NHS
Blood and Transplant

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Annual Report and Accounts 2013/14

Presented to Parliament pursuant to Paragraph 6(3), Section 232, 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 3 July 2014

HC 355

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This publication is available at https://www.gov.uk/government/publications

Print ISBN 9781474107075
Web ISBN 9781474107082

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

ID 13061404 07/14

Printed on paper containing 75% recycled fibre content minimum

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ANNUAL REPORT

Introduction

The accounts for the year ending 31 March 2014 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 manufacturer of biological products and provider of related clinical services. Our core purpose is to ***"Save and Improve Lives"*** through providing a safe and reliable supply of blood components, solid organs, stem cells, tissues and related diagnostic services to the NHS and to the other UK Health Departments where directed.

To this end NHSBT is constituted as a Special Health Authority in England and Wales. NHSBT is also accountable to the Scottish and Northern Ireland Health Departments with regard to its UK-wide role in organ donation and transplantation.

NHSBT is one of the largest services of its type in the world. It is also relatively unusual in that the supply of blood, organs, stem cells and tissues is provided by the one national organisation. In support of this NHSBT is organised into three operating divisions:

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 35,000 units of whole blood are collected every week 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 the four UK Health Departments and hospitals throughout the UK in order to increase numbers the numbers of organs available for transplantation. The cost of these activities (including the retrieval of donated organs) is directly funded by the UK Health Departments.

Diagnostic and Therapeutic Services (DTS). This division is a group of strategic operating units that supply biological products and related highly specialised services, mostly to the NHS in England and North Wales. This includes:

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 hospitals.

Stem Cell Services - NHSBT is the largest UK provider of haemopoetic stem cells for the treatment of blood cancers and operates the British Bone Marrow Registry and the NHS Cord Blood Bank. We additionally provide supporting services to NHS, academic and

commercial organisations seeking to take current and next generation stem cell therapies to the clinic.

Diagnostic Services – NHSBT operates a national network of laboratories that provide specialised matching and reference services in support of blood transfusion (red cell immunohaematology) and organ, stem cells and tissue transplantation (histocompatability & immunogenetics).

Specialist Therapeutic Services (STS) - NHSBT 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.

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 segments, however, other providers exist, both within the NHS and, increasingly, 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.

Strategic Objectives

NHSBT is operationally unique and has characteristics that cannot be found anywhere else apart from similar services in other countries. Our ambition is simple, we want to be recognised as the best service of our type in the world, and evidence this through rigorous benchmarking and comparison of our performance.

Strategic plans have been developed for each of Blood, ODT and the individual units within DTS. The plans identify distinct strategic objectives, targets and plans for each business and 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.

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 attractive experience for our donors and hence a robust and resilient supply of safe products to NHS patients. In so doing we are, however, acutely aware of the financial pressures facing our customers, NHS hospitals. We are therefore pursuing a balanced strategy that aims to deliver across all outcomes from donor service, through product safety and quality in manufacturing, and on to customer service and cost effectiveness.

In support of this the following four strategic themes underpin the strategic objective for Blood Components.

Donor Service / Sufficiency of Supply
We aim to provide a service to our donors that is both a convenient and positive experience. In so doing we will ensure that we can attract donors in sufficient numbers, at the right time and place, and in the right blood group mix, to ensure a robust and dependable supply of safe products for NHS patients.

Customer Service
We want to be as easy to do business with as possible through the implementation of modern, integrated supply chain models that ensure ease of access, reliability, dependability and which minimise wastage "vein to vein". We will ensure that NHSBT will always remain the NHS's most cost effective option for the provision of a complete range of services and clinical advice needed to support transfused patients.

Safety and Compliance
We aim to proactively identify and manage risks to the safety and continuity of the national blood supply and to implement the highest standards of safety and regulatory compliance across the full range of our products and services. In support of this we will work with NHS hospitals to minimise the inappropriate use of blood and reduce the overall volume of blood that is transfused where it is safe to do so.

Efficiency and Effectiveness
We will provide demonstrable value for money in the products and services that we provide and will evidence this through the transparent pricing of our products and benchmarking our operational performance against other national blood services. We will drive efficiency through adopting the principles of modern supply management with integration and planning, lean working and continuous improvement at the core.

Underlying each of these themes is a balanced set of supporting targets covering donor satisfaction, customer satisfaction, product safety, supply chain effectiveness and efficiency. Our headline target is the price of red cells which has been reduced from £140/unit in 2007/8 to £122/unit in 2013/14 through significant reduction of excess capacity in the supply chain. In recognition of the significant financial pressures that are facing the NHS our ambition is to at least maintain flat pricing over the medium term, albeit this is becoming a major challenge as a result of recent and sustained reductions in demand.

Organ Donation and Transplantation: *Strategic Objective*: *Through our vision for "Taking Organ Transplantation to 2020" we will build on the excellent progress of the last five years and aim to match world class performance in organ donation and transplantation.*

Following the publication of the Organ Donation Task Force (ODTF) report in 2008 significant progress has been made in increasing the level of organ donation and transplantation in the UK. In March 2013 the ODTF target to deliver a 50% increase in deceased organ donation (versus a 2007/8 baseline) was achieved.

A chronic shortage of organs available for transplant nevertheless remains. As a result the four UK Governments, supported and facilitated by NHSBT, have developed a new strategy in order to build on the success of the last six years and to set the ambition and direction for organ donation and transplantation through to 2020. The strategy was published in June 2013 and aims to achieve the following outcomes for organ donation and transplantation in 2020:

Outcome 1- Action by society and individuals will mean that the UK's organ donation record is amongst the best in the world and people can donate when and if they can.

Outcome 2 - Action by NHS hospitals and staff will mean that the NHS routinely provides excellent care in support of organ donation and every effort is made to ensure that each donor can give as many organs as possible.

Outcome 3 - Action by hospitals and staff means that more organs are usable and surgeons are better supported to transplant organs safely into the most appropriate recipient.

Outcome 4 - Action by NHSBT and Commissioners means that better support systems and processes will be in place to enable more donations and transplant operations to happen.

This is supported by four strategic targets:

- A consent / authorisation rate in excess of 80%
- 26 deceased donors per million population (currently 20.9 pmp)
- An aim to transplant 5% more of the organs offered from consented, actual donors
- A deceased donor transplant rate of 74 per million population (currently 54.9 pmp)

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

NHSBT is the sole supplier of certain critical tissues (particularly skin) to the NHS. The strategy therefore aims to build on NHSBT's unique capabilities in order to provide bespoke services in support of unmet clinical needs and which can be provided both ethically and cost effectively *("for the NHS, by the NHS"*). The strategy therefore aims to:

- provide high quality care for donor families with NHSBT Tissues recognised as a credible and, trusted brand built on compassion for donor families and ethical supply from within the NHS.
- reinforce NHSBT Tissue Services as the preferred provider for tissue allografts in England, Wales and Northern Ireland and consolidate supply across the NHS in order to leverage the capacity and capability of the Speke tissue bank.
- through the benefits of scale and continuous improvement to supply chain and business support processes, deliver financial surpluses that can be reinvested into further product development and/or lower prices for customers
- pursue a focused, high potential and strategically relevant product development strategy through collaboration with innovative SMEs in the UK

Stem Cell Services: *Strategic Objective: To work in partnership with third sector organisations and the UK Health Departments in the provision of an efficient and effective source of donor haemopoetic 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 stem cell transplants in the NHS through collection, processing and cryopreservation of 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.

As a result of the services we provide for stem cell transplantation NHSBT has developed a unique national footprint of facilities and services. This provides NHSBT with the capabilities to support the development of the next generation of stem cell therapies that are using stem cells and bioactive molecules to regenerate tissues ('regenerative medicine') and to selectively destroy cancerous cells ('cancer vaccines') and viruses. In support of this NHSBT is able to provide the donor stem cells and bring strengths in specialist

manufacturing, regulatory expertise, distribution and R&D in support of this developing industry. This includes the operation of the Clinical Biotechnology Centre (CBC) in Bristol that has unique capabilities in small volume manufacture of plasmids/gene therapy vectors to support early stage clinical trials

NHSBT's objectives are to:

- support the objectives of the UK Stem Cell Strategic Forum to save an additional 200 lives per year through ongoing collaboration with the Anthony Nolan charity, banking an additional 2300 cord blood donations each year, high resolution typing of adult, ethnically diverse donors and seeking further opportunities to improve IT interoperability with other bone marrow registries.
- maintain NHSBT's position as a primary supplier of first generation stem cell transplantation services through maintaining services to the existing key NHS regional customers that are co-located with NHSBT's seven stem cell processing and cryogenic storage facilities.
- grow income from next generation stem cell and molecular therapies through leveraging our national footprint and capabilities to provide supporting services to the NHS, academic and commercial organisations that are taking the next generation of cellular and molecular therapies to the clinic. NHSBT's focus will be on supporting the therapeutic delivery of highly personalised (autologous or tissue matched) cell therapies and will differentiate its service through our access to donors, ability to provide logistical support into NHS hospitals and patient monitoring.

Red Cell Immunohaematology (RCI): *Strategic Objective: To position RCI as an innovative, integrated, technologically-enabled service that saves patients' lives by ensuring they have access to precisely matched blood when needed.*

Red Cell Immunohaematology (RCI) ensures the safety and clinical efficacy of red cell transfusion by providing expert diagnostic and donation selection activities which are beyond the capability of hospital transfusion laboratories. In response to higher demand, and deskilling and downsizing in hospital laboratories, NHSBT has developed a three phase strategy to support a vision for greater integration between NHSBT and hospital transfusion laboratories.

Optimise - develop the capacity, logistics, and electronic requesting and reporting processes required for phase two of the strategy. This would also include the strengthening of the RCI management team and establishing the required operational and business leadership.

Extend - attract further referrals from hospitals, including routine antenatal screening, to increase RCI's productivity and place the service on a financially sustainable footing. This phase would also aim to improve patient outcomes by developing a national database of transfusion-related data.

Integrate - anticipates the consolidation of hospital transfusion laboratories within a hub and spoke model and creates an opportunity for NHSBT to host and manage hub laboratories and integrate RCI with hospital transfusion laboratories. A significant change in NHSBT's core competencies would be required to move to phase three including improved logistics, improved processes for customer engagement, and the acquisition of business development capability.

Histocompatability & Immunogenetics (H&I): *Strategic objective: to maintain our position as the UK's largest provider of H&I services through delivering 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.*

Histocompatability and Immunogenetics (H&I) services are concerned with the genetic testing and matching of solid organ donors, stem cell donors, and platelet donors with the requirements of individual patients. This is generally known as HLA typing or tissue-typing.

There is a critical clinical need for the services provided by NHSBT's H&I laboratories. Each year around 1000 lives are saved through NHSBT's H&I support for stem cell and organ transplantation. A further 18,000 platelet donations are issued on the basis of their HLA types for patients refractory to donations from random donors.

In support of this NHSBT aims to:

- sustain and grow services through understanding and meeting customer requirements, implementing service and technological developments, and by improving business processes and internal supply chain interactions.
- improve patient outcomes through increasing our ability to match blood components and stem cell/solid organ transplants to the needs of individual patients, and by reducing immunological barriers to transplantation.
- increase the repertoire of testing services through leveraging H&I's core capabilities in HLA-related testing and offer NHS, academic and commercial organisations a range of pharmacogenetic tests when highly associated with HLA genetics.

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 we aim 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.

As the only direct patient-facing service in NHSBT we will continue to place great emphasis on the quality of our service and the patient experience that we provide. We will therefore continue to closely monitor patient experience and routinely measure and respond to patient satisfaction surveys.

Corporate Level Actions

In support of our strategic operating units we further identify a group of strategic level actions at corporate level including our Research & Development (R&D) programme, leadership development, corporate social responsibility and the provision of high quality and efficient group services.

Our R&D programme for blood components includes:

- research into donor health, and the behavioural factors which lead people to donate
- investigation of emerging infections and the possibilities for screening and inactivating such threats
- examining the optimal use of blood components and potential alternatives (such as blood derived from stem cells).

In support of diagnostic services we are exploring next generation diagnostics using genotyping and recombinant proteins with the aim of improving 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, in conjunction with hospital partners, to assess novel methods for improving the quality and number of organs available for transplant, including support for the development of ABO incompatible and antibody incompatible transplants. We also continue to develop our strong research programme in Tissues, including partnerships with academic partners, to identify the next generation of tissue based therapies and which would enable NHSBT to meet the otherwise unmet needs of NHS patients.

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.

With regard to our corporate functions we continue to engage with government and departmental plans for delivering back office functions through shared services. In the interim we will continue to deliver continuous improvement in the effectiveness and efficiency of back office functions and benchmark them against comparable organisations.

Strategic and Directors' Report

Key Performance Headlines 2013/14

NHSBT is pleased to report that 2013/14 has been another very successful year, although significant challenges have now emerged as a result of:

- sustained reduction in red cell demand. This is reducing our income and will impact our ability to maintain flat prices for blood components over the medium term

- increases in deceased organ donation activity which, although very welcome for patient outcomes, is leading to a non-linear increase in related costs (especially organ retrieval). This has put ODT into financial deficit in 2013/14 (albeit offset by surpluses in Blood and Specialist Services) and has required additional funding from the four UK Health Departments in 2014/15.

The challenges are described further in the review of the operational areas that follows.

Blood Components

With regard to supply we are pleased to report that stock levels and the availability of blood products has continued to be highly resilient through 2013/14. One of our key performance indicators is the number of times within the year that any red cell 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 2013/14 there were no such instances (following zero instances in 2012/13).

We are, however, totally dependent on the altruism and loyalty of blood donors. Although demand for red cells is currently declining (discussed below) there is a wide variation between blood groups with much smaller demand reduction being seen in the rarer blood groups (O negative, B negative etc). We therefore need to ensure that the donor base is of the right size and mix to meet the longer term changes in hospital demand that we are seeing but is also able to respond in the short term to peak demand periods (such as over the winter period).

This presents a major challenge in that, as capacity is reduced in line with longer term trends in demand, we remain dependant on our donors to be able to respond to short term demand pressures. In addition, and despite falling demand overall, we also need to increase the proportion of rare blood group donors, especially of the ”universal” O negative blood group. In managing this environment we can sometimes be seen as presenting conflicting messages to our donors. This is partly reflected in our donor complaint levels which increased by 26% during 2012/13 to 4,800 complaints per million donations and has increased by a further 25% to 6,000 in 2013/14. A major element of the increase can be attributed to the closure of some smaller collection teams, and reduced visiting frequency to some locations, as we respond to falling demand. In addition to this waiting times and the availability of appointment slots at required times continue to be the key causes of donor complaints and are an ongoing focus for management attention. In response we continue to adjust our appointment grid, to ensure the optimum balance between appointments and slots for walk-in donors, and we anticipate that the roll out of the online Blood Donor Portal will provide opportunity for real and lasting improvement. The new online service was launched in November 2013 for existing blood donors and had 220,000 users at year end (versus a target of 150,000 users within 12 months). This now provides donors with an online capability to book appointments and will be developed during 2014 to provide more real time information on the progress of donor sessions (so that donors can adapt/change plans as necessary) as well as eventually providing the capability for the Donor Heath Check form to be completed on line and in advance. Despite the increasing number of complaints donor satisfaction remains high and at year end was at 68% (measured as the percentage of donors scoring 9 out of 10 or higher for overall service) versus target of 68% and 68% at the end of last year.

From a safety perspective Transfusion Related Acute Lung Injury (TRALI) is a recognised complication of blood transfusion and is monitored by NHSBT to ensure there are no indicators for issues with product safety and/or transfusion practice. There were five confirmed cases in 2013/14 (versus four cases recorded in 2012/13). All patients recovered and there were no indications that NHSBT safety measures had been insufficient or identified as a root cause. 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).

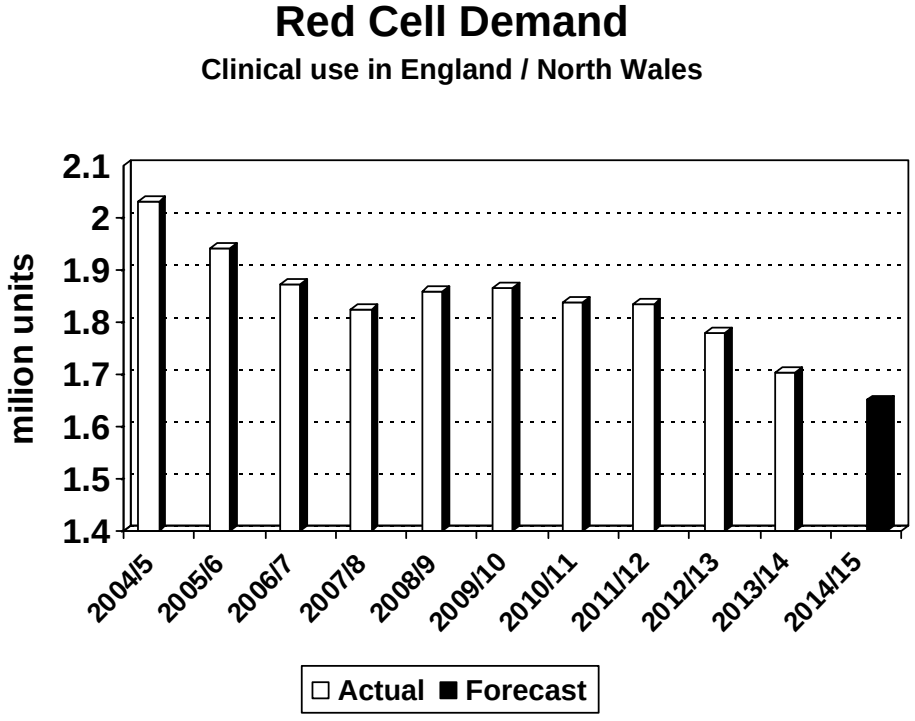
A further key strategic target related to safety, is to ensure that a minimum of 80% of the platelets issued to hospitals are produced via component donation (apheresis). The level of product issued from component donation production was above the target throughout the year, and finished the year at 81.0% (86.5% in 2012/13). Following recommendation by the

Safety Advisory Committee for Blood, Organs and Tissues (SaBTO) the requirement to issue 80% of platelets via apheresis no longer applies. We will therefore be gradually reducing this level over the coming year as we review and re-evaluate our production planning in response to this significant change in the blood safety framework.

In addition to the safety and availability of the blood components that we supply we continue to focus on ensuring the highest standards of regulatory performance within our manufacturing facilities and laboratories. In support of this we have adopted an ambition that there should be zero critical and zero major findings arising from any inspection conducted by our regulators. Following a strong performance trend over recent years we are therefore disappointed to report that in 2013/14 we incurred eight major findings following regulatory inspection by the Medicines and Healthcare products Regulatory Agency (MHRA) within Blood Supply, in addition to a further three majors that were reported in DTS, again by the MHRA (see below). This is receiving increased management attention so that we focus on ensuring that NHSBT is able to proactively respond to the increasing detail of inspections that we have seen during 2013/14.

From a customer perspective hospital satisfaction with NHSBT's service remained high and at year end was at 69% (measured as the percentage of customers scoring 9 out of 10 or higher for overall service) versus plan of 70% and 71% at the end of last year.

As noted above the key trend, with the largest impact on NHSBT during 2013/14, has been a decline in red cell demand. Over the longer term demand for red cells has fallen as a result of improved surgical procedures along with work by NHSBT and the NHS to reduce the inappropriate use of blood within hospital transfusion.



Following a period of relative stability between 2007/08 and 2011/12 demand started to decline sharply in October 2012. This resulted in a reduction of demand of 2.7% in 2012/13. In 2013/14 the trend has continued and has fallen by a further 4.8% to 1.704 million units This has significantly reduced income within the year requiring that short term cost savings,

and rephasing of our transformation plan spending, were needed to offset the impact and ensure that NHSBT did not go into financial deficit. The costs of the blood supply chain are mostly fixed in nature with the variable costs of consumables representing only around 15% of the total. Reduction in demand therefore requires that fixed capacity, and the cost of that capacity, be reduced if the prices of the blood components that we supply to hospitals are not to increase. As noted above the financial impact in 2013/14 has been managed. In 2014/15 prices for blood components were set with a 0% increase overall but assumed red cell volumes that are around 4.3% higher than we now expect to see (1.732 million units planned versus 1.653 million units now forecast). This again will be managed in 2014/15 though further cost savings and rephasing of our transformation plan but it will create a very significant pressure on our ability to maintain flat pricing in 2015/16 and beyond.

Organ Donation and Transplantation (ODT)

In April 2013 NHSBT was delighted to report that the target set by the Organ Donation Task Force in 2008, to increase deceased organ donation in the UK by 50% (versus a 2007/08 baseline), had been met.

Twelve months later we are pleased to note that there has been further growth in the levels of deceased donation and, versus the old ODTF baseline, growth of 63% has now been achieved. The result reflects that there were 1,320 deceased donors in the UK in 2013/14 versus 809 in 2007/08 (and 1,212 in 2012/13). In 2013/14 we also saw 1,142 live donors, compared to 1,099 last year.

As a result there were 4,655 organ transplants (deceased and live) in 2013/14 representing an increase of 43% above the 2007/08 baseline (and a 10.5% increase over the 4,212 organ transplants carried out in 2012/13).

With many more organs being available for transplant many more lives have been saved and improved. However, this has created unexpected financial pressures due to the impact of the higher than expected activity plus the impact that this has had on costs, especially retrieval costs where NHSBT commissions organ retrieval from specialist centres across the UK. As a result ODT has reported a £2.9m deficit in year, although this has been offset by surpluses in Blood and DTS so that, overall, NHBST has reported a net operating surplus of £1.3m, before property revaluations.

Forecast activity in 2014/15 for ODT is expected to drive a further increase in costs, estimated to be £4.2m above the baseline funding provided by the four UK Health Departments. In response NHSBT met with the UK Health Departments to consider the options going forward. The result of these discussions has been positive and the additional £4.2m of funding for 2014/15 has now been provided. As a result NHSBT is able to proceed into 2014/15 with existing plans intact.

The increase in activity has also highlighted weaknesses in the processes underpinning the complex clinical pathway from donor to patient and its ability to cope with the volumes now being experienced. Attention has focused on the NHSBT's Duty Office, effectively the "nerve centre" for co-ordination of the donation pathway across the UK, and the high level of manual data transcription that takes place during the process from (potential) donation to transplantation. A number of errors have arisen during the year that, although they did not lead to Severe Untoward Incidents being declared, were sufficiently serious to warrant a fundamental review by the Board. Corrective action is now underway, and is being overseen by the Governance and Audit Committee. In addition a new Donor Registration Transformation project is being implemented within ODT. This will introduce tablet based

applications that will reduce the volume of data that is manually captured and will also introduce process improvements that will reduce the risk of transcription error.
In the interim ODT continues to work with stakeholders on developing the detailed plans, and associated funding requirements, in support of new UK strategy "Taking Organ Donation to 2020". This will also result in ODT moving away from measuring operational performance against the old ODTF baseline to a new "numbers per million" framework that will allow comparison in performance in the UK with that in the rest of the world. The plan also captures the work that ODT is performing on behalf of the Welsh Health Department in support of implementing the Human Transplantation (Wales) Act 20013. The Bill was passed in September 2013 and will introduce a system of soft opt out for organ and tissue donation in Wales. In order to support this change the UK Health Departments have also agreed to fund the construction a new organ donor register for the UK and NHSBT is now facilitating its procurement and implementation.

Diagnostic and Therapeutic Services (DTS)

Activity in DTS during 2013/14 has been focused on developing and implementing the strategies of the individual operating units. A common theme within each of the strategies is the intent to position NHSBT as a preferred national supplier to the NHS and to grow the income and financial contribution from each business in order to deliver future price reductions and/or fund new patient therapies.

Despite this intent income in Tissues at £7.5m was 4% lower than last year and 19% lower than plan. This was driven by lower demand for femoral heads and skin and reflected lower procedures across the NHS (especially orthopaedic). Spending was constrained to offset the loss of income but the net financial contribution remained £1.5m short of plan. The demand trend continues to be adverse although income from new product launches during the year (Demineralised Bone Matrix and Decellularised Skin) are anticipated to contribute strongly in 2014/15.

Income in Stem Cells Services at £19.4m was 8.8% higher than last year, although 2.8% short of plan. Growth has occurred in matches from the British Bone Marrow Registry, and issues from the NHS Cord Blood Bank, offset by a lower number of transplants in the hospitals that we serve. The objectives of the UK Stem Cell Forum (UKSCF) that reported in July 2010 continue to be met with 2,400 cord blood units banked against a target of 2,300. In addition 33% of these derived from Black and Minority Ethnic communities (versus a 30% target). The NHS Cord Blood Bank now has 22,000 units, of which 7,000 units now have a Total Nucleated Count (TNC) of greater than $14x10^8$. 60 cords were issued from the NHS Cord Blood bank in the year compared to 49 in 2012/13.

Diagnostics has seen significant activity growth with income ahead of last year by 5.7% in RCI and by 7.9% in H&I and provided a £1.2m improvement in financial contribution compared to plan. Operational performance in H&I is notably improving with both customer satisfaction and sample turnaround times ahead of target and on an improving trend. Both services have benefited from the implementation of electronic reporting of test results (SP-ICE) and are now extending this to include an electronic requesting process. Despite this customer satisfaction in RCI fell during the year and was at 49% in March (versus target of 62% and the result of 63% that was achieved in the first quarterly survey in Q1). Improving customer satisfaction in RCI will be an area of focus in 2014/15 as part of the "optimise, extend and integrate" strategy described above

Following recent strong growth in STS, income has levelled out with sales in 2013/14 at £5.5m, 1% ahead of last year. This was 9% lower than plan although the net financial contribution was maintained through control of costs. The major gap to plan was in the

demand for photopheresis services although new contracts are coming on stream and further growth is expected in 2014/15.

Research and Development

Our internationally competitive Research and Development (R&D) Programme continues to generate the evidence required to inform best practice in transfusion and transplantation medicine. In blood donation we are supporting a randomised clinical trial aimed at determining the optimal inter-donation interval for blood donors (www.intervalstudy.org.uk). This study, led by the University of Cambridge, has recruited over 50,000 volunteers and will inform International blood collection policies. In transfusion medicine, we reported in the New England Journal of Medicine, the outcome of TOPPs, a clinical trial on prophylactic platelet transfusion in patients with haematological cancers. This study demonstrated the benefit of such prophylaxis for reducing bleeding in these patients. In organ donation and transplantation, we have collected the first samples of the QUOD National BioBank, a resource being established to support research aimed at improving transplantation outcomes (www.quod.org.uk)

We have strengthened our strategic alliances with leading Universities in England through the appointment of new Principal Investigators (PIs) in Donor Health (Dr Emanuele di Angelantonio, University of Cambridge) and Cord Blood Transplantation (Prof Vanderson Rocha, University of Oxford). These PIs will lead research programmes aimed at determining the long-term effects of blood donation and the outcomes of cord blood transplantation respectively.

In response to changes to R&D funding we initiated a review of our R&D programme to inform the future strategy. As part of this review we have been engaging with internal and external stakeholders to identify future priorities. Following discussions with the National Institute for Health Research, a competition has been launched for up to £15M research funding from 2015-2020 to address research questions in four priority areas (Donor Health and Genomics, Organ Donation and Transplantation, Haematopoetic Stem Cell Transplantation and Immune Therapies and Generation of Blood Cells I*n Vitro*).

An independent review of more than 1,100 publications arising from our R&D Programme between 2002 and 2012 reported that "*the research potential of the current staff at NHSBT should be considered excellent which provides confidence that it will continue to produce publications that can push the boundaries of science and gain recognition for this*".

Group Services

During the year our group services have supported a significant internal change programme (described in the Approved and Planned Developments section below). The programme delivers vital work to increase resilience and advance NHSBT's IT infrastructure, enables the organisation to better meet the needs of our customers and delivers significant efficiency improvements .

Group Services (Finance, Procurement and Human Resources) have also been planning for a migration to the "ISSC 1" shared service initiative for central government. It was announced on the 24th March 2014, however, that the business case for the DH and its Arms length Bodies (ALBs) no longer represented value for money and the requirement for ALBs to join the service was removed. NHSBT is now developing revised plans to further improve the efficiency and effectiveness of our back office services. This will include identifying alternative shared service offerings and market testing our services for value for money. We will also continue to benchmark the cost of our services both within government and the private sector.

Approved or Planned Developments

NHSBT continues to develop and implement a detailed transformation plan that is designed to support the delivery of our ambitious objectives and generate year on year financial efficiencies. Depending on the timing of projects and initiatives NHSBT is spending around £10m - £15m pa on transformation across all of its activities.

Within this programme the major projects that are currently underway or planned include:

- Blood Donation Organisational Design (BDOD). This is a £10m multi year programme of work that is designed to review and improve organisational structure and accountabilities across blood donation, generate improved front line management and service capability and deliver productivity improvement. Annualised benefits of £4m pa are expected to accrue with part year delivery starting in 2014/15.
- Session consolidation – a project that is designed to increase productivity in blood donation through the operation of a smaller number of larger mobile venues (operating a greater number of donation beds at each venue). An initial pilot has been successfully concluded in Newcastle during the year and is now being extended to other parts of the country where the consolidation of teams would be appropriate and effective.
- A number of pilot and desk top studies, costing £0.5m, with partner NHS Trusts that is developing and reviewing the opportunity for integrating the management of stock and introducing a vendor managed inventory solution for blood components. In May 2014 the NHSBT Board approved a business case to extend the stock management solution to 20 hospitals and underpin this with a more robust IT architecture based on an industry standard stock planning and control system (a total new investment of £1.2m).
- Implementation of a Platelet Supply Strategy that was approved by the Board in May 2014. This follows the recommendation by SaBTO in September 2013 that the previously mandated requirement to meet at least 80% of platelet demand through apheresis should be rescinded. As a result NHBST is proposing to initially reduce the level of platelet supply through aphereis to 60% resulting in a number of changes to the way that we operate both our mobile and fixed donation centres. The implementation would require investment of £3.3m (marketing and severance costs) and generate annualised savings of £3.1m pa. The SaBTO recommendation also requires NHSBT to introduce platelet additive solution in the manufacture of pooled platelets resulting in additional costs of £2m pa.
- Implementation of a Transport Management System to secure greater efficiency in our logistics processes and better use of fleet. Investment of £1.9m was approved in November 2013 with benefits of £1.2m pa anticipated.
- Supporting the Welsh Government in its objectives to implement an all Wales blood service by 2106 with substantial progress made by 2014. The incremental costs for NHSBT are being funded by the Welsh Government. The key impact on NHSBT is a further reduction in volume, and related income that will require NHSBT to find savings of around £1.5m pa in order to maintain flat prices.
- Upgrading the hardware and Oracle database used by the Laboratory Information Management System (Hematos) that are now out of life and unsupported. This underpins all stem cell and diagnostic services provided by NHSBT and requires a £0.5m investment to implement the latest versions and extend the safe operating life of the systems.
- Reconfiguration of the estate in the Brentwood area. A £6m investment wil be made in order to exit an old and costly building and provide a more flexible and lower cost estates footprint in the area. The project was approved by the Board in July 2013 and is expected to generate sales proceeds for the site of ca £2.8m, recurring cash benefits of £0.6m pa and avoidance of significant future maintenance costs. Since approval the Platelet Strategy described above proposes that investment in a new donor centre at

Brentwood would no longer be required. This would reduce the planned investment by £1.2m and generate additional savings of £0.9m pa (included in the benefits described in the Platelet Strategy described above).

- In order to upgrade its infrastructure, and enable an exit from an existing data centre on the Bio Products Laboratory site at Elstree (no longer owned by DH), NHSBT is progressing a data centre hosting project that will transfer the existing centres to a 'Co-Location' hosting provider. An initial investment of £0.9m was approved in November 2013 pending a full business case in July 2014.
- Upgrading the IT infrastructure supporting the National Transplant Database and Organ Donor Register that are critical to the effective management of the Organ Donation and Transplant pathway. The current infrastructure no longer meets current and future needs and became end of life in 2007. A £0.8m investment (mostly capital) has been approved to update the ODT infrastructure.
- A project costing £3.2m over 5 years to transform the processes supporting the registration of organ donors and improve the support provided to Specialist Nurses for Organ Donation (SN-OD). Expected benefits include the reduced risk of transcription errors, improved SN-OD effectiveness (by releasing more time to spend with donors and families) and reducing the verbal information transfer risk that occurs across the national transplant pathway.
- Implementation of a new organ donation register for the UK. This is a £4m project over 5 years that is being separately funded by the four UK Health Departments. Approximately 50% of the funding will be provided by Wales in recognition of its criticality to the implementation of the soft opt out system for organs and tissues in Wales that will be introduced by the Human Transplantation (Wales) Act 2013.

Along with the safety, resilience and quality of the products and services provided by NHSBT a key objective of the transformation programme is to generate a stream of financial benefits that will enable NHSBT to hold, if not further reduce, the price of blood components in the future. The programme has delivered a price reduction of red cells from £140/unit in 2007/088 to £122/unit in 2013/14 with resulting savings of around £59m pa being generated for the NHS overall. The programme has also enabled NHSBT to hold prices at £122/unit in 2014/15 despite a major reduction in red cell demand (7.4% over the two years since 2012/13). Looking forward, if demand continues to decline at the same rate it will be increasingly difficult to remove capacity and cost at the same rate with the risk that, although total cost may be reducing, prices will increase.

Financial Review

NHS Blood and Transplant is a Special Health Authority. It is treated as a Non Departmental Public Body (NDPB) under the Government Financial Reporting Manual (FReM) and is recognised as a Public Corporation by the Office of National Statistics.

NHSBT is required to report on a ***Net Expenditure*** basis with programme funding provided by 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 and Expenditure basis***, as this is more appropriate to the nature of NHSBT's activities. On this basis NHSBT generated an operating surplus of £1.3 million in 2013/14 (versus £2.7m in 2012/13).

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.

NHSBT receives the majority of its income from the recovery of costs through the pricing of blood components to NHS Hospitals. This income was £293.5 million in 2013/14 (£294.9m in 2012/13). 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 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 £49.8 million in the year (£47.8m in 2012/13). 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 was 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. In Tissues, however, income was lower than last year as a result of a fall in demand for skin, bone and tendon, reflecting lower orthopaedic procedures within the NHS.

In addition the Department of Health provided programme funding of £61.9 million for the year (£60.4m in 2012/13). £55.5 million of this was allocated to organ donation and transplantation with the balance supporting the activities of the International Blood Group Reference Laboratory and the development of the NHS Cord Blood Bank. NHSBT also received contributions in the year of £10.4 million from the UK Health Departments in support of our UK wide activities in organ donation and transplantation (£8.5m 2012/13), £1.7m for provision of organ donation and transplantation products and services (£1.3m 2012/13), and £12.3 million of other income (£11.5m in 2012/13) for cost recovery in respect of other services provided.

In response to the above income trends, and the actions taken by NHSBT to generate cost efficiencies, NHSBT generated an overall operating surplus for the year of £1.3m. The segmental analysis in Note 2 identifies an operating surplus of £4.2 million for Blood Components and DTS (diagnostics, tissues, stem cell and specialist therapeutic services), offset by a £2.9 million deficit in organ donation and transplantation. As noted above the deficit in organ donation and transplantation was primarily driven by higher numbers of deceased donors than planned and a consequent increase in organ retrieval costs in particular. The operating surplus reported by DTS of £0.2m is a very welcome result representing a major improvement on the deficit of £3.8 million reported in 2012/13. It also marks the end of a long term deficit reduction plan in DTS that commenced in 2007/8 when the deficit was approximately £22m.

NHSBT was allocated capital funding of £8.6 million for 2013/14 (£7.5m in 2012/13), of which £8.4 million 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 increased from £166.2 million (2012/13) to £171.5 million (2013/14). The increase is primarily due to the impact of a quinennial revaluation of land and buildings which was carried out as at March 2014. The working capital position remains satisfactory with a ratio of total current assets to total current liabilities of 2.4:1 Current assets increased from £54.1 million (2012/13) to £62.9 million (2013/14) reflecting a strong cash balance of £20.6m at the end of the year. A significant element of the cash balance is required to fund a number of major projects for

which accruals and provisions were made in the year end balance sheet. The increase of provisions to £5.5 million (£1.8m in 2012/13) is a notable result of this and results from severance charges made in respect of the Blood Donation Organisational Design (BDOD) project in particular.

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 Ombudsman 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 450 Trust visits were completed during 2013/14. 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 68% of hospitals (85% by volume). In response to customer feedback NHSBT will provide historic reports from 2006 (currently they only go back to 2011), this will more than double the sample reports available on Sp-ICE. We have also developed a tool for monitoring Electronic Despatch Note activity. Already in 2014 three times as many accounts have been issued as in the whole of 2013. We have maintained high satisfaction scores during 2014 with 69% of customers scoring us 9 or 10 out of ten for our service provision overall. During 2013/14, we received 616 contacts from hospital customers of which 455 (74%) were complaints and 161 (26%) were compliments.

We were disappointed that the number of blood donors who complained last year increased from 4,800 per million donations during 2012/13 to 6,000 in 2013/14. We have developed a number of customer service initiatives, many of which have been piloted in different teams across the country, and are confident these will lead to a significant reduction in the number of complaints next year. Initiatives include developing a diagnostic tool to identify root causes and action planning on a team by team basis, along with changes to our appointment grids, welcome process and our texting service to donors.

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. In 2013/14 we responded to 96.8% of complaints from our blood donors within 20 days, exceeding our target of 95%.

Within the Organ Donation and Transplantation (ODT) Directorate of NHSBT, formal complaints are managed by the Quality Assurance department in collaboration with the Assistant Director – Education and Excellence and Clinical Governance Team. Formal

complaints are received from three areas – members of the public, family members of organ donors and organ recipients or their family members. As within the wider NHSBT, our responses aim to address the specific concerns raised and are provided by the most informed individual on the issue in question. Targets are in place to ensure a timely response to the complainant and direct contact is made in all cases where contact details have been provided. During the period between April 2013 to March 2014, ODT received 75 formal complaints.

In addition to formal complaints, the Organ Donation Register (ODR) team monitor and respond to queries and complaints concerning disputed registrations onto the organ donor register. In the same period, the ODR team responded to 1206 disputed registrations. Actions involved monitoring and ensuring investigation with third parties when any trends in registration errors were recognised, in addition to correcting the error as per the member of the public's wishes.

All complaints are reviewed, analysed and reported to the ODT Senior Management Team, where trends are discussed to ensure learning informs the continued development and improvement of ODT processes and practice. The management of complaints within ODT has developed significantly during the year with all formal complaints now managed though the quality management system. The directorate is however continuing to develop its management of complaints and is striving for a more proactive approach which provides assurance that any issues raised are dealt with effectively and that they result in continuous improvement and essential learning.

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 us to reduce our carbon emissions by 25% over a five year period from a 2009-10 baseline. In 2013/14 we are in the fourth year of the plan and are on course for delivering reduced carbon emissions reductions in line with our stated targets. The final year of the plan will, however, be challenging as many of the large scale energy reduction projects identified in the plan have been completed and, even though demand for blood products is decreasing, there is limited impact on our energy consumption. Energy, travel and waste are reported quarterly in arrears with overall CO_2 output reported annually. Figures for NHSBT total carbon emissions for 2013-14 will therefore be reported to the NHSBT Board and Executive Team in July 2014.

As management information has improved in respect of our sustainability programme, the final year of the CMP will include a more expansive set of performance measures to run in parallel with the existing baseline and targets. This will reflect a more accurate and descriptive set of environmental impacts.

As 2014/15 markes the end of our existing carbon management plan we have commenced the work to develop are a new strategy for Sustainable Development and to refresh NHSBT's longer term vision and goals for carbon reduction.

NHSBT Total Carbon Emissions (tonnes $C0_2$)

	09/10 Footprint	10/11 Footprint	11/12 Footprint	12/13 Footprint	13/14 Footprint Reported in July 2014
NHSBT CO2 emissions	27,792	24, 514	22,570	21,502	
Target	Baseline	6%	11%	16%	21%
Actual	Baseline	11.8%	18.8%	22.6%	

Environmental Performance

From an environmental perspective NHSBT has continued to make significant improvements in the way it manages its responsibilities. A new full time position of Environmental Manager has been established and this has allowed NHSBT to begin installing the processes necessary to have a dedicated and systematic approach. The organisation has stated its goal to achieve certification to the ISO14001 Environmental Management Standards and good progress has been made toward this during 2013/14. Final audit and verification of the system will take place in quarters 1 and 2 of 2014/15. The implementation of the ISO14001 standards will assist NHSBT in consolidating environmental management across all its operations and to continually improve performance in this area.

With regard to operational improvement, NHSBT has placed a particular focus on its waste operations over the year. The newly introduced Total Waste Management contract (excluding clinical and confidential waste) has had an immediate impact with the amount of waste diverted from landfill increasing to around 63%. The organisation aims to continue to work hard with its contractors to ultimately achieve zero waste to landfill. Apart from the obvious environmental benefits there are also cost benefits to this work in terms of reduced landfill tax burden and overall costs for waste disposal.

Clinical waste operations have experienced similar level of success. In less than two years the organisation has reduced the amount of waste that it sends for incineration from over 90% to under 10%. All possible waste that can be diverted to alternative waste streams is now being handled in this way. This diversion process has resulted in a reduction of CO_2 generated from these wastes by 36%.

Carbon Reduction Commitment Energy Efficiency Scheme

During 2013/14 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 to cover its emissions.

NHSBT has registered for Phase 2 of the scheme that runs from 2014 to 2019.

Carbon Accreditation

The organisation has successfully achieved re-certification for the Carbon Saver Gold Standard. This means that NHSBT has shown demonstrable commitment to reducing energy use and improving energy efficiency over a 5 year period.

Emergency Preparedness

Business Continuity (BC) is central to the delivery of NHSBT's mission of "reliable supply". The Business Continuity Management System (BCMS) therefore must be based on risk, must generate proportionate and appropriate mitigation for the risks identified by the organisation and must be able to provide stakeholders with auditable assurance of the rigour and robustness of the arrangements in place. To achieve this NHSBT certifies its BCMS to an external standard. An NHSBT Business Continuity Team aims to provide leadership, advice and support to deliver a world leading BCMS for NHSBT, which then supports the wider NHS in its emergency response arrangements, and provides a high degree of assurance around the security and sustainability of the organisation's key products and services.

The 2013/14 year was dominated by three main workstreams: the site level risk assessment process, completing the Filton Flood Report recommendations and the transfer of certification from BS25999 to ISO22301 (the international standard for BC). The risk assessment process piloted in Filton was successfully implemented across all blood centres by September 2013. The risk assessments supported the process of transfer of certification of the BCMS covering the blood supply chain from BS25999 to ISO22301. Concurrently, the expansion of the scope of that certification to cover all critical activity in the Filton site fulfilled the Filton Flood Report recommendations. The Command and Control plan was amended and tested, training programmes were reviewed and adjusted and a mass messaging system was procured and is being piloted in the Filton site. All three workstreams were successfully implemented.

The team has also become more involved in supply chain issues conducting audits both paper and physical site visits on key suppliers for blood packs, and apheresis equipment.

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

NHSBT continues to develop communication, consultation and engagement with all NHSBT employees. An annual communications audit and staff survey are conducted to help identify which communication methods work and highlight any areas for development. This way NHSBT's range of face to face, print and online channels are continuously improved. For example, in response to staff feedback NHSBT's Senior Leadership team continued to deliver a series of roadshows to discuss the new Strategic Plan with staff and help them link the plans to their area of work. NHSBT 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. NHSBT has a varied workforce in terms of preferred channels of communication, but also working hours, geography and access to technology, and so staff in NHSBT se a range of communication techniques to help keep people connected.

NHSBT's Partnership Framework has lead to an enhanced partnership approach with our staff side colleagues which has proved to be very effective, enabling NHSBT 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 Health & Safety consultation arrangements which will result in more effective processes for discussing, consulting and managing health and safety issues.

Good staff engagement is a key priority in NHSBT and NHSBT's Board is committed to taking on the challenge of becoming a great place to work. This includes ensuring that staff have a voice within the organisation, feel valued and recognised for the work that they do

and have equal access to good learning opportunities through Shine, NHSBT's learning and development framework. NHSBT also provides the resources to embed a culture of good health and well being with shared values at the heart of our work.

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

- **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** – a series of development modules and 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

NHSBT has successfully deployed a corporate engagement plan this year and has launched a set of organisation wide values of Caring, Expert and Quality bringing these values to life for every single member of staff. These values underpin NHSBT's engagement strategy and supports NHSBT to become a great place to work.

Disabled Employees Statement

NHSBT is committed to disability equality and aims to embed a disability confident organisational culture. A key part of this is making sure that all employees with disabilities feel valued and are able to achieve their potential in the work place. At NHSBT we work to ensure that disabled people in the work place gain equal access to training and development opportunities, and 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.

NHSBT now has 22 advocates from across the organisation that act as a signpost for employees with disabilities or for managers who want advice on how to support their employee with a disability.

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.

NHSBT has also established a Dyslexia Support Network and a Mental Health Awareness support group for NHSBT employees.

Equal Opportunities Statement

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

- Have a workforce that embraces equality and diversity. To 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 and inclusion 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 on the grounds of a person's protected characteristic.

- Ensure individuals experience equality of opportunity.

- Promote an environment free from harassment and bullying on any grounds to all staff donors and patients.

As at 31st March 2014 NHSBT employed 5882 staff members of which 4018 were female and 1864 were male.

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 2013 to December 2013 the total number of whole time equivalent days lost to sickness absence was 47,831 days. This equates to an average of 9.4 days per whole time equivalent; and a sickness absence rate of 4.2%.

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%.

Board Members

Board Members serving during the period 1 April 2013 to 31 March 2014:

Chairman
Mr. Bill Fullagar was Chairman of the NHSBT Board until his retirement on 30 May 2013. He was succeeded as Chairman by Mr. John Pattullo whose appointment came into effect as of 31 May 2013.

Non Executive Directors
Mr John Forsythe (retired from the Board on 30 September 2013)
Mr George Jenkins (retired from the Board on 30 September 2013)
Mr Andrew Blakeman
Dr Christine Costello
Mr Roy Griffins CB
Mr Jeremy Monroe
Mr Shaun Williams
Ms Louise Fullwood (appointed to the Board from 7 October 2013)
Mr Keith Rigg (appointed to the Board from 7 October 2013)

Executive Directors
Ms Lynda Hamlyn - Chief Executive CBE
Mr Rob Bradburn - Finance Director
Ms Sally Johnson - Director of Organ Donation and Transplantation
Dr Clive Ronaldson - Director of Blood Supply
Dr Huw Williams - Director of Diagnostic and Therapeutic Services
Dr 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 26 to 30.

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	**82,854**	**186,506**
Total Non NHS trade invoices paid within target	**79,741**	**183,863**
Percentage of Non NHS trade invoices paid within target	**96.2%**	**98.6%**

Total NHS trade invoices in the year	**9,998**	**7,178**
Total NHS trade invoices paid within target	**9,876**	**7,003**
Percentage of NHS trade invoices paid within target	**98.8%**	**97.6%**

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 2013/14 NHSBT made a payment of £76 arising from claims made under this legislation (£224 paid in 2012/13).

Prompt Payment Code

The Government has encouraged all public sector Organisations to improve payment processes and make payment of Small to Medium Sized Enterprise (SME) invoices wherever possible within 10 days. During 2013/14 NHSBT paid 38.7% (38.5% in 2012/13) of the total number of invoices, representing 42.1% (36.7% in 2012/13) by value, within a 10 day period. NHSBT's income from sales to hospitals, hiowever, is normally paid within 30 days and hence, in order to manage cash flow, NHSBT can only make limited progress in support of this metric.

Review of Tax Arrangements for Public Sector Employees

HM Treasury require all public sector bodies to report on their high value 'off-payroll engagements. These are arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements) and are not classed as employees.

The table below shows all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	27
Of which, the number that have existed:	
for less than one year at the time of reporting	13
for between one and two years at the time of reporting	7
for between 2 and 3 years at the time of reporting	4
for between 3 and 4 years at the time of reporting	2
for 4 or more years at the time of reporting	1

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying tax and, where necessary, that assurance has been sought.

The table below shows all new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements between 1 April 2013 and 31 March 2014	13
Number of new engagements which include contractual clauses giving the NHSBT the right to request assurance in relation to income tax and National Insurance obligations	13
Number for whom assurance has been requested	13
Of which:	
assurance has been received	13
assurance has not been received	0
engagements terminated as a result of assurance not being received, or ended before assurance received.	0

Reason for Continuation

NHSBT continues to implement an ambitious change 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 requires professional change management of the organisation, 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.

The table below shows off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2013 and 31 March 2014:

	Number
The number of off-payroll engagements of board members and/or senior officials with significant financial responsibility	1
The total number of posts, as of 31 March 2014, within the bodies that meet the criteria of “board members and/or senior officials with significant financial responsibility”. This figure includes both off-payroll and on-payroll engagements.	18

Following the resignation of a Director in February 2013 and a subsequent senior reorganisation, NHSBT required the appointment of an Interim Director of Logistics to support a review of NHSBT's logistics function and to oversee the introduction of a complex Transport Management System. It is not expected that NHSBT will require an individual to

operate at this level on a permanent basis once these tasks are completed, and so a short-term contractor with the necessary skills and experience was sought and appointed. In October 2013, the post was converted to a fixed term salaried appointment to complete the work required. A contractor was in post from 14th February 2013 to 14th October 2013.

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 2012/13). 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 auditors are 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 auditors are aware of that information.

The Audit certificate can be found on pages 43 to 44.

The strategic objectives and the principal risks of NHSBT are outlined at page 2 and page 38 respectively.

I confirm, on behalf of all Directors of NHSBT, that so far as we are aware there is no relevant information of which the auditor is unaware and that we have all taken steps to make ourselves aware of relevant information and to establish that the auditor is aware of that information.

Lynda Hamlyn Date: 17 June 2014
Chief Executive

REMUNERATION REPORT

Remuneration Committee Membership

During 2013-14 membership of the Remuneration Committee comprised Shaun Williams and Jeremy Munroe. Bill Fullagar was a member of the committee until his retirement from the Board on 30 May 2013 at which point John Pattullo then became a member. 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.

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.

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, NHS start date 1 August 2012, 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, NHS start date 1 August 1978, 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.

Mark Cox, Interim Director of Logistics. Mark joined NHSBT initially as a contractor on 14 February 2013 and was subsequently appointed as a salaried employee on 14 October 2013, under a 6 month fixed term contract (since extended) . The post is full time. The contract provides for one months notice by the employee and one months notice period by NHSBT.

Ian Bateman, Associate Director of Quality. NHS start date 22 July 2002. NHSBT start date 21 September 2009. Appointed to the Executive Team 1 January 2014. Permanent full-time post with three month's 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 tables on pages 28 and 29. The tables on pages 28, 29 and 30 are subject to audit.

Lynda Hamlyn CBE will retire in September 2014. Ian Trenholm has been appointed as the new Chief Executive of NHSBT. He will join the organisation on 1 July 2014 and is expected to take up the post of CEO in August 2014.

Salary and Pension Entitlement of Senior Managers

a. Remuneration

	Year to 31 March 2014					Year to 31 March 2013				
Name and title	Salary in £5k bands £000	Performance pay and bonuses in £5k bands £000	Expense Payments (taxable) total to nearest £00) £00	All Pension Related Benefits (bands of £2500) £000	Total in £5k Bands £000	Salary in £5k bands £000	Performance pay and bonuses in £5k bands £000	Expense Payments (taxable) total to nearest £00) £00	All Pension Related Benefits (bands of £2500) £000	Total in £5k Bands £000
Mr B Fullagar (Chairman) ended 31 May 2013	10-15	-	-	-	10-15	60-65	-	3	-	60-65
Mr J Pattullo (Chairman) commenced 1 June 2013	50-55	-	1	-	50-55	-	-	-	-	-
Mr A Blakeman (NED)	10-15	-	-	-	10-15	10-15	-	-	-	10-15
Dr C. Costello (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr J Forsythe (NED) ended 30 September 2013	0-5	-	-	-	0-5	5-10	-	-	-	5-10
Ms L Fullwood (NED) commenced 7 October 2013	0-5	-	-	-	0-5	-	-	-	-	-
Mr R Griffins (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr G Jenkins (NED) ended 30 September 2013	0-5	-	-	-	0-5	5.-10	-	-	-	5.-10
Mr J Monroe (NED)	5-10	-	-	-	5-10	0-5	-	-	-	0-5
Mr K Rigg (NED) commenced 7 October 2013	0-5	-	-	-	0-5	-	-	-	-	-
Mr S Williams (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms L Hamlyn (Chief Executive)	180-185	-	2	-	180-185	180-185	-	7	-	180-185
Ms L Austin (Director of Communications)	105-110	-	1	32.5-35	140-145	105-110	-	1	32.5-35	140-145
Mr I Bateman (Associate Director of Quality) commenced 1 January 2014	20-25	-	8	17.5-20	40-45	-	-	-	-	-
Mr R Bradburn (Finance Director)	140-145	-	35	55-57.5	200-205	130-135	-	25	40-42.5	170-175
Mr M Cox (Interim Director of Logistics) **	160-165	-	7	-	160-165	5-10	-	-	-	5-10
Mr D Evans (Director of Workforce) *	95-100	-	5	22.5-25	120-125	115-120	-	10	20-22.5	140-145
Ms S Johnson - (Director of Organ Donation and Transplantation) *	115-120	5-10	-	0	120-125	120-125	-	-	32.5-35	155-160
Mr M Potter (Director of Business Transformation Services)	105-110	-	19	30-32.5	140-145	105-110	-	17	52.5-55	160-165
Dr C Ronaldson (Director of Patient Services)	135-140	5-10	19	70-72.5	215-220	135-140	-	17	75-77.5	210-215
Mr H Williams (Director of Diagnostics and Therapeutic Services)	125-130	-	4	40-42.5	170-175	20-25	-	2	5-7.5	25-30
Dr Lorna Williamson (Medical and Research Director)	210-215	-	-	77.5-80	290-295	205-210	-	-	22.5-25	230-235

NED = Non-Executive Director

Performance pay and bonuses relates to pay earned in 2012/13 and paid in 2013/14. There were two such bonuses paid in 2013/14.

* Salary lower compared to previous year due to a career break taken in year.

** M Cox was appointed on a fixed term contract on 14 October 2013 therefore the amounts disclosed as salary above include gross amounts paid through an agency from 1 April 2013 to 14 October 2013.

Expense payments (taxable) were in relation to the provision of cars and reimbursement of business mileage 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 2013/14 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 increase in the pay multiples from 8.0 (2012/13) to 8.1 (2013/14).

	2013-14	**2012-13**
Highest Director Banded Remuneration	£210k to £215k	£205k to £210k
Median Remuneration	£26,859	£26,121
Remuneration Ratio	8.1	8.0

b. Pension benefits

Name and title	Real increase / (decrease) 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 2014 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Ms L Hamlyn (Chief Executive) *	-	-	-	-	-	-	-
Ms L Austin (Director of Communications)	0-2.5	-	5-10	-	95	69	25
Mr I Bateman (Associate Director of Quality) commenced 1 January 2014	0-2.5	0-2.5	10-15	40-45	288	258	24
Mr R Bradburn (Finance Director)	2.5-5	-	10-15	-	186	141	42
Mr D Evans (Director of Workforce)	0-2.5	2.5-5	35-40	115-120	760	704	40
Ms S Johnson (Director of Organ Donation and Transplantation) **	(0-2.5)	(2.5-5)	40-45	120-125	830	818	(6)
Mr M Potter (Director of Business Transformation Services)	0-2.5	-	20-25	-	228	202	22
Dr C Ronaldson (Director of Patient Services) ***	2.5-5	7.5-10	50-55	160-165	-	-	-
Mr R Williams (Director of Diagnostics and Therapeutic Services)	0-2.5	-	0-5	-	33	4	29
Dr Lorna Williamson (Medical and Research Director) ***	2.5-5	10-12.5	80-85	240-245	-	1,756	-

* is now a deferred member of the NHS Pension scheme, and no up to date pension benefits information is available.

** real decrease in pension is a result of no pension contributions being made whilst on a career break.

*** Cash Equivalent Transfer Values are not applicable for members who are over the normal retirement age

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 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 2013/14. The figures exclude provisions made in the accounts for redundancy costs relating to restructure programmes in early stages of implementation (see note 15 to the accounts).

Exit Package cost band	Number of compulsory redundancies	Cost of compulsory redundancies (£000s)	Number of other departures agreed	Cost of other departures agreed (£000s)	Total number of exit packages	Total cost of exit packages (£000s)	Number of departures where special payments made	Cost of special payment included in exit package
Less than £10,000	1	4	6	58	7	62	1	4
£10,001 - £25,000	13	233	27	477	40	710	-	-
£25,001 - £50,000	19	683	33	1,178	52	1,861	-	-
£50,001 - £100,000	11	760	22	1,591	33	2,351	-	-
£100,001 - £150,000	3	348	3	356	6	704	-	-
£150,001 - £200,000	2	325	-	-	2	325	-	-
Totals for 2013/14	49	2,353	91	3,660	140	6,013	1	4
Totals for 2012/13	21	1,115	9	378	30	1,493	-	-

Redundancy and other departure costs have been paid in accordance with the national NHS redundancy terms and conditions and within the provisions of the NHS Pension Scheme where appropriate. Exit costs in this note are accounted for in full in the year of departure. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

All costs relating to other departures arise from voluntary redundancies, including early retirement contractual costs.

The special payment of £4,000 relates to the settlement of an Employment Tribunal claim.

Lynda Hamlyn
Chief Executive

Date: 17 June 2014

STATEMENT OF CHIEF EXECUTIVE'S RESPONSIBILTY

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 Secretary of State for Health has appointed the Chief executive of NHS Blood and Transplant 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 2013/14

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's accountabilities to the Welsh Government, and to the Scottish and Northern Irish Health Departments in respect of organ donation and transplantation across the UK, are governed via certain Board arrangements and supporting Income Generation Agreements where requested.

NHSBT comprises a group of distinct strategic operating units. As part of our 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, consistent with all applicable governance, internal control and risk management policies, 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 it 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 was reviewed by the Governance and Assurance (GAC) Committee in December 2013. 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 amongst NHSBT employees and to demonstrate how their activities comprise essential parts of the overall governance process 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
- Governance and Clinical Effectiveness
- Clinical Audit
- 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 Transformational Change Programme

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 transplantation.

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 reviews its effectiveness on an annual basis 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. Following the appointment of a new Chair during 2013/14 a small working

party of Non-Executive and Executive Directors was established to review the effectiveness of the Board in more depth. As a result of the review the Board confirmed that it was working effectively but identified a number of improvement opportunities which have since been implemented. Taken together the Board is satisfied that it was operating effectively during 2013/14.

Board Committees

Seven Board Committees have been established and were in operation during 2013/14. The Board Committees are as follows:

Governance & Audit Committee (GAC) - the Committee provides assurance to the Board regarding the effectiveness of NHSBT's governance, risk management and internal control processes across all clinical and non-clinical activities. The GAC receives reports and assurances from directors and managers, guided by an assurance framework and supported by an annual work plan. This is supported by an independent internal audit service 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. These standards 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 individual patients that are awaiting transplantation.

Remuneration Committee – the Committee oversees remuneration and other contractual arrangements for the Chief Executive and NHSBT Directors. This is conducted with due regard, to the provisions of the NHS Very Senior Manager Pay Framework and/or other relevant guidance and best practice. 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 that is required by 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 - 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%
National Administrations Committee	95%
Trust Fund Committee	93%
Expenditure Controls Committee	92%
Transplantation Policy Review Committee	80%
Remuneration Committee	90%
Research and Development 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 (until 30 May 2013)	1
John Pattullo	Chairman (from 31 May 2013)	5
Lynda Hamlyn	Chief Executive	6
Andrew Blakeman	Non-Executive Director	3
Christine Costello	Non-Executive Director	6
John Forsythe*	Non-Executive Director	2
George Jenkins**	Non-Executive Director	2
Shaun Williams	Non-Executive Director	6
Roy Griffins	Non-Executive Director	6
Jeremy Monroe	Non-Executive Director	6
Louise Fullwood***	Non-Executive Director	3
Keith Rigg****	Non-Executive Director	3
Rob Bradburn	Finance Director	6
Sally Johnson	Director of Organ Donation and Transplantation	5
Clive Ronaldson	Director of Patient Services	6
Lorna Williamson	Medical and Research Director	6
Huw Williams	Director of Diagnostics and Therapeutic Services	6

Note:

* *John Forsythe's last Board meeting on resigning from NHSBT was September 2013*

** *George Jenkin's last Board meeting on resigning from NHSBT was September 2013*

*** *Louise Fullwood's first Board on joining the NHSBT Board was November 2013*

**** *Keith Rigg's first Board meeting on joining the Board was November 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 2013/14 NHSBT has reviewed and reissued its risk management strategy and risk management policy as a precursor to a detailed review of its risk management processes during 2014/15.

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 monthly 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 GAC workplan.

Responsibility for our governance systems is delegated to the Medical and Research Director, with support by the Finance Director, who together provide a strong link between the Governance and Audit Committee (GAC) and the Board. The Medical and Research Director has particular responsibility for all aspects of clinical governance and effectiveness across NHSBT and reports regularly to the Executive Team, GAC and Board on all matters of clinical governance and risk. This responsibility is effected by a Clinical Audit, Risk and Effectiveness Committee (CARE) which meets on a bi-monthly basis and is supported by CARE groups embedded within each of the operational directorates. A standing clinical governance item is part of each operational SMT agenda and a combined clinical governance report is provided to the Executive Team (as part of the performance review meeting) and to the GAC and Board as part of a standing agenda item. Reports cover clinical risks, clinical audits, outcomes, incidents including serious untoward incidents (SUIs) and Never Events, clinical complaints/commendations and clinical claims.

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. 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 function leads the NHSBT self inspection schedule. Audits are programmed on a 2 yearly cycle and cover all regulated activities at all licensed sites and include:

- national self inspections that 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 that 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 that are commissioned at the discretion of Senior Management, often in response to individual adverse events, trends or changes to our operational configuration.

The QMS and quality assurance processes are owned by the NHSBT Associate Director of Quality, who reports to directly to me and attends the GAC and Executive Team meetings. 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, GAC and Board. NHSBT is committed to delivering a strong regulatory performance and has a stated ambition that there should be no "critical" and no "major" non-compliances identified during any regulatory inspection. During 2013/14 there were no critical and eleven major non-compliances reported (no critical and one major

non-compliance was reported in 2012/13). Following strong performance over recent years we are disappointed with this result. Looking forward, corrective actions are being implemented so that NHBST is better prepared for increasing regulatory standards and the higher levels of scrutiny that we have started to see.

NHS Blood and Transplant Risk Profile

NHSBT is a supplier of biological products and related clinical 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, haemopoetic 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, are 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, however, 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. In this regard both our clinical governance (CARE) and quality assurance functions are closely involved with strategic projects at all stages of their progress. Overall we are highly committed to delivering our strategy, and its associated benefits, and we endeavour to maintain the right balance between delivery of the strategy and the risks associated with its underlying action plans.

As at 31 March 2014 the NHSBT risk register captured 142 risks. Of these the items considered high/extreme can be summarised as:

Productivity / financial efficiency – Blood Components:
The prices charged for blood components provides a transparent view of the financial efficiency of the blood service. Our medium term objective is to find efficiency gains and productivity improvements that offset inflation, enabling us to maintain flat pricing of blood components. Pricing is, however, highly dependent on volume and the trends that we see in the demand for blood. Since October 2012 a sustained reduction in red cell demand has been seen and we forecast that this trend will continue over the medium term. The costs of the blood supply chain are relatively fixed in nature and it is challenging to reduce costs at the same rate as volume reduction. Our ability to avoid price increases in the future increasingly depends on us removing capacity and increasing productivity, especially within blood donation. This could increase the operational risks and impact our ability to collect sufficient blood. Improvement in efficiencies may therefore lag demand decline and hence, even though total costs may decrease, unit prices would increase.

Medium Term Funding for Organ Donation and Transplantation
The unexpected increase in deceased organ donation, and associated increases in costs (especially in organ retrieval), have led to pressure on budgets. A further increase in activity is expected to lead to a budget deficit of £4.2m in 2014/15 and, in light of this, the four UK Health Departments have confirmed additional programme funding to close the financial gap.

Beyond 2014/15, however, the availability of further additional funding is likely to be highly constrained although further growth in deceased organ donation activity is to be expected and is an explicit objective of the "Taking Organ Donation to 2020" strategy that was agreed by the four UK Heath Departments during 2013/14. Extensive engagement with Ministers and the four UK Heath Departments will be required during 2014/15 to establish a sustainable basis for the future funding of organ donation in the UK.

Change management:
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. There is a risk that this could impact 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.

In addition the need to implement modern IT systems is an increasingly critical component of our change projects. This creates additional implementation risk in its own right but is also a source of further financial risk as the benefits flow from change projects needs to be sufficient to fund the required investments in IT.

In addition, the strategies within DTS are ambitious and include objectives to both grow our services to the NHS and, in blood transfusion, to directly integrate our activities with those of the hospitals that we serve. This presents an execution challenge requiring the acquisition and development of the capability to manage new business models and in the provision of supporting sales, marketing and product management skills.

Business continuity:
NHSBT's supply of products and services could be impacted by loss of a key facility (e.g. Filton, Speke) or loss of a critical IT platform (e.g. Pulse, Hematos, NTxD). 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. Further risk assessments have been undertaken at other key NHSBT sites to enhance resilience.

In addition NHSBT is dependent on small enterprises for the ongoing support and maintenance of some of its critical IT platforms. There is a business continuity risk posed by the dependence on these enterprises.

Process resilience:
NHSBT uses manual paper based and verbal processes within it's operations especially within the organ donation and transplantation pathway (and particularly within the NHSBT Duty Office) as well as in our diagnostic testing areas. Although these are mitigated by control checks there remains a residual risk that these are ineffective and result in errors that could lead to harm to NHS patients. There is also the potential for process failure at specific points in the organ donation and transplantation pathway. This risk has been apparent and has crystallised in errors made in the Duty Office during the year, in part generated by the significantly higher levels of deceased organ donation than was expected and planned. This is now subject to detailed review, overseen by the GAC. Elsewhere in diagnostics the risk of

transcription error is being reduced through the implementation of electronic requesting and reporting of results between NHSBT and customer hospitals.

Serious Untoward Incidents (SUIs)

There were no Never Events in 2013/14 and 3 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 3 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 2012. In 2013/14 there have been 3 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. All three incidents related to ODT Duty Office processes and hence represent a source of significant risk to our processes. A comprehensive action plan to address the issues identified by root cause analysis of each incident is being monitored by GAC.

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.

Internal Audit

As a result of work undertaken during 2013/14 there were a total of 13 reports issued, of which none was given a high risk rating. This audit work has been taken into account in the preparation of the 2013/14 Annual Report and this Governance Statement. Overall, PwC have provided an overall opinion that there is ‘some risk’ that management’s objectives may not be fully achieved. In their reports they identified improvements required to enhance the adequacy and/or effectiveness of governance, risk management and control. All audit findings are monitored by management and presented to GAC to ensure that recommendations are followed up and completed.

Whistleblowing Policy and Counter Fraud Policy

NHSBT has a new Whistleblowing policy. This policy provides clear guidance on what an employee must do to raise concerns of possible danger, professional misconduct, unlawful conduct, or financial malpractice that might affect patients, donors, colleagues or NHSBT. There is also a counter fraud policy explaining how staff must report suspected fraud. Staff have been made aware of both policies during the year.

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 2013/14 all six Specialist Therapeutic Services (STS) units have been inspected by the CQC and have been declared compliant with the standards that were assessed, this is the second year in succession all outcomes were met on all sites on every inspection for STS.

Our blood centres are considered to be non-acute services and are expected to be inspected every other year. During 2013/14 all 15 blood centres and 6 mobile blood collection sites were also inspected. All centres were compliant for all the outcomes that were assessed with the exception of one centre that was non-compliant with Outcome 8 Cleanliness and Infection Control. An action plan addressing the issues raised was approved by the CARE Committee and has been provided to the CQC.

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 had a relatively limited impact on NHSBT. There were no substantive changes to NHSBT's statutory functions and NHSBT did not take on any new functions on behalf of any other person or body. The new system did not therefore create any changes to the statutory arrangements that impact NHSBT and there was 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.

Monitor Provider Licence

NHSBT has reviewed the DH guidance published in December 2013 *Protecting and promoting patient's interests. Licence exemptions: guidance for providers* and has concluded that a licence is not required on the basis that NHSBT is a special Health Authority that is not in the scope of the bodies expected to be licensed by Monitor under the Health and Social Care Act 2012. As a manufacturer of biological products and provider of clinical support services the only healthcare services provided by NHSBT are apheresis based therapies that only generate around £6m of NHSBT's total income. This is below the threshold of income that requires a licence and, additionally, does not meet the definition of a Commissioner Requested Service, providing further evidence that NHSBT is exempt from the need to be licensed under the Act.

Duties of the Secretary of State

As a Special Health Authority NHSBT is carrying out functions of the Secretary of State and is therefore accountable for complying with the duties of the Secretary of State as identified by the Health and Social care Act 2012. NHSBT has reviewed the duties of the Secretary of State and is satisfied that its actions in relation to the NHS and public health has complied with the duties described by the Act. This specifically includes the duty of the Secretary of

State to have regard to the need to reduce inequalities between the people of England with respect to the benefits that may be obtained by them from the health service.

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 nevertheless:

- endorse the findings of the report and recognise the critical importance of putting the patient at the forefront of our decision making
- have considered the implications of the report findings with particular regard for the care of donors and donor families
- have reviewed our governance and reporting processes and modified where appropriate to enhance their effectiveness

An action plan, developed following a detailed review of the 290 recommendations in the report, was approved by the Board in March 2013. An update report was further presented to the Board in January 2014. As a result the Board is assured that NHSBT has paid due care and attention to the recommendations of the Francis report, insofar as they impact the activities of NHSBT. Further monitoring of the action plans will be undertaken via CARE during 2014/15 and will be reported to the Board for review.

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 2014 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: 17 June 2014

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 and Transplant for the year ended 31 March 2014 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 Service 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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. 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 2014 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 the Strategic report and directors report 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.

Sir Amyas C E Morse **Date 25 June 2014**

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 2014

	Notes	**31 March 2014 £000**	31 March 2013 £000
Gross Income			
Income from activities	2	**345,086**	343,972
Other operating income	2	**22,646**	19,938
		367,732	363,910
Expenditure			
Staff costs	3.1	**(202,597)**	(202,291)
Depreciation	8 and 9	**(10,134)**	(10,697)
Other administrative expenses	3.2	**(230,838)**	(219,661)
		(443,569)	(432,649)
Net Operating Expenditure before interest		**(75,837)**	(68,739)
Finance Costs	4	**(481)**	(485)
Net Operating Expenditure after interest	2	**(76,318)**	(69,224)
Other Comprehensive Net Expenditure			
Net gain on revaluation of Property, Plant and Equipment	18	**13,620**	240
Total Comprehensive Net Expenditure		**(62,698)**	(68,984)

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 2014

	Notes	31 March 2014 £000	31 March 2013 £000
Non Current Assets			
Intangible Assets	8	**4,163**	3,601
Property, Plant & Equipment	9	**166,083**	162,110
Trade and other receivables	11	**1,244**	471
Total non-current assets		**171,490**	166,182
Current assets			
Inventories	10	**18,860**	21,647
Trade and other receivables	11	**23,376**	21,278
Cash and cash equivalents	12	**20,637**	11,142
Total current assets		**62,873**	54,067
Current Liabilities			
Trade and other payables	13	**21,927**	19,260
Borrowings	14 and 16	**108**	97
Provisions for liabilities and charges	15	**4,275**	689
Total current liabilities		**26,310**	20,046
Non-current assets plus net current assets		**208,053**	200,203
Non-current liabilities			
Borrowings	14 and 16	**4,512**	4,620
Provisions for liabilities and charges	15	**1,219**	1,063
Total non-current liabilities		**5,731**	5,683
Total Assets Employed:		**202,322**	194,520
Taxpayers' Equity			
General Fund	18.1	**155,320**	153,891
Revaluation Reserve	18.2	**47,002**	40,629
Total Taxpayers' Equity:		**202,322**	194,520

Notes 1 to 25 form part of these accounts.

The financial statements on pages 45 to 71 were approved by the Governance and Audit Committee in accordance with powers within the NHSBT Standing Orders on 13th June 2014, and are signed by the Accounting Officer, Lynda Hamlyn.

Lynda Hamlyn
Accounting Officer

Date: 17 June 2014

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 Changes in Taxpayers' Equity for the year ended 31 March 2014

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2013	153,891	40,629	**194,520**
Changes in taxpayers' equity for 2013/14			
Net expenditure for the financial period	(76,318)	-	**(76,318)**
Net gain on indexation of Property, Plant and Equipment	-	13,620	**13,620**
Transfers between reserves	7,247	(7,247)	**-**
Total recognised income and expense for 2013/14	(69,071)	6,373	**(62,698)**
Grant from Department of Health	70,500	-	**70,500**
Balance at 31 March 2014	**155,320**	**47,002**	**202,322**

Statement of Cash Flows for the year ended 31 March 2014

	Notes	**31 March 2014**	31 March 2013
		£000	£000
Cash flows from operating activities			
Net operating costs		**(75,837)**	(68,739)
Other cashflow adjustments	17.3	**19,927**	11,935
Movement in Working Capital	17.1	**4,136**	(1,174)
Provisions utilised	15	**(386)**	(562)
Net cash (outflow) from operating activities		**(52,160)**	(58,540)
Cash flows from investing activities			
Purchase of plant, property and equipment		**(6,946)**	(7,047)
Purchase of intangible assets		**(1,414)**	(365)
Proceeds from disposal of non current assets		**69**	-
Net cash (outflow) from investing activities		**(8,291)**	(7,412)
Cash flows from financing activities			
Grant from Department of Health		**70,500**	67,900
Capital element paid in respect of finance leases		**(97)**	(88)
Interest paid in respect of finance leases		**(457)**	(466)
Net financing		**69,946**	67,346
Net increase in cash and cash equivalents		**9,495**	1,394
Cash and cash equivalents at 31 March 2013		**11,142**	9,748
Cash and cash equivalents at 31 March 2014	12	**20,637**	11,142

Notes to the Accounts

1. Accounting Policies

The financial statements have been prepared in accordance with the 2013/14 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 2013, with an effective date before or from 1 April 2013. NHS bodies must follow the FreM unless there are divergences agreed by HM Treasury.

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 2013-14. The application of the Standards as revised would not have a material impact on these accounts.

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 1 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

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 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

The treatment of intangible assets, property, plant and equipment in the account is in accordance with the principal capital charges objective, to ensure that such charges are fully reflected in prices. The interest rate applied to capital charges during 2013/14 was 3.5% (2012/13 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 capital charges are not reflected in the Statement of Comprehensive Net Expenditure and NHSBT makes a cash payment in respect of capital charges to the Department of Health.

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 has a cost equal to or greater than £5,000; or
- collectively has 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 are 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. A full valuation of NHSBT land and buildings was carried out in March 2014 and the next full valuation is planned for 2018-19.

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 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.

Pension costs

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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) has been used and replaced 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 rates.

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 cases unsettled at that date and from 1 April 2002 all CNST cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with NHSBT. The value of provisions of 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 NHS Litigation Authority 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.

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

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

Following HM Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, NHS Blood and Transplant has established that as it is the corporate trustee of the linked NHS Blood and Transplant Trust Fund, it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of NHS Blood and Transplant and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' note 22.

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

For the year 1 April 2013 to 31 March 2014	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	345,086	293,499	24,479	7,486	12,502	5,370	1,750
Income from Scottish Parliament	5,320	-	-	-	-	-	5,320
Income from National Assembly for Wales	3,214	-	-	-	-	-	3,214
Income from Northern Ireland Assembly	1,830	-	-	-	-	-	1,830
Other Income	12,282	9,113	364	-	2,555	159	91
Revenue Grant In Aid	61,900	2,074	-	-	4,373	-	55,453
Total Revenue	**429,632**	**304,686**	**24,843**	**7,486**	**19,430**	**5,529**	**67,658**
Expenditure							
Variable Costs	(66,102)	(50,611)	(4,026)	(1,106)	(3,600)	(1,746)	(5,013)
Direct Costs	(218,136)	(130,657)	(12,640)	(4,825)	(9,928)	(2,036)	(58,050)
Direct Support Costs	(94,722)	(77,844)	(3,619)	(2,031)	(2,941)	(781)	(7,506)
Movement in value of stocks	(1,056)	(1,281)	-	225	-	-	-
Other Support Costs	(48,278)	(40,229)	(3,328)	(1,270)	(2,702)	(749)	-
Total Expenditure	**(428,294)**	**(300,622)**	**(23,613)**	**(9,007)**	**(19,171)**	**(5,312)**	**(70,569)**
Operating surplus for the financial period	**1,338**	**4,064**	**1,230**	**(1,521)**	**259**	**217**	**(2,911)**
Add : Notional cost of capital included in expenditure above	6,382						
Less : Downward revaluation of Brentwood site *	(5,224)						
Less : Revenue grant in aid	(61,900)						
Less : Capital charges paid to the Department of Health	(16,914)						
Net Expenditure	**(76,318)**						

***** note 9 refers to a downward revaluation of the Brentwood site arising from a management decision to relocate services during 2014/15 and dispose of the site in 2015/16. The segmental reporting note matches this fall in value against an existing balance in the revaluation reserve. The net expenditure statement treats the fall as an impairment as specified in the FReM adaptation of IAS 36.

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)**						

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

	Total	**31 March 2014 Permanently Employed Staff**	**Other**	31 March 2013 Total
	£000	**£000**	**£000**	£000
Salaries and wages	**170,276**	**155,000**	**15,276**	170,303
Social security costs	**12,185**	**11,770**	**415**	12,092
Employer contributions to NHS Pensions Agency	**20,136**	**19,449**	**687**	19,896
	202,597	**186,219**	**16,378**	202,291

The average number of employees during the year was:

	Total	**Permanently Employed Staff**	**Other**
	Number	**Number**	**Number**
Year ended 31 March 2014	**5,128**	**4,816**	**312**
Year ended 31 March 2013	5,212	4,896	316

Expenditure on staff benefits

The amount spent on staff benefits during the year is estimated at £639,000 (31 March 2013: £653,000).

Early retirements and redundancies

During 2013/14 there were 139 early retirements and/or redundancies from NHSBT. £6,009,000 has been charged to the revenue account in 2013/14 in respect of these redundancies and early retirements (31 March 2013: 30 early retirements and/or redundancies, and a charge to the revenue account of £1,493,000).
A further provision of £3,436,000 has been made for redundancy costs in relation to restructures currently in progress.
A total charge of £9,445,000 for early retirements and redundancies is included within other staff related costs in note 3.2.

3.2 Other Administrative Expenses

	Notes	**31 March 2014** **£000**	31 March 2013 £000
Other staff related costs		**23,319**	14,883
Consumable supplies		**73,950**	74,590
Maintenance of buildings, plant and equipment		**15,761**	15,757
Rent and rates		**11,791**	12,277
Transport costs		**10,738**	10,360
External contractors		**20,035**	20,412
Purchase and lease of equipment and furniture		**3,149**	4,574
Utilities and telecommunications		**7,560**	7,202
Media advertising		**2,116**	2,594
ODT Scheme Payments		**30,908**	28,574
Professional Fees *		**3,574**	4,542
Capital Charges paid over as cash to Department of Health		**16,914**	18,020
Capital Non-cash : Loss on disposal of fixed assets	7.1	**465**	361
Capital Non-cash : Impairments	7.2	**5,224**	-
Auditor's remuneration: Audit Fees **		**90**	90
Miscellaneous		**5,244**	5,425
		230,838	219,661

* Professional Fees include legal and programme management costs

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

4. Finance costs

	31 March 2014 **£000**	31 March 2013 £000
Interest expense under finance leases	**457**	466
Other finance costs - unwinding of discount	**24**	19
Total finance costs	**481**	485

5. Operating leases

NHSBT as lessee

	31 March 2014 **£000**	31 March 2013 £000
Payments recognised as an expense		
Lease and rental payments	**9,076**	9,515
Total future minimum lease payments		
Payable:		
Not later than one year	**5,803**	6,055
Later than one year and not later than five years	**8,202**	7,903
Later than five years	**61**	49
Total	**14,066**	14,007

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

Interest of £76 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 2013: £224 interest and £Nil compensation).

7. Other gains and losses

7.1 Profit / loss on disposal of non-current assets	31 March 2014	31 March 2013
	£000	£000
Loss on disposal of intangible assets	-	(12)
Loss on disposal of transport equipment	(124)	-
Loss on disposal of plant and equipment	(350)	(349)
Profit on disposal of information technology	9	-
Total	(465)	(361)

7.2 Impairments charged in the year to Net Operating Expenditure	31 March 2014	31 March 2013
	£000	£000
Impairment on land and buildings for future sale (see note 9)	5,224	-

8. Intangible non-current assets

8.1 Intangible non-current assets 2013/14

	Total	Software Purchased	Development Expenditure
	£000	£000	£000
Cost or Valuation			
At 1 April 2013	13,848	13,463	385
Additions - purchased	1,414	656	758
Disposals	(33)	(33)	-
At 31 March 2014	15,229	14,086	1,143
Amortisation			
At 1 April 2013	10,247	10,247	-
Provided during the year	852	852	-
Disposals	(33)	(33)	-
At 31 March 2014	11,066	11,066	-
Net book value at 1 April 2013	3,601	3,216	385
Net book value at 31 March 2014	4,163	3,020	1,143
Net book value at 31 March 2014 comprises:			
Purchased	4,163	3,020	1,143
Asset Financing	4,163	3,020	1,143

8.2 Intangible non-current assets 2012/13

	Total	Software Purchased	Development Expenditure
	£000	£000	£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

9. Property, plant and equipment

9.1 Property, plant and equipment 2013/14

	Total	Land	Buildings	Land and Buildings identified for future sale	Assets under constr. + poa	Plant and Machinery	Transport Equipment	Information Technology
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation:								
At 1 April 2013	260,051	23,565	157,507	-	2,629	51,356	4,476	20,518
Additions - purchased	**5,393**	**-**	**258**	**-**	**1,678**	**2,285**	**-**	**1,172**
Reclassification	**-**	**(1,046)**	**(5,291)**	**8,024**	**(1,687)**	**-**	**-**	**-**
Indexation	**1,858**	**-**	**-**	**-**	**-**	**1,731**	**127**	**-**
Other in year revaluations *	**(29,541)**	**(795)**	**(28,746)**	**-**	**-**	**-**	**-**	**-**
Impairments **	**(5,224)**	**-**	**-**	**(5,224)**	**-**	**-**	**-**	**-**
Disposals	**(12,481)**	**-**	**-**	**-**	**-**	**(5,128)**	**(2,511)**	**(4,842)**
At 31 March 2014	**220,056**	**21,724**	**123,728**	**2,800**	**2,620**	**50,244**	**2,092**	**16,848**
Depreciation:								
At 1 April 2013	97,941	22	40,954	-	-	36,578	3,278	17,109
Provided during the year	**9,282**	**11**	**4,142**	**-**	**-**	**3,763**	**314**	**1,052**
Indexation	**1,326**	**-**	**-**	**-**	**-**	**1,233**	**93**	**-**
Other in year revaluations *	**(42,629)**	**(33)**	**(42,596)**	**-**	**-**	**-**	**-**	**-**
Disposals	**(11,947)**	**-**	**-**	**-**	**-**	**(4,779)**	**(2,326)**	**(4,842)**
Accumulated depreciation at 31 March 2014	**53,973**	**-**	**2,500**	**-**	**-**	**36,795**	**1,359**	**13,319**
Net book value at 1 April 2013	162,110	23,543	116,553	-	2,629	14,778	1,198	3,409
Net book value at 31 March 2014	**166,083**	**21,724**	**121,228**	**2,800**	**2,620**	**13,449**	**733**	**3,529**
Net book value at 31 March 2014 comprises:								
Owned assets	**143,157**	**18,584**	**101,442**	**2,800**	**2,620**	**13,449**	**733**	**3,529**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	**16,736**	**-**	**16,736**	**-**	**-**	**-**	**-**	**-**
Held on Finance Lease	**6,190**	**3,140**	**3,050**	**-**	**-**	**-**	**-**	**-**
	166,083	**21,724**	**121,228**	**2,800**	**2,620**	**13,449**	**733**	**3,529**

All assets are purchased assets.

* The change in value of land and buildings primarily relates to a full quinennial revaluation of property assets undertaken during March 2014 by DVS Property Specialists. DVS Property Specialists is an Executive Office of HM Revenue & Customs which provides professional property advice to the public sector.
** The Brentwood site has been valued on a 'for sale' basis by Lambert Smith Hampton, a RICS registered valuer. Approved plans exist to dispose of this site during 2015/16. In accordance with the FReM IAS36 adaptation, the fall in value has been treated as an impairment, although a revaluation reserve in excess of the fall does exist.

9.2 Property, plant and equipment 2012/13

	Total	Land	Buildings	Land and Buildings identified for future sale	Assets under constr. + poa	Plant and Machinery	Transport Equipment	Information Technology
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation:								
At 1 April 2012	259,669	23,565	155,107	-	1,387	55,648	4,298	19,664
Additions - purchased	**8,288**	**-**	**1,276**	**-**	**2,366**	**3,584**	**-**	**1,062**
Reclassification	**-**	**-**	**1,124**	**-**	**(1,124)**	**-**	**-**	**-**
Indexation	**811**	**-**	**-**	**-**	**-**	**633**	**178**	**-**
Disposals	**(8,717)**	**-**	**-**	**-**	**-**	**(8,509)**	**-**	**(208)**
At 31 March 2013	**260,051**	**23,565**	**157,507**	**-**	**2,629**	**51,356**	**4,476**	**20,518**
Depreciation:								
At 1 April 2012	**95,898**	11	36,948	-	-	40,162	2,750	16,027
Provided during the year	**9,840**	**11**	**4,006**	**-**	**-**	**4,119**	**414**	**1,290**
Indexation	**571**	**-**	**-**	**-**	**-**	**457**	**114**	**-**
Disposals	**(8,368)**	**-**	**-**	**-**	**-**	**(8,160)**	**-**	**(208)**
Accumulated depreciation at 31 March 2013	**97,941**	**22**	**40,954**	**-**	**-**	**36,578**	**3,278**	**17,109**
Net book value at 1 April 2012	163,771	23,554	118,159	-	1,387	15,486	1,548	3,637
Net book value at 31 March 2013	**162,110**	**23,543**	**116,553**	**-**	**2,629**	**14,778**	**1,198**	**3,409**
Net book value at 31 March 2013 comprises:								
Owned assets	**139,463**	**21,310**	**96,139**	**-**	**2,629**	**14,778**	**1,198**	**3,409**
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**	**14,778**	**1,198**	**3,409**

All assets are purchased assets.

10. Inventories

	31 March 2014	31 March 2013
	£000	£000
Raw materials and consumables	**4,630**	6,362
Work in progress	**2,326**	2,490
Finished processed goods	**11,904**	12,795
	18,860	21,647

11. Trade and other receivables

	31 March 2014	31 March 2013
	£000	£000
Current		
NHS Receivables - Revenue	**11,619**	9,999
Non NHS Trade Receivables - Revenue	**2,580**	2,490
Provision for impairment of Receivables	**(21)**	(12)
Other Debtors	**133**	162
VAT	**2,518**	2,286
Prepayments and accrued income	**6,547**	6,353
Subtotal	**23,376**	21,278
Non Current		
Other prepayments and accrued income	**1,244**	471
Subtotal	**1,244**	471
Total trade and other receivables	**24,620**	21,749

Provision for irrecoverable debts

	2013-2014	2012-2013
Amounts falling due within one year	£000	£000
Non - NHS trade receivables		
At 1 April	**12**	11
Provided in year	**14**	5
Written off during year	**(5)**	(2)
Recovered during year	**-**	(2)
At 31 March	**21**	12
Aging of debts provided against		
Upto 12 months	**11**	5
Over 12 months	**10**	7
	21	12
Receivables past due but not impaired		
Upto 3 months	**7,280**	5,427
Between 4 and 12 months	**887**	496
Over 12 months	**16**	10
	8,183	5,933

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

	2013-2014	2012-2013
	£000	£000
Balance at 1 April	**11,142**	9,748
Net change in the year	**9,495**	1,394
Balance at 31 March	**20,637**	11,142
Comprising:		
Held with Government Banking Services accounts	**20,635**	11,140
Cash in hand	**2**	2
Cash and cash equivalents as in Statement of cash flows	**20,637**	11,142

13. Trade and other payables

	31 March 2014	31 March 2013
	£000	£000
Current		
NHS Payables - revenue	**4,131**	3,798
Non-NHS trade Payables - revenue	**1,288**	569
Non-NHS trade Payables - capital	**-**	1,553
Tax and Social Security Costs	**4**	13
Accruals and deferred income	**16,504**	13,327
Total trade and other payables	**21,927**	19,260

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 2013	**Product Liability**	**Employee Benefits**	**Redundancy**	**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**

At 31 March 2014	**Product Liability**	**Employee Benefits**	**Redundancy**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Balance at 1 April 2013	60	1,116	-	576	1,752
Provisions - Arising in the year	**-**	**226**	**3,436**	**556**	**4,218**
Utilised during the year	**-**	**(85)**	**-**	**(301)**	**(386)**
Reversed unused	**(10)**	**-**	**-**	**(104)**	**(114)**
Unwinding of discount	**-**	**24**	**-**	**-**	**24**
Balance at 31 March 2014	**50**	**1,281**	**-**	**727**	**5,494**
Expected timing of cash flows:					
Within 1 year	**50**	**62**	**3,436**	**727**	**4,275**
Between 1 year and 5 years	**-**	**260**	**-**	**-**	**260**
Thereafter	**-**	**959**	**-**	**-**	**959**

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.

Redundancy provisions relate to costs expected to arise from restructure programmes that have been approved by the NHSBT Board and which have completed staff side consultation.

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.

£3,599,000 (31 March 2013: £4,111,000) is included in the provisions of the NHS Litigation Authority at 31 March 2014 in respect of clinical negligence liabilities. There is a £156,000 provision in respect of the existing liabilities scheme (31 March 2013: £Nil).

16. Finance leases

Finance lease obligations (ie as lessee)

	Minimum lease payments	
	31 March 2014	31 March 2013
	£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	**10,255**	10,809
	13,025	13,579
Less future finance charges	**(8,405)**	(8,862)
Present value of future lease obligations	**4,620**	4,717

	Present value of minimum lease payments	
	31 March 2014	31 March 2013
	£000	£000
Not later than one year	**108**	97
Later than one year and not later than five years	**568**	510
Later than five years	**3,944**	4,110
Present value of future lease obligations	**4,620**	4,717
Analysed as :		
Current borrowings	**108**	97
Non-current borrowings	**4,512**	4,620
	4,620	4,717

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 2014	31 March 2013
	£000	£000
Increase/(decrease) in receivables within 1 year	**2,098**	(3,418)
Increase in receivables after 1 year	**773**	326
Increase/(decrease) in inventories	**(2,787)**	2,369
(Increase)/decrease in payables within 1 year	**(2,667)**	656
Subtotal	**(2,583)**	(67)
Less Movement in payables relating to items not passing through the Statement of Comprehensive Net Expenditure	**1,553**	(1,241)
Subtotal	**1,553**	(1,241)
Total	**(4,136)**	1,174

17.2 Analysis of changes in net debt

	As at 1 April 2013	**Cash flows**	**As at 31 March 2014**
	£000	**£000**	**£000**
Government Banking Services cash at bank	11,140	9,495	**20,635**
Commercial cash at bank and in hand	2	-	**2**
Total	11,142	9,495	**20,637**

17.3 Other cashflow adjustments

	31 March 2014	31 March 2013
	£000	£000
Depreciation	**9,282**	9,840
Amortisation	**852**	857
Impairments	**5,224**	-
Loss on disposal	**465**	361
Provisions - Arising in Year	**4,218**	952
Provisions - Reversed unused	**(114)**	(75)
Total	**19,927**	11,935

18. Movements on reserves

18.1 General Fund

	2013-2014	2012-2013
	£000	£000
Balance at 1 April	**153,891**	153,019
Net operating expenditure for the financial period	**(76,318)**	(69,224)
Revenue Grant in Aid	**61,900**	60,400
Capital Grant in Aid	**8,600**	7,500
Transfer from Revaluation reserve: realised elements of the revaluation reserve (see 18.2 below)	**7,247**	2,196
Balance at 31 March	**155,320**	153,891

18.2 Revaluation Reserve

	2013-2014	2012-2013
	£000	£000
Balance at 1 April	**40,629**	42,585
Indexation of fixed assets	**532**	240
Revaluation of fixed assets	**13,088**	-
Transfer to General Fund: realised revaluation (see 18.1 above)	**(7,247)**	(2,196)
Balance at 31 March	**47,002**	40,629

19. Contingent Liabilities at 31 March 2014

A contingent liability of £137,000 (31 March 2013: £82,000) 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 2013: £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 2014

At 31 March 2014 the value of contracted capital commitments was £2,591,000 (31 March 2013 : £362,000).

21 Losses and special payments

21.1 Losses Statement

	31 March 2014		31 March 2013	
	No. Cases	£000	No. Cases	£000
Cash Losses	-	-	1	-
Book keeping Losses	3	-	5	-
Losses of pay, allowances and superannuation benefits	12	12	19	7
Losses of Accountable Stores	154	100	141	202
Fruitless Payments	1	7	4	462
Claims waived or abandoned	4	1	8	-
	174	120	178	671

21.2 Special Payments

	31 March 2014		31 March 2013	
	No. Cases	£000	No. Cases	£000
Special Severance Payments	2	4	2	14
Compensation Payments	137	386	150	580
Ex Gratia Payments	9	1	25	2
	148	391	177	596

There were no individual payments that exceeded £300,000 (Period ended 31 March 2013 : no payments over £300,000).

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 £404 million of income (31 March 2013: £401 million), including capital funding and grant in aid, and £55 million of expenditure (31 March 2013: £54 million), which represented trading with 259 separate organisations.

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

Name, Title, and Registered Interest (*)		Income (£000s)	Expenditure (£000s)
Mr R Griffins (NED)	: London Ambulance Service, NED	-	-
Mr J Monroe (NED)	: NW London Commissioning Support Unit, Advsisory Committee member	-	-
Mr K Rigg (NED)	: Nottingham University Hospital NHS Trust, Consultant Surgeon	5,170	327
Mr K Rigg (NED)	: Human Tissue Authority, Board Member	67	101
Mr K Rigg (NED)	: NHS England, Chair of Renal Transplant Clinical Reference Group	1,305	-

* NED - Non-Executive Director

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 IAS 27 the NHS Blood and Transplant Trust Fund is regarded as a related party. Income received from the Trust Fund during the year totalled £89,000 (31 March 2013 : £23,000), and there was a debtor balnce due by the Trust Fund of £6,000 (31 March 2013 : £12,000)

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 customers external to the National Health Service 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	2,892	-	693
Balances with local authorities	-	-	5
Balances with NHS Trusts and organisations	11,619	-	4,134
Total Intra-Government Balances	14,511	-	4,832
Balances with bodies external to government	8,865	1,244	17,095
At 31 March 2014	23,376	1,244	21,927
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

ISBN 978-1-4741-0707-5