NHS
Blood and Transplant

NHS Blood and Transplant
Annual Report and Accounts 2014/15

Presented to Parliament pursuant to Paragraph 6(3), Section 232, Schedule 15 of the National Health Service Act 2006

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

Ordered by the House of Commons to be printed 13 July 2015

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STRATEGIC REPORT AND MANAGEMENT COMMENTARY

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 support of this NHSBT is organised into three operating divisions:

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

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

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

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

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

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

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

The cost of these activities is generally recovered in the prices of the products and services that are provided, with most prices agreed annually through the National Commissioning Group for Blood. In these segments, however, other providers exist, both within the NHS and, increasingly, the private sector. Competition is a developing feature in these segments and, as a consequence, there is an increasing trend for prices to be set on a commercial basis.

Strategic Objectives

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

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

Taking each of our 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 pillars are each 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 2007/8 to £122/unit in 2014/15 as a result of 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 ongoing reduction in demand and also 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.

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

A chronic shortage of organs available for transplant nevertheless remains. As a result the four UK Governments, supported and facilitated by NHSBT, published a new strategy in June 2013 that aims to achieve the following outcomes for organ donation and transplantation in 2020:

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

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

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

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

This is supported by four strategic targets:

- A consent / authorisation rate in excess of 80%
- 26 deceased donors per million population (currently 19.9 pmp)
- An aim to transplant 5% more of the organs offered from consented, actual donors
- A deceased donor transplant rate of 74 per million population (currently 51.5 pmp)

Diagnostic and Therapeutic Services (DTS)

The DTS group supplies a range of biological products (including haemopoetic stem cells and tissues), specialist low volume diagnostic services in support of blood transfusion and organ/stem cell transplantation and therapeutic apheresis services (the only area in which NHSBT treats patients directly).

Strategic plans have been developed for each business that captures its purpose and the rationale for why it is appropriate that NHSBT should provide the products/services to the NHS (as opposed to other parts of the NHS or the private sector). The plans identify the individual objectives, themes, plans and targets for each business. A common theme across

of all the plans within DTS is the opportunity for NHSBT to leverage its unique national footprint and capabilities in order to consolidate services across the NHS. The common objective is to leverage scale across low volume specialist products and services in support of lower costs, higher safety and better availability of specialist therapies for NHS patients.

The objectives for each business are:

Tissues : *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 sub-business units 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.*
>
> ***Histocompatability & 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 recognise two sub-business units and their associated objectives:

> ***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 of donated stem cells. More than 400 patients each year in the UK, however, are denied access to a transplant, with around 200 lives lost due to the lack of a matched stem cell donor. This loss of life disproportionately affects black and ethnic minority patients because of the particular challenges in identifying suitable donors for members of these communities. In December 2010, the UK Stem Cell Strategic Forum set out a strategy for saving 200 lives per year through increasing the UK inventory of cord blood donations and by improving the performance of the UK based stem cell registries to match the best in the world.

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

The two sub units identified with Stem Cell Services therefore recognises NHSBT's objectives to:

- Support the objectives of the UK Stem Cell Strategic Forum to save an additional 200 lives per year through ongoing collaboration with the Anthony Nolan charity, banking an additional 2300 cord blood donations each year, high resolution typing of adult, ethnically diverse donors and seeking further opportunities to improve IT interoperability with other bone marrow registries **(SCDT).**

- Maintain NHSBT's position as a primary supplier of ***first generation*** stem cell transplantation services through maintaining services to the existing key NHS regional customers that are co-located with NHSBT's seven stem cell processing and cryogenic storage facilities. In addition to support the development of the UK regenerative medicine industry through leveraging our national footprint and capabilities to provide supporting services to the NHS, academic and commercial organisations that are taking the ***next generation*** of cellular and molecular therapies to the clinic **(CMT).**

Corporate

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

Our R&D programme for Blood 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 continue to develop our strong research programme in Tissues, including partnerships with academic partners, to identify the next generation of tissue based therapies and which would enable NHSBT to meet the otherwise unmet needs of NHS patients.

Consistent with an organisation whose mission is to 'save and improve lives', we are committed to sustainable development and minimising wherever possible the impact of our operations on our environment. We believe that sustainability is an important value of our donors and that NHSBT should meet their expectations when they make their 'gift of life'. In support of this we have a comprehensive carbon management plan which committed us to reducing carbon emissions by 25% over the five years to 2014/15. We have met the targets established by this plan and are now developing a new plan for 2015/16 and beyond.

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 delivering back office functions through shared services.

Operating Review

Key Performance Headlines 2014/15

- ***Blood*** - 2014/15 has been very successful year with further improvement in service levels, product availability, regulatory performance and productivity. The Division has responded extremely well to the sustained reduction in red cell demand that has seen demand fall by a further 2.6% in 2014/15 (9.5% over the last three years).

- ***ODT*** – the number of deceased donors in 2014/15 was 2.9% lower than 2013/14 with the number of deceased transplants down by 4.9%. In addition living donors were also 4.5% down on 2013/14. This is the first time in many years that the number of donors and transplants has fallen year on year.

- ***DTS*** – income in 2014/15 was 3% higher over the previous year with strong growth in TAS (+14%) and Tissues (+8%). This was offset by an income decline of 20% in SCDT as a result of lower cord blood issues and fewer bone marrow transplants.

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

Blood

Blood stock levels, and the availability of blood products has continued to be highly resilient through 2014/15. Although overall cell stock levels were lower the blood group mix was much improved with strong and consistent levels of O negative red cells in particular. 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 2014/15 there were no such instances (following zero instances in 2013/14).

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

This presents a major challenge in that, as capacity is reduced in line with longer term trends in demand, we remain dependant on our donors to be able to respond to short term demand pressures. In addition, and despite falling demand overall, we also need to increase the proportion of rare blood group donors, especially of the “universal” O negative blood group. It is pleasing that in this challenging environment, and despite ongoing change to the configuration of our services, donor satisfaction (measured as the percentage of donors scoring 9 out of 10 or higher for overall service) rose from 68% at the start of the year to 72% by the end of the year. After falling in the early part of the year donor complaints

(measured as complaints per million donations) did, however, increase around the Winter period before falling back again in March. Despite the increase in complaints seen over the Winter overall donor complaints for the year were at 5,860 versus 6,007 in 2013/14. A major factor in donor complaints is waiting times, and the availability of appointment slots at required times, especially at peak demand periods. We continue to adjust our appointment grid, to ensure the optimum balance between appointments and slots for walk-in donors, and we are seeing major benefits from the roll out of the online Blood Donor Portal. This was launched in November 2013 and further developed in the year to provide more real time information on the progress of donor sessions (so that donors can adapt/change plans as necessary).

With regard to safety there were no Serious Untoward Instances (SUIs) during the year and no materially adverse trend in the reporting of Serious Adverse Blood Reactions. One "major" regulatory finding, following regulatory inspection by the Medicines and Healthcare products Regulatory Agency (MHRA), was reported in Blood during the year. This is a welcome improvement on the eight "majors" reported in 2013/14 and much more consistent with our objective that we receive no "critical" or "major" findings in any regulatory inspection.

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

As noted above the key trend, with the largest ongoing impact on NHSBT, is the decline in red cell demand. Over the longer term demand for red cells has fallen as a result of improved surgical procedures, along with work by NHSBT and the NHS to reduce the inappropriate use of blood within hospital transfusion. Following a period of relative stability between 2007/08 and 2011/12 demand started to decline sharply in October 2012. Red cell demand fell by a further 2.6% in 2014/15 and, cumulatively, has now fallen by 9.5% over the three years since 2011/12. The impact of this is to reduce income and requires that we reduce costs in tandem. The costs of the blood supply chain are mostly fixed in nature with the variable costs of consumables representing only around 15% of the total. Reduction in demand therefore requires that fixed capacity, and the cost of that capacity, be reduced if the prices of the blood components that we supply to hospitals are not to increase.

The financial impact of red cell demand decline has been especially well managed during 2014/15 with major cost savings delivered and productivities increased. This has contributed to a significant financial surplus in 2014/15 but has also allowed NHSBT to again reduce its prices for blood components in 2015/16 (despite an assumed further decline in red cell demand of 3%). NHSBT is proud of the fact that prices for red cells are now lower than they were in 2004/5, despite inflation, investing in higher safety and availability levels and a 21% reduction in demand over that period. Taken together this is resulting in a net cost reduction to the NHS of nearly £70m pa versus 2008/9.

Organ Donation and Transplantation (ODT)

2014/15 has been a disappointing year with regard to organ donation and transplantation outcomes. There were 1,282 deceased donors in 2014/15, 2.9% lower than 2013/14 and 11% lower than plan. This was also reflected in the number of deceased transplants, which at 3,341 was 4.9% down on last year and also 11% lower than plan. In addition there were 1,091 living donors in 2014/15, 4.5% down on 2013/14. As a result this is the first time in many years that the number of donors and transplants has fallen year on year. The factors behind the decline in numbers are not entirely clear, although there is evidence of a general decline in the donor pool (i.e. the number of NHS patients dying in circumstances that would

allow them to be considered as a potential organ donor. Further work is underway with our partners across the NHS to determine the causes of the decline.

Despite the results seen in 2014/15 ODT will continue to work with the four UK Health Services, and all stakeholders, on developing the detailed plans in support of the "Taking Organ Donation to 2020" strategy and delivering its ambitious targets. During 2014/15 we have also made significant progress supporting the Welsh Health Department with regard to implementation of the Human Transplantation (Wales) Act 20013. The Bill was passed in September 2013 and will introduce a system of soft opt out for organ and tissue donation in Wales from 1 December 2015. In order to support this change the UK Health Departments have agreed to fund the construction a new organ donor register for the UK. NHSBT has facilitated the procurement and is now managing implementation of the new register.

Diagnostic and Therapeutic Services (DTS)

Activity in DTS during 2014/15 has continued to focus on developing and implementing the strategies of the individual operating units. A common theme within each of the strategies is the intent to position NHSBT as a preferred national supplier to the NHS and, 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.

Therapeutic Apheresis Service was the strongest performer with income growth of 14% as a result of strong growth in plasma exchange procedures. Progress in Tissues was also good with income growing by 7% over last year, driven by growth in femoral heads and autologous serum eye drops. Some progress was made in the launch of new products (demineralised bone matrix and decellularised dermis), although not the extent planned.

Within Diagnostics RCI income was 3.3% ahead of last year driven by increased antenatal referrals and implementation of extended working hours (and associated pricing). Income in H&I was only 2% higher than last year reflecting lower solid organ referrals than expected (in Birmingham and Newcastle especially).

Within Stem Cells Services, Cellular and Molecular Therapies income was 7% better than 2013/14, mainly as a result of new projects gained at the Clinical Biotechnology Centre. This was offset, however, by a 20% decline in Stem Cell Donation and Transplant income with cord blood bank income down 8% and income from British Bone Marrow Registry (BBMR) matches down by 34%. The decline in cord blood income reflects that the number of cords issued in 2014/15 was only 43 (versus 60 in 2013/14) with cords issued outside of the UK down by 36%. Similarly BBMR matches were down by 19% in the year and, overall. this reflects a lower level of stem cell transplant activity across the UK in 2014/15. The decline of SCDT income materially impacted the overall growth of DTS as income growth of 6% would have been achieved before the decline in SCDT is taken into account.

Across the DTS portfolio there were no Serious Untoward Instances (SUIs) reported but there was one "major" regulatory non compliance reported during the year at the CBC (versus 3 reported in DTS, also the CBC, during 2013/14).

Customer satisfaction across the DTS portfolio was variable. In H&I satisfaction was at 64% versus plan and 62% last year. Satisfaction in RCI, however, declined quarter on quarter and ended the year at 53%, versus plan of 60% (although better than the 49% seen in the March 2014 quarterly survey). Actions have been put in place, including the implementation of an extended working day, and it is expected that these improvements will be reflected in the RCI customer surveys during 2015/16. In TAS a new customer satisfaction metric was at 68% (versus 60% planned). More importantly, given that TAS is the only part of NHSBT that

directly treats NHS patients, patient experience was reported at 100% positive in the last survey in January 2015 (versus 97% in February 2014).

Research and Development

We deliver a world-leading research and development (R&D) programme which informs international best practice in transfusion, transplantation and regenerative medicine. We support large, strategic research initiatives which benefit healthcare in the UK and beyond as well as delivering an innovative and translational R&D programme. During 2014/15 we have:

- Completed recruitment of 50,000 donors to the INTERVAL study, a large randomised trial of inter-donation intervals which will inform future donation practices.
- Consented over 500 organ donors to the QUOD study which will create a National Biobank of samples for future studies to improve the quality of transplanted organs.
- Appointed a new Reader at the University of Cambridge to strengthen our programme or research in the field of stem cell biology.
- In partnership with higher institutions in England, established National Institute for Health Research (NIHR) Blood and Transplant Research Units in Donor Health and Genomics, Organ Donation and Transplantation and Stem cells and immunotherapies.
- Reported the findings of our research activities in nearly 150 scientific manuscripts in 2014.

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 £15.7 million in 2014/15 (versus £1.3m in 2013/14).

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

NHSBT receives the majority of its income through blood and component prices (based on cost) charged to NHS Hospitals. This income was £289.4m in 2014/15 (£293.5m in 2013/14). Prices are set annually via a national commissioning process. The lower income seen in 2014/15 arose primarily from the ongoing decline in the demand for red cells (demand in 2014/15 was 2.6% lower than seen in the previous year).

NHSBT also receives income from prices charged for diagnostics, tissues, stem cell and therapeutic apheresis services(TAS) within DTS, again based on cost, amounting to £50.9m in the year (£49.8m in 2013/14). As noted in the Operating Review above the income growth in DTS was driven by strong growth in TAS (+14%) and Tissues (+8%) offset by an income decline of 6% 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 £63.0m for the year (£61.9m in 2013/14). The increased funding was provided in order to support higher activity levels in ODT (versus the activity levels supported by the funding provided in 2013/14). £56.6m of this (£55.5m in 2013/14) was allocated to organ donation and transplantation with £2.1m supporting the activities of the International Blood Group Reference Laboratory (£2.1m in 2013/14) and £4.4m funding the development of the NHS Cord Blood Bank (£4.4m in 2013/14)). NHSBT also received contributions in the year of £10.9m from the UK Health Departments in support of our UK wide activities in organ donation and transplantation (£10.4m 2013/14).

We additionally receive £12.1m of “other” income (£12.3m in 2013/14) for cost recovery of services provided, much of which is related to ad-hoc deliveries of blood components to hospitals, over and above the scheduled deliveries within our service level agreements and which are priced into the products.

As noted above NHSBT generated an overall operating surplus for the year of £15.7m (£1.3m 2013/14). The segmental analysis in Note 2 identifies an operating surplus of £18.8m for Blood Components (£4.1m 2013/14) offset by a £2.0m deficit in DTS (diagnostics, tissues, stem cell and therapeutic apheresis services - £0.2m surplus in 2013/14) and a £1.1 m deficit (£2.9m deficit in 2013/14) in organ donation and transplantation. The surplus in Blood arose from a combination of strong cost control and early delivery of benefits from our transformation plan along with slippage of some of the major projects into 2015/16 (and hence the associated spend). The deficit in DTS arose from lower income levels than planned and which was only partially offset by efforts to reduce and maintain costs within the lower income envelope. The deficit in ODT was driven by higher costs than planned on transformational projects along with a discretionary but unplanned investment in novel technologies in organ perfusion.

NHSBT was allocated capital funding of £10.5m for 2014/15, although it was mutually agreed with the Department of Health, during the course of the year, that this could be reduced to £8.5m. The reduced allocation of £8.5m was fully allocated to projects (versus £8.6m in 2013/14). 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.

As shown on the Statement of Financial Position non-current assets have increased from £171.5m in 2013/14 to £178.8m in 2014/15. Current assets increased from £62.9m in 2013/14 to £73.1m in 2014/15, reflecting an increase in trade debtors that has mostly arisen on the back of an increase in the level of overdues in debtors with NHS hospitals. Current liabilities decreased from £26.3m (2013/14) to £21.4m (2014/15) as a result of the timing of transformation projects and unusually high provisions for redundancy at the end of 2013/14. We ended the year with a strong cash balance of £22.1m (£20.6m in 2013/14). In part this reflects the slippage of projects into 2015/16 (which will require associated funding) and deliberate attempts to build/maintain cash in recognition of the significant investment that NHSBT will be required to make in its IT infrastructure and applications over the next three years.

NHSBT is the corporate trustee for NHSBT Trust Funds. The total net assets of the trust funds as at 31 March 2014 was £0.741m. Although the Trust Fund assets are controlled by NHSBT a consolidated account is not produced due to their lack of materiality. The 2013/14 Trust Fund Accounts are available on the Charities Commission website at www.nhsbt.nhs.uk/news-and-media/review-accounts
There are no significant contingent liabilities to report as at 31 March 2015.

Principal Risks and Uncertainties

Blood demand / pricing financial efficiency and the impact on services:
The pricing of blood components is highly dependent on demand volumes. Since October 2012 a sustained reduction in red cell demand has been seen and although we forecast that this trend will continue over the medium term the demand picture is uncertain. The costs of the blood supply chain are relatively fixed in nature and it is challenging to reduce costs at the same rate as volume reduction. Our ability to avoid price increases in the future will increasingly depend on our ability to continue removing capacity and increasing productivity, especially within blood donation.

Funding of the Organ Donation and Transplantation strategy:
The "Taking Organ Donation 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 2015/16 the funding model is sub-optimal (does not reflect volume increases) and is disjointed (in England transplants are funded by NHS England and donation by the Department of Health). A revised funding mechanism will be required in order to meet the ambitions and targets of the "Taking Organ Donation to 2020" strategy. Discussions will continue with the four UK Health Departments in order to define a more appropriate mechanism beyond 2015/16.

IT infrastructure and systems - 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 business 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. The supply of critical products and services to the NHS is highly dependent on NHSBT executing these changes without impacting system availability and will require high quality planning and excellence in execution and change management.

Risks are further highlighted in the Governance Statement at page 31.

Sustainability Report

NHSBT's Carbon Management Plan (CMP) commits the organisation to reduce its carbon emissions by 25% over a five year period, from a 2009-10 baseline and thereby help to mitigate the effects of fuel price inflation and carbon taxation. 2014/15 marks the end of this five year CMP and we are pleased to note that we expect to deliver the 25% reduction in carbon emissions that were targeted. Energy, travel and waste are reported quarterly in arrears and overall CO_2 output is reported annually. In quarter 2 of 2014/15, NHSBT was on track to meet its overall targeted reduction and there is no reason to except that anything will prevent the target being met by the end of the 2014/15 reporting period. The final figures for NHSBT total carbon emissions for 2014-15 and against the current CMP target will therefore be reported to the NHSBT Board and Executive Team in July 2015.

The successor to the CMP is currently being drafted and will be presented to the Board after the current reporting period is concluded. The successor to CMP will include a wider range of Environment and Sustainability targets and seek to devolve performance management, in relation to targets, to the directorates.

NHSBT Total Carbon Emissions (tonnes $C0_2$)

	09/10 Footprint	10/11 Footprint	11/12 Footprint	12/13 Footprint	13/14 Footprint	14/15 Footprint
NHSBT CO2 emissions	27,792	24, 514	22,570	21,502	21,636	Reported July 2015
Target	Baseline	6%	11%	16%	21%	25%
Actual	Baseline	11.8%	18.8%	22.6%	22.37	

Environmental

NHSBT's Environmental Management System (EMS) continues to mature and become imbedded in 'Business As Usual' operations. The EMS has now been successfully certified to the ISO14001 standard and this will be used as springboard to make continuous improvements to the way NHSBT manages its environmental performance.

With regard to specific areas of operational control:

1. The Total Waste Management contract (excluding clinical and confidential waste) continues to make a positive impact with the amount of waste diverted from landfill increasing to 91% against 63% in 2014/15.

2. Clinical Waste contract has moved to a new provider in 2014/15 and is delivering savings against budget in excess of £170k, whilst maintaining the environmental improvements gained in previous years.

3. Considerable progress has been made in the area of Sustainable Procurement. This includes the development and introduction of a new Sustainable Procurement Policy and management programme. This will enable us to achieve Level 3 and be well on the way to achieving Level 4 of the government's Sustainability Flexible Framework.

Carbon Reduction Commitment Energy Efficiency Scheme

NHSBT continues to be registered to Phase 2 of the 2014-19 scheme.

Carbon Accreditation

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

Ian Trenholm
Chief Executive and Accounting Officer

Date: 26 June 2015

DIRECTORS' REPORT

Board Members

Board Members serving during the period 1 April 2014 to 31 March 2015:

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
Ms Lynda Hamlyn CBE - Chief Executive to September 2014. Accounting Officer to 31 July 2014.
Mr Ian Trenholm – Chief Executive appointed 1 July 2014. Accounting Officer from 1 August 2014.
Mr Rob Bradburn - Finance Director
Ms Sally Johnson - Director of Organ Donation and Transplantation
Dr Clive Ronaldson - Director of Blood Supply
Dr Huw Williams - Director of Diagnostic and Therapeutic Services
Dr Lorna Williamson - Medical and Research Director

Details of the remuneration of senior managers of the Authority can be found in the Remuneration Report at pages 25 to 29.

Board Member Interests are surveyed annually a full register of interests is available from the Assistant Director of Finance Operations NHSBT LS15 7TW

Approved or Planned Developments

NHSBT continues to deliver transformational change which, amongst other outcomes, has reduced the costs of red cells issued to the NHS by £70m pa (versus 2008/09). This has enabled us to reduce Blood prices with the 2015/16 price being down to £120 per standard red cell unit (£140 in 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. There are currently ten projects underway with a lifetime investment of over £1m. These are:

- Blood Donation Organisational Design (BDOD). This is a £10m multi year programme of work that is designed to review and improve organisational structure and accountabilities across blood donation, generate improved front line management and service capability

and deliver productivity improvement. Annualised benefits of £4m pa began to accrue in 2014/15. The project is forecast to complete June 2015

- Data Centre Hosting. As a consequence of the need to relocate one of our data centres from the Bio Products Laboratory site (now privately owned) NHSBT plans to move its three data centres to a resilient co-location provider by Q1 2016. This project is expected to cost £8.4m and reduce the risk on current mechanical and electrical infrastructure supporting existing data centres. This project underpins our IT infrastructure on which our core systems and many of the projects below rely.

- The Brentwood Estates project will establish the optimal estates requirement in the Brentwood area to meet reduced operational requirements. The project is expected to cost £7.1m, complete in September 2016 and deliver estimated annual benefits of £1.8m along with the return of proceeds form the sale of the site to the DH .

- Donor Registration Transformation (ODT). This £4.4m project will digitise the current process for registering organ donors in hospitals (largely paper based today). The benefits include removing 75 pages of paperwork with approximately 25% duplication removed. The new solution will enable Organ Donation Nurses to increase the time spent at the bedside and with the donor family. It will also lead to better data requiring less phone contact with transplant centres. The project is expected to complete in March 2016.

- A new Organ Donor Register (ODR) for the UK. This project supports the implementation of the Human Transplantation (Wales) Act 2013. The Bill introduces 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 have agreed to fund the construction a new organ donor register for the UK. NHSBT has facilitated the procurement and is now managing implementation of the new register.

- Platelet Strategy. This follows the recommendation by the Advisory Committee to UK Ministers on Blood Tissues and Organs (SaBTO) that we are no longer required to meet 80% of platelet demand through apheresis. NHBST will initially reduce the level of platelet supply through apheresis to 60% resulting in a number of changes to the way that we operate both our mobile and fixed donation centres. The project will require investment of £3.6m (marketing and severance costs) and is expected to generate savings of £3.1m pa. SaBTO also recommends a platelet additive solution is used in the manufacture of pooled platelets which will result in additional costs of £2m pa. The first phase of the project is expected to complete in March 2016.

- The Transport Management System project is expected to cost £1.8m and secure greater efficiency in our logistics processes and better use of fleet. The project is expected to deliver benefits of £1.2m pa and will complete in April 2015.

- The Nottingham Donor Centre project is expected to cost £1.4m and will deliver a new build donor centre in Trinity Square Nottingham and closure of the current donor centre in Castle Quay. The project is expected to complete in July 2015 and deliver both higher collection volumes and increased donor satisfaction.

- The Session Consolidation project is designed to increase productivity in blood donation through the operation of a smaller number of larger mobile venues (operating a greater number of donation beds at each venue). The initial stages of the project will cost £1.2m and complete in May 2015. This project is now focussing on sessions around the West End Donor Centre and in the Yorkshire area and will review other session areas to

recommend priorities for further stages of the project.

- The ODT infrastructure refresh project is expected to cost £1m. This project will replace existing hardware with a new infrastructure, servers and storage on which ODT systems run. The project will avoid future costs and risks and improve the portability of ODT systems. The project completed in April 2015.

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 36 of this report, along with our approach to mitigation.

Events after the Reporting Period

There are no events since the balance sheet date which have had a significant impact on the reported figures.

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.

Hospital complaints are proactively managed through visits to hospitals and customer satisfaction surveys which highlight areas for improvement. Nearly 500 visits were completed during 2014/15. In response to customer feedback changes have been made across the service we provide for the supply of blood and blood components and diagnostic and therapeutic services. For example, the Red Cell Immunohaematology service commenced a range of initiatives to improve the turnaround time for tests, the hours each day that the service is available and the standard of report they issue. We have also implemented the first phase of a transport management system to support improvements to the day to day delivery service and enable us to review the whole service to ensure it best meets customer need whilst being financially sustainable. The transport team made 138,000 deliveries to hospitals across England and North Wales. We also continue to promote our Electronic Despatch Note service we provide free to customers which helps speed up the receipt of components into the hospital transfusion laboratory. We are also conducting a stock management pilot with four partner hospitals which is designed to reduce waste and improve availability of blood in transfusion laboratories. Through these and other initiatives we have maintained high satisfaction scores during 2014/15 with 70% of customers scoring us 9 or 10 out of ten for our service provision overall. During 2014/15, we received 1,008 formal contacts from hospital customers of which 710 (70%) were complaints and 298 (30%) were compliments.

We were pleased that the number of blood donors who complained last year decreased from 6,000 per million donations during 2013/14 to 5,860 in 2014/15. We have developed a

number of customer service initiatives, many of which have been piloted in different teams across the country, and are confident these will lead to a significant reduction in the number of complaints next year. Initiatives include appointment only session in some areas and an initiative which aims to have all donors through their donation process within 1 hour of their arrival at session with or without an appointment. In 2014/15 we responded to 93% of complaints from our blood donors within 20 days, against our target of 95%.

Organ Donation complaints are received from members of the public, family members of organ donors and organ 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 2014 to March 2015, ODT received 114 formal complaints.

In addition to formal complaints, the Organ Donation Register (ODR) team monitor and respond to queries and complaints concerning disputed registrations onto the organ donor register. In 2014/15 the ODR team responded to 1,240 disputed registrations. Actions involved monitoring and ensuring investigation with third parties when any trends in registration errors were recognised, in addition to correcting the error as per the member of the public's wishes.

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

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

Emergency Preparedness

Business Continuity (BC) is central to the delivery of NHSBT's mission of "reliable supply". The Business Continuity Management System (BCMS) therefore must be based on risk, must generate proportionate and appropriate mitigation for the risks identified by the organisation and must be able to provide stakeholders with auditable assurance of the rigour and robustness of the arrangements in place. To achieve this NHSBT certifies its BCMS to 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 objectives for the 2014/15 year included:

- The expansion of the scope of ISO22301 certification to include all activity in NHSBT Blood Centres in Birmingham, Colindale, Liverpool, Newcastle, Oxford, Southampton and Tooting.
- Identifying new roles within the command and control plan, and identifying individuals who may be required to fulfil those roles.

- Training and exercising all levels of the organisation, including the newly identified individuals, to the Command and Control Plan and associated documents.

All of these objectives were completed successfully, with the exception of the exercising of the Executive Team in a quickly escalating incident with potentially catastrophic consequences for the organisation. This exercise will be completed in 2015/16.

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 staff survey, Your Voice, which is key for obtaining feedback from our staff, was distributed to all staff rather than, in previous years, just sent to a random sample. A response rate of 68% was achieved, which is well above the national average for the NHS and is a clear 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' survey identified a number of key priorities for the organisation, supported by directorate action plans, which will become the focus for the coming year as follows:-

- Improving communication between the different parts of NHSBT
- Improving line manager capability and capacity
- Reducing the amount of harassment and bullying and abuse experienced by colleagues.

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

- **Bright Ideas** – our staff suggestion scheme, encouraging staff to feedback their ideas and views
- **Director Roadshows** where Directors visit our national centres to meet with and brief staff on our strategic plans.
- **Connect to a Region** – a more recent initiative where each Executive and their senior managers are responsible for a region of the country in order to provide visibility of senior managers and provide the opportunity for staff to have open dialogue with members of the senior leadership team.
- **Staff Engagement Forum** – a partnership form which meets at a different centre each month 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.
- **Your Voice Focus Groups** – resulting from the Your Voice Staff Survey a number of focus groups have taken place around the country to hear how managers can support and listen to staff

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 a great place to work.

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 free 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 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. A key part of this is making sure that all employees with disabilities feel valued and are able to achieve their potential in the work place. At NHSBT we work to ensure that disabled people in the work place gain equal access to training and development opportunities, and that all our disabled employees are provided with every opportunity to achieve their potential.

As at 31st March 2015 NHSBT employed 5,615 staff members of which 3,824 were female and 1,791 were male.

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.

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 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%.

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

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	**76,973**	**181,091**
Total Non NHS trade invoices paid within target	**74,240**	**178,861**
Percentage of Non NHS trade invoices paid within target	**96.4%**	**98.8%**
Total NHS trade invoices in the year	**10,334**	**7,717**
Total NHS trade invoices paid within target	**10,185**	**7,593**
Percentage of NHS trade invoices paid within target	**98.6%**	**97.7%**

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 2014/15 NHSBT made a payment of £128 arising from claims made under this legislation (£76 in 2013/14).

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 2014/15 NHSBT paid 38.9% (38.7% in 2013/14) of the total number of invoices, representing 44.3% (42.1% in 2013/14) by value, within a 10 day period.

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 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	17
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	10
for between 2 and 3 years at the time of reporting	5
for between 3 and 4 years at the time of reporting	1
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 2014 and 31 March 2015, 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	11
Number of new engagements which include contractual clauses giving the NHSBT the right to request assurance in relation to income tax and National Insurance obligations	10
Number for whom assurance has been requested	11
Of which:	
assurance has been requested and received	11
assurance has not been requested but not been received	0
been terminated as a result of assurance not being received.	0

In line with revised guidance NHSBT reviewed the risk assessment and assurance required in the period. Prior to January 2014 we obtained assurance that tax was being paid. From January 2015 we have enhanced our checks and evidence requirements to assure ourselves that the right amount of tax was being paid. One contractor reported in the table above left NHSBT in May 2014. They had complied with the assurance requirements extant at that time. The remaining contractors have provided sufficient evidence that they are paying the right amount of tax.

The table below identifies off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2014 and 31 March 2015:

	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 2015, 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

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			Level 2			Level 3			Level 4		
Year	12/13	13/14	14/15	12/13	13/14	14/15	12/13	13/14	14/15	12/13	13/14	14/15
BS blood donation	5	18	22	13	10	7	474	375	236	276	598	559
BS national operation	2	1	2	1	1	2	73	58	45	66	77	114
DTS	1	0	0	1	1	1	40	29	33	41	49	56
ODT	0	1	0	0	0	1	1	5	4	26	18	7
Group Services (including Logistics)	4	6	6	5	2	4	38	28	22	46	61	57
Total	12	26	30	20	14	15	626	495	340	455	803	793

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.

During the year there has been an increase in reporting of more serious employee injuries at both level 1 and level 2. Of a total of 30 level 1 injuries 12 were manual handling injuries, with 7 of these relating to donation chairs. The number of donation chair related level 1 incidents has increased from 4 the previous year. The number of level 3 incidents has decreased by 31%. Lastly the number of level 4 incidents has stayed level, the reporting of these types of injuries is encouraged to learn from them, by investigating their root causes and to identify further possible controls. The majority of level 1 root causes are due to human error and as such a behavioural safety programme is being investigated, with the aim of reducing these types of injuries in 2015-16.

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 2013/14). There were no payments to the National Audit Office for non-audit work during the year.

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 1.11.

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.

Financial Instruments

NHSBT does not operate through the use of any complex financial instruments. The majority of NHSBT's activities are financed through the prices charged for products and services to the NHS. As such NHSBT is exposed to some cashflow risk although there has been no material record of NHS institutions failing to pay their invoices. We have noted an increase in the level of overdues with NHS hospitals, however, but NHSBT currently has sufficient cash funds that this does not present a significant funding risk. We are actively managing outstanding debts, and review credit terms regularly to ensure the potential risk is controlled.

We also intend to move our NHS customers on to direct debit arrangements in order to stem the increase in overdue levels as this could present a cash flow risk in the future.

As Accounting Officer:

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

The Audit certificate can be found on page 43.

The strategic objectives and the principal risks of NHSBT are outlined at page 2 and page 11 respectively.

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

Ian Trenholm
Chief Executive and Accounting Officer

Date: 26 June 2015

REMUNERATION REPORT

Remuneration Committee Membership

During 2014-15 membership of the Remuneration Committee comprised Shaun Williams, Jeremy Munroe and John Pattullo. The committee was chaired by Shaun Williams. Lynda Hamlyn/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.

Lynda Hamlyn, Chief Executive, NHS start date 1 April 1986, appointed 14 January 2008. Full time permanent post with three months' notice of termination by the employee, and six months' notice period by NHSBT. Lynda Hamlyn retired from NHSBT 30 September 2014.

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.

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

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

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

Aaron Powell, Interim Director ICT, NHS start date 1 January 2010, appointed 20 October 2014. Temporary interim post with three months' notice of termination by the employee, and three months' notice period by NHSBT.

Michael Potter, Director of Business Transformation Services, NHS start date 9 November 2009, appointed 1 September 2010. Permanent full-time post with three months' notice of termination by the employee, and six months' notice by NHSBT. Michael Potter left NHSBT on 17 October 2014.

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

Huw Williams, Director of Diagnostic and Therapeutic Services, NHS start date 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.

Lorna Williamson, Medical and Research Director, NHS start date 1 August 1978, appointed 1 October 2007. Contract of employment with the University of Cambridge until 30th June 2009. Contract with NHSBT from 1st July 2009. Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT.

Mark Cox, Interim Director of Logistics. Mark joined NHSBT initially as a contractor on 14 February 2013 and was subsequently appointed as a salaried employee on 14 October 2013, under a 6 month fixed term contract (then extended) . The post was full time. Mark Cox left NHSBT on 7 October 2014

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

The remuneration and pension benefits of the most senior officials of the Authority are shown in the tables on pages 26 and 27. The tables on pages 26, 27 and 28 are subject to audit.

Salary and Pension Entitlement of Senior Managers

a. Remuneration

	Year to 31 March 2015					**Year to 31 March 2014**				
Name and title	Salary in £5k Bands £000	Performance pay and bonuses in £5k bands £000	Expense Payments (taxable) total to nearest £00) £00	All Pension Related Benefits (bands of £2500) £000	Total in £5k Bands £000	Salary in £5k bands £000	Performance pay and bonuses in £5k bands £000	Expense Payments (taxable) total to nearest £00) £00	All Pension Related Benefits (bands of £2500) £000	Total in £5k Bands £000
Mr J Pattullo (Chairman)	60-65	-	-	-	60-65	50-55	-	1	-	50-55
Mr A Blakeman (NED)	10-15	-	-	-	10-15	10-15	-	-	-	10-15
Dr C. Costello (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms L Fullwood (NED)	5-10	-	-	-	5-10	0-5	-	-	-	0-5
Mr R Griffins (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr J Monroe (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr K Rigg (NED)	5-10	-	-	-	5-10	0-5	-	-	-	0-5
Mr S Williams (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms L Hamlyn (Chief Executive) ended 30 September 14	90-95	5-10	-	-	100-105	180-185	-	2	-	180-185
Mr I Trenholm (Chief Executive) commenced 1 July 2014***	130-135	-	1	32.5-35	160-165	-	-	-	-	-
Ms L Austin (Director of Communications)	105-110	-	-	30-32.5	140-145	105-110	-	1	32.5-35	140-145
Mr I Bateman (Associate Director of Quality)	100-105	-	33	17.5-20	120-125	20-25	-	8	17.5-20	40-45
Mr R Bradburn (Finance Director)	135-140	-	44	37.5-40	180-185	140-145	-	35	55-57.5	200-205
Mr M Cox (Interim Director of Logistics) ended 7 October 2014	55-60	-	-	-	55-60	160-165	-	7	-	160-165
Mr D Evans (Director of Workforce) *	120-125	5-10	1	7.5-10	135-140	95-100	-	5	22.5-25	120-125
Ms S Johnson - (Director of Organ Donation and Transplantation) **	120-125	-	-	95-97.5	220-225	115-120	5-10	-	-	120-125
Mr M Potter (Director of Business Transformation Services) ended 17 October 2014	55-60	-	9	5-7.5	65-70	105-110	-	19	30-32.5	140-145
Mr A Powell (Interim Director ICT) commenced 20 October 2014****	40-45	-	9	42.5-45	85-90	-	-	-	-	-
Dr C Ronaldson (Director of Blood Supply)	135-140	5-10	22	22.5-25	170-175	135-140	5-10	19	70-72.5	215-220
Mr H Williams (Director of Diagnostics and Therapeutic Services)	125-130	-	-	40-42.5	165-170	125-130	-	4	40-42.5	170-175
Dr Lorna Williamson (Medical and Research Director)	215-220	-	-	2.5-5	220-225	210-215	-	-	77.5-80	290-295

NED = Non-Executive Director

Performance pay and bonuses relates to pay earned in the previous year. There were three such bonuses paid in 2014/15 and two in 2013/14.
* Salary lower in 2013/14 due to a career break taken in year.
**Salary lower in 2013/14 due to a career break. A pension contribution break also occurred which appears above as a nil increase in pension benefits in 2013/14 and a larger than average increase in 2014/15. No additional pension benefits have been paid.
*** Full year salary figure for this position is 170-175
**** Full year salary figure for this position is 95-100
Expense payments (taxable) were in relation to the provision of cars and reimbursement of business mileage and are stated in round £100's not £1000's.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of their workforce. The banded remuneration of the highest paid director in NHSBT in the financial year 2014/15 is shown in the table below, together with the remuneration ratio compared to the highest paid directors pay. This shows the pay multiple remains unchanged at 8.1.

	2014-15	**2013-14**
Highest Director Banded Remuneration	£215k to £220k	£210k to £215k
Median Remuneration	£26,732	£26,589
Remuneration Ratio	8.1	8.1

b. Pension benefits

Name and title	Real increase / (decrease) in pension at at age 60 (bands of £2,500)	Real increase in lump sum at at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Ms L Hamlyn (Chief Executive) ended 30 September 2014 *	-	-	-	-	-	-	-
Mr I Trenholm (Chief Executive) commenced 1 July 2014	0-2.5	-	0-5		19	-	18
Ms L Austin (Director of Communications)	0-2.5	-	5-10		122	95	25
Mr I Bateman (Associate Director of Quality)	0-2.5	0-2.5	15-20	45-50	320	288	24
Mr R Bradburn (Finance Director)	0-2.5	-	15-20	-	223	186	32
Mr M Cox (Interim Director of Logistics) ended 7 October 2014 **	-	-	-	-	-	-	-
Mr D Evans (Director of Workforce)	0-2.5	0-2.5	40-45	120-125	812	760	31
Ms S Johnson (Director of Organ Donation and Transplantation) ****	2.5-5	12.5-15	45-50	135-140	966	830	113
Mr M Potter (Director of Business Transformation Services)	0-2.5	-	20-25	-	239	228	4
Mr A Powell (Interim Director ICT) commenced 20 October 2014	0-2.5	-	5-10	-	63	-	20
Dr C Ronaldson (Director of Blood Supply) ***	0-2.5	2.5-5	55-60	165-170	-	-	-
Mr R Williams (Director of Diagnostics and Therapeutic Services)	0-2.5	-	0-5	-	63	33	29
Dr L Williamson (Medical and Research Director) ***	0-2.5	0-2.5	80-85	250-255	-	-	-

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

** is not a member of the NHS Pension Scheme

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

**** Increase in pension and CETV are higher relative to prior year when a career break with no pension contributions reduced the figures

Cash Equivalent Transfer Value

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

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

Real Increase in CETV

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

Ian Trenholm
Chief Executive and Accounting Officer

Date: 26 June 2015

ANNUAL ACCOUNTS

Basis For Accounts Preparation

The accounts for the year ending 31 March 2015 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.

Statement of Chief Executive'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.

Annual 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 supporting Income Generation Agreements.

The governance structure and process within NHSBT is documented by an NHSBT Integrated Governance Framework that was approved by the Board in 2011/12 and is reviewed annually by the Governance and Audit (GAC) Committee. The Integrated Governance Framework formally 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 is supported by an Assurance Map which outlines the areas on which assurance is required and how assurance is then provided (based on the "three lines of defence" principle).

The Integrated Governance Framework was last reviewed by the GAC in November 2014 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 Assurance Map is regularly reviewed and used as a check list for ensuring NHSBT operates a complete set of assurance processes. It was formally reviewed in February 2015 when it was also updated to reflect DH Guidance Principles for Assurance and ensure compliance with Treasury's Corporate Governance Code.

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

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 assurances provided to the Board and is assessed on a periodic basis to ensure that it provides sufficient information and assurance to the Board regarding the delivery of NHSBT's objectives and management of its risks. During 2013/14 an internal audit was conducted that provided confirmation and assurance that the data appearing in the Board Performance Report was consistent with source systems. A repeat of this audit will be built into the work plan for 2015/16.

The NHSBT Board

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

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

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

The Board reviews its effectiveness on an annual basis and also that of its Committees which support the work of the Board. All Board Committees are required to submit Annual Reports and Workplans which are discussed at the Board as part of its review of effectiveness (on a July to July cycle). Following the appointment of a new Chair during 2013/14 a small working party of Non-Executive and Executive Directors was established to review the effectiveness of the Board in more depth. As a result of the review the Board confirmed that it was working effectively but identified a number of improvement opportunities which have since been implemented during 2014/15. Taken together the Board is satisfied that it was operating effectively during 2014/15. It will next formally review its effectiveness in May 2015.

Board Committees

The Board has established the seven Board Committees described below. All seven Committees were in operation during 2014/15.

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. 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. The GAC also conducts periodic risk reviews covering all of the operations and functions of NHSBT on a rotational basis.

The GAC formally reviewed its effectiveness at its meeting in April 2014. The review was conducted using a questionnaire based on the *NAO Governance and Audit Committee Self-Assessment Checklist* which was completed by GAC members and attendees prior to the meeting. The overall assessment was that the GAC was operating effectively and well. Opportunities for further discussion and improvement were, however, identified and these will be taken into a workshop to be organised in June 2015.

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

Transplantation Policy Review Committee - 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.

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

National Administrations Committee - 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.

Board Committee Average Attendance of Members

Board Committee	Average Attendance of Members (%)
Governance & Audit Committee (GAC)	70%
National Administrations Committee	86%
Trust Fund Committee	94%
Expenditure Controls Committee	100%
Transplantation Policy Review Committee	77.5%
Remuneration Committee	92%
Research and Development Committee	82%

As part of the annual reporting process the remit and terms of reference of all Board Committees were reviewed during the year (in July 2014, except for the Remuneration Committee, October 2014).

Board Meetings – Attendance by Members

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

John Pattullo	Chairman	6
Lynda Hamlyn*	Chief Executive to July 2014	2
Ian Trenholm**	Chief Executive from July 2014	5
Andrew Blakeman	Non-Executive Director	5
Christine Costello	Non-Executive Director	5
Shaun Williams	Non-Executive Director	4
Roy Griffins	Non-Executive Director	5
Jeremy Monroe	Non-Executive Director	5
Louise Fullwood	Non-Executive Director	5
Keith Rigg	Non-Executive Director	5
Rob Bradburn	Finance Director	6
Sally Johnson	Director of Organ Donation and Transplantation	6
Clive Ronaldson	Director of Patient Services	6
Lorna Williamson	Medical and Research Director	6
Huw Williams	Director of Diagnostics and Therapeutic Services	6

** last Board meeting on retiring from NHSBT was July 2014*
*** first Board meeting on joining NHSBT was September 2014*

Risk Management and Control

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

- Risk Management Assessment Framework
- Management of Risk

The GAC is accountable for ensuring that the risk management process is fit for purpose and is working effectively. The MPDs were generated during the year, and reviewed by the GAC, as part of a fundamental review of our risk management processes.

The NHSBT planning, performance and risk management framework maps a path from strategic objectives and risks through to the underlying action plans and risk mitigating activities. This framework is designed to demonstrate that risks are identified and controlled appropriately in order for objectives to be achieved. Strategic objectives and targets are updated and agreed by the Board as part of the annual planning cycle and involved a review of the key risks facing NHSBT in October 2014.

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

NHSBT operates a formal risk register. New risks identified for inclusion on the Corporate Risk Register are assessed for their likelihood and consequence using a 5 x 5 risk matrix in accordance with the Risk Management Policy and 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 Governance and Audit Committee (GAC) reviews all aspects of corporate, operational and clinical governance and is supported by a programme of internal audit that is updated on an annual cycle. The GAC also has a programme in place to review the risks and controls within each of our operating units and key supporting services on a rolling basis. This programme is incorporated within the GAC overall workplan.

Responsibility for our governance systems is delegated to the Medical and Research Director, with support by the Finance Director, who together provide a strong link between the Governance and Audit Committee (GAC) and the Board. The Medical and Research Director has particular responsibility for all aspects of clinical governance and effectiveness across NHSBT and reports regularly to the Executive Team, GAC and Board on all matters of clinical governance and risk. This responsibility is 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 supplied by NHSBT. The regulation of activities within Blood Components is covered by Blood Safety and Quality Regulations (BSQR) and regulated, as Competent Authority, by the MHRA. Regulation of activities within Organ Donation and Transplant, Tissues, Stems Cells and Histocompatability & Immunogenetics is covered by the Human Tissue Act 2004 for England, Wales and Northern Ireland. The Human Tissue (Scotland) Act 2006 governs organ and tissue donation and transplantation in Scotland. The provisions of EU Tissues and Cells Directives, and the related UK legislation, are regulated by the Human Tissue Authority as the Competent Authority on a UK-wide basis.

NHSBT operates a single, comprehensive QMS system across its operations that is designed to ensure compliance with regulation. The QMS comprises operating manuals and

detailed process documentation and is supported by an IT system (QPulse). The QMS ensures continued, demonstrable compliance with a wide range of regulatory requirements which enables NHSBT to maintain its 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
- 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 Associate Director of Quality reports directly to me 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
- monthly reporting of supporting key operational KPIs (to the Board and Executive Team) designed to monitor that key processes remain in control.

NHSBT is subject to regular inspections by its regulators and the results of all inspections are reported to the Executive Team, GAC and Board via the MQR process. 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 2014/15 there were no critical and two major non-compliance reported (no critical and eleven major non-compliances were reported in 2013/14). NHSBT has put action plans in place to address all of the issues raised.

NHS Blood and Transplant Risk Profile

NHSBT is a supplier of biological products and related clinical services to NHS hospitals but does not generally provide clinical services directly to NHS patients. The only area where NHSBT does provide direct clinical services is in the apheresis based therapies that are provided to patients by our Therapeutic Apheresis Teams (representing around 1% of our activity measured by income). NHSBT is, however, totally dependent on the voluntary donation of blood, organs, haemopoetic stem cells and tissues and has extensive direct contact, in particular, with donors of blood and stem cells. With regard to organs and tissues there is limited contact with donors (in a clinical context) but NHSBT must have due regard for the donor, the donor family, the recipient family and the handling of organs and tissues once they have been retrieved and are entrusted to the NHS. Taken together the nature of our operations, and the characteristics of our contact with the public, are very different to,

and unique within, the broader NHS. 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. Our strategy therefore incorporates a balanced set of objectives covering quality and efficiency but we plan for the highest levels of risk mitigation before any steps are taken which could impact the safety or availability of our products/services and ultimately the safety of NHS patients. In this regard both our clinical governance (CARE) and quality assurance functions are closely involved with strategic projects at all stages of their progress. Overall we are highly committed to delivering our strategy, and its associated benefits, and we endeavour to maintain the right balance between delivery of the strategy and the risks associated with its underlying action plans.

As at 31 March 2015 the NHSBT risk register captured 139 risks. Of these the risks considered high/extreme (i.e. with a risk score of 15 or more) were as follows:

Blood – declining demand and service reconfiguration:
The prices charged for blood components provide a transparent view of the financial efficiency of the blood service. 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 maintain flat pricing or better. Pricing is, however, highly dependent on volume and the trends that we see in the demand for blood. Since October 2012 a sustained reduction in red cell demand has been seen and we forecast that this trend will continue over the medium term. The costs of the blood supply chain are relatively fixed in nature and it is 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. The drive for further efficiencies will result in significant changes to the configuration of our services (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 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 who 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.

Funding of the Organ Donation and Transplantation strategy:
The "Taking Organ Donation 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 also been secured for 2015/16. The additional funding provided for 2015/16, is however, predominantly non-recurring in nature and there is therefore no guarantee that it will be available in future years. If funding were to be unavailable NHSBT would be unable to deliver the planned activity levels, or invest in the system resilience, that is described in the strategy. In order to meet the outcomes of the "Taking Organ Donation to 2020" strategy a revised funding mechanism will therefore be required. Discussions will continue with the four UK Health Departments in order to define a more appropriate mechanism beyond 2015/16.

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 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 the short term the immediate requirement for NHSBT is to exit its data centre at the BPL site at Elstree. This project is underway and is due to complete in Q4 2015/16. Given that our data centres support the operation of critical systems the migration of the data centres to new hosted arrangements represents the greatest change risk that NHSBT has ever undertaken.

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.

Estate / IT systems - 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, Heamatos, EOS, NTxD).

In September 2012 a serious flood occurred at NHSBT's Filton site. The business continuity and emergency planning processes worked successfully and full operations at the site were reinstated quickly with no loss of service to hospitals but it also identified gaps within our business continuity planning arrangements. Further risk assessments have since been undertaken at other key NHSBT sites to enhance resilience.

As noted above our IT infrastructure and systems across NHSBT are generally old and close to end of life. Periods of instability have recently become more frequent and, in addition, our plans (e.g. data centre migration) will result in major changes which further increase the risk of instability and lack of availability.

The risk in this area is increasing and will increase further over the near term. Further work will be required in order to provide sufficient assurance that NHBST can manage continuity risks (for example much greater awareness and live testing of business continuity arrangements – see the internal audit section below).

Process resilience:
NHSBT uses manual paper based and verbal processes within its operations especially within the organ donation and transplantation pathway (and particularly within the ODT Duty Office) as well as in our diagnostic testing areas. Although these are mitigated by control checks there remains a residual risk that these are ineffective and result in errors that could lead to harm to NHS patients. This risk has been apparent and has crystallised in errors made in the Duty Office during 2013/14 and is subject to detailed review, overseen by the GAC. The risk of transcription error in diagnostics is being reduced through the implementation of electronic requesting and reporting of results between NHSBT and customer hospitals.

Competition

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 quite 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 SaBTO on the basis 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 completion. As a result our strategies are to avoid outright competition and focus 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 providing support for clinical trials in regenerative medicine based on our unique infrastructure and capabilities from donor through storage, selection and manipulation of stem cells, to delivery at the hospital bedside.

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

There were no Never Events in 2014/15 and one Serious Untoward Incident (SUI), compared to zero and two events respectively in 2013/14. SUIs are subject to a defined management and reporting process that is linked to the Quality Management System and supported by QPulse for incident reporting.

The SUI in 2014/15 related to error in reporting Kell blood typing results on foetal DNA samples from three pregnancies in the International Blood Group Reference Laboratory (IBGRL). None of the babies involved appear to have been harmed but one required a blood transfusion (although it is not clear whether this could have been avoided). Procedures have been amended to ensure reading and documentation of control results, the shelf life of reagents has been shortened and the management of IBGRL transferred from R&D into our operational Diagnostics function. It was agreed at the GAC that the contribution of human factors involved in the error was worth exploring on a wider basis across NHSBT and a plan is being developed for this.

In order to provide greater scrutiny over system failures that could have lead to patient harm a new category of Potential Significant Harm Incident (PoSHI) was defined and ratified by the GAC in 2012. In 2014/15 there have been three incidents classified in this category (versus three in 2013/14). These incidents are investigated using the same methodology and timeframes as SUIs, and are reported to the Board, and reviewed by the GAC, in the same way. Following a review of the process, including best practice guidance from the rest of the NHS and alignment of the definition of Never Events, the PoSHI category will now be deleted in order to create a single category of Serious Incident Requiring Investigation

(SIRI). A revised MPD has been developed and this will be trained out across NHSBT for implementation in May 2015.

Internal Audit

As a result of the programme of work agreed by the GAC there were a total of 19 reports issued during 2014/15 of which 1 was "advisory" in nature and did not express an audit opinion. Of the 18 remaining reports:

- 2 reports received a "substantial" assurance opinion
- 12 received a "moderate" assurance opinion
- 1 received a "limited" assurance opinion
- 3 were rated as "unsatisfactory"

The reports that resulted in an adverse opinion (i.e. lower than moderate) were:

- IT Resilience and Disaster Recovery Planning (unsatisfactory)
- Donor Registration Transformation Project – iOS application (unsatisfactory)
- Southampton SCI cryostorage (unsatisfactory)
- Information Security (limited)

Of the above reports the Southampton cryostorage and Donor Registration Transformation audits primarily reflect concerns regarding the effectiveness of the governance arrangements applied to these projects within our Transformation Programme. Governance arrangements will be reviewed taking into account that we are successfully managing around 40 projects within our Transformation Programme and that these are relatively unusual projects within the context of the overall portfolio. They are, however, potentially reflective of the type of projects we will face in future and hence the challenges to come.

The Donor Registration Transformation Project audit report noted that £0.6m had been spent with a supplier whose contract has now been discontinued. A different supplier has now been contracted to support delivery of this project. The expenditure with the original supplier has not been treated as fruitless (per Treasury's Managing Public Money definitions) as an improved design scope and increased understanding of the complexity of the project was obtained through this work. All the recommended actions from the internal report have been accepted and will be implemented in full.

The audit opinion on business continuity in IT arises from a lack of current documentation / procedures in case that our critical IT systems become unavailable. Given the unique and critical nature of the products and services provided by NHSBT this represents a major risk and is exacerbated by recent instability in IT services. It also provides concern given the extent of the fundamental changes that will be made to IT infrastructure and applications in the near future (in particular the migration of our data centres to a hosted facility and replacement of PULSE) and hence the instability and lack of assurance regarding recovery if the projects were to introduce major issues. This is a Board level concern and reflected in the key risk identified above. Work is underway, including the procurement of expert external advice, in order to close the existing gaps and provide assurance through rigorous testing of business continuity arrangements in case that IT systems become unavailable.

The internal audit work has been taken into account in the preparation of the 2014/15 Annual Report and this Governance Statement. Despite the reports noted above Health Group Internal Audit have provided an overall opinion that:

"In the case of **risk management:** Our review of the risk management process found that NHS BT 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.

In the case of **governance:** Our reviews have found that the overall governance arrangements for NHS BT remain sound but there have been failings in governance over individual projects and programmes. In particular there were specific governance failings in the Southampton Cryogenic Storage Room facility project for which we have provided an unsatisfactory risk rating. However we acknowledge that the failings on which our findings are based occurred in previous years.

In the case of **control:** Key financial controls remain effective and we noted mainly low risk findings in our three financial control reviews and also our four reviews assessing compliance with DH expenditure controls. There are a number of controls that are either failing or are not in place in the area of Information Technology, and these are evidenced by our reviews of IT Resilience and Disaster Recovery, and also Information Security. However, management were aware of these issues and specifically asked for our input on them.

Therefore, in summary, my overall opinion is that I can give **moderate assurance** to the Accounting Officer that the NHS Blood and Transplant Authority has had adequate and effective systems of control, governance and risk management in place for the reporting year 2014/15."

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

Information and Data Management

NHSBT holds details of over 4 million active blood donors and manages an Organ Donor Register with approximately 21 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 2014/15. A summary of non-reportable incidents is included at page 23. The "limited" internal audit opinion on information security noted above reflected concerns regarding the lack of supporting documentation rather than NHSBT being at fundamental risk of an information security failure. Agreed action plans are in place to address the issues identified in this report.

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.

NHSBT has a comprehensive annual plan of work to ensure governance and oversight of counter fraud activity, that all staff are informed and involved in the counter-fraud effort, to prevent and detect frauds and to hold those committing fraud to account. Our counter fraud work is overseen by NHS Protect. In 2014/15 a fuel fraud was detected where an estimated £60,000 worth of fuel had been taken by a member of staff. The individual has been prosecuted and has served time in prison. We have undertaken a lessons learned review and our controls around petrol usage have been enhanced.

Care Quality Commission Registration

NHSBT has 30 blood centres, 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 2014 to March 2015, the CQC did not undertake any inspections of NHSBT locations.

This reflects very positive inspections undertaken in 2013/14 and we continue to maintain our commitment to ensuring the standards set within the Essential Standards of Quality and Safety are achieved. This commitment continues with the introduction of the new Fundamental Standards.

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 only generate around £6m of NHSBT's total income. This is below the threshold of income that requires a licence and, additionally, does not meet the definition of a Commissioner Requested Service. 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. NHSBT has reviewed the duties of the Secretary of State and is satisfied that its actions in relation to the NHS and public health has complied with the duties described by the Act. This specifically includes the duty of the Secretary of State to have regard to the need to reduce inequalities between the people of England with respect to the benefits that may be obtained by them from the health service.

Response to the Francis Report

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

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

An action plan, developed following a detailed review of the 290 recommendations in the report, was approved by the Board in March 2013. An update report was further presented to

the Board in January 2014. As a result the Board is assured that NHSBT has paid due care and attention to the recommendations of the Francis report, insofar as they impact the activities of NHSBT. Further monitoring of the action plans has been provided to the Board via CARE during 2014/15.

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 Internal Auditors
- the auditing and reporting conducted as part of our Quality Assurance and clinical auditing processes
- senior managers within the organisation, who had responsibility for the development and maintenance of the system of internal control evidence provided by the planning, performance and risk management framework

I confirm that the system of internal control has been in place in NHS Blood and Transplant for the year ended 31 March 2015 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.

Ian Trenholm
Chief Executive and Accounting Officer

Date: 26 June 2015

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 2015 under the National Health Service Act 2006. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of NHS Blood & Transplant's affairs as at 31 March 2015 and of the net expenditure for the year then ended; and

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

Opinion on other matters

In my opinion:

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

- the information given in the Strategic report and directors report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

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

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

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

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse **Date 7 July 2015**

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 2015

	Notes	**31 March 2015 £000**	31 March 2014 £000
Gross Income			
Income from activities	2	**343,222**	345,086
Other operating income	2	**22,945**	22,646
		366,167	367,732
Expenditure			
Staff costs	3.1	**(197,502)**	(202,597)
Depreciation and amortisation	8 and 9	**(9,628)**	(10,134)
Other administrative expenses	3.3	**(215,517)**	(230,838)
		(422,647)	(443,569)
Net Operating Expenditure before interest		**(56,480)**	(75,837)
Finance Costs	4	**(474)**	(481)
Net Operating Expenditure after interest	2	**(56,954)**	(76,318)
Other Comprehensive Net Expenditure			
Net gain on revaluation of Property, Plant and Equipment	9	**8,369**	13,620
Total Comprehensive Net Expenditure		**(48,585)**	(62,698)

All income and expenditure is derived from continuing operations

Notes 1 to 24 form part of these accounts.

Statement of Financial Position as at 31 March 2015

	Notes	31 March 2015 £000	31 March 2014 £000
Non Current Assets			
Intangible Assets	8	**4,328**	4,163
Property, Plant & Equipment	9	**173,773**	166,083
Trade and other receivables	11	**741**	1,244
Total non-current assets		**178,842**	171,490
Current assets			
Inventories	10	**16,824**	18,860
Trade and other receivables	11	**34,168**	23,376
Cash and cash equivalents	12	**22,112**	20,637
Total current assets		**73,104**	62,873
Current Liabilities			
Trade and other payables	13	**(19,468)**	(21,927)
Borrowings	14 and 16	**(120)**	(108)
Provisions for liabilities and charges	15	**(1,824)**	(4,275)
Total current liabilities		**(21,412)**	(26,310)
Non-current assets plus net current assets		**230,534**	208,053
Non-current liabilities			
Borrowings	14 and 16	**(4,392)**	(4,512)
Provisions for liabilities and charges	15	**(857)**	(1,219)
Total non-current liabilities		**(5,249)**	(5,731)
Total Assets Employed:		**225,285**	202,322
Taxpayers' Equity			
General Fund		**172,252**	155,320
Revaluation Reserve		**53,033**	47,002
Total Taxpayers' Equity:		**225,285**	202,322

Notes 1 to 24 form part of these accounts.

The financial statements on pages 45 to 72 were approved by the Governance and Audit Committee in accordance with powers within the NHSBT Standing Orders on 26th June 2015, and are signed by the Accounting Officer, Ian Trenholm.

Ian Trenholm
Accounting Officer

Date: 26 June 2015

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

	Notes	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2013		153,891	40,629	**194,520**
Changes in taxpayers' equity for 2013/14				
Net expenditure for the financial period		(76,318)	-	**(76,318)**
Net gain on indexation of Property, Plant and Equipment	9.2	-	13,620	**13,620**
Transfers between reserves		7,247	(7,247)	**-**
Total recognised income and expense for 2013/14		(69,071)	6,373	**(62,698)**
Revenue Grant from Department of Health		61,900	-	**61,900**
Capital Grant from Department of Health		8,600	-	**8,600**
Balance at 31 March 2014		**155,320**	**47,002**	**202,322**

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				
Net expenditure for the financial period		(56,954)	-	**(56,954)**
Net gain on indexation of Property, Plant and Equipment	9.1	-	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 Cash Flows for the year ended 31 March 2015

	Notes	**31 March 2015**	31 March 2014
		£000	£000
Cash flows from operating activities			
Net operating costs		**(56,480)**	(75,837)
Other cashflow adjustments	17.3	**10,337**	19,927
Movement in Working Capital	17.1	**(11,671)**	4,136
Provisions utilised	15	**(3,313)**	(386)
Net cash (outflow) from operating activities		**(61,127)**	(52,160)
Cash flows from investing activities			
Purchase of plant, property and equipment		**(7,111)**	(6,946)
Purchase of intangible assets		**(1,281)**	(1,414)
Proceeds from disposal of non current assets		**-**	69
Net cash (outflow) from investing activities		**(8,392)**	(8,291)
Cash flows from financing activities			
Grant from Department of Health		**71,548**	70,500
Capital element paid in respect of finance leases	16	**108**	(97)
Interest paid in respect of finance leases	4	**(446)**	(457)
Net financing		**71,210**	69,946
Net increase in cash and cash equivalents		**1,691**	9,495
Cash and cash equivalents at 31 March 2014		**20,637**	11,142
Cash and cash equivalents at 31 March 2015	12	**22,328**	20,637

Notes to the Accounts

1. Accounting Policies

The financial statements have been prepared in accordance with the 2014/15 Government Financial Reporting Manual (FreM) issued by HM Treasury. The accounting policies contained in the FreM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The FreM follows EU adopted IFRSs extant at January 2014, with an effective date before or from 1 April 2014. NHS bodies must follow the FreM unless there are divergences agreed by HM Treasury.

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 1.19). They have been applied consistently in dealing with items considered material in relation to the accounts.

Critical judgements and key sources of estimation uncertainty

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

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

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

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 fair value to the business by reference to current costs. This is in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

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

1.2 Income

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

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

The Grant in Aid is credited to the general reserve. Grant in Aid is recognised in the financial period in which it is received.

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

1.3 Taxation

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

1.4 Capital Charges

The treatment of intangible assets, property, plant and equipment in the account is in accordance with the principal capital charges objective, to ensure that such charges are fully reflected in prices. The interest rate applied to calculate notional cost of capital charges during 2014/15 was 3.5% (2013/14 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 £16.3m (2013-14: £16.9m) 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
- collectively has a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

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

(b) Valuation

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

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

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

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. 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 asset is created that can be identified;
- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to use the intangible asset;
- how the intangible asset will generate probable future economic benefits;
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it;
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

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

1.7 Depreciation, amortisation and impairments

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

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

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

iii) Land 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;

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

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

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

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

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

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

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

1.8 Inventories

Inventories are valued as follows:

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

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

1.9 Cash and Cash Equivalents

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

1.10 Losses and Special Payments

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

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

1.11 Employee Benefits

Short-term employee benefits

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

Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to 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:

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

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

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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.

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

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

have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

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

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

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

1.12 Research and Development

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.

1.13 Leases

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

NHSBT as lessee

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

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

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

1.14 Foreign Exchange

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

1.15 Provisions

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

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

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

Clinical Negligence Costs

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

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

Non-clinical Risk Pooling

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

1.16 Contingencies

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

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

1.17 Financial Instruments

Financial assets

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

Financial assets at fair value through Statement of Comprehensive Net Expenditure

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through income and expenditure. They are held at fair value, with any resultant gain or loss recognised in

the Statement of Comprehensive Net Expenditure. The net gain or loss incorporates any interest earned on the financial asset.

Available for sale financial assets

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

Loans and receivables

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

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.
At the Statement of Financial Position date, NHSBT assesses whether any financial assets, other than those held at 'fair value through the Statement of Comprehensive Net Expenditure' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

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

Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when NHSBT becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired. Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through the Statement of Comprehensive Net Expenditure' or other financial liabilities.

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

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

Other financial liabilities

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

1.18 Subsidiaries

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014/15. The application of the Standards as revised would not have a material impact on the accounts for 2014/15, were they applied in that year :

IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers – subject to consultation

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

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)**						

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

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

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

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

The **Blood Components** operating unit provides blood and blood components, primarily to NHS hospitals, and includes research and development activity.

The **Diagnostic Services** operating unit provides specialist laboratory services (Red Cell Immunohaematology and Histocompatability & Immunogenetics) and also reagents.

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

The **Stem Cell Services** operating unit comprises the Cellular and Molecular Therapies function, the British Bone Marrow Registry (BBMR) and the Cord Blood Bank (CBB).

The **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 2015 Permanently Employed Staff**	**Other**	31 March 2014 Total
	£000	**£000**	**£000**	£000
Salaries and wages	**166,146**	**152,866**	**13,280**	170,276
Social security costs	**11,790**	**11,475**	**315**	12,185
Employer contributions to NHS Pensions Agency	**19,566**	**19,043**	**523**	20,136
	197,502	**183,384**	**14,118**	202,597

The average number of employees during the year was:

	Total	**Permanently Employed Staff**	**Other**
	Number	**Number**	**Number**
Year ended 31 March 2015	**4,928**	**4,670**	**258**
Year ended 31 March 2014	5,128	4,816	312

Expenditure on staff benefits

The amount spent on staff benefits during the year is estimated at £955,000 (31 March 2014: £639,000).

3.2 Redundancy Costs and Other Compensation Schemes

Early retirements and redundancies

During 2014/15 there were 199 early retirements and/or redundancies from NHSBT. £5,956,000 has been charged to the revenue account in 2014/15 in respect of these redundancies and early retirements (31 March 2014: 139 early retirements and/or redundancies, and a charge to the revenue account of £6,009,000).
An opening provision of £3,436,000 for redundancy costs has been utilised, or reversed unused, during 2014/15, and a further provision of £689,000 has been made for redundancy costs in relation to restructures currently in progress.
A total charge of £3,209,000 for early retirements and redundancies is included within other staff related costs in note 3.2 (31 March 2014: £9,445,000).

Reporting of Other Compensation Schemes

The table below discloses the number and value by cost band of compensation packages agreed in 2014/15. The figures included payments made, together with accruals. The figures exclude new provisions made in the accounts for redundancy costs relating to restructure programmes that are in the process of being implemented.

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	12	83	18	114	30	197	-	-
£10,001 - £25,000	25	397	47	820	72	1,217	-	-
£25,001 - £50,000	24	884	44	1,598	68	2,482	-	-
£50,001 - £100,000	8	573	17	1,124	25	1,697	-	-
£100,001 - £150,000	3	308	2	216	5	524	-	-
£150,001 - £200,000	-1	-161	-	-	-1	-161	-	-
Totals for 2014/15	71	2,084	128	3,872	199	5,956	-	-
Totals for 2013/14	49	2,353	91	3,660	140	6,013	1	4

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 accounted for in full in the year of departure. Ill-health retirement costs are met by the NHS pension scheme and are not included in the table.

All costs relating to other departures arise from voluntary redundancies, including early retirement contractual costs (and includes one early retirement payment made in the interests of the efficiency of the service under sections 26-28 of the Terms and Conditions of Service NHS Medical and Dental Staff

3.3 Other Administrative Expenses

	Notes	31 March 2015 £000	31 March 2014 £000
Other staff related costs		**15,296**	23,319
Consumable supplies		**70,880**	73,950
Maintenance of buildings, plant and equipment		**15,832**	15,761
Rent and rates		**12,218**	11,791
Transport costs		**10,352**	10,738
External contractors		**19,341**	20,035
Purchase and lease of equipment and furniture		**4,481**	3,149
Utilities and telecommunications		**7,911**	7,560
Media advertising		**2,665**	2,116
ODT Scheme Payments		**30,991**	30,908
Professional Fees *		**4,113**	3,574
Capital Charges paid over as cash to Department of Health		**16,267**	16,914
Capital Non-cash : Loss on disposal of fixed assets	7.1	**39**	465
Capital Non-cash : Impairments	7.2	**198**	5,224
Auditor's remuneration: Audit Fees **		**90**	90
Miscellaneous		**4,843**	5,244
		215,517	230,838

* Professional Fees include legal and programme management costs

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

4. Finance costs

	31 March 2015 £000	31 March 2014 £000
Interest expense under finance leases	**446**	457
Other finance costs - unwinding of discount	**28**	24
Total finance costs	**474**	481

5. Operating leases

NHSBT as lessee

	31 March 2015 £000	31 March 2014 £000
Payments recognised as an expense		
Lease and rental payments	**9,310**	9,076
Total future minimum lease payments		
Payable:		
Not later than one year	**5,117**	5,803
Later than one year and not later than five years	**6,050**	8,202
Later than five years	**-**	61
Total	**11,167**	14,066

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

Interest of £129 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 2014: £76 interest and £Nil compensation).

7. Other gains and losses

7.1 Profit / (loss) on disposal of non-current assets	31 March 2015	31 March 2014
	£000	£000
Loss on disposal of transport equipment	**-**	(124)
Loss on disposal of plant and equipment	**(39)**	(350)
Profit on disposal of information technology	**-**	9
Total	**(39)**	(465)

7.2 Impairments charged in the year to Net Operating Expenditure	31 March 2015	31 March 2014
	£000	£000
Impairment on land and buildings for future sale	**-**	5,224
Impairment on development expenditure	**198**	-
Total	**198**	5,224

8. Intangible non-current assets

8.1 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**
Reclassification	**-**	**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**

***** The impairment arises from a review of the carrying value of development expenditure on a specific project where a change of direction was decided upon during the course of 2014/15.

8.2 Intangible non-current assets 2013/14

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

9. Property, plant and equipment

9.1 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**	**-**	**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.

* 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.

9.2 Property, plant and equipment 2013/14

	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 2013	260,051	23,565	157,507	-	2,629	51,356	4,476	20,518
Additions - purchased	**5,393**	**-**	**258**	**-**	**1,678**	**2,285**	**-**	**1,172**
Reclassification	**-**	**(1,046)**	**(5,291)**	**8,024**	**(1,687)**	**-**	**-**	**-**
Indexation	**1,858**	**-**	**-**	**-**	**-**	**1,731**	**127**	**-**
Other in year revaluations *	**(29,541)**	**(795)**	**(28,746)**	**-**	**-**	**-**	**-**	**-**
Impairments **	**(5,224)**	**-**	**-**	**(5,224)**	**-**	**-**	**-**	**-**
Disposals	**(12,481)**	**-**	**-**	**-**	**-**	**(5,128)**	**(2,511)**	**(4,842)**
At 31 March 2014	**220,056**	**21,724**	**123,728**	**2,800**	**2,620**	**50,244**	**2,092**	**16,848**
Depreciation:								
At 1 April 2013	**97,941**	22	40,954	-	-	36,578	3,278	17,109
Provided during the year	**9,282**	**11**	**4,142**	**-**	**-**	**3,763**	**314**	**1,052**
Indexation	**1,326**	**-**	**-**	**-**	**-**	**1,233**	**93**	**-**
Other in year revaluations *	**(42,629)**	**(33)**	**(42,596)**	**-**	**-**	**-**	**-**	**-**
Disposals	**(11,947)**	**-**	**-**	**-**	**-**	**(4,779)**	**(2,326)**	**(4,842)**
Accumulated depreciation at 31 March 2014	**53,973**	**0**	**2,500**	**-**	**-**	**36,795**	**1,359**	**13,319**
Net book value at 1 April 2013	163,771	23,554	118,159	0	1,387	15,486	1,548	3,637
Net book value at 31 March 2014	**166,083**	**21,724**	**121,228**	**2,800**	**2,620**	**13,449**	**733**	**3,529**
Net book value at 31 March 2014 comprises:								
Owned assets	**143,157**	**18,584**	**101,442**	**2,800**	**2,620**	**13,449**	**733**	**3,529**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	**16,736**	**-**	**16,736**	**-**	**-**	**-**	**-**	**-**
Held on Finance Lease	**6,190**	**3,140**	**3,050**	**-**	**-**	**-**	**-**	**-**
	166,083	**21,724**	**121,228**	**2,800**	**2,620**	**13,449**	**733**	**3,529**

All assets are purchased assets.

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

10. Inventories

	31 March 2015	31 March 2014
	£000	£000
Raw materials and consumables	**4,417**	4,630
Work in progress	**2,838**	2,326
Finished processed goods	**9,569**	11,904
	16,824	18,860

11. Trade and other receivables

	31 March 2015	31 March 2014
	£000	£000
Current		
NHS Receivables - Revenue	**19,981**	11,619
Non NHS Trade Receivables - Revenue	**3,644**	2,580
Provision for impairment of Receivables	**(25)**	(21)
Other Debtors	**109**	133
VAT	**2,887**	2,518
Prepayments and accrued income	**7,572**	6,547
Subtotal	**34,168**	23,376
Non Current		
Other prepayments and accrued income	**741**	1,244
Subtotal	**741**	1,244
Total trade and other receivables	**34,909**	24,620

Provision for irrecoverable debts

	2014-2015	2013-2014
Amounts falling due within one year	£000	£000
Non - NHS trade receivables		
At 1 April	**21**	12
Provided in year	**18**	14
Written off during year	**(5)**	(5)
Recovered during year	**(9)**	-
At 31 March	**25**	21
Aging of debts provided against		
Upto 12 months	**17**	11
Over 12 months	**8**	10
	25	21
Receivables and other debtors past due but not impaired		
Upto 3 months	**10,089**	7,280
Between 4 and 12 months	**2,190**	887
Over 12 months	**3**	16
	12,282	8,183

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

	2014-2015	2013-2014
	£000	£000
Balance at 1 April	20,637	11,142
Net change in the year	1,475	9,495
Balance at 31 March	22,112	20,637
Comprising:		
Held with Government Banking Services accounts	22,110	20,635
Cash in hand	2	2
Cash and cash equivalents as in Statement of cash flows	22,112	20,637

13. Trade and other payables

	31 March 2015	31 March 2014
	£000	£000
Current		
NHS Payables - revenue	2,565	4,131
Non-NHS trade Payables - revenue	1,066	1,288
Non-NHS trade Payables - capital	959	-
Tax and Social Security Costs	9	4
Accruals and deferred income	14,869	16,504
Total trade and other payables	19,468	21,927

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 2014	PAYE and NI Liabilities	Employee Benefits	Redundancy	Product Liability and Other	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2013	-	1,116	-	636	1,752
Provisions - Arising in the year	-	226	3,436	556	4,218
Utilised during the year	-	(85)	-	(301)	(386)
Reversed unused	-	-	-	(114)	(114)
Unwinding of discount	-	24	-	-	24
Balance at 31 March 2014	-	1,281	3,436	777	5,494
Expected timing of cash flows:					
Within 1 year	-	62	3,436	777	4,275
Between 1 year and 5 years	-	260	-	-	260
Thereafter	-	959	-	-	959

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

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 2014/15.

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

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.

£3,614,000 (31 March 2014: £3,599,000) is included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities. There is a £Nil provision in respect of the existing liabilities scheme (31 March 2014: £156,000).

16. Finance leases

Finance lease obligations (ie as lessee)

	Minimum lease payments	
	31 March 2015	31 March 2014
	£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	**9,701**	10,255
	12,471	13,025
Less future finance charges	**(7,959)**	(8,405)
Present value of future lease obligations	**4,512**	4,620

	Present value of minimum lease payments	
	31 March 2015	31 March 2014
	£000	£000
Not later than one year	**120**	108
Later than one year and not later than five years	**633**	568
Later than five years	**3,759**	3,944
Present value of future lease obligations	**4,512**	4,620
Analysed as :		
Current borrowings	**120**	108
Non-current borrowings	**4,392**	4,512
	4,512	4,620

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 2015	31 March 2014
	£000	£000
Increase in receivables within 1 year	**10,792**	2,098
(Decrease)/increase in receivables after 1 year	**(503)**	773
(Decrease) in inventories	**(2,036)**	(2,787)
Decrease/(increase) in payables within 1 year	**2,459**	(2,667)
Subtotal	**10,712**	(2,583)
(Increase)/decrease in payables relating to items not passing through the Statement of Comprehensive Net	**(959)**	1,553
Subtotal	**(959)**	1,553
Total	**11,671**	(4,136)

17.2 Analysis of changes in net debt

	As at 1 April 2014 £000	**Cash flows £000**	**As at 31 March 2015 £000**
Government Banking Services cash at bank	20,635	1,475	**22,110**
Commercial cash at bank and in hand	2	-	**2**
Total	20,637	1,475	**22,112**

17.3 Other cashflow adjustments

	31 March 2015	31 March 2014
	£000	£000
Depreciation (note 9)	**8,710**	9,282
Amortisation (note 8)	**918**	852
Impairments (note 7.2)	**198**	5,224
Loss on disposal (note 7.1)	**39**	465
Provisions - Arising in Year (note 15)	**1,466**	4,218
Provisions - Reversed unused (note 15)	**(994)**	(114)
Total	**10,337**	19,927

18. Contingent Liabilities at 31 March 2015

A contingent liability of £87,000 (31 March 2014: £137,000) relates to potential costs associated with donor claims, personal injury claims, and other employee liability and public liability claims.

A contingent liability of £1,375,000 (31 March 2014: £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 2015

At 31 March 2015 the value of contracted capital commitments was £1,008,000 (31 March 2014 : £2,591,000).

20 Losses and special payments

20.1 Losses Statement

	31 March 2015		31 March 2014	
	No. Cases	£000	No. Cases	£000
Cash Losses	-	-	-	-
Book keeping Losses	1	-	3	-
Losses of pay, allowances and superannuation benefits	17	9	12	12
Losses of Accountable Stores	144	173	154	100
Fruitless Payments	-	-	1	7
Claims waived or abandoned	11	8	4	1
	173	190	174	120

20.2 Special Payments

	31 March 2015		31 March 2014	
	No. Cases	£000	No. Cases	£000
Special Severance Payments	1	-	2	4
Compensation Payments	89	240	137	386
Ex Gratia Payments	6	-	9	1
	96	240	148	391

There were no individual payments that exceeded £300,000 (Period ended 31 March 2014 : 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 £405 million of income (31 March 2014: £404 million), including capital funding and grant in aid, and £54 million of expenditure (31 March 2014: £55 million), which represented trading with 244 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	5,410	329
Mr K Rigg (NED)	: Human Tissue Authority, Board Member	62	130
Mr K Rigg (NED)	: NHS England, Chair of Renal Transplant Clinical Reference Group	2,379	-

* NED - Non-Executive Director

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

In accordance with IAS 27 the NHS Blood and Transplant Trust Fund is regarded as a related party. Income received from the Trust Fund during the year totalled £108,000 (31 March 2014 : £89,000), and there was a debtor balance due by the Trust Fund of £73,000 (31 March 2014 : £6,000)

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.

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	3,834	-	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
Balances with other central government bodies	2,892	-	693
Balances with local authorities	-	-	5
Balances with NHS Trusts and organisations	11,619	-	4,134
Total Intra-Government Balances	14,511	-	4,832
Balances with bodies external to government	8,865	1,244	17,095
At 31 March 2014	23,376	1,244	21,927

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