NHS
Blood and Transplant

NHS Blood and Transplant
Annual Report and Accounts 2011/12

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

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

Ordered by the House of Commons to be printed 5 July 2012

HC 285

SG/2012/105 **£14.75**

NHS
Blood and Transplant

NHS Blood and Transplant
Annual Report and Accounts 2011/12

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

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

Ordered by the House of Commons to be printed 5 July 2012

HC 285

SG/2012/105 **LONDON: The Stationery Office** **£14.75**

Any enquiries regarding this publication should be sent to us at Finance Director, NHS Blood and Transplant, Oak House, Reeds Crescent, Watford, Hertfordshire, WD24 4QN.

This publication is available for download at www.official-documents.gov.uk.
This document is also available from our website at http://www.nhsbt.nhs.uk.

ISBN: 9780102979770

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID: 2499338 07/12

Printed on paper containing 75% recycled fibre content minimum.

Contents

ANNUAL REPORT

The accounts for the year ending 31 March 2012 have been prepared as directed by the Secretary of State for Health in accordance with section 232 (Schedule 15, Paragraph 3) of the National Health Service Act 2006, and in a format as instructed by the Department of Health with the approval of Treasury.

The Nature and Purpose of NHSBT

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

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

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

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

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

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

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

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

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

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

Strategic Objectives

Our strategic plan for 2012-17 is focused on:

- continuing to modernise our blood donation service so that we continue to attract enough donors to meet the needs of NHS patients

- improving our interfaces with NHS hospitals so that we understand their needs and provide services that are as accessible and effective as possible. As part of this we plan to integrate the management of hospital blood bank stocks and use this to facilitate better planning of the end-to-end blood supply chain from donor through to patient

- delivering the 50% growth in deceased organ donation by 2013 (against a 2007-08 baseline) that was targeted by the Organ Donation Task Force whilst bringing stakeholders together to identify the strategy and aspirations for organ donation and transplant in the UK beyond 2013

- building on our unique skills and capabilities in tissues, stem cells, diagnostic services and apheresis based therapies to support the provision of life changing treatments to NHS patients.

In early 2008 we generated a three-year Strategic Plan which established a series of very challenging objectives and reflected the ambition, and far reaching implications, of both the first Organ Donation Taskforce (ODTF) report and the National Blood Service Strategy Review. The programme of initiatives and projects generated by the 2008 plan is mostly complete, subject to meeting the 50% growth in organ donation by 2013 referred to above. This plan included a strong focus on consolidation and cost reduction in the blood supply chain and resulted in a reduction of the price of red cells from £140/unit in 2007/8 to £125/unit in 2011/12, effectively securing £30m savings per annum to the NHS, in real terms, and including the absorption of investment in new safety measures.

The new plan is very different in that it requires we take a longer term view, introduce more effective planning processes and provide more modern interfaces with both our donors and the hospitals we serve. This represents a significant investment in 'change' in both systems and processes and the development of our leadership skills. A summary of the strategic objectives for each operating unit (segment) is described overleaf.

Blood Components: *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 the safe and dependable supply of blood components to NHS hospitals, as well as providing a safe and high quality service to our donors without whom our service would not exist.

We will continue to develop and improve the quality of service to donors and the experience they undergo when donating whole blood or platelets. We will continuously review donor satisfaction and monitor changes in the profile, values and expectations of our donor base to ensure that we can anticipate their needs and respond accordingly.

We intend to further strengthen the interfaces with our customers, NHS hospitals, to ensure we continue to deliver our life saving products on time and in full without fail. We will develop modern, technology based processes that make NHSBT easy to do business with and ensure that we are seen as a supplier of choice, rather than necessity.

In conjunction with this, we will continue to modernise processes and systems throughout each stage of the blood supply chain, from the collection of blood to the processing, testing, issue and delivery of blood components to hospitals. We will work with hospitals to improve the service to patients and realise benefits from the end-to-end supply chain, from donor to patient.

We build on our strong collaboration with international blood services. In particular we will continue to benchmark our performance against our international partners and will use this to identify opportunities for improvement within NHSBT.

Organ Donation and Transplantation: *To increase deceased organ donation by 60% in 2016-2017 and sustain and improve thereafter. To work toward self sufficiency in donation and transplantation across the UK, taking into account the changing donor pool. To change public behaviour with regard to organ donation, especially amongst Black and Minority Ethnic (BME) communities.*

We are committed to continuing the development of NHSBT as the UK wide Organ Donation Organisation envisaged by the report of the first Organ Donation Taskforce (ODTF).

We will deliver the recommendations of the task force that relate specifically to NHSBT and aim to achieve the aspiration for a 50% increase in organ donation in the UK by 2012-13 (versus a 2007-08 baseline). We will build on the infrastructure that has now been put in place and will work with our partners to increase the number of transplants through optimising each stage of the clinical process from (potential) donation through to transplantation.

We will continue to work with the public to inform them about, and influence their perceptions, of organ donation. We will seek approval and funding for appropriate marketing campaigns that will facilitate this and ultimately lead to increased numbers of registrants on the Organ Donation Register (ODR). We will particularly seek to work with BME communities where there is a proportionately lower probability of receiving a matching organ than in the general population.

During 2012-13 we will work with all of our stakeholders to generate the next strategy for organ donation and transplantation beyond 2013.

As part of this we will work closely with all of the UK Health Services to support specific objectives and intentions of their national governments with regards to organ donation. Specifically we will work with the Welsh Government whose legislative programme includes the development of an Organ Donation (Wales) Bill to provide an opt out system for organ donation.

Tissues: *To develop an "NHS Tissues" organisation, for the overall benefit of the NHS, that builds on the capability and capacity of the Speke tissue bank, and which is capable of meeting the present and future needs of NHS patients.*

We aim to leverage the capability of the Speke tissue bank and its highly capable and skilled team. We will grow our revenue and generate a positive financial contribution, through increasing the visibility and recognition of our capabilities by NHS clinicians, and supporting these with high quality sales and marketing plans.

We will develop an appropriate and sustainable new product pipeline, deploying effective evaluation tools, and supporting agreed investments with professional launch and marketing plans.

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

We will continue to develop a portfolio of clinically relevant and financially viable diagnostic services sourced from our unique national network of accredited laboratories and their highly trained staff.

We will provide services where these are consistent with the capabilities and objectives of NHSBT in supplying blood components, organs, tissues and stem cells.

We will look to provide such services where NHSBT is best placed to meet the needs of NHS hospitals and provide them with value for money.

Stem Cells: *To work partners across the UK in the provision of an efficient and effective source of donor haemopoietic stem cells for the treatment of UK patients and provide translational services in support of the development of innovative cell therapies for NHS patients.*

We will continue to work with third sector partners and with the other UK Health Departments to deliver the recommendations of the UK Stem Cell Strategic Forum that are aimed at improving the availability and outcome of stem cell transplants. In particular NHSBT is committed to growing the NHS Cord Blood Bank to 20,000 units of donated cords by 2012-13 and maximising the donation of cords from BME communities and the proportion of rare blood types.

NHSBT intends to become a prime partner for the NHS, academic and commercial organisations seeking to take established cell therapies and next generation cellular and molecular therapies to the clinic by exploiting our strengths in the provision of donor stem cells, expertise in specialist manufacturing, scientific skills, translational experience, regulatory expertise and distribution.

Within our strategic plan we further identify a **"corporate"** strategy in support of our operating units which is: *To be the advocate for the voluntary donation of blood, organs and tissues; to champion a culture of sustainability across all of our activities; to develop*

opportunities for effective collaboration across our Operating Divisions and support them with an effective programme of research and development and an efficient operating infrastructure.

This reflects that NHSBT is one of the largest and most complex organisations of its type in the world requiring strong leadership, with a broad range of skills, and with operations that are supported by an effective programme of research and development and efficient functional services.

In addition, consistent with an organisation whose mission is to 'save and improve lives' we are committed to sustainable development and carbon reduction. We therefore aim to minimise wherever possible the impact of our operations on our environment for the benefit of our donors, the patients we serve and our staff, along with the generations to follow. 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'. Being a low carbon organisation is part of our commitment to meeting their expectations. We will therefore apply sustainable principles to all that we do and will, as a minimum, meet all government and statutory targets for carbon reduction. Our carbon management plan commits us to reducing carbon emissions by 25% over the five years starting in 2009-10.

Management Commentary

Key Performance Headlines 2011/12

NHSBT is pleased to report that 2011/12 has been another successful year. Considering each of our operational areas in turn:

Blood Components

The performance in blood collection and management of stocks has continued to be robust. In preparation for the expected winter pressures, NHSBT was able to successfully increase its stock holding of red cells (from a norm of ca. 45,000 units) to over 50,000 units from late July to early September 2011. Stocks were then managed down to ca. 40,000 units by the end of December 2011 and were maintained within a 40,000 – 50,000 range for the remainder of the year. One of our key performance indicators is the number of times within the year that any blood group falls below the three day alert level for a consecutive period of three days or more. We are pleased to note that during 2011/12 there were no such instances.

One of our strategic targets has been to maintain the proportion of platelets issued to hospitals via component donation (apheresis) at 80%. The level of product issued from component donation production was above the target throughout the year, and finished the year at 87% in March 2012, our highest ever level of production. This was particularly satisfying given the level of underlying growth in platelet demand of 8% pa, making the 80% a continually moving target. We anticipate being able to continue delivering the 80% target during 2012/13, despite our assumption that platelet demand will increase again by ca 4-5%.

NHSBT has been able to reduce the price of red cells to NHS hospitals from £140/unit in 2008/09 to £125/unit in 2011/12. Key to achieving our cost improvement plans has been the work to optimise processes in Blood Donation and the removal of excess capacity in the blood supply chain. The removal of capacity has resulted in a reduction from 12 manufacturing and 11 testing sites in 2008 to 5 and 3 respectively this year. As a result,

manufacturing productivity has risen by 69% and testing productivity by 65% since 2008/09, with productivity in both areas above target and in the top quartile of countries in the European Blood Alliance benchmarking programme.

During the course of this process, we have continued to monitor and manage the satisfaction levels of both our blood donors and our customers (NHS hospitals). Donor satisfaction, measured as the percentage of donors scoring 9 out of 10 or higher for overall service, was at 69% (versus plan of 67% and 66% in the previous year), having achieved our highest ever score of 71% in March 2012. Importantly, the level of donor complaints has continued to remain better than target with a return of 3,818 per million donations, versus a target of 4,000. This reflects a strong focus on managing the service provided to donors and promptly responding to complaints when made. Customer satisfaction measured as the percentage of customers scoring 9 out of 10 or higher for overall service, was at 59% and better than the target of 58% although a little lower than the 59.8% recorded last year.

In relation to blood safety there has been 1 confirmed case of Transfusion Related Acute Lung Injury (TRALI) in 2011/12. This is an improvement on the 3 recorded in 2010/11 and also the 10 cases recorded in 2009/10. A key enabler for minimising the incidence of TRALI is to issue plasma products that are produced from male only donors, which has been at 100% since September 2010. There have been no incidences of Transfusion Transmitted Infection (TTI) from bacterial contamination, which is consistent with last year and continues to be an improvement on the two recorded cases in 2009/10.

We have also continued to focus extensively on ensuring the highest standards of regulatory performance within our manufacturing and laboratory based activities. As a result of this we are pleased to note that during 2011/12 we have had only one instance of a "major" non compliance with regulation as reported by the MHRA. This compares to 3 "critical" findings and 10 "majors" in 2007/8 and 5 "major" findings last year. This reflects successful implementation of a "no criticals" policy and our work towards a "no majors" target from 2012/13 onward.

Organ Donation and Transplantation

There are currently 18.7 million people registered on the Organ Donor Register (c31% of the UK population), with just under 1 million names added in the last year.

Excellent progress has been made over the last four years with deceased organ donation increasing to 34.4% above the 2007/08 baseline, representing a total of 1,087 donors and in line with our target and the expectations of the Organ Donation Task Force (ODTF) report of 2008. The number of deceased organ donors in a rolling 12 month period exceeded 1,000 for the first time ever in November 2010, and has remained consistently above this total to the end of 2011/12.

In addition, live organ donation levels were close to the target of 1,050 (and higher than the 1,023 seen in 2010/11).

The total number of organ transplants carried out in the period April 2011 to March 2012 was 3,953, an improvement on the 3,725 transplants recorded in 2010/11 and representing an increase of 22.2% above the 2007/08 baseline.

During 2011/12, the implementation of the ODTF recommendations for which NHSBT is responsible has continued, and has resulted in:

- All Clinical Leads for Organ Donation appointed, with good progress made toward establishing an Organ Donation Committee within all UK hospitals/boards.

- In excess of 97% of all Specialist Nurse - Organ Donation Teams operational across the UK.
- Continued high level performance of the National Organ Retrieval Service.

Work has also continued throughout the year to implement the recommendations put forward following the Review of the Organ Donation Register by Professor Sir Gordon Duff (October 2011). Almost all of the changes have now been completed and we have further invited external experts and a private sector operator of large consumer databases to review our operations. The Duff Report envisaged that, subject to funding availability, investment in a new ODR should be considered. The further reviews that have been undertaken have confirmed that such an investment would not be worthwhile and hence we are implementing a series of tactical changes to improve its operation. In this regard we also continue to work with the Welsh, Scottish and Northern Irish Health Services and are reviewing, in particular, the options for managing a system of presumed consent in organ donation that is under consideration within Wales

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

Specialist Services

Activity in Specialist Services has been focused on continuing to improve the financial viability of individual service lines and developing our strategies, especially within Tissues and Stem Cells.

NHSBT operates a dedicated tissues processing facility at Speke that has been historically under utilised. We therefore introduced product management skills from the private sector in order to develop our commercial management capability, introduced new sales and marketing strategies and implemented better processes for managing the introduction of new products and technologies. As a result, we are now much better placed to meet the demands of NHS hospitals and their patients, and are now seeing an improvement in our income levels.

In response to the acceleration of activity within Pathology Modernisation we have committed to developing an Integrated Transfusion Service approach, which will allow closer working with our customers and improvement of our offering to hospitals. NHSBT has been in discussion with both our customers and also the private sector suppliers who are providing, or planning to provide, pathology services. NHSBT's activities are directly related to supporting blood transfusion and organs, tissues and stem cells transplantation. Our services are highly specialised and often relate to patients with an urgent clinical need. NHSBT is therefore working with hospitals and other stakeholders to identify where we can deploy out unique capabilities whilst supporting the drive for more effective processes.

Customer satisfaction (measured as the percentage of customers scoring 9 out of 10 or higher for overall service) was significantly better than target (55%) for our Red Cell Reference services (67%), which is particularly pleasing given the response to the level of consolidation we received from our customers during 2010/11. The score for Histocompatability and Immunogenetics services were just below target (54.5%) and work will continue through the next year improve on this performance.

In January 2010 the Minister of State for Public Health asked NHSBT to lead a forum that would address the future of unrelated donor stem cell transplantation in the UK. A report was published in July 2010 with the underlying objective of saving 200 lives each year through increasing the UK inventory of cord blood donations and improving the performance of UK based stem cell registries, such as the British Bone Marrow Registry (BBMR). The report was very well received and NHSBT is now working with the UK Health Services and the Anthony Nolan (a charity) to implement its recommendations. Collections of cords in total, and also from Black and Minority Ethnic (BME) communities in particular, were higher than target. Nearly 2,000 cords were banked during the year of which just under 50% were from BME communities.

NHSBT Corporate

Within "NHSBT Corporate" we generate the strategies that are most appropriately driven at this level, rather than within the operating units. This include plans to improve the organisational capacity and capability of NHSBT, plans to drive sustainable practices across our operating units and plans that are focused on improving the efficiency and effectiveness of our group services (Estates, Medical, Finance, Human Resources and Information Technology).

During 2011/12 we continued our programmes designed to support development of our managers and improve our overall leadership capability. The key element of this is our SHINE talent and leadership development programme. This encompasses all the ways NHSBT is supporting their staff to shine as tomorrow's leaders. The central elements of Shine are four key programmes that support individuals and are based on competencies identified in the NHSBT Leadership Qualities Framework. In order to assist NHSBT staff become better leaders, a Shine toolkit has also been created to help acquire new knowledge and skills and gather information from different sources to help busy managers and staff in their own development and that of their staff.

During 2011/12 we have continued to implement our Carbon Management Plan that was generated in partnership with the Carbon Trust. On 1st April 2010, the government's CRC Energy Efficiency (Carbon Reduction Commitment) legislation came into effect and in the recently published CRC Performance League table, which ranks the relative performance of CRC Energy Efficiency Scheme participants, ranked NHSBT within the top-quartile of 2,103 participants. Performance is being measured against NHSBT's carbon emissions baseline and we have met this year's target of an 11% reduction from the 2009/10 baseline. Plans will continue to be developed to support the achievement of a targeted reduction of 25% carbon emissions over the 5 year period to 2014/15.

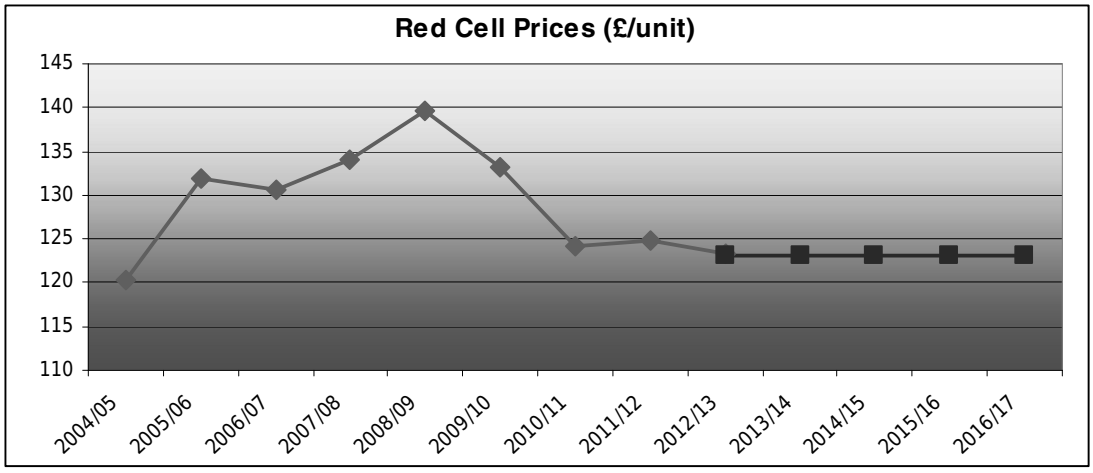
Approved or Planned Future Developments

The NHSBT Strategic Plan is reviewed and updated on an annual basis, as part of our integrated planning, performance, risk management and assurance framework, and was approved by the DH and the NHSBT Board in March 2012. The plan sets out our strategic objectives, themes and targets and the key initiatives that support their delivery. These are described in the section on strategic objectives above.

In updating the plan we have responded to the current economic situation, the state of public finances and the likely constraints that our customers will be required to work within over the next few years. As such it reflects the outcomes of the Government white paper "Equity and Excellence – liberating the NHS" published in July 2010 and the subsequent review of Arm's

Length Bodies (ALBs) issued shortly thereafter. The outcomes from Commercial Review of NHSBT have now been published and we are working closely with the DH and our stakeholders to implement its recommendations. Our payroll services have been transferred to NHS Shared Business Services as of 1 April 2012 and we will continue to work with DH on further opportunities in shared services.

The plan captures our intent to identify and develop opportunities and initiatives that will drive out further efficiencies. This is reflected in our target to hold the significantly reduced prices of red cells that our recent activities have generated. This would see a further reduction of prices to £123/unit in 2012/13 and a target to hold this level over the next four years. The result of this would be that in 2013/14 the price of red cells would be lower in absolute terms than they were in 2005/06, almost 10 years earlier.



The key activities for 2012/13 that are captured in our Strategic Plan include the following:

Blood Components

- Responding to the increasing demands from customers for supporting improvements to stock management and the local consolidation of transfusion services.
- Introducing further projects to develop lean thinking across the supply chain, also applying this to Blood Donation and Group Services as appropriate.
- Further optimisation of the process models in blood donation and continued improvements in productivity and efficiency.
- Undertake research to generate evidence in support of reducing the intervals between donation, determining whether these can be tailored to donors.
- Develop strategies to support the long-term ability to maintain the future of provision of platelets by Component Donation at or above 80%.
- Taking advantage of web based technology to communicate with donors in a way which recognises their needs, and in doing so pursues strategies designed to secure long-term loyalty.
- Extend our ambitions on quality by pursuing a culture of zero major non-compliance from our external regulators.
- Development of an integrated demand and supply planning process across the supply-chain.
- Ongoing review of the configuration of the supply chain and optimisation of our manufacturing, laboratory and office estates footprint.

- New logistical processes in support of the movement of people, equipment and consumables to session in order to minimise wastage and reduce infrastructure costs.
- Optimisation of logistics costs through the introduction of modern tools and technology and better planning of movements.
- Move from our legacy billing processes to design and introduce a modern order to payment process with hospitals.
- Continued focus on procurement savings in manufacturing consumables through partnership with UK and European blood services, while also leveraging procurement savings through further engagement with new public sector processes and frameworks.

Organ Donation and Transplantation (ODT)

- Delivering a 50% increase in deceased organ donors.
- Deriving the benefits from the deployment and ongoing development of the 12 Regional Organ Donation Services Teams and the Clinical Leads for Organ Donation attached to each hospital or trust board across the UK.
- Sustaining regional collaboratives, bringing together clinicians from all parts of the donation and transplantation pathway, with identifiable, accountable Regional Clinical Leads in each Region and supporting this with performance data.
- Continued development and optimisation of the commissioning of organ retrieval and supporting processes.
- Developing strategies and processes aimed at increasing the representation of BME communities within the ODR and the donation process.
- Implementation of a research and development programme and working with hospital partners to assess novel methods for improving the quality and number of organs available for transplant.
- Optimising transplant activity from living donors in order to enable further expansion in live donation.

Diagnostic Services

- Greater engagement with customers in order to better understand the changing landscape in pathology services and the appropriate positioning of NHSBT. In particular, to develop plans that can meet the demands of our customers for NHSBT to provide transfusion services and facilitate local consolidation of transfusion laboratories.
- A review of existing IT applications for diagnostic services to better support the integration of end to end processes between hospitals and NHSBT including the introduction of electronic reporting of pathology results.

Stem Cell Services

- Working with the UK Health Services and third sector partners to develop the provision of a UK Stem Cell Registry, a UK Cord Blood Bank of 35,000 units and a database of patient outcomes.
- Increasing the level of contact with donors.
- Further increasing efforts to improve the representation of BME communities in registries and cord banks.
- Developing educational tools and platforms.
- Implementing standardised commissioning frameworks.

- Consolidating resources and expertise for cord blood transplantation into regional centres of excellence with minimum levels of activity.
- Implementing standardised data collection and outcome monitoring.
- Prospective use of high resolution typing and in respect of new cord blood units and selected existing units.
- Implementing predictive search technologies to increase the chance of matching across international registries.

Tissues

- Adopting an education lead approach to marketing and sales with development of high quality supporting materials and resources and presence at national conferences and exhibitions.
- Development of a product development road map with biological products as a theme (natural tissue, enhanced by biological processing and potentially combined with therapeutic additions).
- Introduction of professional new product evaluation tools leading to high quality, targeted launch plans.
- Continued focus on development of our manufacturing capability at Speke and potentially offering processing services, in the creation of new therapeutic products, to new business start ups.

NHSBT Corporate

- Maintaining our focus on leadership development and our capacity and capability for managing change.
- Pursuing a programme of effective stakeholder engagement that supports delivery of our corporate strategy and ensures our purpose, opportunities and achievements are clearly understood.
- Development of an overall IT applications strategy in support of the objectives and plans of the individual operating divisions, utilising common standards and fit for purpose platforms.
- Optimisation of our Estate through an ongoing process of options generation and appraisal, supported by extensive analysis of costs and benefits.
- Continue to work with the DH in support of the Back-Office agenda.
- Developing opportunities for further improvement to supporting group systems and processes based on reducing transactional activity and increasing automation. As part of this working with the DH to identify opportunities to introduce shared service models in the delivery of back office processes.
- Rolling out our Carbon Management Plan and delivering the 25% reduction in carbon emissions over 5 years that is being targeted.

Progress in delivery of this Plan will be regularly monitored through our performance management framework, which focuses on key performance measures and targets related to our strategic outcomes. These metrics, along with other “health monitoring” KPIs, and regular milestone reporting, will form the basis against which our progress during 2012/13 will be measured.

Financial Review

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

In accordance with this guidance NHSBT reports on a net expenditure basis with grant-in-aid received from the Department of Health recognised in the general reserve. In 2011/12 an initial allocation of £64.1 million revenue grant-in-aid was made of which £57.3 million was allocated to Organ Donation. During the year £3 million of this grant-in-aid was returned to the Department of Health (DH) due to Government spending restraints around marketing activities, and specifically, non approval of our plans for organ donation campaigning. The net amount of £61.1 million revenue grant-in-aid is shown in note 2 of the annual accounts. In addition NHSBT received £7m from the devolved health administrations as their contribution towards the costs of our UK wide activity in organ donation and transplantation.

For 2011/12 NHSBT was allocated capital funding of £7.5 million but returned £1m of this to leave a net spend of £6.5m for the year. 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.

NHSBT receives the majority of its income from the recovery of costs through the pricing of blood components and services to NHS Hospitals. These are set annually via a national commissioning process and are based on volume assumptions for the products and services provided in the year ahead. During the year £13.4 million of this income was refunded to NHS Hospitals, mostly reflecting the over recovery of fixed costs arising from volumes being higher than planned.

Although NHSBT is required by the Department of Health to report on a net expenditure basis, the Board and management of NHSBT review NHSBT's financial performance on an income/expenditure basis, as this is more appropriate to the nature of NHSBT's activities. On this basis NHSBT generated an operating surplus of £4.3 million in 2011/12. The surplus was primarily generated as a result of underspending due to Government spending restrictions, together with expenditure on planned developments which has been deferred into 2012/13.

Note 2 of the accounts reconciles the operating surplus described above to the net expenditure basis on which these accounts are prepared. The note further provides a segmental analysis of our financial performance. The segmental analysis is consistent with our strategic operating units and the management accounting results that are presented to the Board. This analysis identifies an operating deficit of £6.8m made by our Specialist Services, including a stock value adjustment of £1.6m that was made at year end in Tissues. Excluding this stock value adjustment the underlying deficit of £5.2m was £2.4m better than plan as a result of higher income in a number of areas. The reported deficit was higher than the £2.8m that was reported in 2010/11 as a result of the planned exit from the provision of ante natal screening services (income of £4.8m in 2010/11), the impact of which was mostly seen during this year. After taking account of the impact of ante natal screening services the deficit in 2011/12 is in line with our target to remove the deficit by end 2013/14. This represents significant progress given the deficit of approximately £22m that existed in 2007/08, prior to when the deficit reduction plan was put in place.

As shown on the Statement of Financial Position and note 9.1 to the accounts, non current assets have fallen from £171.3 million (2010/11) to £168.0 million (2011/12). Following the impairment of property assets at the end of March 2011 the carrying values of property assets have not been indexed during 2011/12. The working capital position is considered robust with a ratio of total current assets to total current liabilities of 2.6:1 Current assets have increased from £48.4 million (2010/11) to £53.7 million (2011/12) despite a fall in the value of stock of £2.4 million which is mainly attributed to a review of the attribution of costs

to the various stages of production to bring tissue stocks into a saleable condition. Overall there is an increase in total assets employed of £0.8 million.

Principles of Remedy

NHSBT is committed to providing quality responses to our customers' queries and concerns in line with 'Listening, Responding Improving', the Department of Health guidelines and supporting the Ombudsman's 'Principles of Remedy'. We actively seek feedback from our customers: hospitals and blood, tissue and organ donors, 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 and our contact details are provided through leaflets and on our websites.

During 2011/12, we received 1012 contacts from hospital customers of which 123 (12%) were compliments, with feedback from 16,700 blood donors, (44% complainant and 11% complimentary). 95% of hospital complaints were acknowledged by the Customer Service managers within 5 days of receipt, with 99% of blood donor complaints and 86% of organ donor complaints acknowledged in 3 days. We continue to focus on improving the overall timeliness of our responses (91% of 76 final complaint responses were completed within 20 days for organ donors, with 97% for blood donors/ members of the public and over 95% for hospitals).

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. Work to develop a more detailed understanding of errors and incidents continues, so that we can improve our learning from these experiences. We are pursuing direct contact to resolve complaints and 61% of blood donor complaint issues were responded to by telephone during 2011/12. Outcomes with potential solutions were noted for 92% of resolved blood donor complaints.

Complaints are used in conjunction with hospital 'Trust Visit' reports to highlight areas for improvement. Each individual Trust was visited by a team of NHSBT staff, led by the Customer Service manager. On the basis of this feedback, staff in Red Cell Immunohaematology have been provided with training in customer service skills through the "Moments of Truth" Workshops. The online blood ordering system has been rolled out to more than 90% of hospitals and feedback is extremely positive. Electronic Reporting for Specialist Services was also highly requested from hospital staff during visits, and a project is well underway to deliver this by the summer.

Appointment slot availability has overtaken time taken as the top concern for blood donors and we continue our efforts to make more appointment slots available for donors and to increase our flexibility to accommodate donors who wish to 'drop in'. Our efforts to improve the blood donor experience and queue management have contributed to increased overall donor satisfaction, with an improvement in the score for needle insertion and waiting times.

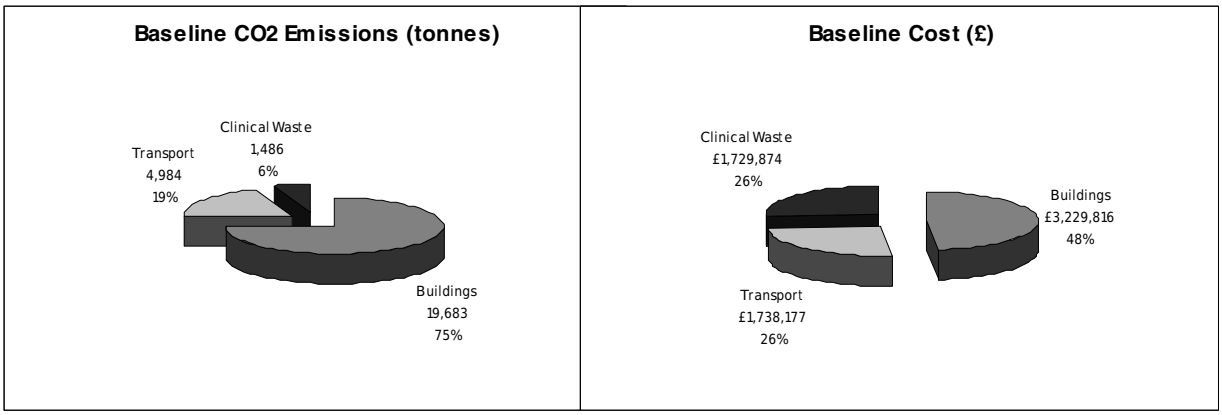
We use the guidance from 'Managing Public Money' to address requests for reimbursement and aim to provide fair and proportionate compensation where appropriate. During 2011/12, one blood donor complaint was referred to the Ombudsman and this was subsequently addressed satisfactorily. We will continue 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 commits it to reduce its carbon emissions by 25% over a five year period from a 2009-10 baseline and thereby helping to mitigate the effects of fuel price inflation and carbon taxation. This target was formally accepted and signed off by the Executive Team in April 2011. Initiatives that are currently contained within the plan are projected to achieve a 20% reduction and predominantly cover the first two to three years; the plan is a dynamic document and therefore it is expected that it will be updated with new and emerging programmes and also reflect changes to strategy.

For the business year 2011-12 performance targets and measures for sustainability were included for the first time. Energy, travel and waste are reported quarterly in arrears; overall CO_2 output is reported annually.

The Carbon Trust Baseline Tool (version 2010-07-09) was utilised to calculate NHSBT emissions baseline.



NHSBT Total Carbon Emissions (C02 Tonnes)

	09/10 Footprint	10/11 Footprint	11/12 Footprint
NHSBT CO2 emissions	26, 152 tonnes of CO2	24, 514 tonnes of CO2	**Reported in July 2012**
Target	Baseline	6%	11%
Actual	Baseline	6.26%	

Figures for NHSBT total carbon emissions will be reported to the Board and Executive Team in July 2012.

Carbon Reduction Commitment Energy Efficiency Scheme

The Carbon Reduction Commitment (CRC) has undergone some significant changes since it was first introduced. Originally this was a cap and trade scheme where allowances would have been purchased at the prevailing carbon floor rate and, depending on an organisations relative position in the performance league table; they would have received a bonus payment or required to pay a penalty. This arrangement has been replaced with a straight carbon tax.

Since the last report NHSBT has complied with the requirements of the CRC legislation and submitted two reports, a Footprint Report and an Annual Report to the Environment Agency (EA). A third report, the Evidence Pack has also been produced; this is a locally held document and is required to provide evidence of assumptions and calculations in constructing the two primary reports.

The CRC performance league table of circa 2100 organisations (public and private sector) was published in November 2011; NHSBT was placed 238th (top 15%) which reflects the significant amount of work undertaken to achieve the early action metrics. In this phase of CRC there are two criteria, each carrying the same weighting that determines an organisations performance. Specifically these are:-

1. Accreditation to a recognised carbon reduction quality standard e.g. Carbon Trust Standard;
2. The degree to which an organisation has implemented automatic meter reading (AMR).

In July 2011 NHSBT was awarded the Carbon Saver Gold Standard (valid for two years), gaining the full 50% for the first metric. For the second metric NHSBT claimed 34%.

Greening Government

The Sustainable Development in Government (SDiG) framework was replaced this year by Greening Government (GG). This programme sets out how the Government will follow on from its 10% carbon reduction in 2010 commitment.

NHSBT had previously reported against the forerunner of SDiG in a limited capacity i.e. only for office buildings. However, the new arrangements have a greater coverage and it was anticipated that a submission would be made for the whole estate. Following discussions with the Department of Health, NHSBT was given the opportunity to opt out of the scheme and following due consideration has exercised that option.

The rationale for this is summarised thus:-

- The target for carbon reduction is set annually and this conflicts with our much more robust arrangements for carbon reduction over a five year period;
- The specific targets for waste and travel are comprehensively covered with projects identified (and currently in flight) within the Carbon Management Plan;
- NHSBT is already close to full compliance with the Flexible Procurement Framework;
- NHSBT is fully aware of where there are weaknesses in its own processes i.e. measuring paper and water consumption however, there are initiatives in place to rectify these anomalies;
- The efforts of NHSBT through its involvement with the Carbon Trust programme, producing a CMP, gaining Carbon Saver accreditation and achieving a relatively high position in the CRC league table would indicate that it has a longer term strategic approach to reduce carbon emissions and its effects on the environment.

There has been a sustained effort to bring about both the operational and governance changes necessary to achieve quick wins and to comply with legislative requirements. However, whilst the statistics for carbon performance are encouraging, we should be aware that in the longer term, sustainability will need to be embedded into all our business processes and behaviours. As part of its agreed workplan, the Governance and Audit Committee received the Sustainable Development Annual Report in February 2012.

Emergency Preparedness

NHSBT maintains emergency preparedness and ensures that its systems are fit for purpose by continuing to work under three headlines: resilience, response and recovery. The significant element central to emergency preparedness for the organisation has been to ensure NHSBT's business continuity arrangements relating to the supply of the key products and services of the blood supply chain are certified against the British Standard for business continuity (BS25999). Certification has also served as validation to establish that the BCM processes we have are fit for purpose and provide a strategic and operational framework that will:

- proactively improve our resilience against disruption of our ability to achieve our key objectives
- ensure a rehearsed method of restoring our ability to supply our key services to an agreed level within an agreed time after a disruption
- deliver a proven capability to manage a business disruption and protect the organisation's reputation and brand
- provided stakeholder assurance prior to the London Olympic and Paralympic Games 2012 that the organisation can respond to any potential disruption challenges to service during the Games
- puts the organisation in a leading position with other international blood services when BS25999 migrates across to ISO 22301.

Our response and recovery arrangements have been brought into line with the broader civil contingencies community through the adoption of a Gold, Silver, Bronze command structure which employs an on call rota system for the management of business continuity and major incidents. A Gold Director will determine the strategy, whilst a National Critical Incident Manager (Silver) will deliver the tactical plan to realise the strategic objectives at a national level, supported by Critical Incident Managers (Bronze) who undertake local management across the country as part of our command and control arrangements. The Emergency Preparedness Committee continues to oversee emergency planning activity and to identify business continuity as a separate but associated work stream. The remit of the committee is the governance of emergency preparedness, structures, plans and maintenance. The committee meets quarterly and has a responsibility to produce an annual report for the attention of the Executive Team and the Governance and Audit Committee.

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

There has been a considerable amount of work done to develop the way we communicate, consult and engage with all NHSBT employees. Our annual communications audit and staff survey help to identify which communication methods are working and more importantly, highlight any areas for development. We use this feedback to continuously improve our range of face to face, print and online channels. For example, in response to staff feedback NHSBT's Senior Leadership team embarked on a series of roadshows to discuss our new Strategic Plan with staff and help them link this to their area of work. We also equip managers to generate a two way dialogue with staff and ensure information is shared in a timely and appropriate way, for example through our monthly face to face Connect Briefing. We have a varied workforce in terms of preferred channels of communication, but also working hours, geography and access to technology, and we use a range of communication techniques to help keep people connected.

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

Disabled Employees Statement

The work of NHSBT impacts on the lives of patients, staff and donors from all sections of the community and the organisation is committed to ensuring equality of opportunity in the employment of disabled people.

As a result of this commitment, NHSBT has taken a number of proactive steps to promote disability equality within the working environment through the development of a number of initiatives:

- NHSBT has signed up to the two ticks symbol and is committed to ensuring disabled applicants are guaranteed an interview where they meet the essential criteria.
- NHSBT continues to carry out reasonable adjustments where appropriate to ensure that the needs of disabled employees and disabled job applicants are accommodated.
- NHSBT has developed a positive action programme for staff members with a disability and staff members from a (BME) Black and Minority background in response to research carried out internally, which illustrated that there is a glass ceiling to development for these groups of staff.
- NHSBT is a member of the Employers Forum for Disability (EFD) and regularly consults with the EFD on a number of disability work related matters.
- NHSBT carried out extensive consultation with disability led organisations in the development of NHSBT's Single Equality Scheme 2011-2015.
- NHSBT has recently developed a disability advocacy programme which is due to be launched in the summer of 2012.
- NHSBT continues to carry out equality impact assessments on all policies and procedures to ensure that there is no adverse impact on disabled employees.
- NHSBT has developed a disability awareness training tracker course

Equal Opportunities Statement

NHSBT is committed to diversity and ensuring equality of opportunity in employment and service provision. In order to achieve our mission to provide world class services, NHSBT will continue to promote value and harness diversity in the workplace as well as equal access in the provision of services.

The key organisational aims are to:

- Have a workforce that embraces diversity and inclusion. In order to do so we will continue to attract, recruit, develop and retain a workforce that is able to deliver high quality services that are fair accessible and responsive to the diverse needs of the community.

- Be an employer of choice; ensuring that NHSBT maintains its competitive advantage by recruiting the best people from a diverse labour market.

- Continue to demonstrate our contribution to the achievement of better health outcomes for all and improved customer access and experience. This will be achieved through the provision of inclusive services where people feel that their individual needs have been catered for and considered – through the provision of blood products, organs and tissues.

NHSBT's Single Equality Scheme 2011-2015 sets out its commitment to promoting equality and diversity. Since May 2011 NHSBT has carried out the following activities:

- Developed a disability awareness training tracker course.

- Carried out an extensive consultation process with staff and external stakeholders to develop the content of NHSBT's Single Equality Scheme 2011-2015.

- Developed a welcoming disabled visitors guide.

- Developed annual diversity monitoring reports.

- Launched a series of religious perspectives on organ donation leaflets in collaboration with faith leaders.

- NHSBT ensured that information on organ donation was made available to the public in a range of accessible formats and translations.

- NHSBT has made large font welcome folders and large font courtesy DHCs available on sessions in response to the requests of disabled donors.

- Proactively promoted and recruited apprenticeships to address the issue of the ageing composition of the workforce.

- Increased the number of cord blood units in order to increase the supply of cord blood to BME communities.

- Developed a positive action programme to address the issue of the lack of representation of (BME) Black and Minority Ethnic Staff and disabled employees at senior levels in the organisation.

- Stream lined the Equality Impact Assessment process and associated guidance.

- Carried out a number of alterations to NHSBT buildings to ensure that our public buildings are fully accessible in order to meet the needs of our disabled donors.

- Ensured that diversity and inclusion issues were included as a key theme throughout the AIM management development programme.

- Carried out a review of data collection methods with regard to key HR workforce equality and diversity data.

- Developed a diversity events plan for inclusion with NHSBT events timetable.

- Relaunched the Multi faith calendar on the diversity WebPages.

- Developed management guidance on transgender equality in order to promote these issues widely in NHSBT.

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 April 2011 to March 2012 the total number of whole time equivalent days lost to sickness absence was 54,585 days. This equates to an average of 10.7 days per whole time equivalent; and a sickness absence rate of 4.77%.

For the financial year period April 2010 to March 2011 the total number of whole time equivalent days lost to sickness absence was 61,603 days. This equates to an average of 12 days per whole time equivalent; and a sickness absence rate of 5.34%.

Board Members

Board Members serving during the period 1 April 2011 to 31 March 2012:

Chairman
Mr Bill Fullagar

Non Executive Directors
Mr Andrew Blakeman
Ms Della Burnside
Dr Christine Costello
Mr John Forsythe
Mr David Greggains (period 1 April 2011 to 30 September 2011)
Mr Roy Griffins (from 1 January 2012)
Mr George Jenkins
Mr Shaun Williams

Executive Directors
Ms Lynda Hamlyn - Chief Executive
Mr Rob Bradburn - Finance Director
Ms Sally Johnson - Director of Organ Donation and Transplantation
Mr Alan McDermott – Director of Blood Donation
Dr Clive Ronaldson - Director of Patient Services
Mrs Lorna Williamson - Medical and Research Director

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

Better Payment Practice Code

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

	Number	£000
Total Non-NHS trade invoices paid in the year	89,953	188,970
Total Non-NHS trade invoices paid within target	83,377	182,409
Percentage of NHS trade invoices paid within target	92.7%	96.5%
Total NHS trade invoices in the year	11,221	7,620
Total NHS trade invoices paid within target	10,910	7,078
Percentage of NHS trade invoices paid within target	97.2%	92.9%

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 2011/12 NHSBT made a payment of £95.00 arising from claims made under this legislation.

Prompt Payment Code

The Government has encouraged all public sector Organisations to speed up the payments process and make payment of invoices wherever possible within 10 days. NHSBT is effectively a trading organisation that is mostly funded from sales of products and services (at cost) to NHS hospitals, rather than Grant In Aid. NHS hospitals are not subject to the same guidance and, hence management of our cash flow dictates that we cannot pay suppliers faster than the cash income from our customers. During 2011/12, however, NHSBT paid 36.1% (33.6% in 2010/11) of the total number of invoices, representing 36.4% (29.8% in 2010/11) by value, within a 10 day period.

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 (£120k 2010-11). 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 38 to 39.

Lynda Hamlyn Date: 13 June 2012
Chief Executive

REMUNERATION REPORT

Remuneration Committee Membership

During 2011-12 membership of the Remuneration Committee comprised David Greggains as Chair for the period 1 April 2011 to 30 September 2011 together with Della Burnside and Bill Fullagar. Lynda Hamlyn and David Evans also attend Committee meetings as 'standing attendees'. From 1 October 2011 the position of Chair was undertaken by Bill Fullagar on an interim basis through to the end of March 2012.

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 through the NHS Appointments Commission.

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.

Senior Management Contract Information

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

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

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

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

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

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

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

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

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

Clive Ronaldson, Director of Patient Services, 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.

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

The remuneration and pension benefits of the most senior officials of the Authority are shown in the table below and in the table on page 25. These tables are subject to audit.

Salary and Pension Entitlement of Senior Managers

a. Remuneration

	Year to 31 March 2012			Year to 31 March 2011		
Name and title	Salary in £5k bands £000	Other remuner. in £5k bands £000	Benefits in kind (rounded to the nearest £00) £00	Salary in £5k bands £000	Other remuner. in £5k bands £000	Benefits in kind (rounded to the nearest £00) £00
Mr B Fullagar (Chairman)	60-65	-	1	60-65	-	4
Mr A Blakeman (NED)	5-10	-	-	5-10	-	-
Ms D Burnside (NED)	5-10	-	-	5-10	-	-
Dr C. Costello (NED)	5-10	-	-	5-10	-	-
Mr J Forsythe (NED)	5-10	-	-	5-10	-	-
Mr D Greggains (NED) ended 30 September 2011	0-5	-	-	5-10	-	-
Mr R Griffins (NED) commenced 1 January 2012	0-5	-	-	-	-	-
Mr G Jenkins (NED)	10-15	-	-	10-15	-	-
Mr S Wiliams (NED)	5-10	-	-	5-10	-	-
Ms L Hamlyn (Chief Executive)	180-185	-	8	180-185	5-10	7
Ms L Austin (Director of Communications	105-110	-	-	105-110	-	-
Mr R Bradburn (Finance Director)	130-135	-	23	130-135	5-10	15
Mr D Dryburgh (Group Director of Estates and Logistics)	100-105	-	26	100-105	0-5	36
Mr D Evans (Group Director of Human Resources)	115-120	-	33	115-120	0-5	33
Ms S Johnson - (Director of Organ Donation and Transplantation)	120-125	-	-	120-125	0-5	-
Mr A McDermott (Director of Blood Donation)	120-125	-	17	120-125	5-10	77
Mr M Potter (Acting Director of Business Transformation Services)	100-105	-	5	55-60	-	8
Dr C Ronaldson (Director of Patient Services)	130-135	-	14	130-135	5-10	26
Dr L Williamson (Medical and Research Director) Commenced 01/07/2009	205-210	-	1	205-210	-	3

NED = Non-Executive Director

Other remuneration relates to performance related pay earned in 2009/10 and paid in 2010/11. There were no bonuses earned or paid in 2011/12.

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

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of their workforce. The banded remuneration of the highest paid director in NHSBT in the financial year 2011/12 is shown in the table below, together with the remuneration ratio compared to the mid point of the highest paid directors banding. This shows a small decrease in the pay multiples from 8.2 (2010/11) to 7.9 (2011/12).

	2011-12	2010-11
Highest Director Banded Remuneration	£205k to £210k	£205k to £210k
Median Remuneration	£26,230	£25,380
Remuneration Ratio	7.9	8.2

b. Pension benefits

Name and title	Real increase in pension at at age 60 (bands of £2,500)	Real increase in lump sum at at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to Accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Ms L Hamlyn (Chief Executive)	0-2.5	0-2.5	80-85	240-245	1,749	1,640	76
Ms L Austin (Director of Communications)	0-2.5	-	0-5	-	43	19	24
Mr R Bradburn (Finance Director)	0-2.5	-	5-10	-	107	69	37
Mr D Dryburgh (Group Director of Estates and Logistics)	0-2.5	5-7.5	5-10	25-30	145	99	44
Mr D Evans (Group Director of Human Resources)	0-2.5	0-2.5	35-40	105-110	658	573	74
Ms S Johnson (Director of Organ Donation and Transplantation)	0-2.5	2.5-5	35-40	115-120	753	655	86
Mr A McDermott (Director of Blood Donation)	0-2.5	2.5-5	5-10	25-30	202	161	38
Mr M Potter (Director of Business Transformation Services)	12.5-15	-	15-20	-	167	16	151
Dr C Ronaldson (Director of Patient Services)	2.5-5	10-12.5	45-50	135-140	-	-	-
Dr L Williamson (Medical and Research Director)	0-2.5	2.5-5	70-75	220-225	1653	1,549	73

Notes to the Remuneration Report

Cash Equivalent Transfer Value

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

The CETV figure, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Reporting of Other Compensation Schemes

The table below discloses the number and value by cost band of compensation packages agreed in 2011/12. Two special payments (£79K and £30k) relating to exit packages have been made in 2011/12 (no special payments in 2010/11), with the former of these (£79k) included in table below being paid for by the Department of Health.

	2011/12			2010/11		
Exit Package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost £000s)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost £000s)
<£20,001	31	3	34 (£427)	38	5	43 (£491)
£20,001 - £40,000	18	15	33 (£1,083)	14	1	15 (£402)
£40,001 - £100,000	24	14	38 (£2,425)	12	4	16 (£1,173)
£100,001 - £150,000	4	2	6 (£650)	5		5 (£595)
£150,001 - £200,000	1	-	1 (£151)	2		2 (£383)
£200,001 - £300,000	-	-	-	3		3 (£772)
Total number of exit packages by type (total cost £000s)	78 (£3,034)	34 (£1,702)	112 (£4,736)	74 (£3,457)	10 (£359)	84 (£3,816)

Lynda Hamlyn Date: 13 June 2012
Chief Executive

ANNUAL ACCOUNTS

Statement of the Chief Executives Responsibilities
As the Accounting Officer of the Special Health Authority

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

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

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

- make judgments and estimates on a reasonable basis;

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

- prepare the financial statements on a going concern basis.

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

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

ANNUAL GOVERNANCE STATEMENT 2011/12

Scope of Responsibility

The Board of NHS Blood and Transplant (NHSBT) is accountable for internal control. 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, as set out in the Accounting Officers Memorandum, issued by the Department of Health (DH).

NHSBT comprises a group of distinct strategic operating units, each with different supply chains and processes. As part of our corporate strategic planning process we identify strategic objectives and targets for each of our strategic operating units, which include the safety and sufficiency of supply, service effectiveness and efficiency. Accountability for delivery, along with delivery of all aspects of governance, internal control and risk management is assigned to the appropriate NHSBT Director and is underpinned by an integrated performance and risk management process. Performance against objectives and targets is reviewed by the Executive Team on (at least) a monthly basis and results in the issue of a comprehensive monthly performance report to the Board.

NHSBT is a supplier of critical life saving products and services to NHS hospitals but does not generally provide clinical services directly to NHS patients. The only area where NHSBT does provide clinical services is in the apheresis based therapies that are provided to patients, on behalf of some NHS hospitals. NHSBT is, however, totally dependent on the voluntary donation of blood, organs, haemapoetic stem cells and tissues and has extensive direct contact, in particular, with donors of blood and stem cells. With regard to organs and tissues there is limited contact with donors (in a clinical context) but NHSBT must have due regard for the donor, the donor family, the recipient family and the handling of organs and tissues once they have been retrieved and are entrusted to the NHS. Taken together the nature and characteristics of our contact with the public is unique within the NHS.

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 comprehensive quality management system that is designed to ensure compliance with regulation. We additionally conduct extensive quality auditing and this represents a critical element in our overall assurance framework. This is described in the section on the Quality Management System below.

Governance Framework of the Organisation

As a highly regulated organisation there is a strong compliance culture within NHSBT and recent history has provided evidence of improved levels of governance (as demonstrated by regulatory and other audits and assessments). During 2010/11, however, a limited assurance report was issued following an internal audit of our governance arrangements. This opinion was driven primarily by the lack of a formal description of our governance

framework and the associated streams of assurance that are provided to the Board. During 2011/12 the Governance & Audit Committee (GAC) has overseen the development of an "Integrated Governance Framework" that now 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. The generation of this document has also stimulated a broader Board discussion regarding the design and status of the NHSBT governance framework and the role of Board members with respect to governance of NHSBT. This process has served to confirm that the framework is sound, with no material gaps, but has identified opportunities to improve the quality and frequency of the assurances that are provided to the Board. As well as developing our assurance processes, during 2012/13, the framework will be launched across NHSBT to generate better awareness of governance at the front line and to demonstrate how existing processes and activities comprise the overall governance framework of NHSBT.

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

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

The Board considers that the framework is complete, with no material gaps, and is consistent with the UK Corporate Governance Code. The Board believes that the processes and information flows it describes have provided reasonable assurance regarding the delivery of NHSBT's statutory and strategic objectives and the effectiveness of its internal controls and risk management processes.

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 Director and Finance Director. Certain 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 transplant.

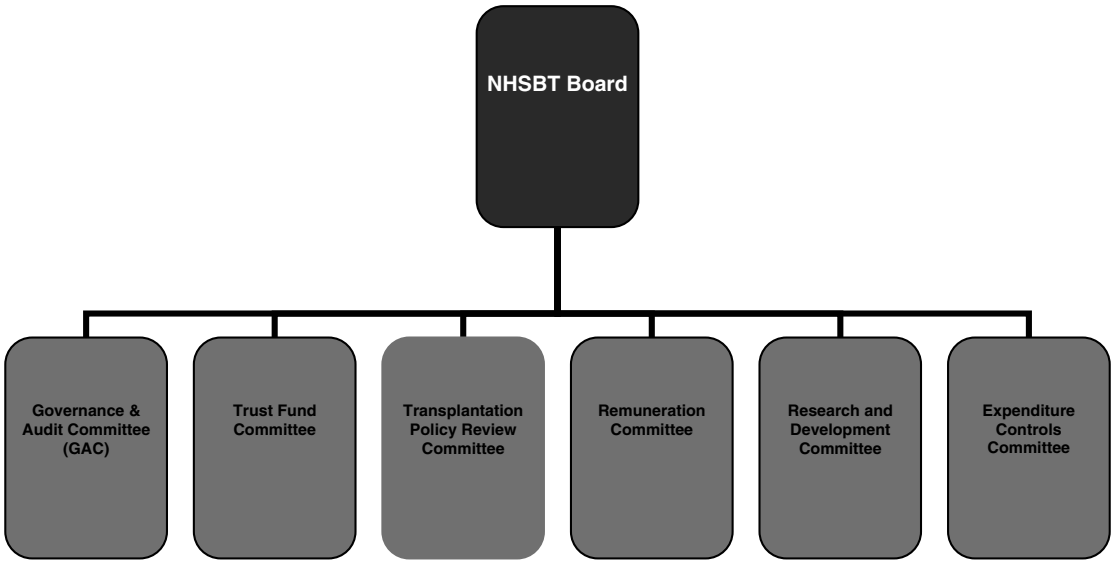
The Board meets six times a year on a bi-monthly basis and receives a comprehensive integrated monthly performance report covering:

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

The Board annually reviews its own effectiveness and also that of its Board 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 this wider review of effectiveness.

Board Committees

Six Board Committees have been established and were in operation during 2011/12. The Board Committees are as follows:



Governance & Audit Committee - The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical). In conducting this work, the Committee deploys an externally provided Internal Audit service and receives reports form our External Auditors. It also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

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

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

Remuneration Committee – the Committee oversees remuneration and other contractual arrangements for the Chief Executive and NHSBT Directors. This is done with due regard, to the provisions of the NHS Very Senior Manager Pay Framework and/or other relevant guidance and best practice, ensuring that they are fairly motivated and rewarded and their terms are reviewed and remain competitive and appropriate. The Committee also advise the Board on termination and severance arrangements in relation to the Chief Executive and NHSBT Directors. It 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 monitor progress on funded projects and commissions research from external sources where appropriate. It also requires assurance that appropriate arrangements are in place for staff development, research governance, agreements with academic and commercial collaborators, and protection of Intellectual Property. It further receives and considers the Annual Report of Research required to be submitted to the DH.

Expenditure Controls Committee - The Committee approves and endorses expenditure on professional services as required by expenditure controls established by the DH and within the limits established by DH and the NHSBT Scheme of Delegation. It reviews quarterly forecasts of professional expenditures submitted to DH and ensures that an audit trail is provided to demonstrate that authorisation of professional services expenditure has been applied in line with DH requirements.

Board Committee Average Attendance of Members

Board Committee	Average Attendance of Members (%)
Governance & Audit Committee (GAC)	87%
Trust Fund Committee	88%
Transplantation Policy Review Committee	93%
Remuneration Committee	100%
Research and Development Committee	89%
Expenditure Controls Committee	100%

The remit and terms of reference of these Board Committees were reviewed during the year and a self assessment conducted for each.

Board Meetings – Attendance by Members

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

Bill Fu1lager	Chairman	6
Lynda Hamlyn	Chief Executive	6
Andrew Blakeman	Non-Executive Director	4
Della Burnside	Non-Executive Director	5
Christine Costello	Non-Executive Director	6
John Forsythe	Non-Executive Director	6
George Jenkins	Non-Executive Director	6
Shaun Williams	Non-Executive Director	5
David Greggains	Non-Executive Director	2
Roy Griffins	Non-Executive Director	2
Rob Bradburn	Finance Director	6
Sally Johnson	Director of Organ Donation and Transplantation	6
Alan McDermott	Director of Blood Donation	6
Clive Ronaldson	Director of Patient Services	6
Lorna Williamson	Medical and Research Director	6

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 2011/12 all Directorate Senior Management Teams (SMTs) were provided training in our risk management process as part of their individual senior management team meetings. All Directorates SMTs have identified Risk Leads who attend the Risk Management Committee.

The NHSBT planning, performance and risk management framework maps a path from strategic objectives, via strategic risks, through to the constituent 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 and updating of the key risks facing NHSBT.

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

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

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

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

NHS Blood and Transplant Risk Profile

NHSBT is a supplier of critical life saving products and services to NHS hospitals but does not generally provide clinical services directly to NHS patients. NHSBT is, however, totally dependent on the voluntary donation of blood, organs, haemapoetic stem cells and tissues. As such our appetite for risk is essentially low as we cannot provide unsafe products or fail to deliver products/services when they are needed.

Our strategy incorporates a balanced set of objectives and targets that cover safety, sufficiency, quality of service and cost, but we plan for the highest levels of mitigation before any steps are taken which could impact the safety or availability of our products/services. We are committed to delivering our strategy, and its associated benefits, and we have endeavoured to maintain the right balance between delivery of the strategic activities and the risks associated with such delivery.

As at 31 March 2012 the NHSBT risk register captured 182 risks. Of these the items considered high/extreme can be summarised as:

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

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

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

Business continuity:
NHSBT's supply of products and services could be impacted by loss of a key facility or loss of a critical IT platform.

Public confidence in the Organ Donation Register (ODR):
The database underpinning the ODR is based on old technology. Investment in a new ODR is not considered to be beneficial and tactical improvements are currently being implemented. The requirements in Wales to implement a system of presumed consent could lead to significant operational and data management challenges and potentially a fundamental re-design of the ODR.

An increasing gap between growth in organ donation and growth in transplants:
Although growth in organ donation versus a 2007/8 baseline is at 34% (31 March 2012), and on course to meet the ODTF target of 50% by end 2013, growth in transplants will lag due to a reduction in the donor pool and organs being increasingly marginal (due to older donors and donors with a higher Body Mass Index).

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

The impact of shared services initiatives across Government:
NHSBT is committed to implementing shared service models that will reduce costs and contribute to pricing targets. NHSBT, however, is a supply chain based organisation where integration of process and systems is fundamental to effectiveness and efficiency. Shared service solutions could adversely impair our ability to deliver significant supply chain efficiencies through models which result in disaggregation of processes and sub-optimal end to end processes.

Quality Management System (QMS)

NHSBT operates a single, comprehensive QMS system across blood and specialist services. It comprises operating manuals and detailed process documentation and is supported by the QPulse system. 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.

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

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

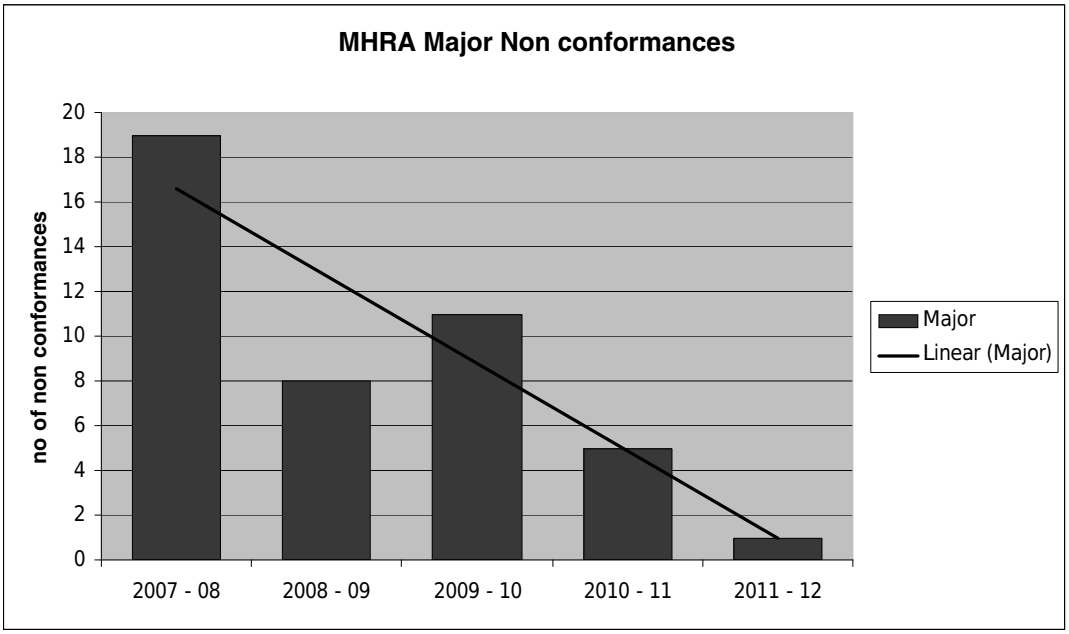
The QMS and quality assurance process are owned by the NHSBT Assistant Director of Quality, who reports to the Director of Patient Services, but who has a reporting line directly to me and attends the GAC. Assurance is delivered through:

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

NHSBT is engaged in a project to implement a formal QMS within Organ Donation and Transplantation by October 2012 as required by the European Organ Donation Directive (EUODD).

NHSBT is subject to regular inspections by its regulators and the results of all reviews are reported to the Executive Team and Board. NHSBT is commited to improving its regulatory peformance and strategic targets have been set regarding the number of non compliances identified during regulatory inspections and also the number of outstanding corrective actions.

As a result of these actions there were no critical non-compliances and only one major non-compliance reported by the MHRA in 2011/12 (versus 5 major non compliances reported in 2010/11 – see below).



Severe Untoward Incidents (SUIs)

There were no Never Events in 2011/12 and three Serious Untoward Incidents (SUI). Severe Untoward Incidents (SUIs) are subject to a defined management and reporting process that is linked to the QMS and supported by QPulse for incident reporting. The three 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. The reviews did not identify any common themes or root causes.

Data Loss Incidents

NHSBT holds details of over 4 million active blood donors and manages an Organ donor register with in excess of 16 million registrants. An accidental disclosure of personal information occurred in June 2011 whereby details of approximately 400 deceased donors were embedded in a presentation distributed to NHS consultants. The incident was treated as a Serious Untoward Incident and reported to the Department of Health, GAC and NHSBT Board. Fortunately the release was contained within the NHS community and NHSBT was able to trace and confirm that the information had been deleted. On this basis DH and NHSBT agreed that it was not necessary to report the incident to the Information Commissioner. In response to this incident, spreadsheets containing deceased donor details are now encrypted and data leakage prevention technology is being deployed to monitor web and e-mail gateways for sensitive information.

There has been one further incident that has been reported to the NHSBT Board, the Department of Health and the Information Commissioner, concerning the loss of 57 paper donor health check forms in transit between a blood collection venue and a Blood Centre. The incident was reported promptly, the individuals affected were informed and the subsequent investigation and corrective/preventive action well managed. The Information Commissioner's Office is satisfied that appropriate action has been taken and considers the matter closed. NHSBT is aware that this case may be revisited by the Information Commissioner should any further breach occur.

Internal Audit

For work completed in 2010/11 there were a total of 17 final reports issued, of which three were given a limited assurance opinion. These were in respect of, General IT Controls (Organ Donation Register), Clinical Governance and Strategic Sourcing and Supplier Management. The two latter reports followed work conducted in late 2010/11 and resulted in draft reports that were available in March 2011. This audit work and the draft limited assurance opinions were taken into account in the preparation of the 2010/11 Annual Report and the associated Statement of Internal Control. This led to a number of corrective actions from the start of 2011/12 and especially the generation of the Integrated Governance Framework referred to earlier. During 2011/12 there were a total of 12 final reports issued, none of which had a high risk rating, with 7 reports in draft of which only 1 report, Records Management, has been highlighed as high risk. Taken as a whole, PwC have therefore provided an overall opinion that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. The reports also identify weaknesses in the design and/or inconsistent application of controls that put the achievement of particular objectives at risk. These have been reported as result of specific individual internal audit reviews and are monitored via the GAC to ensure that recommendations are followed up by management and completed.

Care Quality Commission Registration

NHSBT has 15 locations 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 2011/12 we have met with the CQC to develop increased understanding of NHSBT's registration and compliance requirements. These discussions remain on-going as interpretation of the scope and impact on NHSBT continues to be developed.

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

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 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 2012 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.

During the year, as a result of the development of its Integrated Governance Framework, and the related Board debate that has been generated, I believe that the Authority has made real and sustainable improvements to its governance arrangements. The Authority continues to recognise that the internal control environment can always be strengthened and this work will continue in 2012/13.

Signed: Lynda Hamlyn Date: 13 June 2012
Chief Executive and Accounting Officer

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

I certify that I have audited the financial statements of NHS Blood & Transplant for the year ended 31 March 2012 under the National Health Service Act 2006. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of Chief Executive's Responsibilities, the Board and the Chief Executive as Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Services Act 2006. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of NHS Blood & Transplant's affairs as at 31 March 2012 and of the net expenditure for the year then ended; and

- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and

- the information given in Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or

- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or

- I have not received all of the information and explanations I require for my audit; or

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

Report

I have no observations to make on these financial statements.

Amyas C E Morse **Date 25 June 2012**

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 2012

	Notes	**31 March 2012 £000**	31 March 2011 £000
Gross Income			
Income from activities	2	**351,896**	356,841
Other operating income	2	**17,840**	15,228
		369,736	372,069
Expenditure			
Staff costs	3.1	**(199,717)**	(202,221)
Depreciation	8 and 9	**(10,537)**	(10,478)
Other administrative expenses	3.2	**(226,610)**	(218,606)
		(436,864)	(431,305)
Net Operating Expenditure before interest		**(67,128)**	(59,236)
Finance Costs	4	**(572)**	(503)
Net Operating Expenditure after interest	2	**(67,700)**	(59,739)
Other Comprehensive Net Expenditure			
Net (loss)/gain on revaluation of Property, Plant and Equipment	20	**918**	(6,919)
Total Comprehensive Net Expenditure		**(66,782)**	(66,658)

All income and expenditure is derived from continuing operations

Notes 1 to 28 form part of these accounts.

Statement of Financial Position as at 31 March 2012

	Notes	31 March 2012 £000	31 March 2011 £000
Non Current Assets			
Intangible Assets	8	**4,105**	4,442
Property, Plant & Equipment	9	**163,771**	166,632
Trade and other receivables	13	**145**	215
Total non-current assets		**168,021**	171,289
Current assets			
Inventories	12	**19,278**	21,708
Trade and other receivables	13	**24,696**	26,549
Cash and cash equivalents	14	**9,748**	157
Total current assets		**53,722**	48,414
Current Liabilities			
Trade and other payables	15	**19,916**	18,034
Borrowings	16 and 18	**88**	80
Provisions for liabilities and charges	17	**613**	1,219
Total current liabilities		**20,617**	19,333
Non-current assets plus net current assets		**201,126**	200,370
Non-current liabilities			
Borrowings	16 and 18	**4,717**	4,805
Provisions for liabilities and charges	17	**805**	784
Total non-current liabilities		**5,522**	5,589
Total Assets Employed:		**195,604**	194,781
Taxpayers' Equity			
General Fund	20.1	**153,019**	150,625
Revaluation Reserve	20.2	**42,585**	44,156
Total Taxpayers' Equity:		**195,604**	194,781

Notes 1 to 28 form part of these accounts.

The financial statements on pages 40 to 68 were approved by the Governance and Audit Committee in accordance with powers within the NHSBT Standing Orders on 11th June 2012, and are signed by the Accounting Officer, Lynda Hamlyn.

Lynda Hamlyn
Accounting Officer

Date: 13 June 2012

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2011

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2010	142,245	51,558	**193,803**
Changes in taxpayers' equity for 2010/11			
Net expenditure for the financial period	(59,739)	-	**(59,739)**
Net (loss) on revaluation of Property, Plant and Equipment	-	(6,919)	**(6,919)**
Transfers between reserves	483	(483)	**-**
Total recognised income and expense for 2010/11	(59,256)	(7,402)	**(66,658)**
Grant from Department of Health	67,636	-	**67,636**
Balance at 31 March 2011	**150,625**	**44,156**	**194,781**

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

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

Statement of Cash Flows for the year ended 31 March 2012

	Notes	**31 March 2012**	31 March 2011
		£000	£000
Cash flows from operating activities			
Net operating costs		**(67,128)**	(59,236)
Other cashflow adjustments	19.3	**10,903**	11,241
Movement in Working Capital	19.1	**6,027**	(14,932)
Provisions utilised	17	**(761)**	(1,504)
Net cash (outflow) from operating activities		**(50,959)**	(64,431)
Cash flows from investing activities			
Purchase of plant, property and equipment		**(5,966)**	(4,760)
Purchase of intangible assets		**(460)**	(557)
Proceeds from disposal of non current assets		**5**	13
Net cash (outflow) from investing activities		**(6,421)**	(5,304)
Cash flows from financing activities			
Grant from Department of Health		**67,605**	67,636
Capital element paid in respect of finance leases		**(80)**	(83)
Interest paid in respect of finance leases		**(554)**	(485)
Net financing		**66,971**	67,068
Net increase/(decrease) in cash and cash equivalents		**9,591**	(2,667)
Cash and cash equivalents at 31 March 2011		**157**	2,824
Cash and cash equivalents at 31 March 2012	14	**9,748**	157

(a) Notes to the Accounts

1. Accounting Policies

The financial statements have been prepared in accordance with the 2011/12 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 2011, with an effective date before or from 1 April 2011. NHS bodies must follow the FreM unless there are divergences agreed by HM Treasury. The one agreed divergence for 2011/12, is the non-consolidation of funds held on trust, contrary to the requirements of IAS 27.

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

IFRSs, amendments and interpretations in issue but not yet effective, or adopted

IAS 8, accounting policies, changes in accounting estimates and errors, requires disclosures in respect of new IFRSs, amendments and interpretations that are, or will be applicable after the reporting period. The Treasury FreM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on these accounts.

IAS 1 Presentation of Financial Statements	Minor amendments enabling items of other comprehensive income to be shown in the notes as opposed to the SOCNE. The effective date is June 2012.
IAS 19 Post-employment benefits (pensions)	Amendments to termination benefits to make it easier for users of financial statements to understand how defined benefit plans affect an entity's financial position, financial performance and cash flows. This effective date is January 2013.
IAS 27 Consolidated and Separate Financial Statements	Amendments to IAS 21, IAS 28, and IAS 31 clarifying whether the consequential amendments to these standards require retrospective or prospective application. The effective date is January 2013.
IAS 28 Investments in Associates and Joint Ventures	The objective of IAS 28 (as amended in 2011) is to prescribe the accounting for investments in associates and to set out the requirements for the application of the equity method when accounting for investments in associates and joint ventures. The effective date is January 2013.
IFRS 7 Financial Instruments Disclosure	Strengthening of the current standard requiring further disclosures on transfer transactions

	involving financial assets. The effective date is 1 July 2011 with a requirement to implement in 2012/13.
IFRS 9 Financial Instruments	A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2015.
IFRS 10 Consolidated Financial Statements	Impacts the consolidation and reporting of subsidiaries, associates and joint ventures. Defines investor power and the ability to direct activities of an investee. The effective date is 1 January 2013.
IFRS 11 Joint Arrangements	Provides principles based definition of joint arrangement based on rights and obligations. The effective date is 1 January 2013.
IFRS 12 Disclosure of Interests in Other Entities	Requires more disclosure of the financial effects on, and the risks to, the consolidating entity. The effective date is 1 January 2013.
IFRS 13 Fair Value Measurement	Defines fair value, provides guidance on fair value measurement techniques, and sets out disclosure requirements. The effective date is January 2013.

Critical judgements and key sources of estimation uncertainty

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

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

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

1.1 Accounting Conventions

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

In the application of NHSBT's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to

accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period; or in the period of the revision and future periods if the revision affects both current and future periods.

1.2 Income

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

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

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

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

1.3 Taxation

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

1.4 Capital Charges

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 2011/12 was 3.5% (2010/11 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 to have a cost equal to or greater than £5,000; or
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they have broadly

simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

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

(b) Valuation

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

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

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

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

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

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

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

impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

1.6 Intangible Assets

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

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

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

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

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

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

1.7 Depreciation, amortisation and impairments

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

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

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

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

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

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

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

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

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

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

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

1.8 Non-current assets held for sale

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

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

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

1.9 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.

1.10 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.

1.11 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).

1.12 Employee Benefits

Short-term employee benefits

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

Early Termination Costs

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

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

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

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

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, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

1.13 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.

1.14 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.

1.15 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.

1.16 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 discount rate of 2.2% in real terms (2.8% for early departure obligations).

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

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

Clinical Negligence Costs

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

From 1 April 2000, the NHSLA took over the full financial responsibility for all ELS 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 17.

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.

1.17 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.

1.18 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.

1.19 Subsidiaries

For 2010-11 and 2011-12 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the Corporate Trustee.

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

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

For the year 1 April 2010 to 31 March 2011	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	356,841	308,289	26,670	7,094	9,884	3,878	1,026
Income from Scottish Parliament	2,680	-	-	-	-	-	2,680
Income from National Assembly for Wales	2,065	-	-	-	-	-	2,065
Income from Northern Ireland Assembly	727	-	-	-	-	-	727
Other Income	9,756	8,942	666	-	-	3	145
Revenue Grant In Aid	62,247	3,118	-	-	3,922	-	55,207
Total Revenue	**434,316**	**320,349**	**27,336**	**7,094**	**13,806**	**3,881**	**61,850**
Expenditure							
Variable Costs	(61,153)	(51,544)	(4,809)	(952)	(2,669)	(921)	(258)
Direct Costs	(219,090)	(139,682)	(13,503)	(4,272)	(7,908)	(1,687)	(52,038)
Direct Support Costs	(81,406)	(65,791)	(4,147)	(1,861)	(2,968)	(705)	(5,934)
Movement in value of stocks	37	(754)	-	791	-	-	-
Other Support Costs	(58,384)	(49,050)	(4,518)	(1,425)	(2,724)	(667)	-
Total Expenditure	**(419,996)**	**(306,821)**	**(26,977)**	**(7,719)**	**(16,269)**	**(3,980)**	**(58,230)**
Operating surplus for the financial period	**14,320**	**13,528**	**359**	**(625)**	**(2,463)**	**(99)**	**3,620**
Add : Notional cost of capital included in expenditure above	6,953						
Less : Revenue grant in aid	(62,247)						
Less : Capital charges paid to the Department of Health	(18,765)						
Net Expenditure	**(59,739)**						

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 Stem Cell Biology and Immunotheray function, the British Bone Marrow Registry (BBMR) and the Cord Blood Bank (CBB).
The **Specialist Therapeutic Services** operating unit provides a range of therapeutic 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.

The segmental reporting note follows a new contribution analysis report that is now circulated to the Board on a quarterly basis. This new report incorporates a wider scope to the term 'Income from Activities' and this expanded scope is also reflected in the split of income in the Statement of Comprehensive Net Expenditure.

3.1 Staff Costs and related numbers

	Total	**31 March 2012 Permanently Employed Staff**	**Other**	31 March 2011 Total
	£000	**£000**	**£000**	£000
Salaries and wages	**168,083**	**152,764**	**15,319**	171,275
Social security costs	**11,829**	**11,531**	**298**	11,415
Employer contributions to NHS Pensions Agency	**19,804**	**19,305**	**499**	19,531
	199,717	**183,600**	**16,117**	202,221

The average number of employees during the year was:

	Total	**Permanently Employed Staff**	**Other**
	Number	**Number**	**Number**
Year ended 31 March 2012	**5,154**	**4,916**	**238**
Year ended 31 March 2011	5,421	4,988	433

Expenditure on staff benefits

The amount spent on staff benefits during the year is estimated at £784,000 (31 March 2011 £888,000).

Early retirements and redundancies

During 2011/12 there were 110 early retirements and/or redundancies from NHSBT. £4,628,000 has been charged to the revenue account in 2011/12 in respect of these redundancies and early retirements (31 March 2011: 84 early retirements and/or redundancies, and a charge to the revenue account of £3,816,000). These amounts are included within other staff related costs in note 3.2.

3.2 Other Administrative Expenses

	Notes	£000	31 March 2012 £000	31 March 2011 £000
Other staff related costs			**18,627**	14,747
Consumable supplies			**76,198**	68,776
Maintenance of buildings, plant and equipment			**16,707**	16,705
Rent and rates			**11,976**	11,506
Transport costs			**10,213**	10,061
External contractors			**17,200**	14,916
Purchase and lease of equipment and furniture			**5,981**	3,914
Utilities and telecommunications			**7,578**	7,842
Media advertising			**2,327**	2,597
ODT Scheme Payments			**31,055**	29,241
Professional Fees *			**4,463**	7,821
Capital Charges paid over as cash to Department of Health			**17,524**	18,765
Capital Non-cash : Impairments	10	**-**		2,838
Loss on disposal	7	**208**		247
			208	3,085
Auditor's remuneration: Audit Fees **			**90**	120
Miscellaneous			**6,463**	8,510
			226,610	218,606

* Professional Fees include legal and programme management costs

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

4. Finance costs

	31 March 2012 £000	31 March 2011 £000
Interest expense under finance leases	**554**	485
Other finance costs - unwinding of discount	**18**	18
Total finance costs	**572**	503

5. Operating leases

NHSBT as lessee

	31 March 2012 £000	As restated 31 March 2011 £000
Payments recognised as an expense		
Minimum lease payments	**8,962**	9,533
Total future minimum lease payments		
Payable:		
Not later than one year	**5,186**	5,108
Later than one year and not later than five years	**7,518**	5,933
Later than five years	**40**	191
Total	**12,744**	11,232

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

Interest of £95 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 2011: £41 interest and £Nil compensation).

7. Other gains and losses

	31 March 2012	31 March 2011
	£000	£000
(Loss) on disposal of intangible assets	-	-
(Loss) on disposal of plant and equipment	(208)	(247)
Total	(208)	(247)

8. Intangible non-current assets

8.1 Intangible non-current assets 2011/12

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

8.2 Intangible non-current assets 2010/11

	Total	Software Purchased	Development Expenditure
	£000	£000	£000
Cost or Valuation			
At 1 April 2010	12,605	9,738	2,867
Additions - purchased	557	557	-
Reclassification	-	2,867	(2,867)
At 31 March 2011	13,162	13,162	-
Amortisation			
At 1 April 2010	8,384	8,384	-
Provided during the year	336	336	-
At 31 March 2011	8,720	8,720	-
Net book value at 1 April 2010	4,221	1,354	2,867
Net book value at 31 March 2011	4,442	4,442	-
Net book value at 31 March 2011 comprises:			
Purchased	4,442	4,442	-
Asset Financing	4,442	4,442	-

9. Property, plant and equipment

9.1 Property, plant and equipment 2011/12

	Total	Land	Buildings	Assets under constr. + poa	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2011	255,134	23,565	153,510	982	53,804	4,667	18,595	11
Additions - purchased	**6,174**	**-**	**935**	**1,141**	**3,015**	**-**	**1,083**	**-**
Reclassification *	**-**	**-**	**662**	**(740)**	**78**	**-**	**-**	**-**
Indexation	**3,047**	**-**	**-**	**4**	**2,900**	**142**	**-**	**1**
Disposals	**(4,686)**	**-**	**-**	**-**	**(4,161)**	**(511)**	**(14)**	**-**
At 31 March 2012	**259,669**	**23,565**	**155,107**	**1,387**	**55,636**	**4,298**	**19,664**	**12**
Depreciation:								
At 1 April 2011	88,502	-	32,978		37,930	2,751	14,835	8
Provided during the year	**9,740**	**11**	**3,970**		**4,126**	**426**	**1,206**	**1**
Indexation	**2,129**	**-**	**-**		**2,044**	**84**	**-**	**1**
Disposals	**(4,473)**	**-**	**-**		**(3,948)**	**(511)**	**(14)**	**-**
Accumulated depreciation at 31 March 2012	**95,898**	**11**	**36,948**		**40,152**	**2,750**	**16,027**	**10**
Net book value at 1 April 2011	166,632	23,565	120,532	982	15,874	1,916	3,760	3
Net book value at 31 March 2012	**163,771**	**23,554**	**118,159**	**1,387**	**15,484**	**1,548**	**3,637**	**2**
Net book value at 31 March 2012 comprises:								
Purchased at 31 March 2012	**163,771**	**23,554**	**118,159**	**1,387**	**15,484**	**1,548**	**3,637**	**2**
Asset Financing:	**163,771**	**23,554**	**118,159**	**1,387**	**15,484**	**1,548**	**3,637**	**2**
Owned	**151,942**	**22,450**	**107,434**	**1,387**	**15,484**	**1,548**	**3,637**	**2**
Held on Finance Lease	**11,829**	**1,104**	**10,725**	**-**	**-**	**-**	**-**	**-**
	163,771	**23,554**	**118,159**	**1,387**	**15,484**	**1,548**	**3,637**	**2**

* These figures relate to the reclassification of Assets Under Construction upon completion.

9.2 Property, plant and equipment 2010/11

	Total	Land	Buildings	Assets under constr. + poa	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2010	264,136	23,105	162,559	1,172	55,184	4,907	17,198	11
Additions - purchased *	**5,948**	**1,115**	**77**	**876**	**2,447**	**245**	**1,188**	**-**
Reclassification **	**-**	**55**	**802**	**(1,066)**	**-**	**-**	**209**	**-**
Indexation	**2,838**	**-**	**-**	**-**	**2,777**	**61**	**-**	**-**
Impairments	**(2,838)**	**(300)**	**(2,538)**	**-**	**-**	**-**	**-**	**-**
Other in year revaluations ***	**(7,800)**	**(410)**	**(7,390)**	**-**	**-**	**-**	**-**	**-**
Disposals	**(7,150)**	**-**	**-**	**-**	**(6,604)**	**(546)**	**-**	**-**
At 31 March 2011	**255,134**	**23,565**	**153,510**	**982**	**53,804**	**4,667**	**18,595**	**11**
Depreciation:								
At 1 April 2010	83,293		28,405		38,194	2,855	13,832	7
Provided during the year	**10,142**		**4,573**		**4,158**	**407**	**1,003**	**1**
Indexation	**1,957**		**-**		**1,922**	**35**	**-**	**-**
Disposals	**(6,890)**		**-**		**(6,344)**	**(546)**	**-**	**-**
Accumulated depreciation at 31 March 2011	**88,502**		**32,978**		**37,930**	**2,751**	**14,835**	**8**
Net book value at 1 April 2010	180,843	23,105	134,154	1,172	16,990	2,052	3,366	4
Net book value at 31 March 2011	**166,632**	**23,565**	**120,532**	**982**	**15,874**	**1,916**	**3,760**	**3**
Net book value at 31 March 2011 comprises:								
Purchased at 31 March 2011	**166,632**	**23,565**	**120,532**	**982**	**15,874**	**1,916**	**3,760**	**3**
Asset Financing:	**166,632**	**23,565**	**120,532**	**982**	**15,874**	**1,916**	**3,760**	**3**
Owned	**154,958**	**22,450**	**109,973**	**982**	**15,874**	**1,916**	**3,760**	**3**
Held on Finance Lease	**11,674**	**1,115**	**10,559**	**-**	**-**	**-**	**-**	**-**
	166,632	**23,565**	**120,532**	**982**	**15,874**	**1,916**	**3,760**	**3**

* Land additions relate to a lease that has been reclassified as a finance lease in accordance with changes to IAS17. The asset, and corresponding finance lease liability, have been recognised as at 31st March 2011 because the necessary information for a retrospective adjustment is unavailable.

** These figures relate to the reclassification of Assets Under Construction upon completion.

*** The reduction in value of land and buildings primarily relates to a downward interim revaluation of property assets undertaken during March 2011 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 in year revaluation of land includes an amount of £1,140,000 relating to the value of land held on a 1,000 year lease at a nominal rent.

9.3 Net Book Value of Land and Buildings

The net book value of land, buildings and dwellings as at 31 March 2012 comprises:

	31 March 2012	31 March 2011
	£000	£000
Freehold	**126,493**	128,170
Long leasehold	**15,220**	15,927
	141,713	144,097

10. Impairments

Impairments charged in the year to the Operating Cost Statement

	31 March 2012		31 March 2011	
	Property, plant and equipment	**Intangible assets**	Property, plant and equipment	Intangible assets
	£000	**£000**	£000	£000
Impairments arose from:				
Interim revaluation exercise	**-**	**-**	2,838	-
Total	**-**	**-**	2,838	-

11. Non-current assets held for sale

There were no non-current assets held for sale (2010/11: Nil).

12. Inventories

	31 March 2012	31 March 2011
	£000	£000
Raw materials and consumables	**6,123**	6,192
Work in progress	**2,569**	5,124
Finished processed goods	**10,586**	10,392
	19,278	21,708

A review of the percentage completion rates applied to tissue stocks work in progress took place during the year, and this is the main reason for the fall in the value of this category of stock.

13. Trade and other receivables

	31 March 2012 £000	31 March 2011 £000
Current		
NHS Receivables - Revenue	**11,417**	16,211
Non NHS Trade Receivables - Revenue	**5,338**	2,133
Provision for impairment of Receivables	**(11)**	(28)
Other Debtors	**156**	139
VAT	**2,038**	2,447
Prepayments and accrued income	**5,758**	5,647
Subtotal	**24,696**	26,549
Non Current		
Other prepayments and accrued income	**145**	215
Subtotal	**145**	215
Total trade and other receivables	**24,841**	26,764

Provision for irrecoverable debts

Amounts falling due within one year Non - NHS trade receivables	2011-2012 £000	2010-2011 £000
At 1 April	**28**	57
Provided in year	**-**	16
Written off during year	**(2)**	(29)
Recovered during year	**(15)**	(16)
At 31 March	**11**	28
Aging of debts provided against		
Upto 12 months	**-**	12
Over 12 months	**11**	16
	11	28
Receivables past due but not impaired		
Upto 3 months	**4,373**	6,460
Between 4 and 12 months	**92**	268
Over 12 months	**4**	3
	4,469	6,731

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 24).

14. Cash and Cash equivalents

	2011-2012 £000	2010-2011 £000
Balance at 1 April	**157**	2,824
Net change in the year	**9,589**	(2,667)
Balance at 31 March	**9,746**	157
Comprising:		
Held with Government Banking Services accounts	**9,746**	154
Cash in hand	**2**	3
Cash and cash equivalents as in Statement of cash flows	**9,748**	157

15. Trade and other payables

	31 March 2012	31 March 2011
	£000	£000
Current		
NHS Payables - revenue	**1,992**	1,950
Non-NHS trade Payables - revenue	**1,155**	777
Non-NHS trade Payables - capital	**312**	104
Tax and Social Security Costs	**6**	10
Accruals and deferred income	**16,451**	15,193
Total trade and other payables	**19,916**	18,034

16. Borrowings

Borrowings relate to land and buildings acquired under separate finance leases, full details of which are disclosed in note 18.

17. Provisions for liabilities and charges

At 31 March 2011	Product Liability	Employee Benefits	Tax and NI Liabilities	Other	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2010	60	834	3,500	1,417	5,811
Provisions - Arising in the year	**6**	**30**	**-**	**358**	**394**
Utilised during the year	**(6)**	**(49)**	**(933)**	**(516)**	**(1,504)**
Reversed unused	**-**	**-**	**(2,305)**	**(411)**	**(2,716)**
Unwinding of discount	**-**	**18**	**-**	**-**	**18**
Balance at 31 March 2011	**60**	**833**	**262**	**848**	**2,003**
Expected timing of cash flows:					
Within 1 year	**60**	**49**	**262**	**848**	**1,219**
Between 1 year and 5 years	**-**	**185**	**-**	**-**	**185**
Thereafter	**-**	**599**	**-**	**-**	**599**

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

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 21.

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.

£3,320,000 (31 March 2011: £2,668,000) is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities. There is a £Nil provision in respect of the existing liabilities scheme (31 March 2011: £Nil).

18. Finance leases

Finance lease obligations (ie as lessee)

	Minimum lease payments	
	31 March 2012	31 March 2011
	£000	£000
Not later than one year	**554**	540
Later than one year and not later than five years	**2,216**	2,158
Later than five years	**11,363**	10,539
	14,133	13,237
Less future finance charges	**9,328**	8,352
Present value of future lease obligations	**4,805**	4,885

	Present value of minimum lease payments	
	31 March 2012	31 March 2011
	£000	£000
Not later than one year	**88**	80
Later than one year and not later than five years	**459**	413
Later than five years	**4,258**	4,392
Present value of future lease obligations	**4,805**	4,885
Analysed as :		
Current borrowings	**88**	80
Non-current borrowings	**4,717**	4,805
	4,805	4,885

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.

19.1 Movements in working capital

	31 March 2012	31 March 2011
	£000	£000
Increase/(decrease) in receivables within 1 year	**(1,853)**	(6,221)
Increase/(decrease) in receivables after 1 year	**(70)**	(178)
Increase/(decrease) in inventories	**(2,430)**	(859)
(Increase)/decrease in payables within 1 year	**(1,882)**	22,117
Subtotal	**(6,235)**	14,859
Less Movement in payables relating to items not passing through the I&E statement	**(208)**	(73)
Subtotal	**(208)**	(73)
Total	**(6,027)**	14,932

19.2 Analysis of changes in net debt

	As at 1 April 2011 £000	**Cash flows £000**	**As at 31 March 2012 £000**
Government Banking Services cash at bank	154	9,592	**9,746**
Commercial cash at bank and in hand	3	(1)	**2**
Total	157	9,591	**9,748**

19.3 Other cashflow adjustments

	31 March 2012	31 March 2011
	£000	£000
Depreciation	**9,740**	10,142
Amortisation	**797**	336
Impairments and reversals	**-**	2,838
Loss on disposal	**208**	247
Provisions - Arising in Year	**570**	394
Provisions - Reversed unused	**(412)**	(2,716)
Total	**10,903**	11,241

20. Movements on reserves

20.1 General Fund

	2011-2012	2010-2011
	£000	£000
Balance at 1 April	**150,625**	142,245
Net operating expenditure for the financial period	**(67,700)**	(59,739)
Revenue Grant in Aid	**61,105**	62,247
Capital Grant in Aid	**6,500**	5,389
Transfer from Revaluation reserve: realised elements of the revaluation reserve (see * below)	**2,489**	483
Balance at 31 March	**153,019**	150,625

20.2 Revaluation Reserve

	2011-2012	2010-2011
	£000	£000
Balance at 1 April	**44,156**	51,558
Indexation of fixed assets	**918**	881
Revaluation of fixed assets	**-**	(7,800)
Transfer to General Fund: realised revaluation (see * below)	**(2,489)**	(483)
Balance at 31 March	**42,585**	44,156

* a review of the information held in the Real Asset Management system has resulted in an additional transfer relating to realised revaluation amounts from the Revaluation Reserve to the General Reserve.

21. Contingent Liabilities at 31 March 2012

A contingent liability of £122,000 (31 March 2011: £274,000) 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 2011: £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.

22. Capital commitments at 31 March 2012

At 31 March 2012 the value of contracted capital commitments was £1,426,000 (31 March 2011 : £245,000).

23 Losses and special payments

23.1 Losses Statement

	31 March 2012		31 March 2011	
	No. Cases	£000	No. Cases	£000
Cash Losses	-	-	2	1
Book keeping Losses	5	1	25	3
Losses of pay, allowances and superannuation benefits	22	4	17	13
Losses of Accountable Stores	122	138	145	221
Fruitless Payments	2	1	1	161
Claims waived or abandoned	5	-	10	28
	156	144	200	427

23.2 Special Payments

	31 March 2012		31 March 2011	
	No. Cases	£000	No. Cases	£000
Special Severance Payments	3	31	-	-
Compensation Payments	138	495	187	705
Ex Gratia Payments	73	17	35	3
	214	543	222	708

There were no individual payments that exceeded £250,000 (Period ended 31 March 2011 no cases).

24. 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. During the period these transactions were valued at £410 million of income (31 March 2011: £414 million), including capital funding and grant in aid, and £57 million of expenditure (31 March 2011: £58 million), which represented trading with 207 separate organisations.

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

Name and Title	Registered Interest(s)
Mr G J enkins (Non Executive Director)	South London Healthcare NHS Trust (Chairman) - resigned October 2011
Mr R Griffins (Non Executive Director)	London Ambulance Service NHS Trust (NED)

NHSBT Transactions with Members Registered Interests

	Income £000's	Expenditure £000's
South London Healthcare NHS Trust	2,874	16
London Ambulance Service NHS Trust	-	-

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

In accordance with Treasury guidance the NHS Blood and Transplant trust Fund is regarded as a related party. Income received from the Trust Fund during the year totalled £125,000 (31 March 2011 : £96,000)

25. 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.

26. 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 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 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.

27. 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	5,644	-	1,202
Balances with local authorities	-	-	5
Balances with NHS Trusts and organisations	11,417	-	1,993
Total Intra-Government Balances	17,061	-	3,200
Balances with bodies external to government	7,635	145	16,716
At 31 March 2012	24,696	145	19,916
Balances with other central government bodies	2,930	-	140
Balances with local authorities	-	-	28
Balances with NHS Trusts and organisations	16,211	-	1,950
Total Intra-Government Balances	19,141	-	2,118
Balances with bodies external to government	7,408	215	15,916
At 31 March 2011	26,549	215	18,034

28 Demerger of the Bio Products Laboratory (BPL)

On 27th July 2010 the Secretary of State for Health announced that a decision had been made to transfer Bio Products Laboratories (BPL) out of NHSBT into a limited company owned by the Department of Health.

The transfer of the net assets of BPL to BPL Ltd took place on 1st January 2011.

In accordance with the principles of merger accounting BPL was excluded from the financial statements for the year ended 31st March 2011.

Net assets totalling £129,442,000 were removed from Taxpayers Equity as at 31st March 2010.

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, telephone, fax and email
TSO
PO Box 29, Norwich NR3 1GN
Telephone orders/general enquiries: 0870 600 5522
Order through the Parliamentary Hotline Lo-Call 0845 7 023474
Fax orders: 0870 600 5533
Email: customer.services@tso.co.uk
Textphone: 0870 240 3701

The Parliamentary Bookshop
12 Bridge Street, Parliament Square, London SW1A 2JX
Telephone orders/general enquiries: 020 7219 3890
Fax orders: 020 7219 3866
Email: bookshop@parliament.uk
Internet: http://www.bookshop.parliament.uk

TSO@Blackwell and other accredited agents

ISBN 978-0-10-297977-0