Blood and Transplant

NHS Blood and Transplant
Annual Report and Accounts 2016/17

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

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

Ordered by the House of Commons to be printed 6 July 2017

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

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

Print ISBN 9781474142335
Web ISBN 9781474142342

ID 22031709 07/17

Printed on paper containing 75% recycled fibre content minimum

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

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PERFORMANCE REPORT

Overview

This section gives a summary of NHS Blood and Transplant (NHSBT) purpose, includes a foreword from the Chief Executive, outlines the key risks for NHSBT and summarises how NHSBT has performed in the year.

Chief Executive's Foreword

Welcome to the NHS Blood and Transplant annual report and accounts for 2016/17. We are pleased to report that we have continued to make good progress against the strategic goals outlined in the **Blood 2020** and **Taking Organ Transplantation to 2020** strategies and in the strategies across our Diagnostic and Therapeutic Services Division. We are proud of these achievements which will help us to realise our ambition to be "**the best service of our type in the world"**, whilst also supporting the NHS and the ever increasing pressures that it is facing.

During 2016/17 we have started to make very important progress towards upgrading our ageing IT infrastructure and replacing the critical IT systems on which our services depend. This is a major undertaking, requiring significant cash investment. We must deliver these changes safely and without impacting the delivery of critical products and services to NHS patients. The projects are being funded from cash reserves that were accumulated in anticipation of these investments being made. As a result, NHSBT will record planned income and expenditure deficits in 2016/17 through to 2018/19. As these are technical accounting deficits, planned and funded from internal cash reserves, I would like to reassure all our stakeholders regarding NHSBT's robust financial position, and its ongoing ability and intent to deliver further efficiencies to the NHS.

I'd like to express my sincere gratitude to all my colleagues in NHS Blood and Transplant, and to all our stakeholders, who have made our achievements in 2016/17 possible, and whose ongoing support will enable us to successfully deliver our strategies and major transformation programme over the coming years.

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 National Health Service (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 regarding its UK-wide role in organ donation and transplantation.

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

Blood Components covers the supply of red cells, platelets, plasma and related specialist products to NHS hospitals in England. 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 stock holding units to over 250 NHS Trusts.

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

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

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

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

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

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

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

Going Concern

NHSBT operates a rolling five year planning process which continually updates our assumptions regarding product demand, prices, cash reserves, funding from the four UK Health Departments, operating costs and the projected cost and benefits of our transformation programme.

On the basis of our most recent projections the NHSBT Board continues to have a reasonable expectation that NHSBT will have adequate income and cash resources, that will exceed its projected costs, over the coming 5 year period and thus can continue to adopt the going concern basis in the preparation of these financial statements.

The Department of Health completed a Triennial Review of NHSBT and published the associated review report in September 2016. The review concluded that NHSBT is an efficient and high performing organisation, and in the future should seek to further increase its contribution to the life sciences industry. The report contained a total of 18 recommendations; five regarding the function and form of NHSBT, the remaining 13 intended to support NHSBT`s future performance, efficiency, and governance. As at May 2017, 10 of the recommended actions have been completed and NHSBT is working with the four UK Health Services regarding the 8 outstanding recommendations.

Principal Risks and Uncertainties

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

Blood pricing and investment in our IT infrastructure and systems:
Although good progress has been made in some areas, our IT infrastructure and systems across NHSBT are generally old, close to end of life and, in Blood, is dependent on a single small supplier for its ongoing support and maintenance. Significant investment is therefore required to replace our infrastructure and desktop, migrate to cloud based services and replace the critical operational application underpinning the Blood supply chain (Pulse). This is a major demand on our business and IT leadership, require robust change management capability and the full commitment of the Executive Team and the Board.

The overall cost of change is substantial and in the range of £40m - £50m over 5 years. To be able to fund the investment, and absorb the impact of ongoing demand reduction, the price of red cells has been increased to £122.35 in 2017/18 (excluding the impact of universal Hepatitis E Virus (HEV) screening). The increase took account of the result of the latest 5-year plan and assumes that prices will then remain flat (at worst) over the next four years. Despite the price increase of 2%, the volume decline of 4% will see the cost of blood to the NHS falling by a further 2% in 2017/18. The price will enable NHSBT to complete the significant investment in its IT and business systems whilst providing headroom in case of any unanticipated project costs and any further demand reduction.

Funding of the Organ donation and Transplantation strategy:
The objective of the 'Taking Organ Transplantation Strategy to 2020' (TOT2020) is to reduce the three people who die every day for lack of an available organ through significantly increasing the levels of organ donation and transplantation in the UK. Although we continue to deliver annual growth in the number of deceased organ donors, and the number of deceased organ transplants, we are not yet on a glide path that will deliver the ambitious targets of the TOT2020 strategy.

The key drivers for change are the need to further influence public behaviours (and hence increase the level of donor consent) and to improve organ utilisation through changing practices in the clinical pathway, supported by investment in new organ perfusion technologies (enhanced preservation of organs while in transit). In addition, the National Transplant Database (NTxD) is based on outdated technology and is no longer able to effectively support the donation / transplantation clinical pathway. Replacement of NTxD (known as the Organ Donation and Transplantation (ODT) Hub project) will cost ca £8m. It is now underway and is currently the priority project within ODT.

Indicative funding provided by the four UK Health Departments for ODT is assumed to be flat over the planning period to 2022. This implies that, after prioritising the ODT Hub project, there will be limited funding in support of the public behaviour change initiative and for the development of new perfusion technologies. These were key developments within the TOT2020 strategy and a lack of funding could put delivery of the TOT2020 targets at risk. In conjunction with the four UK Health Departments, NHSBT will therefore continue to explore and review priorities so that the most effective use of the available funding can be made and to make the case for further investment where appropriate.

Blood Supply challenges:
NHSBT recognises the need to demonstrate increasing efficiency and effectiveness which will help mitigate financial pressures on the NHS. NHSBT is continually working with its NHS customers to reduce demand through better patient blood management and reduce the cost in use of the products and services that we provide. The subsequent challenge for NHSBT is to reduce costs that are mostly fixed in nature at the same rate as demand reduction so that flat, or reducing prices, can be maintained. Given that further reduction in demand is anticipated a continued strong focus on efficiencies is required, especially in blood donation where benchmarking highlights that productivity is significantly lower than the best of our international peers. This will result in major changes to what blood donors will experience, such as fewer / larger mobile sessions, reduced frequency of mobile sessions in some areas and greater use of fixed donation sites. This could therefore generate an

adverse reaction from donors (and hence supply) if the rationale and the impact are not effectively communicated and explained.

In addition, although overall demand is reducing, the challenges on supply at the component / blood group level are growing driven by:

- Our plans to increase the supply of pooled platelets and hence reduce the supply of platelets provided through apheresis.
- An increasing demand for Ro red cells to meet the needs of an increasing number of NHS patients with sickle cell disease.
- Maintaining supply of the universal groups i.e. O negative red cells and A negative platelets.

In response NHSBT is adjusting its blood collection plans (for example tripling the number of black donors to meet the demand for Ro units) to increase donors of certain blood groups despite a reduction in total demand and hence overall donor numbers. If NHSBT is unable to manage these differential demands at component/group level substitution can be safely made (O negative red cells for Ro red cells, for example) but this is not consistent with our objective to deliver the best health outcomes for patients that we can.

Risks are further highlighted in the Governance Statement at page 26.

Performance Analysis

Strategic Objectives

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

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

Taking each of our Divisions in turn:

Blood Components

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

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

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

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

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

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

The strategic objectives are supported by action plans and a balanced set of supporting targets covering donor satisfaction, customer satisfaction, product safety, supply chain effectiveness and efficiency. The headline target within the strategy is the price of red cells which has been reduced from £140/unit in 2007/08 to £120/unit in 2016/17 because of a reduction of excess capacity in the supply chain and significant improvements in efficiency. In recognition of the significant financial pressures that are facing the NHS our ambition is to at least maintain flat pricing over the medium term, despite an ongoing reduction in demand and the need to fund significant investment in our IT infrastructure and applications.

Organ Donation and Transplantation

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

The 'Taking Organ Transplantation to 2020' (TOT2020) strategy was published in June 2013. 2016/17 saw the highest number of deceased organ donors and the resulting transplants. Since the original Organ Donation Task Force (ODTF) report was published in 2008 there has been an increase of 75% in deceased organ donors.

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

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

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

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

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

This is supported by four strategic targets:

- A consent / authorisation rate in excess of 80% (currently 63%)
- 26 deceased donors per million population (currently 21.6 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 56.8 pmp)

Diagnostic and Therapeutic Services (DTS)

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

The objectives for each business are:

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

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

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

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

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

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

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

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

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

As a result of the services we provide for bone marrow transplants NHSBT has developed a unique national infrastructure. This provides NHSBT with the capabilities to support the development of the next generation of stem cell therapies that are using stem cells and bioactive molecules to

regenerate tissues ('regenerative medicine') and to selectively destroy cancerous cells ('cancer vaccines') and viruses. Through this infrastructure NHSBT can provide the donor stem cells and bring strengths in specialist manufacturing, regulatory expertise, distribution and Research & Development (R&D) in support of the developing regenerative medicine industry. This includes the operation of the Clinical Biotechnology Centre (CBC) in Bristol that has unique capabilities in small volume manufacture of plasmids/gene therapy vectors to support early stage clinical trials.

Corporate

In support of our strategic business units we also identify a group of strategic level actions at corporate level including our 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 with the aim of improving clinical outcomes through improved donor/patient matching and increasing the availability of blood components with extended genotype. We also conduct research programme in Tissues, primarily based on partnerships with academic partners, to identify the next generation of tissue based therapies that would meet the unmet needs of NHS patients.

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

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

Operating Review

Key Performance Headlines 2016/17

- **Blood**
  2016/17 has been another very successful year with further improvement in service levels, product availability, regulatory performance and productivity. The Division has continued to respond extremely well to the sustained reduction in red cell demand that has seen demand fall by a further 4.8% in 2016/17. NHSBT continues to be proud of the fact that prices for red cells in 2017/18 will be lower than they were in 2004/5, despite inflation, investing in higher safety and availability and a 22% reduction in red cell demand over that period. In aggregate the cost of red cells supplied to the NHS in 2017/18 will be circa £78m pa lower than they were in 2008/09.

- **ODT**
  There were 1,413 deceased donors in 2016/17 (2015/16 1,364), 3.6% higher than 2015/16. As a result, there were 3,712 deceased transplants in 2016/17 (2015/16 3,529), up by 5.2%. These, again, have established new annual records for both the number of deceased donors and the number of deceased transplants in the UK.

- **DTS**
  Income in 2016/17 at £69.3m (2015/16 £65.6m) was 5.6% higher than last year. This was driven by strong growth in Tissue and Eye Services (up by 7.2%) and increased activity in both Therapeutic Apheresis Services (up 17.9%) and Stem Cell Donation and Transplant (up 7.9%).

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

Blood

We continue to see decline in demand for red cells with issues of 1.522 million units in the year, 4.8% lower than 2015/16, albeit broadly in line with plan. We were encouraged to see that demand for O negative red cells (the "universal" type) started to fall during the year although, due to substitution by NHSBT, the proportion of O negative red cells issued by NHSBT increased to 13.2% of the total (versus the 7% of the population that is O negative). The proportion of O negative supply as a proportion of the total was at 12.9% in 2015/16 and hence the proportion of O negative red cells issued by NHSBT, compared to total issues, continues to increase. This is primarily driven by a shortage of group Ro red cells for patients with sickle cell disease, where growth in demand of around 10% pa is currently being seen. This shortage has arisen due to an insufficient number of black donors and, as a result, NHSBT is developing plans to triple the number of new black donors over the next 3 years.

Although platelet demand has been relatively stable for several years demand began to decline in Q4 2015/16, and has continued to fall by 3.9% during 2016/17. Despite a fall in the demand for A negative platelets (the universal type) issues of A negative platelets increased by 9% and were 17% of the total issues (compared to 7% of the population who are A negative donors). This reflects a shortage of AB donors and, again, NHSBT is re-setting its plans to increase donors of this type.

Blood stock levels, and the availability of blood products, remained highly resilient through the year. 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 2016/17 there were no such instances (following zero instances in 2015/16). However, the ever-higher proportion of O negative red cell issues described above, continues to create pressure on the management of O negative red cell stocks which have tended to operate between 3.5 to 4.5 days throughout the year. This is above alert level but is less than a robust level of 5 days or more that we plan for.

Aside from the increasing challenges to supply that are now being seen at the blood group / component level performance and delivery across Blood has continued to be strong during 2016/17. Hence:

- Regarding safety there were no Serious Incidents (SIs) during the year and no adverse trends in the reporting of adverse events following transfusion.
- Only one "major" regulatory non-compliance following regulatory inspection by the Medicines and Healthcare products Regulatory Agency (MHRA) was reported during the year (versus the four "majors" reported in 2015/16).
- Donor satisfaction at 75.6% was consistently at or above the target level of 72% (measured as the percentage of donors scoring 9 out of 10 or higher for overall service)
- Underpinning this we have introduced new functionality within the **blood.co.uk** website that allows donors to book and amend appointments. Over 1.2 million appointments were booked through our web portal and mobile apps in 2016/17.

- From a customer perspective, hospital satisfaction with NHSBT's service remained high and at year end was at 76% (measured as the percentage of customers scoring 9 out of 10 or higher for overall service) versus 72.4% at the end of last year.
- We have supported the intention of the Welsh Government to establish a Welsh Blood Service covering the whole of Wales. We successfully transferred the operations managed by NHSBT in North and Mid Wales to the Welsh Blood Service in May 2016.

In addition, our response to the ongoing demand decline has continued to be well managed with further cost savings delivered and productivity. Although NHSBT has increased red cell prices to £124.46/unit in 2017/18 (including £2.11 for the cost of the universal screening of blood for HEV), due to anticipated further demand decline the cost of red cells to the NHS in 2017/18 is expected to fall by 2%.

The ongoing reduction in demand continues to be the primary challenge in Blood. In response NHSBT has closed excess capacity in processing and testing and can demonstrate world class productivity levels in these areas. Capacity in blood donation has also been reduced to match demand decline, although productivity in this area remains some 20% lower than the best performing blood services in other parts of the world. To hold (if not reduce) prices, and support the financial challenges faced by the NHS, further productivity improvements will be sought, especially in blood donation. This presents a challenge on two fronts:

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

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

NHSBT needs to maintain the right number and blood group mix of active donors to meet the decreasing demand with changing demand at blood group level and do this efficiently while retaining the goodwill of donors. This is an increasingly difficult challenge for the service. In these circumstances, we are pleased that donor satisfaction remains high and that the trend in donor complaints is positive.

Organ Donation and Transplantation (ODT)

We are delighted to report that there were 1,413 deceased donors in 2016/17 (2015/16 1,364), 3.6% higher than 2015/16. As a result, there were also 3,712 deceased transplants in 2016/17 (2015/16 3,529), up by 5.2% over 2015/16. This establishes another new record for both the number of deceased donors and the number of deceased transplants in the UK.

Around 1.1 million new (opt in) registrants were officially added to the Organ Donor Register in 2016/17. This is consistent with previous years but was less than the planned increase of 1.6 million registrants. This was as a result of the continuing need to suspend automatic feeds of new registrants, from certain partner organisations, due to a small number of errors that were being generated in exceptional circumstances. These errors have now been fixed and it expected that the backlog of automatic registrations will be processed early in 2017.

In June 2016, the Donor Registration Transformation system was implemented. This provides organ donation nurses with an iPad based application to register potential organ donors. It has resulted in the removal of existing paper based processes and both improves efficiency and reduces the

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

Diagnostic and Therapeutic Services (DTS)

Activity in DTS during 2016/17 has continued to focus on developing and implementing the strategies of the individual strategic business units. A common theme within each of the strategies is the intent to position NHSBT as a preferred national supplier to the NHS and, in so doing, to grow the income and financial contribution from each business. The additional contribution will then allow NHSBT to offer future price reductions and / or to fund new therapies for patients.

The outcome of this approach can most obviously be seen in **Tissue and Eye Services and Therapeutic Apheresis Services where** income growth of 7.2% and 17.9% respectively was seen through consolidation of activity within NHSBT from other parts of the NHS within NHSBT.

Growth of 7.9% was seen in Stem Cell Donation and Transplant due to higher issues of cord blood units from the NHS Cord Blood Bank. 62 issues were made during the year (versus 45 units in 2015/16) and represents a new record versus the 60 that were issued in 2013/14.

Taken together DTS recorded income of £69.3m in 2016/17 (2015/16 £65.6m), 5.6% higher than last year. Across the DTS portfolio there was only one “major” regulatory non-compliance (versus 1 reported in DTS during 2015/16). Customer satisfaction across the DTS portfolio was variable, both between services and by quarter, but was consistent with previous years. In Therapeutic Apheresis Services (TAS) customer satisfaction was at 71% (versus the 68% reported last year). More importantly, given that TAS is the only part of NHSBT that directly treats NHS patients, patient experience continues to be excellent and was reported at 93% positive in the last survey in December 2016 (albeit this compares to 98% in the December 2016 survey).

Research and Development (R&D)

Our world-leading R&D programme informs international best practice in transfusion, transplantation and regenerative medicine. Our innovative research initiatives deliver translational benefits for healthcare in the UK and beyond. During 2016/17 we:

- Completed the INTERVAL study which recruited 50,000 blood donors to a randomised controlled trial of inter-donation intervals. The results of this trial will be available in early 2017/18 and will increase understanding of donor health and the behavioural factors which lead people to donate (www.intervalstudy.org.uk);
- Recruited 31,000 donors to the COMPARE study which is evaluating new approaches to haemoglobin screening of blood donors with the aim of increasing efficiency of blood collection sessions;
- Investigated emerging infections, with a focus on Hepatitis E virus;
- Commenced recruitment to our first clinical trial of a drug which has the potential to reduce the need for platelet transfusions in patients who have low platelet counts;
- Continued to improve the optimal use of blood components through our support of patient blood management initiatives and clinical trials focused on platelet transfusion triggers and HLA-matching of platelets;

- Continued recruitment to the Quality in Organ Donation (QUOD) study to increase the number of consented organ donors in this National BioBank to over 2,000 (www.quod.org.uk/). A total of 26 studies have now received approval to use the QUOD BioBank;

- Developed novel cell lines which are being used to understand red blood cell biology and which will be developed into novel diagnostic reagents;

- Transferred research protocols for the production of red cells from stem cells into GMP-compliant processes which will be used to test advanced blood components in clinical trials in 2017/18;

- Increased our understanding of the production of red blood cells and platelets from stem cells to develop more efficient manufacturing processes;

- Developed a next generation diagnostics platform for use in patients with platelet and bleeding disorders which has been offered as a national service that has significantly reduced the time to diagnosis;

- Continued to work with the four National Institute for Health Research (NIHR) Blood and Transplant Research Units to deliver translational research in donor health, organ donation and transplantation, stem cells and immunotherapies and manufactured blood cells.

Financial Review

NHSBT is required to report on a ***Net Expenditure*** basis with programme funding provided by the Department of Health recognised in the general reserve. The Board and Management of NHSBT, however, 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 deficit £4.9m in 2016/17 (versus a £4.9m surplus in 2015/16). See note 2 in the financial statements. NHSBT normally aims to deliver a balanced income and expenditure position (i.e. no planned surplus or deficit). Due to the significant investment required to replace our IT infrastructure and systems NHSBT has, through price management and prior year surpluses, generated an internal cash balance to fund the investment. 2016/17 is the first year (of three) when the non-recurring cost of the investment will put NHSBT into a planned deficit funded by our cash reserves. NHSBT ended the year with cash of £32.8m (see note 12 in the financial statements) which will be used to fund planned deficits over the next two years before returning to a planned small surplus position.

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

NHSBT receives most its income through the prices of blood components (based on cost) charged to NHS Hospitals. This income was £266.1m in 2016/17 (3.4% lower than the £275.6m recorded in 2015/16). The lower income seen in 2016/17 arose primarily from the ongoing decline in the demand for red cells where demand in 2016/17 was 4.8% lower than the previous year.

NHSBT also receives income from prices charged for diagnostics services, tissues, stem cells and therapeutic apheresis services (TAS) within DTS, again based on cost. Excluding programme funding, and other income (e.g. from sales of waste products), this amounted to £60.3m in the year (£57.4m in 2015/16). As noted in the Operating Review above the income growth in DTS was particularly driven by growth in:

- Tissues (+7.2%) following acquisition of the Bristol and Manchester eye banks.
- TAS (+17.9%) because of increasing demand, in part driven by the opening on new treatment centres in Birmingham and London.
- Stem Cell Donation and Transplant (+7.9%) because of higher cord blood issues.

In addition to income from the sales of products and services the Department of Health provided programme funding of £65.9m for the year (£63.4m in 2015/16) primarily to support ODT. £61.7m of this (£59.1m in 2015/16) was allocated to organ donation and transplantation with £4.1m funding the development of the NHS Cord Blood Bank (£4.3m in 2015/16). NHSBT also received contributions in the year of £11.4m from the devolved UK Health Departments in support of our UK wide activities in organ donation and transplantation. This totalled £12.2m 2015/16 with the decline reflecting the non-recurring costs of investment in the new Organ Donation Register in 2015/16 to support the new "opt out" legislation in Wales (and to which Wales contributed a proportionately higher level of funding).

We additionally received £10.9m of "other" income (£10.3m in 2015/16) for cost recovery of services provided. £5.9m of this is related to the ad-hoc delivery of blood components to hospitals, over and above the scheduled deliveries within our service level agreements (which are included in prices) (£6.3m 2015/16). The reduction reflects a decline in the number of ah-hoc deliveries and the ongoing trend for hospitals to organise their own pick up of ad-hoc orders.

As noted above NHSBT generated an operating deficit of £4.9m in the year (versus a £4.9m surplus in 2015/16) and is much lower than a deficit of £19.7m that was originally planned and budgeted. The segmental analysis in Note 2 identifies an operating surplus of £4.7m for Blood Components (£14.7m in 2015/16) offset by a £1.3m deficit in DTS and an £8.4m deficit in ODT.

A budgeted deficit was initially planned for Blood in 2016/17 with the recorded surplus arising due to the approach taken to, and timing of, the planned investments in IT. In particular, we changed the approach to our desktop replacement project, which moved from being an upfront "one off" investment to a managed service with costs spread over several years on a cost per user per year basis. The lower surplus versus 2015/16 essentially reflects the timing of projects and their related investment profiles. Despite project investments in 2016/17 being much lower than planned they were £6.1m higher than in 2015/16.

The deficit in DTS of £1.3m in 2016/17 arises from underlying deficits in Tissues and Diagnostics where plans for further growth (Tissues) and turnaround (Diagnotics) are expected to move them to a break-even position over the medium term. The reduced deficit in 2016/17 versus the deficit of £2.9m in 2015/16 reflects the growth and turnaround plans that have already been delivered during the year.

The deficit in ODT reflects the apportionment of NHSBT overhead to the operating unit. Funding received by ODT to implement the recommendations of the Organ Donor Taskforce, and which saw income in ODT grow from c.a. £15m in 2007/08 to £73m now, was provided on a marginal cost basis. This did not, therefore, provide for the group services provided by NHSBT in support of the much greater activity that NHSBT took on. This is now reflected in our activity based cost model and hence implies an underlying cross subsidy from Blood and DTS to ODT. Due to the nature of our income and funding models this is unlikely to change materially over the foreseeable future.

NHSBT spent capital of £6.5m, on a cash basis, in 2016/17 funded by the Department of Health, versus £6.8m in 2015/16. 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, current assets decreased from £82.0m at March 2016 to £79.1m at March 2017 reflecting an increase in cash from £30.5m to £32.8m offset by a £0.7m reduction in Inventories and a £4.4m reduction in Receivables. The cash balance has arisen over recent years and reflects ongoing surpluses that were retained to fund the anticipated IT

investments that we are now undertaking. It is expected that much of this cash will be utilised over the next two years on these planned undertakings.

NHSBT is the corporate trustee for NHSBT Trust Funds. The total net assets of the trust funds as at 31 March 2016 were £0.439m. The 2016/17 Trust Fund Accounts will be published in December 2017. Although the Trust Fund assets are controlled by NHSBT a consolidated account is not produced due to their lack of materiality. The 2015/16 Trust Fund Accounts are available on NHSBT website at www.nhsbt.nhs.uk/news-and-media/review-accounts.
They are also available on the Charities Commission website.

There were no significant contingent liabilities to report as at 31 March 2017. For full details refer to note 18 contingent liabilities in the financial statements.

Sustainability Report

In February 2017 NHSBT launched its 2015-2025 Sustainability Strategy which includes the following objectives:

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

The strategy was developed and is owned by NHSBT's Executive Team, with the Finance Director having Board level responsibility. This involvement of top level leadership has proven to deliver significant results in sustainability since 2010 and its continuation will enable NHSBT to build on the high-level progress made to date.

The strategy will imbed sustainability into the organisational culture, whilst instilling a mindset and determination to improve the business and challenge current ways of working. This now includes a commitment to use the world recognised BREEAM (BRE Environmental Assessment Method) methodology for constructing all major construction projects, with an objective to obtain a BREEAM 'Excellent' rating for any new buildings.

NHSBT understands that a dedicated and engaged work force is critical to achieving its ambitions in sustainability. The organisation has therefore begun to recruit a few Environmental Champions to engage frontline staff and change and embed environmental considerations in the organisational culture. These champions will be report to the local Heads of Centre. An Environment and Sustainability Team will provide training, support and oversight to ensure the work of the Environmental Champions is recognised and supports the corporate strategy.

In support of this a Sustainable Development Committee (SDC), consisting of nominated Executive Team members and the Head of Estates Transformation and Sustainability will oversee progress. To enable management of operational risk and performance, a Sustainable Development Group (SDG) has also been nominated. The membership includes Assistant Directors, with responsibility for delivery, staff side union representatives and the Environmental Manager. Both groups will meet regularly to ensure plans are in place to meet our objectives and are monitored and reported through to the Board.

With regard to progress against the new strategy, NHSBT achieved a 9% CO^2 saving against the 2014/15 baseline within the 2015/16 reporting period. This is encouraging although we anticipate that delivery against the strategic targets is likely to be in step changes rather than incremental continuous improvement.

Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

Expenditure is accrued in 2016/17 accounts based on 2015/16 CO2 emissions. NHSBT will submit its annual report in July 2017, when the submission window opens. Final payment will be made in October 2017, in line with the statutory timetable, based on actual usage in 2016/17.

The government's commitment to scrap the CRC scheme in 2019 remains unchanged. The charge will be recovered at the point of billing via energy taxation. There are financial benefits to NHSBT. However, there will be a reduction in bureaucratic burden in compiling and completing annual report information.

Environmental

NHSBT is close to the final year of its current three year ISO14001 Environmental Management System (EMS) certification cycle. The opportunity has therefore been taken to start the process of transferring our certification to the revised ISO14001:2015 standard. A readiness review has been conducted and we have been given the go ahead to commence the formal process by our certification body (British Standards Institute). Plans are in place to ensure the transition is completed by December 2017. The revised standard requires a high degree of top level leadership engagement and risk management. As stated above this can be readily evidenced and recent activity with the Sustainability Strategy will assist us greatly in demonstrating compliance to the revised standard.

The EMS continues to mature and develop. Work has been undertaken, over the last year to further integrate the EMS into the NHSBT's Quality Management and Risk Management systems, this work will continue, to ensure that good environmental practice is 'business as usual'.

Highlights of the last twelve months' work include:

- Improving and documenting the organisations Fuel Delivery (Diesel and Fuel Oil) processes to include Local Prevention Control Plans. Fuel Delivery and Storage are identified as high risks within the organisations environmental risk portfolio and the changes will ensure that NHSBT can demonstrate a good level of risk control in this area.

- Working with regulators to confirm that NHSBT are not required to routinely apply for, pay for and monitor Consents to Discharge effluent to public sewers, unless "scientific research" is undertaken on a site. This removes all but three of NHSBT's controlled properties from this requirement.

- Improvement of systems and audit within procurement to enable demonstrable levels of governance and assurance that the environment is being protected and the business's sustainability footprint improved.

Following transition to the revised ISO14001 standard, the Environmental Team will interlink the 2015/25 Sustainability Strategy and the EMS.

Approved or Planned Developments

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

Our investment in transformational change in any year is defined by the number and nature of the projects within the programme. Although we continue to focus on efficiency the programme is now

increasingly defined by the major investments that are required to replace our ageing IT infrastructure and the core business systems. As a result, our programme has developed to become one that includes a smaller number of the very much larger projects described below:

- **Core Systems Modernisation (CSM)**
  The CSM project aims to introduce new supply chain systems in Blood, from donor management through manufacturing and processing and on to hospital delivery and stock management, and ultimately to replace the ageing Pulse system that currently supports these processes. The project team is currently working towards implementing the processes that underpin blood donation on a Microsoft Dynamics 365 platform over a number of phases from June through to the end of 2017. Thereafter we will be working to transfer the manufacturing, testing and distribution processes from Pulse onto the new platform. The project is expected to complete by the end of 2018/19 at a cost of £24.8m and is anticipating spending ca £15.6m by the end of 2017.

- **ODT Hub**
  The objective of the ODT Hub project is to introduce new processes in support of the management of the clinical pathway between organ donation and transplantation. As with the CSM project it will also result in the replacement of the existing IT application that supports the current processes i.e. the National Transplant Database (NTxD). The cost of the project is anticipated to be around £10m over five years, with £3m spent to date (years 1 and 2) and a business case for the Year 3 phase (£3.2m) approved by the NHSBT Board in March 2017.

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

- **Brentwood Estate Project**
  The Brentwood Centre was closed on 12 June 2017. Activity has moved to a smaller more efficient estate footprint in the Brentwood area.

A result of the SCM project is that our Sheffield Centre will become further under utilised. Given that our Leeds Centre is also under utilised options have been explored around the configuration of our estate in the Leeds and Sheffield area and it has been determined that a new single centre, situated between the two existing centres, is the preferred option. An outline business case was endorsed by the NHSBT Board in May 2016 and a detailed business case approved by the Board in May 2017 (at an approximate gross capital cost of £15m). Subject to DH approval a new site will be acquired in Autumn 2017 and the project completed by June 2020.

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

Principles of Remedy

NHSBT is committed to providing quality responses to our customers' queries and concerns in line with, the Department of Health guidelines 'Listening, Responding, and Improving' and the Ombudsman's guidelines 'Principles of Remedy'. We actively seek feedback from our customers so that we can take steps to put things right when expectations and needs are not met, and we can understand where we need to improve. Complaints procedures are in line with the six principles that

represent best practice published by the Parliamentary and Health Ombudsman in 2010. Customers can complain in person, by phone to our Hospital or Donor Customer Services staff or in writing. Our contact details are published on complaint leaflets and on our websites. We receive complaints from three main customer groups Hospitals, Blood Donors and from Organ Donation. The paragraphs below outline the activity and level of complaints in each area during the period.

Managing Hospital Complaints
Annually we issue 2.2 million components, make 138,000 deliveries, distribute 300,000 units of reagents and Red Cell Immunohaematology (RCI), and perform diagnostic tests on 60,000 patient samples to support hospital practice. In 2016/17 we received 423 compliments and unfortunately also received 773 complaints. All complaints are investigated and the results reported back to our customers to provide assurance for hospitals and the patients they serve. We report complaints throughout our business and take steps to remove the causes, especially where there is actual or potential patient impact. Complaints are managed by our team of Customer Service Managers' based in our centres across the country with strong links to our hospital customers.

Through our satisfaction survey and other feedback, we are assured by our hospital customers that we are delivering valued services to a high standard. Satisfaction is increasing across our services and reflects the value we place on responding to feedback, involving customers and making change to ensure NHSBT is as easy as possible to work with.

We have improved availability of blood components and at the end of the year met 97.3% of orders on time and in full. We will continue with this in 2017/18. We have revised the Component Portfolio to show availability of specialist components at centre level to make ordering decisions easier for hospitals. We have introduced 100% HEV testing to best support patients.

We are working with hospitals to help reduce the number of Ad Hoc deliveries and make sure routine rounds can be used effectively.

We have improved turnaround times for RCI reporting and have an improvement plan in place to enhance the service further.

We provide a free Electronic Despatch Note service to support the receipt of components into the hospital transfusion laboratory and continue to develop OBOS, our online blood ordering system and Sp-ICE, our diagnostic test reporting service.

Involving hospitals is key to delivering change effectively and positively. We have consulted widely in preparation for manufacturing modernisation and with the review of our estate in Leeds and Sheffield. We involve the National Laboratory Managers Group in decision making on behalf of the hospital transfusion community.

Managing Blood Donor Complaints
We were pleased that the number of blood donors who complained last year decreased from 5342 complainants per million in 2015/16 to 4736 in 2016/17, exceeding our target of 4900.

Initiatives that have helped reduce complaint levels from 2015/16 to 2016/17 included rolling out national enhancements to our appointment grids to help improve donor flow at session, along with the introduction of a triage complaint handling process via our National Contact Centre to improve our speed of response to donors on issues raised.

In 2016/17 we responded to 93.8% of complaints from our blood donors within 20 days, against our target of 90%. Also, pleasing to see was that our Top Box scoring, where we measure donors who give us nine or ten out of ten for overall satisfaction, was at 75.6% versus a target of 72%. During 2016/17, we had 9862 complaints and 6193 compliments in relation to Blood Donation.

Managing Organ Donation Complaints
Complaints within ODT are received from members of the public, family members of organ donors, hospital staff involved in the donation and transplant pathway and occasionally transplant recipients or their family members. We are committed to responding to complaints and feedback in a timely, transparent and open manner. Coupled with this we always endeavour to ensure our processes are flexible and meet the needs of individual complainants. 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 April 2016 to March 2017, ODT received 80 complaints.

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

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

Emergency Preparedness

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

The achievements in the 2016/17 year included:

- The retention of ISO22301 certification.
- The completion and testing of Business Continuity Plans the business units within the Diagnostics and Therapeutic Services Directorate.
- The completion of an Executive Level National Emergency Team (NET) based on a mass casualty event.
- The work of bringing the newly acquired eye banks into the certification of ISO22301 was started.

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	**72757**	**204,854**
Total Non-NHS trade invoices paid within target	**71143**	**203,165**
Percentage of Non-NHS trade invoices paid within target	**97.8%**	**99.2%**
Total NHS trade invoices in the year	**12424**	**6,382**
Total NHS trade invoices paid within target	**12230**	**6,323**
Percentage of NHS trade invoices paid within target	**98.4%**	**99.1%**

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 2016/17 NHSBT made a payment of £nil arising from claims made under this legislation (2015/16 £nil).

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 2016/17 NHSBT paid 30.9% (38.2% in 2015/16) of the total number of invoices, representing 45.9% (48.3% in 2015/16) by value, within a 10-day period.

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

Ian Trenholm
Chief Executive and Accounting Officer

Date: 26 June 2017

ACCOUNTABILITY REPORT

I hereby sign the Accountability Report from pages 19 to 45.

Ian Trenholm
Chief Executive and Accounting Officer

Date: 26 June 2017

Corporate Governance Report – Directors' Report

Board Members

Board Members serving during the period 1 April 2016 to 31 March 2017:

Chairman
Mr. John Pattullo

Non-Executive Directors
Mr Roy Griffins CB
Mr Jeremy Monroe
Mr Shaun Williams
Ms Louise Fullwood
Mr Keith Rigg
Mr Charles St John
Professor Paresh Vyas
Lord Jonathan Oates

Executive Directors
Mr Ian Trenholm – Chief Executive
Mr Rob Bradburn – Finance Director
Ms Sally Johnson – Director of Organ Donation and Transplantation
Dr Huw Williams – Director of Diagnostic and Therapeutic Services
Dr Lorna Williamson – Medical and Research Director left 31 May 2017
Mr Greg Methven – Director of Manufacturing and Logistics commenced 6 February 2017
Dr Gail Miflin – Medical and Research Director commenced 1 June 2016

Details of the remuneration of senior managers of the Authority can be found in the Remuneration and Staff Report at pages 35 to 45.

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

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

The NHSBT Board

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

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

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

- progress against strategic targets;
- performance against certain key indicators designed to demonstrate that key clinical, operational and safety processes are under control;
- new risks, and existing risks with an increased risk score, that have been reviewed and escalated to the Board by the Executive Management Team;
- financial performance; and
- progress against key strategic projects.

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

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

Board Committees

The Board has established the seven Board Committees described below. All seven Committees were in operation during 2016/17.

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

Trust Fund Committee – oversees NHSBT's charitable funds that are used to support, for example, staff welfare and small research and development projects. NHSBT is the corporate trustee of the Trust Fund. The Board of NHSBT acts on behalf of the corporate trustee and Board members are not individual trustees.

Transplantation Policy Review Committee – considers and approves, on behalf of the Board, policies and standards developed by Solid Organ Advisory Groups, the Donation Advisory Group and the Retrieval Consultation Group. These standards relate to potential organ donor selection, organ donor management, patient selection and organ allocation. The Committee ensures that the policies meet all legal, regulatory and ethical requirements and standards, recognising that many of these policies have considerable impact on individual patients that are awaiting transplantation.

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

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

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

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

The average attendance of Members at Board Committees during 2016/17 was:

Board Committee	**(%)**
Remuneration Committee	100%
Trust Fund Committee	95%
Expenditure Controls Committee	100%
Governance & Audit Committee (GAC)	90%
National Administrations Committee	87%
Research and Development Committee	75%
Transplantation Policy Review Committee	70%

The remit and terms of reference are reviewed by each committee annually.

The attendance of Members at Board meetings during 2016/17 was:-

Member Name	Member Position	No.
John Pattullo	Chairman	6
Ian Trenholm	Chief Executive	6
Rob Bradburn	Finance Director	6
Sally Johnson	Director of Organ Donation and Transplantation	6
Huw Williams	Director of Diagnostics and Therapeutic Services	6
Louise Fullwood	Non-Executive Director	6
Roy Griffins	Non-Executive Director	6
Keith Rigg	Non-Executive Director	6
Jeremy Monroe	Non-Executive Director	5
Shaun Williams [1]	Non-Executive Director	5
Charles St John [2]	Non-Executive Director	5
Gail Miflin [3]	Medical and Research Director	5
Paresh Vyas [4]	Non-Executive Director	4
Peter Lidstone [5]	Director of Manufacturing & Logistics	4
Christine Costello [6]	Non-Executive Director	1
Lorna Williamson [7]	Medical and Research Director	1
Greg Methven [8]	Director of Manufacturing & Logistics	-

[1] *last Board meeting was Jan 2017 – contract term ending*
[2] *first Board meeting was May 2016*
[3] *first Board meeting was Jul 2016 – replacing Lorna Williamson*
[4] *first Board meeting was May 2016*
[5] *last Board meeting was Nov 2016 – left NHSBT 1st December replacement Greg Methven*
[6] *last Board meeting was May 2016 – contract term ending*
[7] *last Board meeting was May 2016 – left NHSBT 31st May 2016*
[8] *Joined NHSBT in Feb 2017 – replacing Peter Lidstone*

Personal Data Incidents

NHSBT has a comprehensive process for reporting and addressing all data incidents from minor (level zero) to serious (level 5). Each level is defined as:

Level 0 incidents – No significant reflection on any individual or body.

Level 1 incidents – Damage to an individual's reputation.

Level 2 incidents – Damage to a team's reputation.

Level 3 incidents – Damage to a services reputation.

Level 4 incidents – Damage to an organisation's reputation.

Level 5 incidents – Damage to NHS reputation.

There are 275 incidents on record for 2016/17, 248 were level zero, 25 were level 1 and one was a level 2.

Most our incidents involve mis-handling of paper documents, most of which were subsequently recovered. The increase in the number of level zero incidents reflects increasing awareness and

reporting information integrity and availability incidents, rather than a focus on confidentiality or data loss incidents.

Health and Safety

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

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

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

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

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

The figures below for 2016/17 are as reported to HR Direct as of 18th April 2017.

	14/15				15/16				16/17			
Level	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Blood Donation	22	7	236	559	12	12	240	436	11	6	151	506
Blood Manufacturing & Logistics	8	6	64	153	7	2	46	134	4	1	41	211
DTS	0	1	33	56	0	1	32	47	1	0	34	128
ODT	0	1	4	7	0	0	8	3	0	0	1	12
Group Services	0	0	3	18	0	0	6	20	0	0	4	57
Total	**30**	**15**	**340**	**793**	**19**	**15**	**332**	**640**	**16**	**7**	**231**	**914**

Level 1 and 2 incidents are at the lowest level ever recorded with a 32% reduction from last year that beats the 10% target. Blood Donation has reduced their Level 2 incidents by 50%, whilst Blood Manufacturing and Logistics have reduced both their Level 1 and Level 2 incidents by 43% and 50% respectively. The American Occupational Safety and Health Administration (OSHA) incident rate is now being used as a wider measure of lost time incidents and this has reduced from 2.1 to 1.9 in the rolling 12 months to February 2017. The OHSA incident rate for the ambulance and health care services and medical and diagnostic laboratories are both 2.3*. Level 3 serious incidents have reduced by 30% mainly driven by decreases in Blood Donation. The improved accident performance this year can be linked to the safety culture workshop for managers, the increased commitment from senior leaders, involvement of health and safety representatives in root cause analysis and engagement of staff in health and wellbeing. Near miss reporting fell in 2015/16 linked to the reduction in donation chair issues. A near miss reporting postcard system was successfully trialled and introduced in November 2016 that has increased the numbers reported in all areas. Campaigns are being planned to encourage more near miss reporting and undertaking health and safety observations to continue the good accident performance and reduce work related ill health further.

* Latest figure reported in 2014

Fees and Charges

NHSBT has a statutory duty to produce a breakeven financial plan year on year and to achieve this, the majority of it's costs are recovered through prices. Annual price setting for Blood Components and Specialist services is agreed with the National Commissioning Group (for Blood), on behalf of the NHS. Prices are national, and set per unit, against forecasted sales volumes for the forthcoming financial year and are established to recover the full cost of providing products and services to the NHS (including a return on the cost of capital employed). Built into the price for Blood is a risk-share with the NHS, equivalent to 2% of planned volumes, which provides in-year protection against unforeseen changes to demand. Performance against agreed sales volumes, is reviewed in-year with Commissioners, and in the event of an over-recovery of costs, these would be returned to the NHS in the form of a rebate. Costs, including an allocation of overheads, and service income derived from prices are recognised at a strategic operating unit level, within the segmental reporting note.

This is subject to audit.

Corporate Governance Report – Statement of Accounting Officer's Responsibility

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

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

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

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

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

As Accounting Officer:

- so far as I am aware, there is no relevant audit information of which the NHSBT's auditors are unaware; and
- I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the NHSBT's auditors are aware of that information.
- I confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable.
- I have taken personal responsibility for the Annual Report and Accounts and the judgements required for determining that is it fair, balanced and understandable.

Ian Trenholm
Chief Executive and Accounting Officer

Date: 26 June 2017

Corporate Governance Report – Governance Statement

Scope of Responsibility

The Board of NHS Blood and Transplant (NHSBT) is accountable for ensuring that NHSBT operates in accordance with the law and all applicable regulations. 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 safe and effective achievement of NHSBT's policies, aims and objectives, whilst safeguarding public funds and NHSBT's 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 Board arrangements and through supporting Income Generation Agreements.

The governance structure and process within NHSBT is described in the NHSBT Governance and Assurance Framework. The NHSBT Governance and Assurance Framework was last updated and reviewed by the GAC in September 2016 and was considered at that time 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 had no material gaps and was consistent with applicable guidance (including the principles set out in "Corporate Governance in Central Government Departments"). The Governance and Assurance Framework incorporates an "Assurance Map" which is used by the GAC as a check list of assurance processes (based on the "three lines of defence" principle).

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

Strategic Management and Reporting

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

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

This is further supported by a programme of performance reviews at the Board whereby the performance and execution of the strategies within each of the Blood, Diagnostic and Therapeutic

Services (DTS) and Organ Donation and Transplantation (ODT) Divisions are reviewed on a 6-monthly cycle (with, therefore, each Division's performance being reviewed twice per annum).

Risk Management and Control

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

These describe the process around the operation of the NHSBT risk register. New risks identified for inclusion on the risk register are assessed for their likelihood and consequence using a 5 x 5 risk matrix in accordance with the Risk Management Policy and MPDs. In addition, high scoring risks are reviewed by the Executive Team and escalated to the Board as necessary. Existing and new risks are captured within the monthly performance reporting cycle and are summarised within the monthly Board performance report.

The GAC is accountable for ensuring that the risk management process is fit for purpose and is working effectively. As part of its assurance process the GAC reviews the risks and controls within each of our SBUs on a rolling basis. This programme is incorporated within the GAC annual work plan. In support of this NHSBT has adopted the use of a Board Assurance Framework (BAF). BAFs have therefore been generated for each of NHSBT's SBUs and capture the risks to the delivery of the strategic objectives and the mitigations that are in place for the SBU. The BAF is used to underpin the risk review process, by both the GAC and NHSBT Executive Team, through providing assurance that risks to the delivery of strategic objectives are being adequately managed.

Clinical Governance and Risk

The Medical and Research Director has responsibility for all aspects of clinical governance and effectiveness across NHSBT and reports regularly to the Executive Team, GAC and Board on all matters of clinical governance. 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 incidents (SIs) and Never Events, clinical complaints/commendations and clinical claims.

Quality Management System (QMS)

NHSBT's activities are highly regulated, reflecting the nature of the biological products and supporting services that we supply. The regulation of activities within Blood Components is covered by Blood Safety and Quality Regulations (BSQR) and the Competent Authority is the Medicines and Health Regulatory Agency (MHRA). The MHRA also regulate NHSBT's Investigational Medicinal Product (IMP) and "Specials" Medicinal Product" activities under the applicable medicines regulations and issue the appropriate licenses. 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. European Union 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 comprising operating manuals and detailed process documentation, 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 NHSBT centres and are usually led by the Centre QA manager. They confirm continued compliance, prepare for forthcoming external inspections and organise centre based activities to improve quality.

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

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

- A quarterly Management Quality Review (MQR) Report to the Executive Team and GAC.

- An annual summary report to the Board.

- Monthly reporting of supporting key operational KPIs via the Board performance report which are designed to monitor that key processes remain in control.

NHSBT is committed to delivering a strong regulatory performance and an ambition that there should be no “critical” and no “major” non-compliances identified during any regulatory inspection. During 2016/17 there were no critical and two major non-compliances reported following MHRA regulatory inspections, with one of the major non-compliances reported in Blood and one in DTS. This compares to 2015/16 where there were no critical and five major non-compliances reported.

All regulatory findings are subject to formal review and control by the QA function with action plans put in place to respond to, and learn from, all issues raised by inspections.

Business Continuity

NHSBT supplies biological products and services to the NHS and the wider healthcare economy that are often time critical, and is the sole supplier for some of these (such as blood and skin). Consequently, the management of business continuity risk within NHSBT is extremely important to the health systems in the UK.

NHSBT operates a Business Continuity function that reports to the Director of Diagnostic and Therapeutic Services. The function provides leadership, advice and support to deliver a Business Continuity Management System (BCMS) for NHSBT and supports the wider NHS in its emergency response arrangements. NHSBT is certified to ISO22301 (the international standard for business continuity) with respect to the Blood Service and Diagnostic and Specialist Services and NHSBT remains the only blood service in the world to have achieved this standard. It provides an auditable standard of the quality of our BCMS, provides assurance to the Department of Health (DH), our customers and other stakeholders and meets our regulatory obligations.

As part of the business continuity programme all our main sites (Blood Centres and the ODT Stoke Gifford site) have been assessed for business continuity risk, considering internal risk, risks in our environment and the activity on each site. The Business Continuity function reports on plans and progress to the Executive Team and to each GAC meeting.

NHS Blood and Transplant Risk Profile

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

NHSBT is, however, totally dependent on the voluntary donation of blood, organs, haemopoetic stem cells and tissues and has extensive direct contact 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 its operations be this donor service, customer service to hospitals, product safety, product availability, regulatory performance and efficiency. We are highly committed to the delivery of our strategy and its associated benefits and we endeavour to maintain the right balance between delivery of the strategy and the risks associated with its underlying action plans. Our strategy therefore incorporates a balanced set of objectives covering quality and efficiency but we plan for the highest levels of risk mitigation before any steps are taken which could impact the safety or availability of our products/services and ultimately the safety of NHS patients. In this regard both our clinical governance (CARE) and quality assurance functions are closely involved with strategic projects at all stages of their progress.

As at 31 March 2017 the NHSBT risk register captured 139 risks. Of these there were 13 risks considered high / extreme (i.e. with a risk score of 15 or more) and these are summarised below:

Blood – declining demand and service reconfiguration:
To support the need for greater financial efficiencies across the NHS our medium-term objective is to find efficiency gains and productivity improvements that at least offset inflation, enabling us to at least maintain flat pricing of our products and services. Prices are, however, highly dependent on volume and the trends that we see in the demand for blood. Since October 2012 a sustained reduction in red cell demand has been seen and we forecast that this trend will continue over the medium term. The costs of the blood supply chain are relatively fixed in nature and it is increasingly challenging to reduce costs at the same rate as volume reduction. We have recently implemented a price rise and avoidance of further price increases in the future will increasingly depend on our ability to continue removing capacity and increasing productivity, especially within blood donation where benchmarking indicates that productivity is significantly lower than the best blood services in the world. The drive for further efficiencies will result in significant changes to the configuration of our blood donor service (e.g. fewer, larger mobile blood collection sessions and greater use of fixed venues). This will require careful management and communication of changes to donors to ensure that the drive for greater efficiency is not achieved to the detriment of service effectiveness and hence does not impair the loyalty and support of the donors on whom we critically depend. We are confident, however, that our performance reporting framework will provide sufficient insight and warning to ensure that we continue to balance the delivery of service quality and effectiveness with financial efficiency.

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

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 been re-secured on a "flat" basis for 2015/16 and 2016/17. This funding is extremely welcome but to deliver the "Taking Organ Donation to 2020" strategy increased funding is likely to be required in 2018/19 and beyond. Discussions will continue with the four UK Health Departments to define the priorities and opportunities that can support the delivery of the 2020 targets.

Organisational Transformation - Change management:
The scale of change across NHSBT, in support of providing value for money to the NHS, is significant and ambitious. The need to support change through the implementation of modern supporting IT systems is an increasingly critical component of our programme. In addition, IT infrastructure and systems across NHSBT are generally old, close to end of life and, in some critical areas, dependent on niche Small & Medium Sized Enterprises (SMEs) for their ongoing support and maintenance. Significant investment will therefore be required to replace ageing infrastructure, migrate to cloud based services and replace the critical operational applications underpinning each of the operating divisions.

In 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 will be challenging and will require the development of internal capabilities to manage new business models and supporting sales, marketing and product management skills.

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

Business continuity:
NHSBT's supply of products and services could be severely impacted by loss of a key facility (e.g. Filton, Speke) or loss of a critical IT platform (e.g. Pulse, Hematos, Electronic Offering System (EOS), National Transplant Database (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. There was no loss of service to hospitals but gaps within our business continuity arrangements were identified. Further risk assessments have since been undertaken at NHSBT's critical sites and plans put in place to enhance resilience. The assessments and plans are regularly reviewed by the Executive Team and the GAC.

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

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

Competition and impact on the viability of services:
There is a risk that a competitor could emerge and supply blood components to the UK 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 is in decline across most developed economies, availability of supply into the UK becomes that much greater. In the medium term the risk is considered to remain low, however, as the barriers to entry from a safety perspective are relatively high (i.e. the need for integration of systems and clinical support to manage traceability from donor through to patient). So, it may 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 because of safety concerns.

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

Global cyber attack:
On 12th May a global cyber-attack affected several organisations including many NHS bodies. NHSBT systems were not impacted by this attack and precautionary actions were taken in line with NHS Digital advice to protect against similar attacks in the future.

Lapses in control

Never Events / Serious Incidents (SIs)

There were no Never Events within NHSBT during the year (and none in 2015/16). A Never Event is described as; ‘serious largely preventable patient safety incidents should not occur if the available preventable measures have been implemented by the Healthcare provider’.

During 2016/17 a total of 16 incidents were identified and initially reviewed as Serious Incidents (SIs). The results of these reviews concluded that 5 of the incidents should be recorded and managed as

Serious Incidents (SI) and the remaining 11 incidents were managed as Major Quality Incidents. Each incident was subjected to a full and comprehensive investigation which resulted in action plans that were overseen and monitored to completion by the appropriate Director. Each incident was also reviewed at CARE to ensure organisational learning and to minimise the risk of a similar incident occurring in other parts of NHSBT.

The SIs in 2016/17 related to:

(a) An Human Leukcyte Antigen (HLA) transcription error. An undisturbed environment for tasks requiring concentration has been implemented in the affected laboratory. Manually generated cumulative reports have also been discontinued and where required these are now being generated from the Hematos Laboratory Management Systems (LIMS) system.

(b) Discrepancy of Cytomegalovirus (CMV) results where a recipient of a pancreas died from CMV disease following an incorrect CMV result. Root cause analysis from both NHSBT and Public Health England has been submitted as part of a pre-inquest review and an inquest is scheduled for May 2017.

(c) Blood samples tested by the National Transfusion Microbiology Reference Laboratory (NTMRL) which were tested outside of the assay manufacturers 'instructions for use' with respect to timeframes. Subsequent work has since validated the safe use of longer timeframes.

(d) Incomplete information communicated to a Transplant Centre which resulted in a liver transplant surgery being started, then discontinued.

(e) Incomplete information communicated to a Transplant Centre with an unknown diagnosis of lymphoma in the donor resulting in two kidney recipients requiring removal of their grafts and prophylactic treatment for lymphoma.

The final investigation report for (a) was closed in June 2016. Incidents (b) and (c) were both closed in March 2017. SIs (d) and (e) remain open as they were notified in March 2017 and remain under investigation.

Other Controls / Internal Audit

Our internal audit service is provided by the Health Group Internal Audit Service (HGIAS) of the Department of Health. Under this umbrella arrangement both our Head of Internal Audit, and the supporting audit resources, are provided directly by PriceWaterhouseCoopers under HGIAS contract. A summary of the audit report for the year and the overall opinion follows in the Parliamentary Accountability and Audit Report below.

Information and Data Management

NHSBT holds details of over 4 million blood donors (both active and archived) and manages an Organ Donor Register with approximately 23.5 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 most cases. One severity level 2 incidents were reported to the Information Commissioner's Office (ICO) in December 2016. This involved 137 blood donor records that were transferred in error to the Wales Blood Service. No harm arose from the incident and all records remained within the NHS. The ICO confirmed in March 2017 that this did not meet their criteria for any further action.

Whistle blowing Policy and Counter Fraud Policy

NHSBT has a Whistle blowing 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 frauds to account. Our counter fraud work is overseen by NHS Counter Fraud Authority (formerly NHS Protect).

Care Quality Commission Registration

NHSBT has 30 blood locations, 8 Therapeutic Apheresis Services Units and the Watford Headquarters registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008.

During the period April 2016 to March 2017 the CQC did not undertake any inspections of NHSBT locations.

NHS Provider Licence

NHSBT has reviewed the DH guidance published in December 2013 *Protecting and promoting patients' interests. Licence exemptions: guidance for providers.* As a manufacturer of biological products and provider of clinical support services the only direct healthcare services provided by NHSBT are apheresis based therapies that generate around £7.5m of NHSBT's total income. This is below the threshold of income that requires a licence and, additionally, does not meet the definition of a Commissioner Requested Service. We have concluded that NHSBT is not within the scope of the bodies expected to be licensed by Monitor under the Health and Social Care Act 2012.

Duties of the Secretary of State

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

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

Review of Effectiveness

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

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

As a result of the above I confirm that the system of internal control has been in place in NHS Blood and Transplant for the year ended 31 March 2017 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

Date: 26 June 2017

Chief Executive and Accounting Officer

Remuneration and Staff Report

This report forms part of the Accountability Report on pages 19 to 45.

Remuneration Committee Membership

During 2016/17 membership of the Remuneration Committee comprised Shaun Williams, Jeremy Monroe and John Pattullo. The committee was chaired by Shaun Williams. Ian Trenholm and David Evans also attended Committee meetings as 'standing attendees'.

Remuneration Policy

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

Methods to Assess Performance

All senior managers are appraised regularly and their performance is assessed against personal and corporate objectives. The element of remuneration based on performance for relevant senior staff is as defined by the DH ALB Executive and Senior Manager Pay Framework, and associated guidance issued by the Department of Health.

Senior Management Contract Information

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

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

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

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

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

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

Sally Johnson, Director of Organ Donation and Transplantation, current NHS continuous service start date 23 July 1990, appointed, 1 September 2008. Permanent full-time post three months' notice of termination by the employee, and six months' notice period by NHSBT.

Peter Lidstone, Director of Manufacturing and Logistics, NHS start date 2 November 2015, appointed 2 November 2015. Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT. Peter Lidstone resigned from NHSBT with effect from 1 December 2016.

Greg Methven, Director of Manufacturing and Logistics, NHS start date 6 February 2017, appointed 6 February 2017. Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT (after 6 months' in post).

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

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

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

Dr Gail Miflin, Medical and Research Director, NHS start date 1 August 1991, appointed 1 June 2016. Permanent full-time post with three months' notice by the employee, and three 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.

The remuneration and pension benefits of the most senior officials of the Authority are shown in the tables on 37 and 38. The tables on pages 37 and 38 are subject to audit.

Salary and Pension Entitlement of Senior Managers

a) Remuneration

	Year to 31 March 2017					Year to 31 March 2016				
	Salary	Performance pay and bonuses	Non Cash Benefits	All Pension Related Benefits	Total	Salary	Performance pay and bonuses	Non Cash Benefits	All Pension Related Benefits	Total
	In £5k bands	In £5k bands	To nearest	Bands of £2500	In £5k bands	In £5k bands	In £5k bands	To nearest	Bands of £2500	In £5k bands
Name and title	£000	£000	£00	£000	£000	£000	£000	£00	£000	£000
Mr J Pattullo (Chairman)	60-65	-	-	-	60-65	60-65	-	-	-	60-65
Mr A Blakeman (NED) ended 31 March 2016	-	-	-	-	-	5-10	-	-	-	5-10
Dr C. Costello (NED) ended 31 May 2016	0-5	-	-	-	0-5	5-10	-	-	-	5-10
Ms L Fullwood (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr R Griffins (NED)	10-15	-	-	-	10-15	10-15	-	-	-	10-15
Mr J Monroe (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Lord J Oates (NED) commenced 1 March 2017	0-5	-	-	-	0-5	-	-	-	-	-
Mr K Rigg (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr C St John (NED) commenced 1 April 2016	5-10	-	-	-	5-10	-	-	-	-	-
Mr S Williams (NED) ended 3 March 2017	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Prof P Vyas (NED) commenced 1 April 2016	5-10	-	-	-	5-10	-	-	-	-	-
Mr I Trenholm (Chief Executive) [1]	175-180	5-10	-	1487.5-1490	1670-1675	170-175	-	4	47.5-50	225-230
Ms L Austin (Director of Marketing and Communications)	105-110	-	-	27.5-30	135-140	105-110	-	-	22.5-25	130-135
Mr I Bateman (Director of Quality)	100-105	-	24	17.5-20	120-125	100-105	-	24	15-17.5	115-120
Mr R Bradburn (Finance Director)	140-145	-	52	32.5-35	180-185	135-140	-	48	20-22.5	165-170
Mr D Evans (Director of Workforce and Transformation Services) [2]	100-105	-	-	35-37.5	135-140	125-130	5-10	-	35-37.5	165-170
Ms S Johnson - (Director of Organ Donation and Transplantation)	125-130	5-10	-	65-67.5	200-205	120-125	-	-	2.5-5	125-130
Mr P Lidstone (Director of Blood Manufacturing and Logistics) ended 30 November 2016 [3]	85-90	-	-	-	85-90	50-55	-	-	10-12.5	65-70
Mr G Methven (Director of Blood Manufacturing and Logistics) commenced 6 February 2017 [4]	15-20	-	7	2.5-5	20-25	-	-	-	-	-
Dr Gail Miflin (Medical and Research Director) commenced 1 June 2016 [5]	135-140	-	-	170-172.5	305-310	-	-	-	-	-
Mr A Powell (Chief Digital Officer)	120-125	-	25	42.5-45	165-170	110-115	-	21	75-77.5	190-195
Mr M Stredder (Director of Blood Donation)	125-130	5-10	-	27.5-30	160-165	90-95	-	3	20-22.5	115-120
Mr H Williams (Director of Diagnostics and Therapeutic Services)	125-130	-	-	30-32.5	160-165	125-130	-	-	27.5-30	150-155
Dr Lorna Wlliamson (Medical and Research Director) ended 31 May 2016	40-45	-	-	-	40-45	215-220	-	-	-	215-220

NED = Non-Executive Director

Performance pay and bonuses relates to pay earned in the previous year. There were no bonuses paid in 2016/17.

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

[1] Mr I Trenholm – the significant increase in remuneration is due to a pension transfer from the Civil Service Pension scheme.

[2] Mr D Evans – change in salary is due to reduction in working hours. Effective from 01 April 2016.

[3] Mr P Lidstone – left the pension scheme on 1 December 2016 and withdrew from the scheme.

[4] Mr G Methven – full year salary for this position is 125-130

[5] Dr Gail Miflin – the increase in remuneration is due to Dr Miflin being appointed as Medical and Research Director part way through the year.

b) Pension Benefits

Name and title	Real increase / (decrease) at pension age (bands of £2,500) £000	Real increase in lump sum at pension age (bands of £2,500) £000	Total accrued pension at age at 31 March 2017 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real increase in Cash Equivalent Transfer Value £000
Mr I Trenholm (Chief Executive) [1]	75-77.5	-	80-85	-	960	59	900
Ms L Austin (Director of Marketing and Communications)	0-2.5	-	10-15	-	179	148	31
Mr I Bateman (Director of Quality)	0-2.5	2.5-5	15-20	55-60	392	352	40
Mr R Bradburn (Finance Director)	2.5-5	-	20-25	-	307	262	45
Mr D Evans (Director of Workforce and Transformation Services)	0-2.5	5-7.5	45-50	135-140	943	874	69
Ms S Johnson (Director of Organ Donation and Transplantation)	2-2.5	12.5-15	50-55	155-160	1,140	1,018	122
Mr P Lidstone (Director of Blood Manufacturing and Logistics) left 30 Nov 2016 [2]	(0-2.5)	-	-	-	-	11	(7)
Mr A Powell (Chief Digital Officer)	2.5-5	-	10-15	-	131	103	29
Mr M Stredder (Director of Blood Donation)	0-2.5	-	0-5	-	40	17	24
Dr H Williams (Director of Diagnostics and Therapeutic Services)	0-2.5	-	5-10	-	133	96	37
Dr L Williamson (Medical and Research Director) Left 31 May 2016 [3]	(0-2.5)	0-2.5	80-85	255-260	-	-	-
Mr G Methven (Director of Manufacturing and Logistics) commenced 06 Feb 2017	0-2.5	-	0-5	-	4	-	1
Dr G Miflin (Medical and Research Director) commenced 01 Jun 2016 [3]	5-7.5	15-17.5	35-40	95-100	628	486	118

1. Mr I Trenholm – the significant increase in cash equivalent transfer value is due to a pension transfer from the Civil Service Pension Scheme.
2. Mr P Lidstone – left the pension scheme on 1 December 2016 and withdrew from the scheme.
3. Dr L Williamson – cash equivalent transfer values are not applicable for members who are over the normal retirement age.
4. Dr Gail Miflin – the increase in remuneration is due to Dr Miflin being appointed as Medical and Research Director part way through the year.

Cash Equivalent Transfer Value

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

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

Real Increase in CETV

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

Pension Scheme Liabilities

Most employees are members of the NHS pension scheme which is an unfunded, defined benefit scheme. The scheme is not designed in a way that enables the NHS bodies to identify their shares of the underlying assets and liabilities and so is accounted for as a defined contribution scheme. See Accounting policy 1.10.

Compensation on Early Retirement or Loss of Office

Early Retirements and redundancies

During 2016/17 there were 72 payments for early retirements and/or redundancies from NHSBT. The sum of £2,212,000 has been paid out in 2016/17 in respect of these redundancies and/or early retirements (2015/16 94 early retirements and/or redundancies and payments of £3,349,000).

An opening provision of £2,277,000 for redundancy costs has been utilised, or reversed unused during 2016/17 and a further provision of £2,314,000 has been made for redundancy costs in relation to restructures currently in progress.

A total charge of £2,209,000 for early retirements and redundancies is included within other staff related costs in note 3.1 of the financial statements (2015/16 £3,058,000).

This is subject to audit.

Reporting of Other Compensation Schemes

The table below discloses the number and value by cost band of compensation packages paid in 2016/17.

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	7	49	3	22	10	71	-	-
£10,001 - £25,000	14	226	7	142	21	368	-	-
£25,001 - £50,000	11	367	19	706	30	1,073	-	-
£50,001 - £100,000	4	281	7	419	11	700	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-	-	-
Totals for 2016/17	**36**	**923**	**36**	**1,289**	**72**	**2,212**	**-**	**-**
Totals for 2015/16	**50**	**1,871**	**44**	**1,478**	**94**	**3,349**	**-**	**-**

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

This is subject to audit.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of their workforce. The banded remuneration of the highest paid director in NHSBT in the financial year 2016/17 is shown in the table below, together with the remuneration ratio compared to the highest paid directors pay. This shows the pay multiple has gone down to 6.8 from 8.2 following the 2015/16 highest director banded leaving NHSBT on 31 May 2016.

	2016/17	2015/16
Highest Director Banded Remuneration	£185k to £190k	£215k to £220k
Lowest Banded Remuneration	£0k to £5k	£0k to £5k
Median Remuneration	£27,754	£26,719
Remuneration Ratio	6.8	8.2

This is subject to audit.

Staff Numbers and Costs

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

This is subject to audit.	**Total**	**31 March 2017 Permanently Employed Staff**	**Other**	**31 March 2016 Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	**163,985**	151,646	12,339	168,058
Social security costs	**15,293**	14,826	467	11,655
Employer contributions to NHS Pensions Agency	**20,125**	19,511	614	19,913
	199,403	**185,983**	**13,420**	**199,626**

	Total	**Permanently Employed**	**Other**
	Number	**Number**	**Number**
Year Ended 31 March 2017	**4,749**	**4,507**	**242**
Year Ended 31 March 2016	4,830	4,561	269

Expenditure on Staff Benefits

The amount spent on staff benefits during the year is estimated at £1,412,000 (31 March 2016: £1,179,000)

Sickness Absence Data

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

During the period January 2016 to December 2016 the total number of whole time equivalent days lost to sickness absence was 44,001 days. This equates to an average of 9.3 days per whole time equivalent; and a sickness absence rate of 2.5%.

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

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 mobile technology via the use of hand held devices for staff working remotely is evidence of this ongoing ambition. The introduction of our new desktop also creates greater opportunities for e learning, self service whilst we also continue to promote easier access on the internet to Inside NHSBT.

Staff Engagement

This year our staff survey, *Your Voice* which is key for obtaining feedback from our people, was distributed to all employees. A response rate of 80% or 4214/5239 responses was achieved, which is well above the national average for the NHS (44%) and is a demonstration that staff want to communicate with the organisation and feedback their thoughts, feelings and views on what life is like whilst working at NHSBT.

The *Your Voice* survey identified themes, agreed by the Executive that at NHSBT that we should focus on. This is based on 70% continue; 20% adapt; 10% create:

- Continue to focus on Harassment, Bullying and Abuse (17% reported)
- Continue to focus on Communication (49% positive)
- Continue to focus on well-being improvements (55% positive)
- Adapt – improve management capabilities (65% positive)
- Adapt – improve development opportunities (46% positive)
- Create – increase senior leader approachability (32% positive)
- Create – increase approach to action planning from Your Voice (40% positive)

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

- **Director Roadshows** – where Directors visit our national centres to meet with and brief staff on our strategic plans. This has proved successful and shown a significant increase in areas such as Manufacturing & Logistics engagement scores and response rates to Your Voice.

- **Connect to a Region** – this was implemented in 2014. This initiative ensures that each Executive and their senior managers are responsible for a region of the country to provide more direct support for Heads of Centres and their Partnership Committees to target localised areas for improvement. Data on Connect visits are collated quarterly.

- **Team Talk and Inside NHSBT** – these initiatives by NHSBT's Marketing and Communications Directorate are now well embedded with inside NHSBT being accessible from any device as it is hosted on an external platform. There has been good use of blogs and updates from different parts of the organisation.

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.

High engagement requires engaged and confident managers of people. NHSBT has now identified all people managers (1222) which is the first time that this information has been held as the employee systems identify budget holders as distinct from people managers. This data will now be used to monitor the Management Passport, a mandatory Passport as part of the PDPR/appraisal process. This has been complemented by a seamless learning and development offering from front line manager through to senior leaders in NHSBT. The management passport will be monitored via the Executive Scorecard.

Learning & Development

NHSBT provides a comprehensive learning and development framework for all staff through our 'SHINE' offering. SHINE learning and development offers a full range of in-house development including personal skills development, scientific training and Management and Leadership development. Coaching and mentoring are well embedded across the organisation also. A suite of management development is available from front line supervisor through to aspirant CEO level.

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 and recruit Black, Asian and Minority Ethnic (BAME) employees and donors. Recognising the importance of an inclusive working environment and having a workforce that is representative of the communities we serve; a corporate strategic target was set in 2015 to increase the proportion of Band 8a and above employees from a BAME background by 15% over a three-year period. This increase has been achieved for the first year and is something that we will continue to deliver on over the next two years.

In 2016, NHSBT supported a third cohort of BAME employees attending a positive action leadership programme, called REACH Higher. This programme is aimed to support the progression and career path for BAME staff into senior leadership roles in the organisation.

Work has continued with developing employee networks. The BAME Network Group is focused on both internal and external BAME specific issues including the education and engagement of BAME Communities; to help recruit more BAME donors and collaboration and partnerships with external BAME groups.

We have started to look at how we recruit more diversely and recently ran an Open Day at the Manchester Centre as part of the recruitment strategy to recruit to 35 positions in Manufacturing. The event attracted over 450 people on the day and the online advert attracted over 10,500 views. The overall number of applications received was just under 800.

One of the main aims of the Open Day was to attract applications from a more diverse background. Currently, Manchester's demographic is made up of approximately 17% BAME people and as a comparison, our centre at Plymouth Grove employs just over 6% BAME employees.

37.2% of the applications were from BAME applicants (compared to 25% of Band 2 NHSBT overall applications March 2016 - February 2017).

60% of the applications were from women compared to 70% from previous Band 2 NHSBT overall applications from March 2016 - February 2017.

NHSBT is committed to disability equality and aims to embed a disability confident organisational culture. We do this through:

- Running a disability Health Promotion Advisory Service to ensure that NHSBT is compliant with the Equality Act.
- Our Disability Advocates work with our Health and Safety Service to record reasonable adjustments for staff disabled at work.
- Carrying out reasonable adjustments to duties, equipment, systems for disabled staff where practicable.
- Seeking redeployment for staff who becomes disabled under the terms of our redeployment policy.
- Operating as a member of the Business Disability Forum.
- During 2017 we are preparing for the application of Workforce Disability Equality Scheme reporting.

As part of our Public-Sector Equality Duty, we are required to monitor and publish our data on gender pay gap reporting. We are currently in the process of collecting this data and will be reviewing this by the end of the second quarter this year.

As at 31 March 2017 NHSBT employed 5,609 staff members (of which 12 are directors) of whom 3,796 were female (of which 3 are directors) and 1,813 were male (of which 9 are directors).

Reward and Recognition Schemes

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

A new measure to be introduced in the Executive Scorecard will monitor the volume of Recognition nominations by Directorate.

Expenditure on Consultancy

Consultancy expenditure during 2016/17 is £nil (2015/16 £nil).

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 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	12
Of which, the number that have existed:	
for less than one year at the time of reporting	6
for between one and two years at the time of reporting	4
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	1

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying 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 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements or those that reached 6 months duration during the time period	17
Number of new engagements which include contractual clauses giving NHSBT the right to request assurance in relation to income tax and National Insurance obligations	15
Number for whom assurance has been requested	17
Of which number for whom:	
Assurance has been received	17
Assurance has not been received	0
been terminated as a result of assurance not being received	0

The table below identifies off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017:

	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 2017, 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.	0

Parliamentary Accountability and Audit Report

Basis for Accounts Preparation

The accounts for the year ending 31 March 2017 have been prepared as directed by the Secretary of State for Health in accordance with section 232 (Schedule 15, Paragraph 3) of the National Health Service Act 2006, and in a format as instructed by the Department of Health with the approval of Treasury.

Internal Audit

The programme of work agreed by the GAC resulted in a total of 15 reports being issued during 2016/17. Of the reports issued:

- 2 reports received a “substantial” assurance opinion
- 9 received a “moderate” assurance opinion
- 2 received a “limited” assurance opinion
- 0 received an “unsatisfactory” opinion
- 2 were advisory reports on which an opinion is not given

Reports in the year with a limited assurance opinion were Cyber and International Blood Group Reference Laboratories (IBGRL) Royalties. GAC monitors the completion of all Medium and High importance outstanding audit recommendations and must approve extensions requested to the agreed timescales. The GAC received assurances in March 2017 that there were no overdue Medium and High audit recommendations.

The internal audit work has been considered in the preparation of the 2016/17 Annual Report and the Governance Statement. Despite the reports noted above Health Group Internal Audit have provided an overall opinion that:

- From our work, we consider areas related to risk management our work concluded the **risk management** processes at NHSBT continues to operate an effective framework to identify, manage and monitor its key risks but that there is a need to ensure that this is effectively engaged with on a regular and timely basis. My opinion for this area is moderate.

- Our reviews have found that the overall **governance** arrangements for NHSBT remain sound. My opinion for this area is moderate.

- In the case of **control,** overall the control arrangements are adequate, but our reviews have identified a number of areas where improvement could be made in areas such as Cyber, IBRGL Royalties and confidentiality agreement where some high-risk findings were identified, this will be subject to follow up in 207/18 and ensuring that recommendations from previous reviews are satisfactorily completed. My opinion for this area is moderate.

  Therefore, in summary, my overall opinion is that I can give **moderate assurance** to the Accounting Officer and the GAC that NHSBT has adequate and effective systems of control, governance and risk management in place for the reporting year 2016/17.

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 2015/16). There were no payments to the National Audit Office for non-audit work during the year.

Regularity of Expenditure: Losses and Special Payments

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

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

There were no individual payments that exceeded £300,000 (Period ended 31 March 2016: no payments over £300,000)

Losses Statement	**31 March 2017**		**31 March 2016**	
	No. Cases	**£000**	**No. Cases**	**£000**
Cash losses	-	-	-	-
Book keeping losses	3	-	7	-
Losses of pay, allowance and superannuation benefits	35	34	30	43
Losses of accountable stores	131	134	97	87
Fruitless payments	-	-	1	38
Claims waived or abandoned	1	20	1	-
Total	**170**	**188**	**136**	**168**

Special Payments	**31 March 2017**		**31 March 2016**	
	No. Cases	**£000**	**No. Cases**	**£000**
Special severance payments	-	-	-	-
Compensation payments	84	274	74	387
Ex gratia payments	1	1	7	13
Total	**85**	**275**	**81**	**400**

This is subject to audit.

Remote Contingent Liabilities

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

This is subject to audit.

Notation of Gifts

NHS Blood and Transplant made no political or charitable donations or gifts during the current financial year, or previous financial periods.

This is subject to audit.

The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of NHS Blood and Transplant for the year ended 31 March 2017 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 and Staff Report and the Parliamentary Accountability and Audit Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and the 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 and Transplant's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by NHS Blood and Transplant; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report and Accounts 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 report.

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 and Transplant's affairs as at 31 March 2017 and NHS Blood and Transplant's net operating expenditure for the year then ended; and

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

Opinion on other matters
In my opinion:

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

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

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

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

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

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

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

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

Sir Amyas C E Morse **Date** 5 July 2017

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 2017

	Notes	31 March 2017 £000	31 March 2016 £000
Gross Income			
Income from sale of goods and activities	2	**326,434**	332,937
Other operating income	2	**22,244**	22,546
		348,678	355,483
Expenditure			
Staff costs	3.1	**(199,403)**	(199,626)
Purchase of goods and services	3.2	**(196,178)**	(192,769)
Depreciation, amortisation and impairment changes	8 & 9	**(10,965)**	(10,143)
Other operating expenditure	3.3	**(22,447)**	(20,292)
		(428,993)	(422,830)
Net Operating Expenditure before interest		**(80,315)**	(67,347)
Finance Expense	4	**(443)**	(439)
Net Operating Expenditure after interest	2	**(80,758)**	(67,786)
Other Comprehensive Net Expenditure			
Items which will not be reclassified to net operating costs:		-	-
Net gain on revaluation of Property, Plant and Equipment	9	**7,121**	13,826
Total Comprehensive Net Expenditure		**(73,637)**	(53,960)

All income and expenditure is derived from continuing operations

Notes 1 to 23 form part of these accounts.

Statement of Financial Position as at 31 March 2017

	Notes	**31 March 2017 £000**	31 March 2016 £000
Non Current Assets			
Intangible Assets	8	**4,100**	4,999
Property, Plant & Equipment	9	**186,031**	182,594
Financial Assets	11	**173**	198
Total non-current assets		**190,304**	187,791
Current assets			
Inventories	10	**16,987**	17,662
Trade and other receivables	11	**29,345**	33,752
Cash and cash equivalents	12	**32,755**	30,548
Total current assets		**79,087**	81,962
Current Liabilities			
Trade and other payables	13	**(20,633)**	(19,697)
Provisions for liabilities and charges	15	**(3,346)**	(3,290)
Other liabilities	14 & 16	**(149)**	(133)
Total current liabilities		**(24,128)**	(23,120)
Total assets less current liabilities		**245,263**	246,633
Non-current liabilities			
Provisions for liabilities and charges	15	**(880)**	(834)
Financial liabilities	14 & 16	**(4,110)**	(4,259)
Total non-current liabilities		**(4,990)**	(5,093)
Total Assets less Total Liabilities:		**240,273**	241,540
Taxpayers' Equity			
General Fund		**171,026**	177,031
Revaluation Reserve		**69,247**	64,509
Total Taxpayers' Equity:		**240,273**	241,540

Notes 1 to 23 form part of these accounts.

The financial statements on pages 50 to 74 were approved by the Governance and Audit Committee in accordance with powers within the NHSBT Standing Orders on 23 June 2017, and are signed by the Accounting Officer, Ian Trenholm.

Ian Trenholm — Date: 26 June 2017
Accounting Officer

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

	Notes	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2015		172,252	53,033	**225,285**
Changes in taxpayers' equity for 2015/16				
Comprehensive net expenditure for the financial period		(67,786)	-	**(67,786)**
Net gain on revaluation of Property, Plant and Equipment	9.2	-	13,826	**13,826**
Transfers between reserves		2,350	(2,350)	**-**
Total recognised income and expense for 2015/16		(65,436)	11,476	**(53,960)**
Revenue Grant from Department of Health		63,415	-	**63,415**
Capital Grant from Department of Health		6,800	-	**6,800**
Balance at 31 March 2016		**177,031**	**64,509**	**241,540**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017

	Notes	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2016		177,031	64,509	**241,540**
Changes in taxpayers' equity for 2016/17				
Comprehensive net expenditure for the financial period		(80,758)	-	**(80,758)**
Net gain on revaluation of Property, Plant and Equipment	9.1	-	7,121	**7,121**
Transfers between reserves		2,383	(2,383)	**-**
Total recognised income and expense for 2016/17		(78,375)	4,738	**(73,637)**
Revenue Grant from Department of Health		65,870	-	**65,870**
Capital Grant from Department of Health		6,500	-	**6,500**
Balance at 31 March 2017		**171,026**	**69,247**	**240,273**

Statement of Cash Flows for the year ended 31 March 2017

	Notes	31 March 2017 £000	31 March 2016 £000
Cash flows from operating activities			
Net operating costs		**(80,315)**	(67,347)
Other cashflow adjustments	17.3	**11,825**	12,758
Movement in Working Capital	17.1	**5,869**	1,019
Provisions utilised	15	**(621)**	(991)
Net cash (outflow) from operating activities		**(63,242)**	(54,561)
Cash flows from investing activities			
Purchase of plant, property and equipment		**(6,168)**	(5,169)
Purchase of intangible assets		**(199)**	(1,519)
Proceeds from disposal of non current assets		**0**	9
Net cash (outflow) from investing activities		**(6,367)**	(6,679)
Cash flows from financing activities			
Grant from Department of Health		**72,370**	70,215
Capital element paid in respect of finance leases	16	**(133)**	(120)
Interest paid in respect of finance leases	4	**(421)**	(419)
Net financing		**71,816**	69,676
Net increase in cash and cash equivalents		**2,207**	8,436
Cash and cash equivalents at 31 March 2016		**30,548**	22,112
Cash and cash equivalents at 31 March 2017	12	**32,755**	30,548

NHSBT Notes to the Accounts

1. Accounting Policies

The financial statements have been prepared in accordance with the 2016/17 Government Financial Reporting Manual (FreM) issued by HM Treasury. The accounting policies contained in the FreM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the public sector as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The FreM follows EU adopted IFRSs and interpretations in effect for accounting periods commencing on or after 1 January 2015.

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

Critical judgements and key sources of estimation uncertainty

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

- Use of depreciated replacement cost is used to value land and buildings (see accounting policy note 1.5) and use of amortised cost as a proxy for fair value for intangible assets (see accounting policy note 1.6)

1.1 Accounting Conventions

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

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

1.2 Income

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

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

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

Products and services are billed in the month following delivery with the exception of Blood and Components where customers are billed a monthly contract value which is adjusted a month in arrears for actual products issued and services delivered.

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

1.3 Taxation

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

1.4 Capital Charges

The treatment of intangible assets, property, plant and equipment in the account is in accordance with the principal capital charges objective, to ensure that such charges are fully reflected in prices. The interest rate applied to calculate notional cost of capital charges during 2016/17 was 3.5% (2015/16 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 £17.3m (2015/16 £16.4m) 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 their economic value in use.

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. Professional valuers review the valuations annually on a desktop basis except for where cumulative additions since the last full valuation is greater than £2m and represent a greater than

20% increase in the net book value, in which case a full on site valuation is carried out. 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.

- Land and non-specialised buildings – depreciated replacement cost
- Specialised buildings – depreciated replacement cost

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. Valuations are reviewed annually using a combination of available indices and interim professional revaluations and, if material, the change in valuations are reflected in the accounts. The annual revaluations are carried out by the Valuation Office Agency.

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 and 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:

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

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

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

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

- Equipment assets are depreciated evenly over the expected useful life:
  - Short term equipment assets: one to five years
  - Medium term equipment assets: six to ten years
  - Long term equipment assets: eleven to twenty years

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

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

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

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

1.8 Inventories

Inventories are valued as follows:

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

- Blood products are valued at the lower of cost on a full recovery cost basis, or net realisable value, which represents the 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 Employee Benefits

Short-term employee benefits

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

Retirement Benefit Costs

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

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

Early Termination Costs

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

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

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

Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

c) Scheme provisions

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

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

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

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

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

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

1.11 Research and Development

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

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

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.12 Leases

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

NHSBT as lessee

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

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

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

1.13 Foreign Exchange

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

1.14 Provisions

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

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

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

Clinical Negligence Costs

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

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

Non-clinical Risk Pooling

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

1.15 Contingencies

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

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

1.16 Financial Instruments

Financial assets

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

NHSBT does not have any embedded derivatives.

NHSBT does not have any available for sale financial assets.

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

Other financial liabilities

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

1.17 Subsidiaries

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

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

International Accounting Standards Board has issued the following standards that have not yet been adopted by HM Treasury:

- IFRS 9 – Financial Instruments
- IFRS 14 – Regulatory Deferral Account
- IFRS 15 – Revenue from Contracts with Customers
- IFRS 16 – Leases

When the application of the standards become effective and applied, NHSBT will review for material impact on the financial statements.

2. Segmental Reporting and Reconciliation of net operating expenditure to Programme Funding from the Department of Health

For the year 1 April 2016 to 31 March 2017	Total	Blood Components (incl R&D)	Diagnostics	Tissues	Stem Cells Unit	Therapeutic Apheresis Services	Organ Donation & Transplant
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Revenue							
Provision of Products and Services	326,434	266,097	27,636	12,582	13,055	7,064	-
Income from Scottish Parliament	5,628	-	-	-	-	-	5,628
Income from National Assembly for Wales	3,785	-	-	-	-	-	3,785
Income from Northern Ireland Assembly	1,938	-	-	-	-	-	1,938
Other Income	10,893	5,867	431	-	3,905	498	192
Programme Funding from the Department of Health	65,870	-	-	-	4,173	-	61,697
Total Revenue	**414,548**	**271,964**	**28,067**	**12,582**	**21,133**	**7,562**	**73,240**
Expenditure							
Variable Costs	(58,897)	(42,354)	(5,500)	(1,643)	(3,742)	(2,274)	(3,384)
Direct Costs	(220,890)	(116,734)	(17,885)	(9,169)	(11,210)	(2,896)	(62,996)
Direct Support Costs	(96,432)	(80,530)	(3,016)	(1,910)	(3,387)	(763)	(6,826)
Movement in value of stocks	(101)	(143)	-	42	-	-	-
Other Support Costs	(43,147)	(27,498)	(3,025)	(1,453)	(2,102)	(680)	(8,389)
Total Expenditure	**(419,467)**	**(267,259)**	**(29,426)**	**(14,133)**	**(20,441)**	**(6,613)**	**(81,595)**
Operating surplus/(deficit) for the financial period	**(4,919)**	**4,705**	**(1,359)**	**(1,551)**	**692**	**949**	**(8,355)**
Add : Notional cost of capital included in expenditure above	7,323						
Less : Programme Funding from the Department of Health	(65,870)						
Less : Capital charges paid to the Department of Health	(17,292)						
Net Expenditure	**(80,758)**						

Restated for the year 1 April 2015 to 31 March 2016	Total	Blood Components (incl R&D)	Diagnostics	Tissues	Stem Cells Unit	Therapeutic Apheresis Services	Organ Donation & Transplant
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Revenue							
Provision of Products and Services	332,937	275,567	27,287	11,740	12,195	6,148	-
Income from Scottish Parliament	5,540	-	-	-	-	-	5,540
Income from National Assembly for Wales	4,602	-	-	-	-	-	4,602
Income from Northern Ireland Assembly	2,100	-	-	-	-	-	2,100
Other Income	10,304	6,282	535	-	3,106	267	114
Programme Funding from the Department of Health	63,415	-	-	-	4,273	-	59,142
Total Revenue	**418,898**	**281,849**	**27,822**	**11,740**	**19,574**	**6,415**	**71,498**
Expenditure							
Variable Costs	(61,096)	(44,474)	(5,296)	(1,721)	(3,520)	(2,015)	(4,070)
Direct Costs	(210,419)	(117,551)	(15,784)	(7,160)	(10,388)	(2,465)	(57,071)
Direct Support Costs	(90,971)	(71,609)	(5,194)	(2,506)	(3,408)	(694)	(7,560)
Movement in value of stocks	157	(109)	-	266	-	-	-
Other Support Costs *	(51,669)	(33,332)	(3,747)	(1,586)	(2,469)	(738)	(9,797)
Total Expenditure	**(413,998)**	**(267,075)**	**(30,021)**	**(12,707)**	**(19,785)**	**(5,912)**	**(78,498)**
Operating surplus/(deficit) for the financial period	**4,900**	**14,774**	**(2,199)**	**(967)**	**(211)**	**503**	**(7,000)**
Add : Notional cost of capital included in expenditure above	7,176						
Less : Programme Funding from the Department of Health	(63,415)						
Less : Capital charges paid to the Department of Health	(16,447)						
Net Expenditure	**(67,786)**						

* Prior year numbers are reinstated. Other support costs which are organisational overheads have been re-allocated across all business units including ODT. Previously costs were not allocated to ODT. This reflected how ODT was funded but not the time cost base.

2. Segmental Reporting and Reconciliation of net operating expenditure to Programme Funding from the Department of Health (continued)

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

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

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

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

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

The **Therapeutic Apheresis Services** operating unit provides a range of therapeutic apheresis services (e.g. plasma exchange, photopheresis) direct to patients.

The operating units listed above seek to recover their costs through the pricing of blood components, tissues and services to NHS hospitals, which are primarily set annually via a national commissioning process. Programme Funding from the Department of Health 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 Programme Funding from the Department of Health, along with contributions from the Devolved Health Administrations. The purpose of the unit is to identify and refer increasing numbers of potential organs donors and to increase the number of actual donors so that an increase in the number of transplants is enabled.

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

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

3.1 Staff Costs and related numbers

		31 March 2017		31 March 2016
	Total	**Permanently Employed Staff**	**Other**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	**163,985**	**151,646**	**12,339**	168,058
Social security costs	**15,293**	**14,826**	**467**	11,655
Employer contributions to NHS Pensions Agency	**20,125**	**19,511**	**614**	19,913
	199,403	**185,983**	**13,420**	199,626

The average number of employees during the year was:

	Total Number	**Permanently Employed Staff Number**	**Other Number**
Year ended 31 March 2017	**4,749**	**4,507**	**242**
Year ended 31 March 2016	4,830	4,561	269

Expenditure on staff benefits

The amount spent on staff benefits during the year is estimated at £1,412,000 (31 March 2016: £1,179,000).

3.2 Purchase of Goods and Services

	Notes	**31 March 2017**	31 March 2016
		£000	£000
Consumable supplies		**64,220**	67,049
Maintenance of buildings, plant and equipment		**19,711**	19,096
Rent and rates		**12,365**	12,040
Transport costs		**17,886**	11,008
External contractors		**26,696**	21,508
Purchase and lease of equipment and furniture		**3,650**	3,312
Utilities and telecommunications		**8,265**	7,204
Media advertising		**2,542**	3,237
ODT Scheme Payments		**22,508**	28,630
Other staff related costs		**15,760**	15,760
Professional Fees *		**2,485**	3,835
Auditor's remuneration: Audit Fees **		**90**	90
		196,178	192,769

* Professional Fees include legal and programme management costs

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

3.3 Other Operating Expenditure

	Notes	**31 March 2017**	31 March 2016
		£000	£000
Capital Charges paid over as cash to Department of Health		**17,292**	16,447
Capital Non-cash : Loss on disposal of fixed assets	7.1	**159**	201
Capital Non-cash : Impairments	7.2	**0**	-
Miscellaneous *		**4,996**	3,644
		22,447	20,292

* Amount includes £2,500k relating to IT software licence fees and £1,300k to insurance costs

4. Finance costs

	31 March 2017	31 March 2016
	£000	£000
Interest expense under finance leases	**421**	419
Other finance costs - unwinding of discount	**22**	20
Total finance costs	**443**	439

5. Operating leases

NHSBT as lessee	**31 March 2017**	31 March 2016
	£000	£000
Payments recognised as an expense		
Lease and rental payments	**9,130**	9,416
Total future minimum lease payments		
Payable:		
Not later than one year	**4,350**	4,633
Later than one year and not later than five years	**4,783**	5,449
Later than five years	**866**	450
Total	**9,999**	10,532

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

Interest of £nil was paid in relation to claims made under the Late Payment of CommercialDebts (Interest) Act 1998. No compensation payments were made under this legislation(31 March 2016: £nil interest and £Nil compensation).

7. Other gains and losses

7.1 Profit / (loss) on disposal of non-current assets

	31 March 2017	31 March 2016
	£000	£000
Loss on disposal of transport equipment	**(61)**	(4)
Loss on disposal of plant and equipment	**(98)**	(197)
Profit on disposal of information technology	**-**	-
Total	**(159)**	(201)

7.2 Impairments charged in the year to Net Operating Expenditure

	31 March 2017	31 March 2016
	£000	£000
Impairment on land and buildings for future sale	**-**	-
Impairment on development expenditure	**-**	-
Total	**-**	-

8. Intangible non-current assets

8.1 Intangible non-current assets 2016/17

	Total	**Software Purchased**	**Development Expenditure**
	£000	**£000**	**£000**
Cost			
At 1 April 2016	**17,831**	15,961	1,870
Additions - purchased	**199**	199	-
Reclassification	**0**	1,870	(1,870)
Impairments *	**0**	-	-
Disposals	**0**	-	-
At 31 March 2017	**18,030**	**18,030**	**-**
Amortisation			
At 1 April 2016	**12,832**	12,832	-
Provided during the year	**1,098**	1,098	-
Impairments	**0**	-	-
Disposals	**0**	-	-
At 31 March 2017	**13,930**	**13,930**	**0**
Net book value at 1 April 2016	**4,999**	3,129	1,870
Net book value at 31 March 2017	**4,100**	**4,100**	**-**
Net book value at 31 March 2017 comprises:			
Purchased	**4,100**	4,100	-
Asset Financing	**4,100**	**4,100**	**-**
Revaluation Reserve	**56**	**56**	**-**

8.2 Intangible non-current assets 2015/16

	Total	**Software Purchased**	**Development Expenditure**
	£000	**£000**	**£000**
Cost			
At 1 April 2015	**16,312**	**15,059**	**1,253**
Indexation	**0**	-	-
Additions - purchased	**1,519**	322	1,197
Disposals	**0**	-	-
Reclassification	**0**	580	(580)
Impairments *	**0**	-	-
At 31 March 2016	**17,831**	**15,961**	**1,870**
Amortisation			
At 1 April 2015	**11,984**	11,984	-
Provided during the year	**848**	848	-
Disposals	**0**	-	-
At 31 March 2016	**12,832**	**12,832**	**-**
Net book value at 1 April 2015	**4,328**	3,075	1,253
Net book value at 31 March 2016	**4,999**	**3,129**	**1,870**
Net book value at 31 March 2016 comprises:			
Purchased	**4,999**	3,129	1,870
Asset Financing	**4,999**	**3,129**	**1,870**
Revaluation Reserve	**85**	**85**	**-**

9. Property, plant and equipment

9.1 Property, plant and equipment 2016/17

	Total	Land	Buildings	Land and Buildings identified for future sale	Assets under con-struction	Plant and Machinery	Transport Equipment	Information Technology
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2016	**242,534**	23,437	144,211	2,800	1,650	51,075	1,910	17,451
Additions - purchased	**6,342**	-	249	-	2,560	3,331	-	202
Reclassification	**0**	-	-	-	(547)	-	-	547
Indexation	**4,294**	-	-	-	-	4,233	61	-
Other in year revaluations	**(811)**	190	(551)	(450)	-	-	-	-
Disposals	**(5,759)**	-	-	-	-	(4,366)	(1,382)	(11)
At 31 March 2017	**246,600**	**23,627**	**143,909**	**2,350**	**3,663**	**54,273**	**589**	**18,189**
Depreciation:								
At 1 April 2016	**59,940**	-	4,862	-	-	38,391	1,549	15,138
Provided during the year	**9,867**	22	5,571	-	-	3,340	149	785
Indexation	**3,232**	-	-	-	-	3,182	50	-
Other in year revaluations	**(6,870)**	(22)	(6,848)	-	-	-	-	-
Disposals	**(5,600)**	-	-	-	-	(4,268)	(1,321)	(11)
Accumulated depreciation at 31 March 2017	**60,569**	**-**	**3,585**	**-**	**-**	**40,645**	**427**	**15,912**
Net book value at 1 April 2016	182,594	23,437	139,349	2,800	1,650	12,683	361	2,314
Net book value at 31 March 2017	**186,031**	**23,627**	**140,324**	**2,350**	**3,663**	**13,628**	**162**	**2,277**
Net book value at 31 March 2017 comprises:								
Owned assets	**159,178**	19,892	117,206	2,350	3,663	13,628	162	2,277
Subsequent expenditure on or relating to assets acquired under a Finance Lease	**20,068**	-	20,068	-	-	-	-	-
Held on Finance Lease	**6,785**	3,735	3,050	-	-	-	-	-
	186,031	**23,627**	**140,324**	**2,350**	**3,663**	**13,628**	**162**	**2,277**
All assets are purchased assets.								
Revaluation Reserve	**69,191**	**9,745**	**58,515**	**-**	**-**	**905**	**26**	**-**

9.2 Property, plant and equipment 2015/16

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

10. Inventories

	31 March 2017 £000	31 March 2016 £000
Raw materials and consumables	**4,525**	5,098
Work in progress	**3,795**	3,412
Finished processed goods	**8,667**	9,152
	16,987	17,662

11. Trade and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
NHS Receivables - Revenue	**15,012**	20,031
Non NHS Trade Receivables - Revenue	**4,971**	4,118
Provision for impairment of Receivables	**(12)**	(28)
Other Debtors	**135**	145
VAT	**2,736**	2,753
Prepayments and accrued income	**6,503**	6,733
Subtotal	**29,345**	33,752
Non Current		
Other prepayments and accrued income	**173**	198
Subtotal	**173**	198
Total trade and other receivables	**29,518**	33,950

Provision for irrecoverable debts

Amounts falling due within one year	2016/17 £000	2015/2016 £000
Non - NHS trade receivables		
At 1 April	**28**	25
Provided in year	**5**	21
Written off during year	**(5)**	(4)
Recovered during year	**(16)**	(14)
At 31 March	**12**	28
Aging of debts provided against		
Up to 12 months	**3**	8
Over 12 months	**9**	20
	12	28
Receivables and other debtors past due but not impaired		
Upto 3 months	**8,064**	11,679
Between 4 and 12 months	**1,690**	2,232
Over 12 months	**298**	156
	10,052	14,067

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

	2016/2017	2015/2016
	£'000	£'000
Balance at 1 April	**30,548**	22,112
Net change in the year	**2,207**	8,436
Balance at 31 March	**32,755**	30,548
Comprising:		
Held with Government Banking Services accounts	**32,754**	30,547
Cash in hand	**1**	1
Cash and cash equivalents as in Statement of cash flows	**32,755**	30,548

13. Trade and other payables

	31 March 2017	31 March 2016
Current	**£000**	£000
NHS Payables - revenue	**3,091**	3,454
Non-NHS trade Payables - revenue	**1,673**	1,079
Non-NHS trade Payables - capital	**464**	290
Tax and Social Security Costs	**10**	7
Accruals and deferred income	**15,395**	14,867
Total trade and other payables	**20,633**	19,697

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

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

	PAYE and NI Liabilities	Employee Benefits	Redundancy	Product Liability and	Total
At 31 March 2017	**£000**	**£000**	**£000**	**£000**	**£000**
Balance at 1 April 2016	293	880	2,277	674	**4,124**
Provisions - Arising in the year	293	74	2,314	382	**3,063**
Utilised during the year	-	(49)	(397)	(175)	**(621)**
Reversed unused	(293)	-	(1,880)	(189)	**(2,362)**
Unwinding of discount	-	22	-	-	**22**
Balance at 31 March 2017	**293**	**927**	**2,314**	**692**	**4,226**
Expected timing of cash flows:					
Within 1 year	293	47	2,314	692	**3,346**
Between 1 year and 5 years	-	201	-	-	**201**
Thereafter	-	679	-	-	**679**
	293	**927**	**2,314**	**692**	**4,226**

15. Provisions for liabilities and charges (continued)

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

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

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

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

£8,475,000 (31 March 2016: £5,455,000) is included in the provisions of the NHS Resolution (formely known as NHS Litigation Authority) at 31 March 2017 in respect of clinical negligence liabilities relating to NHSBT. There is £nil provision in respect of the existing liabilities scheme (31 March 2016: £47,000).

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16. Finance leases

Finance lease obligations (ie as lessee)

	Minimum lease payments	
	31 March 2017	31 March 2016
	£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	**8,593**	9,147
	11,363	11,917
Less future finance charges	**(7,104)**	(7,525)
Present value of future lease obligations	**4,259**	4,392

	Present value of minimum lease	
	31 March 2017	31 March 2016
	£000	£000
Not later than one year	**149**	133
Later than one year and not later than five years	**790**	707
Later than five years	**3,320**	3,552
Present value of future lease obligations	**4,259**	4,392
Analysed as :		
Current borrowings	**149**	133
Non-current borrowings	**4,110**	4,259
	4,259	4,392

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 2017 £000	31 March 2016 £000
(Decrease)/Increase in receivables within 1 year (note 11)	**(4,407)**	(416)
(Decrease) in receivables after 1 year (note 11)	**(25)**	(543)
Increase/(Decrease) in inventories (note 10)	**(675)**	838
Decrease/(increase) in payables within 1 year (note 13)	**(936)**	(229)
Subtotal	**(6,043)**	(350)
Decrease/(Increase) in payables relating to items not passing through the Statement of Comprehensive Net Expenditure (note 13)	**174**	669
Subtotal	**174**	669
Total	**(5,869)**	(1,019)

17.2 Analysis of changes in net debt

	As at 1 April 2016 £000	Cash flows £000	As at 31 March 2017 £000
Government Banking Services cash at bank	30,547	2,207	**32,754**
Commercial cash at bank and in hand	1	0	**1**
Total	**30,548**	**2,207**	**32,755**

17.3 Other cashflow adjustments

	31 March 2017 £000	31 March 2016 £000
Depreciation (note 9)	**9,867**	9,295
Amortisation (note 8)	**1,098**	848
Impairments (note 7.2)	**0**	-
Loss on disposal (note 7.1)	**159**	201
Provisions - Arising in Year (note 15)	**3,063**	3,044
Provisions - Reversed unused (note 15)	**(2,362)**	(630)
Total	**11,825**	**12,758**

18. Contingent Liabilities at 31 March 2017

A contingent liability of £128,000 (31 March 2016: £126,000) relates to potential costs associated with donor claims, personal injury claims, and other employee liability and public liability claims.

A contingent liability of £1,425,000 (31 March 2016: £1,425,000) 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 2017

At 31 March 2017 the value of contracted capital commitments was £534,000 (31 March 2016 : £197,000).

20 Losses and special payments

20.1 Losses Statement

	31 March 2017		31 March 2016	
	No. Cases	**£000**	**No. Cases**	**£000**
Cash Losses	**-**	**-**	-	-
Book keeping Losses	**3**	**-**	7	-
Losses of pay, allowances and superannuation benefits	**35**	**34**	30	43
Losses of Accountable Stores	**131**	**134**	97	87
Fruitless Payments	**-**	**-**	1	38
Claims waived or abandoned	**1**	**20**	1	-
	170	**188**	136	168

20.2 Special Payments

	31 March 2017		31 March 2016	
	No. Cases	**£000**	**No. Cases**	**£000**
Special Severance Payments	-	-	-	-
Compensation Payments	**84**	**274**	74	387
Ex Gratia Payments	**1**	**1**	7	13
	85	**275**	81	400

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

21. Related parties

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 £389 million of income (31 March 2016: £391 million), including capital funding and Programme Funding from the Department of Health, and £32 million of expenditure (31 March 2016: £48 million), which represented trading with 247 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 K Rigg (NED)	: Nottingham University Hospital NHS Trust, Consultant Surgeon	5,645	313
Mr K Rigg (NED)	: NHS England, Chair of Renal Transplant Clinical Reference Group	2,928	-

* NED - Non-Executive Director

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

In accordance with IAS 27 the NHS Blood and Transplant Trust Fund and the NHS Pension scheme are regarded as a related party. Income received from the Trust Fund during the year totalled £113,000 (31 March 2016 : £235,000), and there was a debtor balance due by the Trust Fund of £112,000 (31 March 2016 : £305,000).

22. Events after the reporting period

In accordance with the requirements of IAS 10 events after the reporting period are considered up to the date on which the accounts are authorised for issue. This is interpreted as the date of the Certificate and Report of the Comptroller and Auditor General. There were no material post balance sheet events. On 18th April 2017 it was announced a General Election is to be held on 8th June 2017. NHS Blood and Transplant have concluded that, in our opinion, there are unlikely to be any material impacts on the operations of NHS Blood and Transplant as at the time of signing the accounts.

23. Financial Instruments

Financial risk management

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

Liquidity risk

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

Capital expenditure costs are financed from a Capital Allocation from the Department of Health 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.

ISBN 978-1-4741-4233-5