/13. Outcomes with potential solutions were noted for 89% of resolved blood donor complaints.

We use the guidance from 'Managing Public Money' to address requests for reimbursement and aim to provide fair and proportionate compensation where appropriate. We will continue to review our implementation of 'Listening, Responding Improving', for resolving issues of concern across NHSBT, in line with the Ombudsman's principles.

Environmental, Social and Community Matters

NHSBT's Carbon Management Plan (CMP) commits it to reduce its carbon emissions by 25% over a five year period from a 2009-10 baseline and thereby help to mitigate the effects of fuel price inflation and carbon taxation. Now approaching the end of its third year, the plan has ensured we have delivered beyond our stated annual targets each year and this trend is predicted to continue as we come to the end of year three. Energy, travel and waste are reported quarterly in arrears; overall CO_2 output is reported annually. Figures for NHSBT total carbon emissions for 2012-13 will therefore be reported to the Board and Executive Team in July 2013.

During 2012-13 the baseline CO_2 emissions were revised to reflect improved quality of travel information that had become available from internal systems. The revision of the travel baseline resulted in the overall CO_2 baseline increasing from 26,152 tCO_2 (2009-10) to the new figure of 27,792 tCO_2. As part of the revision process, predicted reductions that had previously been linear across all sectors were re-evaluated based on a timeline for projects commencement and their benefits delivery structure. The overall target of a 25% reduction is not affected by these changes and the new baseline will be reflected when the 2012-13 figures are published.

NHSBT Total Carbon Emissions (tonnes $C0_2$)

	09/10 Footprint	10/11 Footprint	11/12 Footprint	12/13 Footprint
NHSBT CO2 emissions	26, 152	24, 514	22,570	**Reported in July 2013**
Target	Baseline	6%	11%	16%
Actual	Baseline	6.3%	13.7%	

Initiatives

A contract has been awarded to introduce an organisation wide contract for non clinical waste with an implementation date planned for spring 2013. The new contract will include the collection of all general waste and the provision of a full recycling service. This will tackle a number of historical problems, not least the base lining of current waste activity; this in turn will allow the organisation to accurately measure and monitor the amount of waste it sends to landfill.

Two new policies have come into effect in the reporting year that affect how NHSBT controls both its fleet of lease vehicles and those privately owned vehicles used for business purposes (grey fleet). The new lease arrangement positively discriminates towards the choice of a lower emitting vehicle and to a reduced mileage. The grey fleet arrangement levers regular drivers over to a lease car and introduces more stringent controls on the use of private vehicles.

The first benefits from these policies will not be seen until 2013/14 and the full benefits coming on line in 2015/16. This is estimated to deliver 9.4% CO_2 saving to the end of the CMP (2015).

The organisation has targeted its clinical waste operations to effectively divert this type of waste away from incineration and into alternative treatment streams. The new arrangements came into effect in June 2012 and it is estimated that at least 85% of waste will be diverted.

NHSBT is an active member of North Bristol SusCom. This is a network of major employers in the North Bristol area and encompasses our Filton site. These employers include Airbus, BAe, GKN, Ministry of Defence, Friends Life, North Bristol NHS Trust, Rolls Royce and the University of the West of England.

The overall aim of the group is to work together to influence and improve local transport provision to combat traffic congestion and reduce the impact upon the environment. The group develop and share initiatives to encourage car sharing, cycling, bus use, walking and rail use as preferred ways to travel to work. North Bristol SusCom is a company limited by guarantee and is funded by member subscriptions and a grant from the Local Sustainable Transport Fund.

In the summer, NHSBT employed a full time Environmental Manager to prepare recommendations to the Executive Team on tackling the management of environmental matters across the organisation. The Executive Team supported the decision to pursue accreditation to ISO14001; this work commenced in February 2013.

Carbon Reduction Commitment Energy Efficiency Scheme

Since the last report NHSBT has complied with the requirements of the CRC legislation, submitting an Annual Report to the Environment Agency (EA) and purchasing the required number of carbon allowances (at a cost of £212k) to cover its emissions. In addition, internal auditors PWC were commissioned to look into NHSBT's governance arrangements for compliance with the legislation. A number of recommendations were made and are being put into effect.

The CRC performance league table that was published in February by the Environment Agency ranked NHSBT in 6th position out of over 2,000 public and private sector organisations. This places NHSBT as the highest ranking NHS organisation and is a reflection of its continuing efforts to reduce both absolute and relative (to revenue spend) emissions.

Emergency Preparedness

NHSBT maintains emergency preparedness and ensures that its systems are fit for purpose by maintaining certification of the blood supply chain to British Standard BS25999. The process of maintaining a system that is certified has also provided assurance and resilience within other parts of NHSBT's business. The system:

- proactively improves our resilience against disruption to our ability to achieve our key objectives
- ensures a rehearsed method of restoring our ability to supply our key services to an agreed level within an agreed time after a disruption
- deliver a proven capability to manage a business disruption and protect the organisation's reputation and brand

There have been a number of significant events in the 2012-13 year:

- NHSBT provided stakeholder assurance prior to the London Olympic and Paralympic Games 2012 that the organisation can respond to any potential disruption challenges to service during the Games.
- The organisation replaced its core IT network with an outage that lasted for several hours, and there was no failure to meet any order on time in full during this upgrade.
- Most significantly, NHSBT's largest site flooded in September 2012 and, whilst a number of lessons have been identified, all operational activity returned to normal within two weeks of the flood and no customer order was unfulfilled.

The lessons identified from the events outlined above are subject to a workplan that has oversight from the Executive Team and the Governance and Audit Committee. They do form the basis of a workplan for the forthcoming year, which includes:

- Transfer of the organisation from certification to BS25999 to ISO 22301.
- The increase of scope for the Business Continuity Management System on a site by site basis, to include Filton in the first instance by November 2013 and to include other sites thereafter.
- A review of the Command and Control process within the organisation.
- A review of the communications that are used during disruption.

A committee continues to oversee emergency planning activity and to identify business continuity as a separate but associated work stream. The remit of the committee is the governance of emergency preparedness, structures, plans and maintenance. The committee meets quarterly and has a responsibility to produce an annual report for the attention of the Executive Team and the Governance and Audit Committee.

Action taken to maintain or develop the provision of information to, and consultation with, employees

There has been a considerable amount of work done to develop the way we communicate, consult and engage with all NHSBT employees. Our annual communications audit and staff survey help to identify which communication methods are working and more importantly, highlight any areas for development. We use this feedback to continuously improve our range of face to face, print and online channels. For example, in response to staff feedback NHSBT's Senior Leadership team embarked on a series of roadshows to discuss our new Strategic Plan with staff and help them link this to their area of work. We also equip

managers to generate a two way dialogue with staff and ensure information is shared in a timely and appropriate way, for example through our monthly face to face Connect Briefing. We have a varied workforce in terms of preferred channels of communication, but also working hours, geography and access to technology, and we use a range of communication techniques to help keep people connected.

NHSBT's Partnership Framework has enhanced our partnership approach with our staff side colleagues which has proved to be very effective, enabling us to manage sometimes difficult situations with minimum disruption. The revised consultative mechanisms have now been in place for sometime and assist the flow of information at a local, regional and national level. This has been enhanced further this year with a review of our Health & Safety consultation arrangements which will result in more effective processes for discussing, consulting and managing health and safety issues.

The benefits of an engaged workforce are well documented and understood. NHSBT is committed to taking on the challenge of becoming a great place to work and the Executive Team have given a clear steer on how this will be achieved. This includes giving staff choice, engaging all managers, providing good learning opportunities through Shine, and providing the resources that lead to a good health and well being environment with shared values at the heart of our work.

These ambitions will be achieved through the three pillars of engagement:

- **Employee Voice** - the adaptation of the NHS "Listening into Action" initiative, a series of conversations with staff at centres and within teams (to reach remote workers) on what matters to them, a next steps programme following the air your views focus groups and staff survey

- **Engaged Managers** – delivery of regional "Making a Difference" events to engage middle managers, aligning them to the strategic direction of NHSBT

- **Engaging Workplace** – a commitment to providing the time and space for three days learning and development for everyone including front line staff

This is an ambitious strategy which will build on what we have learned and provides a starting point of meaningful change.

Disabled Employees Statement

Part of NHSBT's overall journey to becoming the best organisation of our type in the world is being a great place to work. A key part of this is having a diverse workforce that reflects society, and does not discriminate on any level or in any way. This is why we will ensure that disabled people in the work place gain equal access to training and development opportunities, we will also make sure that all our disabled employees are provided with every opportunity to achieve their potential.

NHSBT have already taken a number of proactive measures to mainstream disability equality. An example of this is establishing a disability advocacy programme to promote a culture that heightens awareness of disability equality.

The main purpose of the Disability Advocacy scheme is to develop a disability confident culture within NHSBT and a team of 18 advocates has been assembled across the

organisation to promote disability equality and guide managers and supervisors on disability related matters.

The Advocates act as a signpost for disability matters and in the main they work to:

- Promote reasonable adjustments in the work place
- Work with recruitment to ensure disability equality is a key feature within the recruitment and resourcing strategy. For example the two ticks symbol.
- Work with the BDF Business Disability Forum to promote disability related matters in the work place
- Advising Managers and staff on disability equality matters and assessments

The work of the advocates' link into existing internal and operational strategic groups within NHSBT.

Equal Opportunities Statement

NHSBT is committed to promoting equality & diversity, providing an inclusive and supportive environment for all staff. The key agreed organisational aims are to:

- Have a workforce that embraces equality and diversity. We will recruit, develop and retain a workforce that is able to deliver high quality services that are fair, accessible, appropriate and responsive to the diverse needs of different groups and individuals.

- Be a better place in which to work; ensuring that the NHSBT is seen as an employer of choice, achieving equality of opportunity and fair outcomes in the workplace.

- Have a service that uses its leverage to make a difference – to ensure that the NHSBT exploits its influences and resources as an NHS employer to make a difference to the life opportunities and the health of the population, especially those who are excluded or disadvantaged.

The organisation will:

- Ensure that people are treated solely on the basis of their abilities and potential, regardless of race, colour, nationality, ethnic origin, religious or political belief or affiliation, trade union membership, age, gender, gender reassignment, marital status, sexual orientation, disability, socio-economic background, or any other inappropriate distinction.

- Promote diversity and equality for staff, donors and patients and value the contributions made by individuals and groups of people from diverse cultural, ethnic, socio-economic and distinctive backgrounds.

- Promote and sustain an inclusive and supportive working and clinical environment, which affirms the equal and fair treatment of individuals in fulfilling their potential, and does not afford unfair privilege to any individual or group.

- Wherever reasonable and practicable, promote flexible working hours.

- Treat part time staff fairly and equally.

- Challenge inequality and less favourable treatment.
- Ensure individuals experience equality of opportunity.
- Promote an environment free from harassment and bullying on any grounds to all staff donors and patients.

Sickness Absence Data

Sickness absence data is reported on a calendar year basis to facilitate aggregation of information on a consistent basis nationally.

During the period January 2012 to December 2012 the total number of whole time equivalent days lost to sickness absence was 49,089 days. This equates to an average of 9.7 days per whole time equivalent; and a sickness absence rate of 4.3%.

For the period January 2011 to December 2011 the total number of whole time equivalent days lost to sickness absence was 47,724 days. This equates to an average of 9.4 days per whole time equivalent; and a sickness absence rate of 4.2%.

Board Members

Board Members serving during the period 1 April 2012 to 31 March 2013:

Chairman
Mr Bill Fullagar. Mr Fullagar has since retired from the Board as of 30 May 2013. He is suceeded by Mr. John Pattullo whose appointment comes into effect as of 31 May 2013.

Non Executive Directors
Mr Andrew Blakeman
Ms Della Burnside (period 1 April 2012 to 31 July 2012)
Dr Christine Costello
Mr John Forsythe
Mr Roy Griffins
Mr Jeremy Monroe (commenced 11 February 2013)
Mr George Jenkins
Mr Shaun Williams

Executive Directors
Ms Lynda Hamlyn - Chief Executive
Mr Rob Bradburn - Finance Director
Ms Sally Johnson - Director of Organ Donation and Transplantation
Mr Alan McDermott – Director of Blood Donation (period 1 April 2012 to 15 August 2012)
Dr Clive Ronaldson - Director of Blood Supply
Mr Huw Williams – Director of Diagnostic & Therapeutic Services (commenced 4 February 2013)
Mrs Lorna Williamson - Medical and Research Director

Details of the remuneration of senior managers of the Authority can be found in the Remuneration Report at pages 23 to 26.

Better Payment Practice Code

As a public sector Organisation NHSBT is required to pay all trade creditors in accordance with the Better Payment Practice Code. The target is to pay all valid invoices by the due date or within 30 days of receipt of the goods or a valid invoice, whichever is the later. NHSBT's performance against this code is shown below :

	Number	£'000
Total Non NHS trade invoices paid in the year	89,299	194,653
Total Non NHS trade invoices paid within target	84,872	191,992
Percentage of Non NHS trade invoices paid within target	95.0%	98.6%
Total NHS trade invoices in the year	11,508	7,801
Total NHS trade invoices paid within target	11,194	7,458
Percentage of NHS trade invoices paid within target	97.3%	95.6%

Public sector Organisations are also bound by the Late Payment of Commercial Debts (Interest) Act 1988. This provides a statutory right for suppliers to claim interest on late payments of commercial debt. During 2012/13 NHSBT made a payment of £224 arising from claims made under this legislation.

Prompt Payment Code

The Government has encouraged all public sector Organisations to speed up the payments process and make payment of invoices wherever possible within 10 days. NHSBT is effectively a trading organisation that is mostly funded from sales of products and services (at cost) to our customers (NHS hospitals). Our customers are not subject to the same guidance and NHSBT is therefore limited in its ability to meet such guidance. However, during 2012/13 NHSBT paid 38.5% (36.1% in 2011/12) of the total number of invoices, representing 36.7% (36.4% in 2011/12) by value, within a 10 day period.

Review of Tax Arrangements for Public Sector Appointees

As part of the Review of Tax Arrangements for Public Sector Appointees, published by the Chief Secretary to the Treasury on 23rd May 2012 there is a requirement to disclose the following information relating to 'off payroll workers'.

Engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012 :

Number in place as of 31 January 2012	38
Number that have since come onto the NHSBT payroll	0
Number that have since been re-negotiated to include a contractual clause to provide assurance as to their tax obligations	7
Number currently being re-negotiated to include a contractual clause to provide assurance as to their tax obligations	5
Number that have come to an end	26

New engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months :

Number of new engagements	25
Number of new engagements which include contractual clauses giving the right to request assurance relating to income tax and national insurance obligations*	7
Number for whom assurance has been requested but not received	0
Number since ended	3
Number that have been terminated as a result of assurance not being received	0

* Contracts are currently transferring to Contingency 1 (part of the Government Procurement Service) which contains the necessary contract clauses

Reason for Continuation

NHSBT continues to implement an ambitious changes programme that is delivering demonstrable improvements in the safety, availability and value for money of the critical products and services that we provide. Our programmes include significant changes to our supply chains and require professional change management of the people, processes and IT systems that underpin them. We therefore require the support of specialist contractors in the design and implementation of our change programmes. We are currently in transition to remove all staff with “off payroll” arrangements but this will take further time if it is not to disrupt change programmes and imply that key project deadlines and cost savings targets are missed.

External Audit

The Comptroller and Auditor General (C&AG) is appointed by statute to audit NHSBT and report to Parliament on the truth and fairness of the annual financial statements and regularity of income and expenditure. The cost of audit work performed is £90k (£90k 2011/12). There were no payments to the National Audit Office for non-audit work during the year.

As Accounting Officer:

- so far as I am aware, there is no relevant audit information of which the NHSBT's auditor is unaware; and
- I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the NHSBT's auditor is aware of that information.

The Audit certificate can be found on pages 38 to 39.

Lynda Hamlyn Date: 19 June 2013
Chief Executive

REMUNERATION REPORT

Remuneration Committee Membership

During 2012-13 membership of the Remuneration Committee comprised Shaun Williams and Bill Fullagar together with Della Burnside for the period 1 April 2012 to 31 July 2012. The committee was chaired by Shaun Williams. Lynda Hamlyn and David Evans also attended Committee meetings as 'standing attendees'.

Remuneration Policy

Remuneration of the Chief Executive, Managing Directors and Group Directors is in line with the decisions of the Remuneration Committee and all relevant DH guidance. Increase in pay is in line with nationally agreed pay awards, provided individual business plan targets, as identified within annual appraisals, are met. Remuneration for Non-Executive Board Members is set by the Secretary of State for Health.

Methods to Assess Performance Conditions

All senior managers are appraised regularly and their performance is assessed against personal and corporate objectives. The element of remuneration based on performance for relevant senior staff is as defined by the NHS National Very Senior Managers Pay Framework, and associated guidance issued by the Department of Health. Although there is an opportunity for performance related pay NHSBT has made a decision not to take advantage of this.

Senior Management Contract Information

Contract details for those in senior positions with responsibility for directing or controlling major activities of the Organisation are shown below. The NHS start date is the date of commencement of continuous NHS service for pension purposes.

Lynda Hamlyn, Chief Executive, NHS start date 1 April 1986, appointed 14 January 2008. Full time permanent post with three months’ notice of termination by the employee, and six months’ notice period by NHSBT.

Leonie Austin, Director of Communications, NHS start date 1 April 2010, appointed 1 April 2010. Full term permanent post with three months’ notice of termination by the employee, and six months’ notice of termination by NHSBT.

Rob Bradburn, Finance Director, NHS start date 8 April 2008, appointed 8 April 2008. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Douglas Dryburgh, Group Director of Estates and Logistics, NHS start date 29 August 2006, appointed 29 August 2006 ended 17 February 2013. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT.

David Evans, Director of Workforce, current NHS continuous service start date 30 July 1998, appointed 5 June 2006. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Sally Johnson, Director of Organ Donation and Transplantation, NHS start date 1 August 2007, appointed, 1 September 2008. Permanent full-time post three months' notice of termination by the employee, and six months' notice period by NHSBT.

Alan McDermott, Director of Blood Donation, NHS start date 14 August 2006, appointed 14 August 2006 ended 15 August 2012. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Michael Potter, Director of Business Transformation Services, NHS start date 9 November 2009, appointed 1 September 2010. Permanent full-time post with three months’ notice of termination by the employee, and six months’ notice by NHSBT.

Clive Ronaldson, Director of Blood Supply, NHS start date 1 March 1993, appointed 1 July 2008. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Huw Williams, Director of Diagnostic and Therapeutic Services, Appointed 4th February 2013, Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT.

Lorna Williamson, Medical and Research Director. Appointed 1 October 2007. Contract of employment with the University of Cambridge until 30th June 2009. Contract with NHSBT from 1st July 2009. Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT.

The remuneration and pension benefits of the most senior officials of the Authority are shown in the table below and in the table on page 26. These tables are subject to audit.

Salary and Pension Entitlement of Senior Managers

a. Remuneration

	Year to 31 March 2013			Year to 31 March 2012		
	Salary in £5k bands	Other remuner. in £5k bands	Benefits in kind (rounded to the nearest £00)	Salary in £5k bands	Other remuner. in £5k bands	Benefits in kind (rounded to the nearest £00)
Name and title	£000	£000	£00	£000	£000	£00
Mr B Fullagar (Chairman)	60-65	-	3	60-65	-	1
Mr A Blakeman (NED)	10-15	-	-	5-10	-	-
Ms D Burnside (NED) ended 31 July 2012	0-5	-	-	5-10	-	-
Dr C. Costello (NED)	5-10	-	-	5-10	-	-
Mr J Forsythe (NED)	5-10	-	-	5-10	-	-
Mr R Griffins (NED)	5-10	-	-	0-5	-	-
Mr G Jenkins (NED)	5.-10	-	-	10-15	-	-
Mr J Munroe (NED) commenced 11 February 2013	0-5	-	-	-	-	-
Mr S Williams (NED)	5-10	-	-	5-10	-	-
Ms L Hamlyn (Chief Executive)	180-185	-	7	180-185	-	8
Ms L Austin (Director of Communications)	105-110	-	1	105-110	-	-
Mr R Bradburn (Finance Director)	130-135	-	25	130-135	-	23
Mr M Cox (Interim Director of Logistics) commenced 14 February 2013	5-10	-	-	-	-	-
Mr D Dryburgh (Group Director of Estates and Logistics) ended 17 February 2013	90-95	-	10	100-105	-	26
Mr D Evans (Director of Workforce)	115-120	-	10	115-120	-	33
Ms S Johnson - (Director of Organ Donation and Transplantation)	120-125	-	-	120-125	-	-
Mr A McDermott (Director of Blood Donation) ended 15 August 2012	110-115	-	2	120-125	-	17
Mr M Potter (Director of Business Transformation Services)	105-110	-	17	100-105	-	5
Dr C Ronaldson (Director of Patient Services)	135-140	-	17	130-135	-	14
Mr H Williams (Director of Diagnostics and Therapeutic Services) commenced 4 February 2013	20-25	-	2	-	-	-
Dr Lorna Williamson (Medical and Research Director)	205-210	-	-	205-210	-	1

NED = Non-Executive Director
Other remuneration relates to performance related pay earned in 2011/12 and paid in 2012/13. There were no bonuses earned or paid in 2012/13.

Benefits in kind were in relation to the provision of cars and are stated in round £100's not £1000's.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of their workforce. The banded remuneration of the highest paid director in NHSBT in the financial year 2012/13 is shown in the table below, together with the remuneration ratio compared to the mid point of the highest paid directors banding. This shows a small decrease in the pay multiples from 8.1 (2011/12) to 8.0 (2012/13).

	2012-13	**2011-12**
Highest Director Banded Remuneration	£205k to £210k	£205k to £210k
Median Remuneration	£26,121	£25,586 *
Remuneration Ratio	8.0	8.1 *

* The methodology for calculating the median has been improved to remove some degrees of estimation previously used. The median remuneration and remuneration ratio for 2011-12 have been restated accordingly (from £26,230 and 7.9).

b. Pension benefits

	Real increase in pension at at age 60 (bands of £2,500)	Real increase in lump sum at at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value
Name and title	£000	£000	£000	£000	£000	£000	£000
Ms L Hamlyn (Chief Executive) **	0-2.5	0-2.5	80-85	240-245	1,749	1,749	-
Ms L Austin (Director of Communications)	0-2.5	-	5-10	-	69	43	25
Mr R Bradburn (Finance Director)	0-2.5	-	10-15	-	141	107	32
Mr D Dryburgh (Group Director of Estates and Logistics) ended 17 February 2013	0-2.5	2.5-5	10-15	30-35	180	145	33
Mr D Evans (Director of Workforce)	0-2.5	2.5-5	35-40	110-115	704	658	35
Ms S Johnson (Director of Organ Donation and Transplantation)	0-2.5	2.5-5	40-45	125-130	818	753	52
Mr A McDermott (Director of Blood Donation) ended 15 August 2013	0-2.5	0-2.5	5-10	25-30	224	202	18
Mr M Potter (Director of Business Transformation Services)	2.5-5	-	15-20	-	202	167	31
Dr C Ronaldson (Director of Patient Services)	2.5-5	10-12.5	45-50	145-150	-	-	-
Mr R Williams (Director of Diagnostics and Therapeutic Services) commenced 18 February 2013	0-2.5	0-2.5	0-5	-	4	-	4
Dr Lorna Williamson (Medical and Research Director)	0-2.5	2.5-5	75-80	225-230	1,756	1,653	75

** is now a deferred member of the NHS Pension scheme, and no CETV figure for 31 March 2013 is available. Therefore the 31 March 2012 figure has been used for both years.

Notes to the Remuneration Report

Cash Equivalent Transfer Value

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

The CETV figure, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a

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

Real Increase in CETV

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

Reporting of Other Compensation Schemes

The table below discloses the number and value by cost band of compensation packages agreed in 2012/13. No special payments relating to exit packages have been made in 2012/13 (two special payments in 2011/12 totalling £109k).

	2012/13			**2011/12**		
Exit Package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost £000s)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost £000s)
<£20,001	7	3	10 (£103)	31	3	34 (£427)
£20,001 - £40,000	3	1	4 (£130)	18	15	33 (£1,083)
£40,001 - £100,000	6	4	10 (£533)	24	14	38 (£2,425)
£100,001 - £150,000	4	1	5 (£562)	4	2	6 (£650)
£150,001 - £200,000	1	-	1 (£165)	1	-	1 (£151)
Total number of exit packages by type (total cost £000s)	21 (£1,115)	9 (£378)	30 (£1,493)	78 (£3,034)	34 (£1,702)	112 (£4,736)

Lynda Hamlyn
Chief Executive

Date: 19 June 2013

ANNUAL ACCOUNTS

Statement of the Chief Executive's Responsibilities As the Accounting Officer of the Special Health Authority

Under the National Health Service Act 2006 and with the approval of HM Treasury the Secretary of State has directed NHS Blood and Transplant to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis, and must give a true and fair view of the state of affairs of NHS Blood and Transplant and of its net operating expenditure, changes in taxpayers' equity, and cash flow for the financial year.

In preparing the accounts the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply appropriate accounting policies on a consistent basis;

- make judgments and estimates on a reasonable basis;

- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and

- prepare the financial statements on a going concern basis.

The NHS Chief Executive has appointed the NHS Blood and Transplant Chief Executive as the Accounting Officer for NHS Blood and Transplant.

The responsibilities of an Accounting Officer, including responsibility for the propriety, and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the assets of NHS Blood and Transplant, are set out in Managing Public Money issued by HM Treasury.

ANNUAL GOVERNANCE STATEMENT 2012/13

Scope of Responsibility

The Board of NHS Blood and Transplant (NHSBT) is accountable for ensuring that its operations are conducted in accordance with the law and all applicable standards. In discharging this accountability the Board is accountable for putting in place arrangements for the governance of NHSBT's activities, facilitating the effective exercise of its functions and managing risk As Accounting Officer, I have responsibility, together with the Board, for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, while safeguarding the public funds and assets for which I am personally responsible.

The Governance Framework

NHSBT is a Special Health Authority in England and Wales that was established by Statutory Instrument in 2005. NHSBT's statutory duties are described in NHSBT Directions that are published by the Secretary of State for Health and the National Assembly for Wales.

The relationship between NHSBT and the Department of Health (DH), along with NHSBT's accountabilities to the DH, are described in an NHSBT Framework Document. NHSBT exercises its organ donation and transplantation functions across the whole of the UK. Its accountabilities to the Scottish and Northern Irish Health Departments in this regard are governed via defined Board arrangements and supporting Income Generation Agreements.

NHSBT comprises a group of distinct strategic operating units, each with different supply chains and processes. As part of our corporate strategic planning process we identify strategic objectives and targets for each of our strategic operating units, which include, inter alia, the safety and sufficiency of supply, customer service and operational effectiveness and efficiency. Accountability for delivery, along with delivery of all aspects of governance, internal control and risk management is assigned to the appropriate NHSBT Director and is underpinned by an integrated performance and risk management process. Performance against objectives and targets is reviewed by the Executive Team on (at least) a monthly basis and results in the issue of a comprehensive monthly performance report to the Board. The Board performance report is assessed on a periodic basis to ensure that if provides sufficient information and assurance to the Board regarding the delivery of NHSBT's objectives and management of its risks.

This structure and process is captured within an overall NHSBT Integrated Governance Framework that was approved by the Board in 2011/12 and launched during 2012/13. The Integrated Governance Framework formally describes the assurances provided to the Board regarding the delivery of NHSBT's statutory and strategic objectives and the effectiveness of its internal controls and risk management processes. As well as describing our governance processes the document is intended to increase awareness of governance at the front line and to demonstrate how the existing processes and activities undertaken every day by our staff comprise essential parts of the overall governance processes within NHSBT.

The Integrated Governance Framework describes the processes that provide assurance to the Board under the headings of:

- Board Structure and Governance Processes
- Strategy, Planning, Performance and Reporting

- Accountability and Delegation of Authority
- Performance Management by the Executive Team
- Clinical Governance
- Clinical Audit and Effectiveness
- Product Safety
- Quality Assurance and Reporting
- Risk Management
- Employees
- Stakeholder Management
- Ethics, Equality and Safety
- Internal Audit
- Financial Control
- Information Governance
- Research and Development
- Business Continuity
- Change Control and Change Management

The Board considers that the framework provides reasonable assurance regarding the delivery of NHSBT's statutory and strategic objectives and the effectiveness of its internal controls and risk management processes, that it has no material gaps and is consistent with the Corporate Governance in Central Government Departments : Code of Good Practice 2011.

The NHSBT Board

The NHSBT Board oversees the strategic direction of NHSBT, and the delivery of our objectives, and ensures that, in doing so, we successfully uphold our core purpose and values. The Board is led by the Chairman and comprises Non-Executive Directors (NEDs) and Executive Directors, including the Chief Executive, Medical and Research Director and Finance Director. Three of the NEDs have been designated to represent the interests of Wales (NHSBT being a Special Health Authority in England and Wales) and of Scotland and Northern Ireland in respect of our UK wide role for organ donation and transplantion.

The Board meets six times a year on a bi-monthly basis and receives a comprehensive integrated monthly performance report covering:

- progress against strategic objectives and targets
- performance against certain key indicators designed to demonstrate that key clinical, operational and safety processes are under control
- new risks, and existing risks with an increased risk score, that have been reviewed and escalated to the Board by the Executive Management Team
- financial performance including an analysis of the income/contribution for each of the strategic operating units within NSHBT
- progress against key strategic projects.

The Board annually reviews, and is satisfied with, its own effectiveness and also that of its Committees which support the work of the Board. All Board Committees are required to submit Annual Reports and Workplans which are discussed at the Board as part of its review of effectiveness. As part of this process the Board agreed to the establishment of a new Board Committee, the National Administrations Committee, during 2012/13.

Board Committees

Seven Board Committees have been established and were in operation during 2012/13. The Board Committees are as follows:

Governance & Audit Committee (GAC) - the Committee seeks assurance regarding the effectiveness of NHSBT's governance, risk management and internal control processes across the whole of the organisation's activities (both clinical and non-clinical). The GAC seeks reports and assurances from directors and managers, guided by an assurance framework and supported by an annual work plan and is supported by an independent internal audit services that is sourced externally. The GAC also conducts periodic risk reviews covering all of the operations and functions of NHSBT on a rotational basis

Trust Fund Committee - the Committee oversees NHSBT's charitable funds that are used to support, for example, organ donation, bone marrow transplant, staff welfare and certain research and development projects which cannot be met by treasury funds. NHSBT is the corporate trustee of the Trust Fund. The Board of NHSBT acts on behalf of the corporate trustee and board members are not individual trustees.

Transplantation Policy Review Committee - the purpose of the Committee is to consider and approve, on behalf of the Board, policies and standards developed by solid organ Advisory Groups, the Donation Advisory Group and the Retrieval Consultation Group, which relate to potential organ donor selection, organ donor management, patient selection and organ allocation. The Committee ensures that the policies meet all legal, regulatory and ethical requirements and standards, recognising that many of these policies have considerable impact on individuals awaiting transplantation.

Remuneration Committee – the Committee oversees remuneration and other contractual arrangements for the Chief Executive and NHSBT Directors. This is done with due regard, to the provisions of the NHS Very Senior Manager Pay Framework and/or other relevant guidance and best practice, ensuring that they are fairly motivated and rewarded and their terms are reviewed and remain competitive and appropriate. The Committee also advise the Board on termination and severance arrangements in relation to the Chief Executive and NHSBT Directors. It also ensures that appropriate details of Board Members' remuneration and other benefits are published in the Annual Report.

Research and Development Committee – the Committee provides strategic advice to the Board on the NHSBT research programme. It approves and allocates available funding for research projects within the delegated financial limits of NHSBT. It receives annual reports and monitors progress on funded projects and commissions research from external sources where appropriate. It also seeks assurance that appropriate arrangements are in place for staff development, research governance, agreements with academic and commercial collaborators, and protection of Intellectual Property. It further receives and considers the Annual Report of Research required to be submitted to the DH.

Expenditure Controls Committee - the Committee was established as a requirement of the spending controls implemented by the DH. It approves and endorses expenditure on professional services as required by the expenditure controls, reviews quarterly forecasts of professional expenditures submitted to DH and ensures that adequate audit trails exists in support of the authorisation process.

National Administrations Committee (established during 2012/13) - the Committee is appointed to review the adequacy of the arrangements by which the policies and implementation issues of all four UK Health Departments with regard to organ donation are

managed by the Board. It also provides support and direction to the development of NHSBT's governance arrangements with regard to managing the interests of the UK Health Departments.

Board Committee Average Attendance of Members

Board Committee	Average Attendance of Members (%)
Governance & Audit Committee (GAC)	100%
Trust Fund Committee	93%
Transplantation Policy Review Committee	90%
Remuneration Committee	75%
Research and Development Committee	57%
Expenditure Controls Committee	92%
National Administrations Committee	80%

The remit and terms of reference of all Board Committees were reviewed during the year.

Board Meetings – Attendance by Members

Member's attendance at Board meetings is shown below:-

Bill Fullagar	Chairman	6
Lynda Hamlyn	Chief Executive	5
Andrew Blakeman	Non-Executive Director	6
Della Burnside*	Non-Executive Director	0
Christine Costello	Non-Executive Director	6
John Forsythe	Non-Executive Director	4
George Jenkins	Non-Executive Director	6
Shaun Williams	Non-Executive Director	6
Roy Griffins	Non-Executive Director	6
Jeremy Monroe****	Non-Executive Director	1
Rob Bradburn	Finance Director	6
Sally Johnson	Director of Organ Donation and Transplantation	6
Alan McDermott**	Director of Blood Donation	1
Clive Ronaldson	Director of Patient Services	6
Lorna Williamson	Medical and Research Director	6
Huw Williams***	Director of Diagnostics and Therapeutic Services	4

Note:

** Della Burnside's last Board meeting on resigning from the Board was July 2012*
*** Alan McDermott's last Board meeting on resigning from NHSBT was May 2012*
**** Huw William's first Board on joining NHSBT was in September 2012*
***** Jeremy Monroe's first Board meeting on joining the Board was in March 2013*

Risk Management and Control

The NHSBT approach to risk is documented in our Risk Management policy, which identifies the roles and responsibilities of staff with regard to risk. The Governance and Audit Committee (GAC) is accountable for ensuring that the risk management process is fit for purpose and is working effectively. The NHSBT approach to governance, including risk management, is featured in the Welcome Pack provided to all new staff during induction. During 2012/13 all Directorate Senior Management Teams (SMTs) were provided with

training in our risk management process as part of their individual senior management team meetings. All Directorates SMTs have identified Risk Leads who attend the Risk Management Committee.

The NHSBT planning, performance and risk management framework maps a path from strategic objectives and risks through to the underlying action plans and risk mitigating activities. This framework is designed to demonstrate that risks are identified and controlled appropriately in order for objectives to be achieved. Strategic objectives and targets are updated and agreed by the Board as part of the annual planning cycle and involves discussion of the key risks facing NHSBT.

Performance and risk is reviewed and discussed at one of the two monthly Executive Team performance meetings that is devoted to performance management. Subsequent to this, assurance is provided to the Board on the achievement of corporate objectives and targets, and mitigation of corporate risk, via a monthly integrated performance report.

New risks identified for inclusion on the Corporate Risk Register are assessed for their likelihood and consequence using a 5 x 5 risk matrix in accordance with the Risk Management Policy and Guidelines. In addition the High Scoring Risks are reviewed by the Executive Team and escalated to the Board as necessary. Existing and new risks are captured within the monthly performance reporting cycle and are summarised within the monthly Board performance report.

The Governance and Audit Committee (GAC) reviews all aspects of corporate, operational and clinical governance and is supported by a programme of internal audit that is updated on an annual cycle. The GAC also has a programme in place to review the risks and controls within each of our operating units and supporting services on a rolling basis. This programme is incorporated within the agreed Governance and Audit Committee Workplan.

Responsibility for our governance systems is delegated to the Finance Director who has lead responsibility in providing the link between the Governance and Audit Committee (GAC) and the Board. The Medical Director has responsibility for all aspects of clinical governance across NHSBT and reports regularly to the Executive Team, GAC and Board on all matters of clinical governance and risk.

Quality Management System (QMS)

NHSBT's activities are highly regulated. The regulation of activities within the Blood Components supply chain is covered by Blood Safety and Quality Regulations (BSQR) and regulated, as Competent Authority, by the MHRA. Regulation of activities within Organ Donation and Transplant, Tissues, Stems Cells and Histocompatability & Immunogenetics is covered by the Human Tissue Act 2004 for England, Wales and Northern Ireland. The Human Tissue (Scotland) Act 2006 governs organ and tissue donation and transplantation in Scotland. The provisions of EU Tissues and Cells Directives, and the related UK legislation, are regulated by the Human Tissue Authority as the Competent Authority on a UK-wide basis.

NHSBT operates a single, comprehensive QMS system across its operations that is designed to ensure compliance with regulation. This has traditionally applied to our activities in Blood Components and Specialist Services although, during 2012/13, we have also implemented a formal QMS within Organ Donation and Transplantation as required by the European Organ Donation Directive (EUODD).

The QMS comprises operating manuals and detailed process documentation and is supported by an IT system (QPulse). The QMS ensures continued, demonstrable compliance with a wide range of regulatory requirements which enables NHSBT to maintain its licenses and accreditations. In support of this it also ensures that staff are adequately qualified, trained and competent. The existence and operation of a QMS, along with the process of self inspection (see below), is a major source of assurance regarding the operation of controls, and the management of risk, within the critical operational areas of NHSBT.

Adherence is monitored through a comprehensive schedule of self inspection and provides important assurance regarding operational performance and regulatory compliance. Within NHSBT the Quality Assurance group leads the NHSBT self inspection schedule. Audits are programmed on a 2 yearly cycle and cover all regulated activities at all licensed sites.

- national self inspections are undertaken by a team of approved auditors independent of the site or activity being inspected. They confirm closure of external inspection findings and identify areas for regulatory or quality improvement
- local self inspections are undertaken by approved auditors based at the site and are usually led by the Centre QA manager. They confirm continued compliance; form a baseline for preparations for forthcoming external inspections and an opportunity for quality improvement
- ad-hoc audits are commissioned at the discretion of Senior Management, often in response to individual adverse events, trends or organisational changes.

The QMS and quality assurance processes are owned by the NHSBT Assistant Director of Quality, who reports to the Director of Blood Supply, but has a reporting line directly to me and attends the GAC. Assurance is delivered through:

- a quarterly Management Quality Report to the Executive Team with copy to the GAC and with an annual summary report to the Board
- monthly monitoring of performance, via the Board performance report, against any agreed strategic objectives and targets for quality management
- monthly reporting of supporting key operational KPIs (to the Board and Executive Team) designed to monitor that key processes remain in control.

NHSBT is subject to regular inspections by its regulators and the results of all reviews are reported to the Executive Team and Board. NHSBT is committed to delivering a strong regulatory performance has adopted a policy that requires that there should be no “critical” and no “major” non compliances identified during any regulatory inspection. During 2012/13 there were no critical and only one major non-compliance reported in 2012/13 (the same as 2011/12). We are therefore disappointed to note that in April 2013 four “major” non compliances were reported by our regulators, one at our Lancaster stock holding unit and three at the Clinical Biotechnlogy Centre (CBC) in Bristol. Corrective actions are being implemented and a further review will be undertaken to review processes at our more remote sites. With regard to the CBC, previously part of R&D and transferred to Stem Cell Services on 1 April 2013, we are undertaking a fundamental review of operations and its fit with NHSBT’s stem cell services strategy.

NHS Blood and Transplant Risk Profile

NHSBT is a supplier of products and services to NHS hospitals but does not generally provide clinical services directly to NHS patients. The only area where NHSBT does provide direct clinical services is in the apheresis based therapies that are provided to patients by

our Specialist Therapeutic Service teams (representing around 1% of our activity measured by income). NHSBT is, however, totally dependent on the voluntary donation of blood, organs, haemapoetic stem cells and tissues and has extensive direct contact, in particular, with donors of blood and stem cells. With regard to organs and tissues there is limited contact with donors (in a clinical context) but NHSBT must have due regard for the donor, the donor family, the recipient family and the handling of organs and tissues once they have been retrieved and are entrusted to the NHS. Taken together the nature of our operations and the characteristics of our contact with the public is very different to, and unique within, the broader NHS.

NHSBT's products and services are often required at times of critical need for NHS patients and we cannot provide unsafe products, or fail to provide products at these times. As such our appetite for risk is essentially low.

NHSBT is an ambitious organisation with a stated mission to be recognised by our stakeholders and peers as the best organisation of our type in the world. This requires that NHSBT can demonstrate world class performance across all of its operations be this donor service, customer service, product safety, product availability, regulatory performance and efficiency. Our strategy therefore incorporates a balanced set of objectives covering quality and efficiency but we plan for the highest levels of risk mitigation before any steps are taken which could impact the safety or availability of our products/services and ultimately the safety of NHS patients. We are committed to delivering our strategy, and its associated benefits, and we endeavour to maintain the right balance between delivery of the strategic activities and the risks associated with such delivery.

As at 31 March 2013 the NHSBT risk register captured 125 risks Of these the items considered high/extreme can be summarised as:

Financial/pricing pressures:
Recognition of the financial pressure facing UK public services and NHS hospitals as our customers. Our ability to hold and reduce the prices of our products and services will increasingly depend on achieving increased productivity in blood donation which will increase the operational risks in this area and could impact our ability to collect sufficient blood for NHS patients. Our ability to meet our pricing targets could also be impaired by any DH decision to implement new and significant safety procedures in the blood supply chain in response to the identification of new pathogens or a revised risk assessment regarding existing potential pathogens.

Scale of change:
The scale of change across NHSBT (in part driven by the need to provide value for money to NHS hospitals within a challenging financial environment) is significant and ambitious. Due regard will need to be taken to ensure this does not impact on the supply of critical products and services to NHS hospitals. Delivery of our objectives will depend on having sufficient management capacity and capability in place to execute the changes.

Significant improvement will be required to our core operational (supply chain) systems to facilitate the plans identified in our strategy. Change management processes (of processes and systems) will need to be professionally managed to avoid supply issues or errors that could lead to "Never Events".

Business continuity:
NHSBT's supply of products and services could be impacted by loss of a key facility or loss of a critical IT platform. In September 2012 a serious flood occurred at NHSBT's Filton site. The business continuity and emergency planning processes worked successfully and full operations at the site were reinstated quickly with no loss of service to hospitals. In light of

the incident, further risk assessments are being undertaken at other key NHSBT sites to enhance resilience.

Public confidence in the Organ Donation Register (ODR):
The requirements in Wales to implement an opt out system for organ donation could lead to different operational and data management processes versus the other UK nations which could lead to clinical error within the donation process. For this reason it is assumed that a completely new ODR may be developed and implemented in order to mitigate against this risk.

An increasing gap between growth in organ donation and growth in transplants:
Although growth in deceased organ donation versus a 2007/8 baseline is at 49.8% growth in transplants will lag due to a reduction in the donor pool and organs being increasingly marginal (due to older donors and donors with a higher Body Mass Index).

Capability of our IT systems:
There is a high level of paper based processes and manual data transcription within our existing systems. Although these are subject to extensive checking and control processes there is a residual risk of transcription error that could lead to a "never event".

The impact of shared services initiatives across Government:
NHSBT is committed to implementing shared service models that will reduce costs and contribute to reducing the prices of our products and services to NHS hospitals. NHSBT, however, operates supply chains where integration of process and systems is fundamental to effectiveness and efficiency. Mandated shared service solutions that result in disaggregation of our systems and processes could adversely impair the delivery of significant supply chain efficiencies and our ability to deliver integrated supply solutions to NHS hospitals.

Pathology Modernisation
NHSBT provides highly specialised (low volume) diagnostics services to NHS hospitals in support of blood transfusion and the transplantation of organs, stem cells and tissues. Pathology modernisation provides a significant opportunity for NHBT to leverage its unique, national capabilities in support of lower cost for the NHS and more lives saved. It also represents a risk in case that NHSBT is unable to influence and engage within the emerging pathology networks with a risk of lower volumes and hence higher unit costs, for NHSBT's very specialised services that other bodies will be unable to provide.

Severe Untoward Incidents (SUIs)

There were no Never Events in 2012/13 and four Serious Untoward Incidents (SUI). SUIs are subject to a defined management and reporting process that is linked to the QMS and supported by QPulse for incident reporting. The four SUIs were reviewed in detail by the Board and the GAC and any corrective actions that were identified as part of the root cause analysis were implemented.

In order to provide greater scrutiny over system failures that could have lead to patient harm a new category of Potential Significant Harm Incident (PoSHI) was defined and ratified by the GAC in October 2012. Since its introduction there have been four incidents classified in this category. These incidents are investigated using the same methodology and timeframes as SUIs, and are reported to the Board in the same way.

Information and Data Management

NHSBT holds details of over 4 million active blood donors and manages an Organ Donor Register with approximately 20 million registrants. Data loss incidents in the last year have involved low numbers of paper records in transit and these have been quickly recovered in the majority of cases. NHSBT has implemented Data Leakage protection controls for e-mail and web over the last year, an undertaking made last year, and these are being tested and tuned prior to full release in the early part of 2013/14.

Internal Audit

As a result of work undertaken during 2012/13 there were a total of 12 final reports issued, none of which was given a high risk rating. In addition there are currently 5 reports in draft of which 2, Sales & Billing and Project Resource, have a high risk rating. This audit work has been taken into account in the preparation of the 2012/13 Annual Report and this Governance Statement. Taken as a whole, PwC have therefore provided an overall opinion that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. The audit reports also identify weaknesses in the design and/or inconsistent application of controls that put the achievement of particular objectives at risk. These have been reported as result of specific individual internal audit reviews and are monitored via the GAC to ensure that recommendations are followed up by management and completed.

Care Quality Commission Registration

NHSBT has 15 blood centres and 6 Specialist Therapeutic Services Units registered with the Care Quality Commission under the Health and Social Care Act 2008. A framework is in place to provide assurance on the registration requirements and the 28 Essential Standards of Quality and Safety which underpins this. During 2012/13 all six Specialist Therapeutic Services units have been inspected by the CQC and have been declared compliant with the standards that were assessed.

Our blood centres are considered to be non-acute services and are expected to be inspected every other year. During 2012/13 the blood centres at Manchester and Leeds were also inspected and were compliant for all the standards that were assessed.

NHSBT continues to have Unconditional Registration by the Care Quality Commission.

Implementation of the New Health and Social Care System on 1 April 2013

Implementation of the new health and care system in England on 1 April 2013 has a relatively limited impact on NHSBT. There are no substantive changes to NHSBT's statutory functions and NHSBT is not taking on any new functions on behalf of any other person or body. The new system has therefore not created any changes to the statutory arrangements that impact NHSBT and there is very low risk of NHSBT operating inconsistently within the statutory framework. NHSBT periodically reviews the Directions from the DH and the National Assembly of Wales under which it operates and these are modified as necessary to be consistent with any changes to our operating process and strategies.

Response to the Francis Report

The second report of Robert Francis QC into events at the Mid Staffordshire NHS Trust was published on 6 February 2013. In addition to reiterating the findings of the first report on Mid Staffordshire, the emphasis of the second report was for health care organisations to put the patient back at the centre of their thinking, and for the development of fundamental standards of care which would be underpinned by stronger regulation, including a new criminal offence if not met. Although the report was commissioned in response to events within an acute trust setting, with limited applicability to NHSBT, we :

- endorse the findings of the report and recognise the critical importance of putting the patient at the forefront of our decision making
- will consider the implications of the report findings with particular regard for the care of donors and donor families
- will interpret the recommendations in the context of NHSBT's activities, i.e. as part of the healthcare system, but not (except for STS) as a frontline provider of care to patients

Review of Effectiveness

As Accounting Officer, I had responsibility, together with the Board, for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control was informed by :-

- the oversight by the Board, the work of the Governance and Audit Committee and the Board Committee structure
- the work and opinions provided by Price Waterhouse Coopers (PwC) as our Internal Auditors
- the auditing and reporting conducted as part of our Quality Assurance and clinical auditing processes
- Senior Managers within the organisation, who had responsibility for the development and maintenance of the system of internal control
- evidence provided by the planning, performance and risk management framework

I confirm that the system of internal control has been in place in NHS Blood and Transplant for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts. My review confirms that the system of internal control has been sound with no evidence of material weakness and has supported the achievement of our policies, aims and objectives.

Signed: Lynda Hamlyn Date: 19 June 2013

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSE OF COMMONS AND THE SCOTTISH PARLIAMENT

I certify that I have audited the financial statements of NHS Blood & Transplant for the year ended 31 March 2013 under the National Health Service Act 2006. 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 Chief Executive's Responsibilities, the Board and the Chief Executive as 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 audit, certify and report on the financial statements in accordance with the National Health Services Act 2006. 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 Blood & Transplant's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by NHS Blood & Transplant; 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 NHS Blood & Transplant's affairs as at 31 March 2013 and of the net expenditure for the year then ended; and

- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 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 National Health Service Act 2006; and

- the information given in Management Commentary for the financial year 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 **Date 24 June 2013**

Comptroller and Auditor General

National Audit Office

157-197 Buckingham Palace Road

Victoria

London

SW1W 9SP

Statement of Comprehensive Net Expenditure for the year ended 31 March 2013

	Notes	**31 March 2013 £000**	31 March 2012 £000
Gross Income			
Income from activities	2	**343,972**	351,896
Other operating income	2	**19,938**	17,840
		363,910	369,736
Expenditure			
Staff costs	3.1	**(202,291)**	(199,717)
Depreciation	8 and 9	**(10,697)**	(10,537)
Other administrative expenses	3.2	**(219,661)**	(226,610)
		(432,649)	(436,864)
Net Operating Expenditure before interest		**(68,739)**	(67,128)
Finance Costs	4	**(485)**	(572)
Net Operating Expenditure after interest	2	**(69,224)**	(67,700)
Other Comprehensive Net Expenditure			
Net (loss)/gain on revaluation of Property, Plant and Equipment	18	**240**	918
Total Comprehensive Net Expenditure		**(68,984)**	(66,782)

All income and expenditure is derived from continuing operations

Notes 1 to 25 form part of these accounts.

Statement of Financial Position as at 31 March 2013

	Notes	31 March 2013 £000	31 March 2012 £000
Non Current Assets			
Intangible Assets	8	**3,601**	4,105
Property, Plant & Equipment	9	**162,110**	163,771
Trade and other receivables	11	**471**	145
Total non-current assets		**166,182**	168,021
Current assets			
Inventories	10	**21,647**	19,278
Trade and other receivables	11	**21,278**	24,696
Cash and cash equivalents	12	**11,142**	9,748
Total current assets		**54,067**	53,722
Current Liabilities			
Trade and other payables	13	**19,260**	19,916
Borrowings	14 and 16	**97**	88
Provisions for liabilities and charges	15	**689**	613
Total current liabilities		**20,046**	20,617
Non-current assets plus net current assets		**200,203**	201,126
Non-current liabilities			
Borrowings	14 and 16	**4,620**	4,717
Provisions for liabilities and charges	15	**1,063**	805
Total non-current liabilities		**5,683**	5,522
Total Assets Employed:		**194,520**	195,604
Taxpayers' Equity			
General Fund	18.1	**153,891**	153,019
Revaluation Reserve	18.2	**40,629**	42,585
Total Taxpayers' Equity:		**194,520**	195,604

Notes 1 to 25 form part of these accounts.

The financial statements on pages 40 to 66 were approved by the Governance and Audit Committee in accordance with powers within the NHSBT Standing Orders on 14th June 2013, and are signed by the Accounting Officer, Lynda Hamlyn.

Lynda Hamlyn
Accounting Officer

Date: 19 June 2013

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2012

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2011	150,625	44,156	**194,781**
Changes in taxpayers' equity for 2011/12			
Net expenditure for the financial period	(67,700)	-	**(67,700)**
Net gain on indexation of Property, Plant and Equipment	-	918	**918**
Transfers between reserves	2,489	(2,489)	**-**
Total recognised income and expense for 2010/11	(65,211)	(1,571)	**(66,782)**
Grant from Department of Health	67,605	-	**67,605**
Balance at 31 March 2012	**153,019**	**42,585**	**195,604**

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

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2012	153,019	42,585	**195,604**
Changes in taxpayers' equity for 2012/13			
Net expenditure for the financial period	(69,224)	-	**(69,224)**
Net gain on indexation of Property, Plant and Equipment	-	240	**240**
Transfers between reserves	2,196	(2,196)	**-**
Total recognised income and expense for 2012/13	(67,028)	(1,956)	**(68,984)**
Grant from Department of Health	67,900	-	**67,900**
Balance at 31 March 2013	**153,891**	**40,629**	**194,520**

Statement of Cash Flows for the year ended 31 March 2013

	Notes	**31 March 2013**	31 March 2012
		£000	£000
Cash flows from operating activities			
Net operating costs		**(68,739)**	(67,128)
Other cashflow adjustments	17.3	**11,935**	10,903
Movement in Working Capital	17.1	**(1,174)**	6,027
Provisions utilised	15	**(562)**	(761)
Net cash (outflow) from operating activities		**(58,540)**	(50,959)
Cash flows from investing activities			
Purchase of plant, property and equipment		**(7,047)**	(5,966)
Purchase of intangible assets		**(365)**	(460)
Proceeds from disposal of non current assets		**-**	5
Net cash (outflow) from investing activities		**(7,412)**	(6,421)
Cash flows from financing activities			
Grant from Department of Health		**67,900**	67,605
Capital element paid in respect of finance leases		**(88)**	(80)
Interest paid in respect of finance leases		**(466)**	(554)
Net financing		**67,346**	66,971
Net increase/(decrease) in cash and cash equivalents		**1,394**	9,591
Cash and cash equivalents at 31 March 2012		**9,748**	157
Cash and cash equivalents at 31 March 2013	12	**11,142**	9,748

Notes to the Accounts

1. Accounting Policies

The financial statements have been prepared in accordance with the 2012/13 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The FReM follows EU adopted IFRSs extant at January 2012, with an effective date before or from 1 April 2012. NHS bodies must follow the FReM unless there are divergences agreed by HM Treasury. The one agreed divergence for 2012/13, is the non-consolidation of funds held on trust, contrary to the requirements of IAS 27.

The particular policies adopted by NHSBT are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

IFRSs, 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 reporting period. The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on these accounts.

IAS 27 Consolidated and Separate Financial Statements	HM Treasury has agreed a divergence from the FReM for 2011/12 and 2012-13 for NHS bodies. Under the divergence, NHS linked charitable funds are not to be consolidated where the NHS body is considered to have the power to control the funds in accordance with IAS 27. The effective date is April 2013.
IFRS 9 Financial Instruments	A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2015.
IFRS 10 Consolidated Financial Statements	Impacts the consolidation and reporting of subsidiaries, associates and joint ventures. Defines investor power and the ability to direct activities of an investee. The effective date is 1 January 2013.
IFRS 11 Joint Arrangements	Provides principles based definition of joint arrangement based on rights and obligations. The effective date is 1 January 2013.
IFRS 12 Disclosure of Interests in Other Entities	Requires more disclosure of the financial effects on, and the risks to, the consolidating entity. The effective date is 1 January 2013.

IFRS 13 Fair Value Measurement	Defines fair value, provides guidance on fair value measurement techniques, and sets out disclosure requirements. The effective date is January 2013.

Critical judgements and key sources of estimation uncertainty

There are no critical judgements made in the application of the accounting policies set out below. The key sources of estimation uncertainty that have a risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are:-

a) use of market value for existing use to value land and buildings (see accounting policy note 1.5) and use of amortised cost as a proxy for fair value for intangible assets (see accounting policy note 1.6)

b) use of best estimates to determine the amount and timings of provisions (see accounting policy note 1.16)

1.1 Accounting Conventions

This account is prepared under the historical cost convention, modified to account for the revaluation of intangible assets, property, plant and equipment at their fair value to the business by reference to current costs. This is in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

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

1.2 Income and Grant in Aid

Operating income is income which relates directly to the operating activities of NHSBT. It principally comprises fees and charges for services provided on a full-cost basis to the NHS and external customers.

Income is accounted for applying the accruals convention. The main sources of funding for NHSBT are income from sales to the NHS and Grant in Aid from the Department of Health. Where revenue is received for a specific activity which is to be delivered in the following financial year, that revenue is deferred.

The Grant in Aid is from Request for Resources 1 (RfR1) within an approved cash limit, and is credited to the general reserve. Grant in Aid is recognised in the financial period in which it is received.

The products and services provided to the NHS are primarily blood, components and services such as tissue typing, together with the provision of transplant services by the Organ Donation operating division.

1.3 Taxation

NHSBT 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 Capital Charges (depreciation, amortisation and notional cost of capital)

The treatment of depreciation, amortisation and notional cost of capital in the account is in accordance with the principal capital charges objective, which is to ensure that such charges are fully reflected in prices charged to customers. The interest rate applied to calculate the notional cost of capital during 2012/13 was 3.5% (2011/12 3.5%) on all assets less liabilities, except for donated assets and cash balances held with the Government Banking Service, where the charge is nil.

In accordance with Treasury guidance the notional cost of capital charge is no longer reflected in the Statement of Comprehensive Net Expenditure.

NHSBT makes a cash payment in respect of the total capital charges included in prices to the Department of Health. This payment is included in other administrative expenses within the Statement of Comprehensive Net Expenditure.

1.5 Property, Plant & Equipment

(a) Capitalisation

Property, Plant & Equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is expected to be used for more than one year;
- individually to 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.

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

(b) Valuation

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

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

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

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. An interim valuation will also be carried out at least every three years or sooner if fluctuations in values are thought to be potentially significant. An interim valuation of NHSBT land and buildings was carried out in March 2011 and the next full valuation is planned for 2013-14.

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

Equipment assets are indexed annually in accordance with the appropriate categories within the publicised Health Service Cost Index. The carrying value of existing assets at that date will be written off over their remaining useful lives. New fixtures and equipment are carried at depreciated historic cost, as this is not considered to be materially different from fair value.

Increases arising on revaluation are taken to the Revaluation Reserve except when it reverses a revaluation decrease for the same asset previously recognised in the Statement of Comprehensive Net Expenditure. In this case it is credited to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

1.6 Intangible Assets

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

Expenditure on research activities is not capitalised and is recognised as an expense in the period in which it is incurred.

Intangible assets are capitalised when they have a cost of at least £5,000. Intangible assets acquired separately are initially recognised at fair value. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

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

Following initial recognition, intangible assets are carried at amortised cost as a proxy for fair value. Internally developed software is held at historic cost to reflect the opposite effects of development costs and technological advances, and is amortised.

1.7 Depreciation, amortisation and impairments

Depreciation is charged on each individual intangible asset, property plant and equipment, to write off the costs or valuation, less any residual value, as follows:

i) Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets.

ii) Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives.

iii) Land and assets in the course of construction are not depreciated.

iv) Buildings are depreciated evenly on their revalued amount over the assessed remaining life of the asset as advised by the Valuation Officer. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

v) Equipment assets are depreciated evenly over the expected useful life:

- Short term equipment assets	one to five years
- Medium term equipment assets	six to ten years
- Long term equipment assets	eleven to twenty years

vi) Freehold Land and properties under construction, and assets held for sale are not depreciated.

vii) Intangible assets are amortised over a minimum of 3 years and a maximum of eight years.

The estimated useful lives of intangible assets, and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each Statement of Financial Position date, NHSBT 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.

1.8 Inventories

Inventories are valued as follows:

i) Raw materials and work in progress are valued on a weighted average cost basis.

ii) Blood products are valued at the lower of cost on a full recovery cost basis, or net realisable value, which represents the expected future selling price.

1.9 Cash and Cash Equivalents

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

1.10 Losses and Special Payments

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

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

1.11 Employee Benefits

Short-term employee benefits

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

Early Termination Costs

Early termination costs are charged to the Statement of Comprehensive Net Expenditure in accordance with IAS 19 Employee Benefits (early adoption) when as a result of a decision to terminate an employee's employment, the offer can no longer be withdrawn, and all of the following criteria are met:

i) Actions required to complete the plan indicate that it is unlikely that significant changes to the plan will be made.

ii) The plan identifies the number of employees whose employment is to be terminated, their job classifications or functions and their locations (but the plan need not identify each individual employee) and the expected completion date.

iii) 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 Statement of Compressive Net Expenditure at the time the Organisation commits itself to the retirement, regardless of the method of payment.

Pensions Costs

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted

as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

1.12 Research and Development

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

1.13 Leases

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

NHSBT as lessee

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

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

Where a lease is for land and buildings, the land and building components are separated. Leased land and buildings assessed as to whether they are operating or finance leases in accordance with IAS 17.

1.14 Foreign Exchange

NHSBT's functional currency and presentational currency is sterling. Resulting exchange gains and losses are taken to the Statement of Comprehensive Net Expenditure. All other transactions, which are denominated in a foreign currency, are translated into sterling at the exchange rate ruling on the date of each transaction.

1.15 Provisions

Provisions are recognised when NHSBT has a present legal or constructive obligation as a result of a past event, and it is probable that NHSBT will be required to settle the obligation. NHSBT 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, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's published discount rate of 2.2% in real terms, (2.35% for early departure obligations).

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

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

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which NHSBT pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure.

From 1 April 2000, the NHSLA took over the full financial responsibility for all ELS (Existing Liabilites Scheme) cases unsettled at that date and from 1 April 2002 all CNST (Clinical Negligence Scheme for Trusts) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with NHSBT. The value of provisions relating to NHSBT carried by the NHSLA is disclosed in Note 15.

Non-clinical Risk Pooling

NHSBT participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which NHSBT pays an annual contribution to the NHSLA and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to the Statement of Comprehensive Net Expenditure as and when they become due.

1.16 Contingencies

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

1.17 Financial Instruments

Financial assets

Financial assets are recognised on the Statement of Financial Position when NHSBT 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 at fair value through Statement of Comprehensive Net Expenditure

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 income and expenditure. 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.

Available for sale financial assets

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

Loans and receivables

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

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

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

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

Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when NHSBT 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 the Statement of Comprehensive Net Expenditure' or other financial liabilities.

Financial liabilities at fair value through the Statement of Comprehensive Net Expenditure

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 the Statement of Comprehensive Net Expenditure. 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.

1.18 Subsidiaries

For 2011-12 and 2012-13 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the Corporate Trustee.

2. Segmental Reporting and Reconciliation of net operating expenditure to grant in aid

For the year 1 April 2012 to 31 March 2013	Total	Blood Components (incl R&D)	Diagnostics	Tissues	Stem Cells Unit	Specialist Therapeutic Services	Organ Donation & Transplant
Revenue	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Provision of Products and Services	343,972	294,863	23,100	7,799	11,441	5,485	1,284
Income from Scottish Parliament	3,760	-	-	-	-	-	3,760
Income from National Assembly for Wales	2,884	-	-	-	-	-	2,884
Income from Northern Ireland Assembly	1,830	-	-	-	-	-	1,830
Other Income	11,464	9,042	84	-	2,229	-	109
Revenue Grant In Aid	60,400	2,527	-	-	4,173	-	53,700
Total Revenue	**424,310**	**306,432**	**23,184**	**7,799**	**17,843**	**5,485**	**63,567**
Expenditure							
Variable Costs	(69,559)	(56,258)	(3,728)	(969)	(2,887)	(1,737)	(3,980)
Direct Costs	(218,175)	(136,351)	(12,617)	(4,785)	(9,126)	(1,758)	(53,538)
Direct Support Costs	(78,787)	(62,793)	(4,950)	(1,831)	(3,734)	(840)	(4,639)
Movement in value of stocks	2,097	1,651	-	446	-	-	-
Other Support Costs	(57,152)	(47,594)	(4,195)	(1,406)	(3,102)	(855)	-
Total Expenditure	**(421,576)**	**(301,345)**	**(25,490)**	**(8,545)**	**(18,849)**	**(5,190)**	**(62,157)**
Operating surplus for the financial period	**2,734**	**5,087**	**(2,306)**	**(746)**	**(1,006)**	**295**	**1,410**
Add : Notional cost of capital included in expenditure above	6,462						
Less : Revenue grant in aid	(60,400)						
Less : Capital charges paid to the Department of Health	(18,020)						
Net Expenditure	**(69,224)**						

For the year 1 April 2011 to 31 March 2012	Total	Blood Components (incl R&D)	Diagnostics	Tissues	Stem Cells Unit	Specialist Therapeutic Services	Organ Donation & Transplant
Revenue	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Provision of Products and Services	351,896	304,519	23,197	7,870	11,088	4,317	905
Income from Scottish Parliament	3,040	-	-	-	-	-	3,040
Income from National Assembly for Wales	2,884	-	-	-	-	-	2,884
Income from Northern Ireland Assembly	1,080	-	-	-	-	-	1,080
Other Income	10,836	9,307	48	-	1,332	3	146
Revenue Grant In Aid	61,105	2,807	-	-	3,990	-	54,308
Total Revenue	**430,841**	**316,633**	**23,245**	**7,870**	**16,410**	**4,320**	**62,363**
Expenditure							
Variable Costs	(66,422)	(56,509)	(4,559)	(871)	(3,080)	(1,087)	(316)
Direct Costs	(221,989)	(137,258)	(12,720)	(4,825)	(8,726)	(1,843)	(56,617)
Direct Support Costs	(82,161)	(66,385)	(4,459)	(1,882)	(3,177)	(772)	(5,486)
Movement in value of stocks	(2,328)	(694)	-	(1,634)	-	-	-
Other Support Costs	(53,614)	(44,582)	(3,955)	(1,676)	(2,727)	(674)	-
Total Expenditure	**(426,514)**	**(305,428)**	**(25,693)**	**(10,888)**	**(17,710)**	**(4,376)**	**(62,419)**
Operating surplus for the financial period	**4,327**	**11,205**	**(2,448)**	**(3,018)**	**(1,300)**	**(56)**	**(56)**
Add : Notional cost of capital included in expenditure above	6,602						
Less : Revenue grant in aid	(61,105)						
Less : Capital charges paid to the Department of Health	(17,524)						
Net Expenditure	**(67,700)**						

2. Segmental Reporting and Reconciliation of net operating expenditure to grant in aid ctd

NHSBT comprises a number of strategic operating units, or segments, together with Group Services:

The **Blood Components** operating unit provides blood and blood components, primarily to NHS hospitals, and includes research and development activity.
The **Diagnostic Services** operating unit provides specialist laboratory services (Red Cell Immunohaematology and Histocompatability & Immunogenetics) and also reagents.

The **Tissues** operating unit provides human tissue products.

The **Stem Cell Services** operating unit comprises the Cellular and Molecular Therapies function, the British Bone Marrow Registry (BBMR) and the Cord Blood Bank (CBB).
The **Specialist Therapeutic Services** operating unit provides a range of therapeutic apheresis services (e.g. plasma exchange, photopheresis) direct to patients.

The operating units listed above seek to recover their costs through the pricing of blood components, tissues and services to NHS hospitals, which are primarily set annually via a national commissioning process. Grant in aid is provided by the Department of Health to support the activities of the CBB and the BBMR.

The **Organ Donation and Tranplantation operating unit** is primarily funded through grant in aid from the Department of Health, along with contributions from the Devolved Health Administrations. The purpose of the unit is to identify and refer increasing numbers of potential organs donors and to increase the number of actual donors so that an increase in the number of transplants is enabled.

Group Services comprises overhead departments including Finance, Human Resources, IT Services and Estates & Logistics. The Group Services costs are to support the strategic operating units. These costs are allocated across the segments using activity based costing methodology.

In accordance with the Government Financial Management Reporting Manual issued by HM Treasury, the statement of comprehensive net expenditure does not include a charge for notional cost of capital. For the segmental reporting note the notional cost of capital has been charged to the segments, and then added back as part of the reconciliation to the statement of comprehensive net expenditure.

3.1 Staff Costs and related numbers

	31 March 2013			
	Total	**Permanently Employed Staff**	**Other**	31 March 2012 Total
	£000	**£000**	**£000**	£000
Salaries and wages	**170,303**	**154,288**	**16,015**	168,083
Social security costs	**12,092**	**11,760**	**332**	11,829
Employer contributions to NHS Pensions Agency	**19,896**	**19,350**	**546**	19,804
	202,291	**185,398**	**16,893**	199,717

The average number of employees during the year was:

	Total	**Permanently Employed Staff**	**Other**
	Number	**Number**	**Number**
Year ended 31 March 2013	**5,212**	**4,896**	**316**
Year ended 31 March 2012	5,154	4,916	238

Expenditure on staff benefits

The amount spent on staff benefits during the year is estimated at £653,000 (31 March 2012 £748,000).

Early retirements and redundancies

During 2012/13 there were 30 early retirements and/or redundancies from NHSBT. £1,493,000 has been charged to the revenue account in 2012/13 in respect of these redundancies and early retirements (31 March 2012: 110 early retirements and/or redundancies, and a charge to the revenue account of £4,628,000). These amounts are included within other staff related costs in note 3.2.

3.2 Other Administrative Expenses

	Notes	**31 March 2013** £000	31 March 2012 £000
Other staff related costs		**14,883**	18,627
Consumable supplies		**74,590**	76,198
Maintenance of buildings, plant and equipment		**15,757**	16,707
Rent and rates		**12,277**	11,976
Transport costs		**10,360**	10,213
External contractors *		**20,412**	20,066
Purchase and lease of equipment and furniture		**4,574**	5,981
Utilities and telecommunications		**7,202**	7,578
Media advertising		**2,594**	2,327
ODT Scheme Payments		**28,574**	31,055
Professional Fees **		**4,542**	4,463
Capital Charges paid over as cash to Department of Health		**18,020**	17,524
Capital Non-cash : Loss on disposal of fixed assets	7	**361**	208
Auditor's remuneration: Audit Fees ***		**90**	90
Miscellaneous *		**5,425**	3,597
		219,661	226,610

* Payments to external bodies to carry our research projects on our behalf have been reclassified as External contractor expenditure, from Miscellaneous expenditure.
The prior year figures for External contractors and Miscellaneous have been restated (from £17,200k and £6,463k respectively)

** Professional Fees include legal and programme management costs

*** No payment was made to the auditors for non audit work.

4. Finance costs

	31 March 2013 £000	31 March 2012 £000
Interest expense under finance leases	**466**	554
Other finance costs - unwinding of discount	**19**	18
Total finance costs	**485**	572

5. Operating leases

NHSBT as lessee

	31 March 2013 £000	31 March 2012 £000
Payments recognised as an expense		
Minimum lease payments	**9,515**	8,962
Total future minimum lease payments		
Payable:		
Not later than one year	**6,055**	5,186
Later than one year and not later than five years	**7,903**	7,518
Later than five years	**49**	40
Total	**14,007**	12,744

6. The Late Payment of Commercial Debts (Interest) Act 1998

Interest of £224 was paid in relation to claims made under the Late Payment of CommercialDebts (Interest) Act 1998. No compensation payments were made under this legislation(31 March 2012: £95 interest and £Nil compensation).

7. Other gains and losses

	31 March 2013	31 March 2012
	£000	£000
Loss on disposal of intangible assets	**(12)**	-
Loss on disposal of plant and equipment	**(349)**	(208)
Total	**(361)**	(208)

8. Intangible non-current assets

8.1 Intangible non-current assets 2012/13

	Total £000	**Software Purchased £000**	**Development Expenditure £000**
Cost or Valuation			
At 1 April 2012	13,622	13,622	-
Additions - purchased	**365**	**(20)**	**385**
Disposals	**(139)**	**(139)**	**-**
At 31 March 2013	**13,848**	**13,463**	**385**
Amortisation			
At 1 April 2012	9,517	9,517	-
Provided during the year	**857**	**857**	-
Disposals	**(127)**	**(127)**	**-**
At 31 March 2013	**10,247**	**10,247**	**-**
Net book value at 1 April 2012	4,105	4,105	-
Net book value at 31 March 2013	**3,601**	**3,216**	**385**
Net book value at 31 March 2013 comprises:			
Purchased	3,601	3,216	385
Asset Financing	**3,601**	**3,216**	**385**

8.2 Intangible non-current assets 2011/12

	Total £000	**Software Purchased £000**	**Development Expenditure £000**
Cost or Valuation			
At 1 April 2011	13,162	13,162	-
Additions - purchased	**460**	**460**	**-**
Reclassification	**-**	**-**	**-**
At 31 March 2012	**13,622**	**13,622**	**-**
Amortisation			
At 1 April 2011	8,720	8,720	-
Provided during the year	**797**	**797**	**-**
At 31 March 2012	**9,517**	**9,517**	**-**
Net book value at 1 April 2011	4,442	4,442	-
Net book value at 31 March 2012	**4,105**	**4,105**	**-**
Net book value at 31 March 2012 comprises:			
Purchased	4,105	4,105	-
Asset Financing	**4,105**	**4,105**	**-**

9. Property, plant and equipment

9.1 Property, plant and equipment 2012/13

	Total	Land	Buildings	Assets under constr. + poa	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2012	259,669	23,565	155,107	1,387	55,636	4,298	19,664	12
Additions - purchased	**8,288**	**-**	**1,276**	**2,366**	**3,584**	**-**	**1,062**	**-**
Reclassification	**-**	**-**	**1,124**	**(1,124)**	**-**	**-**	**-**	**-**
Indexation	**811**	**-**	**-**	**-**	**632**	**178**	**-**	**1**
Disposals	**(8,717)**	**-**	**-**	**-**	**(8,509)**	**-**	**(208)**	**-**
At 31 March 2013	**260,051**	**23,565**	**157,507**	**2,629**	**51,343**	**4,476**	**20,518**	**13**
Depreciation:								
At 1 April 2012	95,898	11	36,948	-	40,152	2,750	16,027	10
Provided during the year	**9,840**	**11**	**4,006**	**-**	**4,118**	**414**	**1,290**	**1**
Indexation	**571**	**-**	**-**	**-**	**456**	**114**	**-**	**1**
Disposals	**(8,368)**	**-**	**-**	**-**	**(8,160)**	**-**	**(208)**	**-**
Accumulated depreciation at 31 March 2013	**97,941**	**22**	**40,954**	**-**	**36,566**	**3,278**	**17,109**	**12**
Net book value at 1 April 2012	163,771	23,554	118,159	1,387	15,484	1,548	3,637	2
Net book value at 31 March 2013	**162,110**	**23,543**	**116,553**	**2,629**	**14,777**	**1,198**	**3,409**	**1**
Net book value at 31 March 2013 comprises:								
Owned assets	**139,463**	**21,310**	**96,139**	**2,629**	**14,777**	**1,198**	**3,409**	**1**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	**17,239**	**-**	**17,239**	**-**	**-**	**-**	**-**	**-**
Held on Finance Lease	**5,408**	**2,233**	**3,175**	**-**	**-**	**-**	**-**	**-**
	162,110	**23,543**	**116,553**	**2,629**	**14,777**	**1,198**	**3,409**	**1**

All assets are purchased assets.

9.2 Property, plant and equipment 2011/12

	Total	Land	Buildings	Assets under constr. + poa	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2011	255,134	23,565	153,510	982	53,804	4,667	18,595	11
Additions - purchased	**6,174**	**-**	**935**	**1,141**	**3,015**	**-**	**1,083**	**-**
Reclassification	**-**	**-**	**662**	**(740)**	**78**	**-**	**-**	**-**
Indexation	**3,047**	**-**	**-**	**4**	**2,900**	**142**	**-**	**1**
Disposals	**(4,686)**	**-**	**-**	**-**	**(4,161)**	**(511)**	**(14)**	**-**
At 31 March 2012	**259,669**	**23,565**	**155,107**	**1,387**	**55,636**	**4,298**	**19,664**	**12**
Depreciation:								
At 1 April 2011	**88,502**	-	32,978	-	37,930	2,751	14,835	8
Provided during the year	**9,740**	**11**	**3,970**	**-**	**4,126**	**426**	**1,206**	**1**
Indexation	**2,129**	**-**	**-**	**-**	**2,044**	**84**	**-**	**1**
Disposals	**(4,473)**	**-**	**-**	**-**	**(3,948)**	**(511)**	**(14)**	**-**
Accumulated depreciation at 31 March 2012	**95,898**	**11**	**36,948**	**-**	**40,152**	**2,750**	**16,027**	**10**
Net book value at 1 April 2011	166,632	23,565	120,532	982	15,874	1,916	3,760	3
Net book value at 31 March 2012	**163,771**	**23,554**	**118,159**	**1,387**	**15,484**	**1,548**	**3,637**	**2**
Net book value at 31 March 2011 comprises:								
Owned assets	**140,610**	**21,310**	**97,242**	**1,387**	**15,484**	**1,548**	**3,637**	**2**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	**17,549**	**-**	**17,549**	**-**	**-**	**-**	**-**	**-**
Held on Finance Lease	**5,612**	**2,244**	**3,368**	**-**	**-**	**-**	**-**	**-**
	163,771	**23,554**	**118,159**	**1,387**	**15,484**	**1,548**	**3,637**	**2**

All assets are purchased assets.

10. Inventories

	31 March 2013	31 March 2012
	£000	£000
Raw materials and consumables	**6,362**	6,123
Work in progress	**2,490**	2,569
Finished processed goods	**12,795**	10,586
	21,647	19,278

11. Trade and other receivables

	31 March 2013	31 March 2012
	£000	£000
Current		
NHS Receivables - Revenue	**9,999**	11,417
Non NHS Trade Receivables - Revenue	**2,490**	5,338
Provision for impairment of Receivables	**(12)**	(11)
Other Debtors	**162**	156
VAT	**2,286**	2,038
Prepayments and accrued income	**6,353**	5,758
Subtotal	**21,278**	24,696
Non Current		
Other prepayments and accrued income	**471**	145
Subtotal	**471**	145
Total trade and other receivables	**21,749**	24,841

Provision for irrecoverable debts

	2012-2013	2011-2012
Amounts falling due within one year	**£000**	£000
Non - NHS trade receivables		
At 1 April	**11**	28
Provided in year	**5**	-
Written off during year	**(2)**	(2)
Recovered during year	**(2)**	(15)
At 31 March	**12**	11
Aging of debts provided against		
Upto 12 months	**5**	-
Over 12 months	**7**	11
	12	11
Receivables past due but not impaired		
Upto 3 months	**5,427**	4,373
Between 4 and 12 months	**496**	92
Over 12 months	**10**	4
	5,933	4,469

None of the bad debt provision, nor any of the bad debts written off in the year, arise from transactions with related parties (as defined in note 22).

12. Cash and Cash equivalents

	2012-2013	2011-2012
	£000	£000
Balance at 1 April	9,748	157
Net change in the year	1,394	9,591
Balance at 31 March	11,142	9,748
Comprising:		
Held with Government Banking Services accounts	11,140	9,746
Cash in hand	2	2
Cash and cash equivalents as in Statement of cash flows	11,142	9,748

13. Trade and other payables

	31 March 2013	31 March 2012
	£000	£000
Current		
NHS Payables - revenue	3,798	1,992
Non-NHS trade Payables - revenue	569	1,155
Non-NHS trade Payables - capital	1,553	312
Tax and Social Security Costs	13	6
Accruals and deferred income	13,327	16,451
Total trade and other payables	19,260	19,916

14. Borrowings

Borrowings relate to land and buildings acquired under separate finance leases, full details of which are disclosed in note 16.

15. Provisions for liabilities and charges

At 31 March 2012	Product Liability	Employee Benefits	Tax and NI Liabilities	Other	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2011	60	833	262	848	2,003
Provisions - Arising in the year	-	54	-	516	570
Utilised during the year	-	(50)	(262)	(449)	(761)
Reversed unused	-	-	-	(412)	(412)
Unwinding of discount	-	18	-	-	18
Balance at 31 March 2012	60	855	-	503	1,418
Expected timing of cash flows:					
Within 1 year	60	50	-	503	613
Between 1 year and 5 years	-	191	-	-	191
Thereafter	-	614	-	-	614

At 31 March 2013	Product Liability	Employee Benefits	Tax and NI Liabilities	Other	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2012	60	855	-	503	1,418
Provisions - Arising in the year	-	291	-	661	952
Utilised during the year	-	(49)	-	(513)	(562)
Reversed unused	-	-	-	(75)	(75)
Unwinding of discount	-	19	-	-	19
Balance at 31 March 2013	60	1,116	-	576	1,752
Expected timing of cash flows:					
Within 1 year	60	53	-	576	689
Between 1 year and 5 years	-	222	-	-	222
Thereafter	-	841	-	-	841

15. Provisions for liabilities and charges (continued)

Product liability provisions relate to legal actions brought against the authority through the use of Authority products by individuals, mainly Hepatitis C cases. A provision is held where a reliable estimate can be made. Where a reliable estimate cannot be made a contingent liability is disclosed at note 19.

Employee benefits provisions relate to Permanent Injury Benefit awards which are payable over the life term of the individuals receiving the payments.

Included within the 'Other' category are provisions relating to legal claims for personal injury, legal claims from donors and employees, and other employee liability and public liability claims.

£4,111,000 (31 March 2012: £3,320,000) is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities. There is a £Nil provision in respect of the existing liabilities scheme (31 March 2012: £Nil).

16. Finance leases

Finance lease obligations (ie as lessee)

	Minimum lease payments	
	31 March 2013	31 March 2012
	£000	£000
Not later than one year	**554**	554
Later than one year and not later than five years	**2,216**	2,216
Later than five years	**10,809**	11,363
	13,579	14,133
Less future finance charges	**(8,862)**	(9,328)
Present value of future lease obligations	**4,717**	4,805

	Present value of minimum lease payments	
	31 March 2013	31 March 2012
	£000	£000
Not later than one year	**97**	88
Later than one year and not later than five years	**510**	459
Later than five years	**4,110**	4,258
Present value of future lease obligations	**4,717**	4,805
Analysed as :		
Current borrowings	**97**	88
Non-current borrowings	**4,620**	4,717
	4,717	4,805

Finance leases relate to a building acquired in Speke in 2004/05, depreciated over the primary lease term of 25 years; and to a lease for land in Newcastle, depreciated over the primary lease term of 125 years.

17.1 Movements in working capital

	31 March 2013	31 March 2012
	£000	£000
Decrease in receivables within 1 year	**(3,418)**	(1,853)
Increase/(decrease) in receivables after 1 year	**326**	(70)
Increase/(decrease) in inventories	**2,369**	(2,430)
(Increase)/decrease in payables within 1 year	**656**	(1,882)
Subtotal	**(67)**	(6,235)
Less Movement in payables relating to items not passing through the Statement of Comprehensive Net Expenditure	**(1,241)**	(208)
Subtotal	**(1,241)**	(208)
Total	**1,174**	(6,027)

17.2 Analysis of changes in net debt

	As at 1 April 2012	**Cash flows**	**As at 31 March 2013**
	£000	**£000**	**£000**
Government Banking Services cash at bank	9,746	1,394	**11,140**
Commercial cash at bank and in hand	2	-	**2**
Total	9,748	1,394	**11,142**

17.3 Other cashflow adjustments

	31 March 2013	31 March 2012
	£000	£000
Depreciation	**9,840**	9,740
Amortisation	**857**	797
Loss on disposal	**361**	208
Provisions - Arising in Year	**952**	570
Provisions - Reversed unused	**(75)**	(412)
Total	**11,935**	10,903

18. Movements on reserves

18.1 General Fund

	2012-2013	2011-2012
	£000	£000
Balance at 1 April	**153,019**	150,625
Net operating expenditure for the financial period	**(69,224)**	(67,700)
Revenue Grant in Aid	**60,400**	61,105
Capital Grant in Aid	**7,500**	6,500
Transfer from Revaluation reserve: realised elements of the revaluation reserve (see 18.2 below)	**2,196**	2,489
Balance at 31 March	**153,891**	153,019

18.2 Revaluation Reserve

	2012-2013	2011-2012
	£000	£000
Balance at 1 April	**42,585**	44,156
Indexation of fixed assets	**240**	918
Revaluation of fixed assets	**-**	-
Transfer to General Fund: realised revaluation (see 18.1 above)	**(2,196)**	(2,489)
Balance at 31 March	**40,629**	42,585

19. Contingent Liabilities at 31 March 2013

A contingent liability of £82,000 (31 March 2012: £122,000) relates to potential costs associated with donor claims, personal injury claims, and other employee liability and public liability claims.

A contingent liability of £1,375,000 (31 March 2012: £1,375,000) relates to Hepatitis C cases brought under an action for product liability.

Due to the nature of the contingent liabilities it is difficult to predict with any degree of accuracy the final amounts due and when they will crystallise.

20. Capital commitments at 31 March 2013

At 31 March 2013 the value of contracted capital commitments was £362,000 (31 March 2012 : £1,426,000).

21 Losses and special payments

21.1 Losses Statement

	31 March 2013		31 March 2012	
	No. Cases	£000	No. Cases	£000
Cash Losses	1	-	-	-
Book keeping Losses	5	-	5	1
Losses of pay, allowances and superannuation benefits	19	7	22	4
Losses of Accountable Stores	141	202	122	138
Fruitless Payments	4	462	2	1
Claims waived or abandoned	8	-	5	-
	178	671	156	144

21.2 Special Payments

	31 March 2013		31 March 2012	
	No. Cases	£000	No. Cases	£000
Special Severance Payments	2	14	3	31
Compensation Payments	150	580	138	495
Ex Gratia Payments	25	2	73	17
	177	596	214	543

A payment of £285,143 was made to compensate for loss of nucleic acid test kits that arose from a chain of events that commenced with the flooding that occurred at the Filton site in September 2012 (Period ended 31 March 2012 : no case

22. Related parties

The Authority is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a controlling related party. During the year the Authority has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department, i.e. the majority of NHS trusts and foundation trusts. During the period these transactions were valued at £401 million of income (31 March 2012: £410 million), including capital funding and grant in aid, and £54 million of expenditure (31 March 2012: £57 million), which represented trading with 226 separate organisations.

The following named members of the Board had registered interests in related parties during the year as stated below:

Name and Title	Registered Interest(s)
Mr R Griffins (Non Executive Director)	London Ambulance Service NHS Trust (NED)

There were no transactions during the year with the London Ambulance Service NHS Trust (2011/12 : Nil)

During the period none of the members of the key management staff or other related parties has undertaken any material transactions with NHS Blood and Transplant.

In accordance with Treasury guidance the NHS Blood and Transplant Trust Fund is regarded as a related party. Income received from the Trust Fund during the year totalled £23,000 (31 March 2012 : £125,000)

23. Events after the reporting period

In accordance with the requirements of IAS 10 events after the reporting period are considered up to the date on which the accounts are authorised for issue. This is interpreted as the date of the Certificate and Report of the Comptroller and Auditor General. There were no material post balance sheet events.

24. 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. Because of the way that NHSBT is financed, NHSBT is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. NHSBT has no power to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing NHSBT in undertaking its activities. NHSBT is therefore exposed to little credit, liquidity or market risk.

Liquidity risk

The majority of NHSBT’s operating costs arise in Blood and Specialist Services. These are mainly recovered through prices under annual service agreements with NHS Trusts, Foundation Trusts and Primary Care Trusts, which are financed from resources voted annually by Parliament, and provide an ongoing and predictable level of income. Likewise Organ Donation and Transplantation is financed through grant in aid from resources voted annually by Parliament.

Capital expenditure costs are financed from Grant in Aid resources voted annually by Parliament to the Department of Health. Liquidity risk is low.

Credit Risk

NHSBT makes a relatively small amount of sales to external customers and is not therefore exposed to significant credit risk.

Interest-rate risk

All the NHSBT's financial assets and financial liabilities, including the finance lease, carry nil or fixed rates of interest. It is not therefore exposed to interest-rate risk.

Foreign currency risk

NHSBT has a relatively small amount of foreign currency income or expenditure, converted at the spot rate at the time of the transaction. NHSBT is not therefore exposed to significant foreign currency risk.

Fair values

Fair values are not significantly different from book values and therefore no additional disclosure is required.

25. Intra-government balances

	Receivables Amounts falling due within one year £000	Receivables Amounts falling due after more than one year £000	Payables Amounts falling due within one year £000
Balances with other central government bodies	2,795	-	522
Balances with local authorities	-	-	14
Balances with NHS Trusts and organisations	9,999	-	3,798
Total Intra-Government Balances	12,794	-	4,334
Balances with bodies external to government	8,484	471	14,926
At 31 March 2013	21,278	471	19,260
Balances with other central government bodies	5,644	-	1,202
Balances with local authorities	-	-	5
Balances with NHS Trusts and organisations	11,417	-	1,993
Total Intra-Government Balances	17,061	-	3,200
Balances with bodies external to government	7,635	145	16,716
At 31 March 2012	24,696	145	19,916

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