NHS
Blood and Transplant

NHS Blood and Transplant
Annual Report and Accounts 2015/16

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 7 July 2016

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PERFORMANCE REPORT

Overview

Chief Executive Foreword

Welcome to the 2015/16 annual report and accounts. In 2015/16 we are pleased to report that we have continued to make significant progress against the strategic goals outlined in the **Blood 2020** and **Taking Organ Transplantation to 2020** strategies and in the strategies across our Diagnostic and Therapeutic Services Division.

We are proud of these achievements but know that we must try even harder to realise our ambition to consistently be "the best service of our type in the world" whilst also supporting the NHS and the ever increasing pressures that it is facing.

We face a particular challenge in 2016/17 and beyond as we work to upgrade an ageing IT infrastructure and replace our critical IT systems. This will require significant cash investment and, being the type of organisation that we are, demands that we deliver these changes safely and without impacting the delivery of critical products and services to NHS patients, often at their time of greatest need.

I'd like to express my sincere thanks to my colleagues in NHS Blood and Transplant (NHSBT), and to all of our stakeholders, who have made the safe delivery of our achievements in 2015/16 possible and who will be working with me to deliver the challenges ahead.

The Nature and Purpose of NHSBT

The core purpose of NHSBT is to ***"Save and Improve Lives"*** through providing a safe and reliable supply of blood components, solid organs, stem cells, tissues and related diagnostic services to the NHS and to the other UK Health Departments where directed.

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

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

Blood Components covers the supply of red cells, platelets, plasma and related specialist products to NHS hospitals in England and North Wales. The cost of these products is recovered in the prices that are agreed annually through the National Commissioning Group for Blood. Around 35,000 units of whole blood are collected every week via a network of fixed sites and mobile blood collection teams. The blood is processed in five processing centres (two of which are also testing facilities) and distributed via a network of fifteen issue centres to over 200 NHS Trusts.

Organ Donation and Transplantation (ODT). Three people die every day in the UK due to the lack of an organ for transplant. NHSBT is the UK "Organ Donation Organisation" that is working with the four UK Health Departments and hospitals throughout the UK in order to increase the numbers of organs available for transplantation. The cost of these activities (including the retrieval of donated organs) is directly funded by the UK Health Departments.

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

- ***Tissue and Eye Services*** – NHSBT retrieves tissues (such as skin, bone and eyes) from deceased donors and processes and stores these at its facility in Speke prior to issue to hospitals.

- ***Stem Cell Services*** – NHSBT is the largest UK provider of haemopoetic stem cells for the treatment of blood cancers and operates the British Bone Marrow Registry and the NHS Cord Blood Bank. We additionally provide supporting services to NHS, academic and private sector organisations seeking to take next generation stem cell therapies to the clinic.

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

- ***Therapeutic Apheresis Services (TAS)*** – NHSBT provides a service for collecting stem cells, related immunotherapy products and serum for production of autologous tears. We also provide various apheresis based therapies such as phototherapy and plasma exchange.

The cost of the products and services provided by the DTS SBUs is generally recovered through the prices that are set within each SBU and agreed annually through the National Commissioning Group for Blood.

Going Concern

NHSBT operates a five year planning process which includes assumptions regarding demand, prices, programme funding, operating costs and the projected cost and benefits of the transformation programme.

As a result of the latest plan the Directors have a reasonable expectation that NHSBT will have adequate resources over the coming 5 year period and thus they continue to adopt the going concern basis in preparing the annual financial statements.

Principal Risks and Uncertainties

Our strategies are subject to the following principal risks and uncertainties:

IT infrastructure and systems:
The IT infrastructure and systems across NHSBT are generally old, close to end of life and, in some critical areas, dependent on Small and Medium Sized Enterprises (SMEs) for their ongoing support and maintenance. A significant programme of work is therefore required to update ageing infrastructure, replace critical operational applications (especially the Pulse system in Blood and the National Transplant Database in ODT) and migrate to cloud based services. The scale of work is challenging, needs to be conducted without impairing the quality of “business as usual”, demands robust implementation methodologies (i.e. without impacting the safety and availability of critical products and services) and will limit the availability of resources for other elements of our change programmes over the next three years.

Financial Strategy - Blood:
Our intent is to fund the extensive changes described above from existing cash resources and within an income envelope that is defined by an objective to retain flat pricing for blood components over the medium term. Our current projections indicate that this is deliverable, subject to identifying

additional (and relatively modest) cost savings. This broad intent, however, is subject to two major risks:

- the demand for red cells (and now platelets) continues to decline and may fall quicker and beyond existing assumptions. Further reduction would reduce our income and limit our ability to fund the IT investment required without increasing the prices of blood components to the NHS.
- we are at the early stages of the IT change programme. Hence there is a high degree of uncertainty regarding the size and timing of the relevant cash investments required and a risk that the programme may cost more than existing assumptions. This would again put upward pressure on the prices of blood components to the NHS.

Blood Supply challenges

The demand for red cells (and lately platelets) has been decreasing at around 3% pa since 2012 and this is expected to continue over the medium term. At blood group level, however, we are seeing differential demand trends with demand for "universal" components (O negative red cells and A negative platelets) increasing in absolute terms and as a proportion of the whole. These differential trends, at detailed blood group/component level, appear to be sustained and are predicated to be driven by reducing capability within NHS hospitals (exacerbated by 24/7 working patterns) such that resort is too often made to ordering universal components over a suitably matched component.

We will continue to work with hospitals on patient blood management but, in case these trends continue, we may be unable to attract the disproportionate number of specific donors that would be required (i.e. far greater than their prevalence in the broader population) and may need to influence demand through revised pricing mechanisms, involving much higher (punitive) prices for O negative red cells for example. This is likely to be unpopular with NHS hospitals and impact on our customer satisfaction ratings.

Funding of the Organ Donation and Transplantation strategy:

The "Taking Organ Transplantation to 2020" strategy that was agreed by the four UK Heath Departments during 2013/14 aims to increase the levels of organ donation and transplantation in the UK to world class levels. It further requires investment in the supporting systems and processes to ensure that the clinical pathway from donor to patient can be managed on a safe and resilient basis. Although sufficient funding is available in 2016/17 the funding model is not ideal (for example it does not take direct account of volume increases) and is disjointed (in England transplants are funded by NHS England and donation by the Department of Health). Discussions will continue with the four UK Health Departments in order to consider a more appropriate mechanism beyond 2016/17 so that funding will be sufficient to meet the ambitions and targets of the "Taking Organ Transplantation to 2020"

Risks are further highlighted in the Governance Statement at page 24.

Performance Analysis

Strategic Objectives

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

Strategic plans have been developed for each of Blood, ODT and the individual business units within DTS. The plans identify distinct strategic objectives, targets and plans for each business and are summarised below. The segmental reporting within these accounts (Note 2) reflects the strategic structure of NHSBT and identifies the income, contributions and allocation of overheads that are applied to each.

Taking each of our Divisions in turn:

Blood Components

Strategic Objective*: To ensure for all patients, including patients with complex needs, that the right blood components are available at the right time, and are supplied via an integrated, cost efficient and best in class supply chain and service*.

This objective is expressed in the Blood 2020 strategy that was published in January 2015 and is founded on the following four pillars.

Blood Collection
We will ensure a sustainable donor base underpinned by flexible collection and donor invitation processes; modern donor service, excellent session experience and high levels of collection productivity.

Manufacturing
Our manufacturing activity will be hospital focused with high levels of safety, productivity, regulatory compliance and order fulfilment.

Customer Service
We will provide excellent customer service with a tailored, cost-effective offering and a modern interface with hospitals.

Integration
Our aim is to integrate NHSBT with key hospitals and any related networks, to drive improved patient outcomes and reduce system costs through integration of blood supply from “vein to vein”.

The strategic objectives are supported by action plans and a balanced set of supporting targets covering donor satisfaction, customer satisfaction, product safety, supply chain effectiveness and efficiency. The headline target within the strategy is the price of red cells which has been reduced from £140/unit in 2007/08 to £120/unit in 2015/16 as a result of a reduction of excess capacity in the supply chain and significant improvements in efficiency. In recognition of the significant financial pressures that are facing the NHS our ambition is to at least maintain flat pricing over the medium term, despite an ongoing reduction in demand and the need to fund significant investment in our IT infrastructure and applications.

Organ Donation and Transplantation

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

The 'Taking Organ Transplantation to 2020' strategy was published in June 2013. 2015/16 saw the highest number of deceased organ donors and the resulting transplants. Since the original Organ Donation Task Force (ODTF) report was published in 2008 there has been an increase of 68% in deceased organ donors.

A chronic shortage of organs available for transplant nevertheless remains. We continue to work towards the 2020 strategy that aims to achieve the following outcomes for organ donation and transplantation:

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

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

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

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

This is supported by four strategic targets:

- A consent / authorisation rate in excess of 80%
- 26 deceased donors per million population (currently 20.1 pmp)
- An aim to transplant 5% more of the organs offered from consented, actual donors
- A deceased donor transplant rate of 74 per million population (currently 52.4 pmp)

Diagnostic and Therapeutic Services (DTS)

The DTS group supplies a range of biological products and specialist diagnostic through the Strategic Business Units (SBUs) described below. Strategic plans have been developed for each business that captures its purpose and the rationale for its inclusion within the NHSBT portfolio of businesses. Each of the DTS business units operate on a national basis with a unique footprint of facilities and capabilities and are often competing with other parts of the NHS. A common objective of each business, therefore, is to leverage this capability and seek the opportunity to consolidate the provision of such services to the NHS within NHSBT. In turn this should generate benefits of scale and drive greater efficiency, higher safety and better availability of specialist services and therapies for NHS patients.

The objectives for each business are:

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

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

Within ***Diagnostics*** we recognise two SBUs and their associated objectives:

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

Histocompatibility & Immunogenetics (H&I): *To maintain our position as the UK's largest provider of H&I services through delivering an innovative, integrated and technologically enabled service which will save more patients' lives by ensuring they have access to precisely matched blood, stem cells and organs when needed.*

Within ***Stem Cell Services*** we also recognise two SBUs i.e.:

Stem Cell Donation and Transplant (SCDT)*: To maximise the number of patients offered a potentially curative stem cell transplant by providing an effective, affordable and financially sustainable supply of well-matched unrelated donor stem cells.*

Cellular & Molecular Therapies (CMT): *To establish NHSBT as the preferred provider of established cell therapies to the NHS, and of innovative cellular and DNA-based therapies for academic and commercial organisations.*

NHSBT directly supports around 50% of all stem cell (bone marrow) transplants in the NHS through collection, processing and cryopreservation and supply of donated stem cells. More than 400 patients each year in the UK, however, are denied access to a transplant, with around 200 lives lost due to the lack of a matched stem cell donor. This loss of life disproportionately affects black and ethnic minority patients because of the particular challenges in identifying suitable donors for members of these communities. In December 2010, the UK Stem Cell Strategic Forum set out a strategy for saving 200 lives per year through increasing the UK inventory of cord blood donations and by improving the performance of the UK based stem cell registries to match the best in the world. NHSBT is supporting this initiative through increased collaboration with the Anthony Nolan charity, banking an additional 2,300 cord blood donations each year, high resolution typing of adult, ethnically diverse donors and seeking further opportunities to improve IT interoperability with other bone marrow registries.

As a result of the services we provide for bone marrow transplants NHSBT has developed a unique national infrastructure. This provides NHSBT with the capabilities to support the development of the next generation of stem cell therapies that are using stem cells and bioactive molecules to regenerate tissues ('regenerative medicine') and to selectively destroy cancerous cells ('cancer vaccines') and viruses. Through this infrastructure NHSBT is able to provide the donor stem cells and bring strengths in specialist manufacturing, regulatory expertise, distribution and R&D in support of the developing regenerative medicine industry. This includes the operation of the Clinical Biotechnology Centre (CBC) in Bristol that has unique capabilities in small volume manufacture of plasmids/gene therapy vectors to support early stage clinical trials.

Corporate

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

Our R&D programme for Blood includes:

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

In ODT we are developing an R&D programme, in conjunction with hospital partners, to assess novel methods for improving the quality and number of organs available for transplant, including support for the development of blood group (ABO) incompatible and antibody incompatible transplants.

Within DTS we are exploring next generation diagnostics using genotyping and recombinant proteins with the aim of improving clinical outcomes, including alloimmunisation, by improved donor/patient matching, and increasing the availability of extended genotype blood stocks for hospitals. We also conduct research programme in Tissues, primarily based on partnerships with academic partners, to identify the next generation of tissue based therapies that would enable NHSBT to meet the potentially unmet needs of NHS patients.

Consistent with an organisation whose mission is to 'save and improve lives', we are committed to sustainable development and minimising wherever possible the impact of our operations on our environment. We believe that sustainability is an important value of our donors and that NHSBT should meet their expectations when they make their 'gift of life'. In support of this the Executive Team signed up to new challenging targets in July 2015, including targets to cut carbon emissions by 50% over a 2014/15 baseline, and achieve zero waste to landfill (excluding clinical waste), by 2025.

With regard to our corporate functions we are committed to continuous improvement in the effectiveness and efficiency of back office functions and continually benchmark them against comparable organisations. In support of this we also continue to engage with government and departmental plans for shared support services.

Operating Review

Key Performance Headlines 2015/16

- **Blood**
  2015/16 has been another very successful year with further improvement in service levels, product availability, regulatory performance and productivity. The Division has continued to respond extremely well to the sustained reduction in red cell demand that has seen demand fall by a further 4.0% in 2015/16. NHSBT continues to be proud of the fact that prices for red cells in 2016/17 will be lower than they were in 2004/5, despite inflation, investing in higher safety and availability and a 17% reduction in red cell demand over that period. In aggregate the cost of red cells supplied to the NHS in 2016/17 will be circa £75m pa lower than they were in 2008/09.

- **ODT**
  There were 1,364 deceased donors in 2015/16, 6.1% higher than 2014/15. As a result there were 3,529 deceased transplants in 2015/16, up by 5.6%. These establish new annual records for both the number of deceased donors and the number of deceased transplants in the UK.

- **DTS**
  Income in 2015/16 at £65.6m was 11.7% higher than last year. This reflected strong growth in Tissue and Eye Services (up by 45.6%) following acquisition of the Bristol and Manchester eye banks on 1 April 2015. This was only partly offset by much lower activity in SCDT where much lower cord blood issues and BBMR matches saw income fall by 3.4% over 2014/15.

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

Blood

We continue to see decline in demand for red cells with issues of 1.594 million units in the year, 4.0% lower than 2014/15, albeit broadly in line with plan. At blood group level, however, demand for O negative red cells (the "universal" type) increased by 0.7%. As a consequence issues of O negative red cells were 12.9% of the total, versus the 7% of the population that is O negative. The proportion of O negative supply as a proportion of the total continues to grow and was at 12.1% in 2014/15.

Although platelet demand has been relatively stable for a number of years demand began to decline in Q4 2015/16 and indications are that this may become a sustained trend as has been seen in red cells (and in other blood services across the world). Again, however, the demand for A negative platelets (the universal type) increased by 2% and issues were 15% of the total, versus the 7% of the population who are A negative donors.

Blood stock levels, and the availability of blood products remained highly resilient through the year with strong and consistent levels of O negative red cells in particular (consistently at 5 to 7 days of stock). One of our key performance indicators is the number of times within the year that any red cell blood group falls below a three day alert level for a consecutive period of three days or more. We are pleased to note that during 2015/16 there were no such instances (following zero instances in 2014/15). However, the differential demands at blood group/component level described above are unsustainable in the longer term and the impact started to be seen in mid March 2016 where the level of O negative red cells stocks fell to around 3.5 days and have stayed at a similar level through April. The very recent trend in O negative red cells is unprecedented in historical terms and will require action to both improve supply (increase the pool of active O negative donors) as well as with hospitals to reduce the level of demand (possibly supported by differential pricing to influence ordering behaviours). The same also applies to managing the supply/demand balance for A negative platelets.

Aside from the increasing challenges to supply that are now being seen at the blood group / component level performance and delivery across Blood has continued to be strong during 2015/16. Hence:

- With regard to safety there were no Serious Untoward Instances (SUIs) during the year and no adverse trends in the reporting of adverse events following transfusion.
- Four "major" regulatory non-compliances following regulatory inspection by the Medicines and Healthcare products Regulatory Agency (MHRA), were reported during the year. This is an increase over the one "major" reported in 2014/15. Our internal quality function have compared our performance and processes over time and believe our performance has achieved consistent standards. NHSBT welcomes the continuous improvement in standards and is addressing all the issues raised.
- Donor satisfaction was consistently at or above the planned level of 70% (measured as the percentage of donors scoring 9 out of 10 or higher for overall service) and was at 72.4% in March 2016.
- Underpinning this we have introduced new functionality within the **blood.co.uk** website that allows donors to book and amend appointments. We now have more than 1 million donors using this improved on-line capability.
- From a customer perspective, hospital satisfaction with NHSBT's service remained high and at year end was at 74% (measured as the percentage of customers scoring 9 out of 10 or higher for overall service) versus 70% at the end of last year.
- We have supported the intention of the Welsh Government to establish a Welsh Blood Service covering the whole of Wales. We expect to successfully transfer the operations managed by NHSBT in North and Mid Wales to the Welsh Blood Service in May 2016.

In addition our response to the financial impact of demand decline has continued to be well managed with further cost savings delivered and productivities increased. This has allowed NHSBT to hold the red cell price at £120/unit next year (2016/17) despite an assumed further decline in red cell demand of 3.4%.

Responding to the ongoing reduction in demand continues to be the primary challenge in Blood. In response NHSBT has closed excess capacity in processing and testing and can demonstrate world class productivity levels in these areas. Capacity in blood donation has also been reduced to match demand decline, although productivity in this area remains some 20% lower than the best performing blood services in the world. In order to hold prices, and support the financial challenges faced by the NHS, further productivity improvements will be sought, especially in blood donation. This presents a challenge on two fronts:

- A significant element of the productivity improvement will be delivered through fewer, larger mobile sessions and greater use of fixed donation centres. The resulting service configuration will therefore look different to some of our donors (e.g. less frequent visits to some areas) and it will be important that we communicate these changes well so that we retain the loyalty of our donors and their willingness to donate.

- The changes will result in some loss of donors who are unwilling or unable to change to any new donation arrangements in their area. Although fewer donors are needed to meet lower demand we need to retain the flexibility to respond to any future increases in demand and we need to retain O negative (and A negative) donors in order to meet the differential demand that is being seen for O negative red cells and A negative platelets.

Striking the right balance between matching the number of active donors with decreasing demand overall, but with differing trends at blood group level, and doing so productively, will be an increasingly difficult challenge for the service. In these circumstances we are pleased that donor satisfaction as reported above remains high and that the trend in donor complaints is positive.

Organ Donation and Transplantation (ODT)

2014/15 was a disappointing year with regard to organ donation and transplantation outcomes with 2.9% fewer deceased donors than 2013/14 and 4.9% fewer deceased transplants. It was the first time in many years that the number of donors and transplants had fallen year on year.

We are therefore delighted to report that there were 1,364 donors in 2015/16 from the deceased population, 6.0% higher than 2014/15. As a result there were also 3,529 deceased transplants in 2015/16, up by 5.6% over 2014/15. More importantly these are both higher than the numbers recorded in 2013/14 and hence 2015/16 has seen the establishment of new records for both the number of deceased donors and the number of deceased transplants in the UK.

ODT continues to work with the four UK Health Services, and all stakeholders, on developing the detailed plans in support of the “Taking Organ Transplantation to 2020” strategy and delivering its ambitious targets. During 2015/16 we have made significant progress supporting the Welsh Health Department with regard to implementation of the Human Transplantation (Wales) Act 2013. The Bill was passed in September 2013 and introduced a system of “soft opt out” for organ and tissue donation in Wales from 1 December 2015. In order to support this change, the UK Health Departments agreed to fund the construction of a new organ donor register for the UK. The new register supports the opt out arrangements in Wales, alongside the opt in arrangements that apply elsewhere in the UK, and was successfully implemented by NHSBT during 2015/16.

Around 1 million new (opt in) registrants were officially added to the Organ Donor Register in 2015/16. This is consistent with previous years but was much less than the planned increase of 2 million registrants. This was as a result of the need to suspend the automatic feed of new registrants from partner organisations such as the DVLA due to a small number of errors that were being generated in certain circumstances. The errors have now been fixed and it expected that the backlog of automatic registrations will be processed in May 2016.

During 2015/16 ODT made significant progress with the Donor Registration Transformation project which provides organ donation nurses with an iPad based application to register potential organ donors. This is due to go live in June 2016 and will lead to the removal of existing paper based

processes both helping efficiency and reducing the potential for data transcription errors. During the year ODT has also commenced with the first phase of the ODT Hub project that will facilitate better coordination and management of the donation/transplant pathway and ultimately to the replacement of the National Transplant Database (NTxD) which is based on outdated software and infrastructure.

Diagnostic and Therapeutic Services (DTS)

Activity in DTS during 2015/16 has continued to focus on developing and implementing the strategies of the individual strategic business units. A common theme within each of the strategies is the intent to position NHSBT as a preferred national supplier to the NHS and, in so doing, to grow the income and financial contribution from each business in support of future price reductions and / or to fund new therapies in respect of unmet patient needs.

The outcome of this approach can most obviously be seen in **Tissue and Eye Services**. Where income growth of 46% was seen as a result of our acquisition of the activities of the Bristol and Manchester Eye banks on 1 April 2015.

Growth of 13.6% was seen in **Cellular and Molecular Therapies** income on the back of increased service income (in support of stem cell transplants) and sales growth in contracts won by our Clinical Biotechnology Centre in Bristol. Positive growth of 8% was also seen in **H&I** income driven by strong demand for stem cell related investigations (up 21%) and solid organ investigations (up 6%).

This was only partially offset by a decline of 3.4% in SCDT income driven by a decline in the number of BBMR matches and cord blood issues. Only 45 cord blood units were issued in the year versus the 43 that were issued in 2014/15 and 60 in 2013/14. This compares adversely to the 150 issues that were anticipated by the UK Stem Cell Forum and hence a fundamental review of the SCDT strategy will be conducted by the Board during 2016/17.

Taken together DTS recorded income of £65.6m in 2015/16, 11.7% higher than last year and with the eye banking acquisition referred to above being the primary driver. Across the DTS portfolio there were no Serious Untoward Instances (SUIs) reported but there was one “major” regulatory non compliance reported relating to a pre-licensing inspection of our Birmingham Advanced Therapies Unit facility (versus 1 reported in DTS during 2014/15 in respect of the CBC i.e. in a similar operational area). The “major” was a collation of several items related to the design and set up of the clean room, the monitoring practices and systems and some gowning practice issues. Some of this reflects the incremental nature of how our units have evolved over time and, as a result, we will be taking a more strategic approach to the design and development of such facilities underpinned by a “centre of excellence” approach whereby we will limit the manufacture of advanced therapy medicinal products to fit for purpose facilities designed to provide Good Manufacturing Process (GMP) standards.

Customer satisfaction across the DTS portfolio was variable, both between services and by quarter. In H&I, following a poor result of 54% in September, satisfaction improved and was at 74% for the year versus 64% last year. Satisfaction in RCI, however, was at 60% for the year versus plan of 65%, although this was a distinct improvement over the 53% seen in 2014/15. Improvement actions continue to be taken with our Tooting Centre being a focus area for improvement. In Therapeutic Apheresis Services (TAS) customer satisfaction continued to be at 68% (versus the 68% reported last year). More importantly, given that TAS is the only part of NHSBT that directly treats NHS patients, patient experience continues to be excellent and was reported at 99% positive in the last survey in December 2015.

Research and Development

Our world-leading research and development (R&D) programme informs international best practice in transfusion, transplantation and regenerative medicine. Our innovative research initiatives deliver

translational benefits for healthcare in the UK and beyond and were approved in May 2015 as part of our 2015 – 2020 R&D Strategy. During 2015/16 we:

- Implemented phase II of the INTERVAL study to increase understanding of donor health and the behavioural factors which lead people to donate (www.intervalstudy.org.uk);
- Investigated emerging infections, including Hepatitis E virus, Ebola and Zika, and the possibilities for screening and inactivating such threats;
- Examined the optimal use of blood components, focusing on platelet transfusion triggers in neonates and HLA-matched platelets in aplastic anaemia, myelodysplastic syndrome or acute myeloid leukaemia;
- Initiated a clinical trial of tranexamic acid in patients with haematological malignancies with severe thrombocytopenia. This is our first clinical trial of an investigational medicinal product;
- Initiated an assessment of novel methods for improving the quality and number of organs available for transplant in conjunction with hospital partners;
- Consented over 500 donors to the Quality in Organ Donation (QUOD) study to create a National Biobank of samples for use in studies aimed at improving transplant outcomes (www.quod.org.uk/);
- Continued to enhance our understanding of the production of red blood cells and platelets from stem cells with the intent of taking these advanced blood components into clinical trials in 2017;
- Deployed next generation diagnostics using genotyping and recombinant proteins to improve patient diagnoses and therefore improve clinical outcomes;
- Appointed to University Research Fellow positions in virology and cell biology to increase capacity and expertise in these critical areas;
- Established four National Institute for Health Research (NIHR) Blood and Transplant Research Units which will deliver translational research in donor health, organ donation and transplantation, stem cells and immunotherapies and manufactured blood cells;

Financial Review

NHSBT is required to report on a ***Net Expenditure*** basis with programme funding provided by the Department of Health recognised in the general reserve. Although NHSBT is required to report on a net expenditure basis, the Board and Management of NHSBT review NHSBT's financial performance on an ***Income and Expenditure*** **basis**, as this is more appropriate to the trading nature of most of NHSBT's activities. On this basis NHSBT generated an operating surplus of £4.9m in 2015/16 (versus £15.7m in 2014/15). See note 2 in the financial statements. NHSBT normally aims to deliver a balanced income/expenditure position (ie no planned surplus or deficit). Surpluses generally arise due to the slippage of projects against plan and hence planned expenditures falling into subsequent years. The larger surplus recorded in 2014/15 therefore simply reflects greater slippage of projects versus plan in that year versus what was seen in 2015/16.

Note 2 of the accounts reconciles the operating surplus described above to the net expenditure basis on which the primary statement of these accounts is prepared. The note further provides a segmental analysis of our financial performance that is consistent with the business units defined by our strategies and the presentation of our management accounts.

NHSBT receives the majority of its income through the prices of blood components (based on cost) charged to NHS Hospitals. This income was £275.6m in 2015/16 (4.8% lower than the £289.4m recorded in 2014/15). The lower income seen in 2015/16 arose primarily from the ongoing decline in the demand for red cells (demand in 2015/16 was 4.0% lower than the previous year) plus a reduction in the red cell price from £122/unit to £120/unit.

NHSBT also receives income from prices charged for diagnostics, tissues, stem cell and therapeutic apheresis services (TAS) within DTS, again based on cost. Excluding programme funding, and other income (e.g. from sales of waste products), this amounted to £57.4m in the year (£50.9m in 2014/15). As noted in the Operating Review above the income growth in DTS was driven by strong growth in Tissues (+46%) due to the acquired eye banking activities offset by an income decline of 5% in Stem Cell Services (as a result of lower cord blood issues and fewer bone marrow transplants).

In addition to income from the sales of products and services the Department of Health provided programme funding of £63.4m for the year (£63.0m in 2014/15) primarily to support ODT. £59.1m of this (£56.6m in 2014/15) was allocated to organ donation and transplantation with £4.3m funding the development of the NHS Cord Blood Bank (£4.4m in 2014/15). In 2014/15 £2.1m of this funding was also allocated to support the activities of the International Blood Group Reference Laboratory (IBGRL). During 2015/16 this unit was transferred from R&D and brought within DTS operations. As a result its funding was brought into the scope of prices and the programme funding reallocated to support ODT and reflected in the increased funding noted above. NHSBT also received contributions in the year of £12.2m from the devolved UK Health Departments in support of our UK wide activities in organ donation and transplantation (£10.9m 2014/15). The increase reflects the higher activity in deceased donation and to meet their commitment of providing funding in line with share of population.

We additionally receive £10.3m of “other” income (£12.1m in 2014/15) for cost recovery of services provided. Much of this is related to the ad-hoc delivery of blood components to hospitals, over and above the scheduled deliveries within our service level agreements (which are included in prices). The reduction reflects volume decline and also the ongoing trend for hospitals to organise their own pick up of ad-hoc orders.

As noted above NHSBT generated an overall operating surplus for the year of £4.9m (£15.7m in 2014/15). The segmental analysis in Note 2 identifies an operating surplus of £7.4m for Blood Components (£18.8m 2014/15) and a surplus in ODT of £2.8m. This surplus was partially offset by a £5.3m deficit in DTS. The surplus in Blood arose from a combination of cost control and early delivery of benefits from our transformation plan along with slippage of some of the major projects into 2016/17 (and hence the associated spend). The surplus in ODT similarly reflects slippage of transformation project spend into 2016/17 (especially the ODT Hub) but also lower costs than expected in organ retrieval. The deficit in DTS reflects lower income than planned (especially in SCDT) along with the transfer of IBGRL from R&D and hence the transfer of an operational deficit through removal of its past programme funding. Action will be taken to close this deficit in 2016/17 through growth in Tissues income, income growth/cost reduction in SCDT and a longer term programme of action in IBGRL to both grow income and reduce activity.

NHSBT spent capital of £6.8m, on a cash basis, in 2015/16 funded by the Department of Health, versus £8.4m in 2014/15. Much of this expenditure is incurred in the continual improvement of manufacturing and laboratory facilities, replacement of the manufacturing and testing equipment, and IT hardware / applications used to support our operations. The reduction primarily reflects the timing of projects and is planned to increase to £12.5m in 2016/17.

As shown on the Statement of Financial Position, current assets increased from £73.1m in 2014/15 to £82.0m in 2015/16 reflecting an increase in cash from £22.1m to £30.5m. The cash balance has arisen over recent years and reflects ongoing surpluses that were primarily driven by lower spend than anticipated by our transformation plans. The accumulated cash will be necessary to fund the significant increase in transformation activity that is now planned and will result in the necessary

renewal of the NHSBT desktop (currently based on Office 2003) and replacement of the Pulse system that is critical to the operations in Blood.

NHSBT is the corporate trustee for NHSBT Trust Funds. The total net assets of the trust funds as at 31 March 2015 were £0.479m. Although the Trust Fund assets are controlled by NHSBT a consolidated account is not produced due to their lack of materiality. The 2015/16 Trust Fund Accounts will be available on the Charities Commission website at www.nhsbt.nhs.uk/news-and-media/review-accounts

There were no significant contingent liabilities to report as at 31 March 2016. For full details refer to note 18 contingent liabilities in the financial statements.

Sustainability Report

In 2014/15 we were pleased to report that we had delivered our five year plan to deliver a 25% reduction in carbon emissions (measured against a 2009/10 baseline). In July 2015 the Executive Team agreed to a new set of challenging targets described below:

- 50% cut in carbon emissions;
- Zero waste to landfill (excluding clinical waste);
- A resilient business;
- A sustainable supply chain; and
- Sustainability embedded into organisational culture.

These objectives are being drafted into NHSBT's 2025 Sustainability Strategy for launch in June 2016. The 50% reduction of carbon emissions will be baselined against the CO2 generated from gas/energy/transport in NHSBT within the 2014/15 financial year. The 0% waste to landfill target will be baselined against the total 2014/15 (non-clinical waste) volumes and will be fully itemised within the final strategy document. The targets are ambitious, unlikely to be delivered in a linear manner, and will depend on step changes in the management of energy, our estate and our fleet.

Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

NHSBT accounts have been charged for 2015/16 CRCs based on 2014/15 CO2 emissions, multiplied by the 2015/16 unit cost of credits. NHSBT will commence payments in July 2016, when the submission window opens. The CO2 emissions data for prior years is shown below:

CO2 Emissions 2009/10 to 2014/15

NHSBT	09/10 Footprint	10/11 Footprint	11/12 Footprint	12/13 Footprint	13/14 Footprint	14/15 Footprint
CO2 Emissions	27,792	24,514	22,570	21,502	21,636	20,461
Target	Baseline	6%	11%	16%	21%	25%
Actual	Baseline	11.8%	18.8%	22.6%	22.37%	26.33%

The Chancellor announced the following, within the 2016 Budget Statement:

"…abolish the bureaucratic and burdensome Carbon Reduction Commitment energy efficiency scheme and replace it, in a revenue neutral way, with an increase in the Climate Change Levy from 2019."

In effect, therefore, from 2019, NHSBT will no longer need to submit an annual CRC return. Instead the business will be taxed at source, within its energy supplier's statements.

Environmental

NHSBT's Environmental Management System (EMS) continues to mature and become embedded in NHSBT's operations. The EMS has successfully passed its first eight external surveillance audits and maintained certification, through BSi.

NHSBT's current certification is to ISO14001:2005 and this will begin to be transferred to the new ISO14001:2015 standard from October 2016. It is anticipated that this will be completed by the end of the current certification period (December 2017).

Approved or Planned Developments

NHSBT continues to deliver transformational change. Amongst other outcomes this has resulted in efficiency savings that has enabled NHSBT to reduce the costs of red cells from £140/standard unit in 2008/09 to £120/unit in 2016/17 (a reduction in cost to the NHS of £75m pa versus 2008/09). Transformational change in NHSBT is delivered through a programme of major change projects, underpinned by a commitment to continuous improvement and lean working.

Our investment in transformational change in any year is defined by the number and nature of the projects within the programme. Although we continue to focus on efficiency the programme is now increasingly defined by the major investments that are required to replace our ageing IT infrastructure and the core operational applications. As a result our programme has developed to become one that includes the smaller number of very much larger projects described below:

- **Core Systems Modernisation (CSM)**
  The CSM project aims to introduce new supply chain systems in Blood, from donor management through manufacturing and processing and on to hospital delivery and stock management, and ultimately to replace the ageing Pulse system that currently supports these processes. The project is currently in its early stages with regard to defining the new Operating Model and the project blueprint. As such the cost of the project is yet to be defined but it is likely to be in the range of £30m - £40m over the next five years. In support of this an Outline Business Case is due to be presented to the NHSBT Board in July 2016.

- **ODT Hub**
  The objective of the ODT Hub project is to introduce new processes in support of the management of the clinical pathway between organ donation and transplantation. As with the CSM project it will also result in the replacement of the existing IT application that supports the current processes i.e. the National Transplant Database (NTxD). The cost of the project is anticipated to be £8m over four years. A business case for the Year 1 phase (£1.5m) was been approved during 2015. A business case for Year 2 (£2.5m) was approved by the NHSBT Board in May 2016.

- **Supply Chain Modernisation (SCM)**
  The SCM will result in the closure of blood processing at Sheffield and Newcastle and consolidate these activities within Manchester. The programme therefore includes a need to invest in the manufacturing facilities in Manchester to facilitate the consolidation as well as a net reduction in jobs and related redundancy costs. The project was approved by the Board in July 2015 at a cost of £6.1m. It is due to complete in August 2017 and is expected to deliver net recurring saving of £1.4m pa.

  As a result of this change there is further under utilisation of our Sheffield Centre. Our Leeds centre is also under utilised. Options have been explored around the configuration of our estate in the Leeds and Sheffield area and it has been determined that a new single centre, situated between the two existing centres, is the preferred option. An outline business case was endorsed by the NHSBT Board in May 2016 and this will be developed into a detailed business case for

approval by the Board in May 2017. The cost is anticipated to be approximately £13m with most of this capital related.

- **Brentwood Estate project**
  This project will result in the closure and sale of the underutilised Brentwood Centre and establish a smaller and more efficient estate footprint in the Brentwood area. The project is expected to cost £7.1m, including the establishment of a new Stock Holding Unit and Team Base in the area. It is due to complete in April 2017 and delivers recurring savings of £1.1m along with the return of proceeds from the sale of the existing site (estimated at £3.45m).

The transformational change programme will enable us to update IT infrastructure, improve the quality of our services and products, and maintain or reduce blood prices while absorbing the impacts of demand for our products. There are risks to achieving this aim which are outlined on page 30 of this report, along with our approach to mitigation.

Principles of Remedy

NHSBT is committed to providing quality responses to our customers' queries and concerns in line with, the Department of Health guidelines 'Listening, Responding, and Improving' and the Ombudsman's guidelines 'Principles of Remedy'. We actively seek feedback from our customers so that we can take steps to put things right when expectations and needs are not met, and we can understand where we need to improve. Complaints procedures are in line with the six principles that represent best practice published by the Parliamentary and Health Ombudsman in 2010. Customers can complain in person, by phone to our Hospital or Donor Customer Services staff or in writing. Our contact details are published on complaint leaflets and on our websites. We receive complaints from three main customer groups Hospitals, Blood Donors and from Organ Donation. The paragraphs below outline the activity and level of complaints in each area during the period.

During 2015/16, we received 942 formal contacts from our hospital customers of which 684 (73%) were complaints and 258 (27%) were compliments. We use every one of these complaints and compliments to help us improve our services alongside customer feedback through our satisfaction surveys and hospital visits. All complaints are taken very seriously, are investigated and the results reported back to our customers to provide assurance for hospitals and the patients they serve. We report complaints throughout our business and take steps to remove the causes, especially where there is potential for patient impact. Complaints are managed by our team of Customer Service Managers' based in our centres across the country.

In response to customer feedback we have made changes across the services we provide for the supply of blood and blood components as well as diagnostic and therapeutic services. For example, the Transport team have implemented a transport management system to improve deliveries and increase fuel efficiency.

Transport now use continuous improvement methods to further enhance their service and ensure it best meets customer needs whilst being financially sustainable. Our drivers are particularly valued with 92% of customers scoring them at 9 or 10/10. The Red Cell Immunohaematology service have lengthened their working day to increase availability of the service and have made many operational improvements to speed up test turnaround times whilst keeping a firm eye on quality of reporting and responding to customer needs. Our manufacturing and hospital services teams work hard to use every donation to meet hospital requirements and develop our component range to best support patient care. We provide a free Electronic Despatch Note service which helps speed up the receipt of components into the hospital transfusion laboratory. Our stock management pilot has widened its reach and our partner hospitals are very satisfied with the benefits of an optimised stock holding. Through these and other initiatives we have increased customer satisfaction further during 2015/16 with 74% of customers scoring us 9 or 10 out of 10 for our service provision overall.

We were pleased that the number of blood donors who complained last year decreased from 5,860 per million donations during 2014/15 to 5,342 in 2015/16. Initiatives that have helped reduce complaint levels from 2014/15 to 2015/16 included the introduction of an arrival time for booked appointments, with the aim to have donors through their donation process within one hour. Next year we have a range of initiatives to help reduce complaints including rolling out enhancements to our appointment grids to help improve donor flow at session.

In 2015/16 we responded to 90.4% of complaints from our blood donors within 20 days, against our target of 90%. Also pleasing to see was that our Top Box scoring, where we measure donors who give us nine or ten out of ten for overall satisfaction, was at 72.5% versus a target of 70%. During 2015/16, we had 8,887 complaints and 6,753 compliments in relation to Blood Donation.

Complaints are a very important source of information about service user's views regarding the quality of services and care provided by the Organ Donation and Transplantation Directorate (ODT). All complaints received are fully investigated through ODT's complaints procedure. All staff are encouraged to respond to concerns raised by healthcare professionals, staff, relatives or any stakeholder as soon as they become aware of them, rather than waiting to receive a formal written complaint.

Complaints within ODT are received from members of the public, family members of organ donors, hospital staff involved in the donation and transplant pathway and occasionally transplant recipients or their family members. Targets are in place to ensure a timely response to the complainant and direct contact is made in all cases where contact details have been provided. During the period between April 2015 to March 2016, ODT received 332 complaints.

Within the Directorate we actively seek the views and opinions of the families we care for in the form of a service evaluation. Any feedback that does not meet the standards we expect is also dealt with via the complaints process. Through this and other initiatives we continue to receive high satisfaction scores during this period with the majority of families scoring us very highly for our service provision overall (scores between 8-10 overall).

All complaints are reviewed, analysed and reported to the ODT Clinical Audit, Risk and Effectiveness Group (CARE). Trends are discussed to ensure learning informs the continued development and improvement of ODT processes and practice.

Emergency Preparedness

Business Continuity (BC) is central to the delivery of NHSBT's mission of "reliable supply". Our Business Continuity Management System (BCMS) therefore must be based on risk, and is designed to generate proportionate and appropriate mitigation for the risks identified. It also provides stakeholders with auditable assurance of the rigour and robustness of the arrangements in place. To achieve this NHSBT certifies its BCMS to the international standard for Business Continuity Management ISO22301. The NHSBT Business Continuity Team aims to provide leadership, advice and support to deliver a world leading BCMS for NHSBT, which then supports the wider NHS in its emergency response arrangements, and provides a high degree of assurance around the security and sustainability of the organisation's key products and services.

The achievements in the 2015/16 year included:

- Major NHSBT sites are now ISO22301 certified.
- Review of the national cold room failure plan and the national reprovisioning plan for blood (last reviewed following the Filton flood in 2012) by Q4.
- A live play exercise for the National Emergency Team (NET) and lessons learned.

- Developing a cadre of trained loggists who are responsible for capturing through note taking the decision making process during a critical incidents.
- Scope and define the system for the BC support for other blood services (In line with UKF timetable).

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	**79,989**	**187,956**
Total Non NHS trade invoices paid within target	**77,824**	**186,191**
Percentage of Non NHS trade invoices paid within target	**97.3%**	**99.1%**
Total NHS trade invoices in the year	**10,783**	**6,554**
Total NHS trade invoices paid within target	**10,657**	**6,468**
Percentage of NHS trade invoices paid within target	**98.8%**	**98.7%**

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 2015/16 NHSBT made a payment of £nil arising from claims made under this legislation (£129 in 2014/15).

Prompt Payment Code

The Government has encouraged all public sector Organisations to improve payment processes and make payment of Small to Medium Sized Enterprise (SME) invoices wherever possible within 10 days. During 2015/16 NHSBT paid 38.2% (38.9% in 2014/15) of the total number of invoices, representing 48.3% (44.3% in 2014/15) by value, within a 10 day period.

NHSBT's income from sales to hospitals, however, is normally paid within 30 days and hence, in order to balance its working capital and manage cashflow, NHSBT is only able to make limited progress in support of this metric.

Ian Trenholm — Date: 27 June 2016
Chief Executive and Accounting Officer

ACCOUNTABILITY REPORT

I hereby sign the Accountability Report from pages 18 to 44

Ian Trenholm
Chief Executive and Accounting Officer

Date: 27 June 2016

Corporate Governance Report – Directors Report

Board Members

Board Members serving during the period 1 April 2015 to 31 March 2016:

Chairman

Mr. John Pattullo

Non Executive Directors

Mr Andrew Blakeman
Dr Christine Costello
Mr Roy Griffins CB
Mr Jeremy Monroe
Mr Shaun Williams
Ms Louise Fullwood
Mr Keith Rigg

Executive Directors

Mr Ian Trenholm – Chief Executive
Mr Rob Bradburn – Finance Director
Ms Sally Johnson – Director of Organ Donation and Transplantation
Dr Clive Ronaldson – Director of Blood Supply to 6 December 2015
Mr Peter Lidstone – Director of Blood Manufacturing and Logistics with effect 2 November 2015
Dr Huw Williams - Director of Diagnostic and Therapeutic Services
Dr Lorna Williamson - Medical and Research Director

Details of the remuneration of senior managers of the Authority can be found in the Remuneration and Staff Report at pages 36 to 44.

Board Member Interests are surveyed annually. A full register of interests is available from the NHSBT website, please use link:

http://www.nhsbt.nhs.uk/news-and-media/review-accounts/

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 uphold our core purpose and values. The Board is led by the Chairman and comprises Non-Executive Directors (NEDs) and Executive Directors, including the Chief Executive, Medical and Research Director and Finance Director. Three of the NEDs have been designated to represent the interests of Wales (NHSBT being a Special Health Authority in England and Wales) and of Scotland and Northern Ireland (reflecting our UK wide role for organ donation and transplantation).

NHSBT comprises a group of distinct strategic business units (SBUs). As part of our strategic planning process strategic objectives and targets are identified for each SBU, which include, alongside the objectives set by our stakeholders, the safety and sufficiency of supply, customer service and operational effectiveness and efficiency. Accountability for delivery, consistent with all applicable governance, internal control and risk management policies, is assigned to the appropriate NHSBT Director and is underpinned by an integrated performance and risk management process.

The Board meets six times a year (bi-monthly) but receives a comprehensive integrated performance report every month covering:

- progress against strategic 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; and
- progress against key strategic projects.

The Board reviews its effectiveness after each meeting, with each Board members assessing the groups' performance against their agreed way of working, based on NHSBT values. There are annual Board Development Days and there are more formal reviews of Board effectiveness every 3 years. The latest formal assessment was in May 2015, facilitated by PwC, and utilising a PwC assessment tool. As a result of this process the Board was assured and satisfied that it is working effectively.

The Board reviews the effectiveness of its Committees, which support the work of the Board, on an annual basis. All Board Committees are required to submit Annual Reports and Workplans which are reviewed at the Board in July each year.

Board Committees

The Board has established the seven Board Committees described below. All seven Committees were in operation during 2015/16.

The Governance & Audit Committee (GAC) – provides assurance to the Board regarding the effectiveness of NHSBT's governance, risk management and internal control processes across all clinical and non-clinical activities. It also ensures there is an effective Internal Audit function and reviews the work and findings of the External Auditors. The GAC receives reports and assurances from directors and managers, guided by an assurance framework and supported by an annual work plan. This is supported by an independent internal audit service that is sourced externally and is currently provided via the Department of Health Group Assurance function, by PwC. The GAC also conducts periodic risk reviews covering all of the operations and functions of NHSBT on a rotational basis and approves the Annual Report and Accounts on behalf of the Board. During the year the GAC received reports on other matters including the data centre move, the transformation programme, the ODT duty office and the serious incidents.

Trust Fund Committee – oversees NHSBT's charitable funds that are used to support, for example, staff welfare and small research and development projects. 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 – considers and approves, on behalf of the Board, policies and standards developed by Solid Organ Advisory Groups, the Donation Advisory Group and the Retrieval Consultation Group. These standards relate to potential organ donor selection, organ donor management, patient selection and organ allocation. The Committee ensures that the policies meet all legal, regulatory and ethical requirements and standards, recognising that many of these policies have considerable impact on individual patients that are awaiting transplantation.

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

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

National Administrations Committee – reviews the adequacy of the arrangements by which the policies and implementation issues of all four UK Health Departments with regard to organ donation are managed by the Board. It also provides support and direction to the development of NHSBT's governance arrangements with regard to managing the interests of all four UK Health Departments.

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

The average attendance of Members at Board Committees during 2015/16 was:

Board Committee	**(%)**
Remuneration Committee	100%
Trust Fund Committee	100%
Expenditure Controls Committee	100%
Governance & Audit Committee (GAC)	96%
National Administrations Committee	82%
Research and Development Committee	75%
Transplantation Policy Review Committee	68%

The remit and terms of reference of all Board Committees were last reviewed in July 2014 (October 2014 in respect of the Remuneration Committee). They are due to be formally reviewed again in July 2016.

The attendance of Members at Board meetings during 2015/16 was:-

Member Name	Member Position	No.
John Pattullo	Chairman	6
Ian Trenholm	Chief Executive	6
Andrew Blakeman [1]	Non-Executive Director	6
Christine Costello [2]	Non-Executive Director	6
Louise Fullwood	Non-Executive Director	6
Roy Griffins	Non-Executive Director	6
Jeremy Monroe	Non-Executive Director	6
Keith Rigg	Non-Executive Director	5
Shaun Williams	Non-Executive Director	6
Rob Bradburn	Finance Director	6
Sally Johnson	Director of Organ Donation and Transplantation	6
Peter Lidstone [3]	Director of Manufacturing & Logistics	3
Clive Ronaldson [4]	Director of Patient Services	3
Huw Williams	Director of Diagnostics and Therapeutic Services	3
Lorna Williamson	Medical and Research Director	5

[1] *last Board meeting was March 2016 – contract term ending*
[2] *last Board meeting is May 2016 – contract term ending*
[3] *first Board meeting was November 2015 – joining NHSBT (replacing Mr. Ronaldson)*
[4] *last Board meeting was September 2015 – retiring from NHSBT*

Personal Data Incidents

NHSBT has a comprehensive process for reporting and addressing all data incidents from minor (level zero) to serious (level 5). There are 125 incidents on record to date, 99 were level zero, 21 were level 1 and 5 were level 2. The majority of our incidents involve mis-handling of paper documents, most of which were subsequently recovered.

Health and Safety

The table below shows the Health and Safety incidents, by NHSBT directorate, and 'Level' reported over the last three years. The definition of each level is shown below the table.

Level 1 incidents - over 7 day lost time injuries or specified injuries reported to the Health and Safety Executive e.g. fractures or injuries requiring an over 24 hour stay in hospital.

Level 2 incidents - over 3 but less than 8 day lost time injuries.

Level 3 incidents - injuries or near miss incidents graded as serious by Health and Safety Department based on their severity and likelihood of reoccurrence.

Level 4 incidents - minor injuries or all other near miss incidents where no injury to staff.

	13/14				14/15				15/16			
Level	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Blood Donation	18	10	375	598	22	7	236	559	12	12	240	436
Blood Manufacturing & Logistics	7	3	76	114	8	6	64	153	7	2	46	134
DTS	0	1	29	49	0	1	33	56	0	1	32	47
ODT	1	0	5	18	0	1	4	7	0	0	8	3
Group Services	0	0	10	24	0	0	3	18	0	0	6	20
Total	26	14	495	803	30	15	340	793	19	15	332	640

The annual rolling target for level 1 and 2 incidents has been achieved with 34 against the target of less than 40, decreasing by 24% from 45 to 34. All level 1 incidents are investigated by Health, Safety and Wellbeing with input into the root cause analysis from the relevant Assistant Director and the investigation report authorised for issue by the Director. To demonstrate their commitment to accident reduction and ensuring employees are supported Senior Management then follow up with a visit to the area concerned. Blood Donation has seen the most significant reduction in level 1 incidents from 22 to 12. Blood Manufacturing and Logistics saw the most significant reduction in level 2 from 6 to 2. An increase in level 2 incidents in Blood Donation is a result of the success in early intervention supporting staff back to work preventing the incidents becoming level 1s. DTS and ODT maintain their good control and prevention of level 1 and 2 incidents. Overall Level 3 incidents have reduced slightly with Blood Manufacturing and Logistics contributing most to this figure. Level 4 incidents are ones we encourage staff to report in order to identify concerns and learn lessons before they cause more serious incidents. Numbers in Blood Donation have dropped significantly since 2013/14, which is a reflection on the reduction in reported near misses with donation chairs as employees become more familiar with their operation. In 2016/17 new targets will be set in directorate H&S plans to increase level 4 reporting and the development and implementation of a simplified near miss reporting card will make it easier to report these incidents.

Corporate Governance Report – Statement of Accounting Officer's Responsibility

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

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

- observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply appropriate accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Secretary of State for Health has appointed the Chief Executive of NHS Blood and Transplant as the Accounting Officer for NHS Blood and Transplant.

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

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.
- I confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable.
- I have taken personal responsibility for the Annual Report and Accounts and the judgements required for determining that is it fair, balanced and understandable.

Ian Trenholm Date: 27 June 2016
Chief Executive and Accounting Officer

Corporate Governance Report – Governance Statement

Scope of Responsibility

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

The Governance Framework

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

The relationship between NHSBT and the Department of Health (DH), along with NHSBT's accountabilities to the DH, are described in an NHSBT Framework Document. NHSBT's accountabilities to the Welsh Government, and to the Scottish and Northern Irish Health Departments in respect of organ donation and transplantation across the UK, are governed via certain Board arrangements and through supporting Income Generation Agreements.

The governance structure and process within NHSBT is described in the NHSBT Integrated Governance Framework which describes the assurances provided to the Board regarding the delivery of NHSBT's statutory and strategic objectives, its internal controls and risk management processes. The Integrated Governance Framework was last reviewed by the GAC in November 2015 and was considered to provide reasonable assurance regarding the delivery of NHSBT's statutory and strategic objectives and the effectiveness of its internal controls and risk management processes, that it has no material gaps and is consistent with applicable guidance (including the principles set out in "Corporate Governance in Central Government Departments). The Integrated Governance Framework is supported by an Assurance Map which is used as a check list of assurance processes (based on the "three lines of defence" principle). It was reviewed by the GAC in February 2015 when it was also updated to reflect DH Guidance Principles for Assurance and to ensure compliance with the Treasury's Corporate Governance Code.

Responsibility for our governance systems is delegated to the Medical and Research Director who, with support by the Finance Director, provides a strong link between the Executive Team, the Governance and Audit Committee (GAC) and the Board.

Strategic Management and Reporting

Strategies are approved by the Board for each of our SBUs and capture the objectives, targets and milestones relevant to each.

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 and integrated monthly performance report to the Board (which further includes trend data, progress on strategic projects and a summary of risks). The Board Performance Report is therefore a key element of the governance and assurance process and is reviewed on a periodic basis to ensure that it provides sufficient information and assurance to the Board regarding the delivery of NHSBT's objectives and management of its risks.

This is further supported by a programme of performance reviews at the Board whereby the performance and execution of the strategies within each of the Blood, DTS and ODT Divisions are reviewed on a 6 monthly cycle, with each Division being reviewed at least twice per annum.

Risk Management and Control

The NHSBT approach to risk is documented in our Risk Management Strategy, which identifies the roles and responsibilities of staff with regard to risk. This is underpinned by two Management Process Descriptions (MPDs):

- Risk Management Assessment Framework; and
- Management of Risk.

These describe the process around the operation of the NHSBT risk register. New risks identified for inclusion on the risk register are assessed for their likelihood and consequence using a 5 x 5 risk matrix in accordance with the Risk Management Policy and MPDs. In addition, 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 GAC is accountable for ensuring that the risk management process is fit for purpose and is working effectively. As part of its assurance process the GAC reviews the risks and controls within each of our SBUs on a rolling basis. This programme is incorporated within the GAC annual work plan. During 2015/16 NHSBT has adopted the use of Board Assurance Frameworks (BAF). BAFs have therefore been generated for each SBU and capture the risks to the delivery of the strategic objectives and the mitigations that are in place. The BAF is used to underpin the risk review process, by both the GAC and NHSBT Executive Team, through providing assurance that risks to the delivery of strategic objectives are being adequately managed.

Clinical Governance and Risk

The Medical and Research Director has responsibility for all aspects of clinical governance and effectiveness across NHSBT and reports regularly to the Executive Team, GAC and Board on all matters of clinical governance and risk.

This responsibility is supported by a Clinical Audit, Risk and Effectiveness Committee (CARE) which meets on a bi-monthly basis and is supported by CARE groups embedded within each of the operational directorates.
A standing clinical governance item is part of each operational Senior Management Team agenda and a combined clinical governance report is provided to the Executive Team (as part of the performance review meeting) and to the GAC and Board as part of a standing agenda item. Reports cover clinical risks, clinical audits, outcomes, incidents including serious untoward incidents (SUIs) and Never Events, clinical complaints/commendations and clinical claims.

Quality Management System (QMS)

NHSBT's activities are highly regulated, reflecting the high risk nature of the products and services we supply. The regulation of activities within Blood Components is covered by Blood Safety and Quality Regulations (BSQR) and as Competent Authority, by the MHRA. Regulation of activities within Organ Donation and Transplant, Tissues, Stems Cells and Histocompatibility & Immunogenetics is covered by the Human Tissue Act 2004 for England, Wales and Northern Ireland. The Human Tissue (Scotland) Act 2006 governs organ and tissue donation and transplantation in

Scotland. The provisions of EU Tissues and Cells Directives, and the related UK legislation, are regulated by the Human Tissue Authority as the Competent Authority on a UK-wide basis.

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

Self inspections of NHSBT facilities are programmed on a 2 yearly cycle and cover all regulated activities at all licensed sites and include:

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

The NHSBT Director of Quality reports directly to the Chief Executive and delivers assurance to GAC and Executive Team meetings through:

- a quarterly Management Quality Review (MQR) 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; and
- monthly reporting of supporting key operational KPIs (to the Board and Executive Team) designed to monitor that key processes remain in control.

NHSBT is committed to delivering a strong regulatory performance and an ambition that there should be no “critical” and no “major” non-compliances identified during any regulatory inspection. During 2015/16 there were no critical and five major non-compliances reported following MHRA regulatory inspections, with four of the major non compliances reported in Blood Supply and one in DTS. This compares to 2014/15 where there were no critical and two major non-compliances reported.

NHSBT’s internal quality function have compared performance and processes over time and conclude that consistent standards have been achieved. NHSBT welcomes the continuous improvement in standards. All regulatory findings are subject to formal review and control by the QA function with action plans put in place to respond to, and learn from, all issues raised by inspections.

Business Continuity

NHSBT supplies critical products and services to the NHS and the wider healthcare economy, and is the sole supplier of some critical products and services (such as blood and skin). As a consequence the management of business continuity risk is extremely important.

In support of this, NHSBT operates a Business Continuity function that reports to the Director of Diagnostic and Therapeutic Services. The function provides leadership, advice and support in order to deliver a Business Continuity Management System (BCMS) for NHSBT and also supports the wider NHS in its emergency response arrangements. In support of this, NHSBT is certified to ISO22301 (the international standard for business continuity) with respect to the Blood Service and

Diagnostic and Specialist Services and NHSBT remains the only blood service in the world to have achieved this standard. It provides an externally auditable standard of the quality of our BCMS, provides assurance to the Department of Health (DH), our customers and other stakeholders and meets our regulatory obligations.

As part of the business continuity programme all of our main sites (Blood Centres and the ODT Stoke Gifford site) have been assessed for business continuity risk, taking into account internal risk, risks in our environment and the activity on each site. All of the IT continuity arrangements have been tested over the past year and moved services into two new, resilient and managed data centres. The Business Continuity function reports on plans and progress to the Executive Team and to each GAC meeting.

NHS Blood and Transplant Risk Profile

NHSBT supplies biological products and related clinical services to NHS hospitals but does not generally provide clinical services directly to NHS patients. The only area where NHSBT does provide direct clinical services is in the apheresis based therapies that are provided to patients by our Therapeutic Apheresis Teams (representing around 1.5% of our activity measured by income).

NHSBT is, however, totally dependent on the voluntary donation of blood, organs, haemopoetic stem cells and tissues and has extensive direct contact, in particular, with donors of blood and stem cells. With regard to organs and tissues there is limited contact with donors (in a clinical context) but NHSBT must have due regard for the donor, the donor family, the recipient family and the handling of organs and tissues once they have been retrieved and are entrusted to the NHS.

Taken together the nature of our operations, and the characteristics of our contact with the public, are very different to, and unique within, the broader NHS. As NHSBT's products and services are often required at times of critical need for NHS patients, our appetite for risk is essentially low.

NHSBT is, however, an ambitious organisation with a stated mission to be recognised by our stakeholders and peers as the "best organisation of our type in the world". This requires that NHSBT can demonstrate world class performance across all of its operations be this donor service, customer service to hospitals, product safety, product availability, regulatory performance and efficiency. We are highly committed to the delivery of our strategy and its associated benefits and we endeavour to maintain the right balance between delivery of the strategy and the risks associated with its underlying action plans. Our strategy therefore incorporates a balanced set of objectives covering quality and efficiency but we plan for the highest levels of risk mitigation before any steps are taken which could impact the safety or availability of our products/services and ultimately the safety of NHS patients. In this regard both our clinical governance (CARE) and quality assurance functions are closely involved with strategic projects at all stages of their progress.

As at 31 March 2016 the NHSBT risk register captured 157 risks. Of these, the risks considered high / extreme (i.e. with a risk score of 15 or more) were:

Blood – declining demand and service reconfiguration:
In order to support the need for greater financial efficiencies across the NHS our medium term objective is to find efficiency gains and productivity improvements that at least offset inflation, enabling us to at least maintain flat pricing of our products and services. Prices are, however, highly dependent on volume and the trends that we see in the demand for blood. Since October 2012 a sustained reduction in red cell demand has been seen and we forecast that this trend will continue over the medium term. The costs of the blood supply chain are relatively fixed in nature and it is increasingly challenging to reduce costs at the same rate as volume reduction. Our ability to avoid price increases in the future will increasingly depend on our ability to continue removing capacity and increasing productivity, especially within blood donation where benchmarking indicates that productivity is significantly lower than the best blood services in the world. The drive for further efficiencies will result in significant changes to the configuration of our blood donor service (e.g.

fewer, larger mobile blood collection sessions and greater use of fixed venues). This will require careful management and communication of changes to donors in order to ensure that the drive for greater efficiency is not achieved to the detriment of service effectiveness and hence does not impair the loyalty and support of the donors on whom we critically depend. We are confident, however, that our performance reporting framework will provide sufficient insight and warning to ensure that we continue to balance the delivery of service quality and effectiveness with financial efficiency.

Blood - Supply challenges / product availability:
The demand for red cells (and lately platelets) has been decreasing and this is expected to continue over the medium term. At blood group level, however, we are seeing differential demand trends with demand for "universal" components (O negative red cells and A negative platelets) increasing in absolute terms and as a proportion of the whole. These differential trends are also exacerbated by our platelet strategy whereby, for reasons of greater efficiency, we are reducing the proportion of platelets provided by apheresis donors and increasing the proportion of pooled platelets manufactured from whole blood donation. Taken together there are increasingly very large differences in demand at the blood group and component level which, in turn, is generating a challenge to ensure that we have sufficient donor numbers for the rarer blood groups. Although we need to increase our efforts to increase the number of donors in certain blood groups, given the backdrop of reducing demand, and a need for fewer donors overall, it is also clear that we cannot manage the ongoing differential trends through donor numbers (supply) alone. We will also need to influence demand and, although we continue to manage this through our existing patient blood management initiatives, we may need to introduce revised pricing mechanisms. If a revised pricing scheme is to influence demand in a material way it may need for example much higher prices for O negative red cells. This may be extremely unpopular with NHS hospitals and could impact our customer satisfaction.

Funding of the Organ Donation and Transplantation strategy:
The "Taking Organ Transplantation to 2020" strategy that was agreed by the four UK Heath Departments during 2013/14 aims to increase the levels of organ donation and transplantation in the UK to world class levels. It further requires investment in the supporting systems and processes to ensure that the clinical pathway from donor to patient can be managed on a safe and resilient basis. Additional funding for the strategy, from the four UK Health Departments, was provided in 2014/15 and has been re-secured on a "flat" basis for 2015/16 and 2016/17. In the current financial climate this is extremely welcome but in order to meet the outcomes of the "Taking Organ Transplantation to 2020" strategy increased funding is likely to be required in 2018/19 and beyond. Discussions will continue with the four UK Health Departments in order to define the priorities and opportunities that can ensure the delivery of the 2020 targets.

Organisational Transformation - Change management:
The scale of change across NHSBT, in support of providing value for money to the NHS, is significant and ambitious. The need to support change through the implementation of modern supporting IT systems is an increasingly critical component of our programme. In addition IT infrastructure and systems across NHSBT are generally old, close to end of life and, in some critical areas, dependent on niche Small & Medium Sized Enterprises (SMEs) for their ongoing support and maintenance. Significant investment will therefore be required to replace ageing infrastructure, migrate to cloud based services and replace the critical operational applications underpinning each of the operating divisions. In 2015/16 there was an immediate requirement for NHSBT to exit its data centre at the BPL site at Elstree. This project completed in Q4 2015/16, on time and under budget.

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

Taken together the delivery of our objectives will depend on having sufficient management capacity and capability in place to execute major change without it impacting on the supply of our critical products and services.

Business continuity:
NHSBT's supply of products and services could be severely impacted by loss of a key facility (e.g. Filton, Speke) or loss of a critical IT platform (e.g. Pulse, Hematos, EOS, NTxD).

During the year the data centre hosting move represented a significant risk to NHSBT's business continuity. The business continuity and emergency planning processes worked successfully with the project managers and mitigated all risks. There was no loss of service to hospitals or internal NHSBT operations. The assessments and plans were regularly reviewed by the Executive Team and the GAC.

As noted above our IT infrastructure and systems across NHSBT are generally old and close to end of life. Our need to replace key operational systems, such as Pulse and NTxD, will result in extensive IT and business process change and hence increased risk to business continuity. Further work is planned, in conjunction with the Board and the GAC, in order to provide assurance that NHSBT will be able to safely navigate through a planned period of extensive IT change over the next 5 years.

Transcription error resulting in harm to patients:
NHSBT uses manual paper based and verbal processes within its operations especially within the organ donation and transplantation pathway as well as in our diagnostic testing laboratories. Although these are mitigated by extensive control checks there remains a residual risk that these are ineffective and result in errors that could lead to harm to NHS patients. The risk of transcription errors in both areas is being reduced through the introduction of new systems, such as the Donor Registration System and the ODT Hub in ODT, and electronic requesting and reporting of results between NHSBT and customer hospitals in Diagnostics.

Competition and impact on the viability of services:
With regard to Blood there is a risk that private, public or third sector entities could supply blood sourced from European donors. In the past the risk has been considered low due to the limited availability of volumes although, as demand for red cells decline across most developed economies, availability of supply into the UK becomes that much greater. In the medium term the risk is considered to remain low, however, as the barriers to entry from a safety perspective are relatively high (i.e. the need for integration of systems and clinical support to manage traceability from donor through to patient). Indeed it would therefore be more likely that a supply would be offered to NHSBT rather than in competition to it. In the past the offer of (limited) supply has been rejected by the Advisory Committee for the Safety of Blood Tissues and Organ (SaBTO) because of safety concerns.

Within DTS, as a result of historical development in services at local/regional level, NHSBT mostly competes with other parts of the NHS. Our strategies generally involve leveraging our national footprint and capabilities so that the specialist products and services that we can provide are consolidated within NHSBT. This provides benefits of scale (and hence lower costs to the NHS) along with much greater assurance regarding service availability and safety. Within Tissues there are similar issues (e.g. bone banking) but we are also potentially exposed to powerful private sector competition in some segments of the business. As a result our Tissues strategy tends to avoid outright competition and focuses on skin derived from UK donors (as a sole supplier of skin "from the NHS for the NHS") and areas of unmet clinical need. In stem cells there is also the potential for NHSBT to compete with NHS bodies, academic institutions and biopharmaceutical companies in the private sector in the development of new therapies based on regenerative medicine. In response our strategy is to focus on our strengths in providing the supporting infrastructure required by clinical trials in regenerative medicine. This is based on our unique capabilities starting from the stem cell donor through to storage, selection and manipulation of stem cells, and onto delivery at the hospital bedside.

Lapses in control – Never Events / Serious Untoward Incidents (SUIs)

There were no Never Events within NHSBT during the year (and none in 2014/15).
A total of eight incidents were, however, initially investigated as Serious Incidents Requiring Investigation (SIRIs) during the year. The results of these investigations concluded that five of the incidents should be recorded and managed as Serious Untoward Events (SUIs) and three incidents were neither Never Events nor SUIs. In 2014/15 NHSBT reported only one SUI. Each incident was subjected to a full and comprehensive investigation which resulted in action plans that were overseen and monitored to completion by the appropriate Director. Each incident was also reviewed at CARE to ensure organisational learning and to minimise the risk of a similar incident occurring in other parts of NHSBT.

The SUIs in 2015/ 2016 related to:

- An injury to a child from a discarded needle stick following a donor session in a school (April 2015);
- Fungal infection of corneal transplants arising from our newly acquired eye banking operations in Bristol (April 2015);
- A wrongly labelled pulmonary valve being issued from our Speke tissue bank (June 2015);
- A bone infection developed by a bone marrow donor (September 2015); and
- An incorrect product transfused to a baby (September 2015).

The final investigation reports were all scrutinised and closed as appropriate by the Governance and Audit Committee (GAC).

In order to further enhance the management of serious incidents and system failures that could lead to patient harm, a revised process and supporting Management Process Description (MPD) has been developed and implemented across NHSBT.

To ensure NHSBT continues to be open and transparent throughout investigations into serious incidents, a revised MPD regarding Being Open / Duty of Candour has also been implemented across the organisation during 2015.

Information and Data Management

NHSBT holds details of over 4 million blood donors (both active and archived) and manages an Organ Donor Register with approximately 22 million registrants. Data loss incidents in the last year have involved low numbers of paper records in transit and these have been quickly recovered in the majority of cases. No incidents required reporting to the information commissioner in 2015/16 and this was the first year that, since formal recording of information incidents began, that none of severity 2 or higher were recorded (on a scale of zero to 5). A summary of non-reportable incidents is included at page 24.

Whistleblowing Policy and Counter Fraud Policy

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

NHSBT has a comprehensive annual plan of work. Risks areas are assessed based upon knowledge of the business, control systems in operation and recent experience. The plan includes:

- activity on governance and oversight of counter fraud;
- informing staff of the counter-fraud effort; and
- work to prevent and detect frauds and to hold those committing fraud to account.

Our counter fraud work is overseen by NHS Protect.

Care Quality Commission Registration

NHSBT has 30 blood locations, 6 Therapeutic Apheresis Services Units and the Watford Headquarters registered with the Care Quality Commission under the Health and Social Care Act 2008.

During the period April 2015 to March 2016 the CQC did not undertake any inspections of NHSBT locations.

Monitor Provider Licence

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

Duties of the Secretary of State

As a Special Health Authority NHSBT is carrying out functions of the Secretary of State and is therefore accountable for complying with the duties of the Secretary of State as identified by the Health and Social care Act 2012. As a provider of products and services to the NHS (rather than clinical care) we are a step removed from the front line heath and care system and hence there is limited direct relevance of the duties of the Secretary of State to the day to day operations of NHSBT. NHSBT has, however, reviewed the duties of the Secretary of State and is satisfied that its actions in relation to the NHS and public health has complied with the duties described by the Act.

NHSBT's strategies in Blood, Organs and Stem Cells, however, all include objectives to improve rates of donation from black and minority ethnic communities in order to improve the probability that patients from these communities can receive matching blood transfusions and organ and bone marrow transplants. Our work in this area, however, is therefore highly relevant to the duty of the Secretary of State to "have regard to the need to reduce inequalities between the people of England with respect to the benefits that may be obtained by them from the health service". We are satisfied that our strategies and plans take into account the duty of the Secretary of State within this particular and relevant area.

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 Health Group Internal Audit as our (independent) internal auditors;
- the auditing and reporting conducted as part of our Quality Assurance and clinical auditing processes, both internally as well as by our regulators;
- senior managers within the organisation, who had responsibility for the development and maintenance of the system of internal control; and
- evidence provided by reporting from NHSBT's planning, performance and risk management processes.

As a result of the above I confirm that the system of internal control has been in place in NHS Blood and Transplant for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts. As a result of my review I am satisfied that the system of internal control has been sound with no evidence of weaknesses of sufficient materiality that would prejudice the achievement of our policies, aims and objectives.

Remuneration and Staff Report

This report forms part of the Accountability Report on pages 21 to 47.

Remuneration Committee Membership

During 2015-16 membership of the Remuneration Committee comprised Shaun Williams, Jeremy Monroe and John Pattullo. The committee was chaired by Shaun Williams. Ian Trenholm and David Evans also attended Committee meetings as 'standing attendees'.

Remuneration Policy

Remuneration of the Chief Executive and Executive Directors is in line with the decisions of the Remuneration Committee and all relevant DH guidance. Any cost-of-living pay increases are paid in line with nationally agreed pay awards. Remuneration for Non-Executive Board Members is set by the Secretary of State for Health.

Methods to Assess Performance

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.

Ian Trenholm, Chief Executive, NHS start date 1 July 2014, appointed 1 July 2014. 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 time permanent post with three months' notice of termination by the employee, and six months' notice of termination by NHSBT.

Ian Bateman, Director of Quality. NHS start date 22 July 2002. NHSBT start date 21 September 2009. Appointed to the Executive Team 1 January 2014. Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT.

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

David Evans, Director of Workforce and Transformation Services, 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 23 July 1990, appointed, 1 September 2008. Permanent full-time post three months' notice of termination by the employee, and six months' notice period by NHSBT.

Peter Lidstone, Director of Manufacturing and Logistics, NHS start date 2 November 2015, appointed 2 November 2015, Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT.

Aaron Powell, Chief Digital Officer, NHS start date 1 January 2010, appointed 20 October 2014 on an interim basis and substantively from 17 July 2015. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Clive Ronaldson, Director of Blood Supply, NHS start date 1 March 1993, appointed 1 July 2008. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT. Clive Ronaldson retired from NHSBT on 6 December 2015.

Mike Stredder, Director of Blood Donation, NHS start date 29 June 2015, appointed 29th June 2015, Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT.

Lorna Williamson, Medical and Research Director, NHS start date 1 August 1978, appointed 1 October 2007. Contract of employment with the University of Cambridge until 30th June 2009. Contract with NHSBT from 1st July 2009. Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT. Lorna is due retire on 31 May 2016. She will be replaced by Dr Gail Miflin on 1 June 2016.

Huw Williams, Director of Diagnostic and Therapeutic Services, NHS start date 4 February 2013, appointed 4th February 2013, 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 tables on pages 38 and 39. The tables on pages 38 and 39 are subject to audit.

Salary and Pension Entitlement of Senior Managers

a) Remuneration

	Year to 31 March 2016					Year to 31 March 2015				
	Salary	Performance pay and bonuses	Non Cash Benefits	All Pension Related Benefits	Total	Salary	Performance pay and bonuses	Non Cash Benefits	All Pension Related Benefits	Total
	In £5k bands	In £5k bands	To nearest	Bands of £2500	In £5k bands	In £5k bands	In £5k bands	To nearest	Bands of £2500	In £5k bands
Name and title	**£000**	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**	**£00**	**£000**	**£000**
Mr J Pattullo (Chairman)	60-65	-	-	-	60-65	60-65	-	-	-	60-65
Mr A Blakeman (NED)	5-10	-	-	-	5-10	10-15	-	-	-	10-15
Dr C. Costello (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms L Fullwood (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr R Griffins (NED)	10-15	-	-	-	10-15	5-10	-	-	-	5-10
Mr J Monroe (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr K Rigg (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr S Williams (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr I Trenholm (Chief Executive)*	170-175	-	4	47.5-50	225-230	130-135	-	1	32.5-35	160-165
Ms L Austin (Director of Communications)	105-110	-	-	22.5-25	130-135	105-110	-	-	30-32.5	140-145
Mr I Bateman (Director of Quality)	100-105	-	24	15-17.5	115-120	100-105	-	33	17.5-20	120-125
Mr R Bradburn (Finance Director)	135-140	-	48	20-22.5	165-170	135-140	-	44	37.5-40	180-185
Mr D Evans (Director of Workforce)	125-130	5-10	-	35-37.5	165-170	120-125	5-10	1	7.5-10	135-140
Ms S Johnson - (Director of Organ Donation and Transplantation)	120-125	-	-	2.5-5	125-130	120-125	-	-	95-97.5	220-225
Mr P Lidstone (Director of Blood Manufacturing and Logistics) commenced 2 November 2015 **	50-55	-	-	10-12.5	65-70	-	-	-	-	-
Mr A Powell (Chief Digital Officer) ****	110-115	-	21	75-77.5	190-195	40-45	-	9	42.5-45	85-90
Dr C Ronaldson (Director of Blood Supply) ended 6 December 2015	75-80	5-10	19	-	80-85	135-140	5-10	22	22.5-25	170-175
Mr M Stredder (Director of Blood Donation) commenced 29 June 2015 ***	90-95	-	3	20-22.5	115-120	-	-	-	-	-
Mr H Williams (Director of Diagnostics and Therapeutic Services)	125-130	-	-	27.5-30	150-155	125-130	-	-	40-42.5	165-170
Dr Lorna Williamson (Medical and Research Director)	215-220	-	-	-	215-220	215-220	-	-	2.5-5	220-225

NED = Non-Executive Director

Performance pay and bonuses relates to pay earned in the previous year. There were two such bonuses paid in 2015/16 and three in 2014/15 of which one was paid to the former Chief Executive not shown in tables above.

* Ian Trenholm had a pending pension transfer from the Civil Service Pension scheme at 31st March. The significant increase in remuneration is due to Ian commencing employment part way through 2014/15.

** Full year salary for this position is 125-130

*** Full year salary for this position is 125-130

**** The significant increase in remuneration is due to Mr Powell being appointed as Chief Digital Officer part way through 2014/15.

Non Cash Benefits were in relation to the provision of cars and reimbursement of business mileage and are stated in round £100's not £1000's.

b) Pension Benefits

Name and title	Real increase / (decrease) at pension age (bands of £2,500) £000	Real increase in lump sum at pension age (bands of £2,500) £000	Total accrued pension at age at 31 March 2016 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase in Cash Equivalent Transfer Value £000
Mr I Trenholm (Chief Executive)	2.5-5	-	5-10	-	59	19	40
Ms L Austin (Director of Communications)	0-2.5	-	10-15	-	148	122	24
Mr I Bateman (Director of Quality)	0-2.5	2.5-5	15-20	50-55	352	320	28
Mr R Bradburn (Finance Director)	0-2.5	-	15-20	-	262	223	35
Mr D Evans (Director of Workforce)	0-2.5	5-7.5	40-45	130-135	874	812	53
Ms S Johnson (Director of Organ Donation and Transplantation)	0-2.5	2.5-5	45-50	145-150	1,018	966	41
Mr P Lidstone (Director of Blood Manufacturing and Logistics) commenced 2 November 2015	0-2.5	-	0-5	-	11	-	11
Mr A Powell (Chief Digital Officer)	2.5-5	-	10-15	-	103	63	39
Dr C Ronaldson (Director of Blood Supply) ended 6 December 2015 *	0-2.5	0-2.5	55-60	170-175	-	-	-
Mr M Stredder (Director of Blood Donation) commenced 29 June 2015	0-2.5	-	0-5	-	17	-	17
Dr H Williams (Director of Diagnostics and Therapeutic Services)	0-2.5	-	5-10	-	96	63	32
Dr L Williamson (Medical and Research Director) *	0-2.5	2.5-5	85-90	255-260	-	-	-

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

Cash Equivalent Transfer Value

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

The CETV figure, and other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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.

Pension Scheme Liabilities

The majority of employees are members of the NHS pension scheme which is an unfunded, defined benefit scheme. The scheme is not designed in a way that enables the NHS bodies to identify their

shares of the underlying assets and liabilities and so is accounted for as a defined contribution scheme. See Accounting policy 1.10.

Compensation on Early Retirement or Loss of Office

Early Retirements and redundancies

During 2015/16 there were 94 payments for early retirements and/or redundancies from NHSBT. The sum of £3,349,000 has been paid out in 2015/16 in respect of these redundancies and/or early retirements (2014/15 209 early retirements and/or redundancies and payments of £7,742,000).

An opening provision of £689,000 for redundancy costs has been utilised, or reversed unused during 2015/16 and a further provision of £2,277,000 has been made for redundancy costs in relation to restructures currently in progress.

A total charge of £3,058,000 for early retirements and redundancies is included within other staff related costs in note 3.1 of the financial statements (2014/15 £3,209,000).

This is subject to audit.

Reporting of Other Compensation Schemes

The table below discloses the number and value by cost band of compensation packages paid in 2015/16.

Exit Package cost band	Number of compulsory redundancies	Cost of compulsory redundancies (£000s)	Number of other departures agreed	Cost of other departures agreed (£000s)	Total number of exit packages	Total cost of exit packages (£000s)	Number of departures where special payments made	Cost of special payment included in exit package
Less than £10,000	8	63	5	37	13	100	-	-
£10,001 - £25,000	11	198	16	286	27	483	-	-
£25,001 - £50,000	16	568	15	547	31	1,115	-	-
£50,001 - £100,000	15	1,042	7	506	1	102	-	-
£100,001 - £150,000	-	-	1	102	1	102	-	-
£150,001 - £200,000	-	-	-	-	-	-	-	-
Totals for 2015/16	**50**	**1,871**	**44**	**1,478**	**94**	**3,349**	**-**	**-**

Totals for 2014/15	**81**	**2,868**	**128**	**4,874**	**209**	**7,742**	**-**	**-**

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

This is subject to audit.

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 2015/16 is shown in the table below, together with the remuneration ratio compared to the highest paid directors pay. This shows the pay multiple has gone up to 8.2.

	2015-16	**2014-15**
Highest Director Banded Remuneration	£215k to £220k	£215k to £220k
Lowest Banded Remuneration	£0k to £5k	£0k to £5k
Median Remuneration	£26,719	£26,732
Remuneration Ratio	8.2	8.1

This is subject to audit.

Staff Numbers and Costs

The analysis of staff numbers and costs distinguishing between staff permanently employed and other staff engaged on the objectives of NHSBT such as agency staff are presented below. This exact information is also disclosed in note 3.1 of the financial statements.

	Total	**31 March 2016 Permanently Employed Staff**	**Other**	**31 March 2015 Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	168,058	153,918	14,140	166,146
Social security costs	11,655	11,318	337	11,790
Employer contributions to NHS Pensions Agency	19,913	19,338	575	19,566
	199,626	184,574	15,052	197,502

	Total	**Permanently Employed**	**Other**
	Number	**Number**	**Number**
Year Ended 31 March 2016	**4,830**	**4,561**	**269**
Year Ended 31 March 2015	4,928	4,670	258

Expenditure on Staff Benefits

The amount spent on staff benefits during the year is estimated at £1,179,000 (31 March 2015: £955,000)

Sickness Absence Data

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

During the period January 2015 to December 2015 the total number of whole time equivalent days lost to sickness absence was 44,627 days. This equates to an average of 9.4 days per whole time equivalent; and a sickness absence rate of 2.6%.

During the period January 2014 to December 2014 the total number of whole time equivalent days lost to sickness absence was 48,347 days. This equates to an average of 9.8 days per whole time equivalent; and a sickness absence rate of 4.4%.

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

Communication

NHSBT is committed to developing open and honest communication and engagement with its employees at all levels throughout the organisation. A range of communication techniques are used to communicate with staff taking account of geography, access to technology and shift patterns and each year a communications audit is conducted to ensure these methods remain robust but also highlight any areas for development. NHSBT remains committed to seeking new opportunities for enhancing communication with staff and this year the introduction of mobile technology via the use of hand held devices for staff working remotely is evidence of this ongoing ambition.

Staff Engagement

This year our temperature check staff survey, *Your Voice- Check Up!* which is key for obtaining feedback from our people, was distributed to all employees. A response rate of 42% or 2255 responses was achieved, which is above the national average for the NHS and is a demonstration that staff want to communicate with the organisation and feedback their thoughts, feelings and views on what life is like whilst working at NHSBT.

The *Your Voice-Check Up!* survey identified themes, agreed by the Executive that at NHSBT we should continue focusing on a number of key priorities for the organisation which were established from the results of its 2014 *Your Voice* survey, supported by Corporate, Centre and Directorate based action plans, which focus on the following areas:

- Improving communication between the different parts of NHSBT;
- Improving Line Manager capability and capacity; and
- Eliminating Harassment, Bullying Abuse and associated reporting mechanisms/outcomes.

In addition to the survey there are a range of initiatives used by NHSBT to ensure open dialogue as follows:

- **Director Roadshows** where Directors visit our national centres to meet with and brief staff on our strategic plans. This has proved successful. A good case study is in our

Manufacturing & Logistics Directorate and this has helped to achieve improved engagement scores.

- **Connect to a Region** – this was implemented in 2014. This initiative ensures that each Executive and their senior managers are responsible for a region of the country to provide more direct support for Heads of Centres and their Partnership Committees to target localised areas for improvement. Data on Connect visits are collated quarterly.
- **Team Talk and Inside NHSBT** – NHSBT's Communications Directorate has launched Team Talk as a communication mechanism using brief, relevant discussion topics which should be discussed within all teams in the organisation. Furthermore, Inside NHSBT has been launched on an external news platform aimed at our more remote colleagues with information such as news and blogs.
- **Staff Engagement Forum** – a partnership forum which meets at different centres to review staff engagement issues and meet different staff from around the country who get to attend the meeting and raise any concerns or ideas they might have in respect of increased staff engagement. Thus far, Organisational Workforce Development (OWD) has hosted three engagement forums this year at centres throughout the country. The staff engagement forum will be reviewed in 2016 for effectiveness.
- **Directorate and Centre based Survey Reviews and Action Planning** – Because of the diverse and remote nature of the organisation, NHSBT has now expanded its action planning to include Directorates as well as Centres. Centre based action plans are reviewed by employees at staff side partnership committees to address any locally stemming issues from a local level.
- **Corporate Action Planning** – This year, NHSBT's Your Voice Project Board has been re-established to include representatives from nearly all Directorates as well as union representation, to better share ideas on how to improve the organisation as a whole. They will also produce a new communications strategy to ensure that colleagues in all areas of the organisation are targeted, including remote M&L/Blood Donation teams so they may complete the 2016 survey and will provide their say on what it is like to work at NHSBT.

Another key relationship is our engagement with our union colleagues. NHSBT has a robust Partnership Framework which continues to be productive and effective in enhancing the partnership working approach. On a yearly basis the Executive Team meet with the national representatives to share plans for the year ahead. This continues to demonstrate our open and transparent approach and allows for discussion, in respect of some strategies, at an earlier stage.

NHSBT has also successfully embedded a set of organisation wide values of Caring, Expert and Quality bringing these values to life for every single member of staff. These values underpin NHSBT's engagement strategy and supports NHSBT to become an even better place to work. In addition managers will be monitored via a Management Passport tool as part of the PDPR/appraisal process to increase management capability.

Learning & Development

NHSBT provides a comprehensive learning and development framework for all staff through our 'SHINE' offering. SHINE learning and development offers a full range of in-house development including personal skills development, scientific training and Management and Leadership development. Coaching and mentoring are well embedded across the organisation also.

Staff are encouraged to have personal development plans and this remains an important part of our appraisal process. The organisation also has an annual panel to agree funding for external development opportunities which are supported up to 75% funding and up to 100% funding if the development is essential to the role.

A diverse organisation

NHSBT supports targeted positive action to support Black, Asian and Minority Ethnic (BAME) staff and donors. NHSBT has a strategic target to increase by 15% the number of BAME staff at Band 8

and above which has been achieved in the past year and operates a positive action programme for BAME staff, called REACH Higher.

This year a BAME staff network launched to focus on internal and external BAME specific issues including Education and Engagement of BAME Community; Workforce issues; Collaboration and Partnerships with external BAME groups.
NHSBT is committed to disability equality and aims to embed a disability confident organisational culture. We do this through:

- Running a disability Health Promotion advisory Service to ensure that NHSBT is compliant with the Equality Act.
- Our Disability Advocates work with our Health and Safety Service to record reasonable adjustments for staff disabled at work.
- Carrying out reasonable adjustments to duties, equipment, systems for disabled staff where practicable.
- Seeking redeployment for staff who becomes disabled under the terms of our redeployment policy.
- Operating as a member of the Business Disability Forum.
- Applying the two ticks symbol as part of our recruitment practice, demonstrating our commitment to ensuring disabled applicants are guaranteed an interview where they meet the essential criteria.

As at 31 March 2016 NHSBT employed 5,684 staff members (of which 19 are directors) of whom 3,854 were female (of which 5 are directors) and 1,830 were male (of which 14 are directors).

Reward and Recognition Schemes

NHSBT also recognises staff through our 'Recognition of Excellence' scheme and an annual awards ceremony is held to celebrate the very best staff offer in a wide variety of categories.

NHSBT's Recognition of Excellence programme has established a new voting panel in the past year with representation from all Directorates and has produced clearer guidelines on nominations to ensure a fairer selection process for our quarterly and annual winners.

Expenditure on Consultancy

Consultancy expenditure during 2015/16 totals £411,000 (2014/15 £844,000) and was approved by the Expenditure Controls committee.

Review of Tax Arrangements for Public Sector Appointees

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

The table below identifies all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016	21
Of which, the number that have existed:	
for less than one year at the time of reporting	13
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	5
for between 3 and 4 years at the time of reporting	2
for 4 or more years at the time of reporting	0

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

The table below identifies all new off-payroll engagements, or those that reached 6 month duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements or those that reached 6 months duration during the time period	17
Number of new engagements which include contractual clauses giving NHSBT the right to request assurance in relation to income tax and National Insurance obligations	9
Number for whom assurance has been requested	17
Of which number for whom:	
Assurance has been received	17
Assurance has not been received	0
been terminated as a result of assurance not being received	0

The table below identifies off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2015 and 31 March 2016:

	Number
The number of off-payroll engagements of board members and/or senior officials with significant financial responsibility	0
The total number of posts, as of 31 March 2016, within the bodies that meet the criteria of “board members and/or senior officials with significant financial responsibility”. This figure includes both off-payroll and on-payroll engagements.	18

Parliamentary Accountability and Audit Report

Basis for Accounts Preparation

The accounts for the year ending 31 March 2016 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.

Internal Audit

As a result of the programme of work agreed by the GAC there were a total of 23 reports issued during 2015/16 of which 4 were "advisory" in nature and did not express an audit opinion. Of the remaining 19 reports:

- 7 reports received a "substantial" assurance opinion
- 10 received a "moderate" assurance opinion
- One received a "limited" assurance opinion
- One received an "unsatisfactory" opinion

The report that resulted in an unsatisfactory opinion related to a review of the ODT Duty Office where it was noted that, in dealing with recipients or donors, our staff were not following procedure with regard to confirming a minimum of three items of patient identifiable data on every telephone call. Corrective actions were immediately put in place and the Duty Office was re-audited later in the year. Following the re-audit it received a moderate opinion and a further audit is included in the plan for later in 2016/17).

The internal audit work has been taken into account in the preparation of the 2015/16 Annual Report and this Governance Statement. Despite the reports noted above Health Group Internal Audit have provided an overall opinion that:

- Our review of the **risk management** process found that NHSBT continues to operate an effective framework to identify, manage and monitor its key risks but that there is a need to ensure that this is effectively engaged with on a regular and timely basis.

- Our reviews have found that the overall **governance** arrangements for NHSBT remain sound but there have been failings in governance over individual areas such as the ODT Duty Office for which we issued an unsatisfactory report. We did however follow this report up later in the year and noted that improvements had been made to address our earlier findings.

- In the case of **control,** overall the control arrangements are adequate, but our reviews have identified a number of areas where improvement could be made, this will be subject to follow up in 2016/17 and ensuring that recommendations from previous reviews are satisfactorily completed.

  Therefore, in summary, my overall opinion is that I can give **moderate assurance** to the Accounting Officer that the Department has had adequate and effective systems of control, governance and risk management in place for the reporting year 2015/16."

All audit findings are monitored by management and presented to GAC to ensure that recommendations are followed up and completed.

External Audit

The Comptroller and Auditor General (C&AG) is appointed by statute to audit NHSBT and report to Parliament on the truth and fairness of the annual financial statements and regularity of income and expenditure. The cost of audit work performed is £90k (£90k 2014/15). There were no payments to the National Audit Office for non-audit work during the year.

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).

There were no individual payments that exceeded £300,000 (Period ended 31 March 2015: no payments over £300,000)

Losses Statement	**31 March 2016**		**31 March 2015**	
	No. Cases	**£000**	**No. Cases**	**£000**
Cash losses	-	-	-	-
Book keeping losses	7	-	1	-
Losses of pay, allowance and superannuation benefits	30	43	17	9
Losses of accountable stores	97	87	144	173
Fruitless payments	1	38	-	-
Claims waived or abandoned	1	-	11	8
Total	**136**	**168**	**173**	**190**

Special Payments	**31 March 2016**		**31 March 2015**	
	No. Cases	**£000**	**No. Cases**	**£000**
Special severance payments	-	-	1	-
Compensation payments	74	387	89	240
Ex gratia payments	7	13	6	-
Total	**81**	**400**	**96**	**240**

Remote Contingent Liabilities

There are no known material remote contingent liabilities. For disclosable contingent liabilities see note 18 in the financial statements.

The Certificate and Report of the Comptroller and Auditor General to the House of Commons and the Scottish Parliament

I certify that I have audited the financial statements of NHS Blood and Transplant for the year ended 31 March 2016 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 Accounting Officer and auditor
As explained more fully in the Statement of Accounting Officer's Responsibilities, the Chief Executive as Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006 and the Scotland Act 1998. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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

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

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

Opinion on financial statements
In my opinion:

- the financial statements give a true and fair view of the state of NHS Blood & Transplant's affairs as at 31 March 2016 and MHS Blood and Transplant's net operating 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 and Staff Report and the Parliamentary Accountablility and Audit Report to be audited has been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and

- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

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

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

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

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

Report
I have no observations to make on these financial statements.

Sir Amyas C E Morse **Date 29 June 2016**

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 2016

	Notes	31 March 2016 £000	Restated * 31 March 2015 £000
Gross Income			
Income from sale of goods and activities	2	**332,937**	343,222
Other operating income	2	**22,546**	22,945
		355,483	366,167
Expenditure			
Staff costs	3.1	**(199,626)**	(197,502)
Purchase of goods and services	3.2	**(192,769)**	(194,170)
Depreciation, amortisation and impairment changes	8 and 9	**(10,143)**	(9,628)
Other operating expenditure	3.3	**(20,292)**	(21,347)
		(422,830)	(422,647)
Net Operating Expenditure before interest		**(67,347)**	(56,480)
Finance Expense	4	**(439)**	(474)
Net Operating Expenditure after interest	2	**(67,786)**	(56,954)
Other Comprehensive Net Expenditure			
Items which will not be reclassified to net operating costs:			
Net gain on revaluation of Property, Plant and Equipment	9	**13,826**	8,369
Total Comprehensive Net Expenditure		**(53,960)**	(48,585)

All income and expenditure is derived from continuing operations

Notes 1 to 24 form part of these accounts.

* Prior year 'Other administrative expenses' represented into 'Purchase of goods and services' and 'Other operating expenditure' in line with FReM 2015/2016 - see notes 3.2 and 3.3

Statement of Financial Position as at 31 March 2016

	Notes	31 March 2016 £000	31 March 2015 £000
Non Current Assets			
Intangible Assets	8	**4,999**	4,328
Property, Plant & Equipment	9	**182,594**	173,773
Financial Assets	11	**198**	741
Total non-current assets		**187,791**	178,842
Current assets			
Inventories	10	**17,662**	16,824
Trade and other receivables	11	**33,752**	34,168
Cash and cash equivalents	12	**30,548**	22,112
Total current assets		**81,962**	73,104
Current Liabilities			
Trade and other payables	13	**(19,697)**	(19,468)
Provisions for liabilities and charges	15	**(3,290)**	(1,824)
Other liabilities	14 and 16	**(133)**	(120)
Total current liabilities		**(23,120)**	(21,412)
Non-current assets plus net current assets		**246,633**	230,534
Non-current liabilities			
Provisions for liabilities and charges	15	**(834)**	(857)
Financial liabilities	14 and 16	**(4,259)**	(4,392)
Total non-current liabilities		**(5,093)**	(5,249)
Total Assets Employed:		**241,540**	225,285
Taxpayers' Equity			
General Fund		**177,031**	172,252
Revaluation Reserve		**64,509**	53,033
Total Taxpayers' Equity:		**241,540**	225,285

Notes 1 to 24 form part of these accounts.

The financial statements on pages 47 to 71 were approved by the Governance and Audit Committee in accordance with powers within the NHSBT Standing Orders on 27th June 2016, and are signed by the Accounting Officer, Ian Trenholm.

Ian Trenholm
Accounting Officer

Date: 27 June 2016

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2015

	Notes	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2014		155,320	47,002	**202,322**
Changes in taxpayers' equity for 2014/15				
Comprehensive net expenditure for the financial period		(56,954)	-	**(56,954)**
Net gain on revaluation of Property, Plant and Equipment	9.2	-	8,369	**8,369**
Transfers between reserves		2,338	(2,338)	**-**
Total recognised income and expense for 2014/15		(54,616)	6,031	**(48,585)**
Revenue Grant from Department of Health		63,048	-	**63,048**
Capital Grant from Department of Health		8,500	-	**8,500**
Balance at 31 March 2015		**172,252**	**53,033**	**225,285**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2016

	Notes	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2015		172,252	53,033	**225,285**
Changes in taxpayers' equity for 2015/16				
Comprehensive net expenditure for the financial period		(67,786)	-	**(67,786)**
Net gain on revaluation of Property, Plant and Equipment	9.1	-	13,826	**13,826**
Transfers between reserves		2,350	(2,350)	**-**
Total recognised income and expense for 2015/16		(65,436)	11,476	**(53,960)**
Revenue Grant from Department of Health		63,415	-	**63,415**
Capital Grant from Department of Health		6,800	-	**6,800**
Balance at 31 March 2016		**177,031**	**64,509**	**241,540**

Statement of Cash Flows for the year ended 31 March 2016

	Notes	31 March 2016	Restated* 31 March 2015
		£000	£000
Cash flows from operating activities			
Net operating costs		**(67,347)**	(56,480)
Other cashflow adjustments	17.3	**12,758**	10,337
Movement in Working Capital	17.1	**1,019**	(11,671)
Provisions utilised	15	**(991)**	(3,313)
Net cash (outflow) from operating activities		**(54,561)**	(61,127)
Cash flows from investing activities			
Purchase of plant, property and equipment		**(5,169)**	(7,111)
Purchase of intangible assets		**(1,519)**	(1,281)
Proceeds from disposal of non current assets		**9**	
Net cash (outflow) from investing activities		**(6,679)**	(8,392)
Cash flows from financing activities			
Grant from Department of Health		**70,215**	71,548
Capital element paid in respect of finance leases	16	**(120)**	(108) *
Interest paid in respect of finance leases	4	**(419)**	(446)
Net financing		**69,676**	70,994
Net increase in cash and cash equivalents		**8,436**	1,475
Cash and cash equivalents at 31 March 2015		**22,112**	20,637
Cash and cash equivalents at 31 March 2016	12	**30,548**	22,112

*subsequent examination of the statement of cashflows identified a typographical error in the presentation of the capital element paid in respect of finance leases in the 2014/15 financial statements which was stated as £108k. This has been corrected to £(108)k.

NHSBT Notes to the Accounts

1. Accounting Policies

The financial statements have been prepared in accordance with the 2015/16 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 public sector as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The FreM follows EU adopted IFRSs and interpretations in effect for accounting periods commencing on or after 1 January 2015.

The financial statements have been prepared on a going concern basis and the particular policies adopted by NHS Blood and Transplant (NHSBT) are described below (1.1 to 1.18). They have been applied consistently in dealing with items considered material in relation to the accounts. The accounts are presented in sterling and presented to the nearest thousand.

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:-

- Use of depreciated replacement cost is used 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)

- Use of best estimates to determine the amount and timings of provisions (see accounting policy note 1.15)

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 economic value in use 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. Where revenue is received for a specific activity which is to be delivered in the following financial year, that revenue is deferred.

The products and services provided to the NHS are primarily blood, components and services such as tissue typing.

NHSBT also receives Grant in Aid funding from Department of Health, for the provision of transplant services by the Organ Donation operating division. The Grant in Aid is credited to the general reserve and not recorded as income. Grant in Aid is recognised in the financial period in which it is received.

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 calculate notional cost of capital charges during 2015/16 was 3.5% (2014/15 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 notional cost of capital charges are not reflected in the Statement of Comprehensive Net Expenditure, although the charge is shown as an expenditure item in segmental reporting note 2. NHSBT makes a cash payment of £16.5m (2014/15 £16.3m) in respect of all capital charges included in prices to the Department of Health which is shown in Note 3.3.

1.5 Property, Plant & Equipment

(a) Capitalisation – Property, Plant & Equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is expected to be used for more than one year;
- individually has a cost equal to or greater than £5,000; or
- collecttively has a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

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

(b) Valuation

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

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 – depreciated replacement cost
- Specialised buildings – depreciated replacement cost

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. Valuations are reviewed annually using a combination of available indices and interim professional revaluations and, if material, the change in valuations are reflected in the accounts. A full valuation of NHSBT land and buildings was carried out in March 2014 and the next full valuation is planned for March 2019.

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 are charged 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 assset 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:

- Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets;

- Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives;

- Land held under a finance lease where ownership does not transfer to NHSBT at the end of the lease is depreciated over the term of the lease;

- 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;

- 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

- Freehold Land, assets under construction, and assets held or identified for future sale are not depreciated;

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

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

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

1.8 Inventories

Inventories are valued as follows:

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

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

1.9 Cash and Cash Equivalents

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

1.10 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.

Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is accounted for as if it were a defined contribution scheme: the cost to NHSBT of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Early Termination Costs

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

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

- 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.

Pension costs

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. A further actuarial valuation has been undertaken at 31 March 2016. The impacts of this revaluation are expected to be reflected in contributions from 2019.

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

c) Scheme provisions

The NHS Pension Scheme is a defined benefits scheme. NHSBT employees are members of the 1995, 2008 and 2015 schemes. Each has different benefits and conditions. Below is a summary of key features of each and is a illustrative guide only.

The 2015 scheme is a career average revalued earning (CARE) scheme. In the CARE scheme the member's pension is based on pensionable pay throughout their career. The members earn 1/54th of their pensionable pay each year they work, this is revalued each year up to retirement or leaving. The final pensionable pay is calculated by adding together the revalued pensions earned in each year of membership.

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

Annual increases are applied to pension payments based on the consumer price index (CPI) in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension is available to members of the schemes who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer. Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.11 Research and Development

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Development expenditure is capitalised to the extent that it results in the creation of an asset and only if, all of the following have been demonstrated from the date when the criteria for recognition are initially met:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to reliably measure 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. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.12 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.

1.13 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.

1.14 Provisions

Provisions are recognised when NHSBT has a present legal or constructive obligation as a result of a past event, and it is probable that NHSBT will be required to settle the obligation. NHSBT provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's published discount rates.

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

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

Clinical Negligence Costs

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

From 1 April 2000, the NHSLA took over the full financial responsibility for all existing liability scheme cases unsettled at that date and from 1 April 2002 all clinical neglience schemes for trust. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with NHSBT. The value of provisions of NHSBT carried by the NHSLA is disclosed in Note 15.

Non-clinical Risk Pooling

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

1.15 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 virutally certain.

1.16 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

NHSBT does not have any embedded derivatives.

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.

1.17 Subsidiaries

Following HM Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, NHS Blood and Transplant has established that as it is the corporate trustee of the linked NHS Blood and Transplant Trust Fund, it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of NHS Blood and Transplant and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' note 21.

1.18 Accounting Standards that have been issued but have not yet been adopted

HM Treasury issued IFRS – 13 Fair Value Measurement as a new standard and effective in the FReM 2015/16 for the first time. The application of this standard has been applied and there is no material impact on the financial statements.

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

For the year 1 April 2015 to 31 March 2016	Total	Blood Components (incl R&D)	Diagnostics	Tissues	Stem Cells Unit	Therapeutic Apheresis Services	Organ Donation & Transplant
Revenue	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Provision of Products and Services	332,937	275,567	27,287	11,740	12,195	6,148	-
Income from Scottish Parliament	5,540	-	-	-	-	-	5,540
Income from National Assembly for Wales	4,602	-	-	-	-	-	4,602
Income from Northern Ireland Assembly	2,100	-	-	-	-	-	2,100
Other Income	10,304	6,282	535	-	3,106	267	114
Revenue Grant In Aid	63,415	-	-	-	4,273	-	59,142
Total Revenue	**418,898**	**281,849**	**27,822**	**11,740**	**19,574**	**6,415**	**71,498**
Expenditure							
Variable Costs	(61,096)	(44,474)	(5,296)	(1,721)	(3,520)	(2,015)	(4,070)
Direct Costs	(210,419)	(117,551)	(15,784)	(7,160)	(10,388)	(2,465)	(57,071)
Direct Support Costs	(90,971)	(71,609)	(5,194)	(2,506)	(3,408)	(694)	(7,560)
Movement in value of stocks	157	(109)	-	266	-	-	-
Other Support Costs	(51,669)	(40,724)	(4,802)	(2,032)	(3,165)	(946)	-
Total Expenditure	**(413,998)**	**(274,467)**	**(31,076)**	**(13,153)**	**(20,481)**	**(6,120)**	**(68,701)**
Operating surplus for the financial period	**4,900**	**7,382**	**(3,254)**	**(1,413)**	**(907)**	**295**	**2,797**
Add : Notional cost of capital included in expenditure above	7,176						
Less : Revenue grant in aid	(63,415)						
Less : Capital charges paid to the Department of Health	(16,447)						
Net Expenditure	**(67,786)**						

For the year 1 April 2014 to 31 March 2015	Total	Blood Components (incl R&D)	Diagnostics	Tissues	Stem Cells Unit	Therapeutic Apheresis Services	Organ Donation & Transplant
Revenue	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Provision of Products and Services	343,222	289,413	25,047	8,063	11,690	6,097	2,912
Income from Scottish Parliament	5,670	-	-	-	-	-	5,670
Income from National Assembly for Wales	3,250	-	-	-	-	-	3,250
Income from Northern Ireland Assembly	1,941	-	-	-	-	-	1,941
Other Income	12,084	8,505	368	-	2,870	192	149
Revenue Grant In Aid	63,048	2,074	-	-	4,373	-	56,601
Total Revenue	**429,215**	**299,992**	**25,415**	**8,063**	**18,933**	**6,289**	**70,523**
Expenditure							
Variable Costs	(63,109)	(47,413)	(4,634)	(1,122)	(3,409)	(1,898)	(4,633)
Direct Costs	(215,134)	(124,007)	(13,720)	(4,798)	(10,396)	(2,240)	(59,973)
Direct Support Costs	(87,828)	(70,749)	(4,011)	(2,260)	(3,023)	(746)	(7,039)
Movement in value of stocks	(1,823)	(1,828)	-	5	-	-	-
Other Support Costs	(45,663)	(37,172)	(3,634)	(1,328)	(2,735)	(794)	-
Total Expenditure	**(413,557)**	**(281,169)**	**(25,999)**	**(9,503)**	**(19,563)**	**(5,678)**	**(71,645)**
Operating surplus for the financial period	**15,658**	**18,823**	**(584)**	**(1,440)**	**(630)**	**611**	**(1,122)**
Add : Notional cost of capital included in expenditure above	6,703						
Less : Revenue grant in aid	(63,048)						
Less : Capital charges paid to the Department of Health	(16,267)						
Net Expenditure	**(56,954)**						

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

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

The **Blood Components** operating unit provides blood and blood components, primarily to NHS hospitals, and includes research and development activity.
The **Diagnostic Services** operating unit provides specialist laboratory services (Red Cell Immunohaematology and Histocompatability & Immunogenetics) and also reagents.
The **Tissues** operating unit provides human tissue products.
The **Stem Cell Services** operating unit comprises the Cellular and Molecular Therapies function, the British Bone Marrow Registry (BBMR) and the Cord Blood Bank (CBB).
The **Therapeutic Apheresis Services** operating unit provides a range of therapeutic apheresis services (e.g. plasma exchange, photopheresis) direct to patients.

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

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

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

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

3.1 Staff Costs and related numbers

	Total	**31 March 2016 Permanently Employed Staff**	**Other**	31 March 2015 Total
	£000	**£000**	**£000**	£000
Salaries and wages	**168,058**	**153,918**	**14,140**	166,146
Social security costs	**11,655**	**11,318**	**337**	11,790
Employer contributions to NHS Pensions Agency	**19,913**	**19,338**	**575**	19,566
	199,626	**184,574**	**15,052**	197,502

The average number of employees during the year was:

	Total	**Permanently Employed Staff**	**Other**
	Number	**Number**	**Number**
Year ended 31 March 2016	**4,830**	**4,561**	**269**
Year ended 31 March 2015	4,928	4,670	258

Expenditure on staff benefits

The amount spent on staff benefits during the year is estimated at £1,179,000 (31 March 2015: £955,000).

3.2 Purchase of Goods and Services

	Notes	31 March 2016 £000	Restated * 31 March 2015 £000
Consumable supplies		**67,049**	70,880
Maintenance of buildings, plant and equipment		**19,096**	15,832
Rent and rates		**12,040**	12,218
Transport costs		**11,008**	10,352
External contractors		**21,508**	19,341
Purchase and lease of equipment and furniture		**3,312**	4,481
Utilities and telecommunications		**7,204**	7,911
Media advertising		**3,237**	2,665
ODT Scheme Payments		**28,630**	30,991
Other staff related costs		**15,760**	15,296
Professional Fees **		**3,835**	4,113
Auditor's remuneration: Audit Fees ***		**90**	90
		192,769	194,170

* Prior year 'Other administrative expenses' represented into 'Purchase of goods and services' and 'Other operating expenditure' in line with FReM 2015/2016 - see note 3.3

** Professional Fees include legal and programme management costs

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

3.3 Other Operating Expenditure

	Notes	31 March 2016 £000	Restated * 31 March 2015 £000
Capital Charges paid over as cash to Department of Health		**16,447**	16,267
Capital Non-cash : Loss on disposal of fixed assets	7.1	**201**	39
Capital Non-cash : Impairments	7.2	**-**	198
Miscellaneous		**3,644**	4,843
		20,292	21,347

* Prior year 'Other administrative expenses' represented into 'Purchase of goods and services' and 'Other operating expenditure' in line with FReM 2015/2016 - see note 3.2

4. Finance costs

	31 March 2016 £000	31 March 2015 £000
Interest expense under finance leases	**419**	446
Other finance costs - unwinding of discount	**20**	28
Total finance costs	**439**	474

5. Operating leases

NHSBT as lessee

	31 March 2016 £000	31 March 2015 £000
Payments recognised as an expense		
Lease and rental payments	**9,416**	9,310
Total future minimum lease payments		
Payable:		
Not later than one year	**4,633**	5,117
Later than one year and not later than five years	**5,449**	6,050
Later than five years	**450**	-
Total	**10,532**	11,167

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

Interest of £nil 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 2015: £129 interest and £Nil compensation).

7. Other gains and losses

7.1 Profit / (loss) on disposal of non-current assets	31 March 2016	31 March 2015
	£000	£000
Loss on disposal of transport equipment	**(4)**	-
Loss on disposal of plant and equipment	**(197)**	(39)
Total	**(201)**	(39)

7.2 Impairments charged in the year to Net Operating Expenditure	31 March 2016	31 March 2015
	£000	£000
Impairment on land and buildings for future sale	**-**	-
Impairment on development expenditure	**-**	198
Total	**-**	198

8. Intangible non-current assets

8.1 Intangible non-current assets 2015/16

	Total	**Software Purchased**	**Development Expenditure**
	£000	**£000**	**£000**
Cost			
At 1 April 2015	16,312	15,059	1,253
Additions - purchased	**1,519**	**322**	**1,197**
Reclassification	**-**	**580**	**(580)**
At 31 March 2016	**17,831**	**15,961**	**1,870**
Amortisation			
At 1 April 2015	11,984	11,984	-
Provided during the year	**848**	**848**	-
At 31 March 2015	**12,832**	**12,832**	**-**
Net book value at 1 April 2015	4,328	3,075	1,253
Net book value at 31 March 2016	**4,999**	**3,129**	**1,870**
Net book value at 31 March 2016 comprises:			
Purchased	4,999	3,129	1,870
Asset Financing	**4,999**	**3,129**	**1,870**
Revaluation Reserve	**85**	**85**	**-**

8.2 Intangible non-current assets 2014/15

	Total	**Software Purchased**	**Development Expenditure**
	£000	**£000**	**£000**
Cost			
At 1 April 2014	15,229	14,086	1,143
Additions - purchased	**1,281**	**28**	**1,253**
Disposals	**0**	**945**	**(945)**
Impairments *	**(198)**	**-**	**(198)**
At 31 March 2015	**16,312**	**15,059**	**1,253**
Amortisation			
At 1 April 2014	11,066	11,066	-
Provided during the year	**918**	**918**	**-**
At 31 March 2015	**11,984**	**11,984**	**-**
Net book value at 1 April 2014	4,163	3,020	1,143
Net book value at 31 March 2015	**4,328**	**3,075**	**1,253**
Net book value at 31 March 2015 comprises:			
Purchased	4,328	3,075	1,253
Asset Financing	**4,328**	**3,075**	**1,253**
Revaluation Reserve	**113**	**113**	**-**

9. Property, plant and equipment

9.1 Property, plant and equipment 2015/16

	Total	Land	Buildings	Land and Buildings identified for future sale	Assets under constr.	Plant and Machinery	Transport Equipment	Information Technology
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation:								
At 1 April 2015	230,649	23,062	129,821	2,800	4,128	51,383	2,004	17,451
Additions - purchased	**4,500**	**-**	**618**	**-**	**1,218**	**2,664**	**-**	**-**
Reclassification	**-**	**-**	**3,590**	**-**	**(3,695)**	**105**	**-**	**-**
Indexation	**(806)**	**-**	**-**	**-**	**(1)**	**(838)**	**33**	**-**
Other in year revaluations *	**10,557**	**375**	**10,182**	**-**	**-**	**-**	**-**	**-**
Disposals	**(2,366)**	**-**	**-**	**-**	**-**	**(2,239)**	**(127)**	**-**
At 31 March 2016	**242,534**	**23,437**	**144,211**	**2,800**	**1,650**	**51,075**	**1,910**	**17,451**
Depreciation:								
At 1 April 2015	56,876	0	3,387	-	-	37,858	1,452	14,179
Provided during the year	**9,295**	**21**	**4,936**	**-**	**-**	**3,193**	**187**	**958**
Indexation	**(593)**	**-**	**-**	**-**	**-**	**(617)**	**24**	**-**
Other in year revaluations *	**(3,482)**	**(21)**	**(3,461)**	**-**	**-**	**-**	**-**	**-**
Disposals	**(2,156)**	**-**	**-**	**-**	**-**	**(2,042)**	**(114)**	**-**
Accumulated depreciation at 31 March 2016	**59,940**	**-**	**4,862**	**-**	**-**	**38,392**	**1,549**	**15,137**
Net book value at 1 April 2015	173,773	23,062	126,434	2,800	4,128	13,525	552	3,272
Net book value at 31 March 2016	**182,594**	**23,437**	**139,349**	**2,800**	**1,650**	**12,683**	**361**	**2,314**
Net book value at 31 March 2016 comprises:								
Owned assets	**155,905**	**19,839**	**116,258**	**2,800**	**1,650**	**12,683**	**361**	**2,314**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	**20,041**	**-**	**20,041**	**-**	**-**	**-**	**-**	**-**
Held on Finance Lease	**6,648**	**3,598**	**3,050**	**-**	**-**	**-**	**-**	**-**
	182,594	**23,437**	**139,349**	**2,800**	**1,650**	**12,683**	**361**	**2,314**
All assets are purchased assets.								
Revaluation Reserve	**64,424**	**9,545**	**54,150**	**404**	**-**	**266**	**59**	**-**

* The change in value of land and buildings relates to a desktop revaluation of property assets undertaken during March 2016 by DVS Property Specialists.
The desktop revaluation used the full valuation carried out as at 31st March 2014 as its base aside from Birmingham Vincent Drive which had a full revaluation.
DVS Property Specialists is an Executive Office of HM Revenue & Customs which provides professional property advice to the public sector.

9.2 Property, plant and equipment 2014/15

	Total	Land	Buildings	Land and Buildings identified for future sale	Assets under constr.	Plant and Machinery	Transport Equipment	Information Technology
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation:								
At 1 April 2014	220,056	21,724	123,728	2,800	2,620	50,244	2,092	16,848
Additions - purchased	**8,070**	**-**	**1,050**	**-**	**3,086**	**3,331**	**-**	**603**
Reclassification	**-**	**-**	**1,578**	**-**	**(1,578)**	**-**	**-**	**-**
Indexation	**34**	**-**	**-**	**-**	**-**	**-**	**34**	**-**
Other in year revaluations *	**4,803**	**1,338**	**3,465**	**-**	**-**	**-**	**-**	**-**
Disposals	**(2,314)**	**-**	**-**	**-**	**-**	**(2,192)**	**(122)**	**-**
At 31 March 2015	**230,649**	**23,062**	**129,821**	**2,800**	**4,128**	**51,383**	**2,004**	**17,451**
Depreciation:								
At 1 April 2014	**53,973**	0	2,500	-	-	36,795	1,359	13,319
Provided during the year	**8,710**	**21**	**4,420**	**-**	**-**	**3,216**	**193**	**860**
Indexation	**22**	**-**	**-**	**-**	**-**	**-**	**22**	**-**
Other in year revaluations *	**(3,554)**	**(21)**	**(3,533)**	**-**	**-**	**-**	**-**	**-**
Disposals	**(2,275)**	**-**	**-**	**-**	**-**	**(2,153)**	**(122)**	**-**
Accumulated depreciation at 31 March 2015	**56,876**	**0**	**3,387**	**-**	**-**	**37,858**	**1,452**	**14,179**
Net book value at 1 April 2014	166,083	21,724	121,228	2,800	2,620	13,449	733	3,529
Net book value at 31 March 2015	**173,773**	**23,062**	**126,434**	**2,800**	**4,128**	**13,525**	**552**	**3,272**
Net book value at 31 March 2015 comprises:								
Owned assets	**148,189**	**19,662**	**104,250**	**2,800**	**4,128**	**13,525**	**552**	**3,272**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	**19,134**	**-**	**19,134**	**-**	**-**	**-**	**-**	**-**
Held on Finance Lease	**6,450**	**3,400**	**3,050**	**-**	**-**	**-**	**-**	**-**
	173,773	**23,062**	**126,434**	**2,800**	**4,128**	**13,525**	**552**	**3,272**
All assets are purchased assets.								
Revaluation Reserve	**52,920**	**9,159**	**42,533**	**404**	**-**	**738**	**86**	**-**

* The change in value of land and buildings relates to a desktop revaluation of property assets undertaken during March 2015 by DVS Property Specialists.
The desktop revaluation used the full valuation carried out as at 31st March 2014 as it's base.
DVS Property Specialists is an Executive Office of HM Revenue & Customs which provides professional property advice to the public sector.

10. Inventories

	31 March 2016	31 March 2015
	£000	£000
Raw materials and consumables	**5,098**	4,417
Work in progress	**3,412**	2,838
Finished processed goods	**9,152**	9,569
	17,662	16,824

11. Trade and other receivables

	31 March 2016	31 March 2015
	£000	£000
Current		
NHS Receivables - Revenue	**20,031**	19,981
Non NHS Trade Receivables - Revenue	**4,118**	3,644
Provision for impairment of Receivables	**(28)**	(25)
Other Debtors	**145**	109
VAT	**2,753**	2,887
Prepayments and accrued income	**6,733**	7,572
Subtotal	**33,752**	34,168
Non Current		
Other prepayments and accrued income	**198**	741
Subtotal	**198**	741
Total trade and other receivables	**33,950**	34,909

Provision for irrecoverable debts

	2015-2016	2014-2015
Amounts falling due within one year	**£000**	£000
Non - NHS trade receivables		
At 1 April	**25**	21
Provided in year	**21**	18
Written off during year	**(4)**	(5)
Recovered during year	**(14)**	(9)
At 31 March	**28**	25
Aging of debts provided against		
Up to 12 months	**8**	17
Over 12 months	**20**	8
	28	25
Receivables and other debtors past due but not impaired		
Upto 3 months	**11,679**	10,089
Between 4 and 12 months	**2,232**	2,190
Over 12 months	**156**	3
	14,067	12,282

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 21).

12. Cash and Cash equivalents

	2015-2016	2014-2015
	£000	£000
Balance at 1 April	**22,112**	20,637
Net change in the year	**8,436**	1,475
Balance at 31 March	**30,548**	22,112
Comprising:		
Held with Government Banking Services accounts	**30,547**	22,110
Cash in hand	**1**	2
Cash and cash equivalents as in Statement of cash flows	**30,548**	22,112

13. Trade and other payables

	31 March 2016	31 March 2015
	£000	£000
Current		
NHS Payables - revenue	**3,454**	2,565
Non-NHS trade Payables - revenue	**1,079**	1,066
Non-NHS trade Payables - capital	**290**	959
Tax and Social Security Costs	**7**	9
Accruals and deferred income	**14,867**	14,869
Total trade and other payables	**19,697**	19,468

14. Borrowings

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

15. Provisions for liabilities and charges

At 31 March 2015	PAYE and NI Liabilities	Employee Benefits	Redundancy	Product Liability and Other	Total
	£000	**£000**	**£000**	**£000**	**£000**
Balance at 1 April 2014	-	1,281	3,436	777	5,494
Provisions - Arising in the year	**200**	**-**	**689**	**577**	**1,466**
Utilised during the year	**-**	**(52)**	**(3,086)**	**(175)**	**(3,313)**
Reversed unused	**-**	**(354)**	**(350)**	**(290)**	**(994)**
Unwinding of discount	**-**	**28**	**-**	**-**	**28**
Balance at 31 March 2015	**200**	**903**	**689**	**889**	**2,681**
Expected timing of cash flows:					
Within 1 year	**200**	**46**	**689**	**889**	**1,824**
Between 1 year and 5 years	**-**	**193**	**-**	**-**	**193**
Thereafter	**-**	**664**	**-**	**-**	**664**

At 31 March 2016	PAYE and NI Liabilities	Employee Benefits	Redundancy	Product Liability and Other	Total
	£000	**£000**	**£000**	**£000**	**£000**
Balance at 1 April 2015	200	903	689	889	2,681
Provisions - Arising in the year	**293**	**3**	**2,277**	**471**	**3,044**
Utilised during the year	**-**	**(46)**	**(653)**	**(292)**	**(991)**
Reversed unused	**(200)**	**-**	**(36)**	**(394)**	**(630)**
Unwinding of discount	**-**	**20**	**-**	**-**	**20**
Balance at 31 March 2016	**293**	**880**	**2,277**	**674**	**4,124**
Expected timing of cash flows:					
Within 1 year	**293**	**46**	**2,277**	**674**	**3,290**
Between 1 year and 5 years	**-**	**191**	**-**	**-**	**191**
Thereafter	**-**	**643**	**-**	**-**	**643**
	293	**880**	**2,277**	**674**	**4,124**

15. Provisions for liabilities and charges (continued)

PAYE and NI Liabilities provisions relate to expected liabilities arising from payments made to some staff for home-to-base travel, as identified in a professional review carried out during 2015/16.

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

Redundancy provisions relate to costs expected to arise from restructure programmes that have been approved by the NHSBT Board, have completed staff side consultation, and are in the process of implementation.

Included within the 'Product Liability and Other' category are provisions relating to legal actions brought against the Authority through the use of Authority products by individuals, legal claims for personal injury, legal claims from donors and employees, and other employee liability and public liability claims. Where a reliable estimate cannot be made a contingent liability is disclosed at note 18.

£5,455,000 (31 March 2015: £3,614,000) is included in the provisions of the NHS Litigation Authority at 31 March 2016 in respect of clinical negligence liabilities relating to NHSBT. There is a £47,000 provision in respect of the existing liabilities scheme (31 March 2015: £Nil).

16. Finance leases

Finance lease obligations (ie as lessee)

	Minimum lease payments	
	31 March 2016	31 March 2015
	£000	£000
Not later than one year	**554**	554
Later than one year and not later than five years	**2,216**	2,216
Later than five years	**9,147**	9,701
	11,917	12,471
Less future finance charges	(7,525)	(7,959)
Present value of future lease obligations	**4,392**	4,512

	Present value of minimum lease payments	
	31 March 2016	31 March 2015
	£000	£000
Not later than one year	**133**	120
Later than one year and not later than five years	**707**	633
Later than five years	**3,552**	3,759
Present value of future lease obligations	**4,392**	4,512
Analysed as :		
Current borrowings	**133**	120
Non-current borrowings	**4,259**	4,392
	4,392	4,512

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

17.1 Movements in working capital

	31 March 2016	31 March 2015
	£000	£000
(Decrease)/Increase in receivables within 1 year	**(416)**	10,792
(Decrease) in receivables after 1 year	**(543)**	(503)
Increase/(Decrease) in inventories	**838**	(2,036)
Decrease/(increase) in payables within 1 year	**(229)**	2,459
Subtotal	**(350)**	10,712
Decrease/(Increase) in payables relating to items not passing through the Statement of Comprehensive Net Expenditure (note 13)	**669**	(959)
Subtotal	**669**	(959)
Total	**(1,019)**	11,671

17.2 Analysis of changes in net debt

	As at 1 April 2015 £000	**Cash flows £000**	**As at 31 March 2016 £000**
Government Banking Services cash at bank	22,110	8,437	**30,547**
Commercial cash at bank and in hand	2	(1)	**1**
Total	22,112	8,436	**30,548**

17.3 Other cashflow adjustments

	31 March 2016	31 March 2015
	£000	£000
Depreciation (note 9)	**9,295**	8,710
Amortisation (note 8)	**848**	918
Impairments (note 7.2)	**-**	198
Loss on disposal (note 7.1)	**201**	39
Provisions - Arising in Year (note 15)	**3,044**	1,466
Provisions - Reversed unused (note 15)	**(630)**	(994)
Total	**12,758**	10,337

18. Contingent Liabilities at 31 March 2016

A contingent liability of £126,000 (31 March 2015: £87,000) relates to potential costs associated with donor claims, personal injury claims, and other employee liability and public liability claims.

A contingent liability of £1,425,000 (31 March 2015: £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.

19. Capital commitments at 31 March 2016

At 31 March 2016 the value of contracted capital commitments was £197,000 (31 March 2015 : £1,008,000).

20 Losses and special payments

20.1 Losses Statement

	31 March 2016		31 March 2015	
	No. Cases	£000	No. Cases	£000
Cash Losses	-	-	-	-
Book keeping Losses	7	-	1	-
Losses of pay, allowances and superannuation benefits	30	43	17	9
Losses of Accountable Stores	97	87	144	173
Fruitless Payments	1	38	-	-
Claims waived or abandoned	1	-	11	8
	136	168	173	190

20.2 Special Payments

	31 March 2016		31 March 2015	
	No. Cases	£000	No. Cases	£000
Special Severance Payments	-	-	1	-
Compensation Payments	74	387	89	240
Ex Gratia Payments	7	13	6	-
	81	400	96	240

There were no individual payments that exceeded £300,000 (Period ended 31 March 2015 : no payments over £300,000).

21. Related parties

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

The Department of Health is regarded as a controlling related party. During the year the Authority has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department, i.e. the majority of NHS trusts and foundation trusts. During the period these transactions were valued at £391 million of income (31 March 2015: £405 million), including capital funding and grant in aid, and £48 million of expenditure (31 March 2015: £54 million), which represented trading with 257 separate organisations.

The following named members of the Board had registered interests in related parties during the year as stated below, and also disclosed is the value of NHSBT income and expenditure transactions with those parties:

Name, Title, and Registered Interest (*)	Income (£000s)	Expenditure (£000s)
Mr J Monroe (NED) : NW London Commissioning Support Unit, Advisory Committee member	-	-
Mr K Rigg (NED) : Nottingham University Hospital NHS Trust, Consultant Surgeon	5,411	294
Mr K Rigg (NED) : NHS England, Chair of Renal Transplant Clinical Reference Group	2,487	-
Mr A Blakeman (NED): Milton Keynes University Hospital NHS Foundation Trust, NED	1,041	22
Mr A Blakeman (NED): Public Health England, Committee Member, Quality Committee	133	64

* NED - Non-Executive Director

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

In accordance with IAS 27 the NHS Blood and Transplant Trust Fund and the NHS Pension scheme are regarded as a related party. Income received from the Trust Fund during the year totalled £235,000 (31 March 2015 : £108,000), and there was a debtor balance due by the Trust Fund of £305,000 (31 March 2015 : £73,000).

22. 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. On 23rd June 2016 Britain voted to opt out of the European Union. NHS Blood and Transplant have concluded that, in our opinion, there are unlikely to be any material impacts on the operations of NHS Blood and Transplant as at the time of signing the accounts.

23. Financial Instruments

Financial risk management

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

Liquidity risk

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

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

Credit Risk

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

Interest-rate risk

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

Foreign currency risk

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

Fair values

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

24. 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	3,574	-	2,097
Balances with local authorities	-	-	1
Balances with NHS Trusts and organisations	20,031	-	3,454
Total Intra-Government Balances	23,605	-	5,552
Balances with bodies external to government	10,147	198	14,145
At 31 March 2016	33,752	198	19,697
Balances with other central government bodies	3,834	-	428
Balances with local authorities	-	-	5
Balances with NHS Trusts and organisations	19,981	-	2,565
Total Intra-Government Balances	23,815	-	2,998
Balances with bodies external to government	10,353	741	16,470
At 31 March 2015	34,168	741	19,468

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