NHS
Blood and Transplant

NHS Blood and Transplant
Annual Report and Accounts 2017/18

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 2 July 2018

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CONTENTS – THE ANNUAL REPORT AND ACCOUNTS 2017/18

THE PERFORMANCE REPORT

THE ACCOUNTABILITY REPORT

THE FINANCIAL STATEMENTS

PERFORMANCE REPORT

I hereby sign the Performance Report from pages 1 to 18.

Ian Trenholm
Chief Executive and Accounting Officer

Date: 18 June 2018

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

During 2017/18 we have continued to make very strong progress against the strategic goals outlined in **Taking Organ Transplantation to 2020** and have supported the four UK Governments in delivering another record year for the number of deceased organ donors and deceased organ transplants in the UK. We have also made further progress in the strategies across our Diagnostic and Therapeutic Services Division that have seen its income grow by 8% this year, reflecting an increase in the number of patients with complex conditions being supported.

In Blood we faced the challenges presented by the ongoing decline in demand for red cells, low blood stocks over the winter and the implementation of the Core Systems Modernisation project (CSM) that is designed to replace the Pulse system that underpins the collection, processing and delivery of Blood. Underlying this, good progress has continued to be made, with strong performance against our operational and service targets. We have also delivered a number of major projects including consolidating of our manufacturing sites from five to three, closure and disposal of our Brentwood Site and the approval and commencement of work for a new centre in Barnsley to replace our existing centres in Leeds and Sheffield

The investment in the CSM programme described above has been planned over a number of years and is being funded from accumulated cash reserves. In February 2018 the CSM Programme Board were informed that the CSM business case could not be delivered within cost or timescale. Subsequently a revised business case is being developed proposing that the programme be rescheduled for delivery over a longer period of time (see pages 12,15, 29, 31 and 33 for more information). The income and expenditure deficit in 2017/18, and potentially the next 4-5 years, are driven by the investment in CSM and are consistent with our plans and expectations. NHSBT's financial position remains robust and that we continue to report trading results that are in line with our projections.

I would 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 2017/18 possible. I am grateful for their ongoing support in helping NHSBT deliver its strategies and its associated transformation programme over the years. As I leave NHSBT in July 2018 I look forward to seeing the NHSBT team go from strength to strength, saving and improving even more lives.

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 28,000 units of blood are collected every week via a network of fixed sites and mobile blood collection teams. The blood is processed in three 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. This includes:

- ***Tissues 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 hematopoietic 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 is the UK's largest single provider of Therapeutic Apheresis Services. Services provided include extracorporeal photophoresis, plasma and red cell exchange, peripheral blood cell stem collection and low-density lipid removal.

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.

Principal Risks and Uncertainties

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

Business Continuity
NHSBT is the sole supplier in England of short shelf life biological products (e.g. blood). The supply of products and services could be severely impacted by loss of a key facility, such as Filton or Speke, or loss of a critical IT platform i.e. Pulse in Blood, Haematos in DTS, and the Electronic Offering System (EOS) and National Transplant Database (NTxD) in ODT. Any sustained business outage would have a material impact on the NHS and its patients.

Blood – Execution of the CSM Programme
The Blood supply chain is critically dependant on the Pulse blood management system. The system is around 20 years old and comprises a collection of old technologies (hardware, operating system, database technology and application language) and its maintenance and support is critically dependent on a small, but longstanding, partner.

The Core Systems Modernisation (CSM) programme has been established to replace Pulse with a Microsoft Dynamics platform. This is a major programme and is the largest and most complex change programme ever undertaken by NHSBT. As with any programme of this scale there are considerable risks arising out of the challenges of understanding the various dependencies in existing systems and our ability to accurately quantify costs and timescales (see pages 12,15, 29, 31 and 33 for more information).

Transcription Error Resulting in Harm to Patients
Within the NHS clinical pathways that NHSBT supports there are numerous “hand offs” and, within NHSBT, ongoing use of certain paper based and verbal processes. This is particularly prevalent within the organ donation and transplantation pathway as well as in the provision of our diagnostic testing services. Although mitigated by extensive control checks there remains a residual risk that these are ineffective and result in transcription errors that could cause serious harm to NHS patients.

Blood – Differential Demand Trends
The demand for red cells has been decreasing over the last 5 years and the trend is expected to continue over the medium term. At blood group level, however, we are seeing differential demand trends for “universal” components (O negative red cells and A negative platelets) and increasing demand for specific components e.g. R_o red cells (see page 30 for more detail). This results in a significant and increasing challenge for NHSBT, as we look to reduce overall blood collection capacity to match reducing overall demand (e.g. through fewer / larger collection sessions), but without losing the donors needed for the specific components where demand is not declining (or is indeed increasing).

Blood – Management of Donor Iron Levels
A recent study (INTERVAL) identified that some donors (5% of men and up to 14% of women) are being accepted with lower haemoglobin results than regulatory limits. For most donors this is not a

clinical concern as the results are only just below this level. However, 1.1% male and 2.8% female donors had levels that implied they were anaemic prior to donating, albeit being seen to be "healthy". More importantly approximately 0.1% donors were accepted with significantly low haemoglobin results. A subsequent study (COMPARE) was immediately devised to establish the optimal method of haemoglobin screening. Following this we have improved our processes for screening donors and, through a pilot of 5000 donors, have demonstrated that the above risks are mitigated. We are currently in the processes of rolling out these changes nationally. However, there remains a risk of making donors iron deficient through regular donation that most international services are trying to understand fully. There remains a risk that we will need a different process for testing donors in the future that gives us an understanding of donor's iron levels. The most effective method of this is now being explored. The risk is that a new process will cost more and that donors may need longer intervals between blood donation. This will mean that we need to recruit more donors as a result, which will cost money.

Mitigations and controls regarding the above risks are considered in the Governance Statement at page 25.

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. Even amongst our international peers NHSBT is unusual in that the supply of blood, organs, stem cells and tissues is provided by the one national organisation. To deliver this NHSBT operates a Divisional structure comprising:

- Blood
- Organ Donation and Transplantation (ODT)
- Diagnostic and Therapeutic Services (DTS)

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 key outcome with regard to efficiency is the price of red cells, which was reduced from £140/unit in 2007/08 to £120/unit in 2016/17, driven by a reduction of excess capacity in the supply chain and significant operational improvements. Since 2016/17 prices have increased, partially because of ongoing decline in demand for red cells, but the total cost of blood supply to the NHS has continued to reduce. At present, however, the trend in demand decline has gone significantly beyond what was anticipated in the Blood 2020 strategy. In addition, the status of CSM programme, and other issues such as the demand for R_o red cells were also not anticipated by the strategy. A new strategy for Blood is therefore now required. This will be developed during 2018/19.

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. 2017/18 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 services 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 recruiting 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.

NHSBT has developed a unique national infrastructure to facilitate bone marrow transplantation and can use this infrastructure to support the development of next generation stem cell therapies which use stem cells and bioactive molecules to regenerate tissues ('regenerative medicine') and to selectively destroy cancerous cells ('cancer vaccines') and viruses. NHSBT can provide the donor stem cells and

bring strengths in specialist manufacturing, regulatory expertise, distribution and Research & Development (R&D) to support the developing regenerative medicine industry. This includes the operation of the Clinical Biotechnology Centre (CBC) in Bristol which has unique capabilities in small volume manufacture of plasmids/gene therapy vectors for use in early stage clinical trials.

Corporate

To support our strategic business units we operate an R&D programme, leadership development, corporate social responsibility and provide 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, for example, 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 programmes 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’. We set ourselves 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. Sustainability Report detailing the targets can be found on page 13.

Our corporate functions are committed to continuous improvement in the effectiveness and efficiency of back office functions and benchmark them against comparable organisations. We continue to engage with government and departmental plans for shared support services.

Operating Review

Key Performance Headlines 2017/18

Blood

2017/18 has been a very challenging year due to:

- Ongoing decline in the demand for red cells and so the need to reduce capacity and associated cost across the blood supply chain;
- Despite overall demand declining the impact of flat or increasing demand for universal or special components e.g. O- red cells, A- platelets, R_o red cells (see page 30 for more information);
- The impact of the CSM programme to replace the Pulse system that supports the collection, processing and distribution of blood (see pages 12,15, 29, 31 and 33 for more information).

The impact of the first two issues has resulted in an insufficient number of active donors of the right type and in the right location (i.e. consistent with where our collection capacity is deployed) to meet demand and, in turn, was a primary driver for very low red cell stock levels between December 2017

and March 2018. Stocks are now building and investment is in place to increase the number of active blood donors.

In February 2018 the CSM Programme Board identified that NHSBT would not be able to deliver the business case for the project (regarding both cost and timescale). A revised approach is being developed and a new business case will be presented to the NHSBT Board in 2018. (see pages 12,15, 29, 31 and 33 for more information).

ODT
There were 1,575 deceased donors in 2017/18 11.5% higher than in 2016/17 (1,413). As a result there were 4,035 deceased transplants in 2017/18 and therefore an 8.7% increase in the number of patients in the UK that received a life-saving transplant over 2016/17. This sets new annual records for the number of deceased donors and the number of deceased transplants in the UK.

DTS
Income in 2017/18 at £75.0m (2016/17 £69.3m) was 8.2% higher than last year. This was driven by strong growth in Therapeutic Apheresis Services (up 31%), RCI (up 14%) and Cellular and Molecular Therapies (up 8%).

Further detail is provided below.

Blood
We continue to see decline in demand for red cells with issues of 1.443 million units in the year, 4.9% lower than 2016/17, but broadly in line with plan. We were encouraged to see that demand for O negative red cells (the "universal" type) continued to fall during the year although, due to substitution by NHSBT, the proportion of O negative red cells issued by NHSBT increased to 13.4% (versus 13.1% in 2016/17). This compares to 7% of the population who are O negative. The increasing need to substitute O negative red cells is primarily driven by a shortage of group R_o red cells, where growth in demand of around 15% p.a. is currently being seen. The shortage primarily derives from NHSBT having an insufficient number of black donors who are more likely to have R_o blood. During 2017/18 NHSBT developed plans to triple the number of new black donors over the following 3 years.

Despite declining demand, we entered December 2017 with lower red cell stocks than planned, both at total level and in the "vulnerable" blood groups (primarily O negative and B negative). Blood stock levels remained under pressure over the winter period and, following adverse weather in early March 2018, they fell to unprecedented levels of around 17,000 units (around 3.5 days of stock) during the month with O negative and B negative falling below 3-day alert levels for a number of days. One of our key performance indicators is the number of times that any red cell blood group falls below a three-day alert level for a consecutive period of three days or more. This happened on 10 occasions during 2017/18 (versus none in 2016/17) with 8 of these occurring in March.

The underlying cause for the low blood stock position was low blood collection levels in the run up to December 2018 and we therefore entered the winter period with lower stocks than planned. This, in turn, arose on the back of a lower number of active blood donors than needed to meet demand and a generally adverse performance in donor retention. We are pleased to note that collection performance has been much improved during April 2018 and stocks are now above 25,000 units, although O negative and B negative remain vulnerable to spikes in short term demand. We have also substantially added to our investment in donor marketing to increase overall donor numbers but especially the number of black donors and donors in the O negative and B negative groups.

Despite the low stocks delivery performance remained strong with "on time in full delivery" (OTIF) to hospitals at 96.9% before substitution (primarily by O negative red cells) versus our target of 97.0% and a healthy improvement on the 95.9% recorded last year. In addition:

- Regarding safety there were no Serious Incidents (SIs) during the year and no adverse trends in the reporting of adverse events following transfusion.

- Donor satisfaction at 77.2% (measured as the percentage of donors scoring 9 out of 10 or higher for overall service) was consistently at or above the target level of 75% and higher than the 75.6% seen in 2016/17.

- From a customer perspective, hospital satisfaction with NHSBT's service fell during the year from over 80% to 66% (measured as the percentage of customers scoring 9 out of 10 or higher for overall service) in part reflecting the availability of specific components.

Regarding regulatory performance we were disappointed to record seven "major" regulatory non-compliance following regulatory inspection by the Medicines and Healthcare Products Regulatory Agency (MHRA) during the year, versus the one "major" reported in 2016/17. The seven major non-compliances related to an aggregation of smaller Good Manufacturing Practice (GMP) issues that were raised across a number of sites that were inspected during the year. Work is ongoing to improve performance and meet our aspiration of recording zero major or critical non-compliances during any inspection.

In addition, we continue to manage the ongoing demand decline for red cells, through delivering further efficiency improvement. Although NHSBT will increase red cell prices to £128.99/unit in 2018/19, due to further demand decline, the total cost of red cells to the NHS in 2018/19 is expected to be the same as 2017/18. The ongoing reduction in demand continues to be the primary challenge in Blood, and continuing to remove fixed capacity at the same rate as demand decline is becoming increasingly difficult. In the recent past NHSBT has closed excess capacity in processing and testing and closed a further two processing sites (Sheffield and Newcastle) during 2017/18. As a result, we can demonstrate world class productivity levels in these areas and blood prices that are amongst the lowest in the developed world. This outcome has been supported by productivity improvement in blood donation, 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 which represents around 40% of the cost of a red cell. 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 overall are needed to meet lower demand we need to differentially maintain the number of O negative and B negative donors, and significantly increase the number of black donors.

As can be seen in the collection performance prior to winter, and the low stock position that was then seen, getting the balance right between capacity reduction but maintaining donor collection levels of the rarer types is critical. In these circumstances, we are pleased that donor satisfaction remains high but the near-term outlook for productivity is adverse given the need to both increase investment in donor marketing and maintain capacity so that we can continue to bring through the donors that we need.

Organ Donation and Transplantation (ODT)

We are delighted to report an 8.7% increase the number of patients in the UK that received a life-saving transplant over 2016/17. We are immensely grateful to the 1,575 people and their families who agreed to donate their loved one's organs in 2017/18 (11.5% higher than in 2016/17), giving us 4,035 organs to save other people's lives. These results have again set new records for transplants in the UK.

At these levels we are also broadly at the targets that were established by the 'Taking Organ Transplantation to 2020' strategy. The targets increase significantly, again, in 2018/19 and 2019/20 but the results of the last two years provide us with great confidence that we can be at, or close to, the challenging aspirations set by the strategy.

Around 1.24 million new (opt in) registrants were officially added to the Organ Donor Register (ODR) in 2017/18, better than target and last year (both 1.1 million). A new ODR was implemented in 2015/16 to support the introduction of the Human Transplantation (Wales) Act 2013, which introduced a system of "soft opt out" for organ and tissue donation in Wales from 1 December 2015. The register now supports the opt out arrangements in Wales, alongside the opt in arrangements that apply elsewhere in the UK and, at the end of 2017/18, there were around 510,000 opt-out registrations (versus 230,000 as at 1 January 2018).

During the year ODT commenced the third year of the ODT Hub Programme. This is an ambitious £10m project with a vison to provide "*a simpler, safer and responsive service that supports clinicians in matching world class performance in organ donation and transplantation, with a clinically led 24/7 support centre at its core and renewed technology as its foundation*". The project continues to go well delivering against both its business case cost and implementation targets. Of particular note, a new liver allocation scheme for the UK was implemented during March 2018, to add to the implementations already delivered i.e. a heart, lung, liver and intestinal offering scheme, opening of the ODT Hub office in Bristol, centralisation of all organ offering and a single referral line for deceased organ donation.

Diagnostic and Therapeutic Services (DTS)

Activity in DTS during 2017/18 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 enable NHSBT to offer future price reductions or to fund the development of new therapies for patients.

The outcome of this approach can most obviously be seen in **Therapeutic Apheresis Services where** income growth of 32% was seen as a result of opening new, hospital based centres, that supported consolidation of activity within NHSBT from other parts of the NHS.

Growth of 17% was also seen in **RCI**, 14% in **Cellular and Molecular Therapies** and 7% in **Tissue and Eye Services** resulting in overall growth of 8.2% overall for DTS (to £75m, including both invoiced sale and income from the Department of Health and Social Care (DHSC) in support of stem cell donation / cord blood banking).

Progress continued to be made with building the NHS Cord Blood Bank which, at the current run rate, is on course to have the targeted 20,000 clinically effective units by September 2019. Cord donations from black and multi-ethnic communities were ahead of target with 42% of cords banked from these communities, versus 40% planned. It was, therefore, disappointing that there were only 47 cord issues in the year (versus a target of 75 and 62 issued last year) with International issues 5 below plan and UK issues 23 below. Offsetting this, however, adult donor provisions from the British Bone Marrow Registry were higher than plan at year end with 243 versus a target of 216 (and 211 last year).

Across the DTS portfolio there 5 "major" regulatory non-compliances (versus 1 reported in DTS during 2016/17). All five non-compliances were as a result of an inspection at the Advanced Therapies Unit in Birmingham and we are working closely with the MHRA to put a corrective action plan in place.

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 70% (versus the 71% 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 97% positive in the last survey in December 2017 (versus 93% in the previous 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 2017/18 we:

- Completed the COMPARE study to evaluate new approaches to haemoglobin screening of blood donors. The results of this study have been used to inform changes to how we measure haemoglobin in specific groups of donors;
- Investigated emerging infections, with a focus on Hepatitis E virus;
- Completed recruitment to clinical trials of platelet transfusion triggers in neonates and HLA-matching of platelets;
- Recruited organ donors to the Quality in Organ Donation (QUOD) study to support a National BioBank of over 2,500 individuals. We were also successful in obtaining external funding to expand the remit of this BioBank;
- Used novel gene-editing technologies (CRISPR-CAS9) to develop exciting new diagnostic reagents;
- 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;
- Published the results of our research in 250 scientific papers in International journals;
- 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;

Financial Review

NHSBT is required to report on a ***Net Expenditure*** basis with programme funding provided by the DHSC 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 of £10.2m in 2017/18 compared to a £4.9m deficit in 2016/17 and a budgeted deficit of £13.8m.

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.

Consistent with its constitution NHSBT would normally be required 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, and especially the CSM programme, NHSBT has, through price management and prior year surpluses, generated an internal cash balance to fund the

investment. 2017/18 was due to be the second year (of four) when the non-recurring cost of the investment would put NHSBT into a planned deficit funded by our cash reserves. NHSBT ended the year with cash of £23.5m (see note 10 in the financial statements). It was originally anticipated that this would be used to fund future deficits over the next two years, driven by the timeline set by the original CSM business case, before returning to a planned small surplus position.

The planning position has, however, changed due to the different approach that will now be taken to the CSM programme. The business case for CSM was approved in July 2016 at a cost of £25m. In November 2017 it was identified that the programme would cost materially more than the approved business case. In February 2018 the CSM Programme Board was notified that the project could not meet its planned timelines and confirmed that the cost would therefore be significantly higher than even the indications made in November. A revised approach was presented to the Board in March 2018 and a new business case is now being developed for the Board. The revised approach proposes a "longer / thinner approach" with the higher cost spread over four to five years (see pages 15, 29, 31 and 33 for more information). From a financial perspective this implies that the spend in 2018/19 will now be much lower than planned but it implies a longer period of planned, albeit smaller deficits as the longer, thinner programme progresses. As a result, the current assumption is that NHSBT may not return to a balanced position for 4-5 years hence, although it continues to retain the cash reserves to fund the deficits that are planned.

NHSBT receives most of its income through the prices of blood components (based on cost) charged to NHS Hospitals. This income was £260.7m in 2017/18 (2.0% lower than the £266.1m recorded in 2016/17). The lower income seen in 2017/18 arose primarily from the ongoing decline in the demand for red cells, with demand 4.9% lower than the previous year, offset partially by a price increase of around 2% (excluding the impact of testing of HEV which became a test performed on all red cells in April 2017).

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 this amounted to £66.3m in the year (£60.3m in 2016/17). As noted in the Operating Review above the income growth in DTS was particularly driven by growth in TAS (+32%), RCI (+17%), CMT (+14%) and TES (+7%).

In addition to income from the sales of products and services the DHSC provided programme funding of £66.1m for the year (£65.9m in 2016/17). £61.9m of this (£61.7m in 2016/17) was allocated to Organ Donation and Transplantation with £3.9m funding the development of the NHS Cord Blood Bank (£4.2m in 2016/17). NHSBT also received contributions in the year of £11.8m from the devolved UK Health Departments to fund our UK wide activities in Organ Donation and Transplantation (compared to £11.4m in 2016/17).

We additionally received £10.0m of "other" income (£10.9m in 2016/17) for cost recovery of services provided. £5.3m 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) (£5.9m 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 £10.2m in the year (versus a £4.9m deficit in 2016/17), lower than the deficit of £13.8m that was originally planned and budgeted. This deficit includes a £2.35m accounting loss on transfer of the Brentwood property to Homes England in June 17 for which no consideration was received (See Note 3.3 Loss on Disposal of Fixed Assets). The segmental analysis in Note 2 identifies operating deficits of £4.5m for Blood (£4.7m surplus in 2016/17) and £7.4m for ODT (£8.4m deficit in 2016/17) offset by a £1.7m surplus in DTS (£1.3m deficit in 2016/17).

The higher deficit in Blood was driven by increased transformation costs, especially regarding the CSM programme on which £14.8m was spent in 2017/18 (£7.0m in 2016/17).

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 £74m now, was provided on a marginal cost basis. This did not fund the group services provided by NHSBT to ODT. The full cost is now reflected in our activity based cost model and hence implies an underlying cross subsidy from Blood and DTS to ODT of around £9m. Due to the nature of our income and funding models this is unlikely to change materially over the foreseeable future.

The surplus in DTS of £1.7m in 2017/18 comprises surpluses across most of the business units with the exception of a £2.4m deficit in Tissue and Eye Services. The surpluses reflect the growth in income seen across the businesses and hence a growth in contribution. The deficit in TES has become more persistent and, whereas we had expected the unit to grow into surplus, price rises will probably now be required to close out the deficit.

NHSBT spent capital of £6.7m, on a cash basis, in 2017/18 funded by the DHSC, versus £6.5m in 2016/17. Much of this was 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, net assets decreased marginally from £240.3m at March 2017 to £240.1m at March 2018 with cash decreasing from £32.8m to £23.5m. The cash balance has arisen over recent years from cumulative surpluses retained to fund the investments in the CSM Programme that we are now undertaking. It is expected that much of this cash will be utilised on CSM over the next five years.

NHSBT is the corporate trustee for NHSBT Trust Funds. The total net assets of the trust funds as at 31 March 2017 were £0.316m (compared to £0.439m in March 2016). The 2017/18 Trust Fund Accounts will be published in December 2018. Although the Trust Fund assets are controlled by NHSBT a consolidated account is not produced due to their lack of materiality. The 2016/17 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 2018. For full details refer to note 15 contingent liabilities in the financial statements.

Sustainability Report

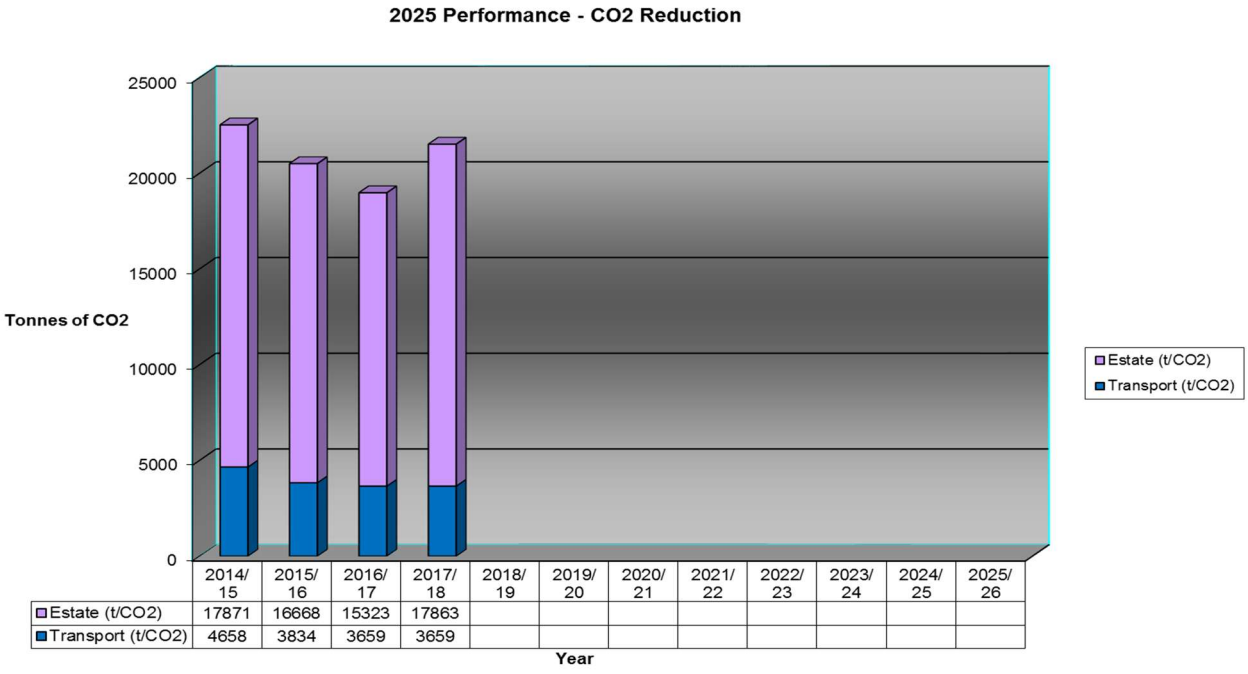
In February 2017 NHSBT launched its 2015-2025 Sustainability Strategy which includes the following objectives:

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

The strategy was developed and is owned by NHSBT's Executive Team, with the Finance Director having Board level responsibility. This continuation of top level leadership has proven to deliver significant results in sustainability since 2010, and will build on the high level of success and progress previously made. In support of this a Sustainable Development Group (SDG) has been established to drive the programme and review performance and risks.

To date, NHSBT has achieved a 5% CO2 saving against the 2014/15 baseline although performance dropped 12% in 2017/18 compared to the prior year (see the chart below). The reduced performance

was related to increased consumption of electricity within NHSBT, in part due to increased activity and growth in DTS driving a greater demand for environmental cooling. Work is underway to better understand future energy consumption trends within our operating areas and to identify plans to mitigate the increased CO2 production.



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Estate (t/CO2)	17871	16668	15323	17863								
Transport (t/CO2)	4658	3834	3659	3659								

Environmental

NHSBT was recertified to the revised ISO14001:2015 environmental management standard, within 2017/18. The Sustainability and Procurement teams have also been working to align their processes to ISO20400 – sustainable procurement. Assessment to this standard will be completed in the second quarter of 2018/19.

Highlights of the last twelve months work include:

- Work has begun on the new Barnsley Centre using BREEAM sustainable building methodology. The organisation is on track to meet its objective to achieve an 'Excellent' rating for this project.

- Alignment of the environmental management system and risk assessment process with the corporate risk management system. This piece of work will be completed during quarter 2-3 of 2018/19 and will allow NHSBT to meet the objective of having 'a resilient business'.

- A Cold Chain Group has been initiated, which is working to reduce the CO2 output from the extensive use of fridges and freezers across the organisation.

- The appointment and training of Sustainability Champions across NHSBT, which has allowed ideas from employees to be captured and implemented, as well as, a greater level of communication on sustainability issues.

- Feasibility studies regarding the installation of solar power generation on NHSBT sites.

- Training with Transport and Estates & Facilities, on all sites, regarding the management of fuel spillages. This completes a piece of work to mitigate the risks from fuel storage on NHSBT controlled sites.

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 £124.46/unit in 2017/18 (a reduction in the cost of red cells to the NHS of £80m 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 core business systems. As a result, our programme now includes two major IT programmes (funded through revenue) plus the recent addition of two significant capital projects as below:

- **Core Systems Modernisation (CSM)**
  The CSM project aims to introduce a Microsoft Dynamics 365 platform in Blood to underpin the blood supply chain from donor management through manufacturing and processing and on to hospital delivery and stock management, and ultimately to replace the Pulse system that currently supports these processes. As noted elsewhere the project has encountered significant challenges and will exceed the cost and timeline described in the original business case. The Board therefore agreed that a revised approach to the CSM Programme was required and that a new business case should be developed. In lieu of this the NHSBT Board has approved expenditure of £3.8m in the first 6 months of 2018/19 as part of a proposed spend of £8.8m for the full year (see pages 29, 31 and 33 more information).

- **ODT Hub**
  The objective of the ODT Hub project is to introduce new processes for the management of the clinical pathways in Organ Donation and Transplantation. The cost of the project is anticipated to be around £10.2m over five years. It is proceeding to plan, with £6.2m spent to date (years 1 to 3) and a business case for the Year 4 phase (£2.8m) approved by the NHSBT Board in March 2018.

- **Barnsley Centre**
  The existing NHSBT centres at Leeds and Sheffield are ageing, require significant investment and occupy a space that is around double what NHSBT now needs. In May 2017 the NHSBT Board approved a proposal to establish a new centre between the two at Barnsley, close to Junction 37 of the M1. The project was subsequently approved by the DHSC and NHSBT has agreed a 30-year lease to construct a purpose-built, flexible, efficient and modern facility, with some scope for future expansion, by June 2020. The existing centres will be sold. The capital cost to fit out of the new centre will be £14.5m, plus £0.6m for two team bases at Leeds and Sheffield. The project is proceeding to plan.

- **Clinical Biotechnology Centre**
  The Clinical Biotechnology Centre (CBC), based at Langford near Bristol, was originally established to manufacture DNA-based therapeutics as part of NHSBT's cell and gene therapy portfolio. Activity has grown significantly over recent years and the CBC has established a strong reputation and a loyal and growing customer base. The market for cell and gene therapies is anticipated to grow substantially over the next few years and is expected to drive an increased demand for small scale batches of GMP-grade materials for early phase clinical trials. The existing facility is ageing, requiring significant investment, but its layout does not permit multi-product manufacture. As a result, in January 2018, the NHSBT Board approved a proposal to build a new facility within an extension to our existing Filton site where it can integrate with existing stem cell and support

activities. The extension will cost £6.8m in capital, plus £0.6m of non-recurring revenue funding. The project has been approved by the DHSC. It is in its early stages and we are currently developing a detailed design for the laboratories and clean rooms.

Principles of Remedy

NHSBT is committed to providing quality responses to our customers' queries and concerns in line with, the DHSC 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 or compliment us in person, by phone, via the website, social media or email, these are received by our Hospital or Donor Customer Services staff. Our contact details are published on our compliments and complaints leaflets and on our websites. We receive compliments and 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 1.97 million components, make 138,000 deliveries, dispatch 267,000 units of reagents and Red Cell Immunohaematology (RCI) perform diagnostic tests on 70,000 patient samples to support hospital practice. In 2017/18 we received 349 compliments and unfortunately also received 900 complaints. All complaints are investigated and the results reported back to our customers to provide assurance. 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.

Through our satisfaction survey and other feedback, we are assured by our hospital customers that we are delivering valued services to a high standard. Our customers tell us we need to work harder on some areas of our services and we are doing all we can to respond to this feedback. Satisfaction with NHSBT as a supplier to hospitals is increasing and this 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 launched our new Commercial and Customer Service Strategy in 2017 and it is very much aimed at effective collaboration with our customers. We have four objectives:

- **Involve** – keeping our customers at the heart of everything we do;
- **Inform** – deliver structured intelligence to shape business decisions and support best practice in hospitals;
- **Improve** – improve customer experience, practice and business growth through influence and innovation; and
- **Invest** – deliver best value in all we do and the outcomes we achieve.

We will deliver our strategy through the expert and caring staff we have in our teams and want our customers to recognise the quality of what we do and how committed we are to an effective partnership with hospitals.

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. We are investing in the core systems that support our business to ensure we are fit for the future.

Involving hospitals is key to delivering change effectively and positively. We have consulted widely with the review of our estate in Leeds and Sheffield and will continue to involve hospitals as we build the new centre and services in Barnsley. We involve the National Transfusion Laboratory Managers

Group in decision making on behalf of the hospital transfusion community, ensuring a 'hospital voice' and effective challenge is in place.

Managing Blood Donor Complaints
We were pleased that the number of blood donors who complained last year decreased from 4736 complainants per million in 2016/17 to 4165 in 2017/18, compared to our target of 4400.

Initiatives that have helped reduce complaint levels from 2016/17 to 2017/18 included rolling out additional national enhancements to our appointment grids to help improve donor flow at session. We have also strived to improve our ongoing communications with donors.

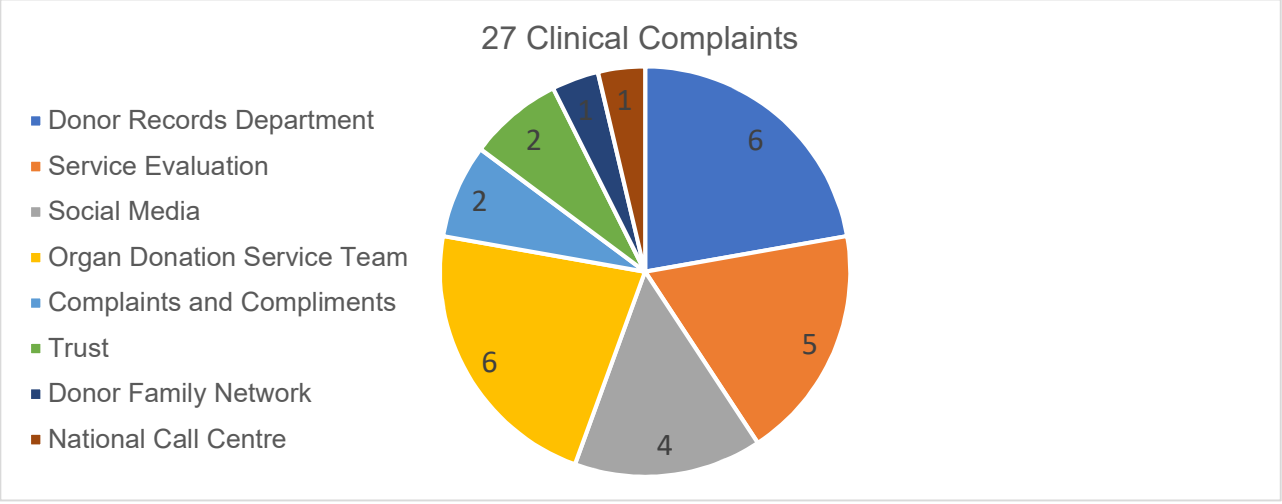
In 2017/18 we responded to 93.9% of complaints from our blood donors within 18 days, against our target of 90%. Also pleasing to see that our Top Box scoring, where we measure donors who give us nine or ten out of ten for overall satisfaction, was at 77% versus a target of 75%. During 2017/18, we had 14,568 complaints and 10,021 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. ODT staff have facilitated 1575 donors during the period April 2017 to March 2018 and have received 39 complaints. Of the 39 complaints, 27 were clinical and 12 non-clinical.

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 from 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. Of the feedback received at the end of 2017/18 the percentage of families scoring 9 or 10 for overall satisfaction is 93%.

Service users can provide feedback or raise concerns about NHSBT's services via several different routes and a summary for clinical complaints within ODT is provided in the chart below.

Chart showing distribution of Clinical Complaints per route of entry



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. As part of the updated complaints and compliments process, reports will be cascaded quarterly via Regional Managers and Team Managers in order to share learning and highlight any trends throughout ODT.

Ethical supply chain

NHSBT is committed to upholding human rights, anti-corruption and anti-bribery within NHSBT and through the supply chain. Audits and checks are carried out on suppliers to ensure compliance.

ACCOUNTABILITY REPORT

I hereby sign the Accountability Report from pages 19 to 51.

Ian Trenholm
Chief Executive and Accounting Officer

Date: 18 June 2018

Corporate Governance Report – Directors' Report

Board Members

Board Members serving during the period 1 April 2017 to 31 March 2018:

Chairman

Mr. John Pattullo – left 31 May 2017
Ms Millie Banerjee – commenced 1 June 2017

Non-Executive Directors

Mr Roy Griffins CB
Mr Jeremy Monroe
Ms Louise Fullwood
Mr Keith Rigg
Mr Charles St John
Professor Paresh Vyas
Lord Jonathan Oates

Executive Directors

Mr Ian Trenholm – Chief Executive- leaving July 2018.
Mr Rob Bradburn – Director of Finance and Estates
Ms Sally Johnson – Director of Organ Donation and Transplantation
Dr Huw Williams – Director of Diagnostic and Therapeutic Services
Greg Methven – Director of Manufacturing and Logistics
Dr Gail Miflin – Medical and Research Director

Details of the remuneration of senior managers of the Authority can be found in the Remuneration and Staff Report at pages 36 to 49.

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/who-we-are/transparency/accounts/board-expenses-and-interests/

The NHSBT Board

The NHSBT Board oversees the strategic direction, the delivery of objectives, and ensures that we uphold our core purpose and values of the organisation. 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 strategic business units (SBUs). Strategic objectives and targets are set for each SBU, which include, the safety and sufficiency of supply, customer service, operational effectiveness and efficiency as required by NHSBT stakeholders. Accountability for delivery, governance, internal control and risk management sits with the SBU Director. The SBU governance is underpinned by an NHSBT 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 next effectiveness review is planned for July 2018.

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 2017/18.

The Governance & Audit Committee (GAC) – provides the Board assurance that governance, risk management and internal control processes across all clinical and non-clinical activities are effective. The GAC receives reports following an annual workplan aligned to NHSBTs Assurance Framework. The reports to GAC are from Directors and Managers and Internal and External Auditors. During the year the GAC had a strong focus on the transformation programme and the projects replacing core systems in Blood and ODT. The internal auditors are PwC provided via the Health Group Internal Audit Service. The GAC also approves the Annual Report and Accounts on behalf of the Board and reviews the work and findings of the Comptroller and Auditor General.

Trust Fund Committee – oversees NHSBT's charitable funds which are used to support 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 – reviews and concludes on the policies for ODT on behalf of the Board. The Committee receives proposals form the Solid Organ Advisory Groups, the Donation Advisory Group and the Retrieval Consultation Group for how organ donor selection, organ donor management, patient selection and organ allocation could be run. The Committee ensures that policies meet legal, regulatory and ethical requirements. These policies can have considerable impact on patients awaiting transplantation.

Remuneration Committee – oversees remuneration and contractual arrangements for the Chief Executive and NHSBT Directors. The committee considers the NHS Very Senior Manager Pay Framework and other relevant guidance and best practice. The Committee also advise the Board on termination and severance arrangements in relation to the Executive. 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 DHSC.

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 DHSC in response to Cabinet Office spending controls. It reviews and approves expenditure on professional services as required by the expenditure controls and ensure that adequate audit trails exist in support of the authorisation.

The average attendance of Members at Board Committees during 2017/18 was:

Board Committee	**(%)**
Remuneration Committee	94%
Trust Fund Committee	100%
Expenditure Controls Committee	100%
Governance & Audit Committee (GAC)	95%
National Administrations Committee	87%
Research and Development Committee	88%
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 2017/18 was:

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

[1] *last Board meeting was May 2017 – left NHSBT 31 May 2017 replacement Millie Banerjee*
[2] *first Board meeting was July 2017 – replacing John Pattullo.*

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 220 incidents on record for 2017/18, 182 were level zero and 38 were level 1. As above there were no level 2 or above incidents (level reportable to the Information Commissioners Office).

Most of our incidents involve mishandling of paper documents, particularly Donor Health Check forms (DHC), nearly all of which were subsequently recovered.

Health and Safety

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

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

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

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

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

The figures below for 2017/18 are.

	15/16				16/17				17/18			
Level	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Blood Donation	12	12	240	436	11	6	151	506	9	4	108	656
Blood Manufacturing & Logistics	7	2	46	134	4	1	41	211	2	2	34	269
DTS	0	1	32	47	1	0	34	128	1	0	26	155
ODT	0	0	8	3	0	0	1	12	0	0	7	18
Group Services	0	0	6	20	0	0	4	57	1	0	5	100
Total	**19**	**15**	**332**	**640**	**16**	**7**	**231**	**914**	**13**	**6**	**180**	**1198**

Level 1 and 2 incidents are at the lowest level ever recorded with a 17% reduction from last year that beats the 10% target. Level 1 and 2 incidents in Blood Donation have reduced by 24% and in Blood Manufacturing and Logistics by 20%. The American Occupational Safety and Health Administration (OSHA) incident rate, of all work related lost time cases divided by hours worked, is now being used as a wider measure and this has reduced from 1.9 to 1.5 in the rolling 12 months to February 2018. The latest incident rate figure reported by OHSA for the USA ambulatory health care services is 2.2*.

Level 3 serious incidents have reduced overall by 22%, with increases in ODT and Group Services but on low numbers.

Level 4 incidents including near miss reporting has increased in all areas, with increased awareness of the benefits of early intervention being more widely understood.

The good accident performance has been delivered by the successful implementation of the last 5 year strategy. The new strategy for Health, Safety and Wellbeing has been approved by the Executive Team and focuses on four themes: Visible Leadership; Prevention Culture, Wellbeing and Communications.

* Latest figure reported in 2016

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: 18 June 2018

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 and, in support of this, implements appropriate governance arrangements to assure itself that NHSBT is operating as required and managing risks. 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 Social Care and the National Assembly for Wales.

The relationship between NHSBT and the Department of Health and Social Care (DHSC), along with NHSBT's accountabilities to the DHSC, 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 Income Generation Agreements.

The governance structure, and supporting assurance processes, within NHSBT is described in the NHSBT Governance and Assurance Framework. The Framework was last updated and reviewed by the Governance and Audit Committee (GAC) in November 2017 and was considered to provide reasonable assurance of the delivery of NHSBT's statutory and strategic objectives and the effectiveness of its internal controls and risk management processes. The review also confirmed that there were no material gaps within the Framework and that it is consistent with 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 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 high-level milestone plans relevant to each.

Performance against objectives and targets are reviewed monthly by the Executive Team and is collated into a comprehensive and integrated monthly performance report to the Board (including trend data, progress on strategic projects and a summary of risks). The Board Performance Report is a key element of the governance and assurance process and its content is reviewed on a periodic basis to ensure that it provides sufficient information and assurance to the Board on the delivery of objectives and management of 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 (i.e. each Division is reviewed twice per annum).

Risk Management and Control

The NHSBT approach to risk is documented in our Risk Management Strategy and identifies the roles and responsibilities for managing risk. The strategy is underpinned by Management Process Descriptions (MPDs) that are incorporated within the NHSBT Risk Manual.

The manual describes the operation of the NHSBT risk register. New risks, that are identified for potential inclusion on the risk register, are assessed for their likelihood and consequence using a 5 x 5 risk matrix. 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. To gain assurance, the GAC reviews the risks and controls within each of our SBUs on a rolling basis (and captured 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. 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 included within 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.

In addition, in 2017/18 a new Serious Incident 'deep dive' process was introduced whereby the members of the GAC review, in detail, a serious incident (of their choice) for how the incident was investigated in relation to the standard procedures and the relevance of actions and mitigating processes taken to prevent any future occurrence.

Quality Management System (QMS)

NHSBT's activities are highly regulated, reflecting the nature of the products and services we supply. The regulation of activities within Blood Components is covered by Blood Safety and Quality Regulations (BSQR) and the Competent Authority is the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA also regulate NHSBT's Investigational Medicinal Product (IMP) and "Special Medicinal Product" activities under the applicable medicines regulations and issue the appropriate licences. Activities within Organ Donation and Transplantation are covered by the Quality and Safety of Organs Intended for Transplantation Regulations; and Tissues and Stems Cell activities are covered by the Tissue Quality and Safety Regulations. The Human Tissue Act 2004 underpins organ and tissue donation in England, Wales and Northern Ireland; and 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 procedural and detailed process documents, 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. The system ensures that staff are adequately qualified, trained and competent. The operation of a QMS and robust process of self-inspection (see below), provides assurance that controls are in place and risks are managed 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 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 and quality improvement.

- Local self-inspections undertaken by approved auditors based at NHSBT centres and are usually led by the Centre QA manager. They confirm continued compliance and identify areas for regulatory and quality improvement.

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

The NHSBT 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, designed to monitor that key processes remain in control, via the Board Performance Report

Business Continuity

Preparation for emergencies in NHSBT is supported by:

- Compliance with the NHS England Emergency Preparedness Framework 2013, and
- The NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2015
- Certification to Societal Security – Business Continuity Management Systems – Requirements (ISO 22301).

Business Continuity (BC) is central to the delivery of NHSBT's stated objectives of a sustainable and sufficient supply of blood products, enabling more organ donations and reliable diagnostic and therapeutic services. Our Business Continuity Management System (BCMS) is risk-based 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.

Consistent with many NHS organisations NHSBT has continued to develop its responses to mass casualty and other emergency scenarios. Consideration is being given to the appropriate level of stock holding, balancing the fall in demand for red cells with the stock required for a mass casualty incident.

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 challenges and achievements in the 2017/18 year included:

- Responding to the requirements of hospitals affected by the Wannacry ransomware attack.
- Responding to the attacks on Westminster Bridge, Manchester, London Bridge and the disaster at Grenfell Tower
- Dealing with an incident of a fire at a close neighbour in one of our blood manufacturing centres
- The re-certification of the BCMS to ISO22301
- The completion and testing of Business Continuity Plans for the business units within the Diagnostics and Therapeutic Services Directorate.
- The completion of an Executive Level National Emergency Team exercise and participation in two exercises regionally – including a cross-border exercise involving the Scottish National Blood Service.

The organisation was challenged during many of these events, but maintained supply of key products and services throughout. All orders were fulfilled and lessons learned from the events are being incorporated into our response systems and business as usual processes.

NHS Blood and Transplant Risk Profile

NHSBT supplies products and services to NHS hospitals and does not generally provide care direct to 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 2% of our activity measured by income).

NHSBT is, however, totally dependent on the voluntary donation of blood, organs, hematopoietic stem cells and tissues and has extensive direct contact, in particular, with donors of blood and stem cells. Regarding 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.

However, we are an ambitious organisation with a stated mission to be the "best organisation of our type in the world". To meet this aim we need to demonstrate world class performance across all of our activities 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 strategies and their 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 2018 the NHSBT risk register captured 124 risks. Of these there were 11 risks considered high / extreme (i.e. with a risk score of 15 or more) and these are grouped into themes and summarised below:

Business continuity:
NHSBT is the sole supplier in England of certain short shelf life biological products (e.g. blood). The 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, Haematos, Electronic Offering System (EOS), National

Transplant Database (NTxD) and any sustained business outage would have a material impact on the NHS and its patients.

To mitigate the risk NHSBT operates a Business Continuity function, as described above, which conducts appropriate risk assessments, ensures that capacity and plans are in place to maximise resilience and organises rehearsals of our ability to respond to critical incidents and emergencies. The assessments and plans are regularly reviewed by the Executive Team and the GAC.

NHSBT has an active and ambitious programme to modernise its IT infrastructure and key applications. Nonetheless, some of the systems remain old and close to end of life. The combination of older systems (which cannot be easily replaced) and an ambitious modernisation programme puts NHSBT at greater risk than normal from a loss of IT services. We therefore apply extensive change control procedures, overseen by the Quality Assurance function and with involvement of the CARE and Business Continuity functions. We additionally undertake extensive testing before any changes are implemented.

Blood – execution of the CSM programme

The Blood supply chain is critically dependant on the Pulse blood management system. The system is around 20 years old and currently comprises a collection of ageing technologies (hardware, operating system, database technology and application language) and its maintenance and support is critically dependent on a small, but longstanding, partner.

The Core Systems Modernisation (CSM) programme has been established to replace Pulse with a Microsoft Dynamics platform. This is a major programme and is the largest and most complex change programme ever undertaken by NHSBT. As with any programme of this scale there are considerable risks arising out of the challenges of understanding the various dependencies in existing systems and our ability to accurately quantify costs and timescales. These risks have materialised in that the programme has not delivered its original objectives within the budget and costs agreed in the business case. The business case, approved by the Board in July 2016 approved an investment of £25m, with Pulse decommissioned by around March 2019. By the end of 2017/18 the spend on CSM was £22.5m, with only limited releases of live software achieved, although substantially more software has been developed and not yet deployed. In February 2018 the Programme Board was notified that the project would take longer and cost significantly more. A revised approach has therefore been developed and it is planned that the Board will be presented with a revised business case in 2018 with Pulse decommissioned in 2023. The Pulse system and support is currently stable and reliable. Options to re-platform the system are being explored that would enable it to be reliably operated for at least 5 years beyond March 2019. This will be supported by an independent technical appraisal of the investment options and residual risk that would apply under each option (see pages 31 and 33 more information).

Transcription error resulting in harm to patients:

Within the NHS clinical pathways that NHSBT supports there are numerous “hand offs” and, within NHSBT, ongoing use of certain paper based and verbal processes. This is particularly prevalent within the organ donation and transplantation pathway as well as in the provision of our diagnostic testing services. Although mitigated by extensive control checks there remains a residual risk that these are ineffective and result in transcription errors that could cause serious harm to NHS patients. The risk of transcription errors in both areas has been, and continues to be, 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. Any incidents are captured by our CARE and Quality Management processes with full root cause analysis conducted and corrective actions implemented. Quality Incidents are reported to the Executive Team, GAC and Board on a periodic basis. Each serious incident is reported in same detail.

Blood – differential demand / product availability / cost effectiveness

The demand for red cells has been decreasing over the last 5 years and the trend is expected to continue over the medium term. However, we are seeing differential demand trends for blood groups

and sub-groups. For example, although around 7% of the population is O negative, the proportion of O negative red cells supplied to the NHS is now around 13% of the total.

Where people have long term health conditions and require multiple transfusions blood needs to be matched more closely using more categorisation 'systems' to avoid patients reacting to the transfusions over their treatment. NHSBT aims to meet hospital requests exactly 97% of the time. One area we have not fully delivered to request in 2017/18 is the Ro subtype. In February 2018, for example, over 4,000 Ro red cells were requested by hospitals but just over 2,000 were issued. We need to collect more Ro blood to meet demand. The Ro subtype is more common (but not exclusively) in the black community and so focused recruitment efforts have commenced.

This differential demand presents a significant challenge to NHSBT, as we need to reduce blood collection capacity (e.g. through fewer / larger collection sessions) to match reducing overall demand, without losing the donors needed for the specific components.

NHSBT therefore faces an increasing challenge to reduce overall supply, demand and cost while retaining sufficient donors and maintaining sufficient stock of specific components so we are not vulnerable to short term supply/demand fluctuations (e.g. endemic flu, impact of severe weather). In recognition of this NHSBT is continually working towards upgrading its donor management, demand forecasting and supply planning processes. In the worst-case capacity will need to be retained such that efficiencies will decline (and prices to the NHS increased).

Blood – management of donor iron levels

A recent study (INTERVAL) identified that some donors (5% of men and up to 14% of women) are being accepted with lower haemoglobin results than regulatory limits. For most donors this is not a clinical concern as the results are only just below this level. However, 1.1% male and 2.8% female donors had levels that implied they were anaemic prior to donating, albeit being seen to be "healthy". More importantly approximately 0.1% donors were accepted with significantly low haemoglobin results. A subsequent study (COMPARE) was immediately devised to establish the optimal method of haemoglobin screening. Following this we have improved our processes for screening donors and, through a pilot of 5000 donors, have demonstrated that the above risks are mitigated. We are currently in the processes of rolling out these changes nationally. However, there remains a risk of making donors iron deficient through regular donation that most international services are trying to understand fully. There remains a risk that we will need a different process for testing donors in the future that gives us an understanding of donors iron levels. The most effective method of this is now being explored. The risk is that a new process will cost more and that donors may need longer intervals between blood donation. This will mean that we need to recruit more donors as a result, which will cost money.

An improved haemoglobin screening method, based on our current methods, has been implemented and a pilot study to understand the impact of changing screening methods has been completed. Analysis of the pilot study is underway with recommendation for any subsequent action, should this be required, anticipated in July 2018. It should be noted that the risk of iron deficiency in donors is an emerging issue which is being discussed in Blood Establishments worldwide.

Lapses in control

Never Events / Serious Incidents (SIs)

There were no Never Events within NHSBT during the year (none in 2016/17). The NHS Never Event list is defined by NHS Improvement and are defined as being serious largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by the Healthcare provider.

Serious Incidents are adverse events, where the consequences to patients, families and carers, staff, donors, visitors or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified and warrant the use of additional resources. During 2017/18 a total of 6 incidents were identified as being Serious Incidents (SIs) versus 5 in 2016/17. One of these events, however, was defined as a serious incident although it arose as part of a system wide failing (that NHSBT could influence), rather than NHSBT error. 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.

Three of the events were related to ***consent***. Under our GDPR project all aspects of consent, including withdrawal of consent, are being considered. The remaining two events related to clinical events. One of these involved the transmission of a virus through organ transplantation that had not been previously recognised to be a risk, and was treated as an SI because of the novelty of the transmission of the virus involved. The second was related to information flow within our cornea supply chain. Process changes, including controlled release of the corneas within the IT system, have now mitigated this risk.

Non-compliance with Regulatory Requirements

NHSBT is committed to delivering a strong regulatory performance with an ambition that there should be no “critical” and no “major” non-compliances identified during any regulatory inspection. During 2017/18 there were no critical and twelve major non-compliances reported following MHRA regulatory inspections. Seven of the major non-compliances were reported in Blood and five in DTS. This compares to 2016/17 where there were no critical and two 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. The seven major non-compliances within Blood were all collections of Good Manufacturing Practice (GMP) issues and were raised across a number of sites inspected during the year. The five majors reported in DTS were again GMP related issues and arose during an inspection of the Advanced Therapy Unit in Birmingham. Corrective and preventive action plans have been developed and agreed with the MHRA for all the non-compliances raised.

Governance – CSM Programme

As referred to above, during the year it was identified that the CSM Programme would exceed its original business case (from July 2016) regarding both cost and time scale. The project has been subject to NHSBT’s normal corporate project governance and reporting processes which had rated it at “red” status throughout 2017/18 (due to early sub-programme time lines not being met) with, accordingly, a strong focus in the Board and GAC. As a result of the ongoing issues, an independent programme assessment was commissioned in September 2017, supported by PwC as our internal auditors. This identified that the programme scope was unclear, there were material gaps in the governance structure and supporting processes and also that, for a programme of this size, a number of project management artefacts had not been developed. In response, a re-set process was implemented (overseen by the GAC) to improve the governance process and produce the missing project artefacts.

In November 2017 the NHSBT Board was notified that there was a material risk that the project would take longer and cost more than was approved in the business case. In February 2018, the CSM Programme Governance Board was formally notified that it would not be able to meet the time line established by the business case and that the project would take longer, and therefore cost substantially more than the business case. A revised approach was presented to the Board in March 2018 and a new business case is now being worked up (see page 33 for more information).

Internal Audit – including the opinion of the Head of Internal Audit

Our internal audit service is provided by the Health Group Internal Audit Service (HGIAS) of the Department of Health and Social Care. Under this umbrella arrangement both our Head of Internal Audit, and the supporting audit resources, are provided directly by Price Waterhouse Coopers (PwC) under HGIAS contract.

The programme of work agreed by the GAC resulted in a total of 12 reports being issued during 2017/18. Of the reports issued:

- 3 reports received a "substantial" assurance opinion
- 5 received a "moderate" assurance opinion
- 0 received a "limited" assurance opinion
- 0 received an "unsatisfactory" opinion
- 4 were advisory reports on which an opinion is not given

The above assurance opinion types are defined at the foot of this note.

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 2018 that there were no overdue Medium and High audit recommendations.

The internal audit work has been considered in the preparation of the 2017/18 Annual Report and the Governance Statement. Despite the reports noted above Health Group Internal Audit Service have provided an overall opinion that:

- In the case of **governance:**

We conducted reviews of Integrated Governance and Risk Management (Moderate) and Care Governance (Substantial) during the year, which informed our understanding of the governance arrangements in these areas.

- In the case of **risk management:**

We conducted reviews on Business Continuity and Integrated Governance and Risk management during the year to understand the arrangements and progress made over the last year. Both reviews have been rated as 'moderate'. We noted progress made during the period to embed a revised approach to risk management, including the addressing of prior audit recommendations.

- In the case of **control:**

8 assurance based reviews have been completed within the 2017/18 internal audit plan, of which all have been rated as either 'moderate' (5 audits) or 'substantial' (3 audits). Our work around the follow-up of audit recommendations has identified good progress by management in the implementing of agreed actions.

Therefore, in summary, my overall opinion is that I can give **MODERATE** assurance to the Accounting Officer that NHS Blood and Transplant has had adequate and effective systems of control, governance and risk management in place for the reporting year 2017/18.

Explanation of assurance opinions used:

Rating	Definition
Substantial	In my opinion, the framework of governance, risk management and control is adequate and effective.
Moderate	In my opinion, some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	In my opinion, there are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
Unsatisfactory	In my opinion, there are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

The advisory work on the CSM and ODT Hub Programmes identified concerns over aspects of the CSM Programme including resource and capability and supplier management. This lead directly to the CSM Programme "re-set" activities that took place over the period October 2017 to January 2018 (with close review by the GAC) before the Programme Board identified in February 2018 that the original business case could not be met and a new approach to the programme was required.

Information and Data Management

NHSBT holds details of nearly 10 million blood donors (active, inactive and archived) and manages an Organ Donor Register with around 25 million registrants.

No incidents have been reported to the ICO in the financial year 2017/18.

NHSBT has completed a gap analysis of compliance readiness for the General Data Protection Regulation 2016/679 during the year. A formal project was established to address the gaps identified and ensure a satisfactory level of compliance by 25th May 2018. Particular areas of focus have included reviewing our consent notices for data processing and contracts with suppliers to ensure end to end compliance.

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 an Anti-Fraud, Bribery and Corruption policy explaining how staff must report suspected fraud. Staff have been made aware of both policies during the year.

Compared to the broader NHS, NHSBT considers its inherent risk of fraud to be relatively low, and also mitigates fraud through strong control functions including a strong procurement function that is Chartered Institute of Procurement and Supply (CIPS) accredited and delivers very high levels of contract coverage. In addition, NHSBT undertakes an 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.

Care Quality Commission Registration

The CQC considers NHSBT to be a health service body, not an NHS Trust and places NHSBT within the community health care services category. NHSBT currently operate thirty-eight locations that are listed on the CQC Certificate of Registration. An application to remove one Donor Centre is currently with the CQC and may result in the number of locations reducing to thirty-seven during 2018/19. During the period April 2017 to March 2018 the CQC did not undertake any inspections of NHSBT locations

NHS Provider Licence

During the year NHSBT has repeated its review of the DHSC 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 nearly £10.0m of NHSBT's income. As a result of our review 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 operates on behalf of the Secretary of State for Health and Social Care 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 oversight provided by the CARE process
- 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 2018 and up to the date of approval of the annual report and accounts. As a result of my review I am satisfied that the system of internal control has been sound with no evidence of weaknesses of sufficient materiality that would prejudice the achievement of our policies, aims and objectives.

Remuneration and Staff Report

This report forms part of the Accountability Report on pages 19 to 51.

Remuneration Committee Membership

During 2017/18 membership of the Remuneration Committee comprised of Louise Fullwood, Millie Banerjee, Jeremy Monroe and Jonathan Oates. The Committee was chaired by Louise Fullwood. Ian Trenholm and Katherine Robinson also attended the Committee meetings as 'standing attendees'. They excuse themselves from the meeting when their remuneration is being discussed.

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 and Executive Senior Management (ESM) Framework. 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 DHSC ALB Executive and Senior Manager Pay Framework, and associated guidance issued by DHSC.

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. Ian Trenholm has resigned from NHSBT and is working his notice period until the end of July 2018.

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. Leonie Austin has resigned and will leave NHSBT at the end of May 2018.

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, 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. David Evans resigned from NHSBT with effect from 31 July 2017.

Katherine Robinson, Director of People, current NHS continuous service start date 25 July 1994 appointed to the Executive team on 1 July 2017. 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.

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 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 29 June 2015. Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT.

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 pages 38 and 39. The tables on pages 38 and 39 are subject to audit.

Salary and Pension Entitlement of Senior Managers

a) Remuneration

	Year to 31 March 2018					Year to 31 March 2017				
Name and title	Salary In £5k bands £000	Performance pay and bonuses In £5k bands £000	Non Cash Benefits To nearest £00	All Pension Related Benefits Bands of £2500 £000	Total In £5k bands £000	Salary In £5k bands £000	Performance pay and bonuses In £5k bands £000	Non Cash Benefits To nearest £00	All Pension Related Benefits Bands of £2500 £000	Total In £5k bands £000
Mr J Pattullo (Chairman) [1]	10-15	-	-	-	10-15	60-65	-	-	-	60-65
Ms M Banerjee [2]	50-55	-	-	-	50-55	-	-	-	-	-
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) [3]	5-10	-	-	-	5-10	0-5	-	-	-	0-5
Mr K Rigg (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr C St John (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Prof P Vyas (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Dr C Costello (NED) [9]	-	-	-	-	-	0-5	-	-	-	0-5
Mr S Williams (NED)[10]	-	-	-	-	-	5-10	-	-	-	5-10
Mr I Trenholm (Chief Executive) [4]	175-180	5-10	-	37.5-40	220-225	175-180	5-10	-	1487.5-1490	1670-1675
Ms L Austin (Director of Marketing and Communications)	110-115	-	-	25-27.5	140-145	105-110	-	-	27.5-30	135-140
Mr I Bateman (Director of Quality)	100-105	-	15	15-17.5	115-120	100-105	-	24	17.5-20	120-125
Mr R Bradburn (Finance Director)	140-145	-	56	35-37.5	180-185	140-145	-	52	32.5-35	180-185
Mr D Evans (Director of Workforce) [5]	30-35	-	-	-	30-35	100-105	-	-	35-37.5	135-140
Ms S Johnson - (Director of Organ Donation and Transplantation)	130-135	5-10	-	27.5-30	165-170	125-130	5-10	-	65.67.5	200-205
Mr G Methven (Director of Blood Manufacturing and Logistics [6]	125-130	-	-	27.5-30	155-160	15-20	-	7	2.5-5	20-25
Dr Gail Miflin (Medical and Research Director) [7]	190-195	-	-	90-92.5	280-285	135-140	-	-	170-172.5	305-310
Mr A Powell (Chief Digital Officer)	120-125	-	19	27.5-30	150-155	120-125	-	25	42.5-45	165-170
Mr M Stredder (Director of Blood Donation)	125-130	5-10	-	27.5-30	160-165	125-130	5-10	-	27.5-30	160-165
Mr H Williams (Director of Diagnostics and Therapeutic Services)	130-135	-	-	30-32.5	160-165	125-130	-	-	30-32.5	160-165
Mrs K Robinson (People Director) [8]	110-115	-	46	92.5-95	205-210	-	-	-	-	-
Mr P Lidstone (Director of Blood Manufacturing and Logistics) [11]	-	-	-	-	-	85-90	-	-	-	85-90
Dr Lorna Williamson (Medical and Research Director)[12]	-	-	-	-	-	40-45	-	-	-	40-45

NED = Non-Executive Director

Performance pay and bonuses relates to pay earned in the previous year.

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 J Pallutto – left on 31 May 2017. Full year salary (£5k bands) is £60-65
2 Ms M Banerjee – commenced on 01 June 2017. Full year salary is (£5k bands) is £60-65
3 Lord J Oates – prior year remuneration lower amount due to commencement part way through the year on 1 March 2017
4 Mr I Trenholm – prior year remuneration significantly increased due to a pension transfer from the Civil Service Pension Scheme
5 Mr D Evans – left on 31 July 2017. Full year salary (£5k bands) is £125-130
6 Mr G Methven – prior year remuneration lower amount due to commencement part way through the year on 6 February 2017
7 Dr G Miflin – prior year remuneration lower amount due to appointment part way through the year on 1 June 2016
8 Mrs K Robinson – appointed as People Director on 01 July 2017 (David Evans replacement). Full year salary (£5k bands) is £115-120
9 Dr C Costello – left on 31 May 2016
10 Mr S Williams – left on 03 March 2017
11 Mr P Lidstone – left on 30 November 2016
12 Dr L Williamson – left on 31 May 2016

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 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Real increase in Cash Equivalent Transfer Value £000
Mr I Trenholm (Chief Executive)	2.5-5	-	85-90	-	1,066	960	71
Ms L Austin (Director of Marketing & Communications)	0-2.5	-	15-20	-	218	179	22
Mr I Bateman (Director of Quality)	0-2.5	2.5-5	20-25	60-65	444	392	34
Mr R Bradburn (Finance Director)	2.5-5	-	20-25	-	366	307	35
Mr D Evans (Director of Workforce) [1]	(2.5-5)	(5-7.5)	35-40	120-125	-	943	-
Ms S Johnson (Director of Organ Donation & Transplantation)	2.5-5	7.5-10	55-60	165-170	1,266	1,140	83
Mr A Powell (Chief Digital Officer)	0-2.5	-	15-20	-	162	131	12
Mr M Stredder (Director of Blood Donation)	0-2.5	-	5-10	-	67	40	7
Dr H Williams (Director of Diagnostics & Therapeutic Services)	0-2.5	-	10-15	-	176	133	23
Mrs K Robinson (People Director) [2]	2.5-5	10-12.5	30-35	75-80	451	352	56
Mr G Methven (Director of Manufacturing & Logistics)	0-2.5	-	0-5	-	28	4	6
Dr G Miflin (Medical and Research Director)	5-7.5	7.5-10	40-45	105-110	752	628	92

[1] Mr D Evans – left on 31 July 2017
[2] Mrs K Robinson – appointed as People Director on 01 July 2017

Cash Equivalent Transfer Value

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

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

Real Increase in CETV

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

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 2017/18 there were 111 payments for early retirements and/or redundancies from NHSBT. The sum of £4,267,000 has been paid out in 2017/18 in respect of these redundancies and/or early retirements (2016/17 72 early retirements and/or redundancies and payments of £2,212,000).

An opening provision of £2,314,000 for redundancy costs has been utilised, or reversed unused during 2017/18 and a further provision of £366,000 has been made for redundancy costs in relation to restructures currently in progress.

A total charge of £1,957,000 for early retirements and redundancies is included within other staff related costs in note 3.1 of the financial statements (2016/17 £2,209,000).

This is subject to audit.

Reporting of Other Compensation Schemes

The table below discloses the number and value by cost band of compensation packages paid in 2017/18.

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	11	76	1	15	12	91	-	-
£10,001 - £25,000	28	504	6	120	34	624	-	-
£25,001 - £50,000	36	1,393	7	250	43	1,643	-	-
£50,001 - £100,000	10	775	6	427	16	1,202	-	-
£100,001 - £150,000	5	553	-	-	5	553	-	-
£150,001 - £200,000	1	154	-	-	1	154	-	-
Totals for 2017/18	**91**	**3,455**	**20**	**812**	**111**	**4,267**	**-**	**-**
Totals for 2016/17	**36**	**923**	**36**	**1,289**	**72**	**2,212**	**-**	**-**

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 2017/18 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 6.6

	2017/18	2016/17
Highest Director Banded Remuneration	£190k to £195k	£185k to £190k
Lowest Banded Remuneration	£0k to £5k	£0k to £5k
Median Remuneration	£29,100	£27,754
Remuneration Ratio	6.6	6.8

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 2018 Permanently Employed Staff**	**Other**	**31 March 2017 Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	**164,078**	153,143	10,935	163,985
Social security costs	**15,506**	14,990	516	15,293
Employer contributions to NHS Pensions Agency	**20,384**	19,705	679	20,125
	199,968	**187,838**	**12,130**	**199,403**

Whole Time Equivalents	**Total Number**	**Permanently Employed Number**	**Other Number**
Year Ended 31 March 2018	**4,674**	**4,427**	**247**
Year Ended 31 March 2017	4,749	4,507	242

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 2017 to December 2017 the total number of whole time equivalent days lost to sickness absence was 39,901 days (2016 44,001 days). This equates to an average of 8.6 days per whole time equivalent (2016 9.3 days) and a sickness absence rate of 2.3% (2016 2.5%).

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

Our last staff survey, *Your Voice (renamed Our Voice)* was completed in early 2017. The focus in the last year has been on responding to the findings from the survey.

We are planning to build on this by using targeted 'Pulse' surveys to check progress on the themes identified below:-

- Harassment, Bullying and Abuse (17% reported)
- Communication (49% positive)
- Well-being improvements (55% positive)
- Management capabilities (65% positive)
- Development opportunities (46% positive)
- Senior leader approachability (32% positive)
- 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.

- **Leadership conferences** – these engagement events are held to encourage discussion and understanding of organisational items and issues.

- **Recognition of excellence** – a scheme where colleagues or managers can nominate others for exceptional work and behaviours.

Succession planning and high potential talent engagement requires engaged and confident managers of people. NHSBT now has a clear and agreed succession plan for key positions and for all posts of 8b and above. Apart from the key posts being identified, each position has named possible successors. Each named successor has a development plan. This has led to a greater movement of people across different directorates, giving future leaders a wide and fuller knowledge of the organisation. In addition to this, future leaders are being identified via a high potential process at all levels in the organisation.

Trade Union Relationships

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

NHSBT provides national time off release for 4.3 whole time equivalent Trade Union representatives to carry out national consultation/partnership working duties across NHSBT as part of our Partnership working agreement. This amounts to 161.25 hour's time release per week and reflects the scale of change consultation within NHSBT and geographic spread of employees across our national organisation. In addition, there is some local time release for workplace union representatives and the arrangements for formally recording these hours are being reviewed subject to final Public-Sector Facility Guidance being issued. Please see below for details of Union Officials:

Relevant Union Officials	
No. of employees who were relevant union officials during the relevant period	**Full time equivalent employee number**
8	4.3

Excludes local facilities time not currently recorded

Percentage of time spent on facility time	
Percentage of time	**Number of employees**
0%	
1-50%	6
51-99%	1
100%	1

Excludes local facilities time not currently recorded

Percentage of pay bill spent on facility time	
Description	**£000**
Total of cost facility time	184
Total pay bill	199,968
Percentage of the total pay bill spent on facility time	0.09%

Excludes local facilities time not currently recorded

Paid Trade Union activities	
Time spent on trade union activities as a percentage of the total paid facility time hours	Not available*

Actual time spent is not currently recorded by national or local representatives. We are exploring time recording options.

Learning & Development

NHSBT provides an award winning 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. The organisation now has 10 fully qualified coaches.
A suite of management development is available from front line supervisor through to aspirant CEO level. These include:

- **Effective Line manager (ELM)** – for all managers and aspiring managers.
- **Advanced Line management (ALM)** – for new and developing managers.
- **Hubbub BT** – for middle managers and leaders.
- **Senior Leadership Development programme (SLDP)** – for senior managers and aspiring directors.

NHSBT also plays a key part in the DHSC Healthcare Sector leadership programme.

There are also a wide range of online resources for learners. These include video talks, toolkits, e-learning programmes, workbooks and factsheets.

Staff are encouraged to have personal development plans and this remains an essential part of our appraisal process. The organisation also has a process 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.

Apprenticeship Levy

The Apprenticeship Levy was introduced by the UK Government on 6 April 2017, requiring all employers operating in the UK with a pay bill over £3m each year, to invest in apprenticeships. NHSBT is required to pay a levy of 0.5% of its pay bill, less an allowance of £15,000 to fund apprenticeships through a GOV.UK digital apprenticeship service account. These funds will be used to make payments directly to approved training providers to pay for the training and assessment of the apprenticeship. NHSBT's levy balance as at 31 March 2018 is £741,361. £25.5k has been paid to providers in 2017/18. Where possible internal training will be moved to apprenticeships to maximise the use of our levy.

NHSBT has established itself as a Top 100 employer for apprenticeships. To date it currently has 124 apprentices who have either completed an apprenticeship, are on an apprenticeship or are waiting to start since the scheme commenced in August 2016. Our apprentices are currently entry level new recruits joining NHSBT and existing employees enhancing their skills over 10 different programmes. An example of the programmes is in leadership and management, business and administrative, logistics and technical areas of the organisation. Apprenticeships form an essential part of our talent pipeline. In line with government policy, this scheme will expand year on year with the aim to continually meet our public-sector target of 2.3% of apprentice starts per year (equates to 130 starts per year).

Breakdown of apprentice starts and funding:

- 34 apprentices are live and being funded from the levy (started on or after 1 April 2017)
- 19 completed on programme. None funded from the levy as started prior to April 2017.
- 21 apprentices live on programme. None funded from the levy as started prior to April 2017.
- 50 existing employees currently on the waiting list and will be funded from the levy post April 2018.

A diverse organisation

NHSBT employs 753 Black, Asian and Minority Ethnic (BAME) colleagues, which is 13.6% of our employee workforce.

To create a workforce more representative of the communities we serve, we are committed to supporting and recruiting BAME employees, with targeted positive action interventions. These aim to encourage both career progression and development and more diverse employee representation within NHSBT.

Recognising the importance of an inclusive workforce; a corporate strategic target was set in 2015 to increase the proportion of Senior Manager and Senior Professionals from a BAME background by 15% over a five-year period. As we have achieved the original target set for 2020 of 50 Senior Manager/Senior Professionals coming from our BAME colleagues, these targets have now been reviewed to increase the number to 55 (9.3%) by 2020.

In conjunction with this, diverse Interview Panels were set up almost two years ago, to increase diversity across the senior leadership team and an outcome of this intervention has seen a more balanced interview panel composition for senior leadership posts. A complete set of Diversity and Inclusion questions are also now included within the NHSBT Core Values questions asked at each interview.

A Careers Master Class for BAME colleagues has been developed and is run by a training provider with specialist knowledge in this area. The content of the day has been designed to provide employees from BAME backgrounds with insights, tools and techniques that will enable them to further their career within NHSBT and/or the wider NHS. A key objective is to support and empower colleagues to develop their career pathway and aspire to senior managerial and professional positions in the organisation. The Careers Masterclass commenced in September 2017 and 144 places for training have been made available to all BAME employees across all pay bands and to date 102 BAME colleagues have attended a workshop.

Employee Networks & Lesbian, Gay, Bisexual and Transgender (LGBT) representation

Work has continued with developing employee networks. The LGBT+ Employee Network was established in October 2017 to engage with and provide support to LGBT+ colleagues. The network will also focus on different issues affecting LGBT+ colleagues with the goal of making NHSBT a more inclusive place to work.

Health & Well-being

Listening to feedback from our annual employee staff survey; Our Voice, we are committed to providing more support for Health and Wellbeing of our employees. Recently we have worked with Mental Health First Aid England to train up over 92 Mental Health Wellbeing Champions to help colleagues support and signpost others who may need help with their mental health.

Diversity Data

During 2018 we will be working towards giving NHSBT colleagues self-service access to their own personal data within the electronic employee record system. This will enable colleagues to update their own personal diversity and protected characteristic data on the understanding that their personal data is held confidentially and is used for equality monitoring purposes.

This will help to give us a better understanding of our workforce so that we can tailor specific campaigns and initiatives towards making NHSBT a more diverse and inclusive workplace.

Gender

As at 31 March 2018 NHSBT employed 5,544 staff members (of which 10 are directors) of whom 3,752 were female (of which 4 are directors) and 1,792 were male (of which 6 are directors).

As part of our Public-Sector Equality Duty, we are required to monitor and publish our data on gender pay gap reporting and this has recently been published at 7.9% using mean hourly wage of all men and women across the organisation. This compares favourably with other NHS organisations and we are considering and planning further actions to further reduce the percentage gap.

Disability Equality

NHSBT is committed to disability equality and aims to embed a disability confident organisational culture. This year, we have done this by:

- Taking part in NHS England's pilot of the Workforce Disability Equality Standard (WDES). This has been a valuable exercise in getting our reporting data ready for when we officially start to report on the WDES in April 2019.

- Undertaking the Business Disability Forum (BDF) Self-Assessment Standard to help assess what is currently in place across NHSBT and where the gaps are; this will also assist in improvement of WDES scores; assist in improvement of Our Voice (employee staff survey) scores; and also assist in improvement of general staff engagement scores.

- Running health and wellbeing campaigns throughout the year to focus communications around topics of Mental Health and Disability in the workplace by using personal stories in blogs and feature articles.

- Training on Disability and Health Promotion was delivered to all Disability and Well-Being Advocates.

- A new Tailored Adjustment Agreement Reporting Tool was rolled out in December and enables better recording and review of any workplace adjustments and gives NHSBT a good overview for assurance of any support in place for employees. This is where we are making workplace adjustments for individuals if they need support in the workplace for any reason, including health issues, disabilities or following surgery.

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 2017/18 is £nil (2016/17 £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 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	3
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

The table below identifies all new off-payroll engagements, or those that reached 6 month duration, between 1 April 2017 and 31 March 2018, for more than £245 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	9
Number of new engagements which include contractual clauses giving NHSBT the right to request assurance in relation to income tax and National Insurance obligations	9
Number for whom assurance has been requested	9
Of which number for whom:	
Assurance has been received	9
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 2017 and 31 March 2018:

	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 2018, 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.	19

Parliamentary Accountability and Audit Report

Basis for Accounts Preparation

The accounts for the year ending 31 March 2018 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 DHSC with the approval of Treasury.

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 £87k (£90k 2016/17). There were no payments to the C&AG 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 2017: no payments over £300,000)

Losses Statement	**31 March 2018**		**31 March 2017**	
	No. Cases	**£000**	**No. Cases**	**£000**
Cash losses	1	5	-	-
Book keeping losses	-	-	3	-
Losses of pay, allowance and superannuation benefits	31	7	35	34
Losses of accountable stores	114	105	131	134
Claims waived or abandoned	1	1	1	20
Total	**147**	**118**	**170**	**188**

Special Payments	**31 March 2018**		**31 March 2017**	
	No. Cases	**£000**	**No. Cases**	**£000**
Contractual payments	1	30	-	-
Compensation payments	42	187	84	274
Ex gratia payments	-	-	1	1
Total	**43**	**217**	**85**	**275**

NHSBT received £132,000 from Network Rail for full and final settlement in relation to a flood at the Filton site in 2012. Previously reported fruitless payments from the flood totalled £285,143.

This is subject to audit.

Remote Contingent Liabilities

There are no known material remote contingent liabilities. For disclosable contingent liabilities see note 15 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.

Fees and Charges

NHSBT has a statutory duty to deliver a breakeven financial plan year on year, except where approved to make investments from planned accumulated surpluses. The majority of its 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 reductions to demand. Performance against agreed sales volumes, is reviewed in-year with Commissioners, and in the event of an over-recovery of costs, these are 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 2 which is subject to audit.

This is subject to audit.

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

Opinion on financial statements
I certify that I have audited the financial statements of NHS Blood and Transplant for the year ended 31 March 2018 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 including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.

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 2018 and of the net expenditure for the year then ended; and
- The financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on regularity
In my opinion, in all material respects the income and expenditure 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.

Basis of opinions
I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent of NHS Blood and Transplant in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Board and Accounting Officer for the financial statements
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.

Auditor's responsibilities for the audit of the financial statements
My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006.

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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements

As part of an audit in accordance with ISAs (UK), I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of

not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of NHS Blood and Transplant's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on NHS Blood and Transplant's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

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

Other Information

The Board and the Accounting Officer are responsible for the other information. The other information comprises information included in the annual report, other than the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006;
- in the light of the knowledge and understanding of the NHS Blood and Transplant and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report or the Accountability Report; 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 parts of the Accountability 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** 27 June 2018

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 2018

	Notes	31 March 2018 £000	31 March 2017 £000
Gross Income			
Income from sale of goods and services	2	327,019	326,434
Other operating income	2	21,830	22,244
		348,849	**348,678**
Expenditure			
Staff costs	3.1	(199,968)	(199,403)
Purchase of goods and services	3.2	(199,911)	(196,178)
Depreciation, amortisation & impairment charges	6 & 7	(10,558)	(10,965)
Other operating expenditure	3.3	(24,403)	(22,447)
		(434,840)	**(428,993)**
Net operating expenditure before interest		**(85,991)**	**(80,315)**
Finance expense		(428)	(443)
Net operating expenditure after interest	2	**(86,419)**	**(80,758)**
Other Comprehensive Net Expenditure Items which will not be reclassified to net operating costs:			
Net gain on revaluation of Property, Plant and Equipment	7	13,645	7,121
Total comprehensive net expenditure		**(72,774)**	**(73,637)**

Notes 1 to 19 form part of these accounts.

All income and expenditure is derived from continuing operations.

Statement of Financial Position as at 31 March 2018

	Notes	31 March 2018 £000	31 March 2017 £000
Non-Current Assets			
Intangible assets	6	2,788	4,100
Property, plant and equipment	7	194,226	186,031
Financial assets	9	171	173
Total non-current assets		**197,185**	**190,304**
Current Assets			
Inventories	8	15,030	16,987
Trade and other receivables	9	35,696	29,345
Cash and cash equivalents	10	23,479	32,755
Total current assets		**74,205**	**79,087**
Current Liabilities			
Trade and other payables	11	(25,506)	(20,633)
Provisions for liabilities and charges	12	(807)	(3,346)
Other liabilities	13	(166)	(149)
Total current liabilities		**(26,479)**	**(24,128)**
Total assets less current liabilities		**244,911**	**245,263**
Non-Current Liabilities			
Provisions for liabilities and charges	12	(867)	(880)
Financial liabilities	13	(3,944)	(4,110)
Total non-current liabilities		**(4,811)**	**(4,990)**
Total assets less total liabilities		**240,100**	**240,273**
Taxpayers' Equity			
General Fund		160,046	171,026
Revaluation Reserve		80,054	69,247
Total taxpayers' equity		**240,100**	**240,273**

Notes 1 to 19 form part of these accounts.

The financial statements on pages 55 to 80 were approved by the Governance and Audit Committee in accordance with powers within the NHSBT Standing Orders on 18 June 2018 and are signed by the Accounting Officer, Ian Trenholm.

Ian Trenholm
Accounting Officer

Date: 18 June 2018

Statement of Cash Flows for the year ended 31 March 2018

	Notes	31 March 2018 £000	31 March 2017 £000
Cash flows from operating activities			
Net operating costs		(85,991)	(80,315)
Other cashflow adjustments	14.2	12,936	11,825
Movement in working capital	14.1	669	5,869
Provisions utilised	12	(2,362)	(621)
Net cash (outflow) from operating activities		**(74,748)**	**(63,242)**
Cash flows from investing activities			
Purchase of plant, property & equipment		(6,576)	(6,168)
Purchase of intangible assets		-	(199)
Proceeds from disposal of non-current assets		2	-
		(6,574)	**(6,367)**
Cash flows from financing activities			
Grant from DHSC		72,600	72,370
Capital element paid in respect of finance leases	13	(149)	(133)
Interest paid in respect of finance leases		(405)	(421)
Net financing		**72,046**	**71,816**
Net increase in cash and cash equivalents		(9,276)	2,207
Cash and cash equivalents at 01 April 2017		32,755	30,548
Cash and cash equivalents at 31 March 2018	10	**23,479**	**32,755**

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

	Notes	General Fund £000	Revaluation Reserve	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	7	-	7,121	7,121
Transfer between reserves		2,383	(2,383)	-
Total recognised income and expense for 2016/17		**(78,375)**	**4,738**	**(73,637)**
Revenue Grant from DHSC		65,870	-	65,870
Capital Grant from DHSC		6,500	-	6,500
Balance at 31 March 2017		**171,026**	**69,247**	**240,273**

Statement of Changes in Taxpayers' Equity for the year end 31 March 2018

	Notes	General Fund £000	Revaluation Reserve	Total Reserves £000
Balance at 1 April 2017		171,026	69,247	240,273
Changes in taxpayers' equity for 2017/18				
Comprehensive net expenditure for the financial period		(86,419)	-	(86,419)
Net gain on revaluation of property, plant and equipment	7	-	13,645	13,645
Transfer between reserves		2,839	(2,839)	-
Total recognised income and expense for 2017/18		**(83,580)**	**10,806**	**(72,774)**
Revenue Grant from DHSC		66,100	-	66,100
Capital Grant from DHSC		6,500	-	6,500
Balance at 31 March 2018		**160,046**	**80,054**	**240,100**

NHSBT Notes to the Accounts

1. Accounting Policies

The financial statements have been prepared in accordance with the 2017/18 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 2017.

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 to value land and buildings (see accounting policy note 1.5)
- 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 Social Care 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 DHSC, 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 2017/18 was 3.5% (2016/17 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 £17.5m (2016/17 £17.3m) in respect of all capital charges included in prices to the Department of Health and Social Care (DHSC) 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. The annual revaluations are carried out by the Valuation Office Agency.

- Non- specialist operational assets – current value in existing use
- Specialist operational assets – depreciated replacement cost. This is the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

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 2018, is based on an assessment of liabilities at 31 March 2017, updated to 31 March 2018 with an approximation to reflect known changes. 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 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 arising 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 Resolution (NHSR) operates a risk pooling scheme under which NHSBT pays an annual contribution to the NHSR, which in return settles all clinical negligence claims. The contribution is charged to expenditure.

The NHSR 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 NHSR. Although the NHSR 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 NHSR is disclosed in Note 12.

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 Resolution 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 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 17.

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

International Accounting Standard 8, accounting for policies, changes in accounting estimates and errors, requires disclosure in respect of new IFRSs, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for Financial Statements after this accounting period.

The following have not been adopted early in these accounts:

- **IFRS 9 – Financial Instruments**: This standard is effective from April 2018. A preliminary assessment indicates there will be no material change as NHSBT assets and liabilities are simple debtors, trade payables and accruals. Impairments are unlikely to be significant as the majority of debt is with other DHSC bodies for whom DHSC provides a guarantee of last resort additionally following HMT guidance NHSBT must not recognise credit losses for intra-DHSC debt.

- **IFRS 15 – Revenue with Contracts from Customers**: This standard is effective from April 2018. A preliminary assessment indicates there will be no material change. The material revenue contracts subject to IFRS are the blood and testing income contracts with NHS customers. Our expectation is that there will be no change on the timing of the recognition of income.

- **IFRS 16 – Leases**: The impact of IFRS 16 cannot be reasonably estimated at this time because it will be dependent on the leases that NHSBT holds at the time of implementation. The new standard will require NHSBT to assess its accounting processes and internal controls relating to the reporting of leases and this will not be complete until application guidance is issued by HMT.

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

Note 2 – Segmental Reporting and Reconciliation of net operating expenditure to Programme Funding from the Department of Health and Social Care (DHSC)

For the year 1 April 2017 to 31 March 2018	Total £000	Blood Components (incl R&D) £000	Diag-nostics £000	Tissues £000	Stem Cells Unit £000	Therapeutic Apheresis Services £000	Organ Donation & Transplant £000
Revenue							
Provision of Products and Services	**327,019**	260,699	29,957	12,853	14,122	9,388	-
Income from Scottish Parliament	**6,043**	-	-	-	-	-	6,043
Income from National Assembly for Wales	**3,707**	-	-	-	-	-	3,707
Income from Northern Ireland Assembly	**2,080**	-	-	-	-	-	2,080
Other Income	**10,000**	5,278	599	-	3,398	553	172
Programme Funding from the DHSC	**66,100**	-	224	-	3,949	-	61,927
Total Revenue	**414,949**	**265,977**	**30,780**	**12,853**	**21,469**	**9,941**	**73,929**
Expenditure							
Variable costs	**(58,424)**	(40,937)	(5,404)	(1,866)	(3,091)	(3,565)	(3,561)
Direct costs	**(207,651)**	(108,512)	(17,627)	(9,572)	(11,207)	(3,390)	(57,343)
Direct support costs	**(81,628)**	(65,570)	(2,426)	(2,038)	(4,151)	(809)	(6,634)
Movement in value of stocks	**(1,373)**	(1,288)	-	(85)	-	-	-
Other support costs	**(47,045)**	(29,925)	(3,168)	(1,687)	(2,295)	(966)	(9,004)
Total Expenditure	**(396,121)**	**(246,232)**	**(28,625)**	**(15,248)**	**(20,744)**	**(8,730)**	**(76,542)**
Operating surplus for the financial period	**18,828**	**19,745**	**2,155**	**(2,395)**	**725**	**1,211**	**(2,613)**
Transformation costs	(29,025)	(24,196)	-	-	-	-	(4,829)
Operating deficit for the financial period	**(10,197)**	**(4,451)**	**2,155**	**(2,395)**	**725**	**1,211**	**(7,442)**
Add: Notional cost of capital included in expenditure above	7,422						
Less: Programme Funding from DHSC	(66,100)						
Less: Capital charges paid to the DHSC	(17,544)						
Net expenditure	**(86,419)**						

For the year 1 April 2016 to 31 March 2017 – (Restated)	Total £000	Blood Components (inc R&D) £000	Diag-nostics £000	Tissues £000	Stem Cells Unit £000	Therapeutic Apheresis Services £000	Organ Donation & Transplant £000
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 DHSC	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	(215,674)	(116,734)	(17,885)	(9,169)	(11,210)	(2,896)	(57,780)
Direct support costs	(78,663)	(62,761)	(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	**(396,482)**	**(249,490)**	**(29,426)**	**(14,133)**	**(20,441)**	**(6,613)**	**(76,379)**
Operating surplus for the financial period	**18,066**	**22,474**	**(1,359)**	**(1,551)**	**692**	**949**	**(3,139)**
Transformation costs	(22,986)	(17,770)	-	-	-	-	(5,216)
Operating deficit for the financial period	**(4,920)**	**4,704**	**(1,359)**	**(1,551)**	**692**	**949**	**(8,355)**
Add: Notional cost of capital in expenditure	7,323						
Less: Programme Funding from DHSC	(65,870)						
Less: Capital charges paid to the DHSC	(17,292)						
Net expenditure	**(80,758)**						

Presentation to note 2 has been updated to separate out of 'Direct costs' the non-recurring 'Transformation costs'. This is in line with management accounts reporting.

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 Immunohematology and Histocompatibility & 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 DHSC is provided by the DHSC to support the activities of the CBB and BBMR.

The **Organ Donation and Transplantation** operating unit is primarily funded through Programme Funding from the DHSC, 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 numbers of actual donors so that an increase in the number of transplants is enabled.

Group Services comprises overhead departments including Finance, People, IT Services and Estates & Facilities. 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 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.

Note 3.1 – Staff Costs and related numbers

	Total	31 March 2018 Permanently Employed Staff	Other	31 March 2017 Total
	£000	£000	£000	£000
Salaries and wages	**164,078**	153,143	10,935	163,985
Social security costs	**15,506**	14,990	516	15,293
Employer contributions to NHS Pensions Agency	**20,384**	19,705	679	20,125
Total	**199,968**	**187,838**	**12,130**	**199,403**

Whole Time Equivalents	Total Number	Permanently Employed Number	Other Number
Year Ended 31 March 2018	**4,674**	**4,427**	**247**
Year Ended 31 March 2017	4,749	4,507	242

Note 3.2 – Purchase of Goods and Services

	31 March 2018 £000	31 March 2017 £000
Consumables	64,272	64,220
Maintenance of buildings, plant and equipment	16,742	19,711
Rent and rates	12,062	12,365
Transport costs	18,672	17,886
External contractors	34,814	26,696
Purchase and lease of equipment and furniture	4,657	3,650
Utilities and telecommunications	8,847	8,265
Media advertising	3,624	2,542
ODT Scheme payments	19,642	22,508
Other staff and related costs	13,828	15,760
Professional fees	2,664	2,485
External Auditor's remuneration: Audit fees *	87	90
Total	**199,911**	**196,178**

* No payment was made to the External Auditors for non-audit work

Note 3.3 – Other Operating Expenditure

	Notes	31 March 2018 £000	31 March 2017 £000
Capital charges paid over as cash to DHSC		17,544	17,292
Capital non-cash: Loss on disposal of fixed assets*	5.1	2,591	159
Miscellaneous **		4,268	4,996
Total		**24,403**	**22,447**

* Loss on disposal includes £2.35m of accounting loss on transfer of the Brentwood property to Homes England in June 17 for which no consideration was received.

** Amount includes £3.1m relating to IT software licence fees and £1.2m to insurance costs.

Note 4 – Operating Leases

NHSBT as lessee	31 March 2018 £000	31 March 2017 £000
Payments recognised as an expense		
Lease and rental payments	7,556	9,130
Total future minimum lease payments payable		
Not later than one year	4,527	4,350
Later than one year and not later than five years	7,209	4,783
Later than five years	806	866
Total	**12,542**	**9,999**

Note 5 – Other Gains and Losses

	31 March 2018 £000	31 March 2017 £000
5.1 Profit / (Loss) on disposal of non-current assets		
Loss on disposal of transport equipment	(144)	(61)
Loss on disposal of plant and equipment	(97)	(98)
Loss on disposal of Brentwood property	(2,350)	-
	(2,591)	**(159)**

Note 6 – Intangible Non-Current Assets

	Total £000	Software Purchased £000	Development Expenditure £000
Cost			
At 1 April 2017	**18,030**	18,030	-
Additions purchased	**-**	-	-
Reclassification	**-**	-	-
Disposals	**-**	-	-
At 31 March 2018	**18,030**	**18,030**	**-**
Amortisation			
At 1 April 2017	**13,930**	13,930	
Provided during the year	**1,312**	1,312	-
Impairments	**-**	-	-
Disposals	**-**	-	-
At 31 March 2018	**15,242**	**15,242**	**-**
Net book value at 1 April 2017	**4,100**	4,100	-
Net book value at 31 March 2018	**2,788**	**2,788**	**-**
Net book value at 31 March 2018 comprises:			
Purchased	**2,788**	2,788	-
Asset financing	**2,788**	**2,788**	**-**
Revaluation reserve	**28**	**28**	**-**
Cost			
At 1 April 2016	**17,831**	15,961	1,870
Additions purchased	**199**	199	-
Reclassification	**-**	1,870	(1,870)
Disposals	**-**	-	-
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	-
Disposals	**-**	-	-
At 31 March 2017	**13,930**	**13,930**	**-**
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**	**-**

Note 7 – Property, Plant and Equipment

	Total	Land	Buildings	L&B Identified for future sale	Assets Under Con-struction	Plant & Machinery	Transport Equipment	Information Technology
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2017	**246,600**	23,627	143,909	2,350	3,663	54,273	589	18,189
Additions purchased	**6,389**	-	580	-	1,483	4,326	-	-
Reclassification	**-**	-	3,663	-	(3,663)	-	-	-
Indexation	**1,416**	-	-	-	-	1,385	31	-
Other in year revaluations	**8,313**	114	8,199	-	-	-	-	-
Disposals	**(7,229)**	-	-	(2,350)	-	(4,269)	(610)	-
At 31 March 2018	**255,489**	**23,741**	**156,351**	**-**	**1,483**	**55,715**	**10**	**18,189**
Depreciation:								
At 1 April 2017	**60,569**	-	3,585	-	-	40,645	427	15,912
Provided during the year	**9,246**	22	5,426	-	-	2,982	23	793
Indexation	**1,059**	-	-	-	-	1,037	22	-
Other in year revaluations	**(4,975)**	(22)	(4,953)	-	-	-	-	-
Disposals	**(4,636)**	-	-	-	-	(4,172)	(464)	-
Accumulated depreciation at 31 March 2018	**61,263**	**-**	**4,058**	**-**	**-**	**40,492**	**8**	**16,705**
Net book value at 1 April 2017	**186,031**	23,627	140,324	2,350	3,663	13,628	162	2,277
Net book value at 31 March 2018	**194,226**	**23,741**	**152,293**	**-**	**1,483**	**15,223**	**2**	**1,484**
Net book value at 31 March 2018 comprises:								
Owned assets	**165,296**	19,928	127,176	-	1,483	15,223	2	1,484
Subsequent expenditure on or relating to assets acquired under a Finance Lease	**22,067**	-	22,067	-	-	-	-	-
Held on Finance Lease	**6,863**	3,813	3,050	-	-	-	-	-
	194,226	**23,741**	**152,293**	**-**	**1,483**	**15,223**	**2**	**1,484**
Revaluation reserve	**80,026**	**9,871**	**69,231**	**-**	**-**	**923**	**1**	**-**
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	**-**	-	-	-	(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**
Revaluation reserve	**69,191**	**9,745**	**58,515**	**-**	**-**	**905**	**26**	**-**

Note 8 – Inventories

	31 March 2018 £000	31 March 2017 £000
Raw materials and consumables	3,941	4,525
Work in progress	3,687	3,795
Finished processed goods	7,402	8,667
Total	**15,030**	**16,987**

Note 9 – Trade and Other Receivables

	31 March 2018 £000	31 March 2017 £000
Current		
NHS receivables – Revenue	18,904	15,012
Non-NHS trade receivables – Revenue	5,285	4,971
Provision for impairment of receivables	(2)	(12)
Other debtors	96	135
VAT	3,171	2,736
Prepayments and accrued income	8,242	6,503
Subtotal	**35,696**	**29,345**
Non-Current		
Financial Assets*	171	173
Subtotal	**171**	**173**
Total trade and other receivables	**35,867**	**29,518**

*prepayments and accrued income

Provision for irrecoverable debts

Amounts falling due within one year	2017/18 £000	2016/17 £000
At 1 April	12	28
Provided in year	2	5
Written off during year	(10)	(5)
Recovered during year	(2)	(16)
At 31 March	**2**	**12**
Aging of debts provided against		
Up to 12 months	2	3
Over 12 months	-	9
	2	**12**

Receivables and other debtors past due but not impaired		
Up to 3 months	8,919	8,064
Between 4 and 12 months	4,256	1,690
Over 12 months	480	298
	13,655	**10,052**

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 17).

Note 10 – Cash and Cash Equivalents

	31 March 2018	31 March 2017
	£000	£000
Balance 1 April	32,755	30,548
Net change in year	(9,276)	2,207
Balance 31 March	**23,479**	**32,755**
Comprising:		
Held with Government Banking Service accounts	23,478	32,754
Cash in hand	1	1
Cash and cash equivalents as in Statement of Cash Flows	**23,479**	**32,755**

Note 11 – Trade and Other Payables

	31 March 2018	31 March 2017
	£000	£000
Current		
NHS payables – Revenue	4,582	3,091
Non-NHS trade payables – Revenue	3,431	1,673
Non-NHS trade payables – capital	276	464
Tax and social security costs	10	10
Accruals and deferred income	17,207	15,395
Trade and other payables	**25,506**	**20,633**

Note 12 – Provisions for Liabilities and Charges

At 31 March 2017	PAYE & Liabilities £000	Employee Benefits £000	Redun-dancy £000	Product Liability & Other £000	Total £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 and 5 years	-	201	-	-	201
Thereafter	-	679	-	-	679
	293	**927**	**2,314**	**692**	**4,226**

At 31 March 2018					
Balance at 1 April 2017	293	927	2,314	692	4,226
Provisions arising in the year	-	12	366	240	618
Utilised during the year	-	(47)	(2,142)	(173)	(2,362)
Reversed unused	(293)	-	(172)	(366)	(831)
Unwinding of discount	-	23	-	-	23
	-	**915**	**366**	**393**	**1,674**
Expected timing of cash flows:					
With 1 year	-	48	366	393	807
Between 1 year and 5 years	-	202	-	-	202
Thereafter	-	665	-	-	665
Balance at 31 March 2018	**-**	**915**	**366**	**393**	**1,674**

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.

Product Liability and Other includes 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 15.

£7,600,000 (31 March 2017 £8,475,000) is included in the provisions of the NHS Resolution at 31 March 2018 in respect of clinical negligence liabilities relating to NHSBT. There is a £nil provision in respect of existing liabilities scheme (31 March 2017 £nil).

Note 13 – Finance Liabilities (Leases)

Minimum Lease Payments	31 March 2018 £000	31 March 2017 £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	8,039	8,593
	10,809	**11,363**
Less future finance charges	(6,699)	(7,104)
Present value of future lease obligations	**4,110**	**4,259**

Present Value of Minimum Lease	31 March 2018 £000	31 March 2017 £000
Not later than one year	166	149
Later than one year and not later than five years	884	790
Later than five years	3,060	3,320
Present value of future lease obligations	**4,110**	**4,259**
Analysed as:		
Current borrowings	166	149
Non-current borrowings	3,944	4,110
	4,110	**4,259**

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.

Note 14 – Working Capital

14.1 – Movement in Working Capital	31 March 2018 £000	31 March 2017 £000
(Decrease)/Increase in receivables with 1 year (note 9)	6,351	(4,407)
(Decrease)/Increase in receivables after 1 year (note 9)	(2)	(25)
(Decrease)/Increase in inventories (note 8)	(1,957)	(675)
Decrease/(Increase) in payables with 1 year (note 11)	(4,873)	(936)
Subtotal	**(481)**	**(6,043)**
Decrease/(Increase) in payables relating to items not passing through the Statement of Comprehensive Net Expenditure (note 11)	(188)	174
Subtotal	**(188)**	**174**
Total	**(669)**	**(5,869)**

14.2 – Other Cash Flow Adjustments	31 March 2018 £000	31 March 2017 £000
Depreciation (note 7)	9,246	9,867
Amortisation (note 6)	1,312	1,098
Impairments (note 5.2)	-	-
Loss on disposal (note 5.1)	2,591	159
Provisions arising in year (note 12)	618	3,063
Provisions reversed in year (note 12)	(831)	(2,362)
Total	**12,936**	**11,825**

Note 15 – Contingent Liabilities at 31 March 2018

A contingent liability of £62,000 (31 March 17 £128,000) 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 2017 £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.

Note 16 – Capital Commitments at 31March 2018

At 31 March 2018 the value of contracted capital commitments was £228,000 (31 March 2017 £534,000).

Note 17 – Related Parties

The DHSC 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 Foundations Trusts.

During the period these transactions were valued at £389m of income (31 March 2017 £389m) including capital funding and programme funding from the DHSC and £27m of expenditure (31 March 2017 £32m) which represented trading with 230 separate organisations.

The following named members of the Board had registered interests in related parties during the year. Disclosed below is the value of NHSBT income and expenditure transactions with those parties:

Name and Title	Registered Interest	Income £000	Expenditure £000
Mr K Rigg (NED)	Nottingham University Hospitals NHS Trust, Consultant Surgeon	5,659	269

* 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 24 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 £28,000 (31 March 2017 £113,000) and there was a debtor balance due by the Trust Fund of £55,000 (31 March 2017 £112,000).

Note 18 – Events after the Reporting Period

In accordance with the requirements of IAS10 events after the reporting period are considered up to the date on which the accounts are authorised for issue. This is as the date of the Certificate and Report of the Comptroller and Auditor General. There were no material post balance sheet events.

Note 19 – Financial Instruments

Financial reporting standard IFRS7 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 IFRS7 mainly applies. NHSBT has no power to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing NHSBT in undertaking its activities. NHSBT is therefore exposed to little credit, liquidity or market risk.

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

Capital expenditure costs are financed from a Capital Allocation from the DHSC voted annually by Parliament to the DHSC. 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 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. It is converted at the spot rate at the time of the transactions. 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.

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