NHS
Blood and Transplant

Board Meeting in Public

Tuesday, 20 May 2025

Title of Paper	Audit, Risk and Governance Committee Board Assurance Report	**Agenda No.**	5.2.1
Nature of Paper	☒ Official	☐ Official Sensitive	
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Presenter(s) at Meeting	Ian Murphy, Committee Chair		
Presented for	☐ Approval ☒ Assurance	☐ Information* ☐ Update	

Executive Summary (max 300 word count)

The purpose of this report is to summarise the Audit, Risk and Governance Committee's activity across 2024-25 and demonstrate that it has effectively discharged its delegated responsibilities, as set out within its terms of reference. The report will also inform the Accountable Officer's Annual Governance Statement 2024/25.

The report was considered by the Audit, Risk and Governance Committee on 2 May 2025. The Committee approved the report and agreed that:

a) an annual review of internal audit effectiveness be included on the forward plan each year.
b) moving forwards the Risk Management Committee should provide either the minutes of their most recent meeting (which should be approved by the RMC Chair, but may remain subject to confirmation at the next RMC meeting) or alternatively a report on the activities and key decisions of the most recent meeting of the Committee.

Previously Considered by	
Audit, Risk and Governance Committee on 2 May 2025.	
Recommendation	The Board is asked to receive the ARGC Committee Board Assurance Report for assurance.
Risk(s) identified (Link to Board Assurance Framework Risks)	
N/A.	
Strategic Objective(s) this paper relates to: [Click on all that apply]	
☐ Collaborate with partners ☐ Invest in people and culture ☐ Drive innovation ☒ Modernise our operations ☐ Grow and diversify our donor base	
Appendices:	Appendix 1 - Gap analysis against Audit, Risk and Governance Committee delegations.

NHS BLOOD AND TRANSPLANT AUDIT, RISK & GOVERNANCE COMMITTEE

COMMITTEE BOARD ASSURANCE REPORT 2024-25

Status: Official

Introduction

The Audit, Risk and Governance Committee (ARGC or the Committee) is established by the Board of NHSBT in compliance with Treasury Guidance as a non-executive committee of the Board with powers and responsibilities delegated to it within the NHSBT Standing Orders, Scheme of Delegations and its Terms of Reference.

The purpose of this Board Assurance report is to summarise the Committee's activity during 2024-25 and demonstrate that it has effectively discharged its delegated responsibilities, as set out in its terms of reference. The report will also inform the Accountable Officers Annual Governance Statement 2024-25.

Purpose of the Audit, Risk and Governance Committee

The purpose of the Committee is to support the Board and Accounting Officer by reviewing assurances on governance, risk management and the control environment to ensure that they are comprehensive and reliable. The Committee will also review and assess the integrity of financial statements and the annual report. The Committee is responsible for providing assurance of an effective system of corporate governance, risk management and internal control, across the whole of the organisation's activities. The scope of the Committee encompasses all the assurance needs of the Board and Accounting Officer.

The Committee has the following specific delegated authority from the Board:

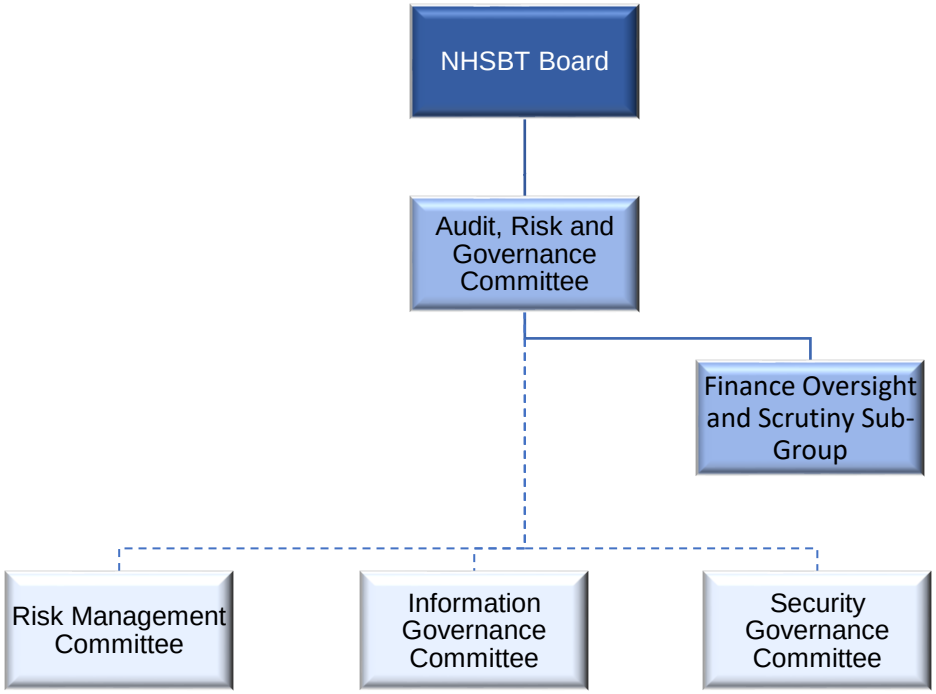
- Oversight of Risk Management
- Responsibility for effective Internal Audit
- Appointment and Review of External Audit
- Assurance oversight of Clinical Governance and People Committees
- Review of Assurance Mapping
- Reporting body for Risk Management Committee, Information Governance Committee and Security Governance Committee
- Review of External Assurance Function reviews and reports
- Review of management reports on governance, risk management and internal control
- Review of Financial Reporting
- Review of Financial Performance
- Review of Budget and Performance against budget

Reporting structure

The Audit, Risk and Governance Committee reports its activities to the Board, escalating significant matters after each meeting.

The Committee has established a non-executive Finance Oversight and Scrutiny Sub-Group. The Group is responsible for scrutinising NHSBT financial and planning reports, and carrying out a limited review of performance against budget, business plan and strategy, making recommendations to the ARGC on financial performance, planning and pricing issues. It is intended that the Group will enable scrutiny by the ARGC to be more focussed.

Three executive committee's report to the Audit, Risk and Governance Committee as shown below by the dotted lines.



Committee membership and attendance 2024-25

During 2024-25, the Committee met seven times. Meetings have been well attended. On two occasions (November 2024 and March 2025) absences led to issues with achieving a quorum, as per the Terms of Reference. On both occasions members who were not able to attend considered the published papers and provided relevant approvals by email to ensure that decisions could be made at the meetings. It is proposed to consider whether the quorum requirements require relaxing to include the Associate NED and Independent Member at the next review of the Terms of Reference.

The annual attendance of voting (V) and non-voting (NV) members is shown below:

Members	16.05.2024	27.06.2024	18.07.2024	12.09.2024	14.11.2024	06.01.2025	07.03.2025	Total
Piers White, NED (V) [1] Chair to 17.02.2025	√	√	√	√	√	√	-	**6/6**
Ian Murphy, NED (V) Chair from 18.02.2025	√	√	√	√	x	√	√	**6/7**
Rachel Jones, NED (V)	√	√	√	√	x	√	x	**5/7**
Nicola Yates, (NV) Associate NED	√	√	√	x	√	√	√	**6/7**
Niamh McKenna, (NV) Independent Member	√	√	√	√	√	√	√	**7/7**

[1] Piers White left the Board on 17.02.2025 having reached the end of his permissible term of office.

NHSBT has arrangements in place regarding the identification and management of any conflicts of interest. Members' interests are included on the agenda for visibility. Niamh McKenna has declared her executive director role at NHS Resolution. No further conflicts of interest requiring management were raised.

Summary of Activity

Key areas of focus for the Committee in 2024-25 have included:

Risk Management

a) The Committee has reviewed the Board Assurance Framework (BAF) at each of its standard meetings, seeking clarity on actions and mitigation of the principal risks, and their contributory risks. They have received updates on the addition of reputational risks to the BAF, and agreed that these will be included in future principal risk deep dives. The addition of a Corporate Governance principal risk to the BAF was agreed by the Committee.

b) A schedule of annual deep dives into principal risks was agreed by the Committee, and during the year deep dives into the following risks were received:

- P-02 Service Disruption
- P-03 Critical IT System Failure
- P-04 Number and Diversity of Donors
- P-05 Financial Stability Deep Dive
- P-09 Non-compliance with current or emerging regulations
- P-10 Scale and pace of the NHSBT Change Programme
- P-11 Corporate Governance

In addition, reports were received from the Clinical Governance Committee on their deep dives into:

- P-01 Donor & Patient Safety, and
- P-06 Clinical Outcomes and Health Inequalities

Reports from the People Committee were also received in relation to their deep dives into:

- P-07 Staff Capacity, Capability, Recruitment, Retention
- P-08 Leaders and Managers.

c) During the year subsequent progress update reports related to the deep dive into P-03 Loss of Critical ICT have been received together with reports in relation to cyber security, overall security (cyber, physical and people) and work in relation to the Data Security and Protection Toolkit.

d) The Committee reviewed findings from an ET Risk Workshop held in April 2024 and monitored work to address the findings, which was confirmed as completed prior to the year end. They also discussed plans for a Board Risk Workshop which was then held in November 2024, with the outputs of this being considered further by the Committee. Re-wording of risks will be completed within the May 2025 BAF, with more substantial changes to principal risks completed within the November 2025 BAF which will be considered in the next Board Risk Workshop.

e) The ARGC has reviewed areas of financial risk faced by NHSBT that have no, or limited, indemnity. This work culminated in a briefing note being prepared for DHSC to ensure they are sighted on the broad quantum of risk and to confirm interpretation of the policy on the use of commercial insurance (i.e. that it is used where required by legislation or where there is a commercial requirement).

f) The Committee has received reports in relation to supplier management throughout the year to seek assurance of the measures in place and guidance has been provided on how the current approach can be improved.

g) Regular updates were provided to the Committee during the year in relation to the development of assurance mapping. The first iteration of the assurance map was completed prior to the year end.

h) The Committee has reviewed NHSBT's gap analysis in relation to the Government Functional Standards, noting actions that are required to comply with 'Shall' mandatory standards and the timescale for such. 56 elements require action, and target dates for most aim to be compliant by the end of the financial year 2025/26. Some actions will take longer due to the nature of the work required and investment needed.

Audit

a) The Committee started the year by considering the annual opinion and report of the internal auditor, the Government Internal Audit Agency (GIAA). A 'limited' opinion had been given for the 2023-24 financial year, citing that there were significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective. During 2024-25 the Committee has monitored work to improve the position and to evidence the higher standards that are being operated. At the ARGC meeting held on 2 May 2025, it was confirmed that the GIAA Chief Executive had cleared the issuing of a

'moderate' opinion for 2024/25, subject to the usual caveats in relation to post balance sheet events.

b) In addition to approving the internal audit plan for 2024-25 and receiving progress reports and findings from audits from GIAA at each standard meeting, the Committee has monitored the closure of internal audit actions seeing a much-improved position achieved as the year progressed. At the yearend there were no overdue actions that had not had evidence submitted to GIAA for confirmation of closure.

c) The ARGC considered the audit schedules/plans in relation to internal audit, quality assurance audits, clinical audits, regulatory audits and supplier audits during the year.

d) Whilst the Clinical Governance Committee is responsible for monitoring clinical safety, the Committee has received for information and assurance Management Quality Review reports during the year.

External Audit

a) ARGC have liaised with the external audit teams from the National Audit Office and their appointed auditor Forvis Mazars Group throughout the year, agreeing the audit plan and the audit risks, considering progress and reviewing the final completion audit report for the financial year 2023-24 together with the Management Representation Letter (MRL). Recommendations were made to the Board and the Accounting Officer in relation to signing of the MRL.

b) Recommendations from the audit have been discussed with management and progress in addressing these monitored.

Financial Reporting

a) During the year the Committee considered the proposed form and detail of the 2023-24 Annual Report and Accounts including the Governance Statement, approving its final form and recommending this to the Board and Accounting Officer for signature. The Committee has discussed streamlining of the report for future years.

b) The Committee established a Sub-Group during the year to assist with their role in providing high level scrutiny of NHSBT's financial planning and performance against budget, business plan and strategy. The Committee has received reports from the sub-group and has considered significant issues raised by the Committee, including in relation to blood pricing and the impacts of funding.

Governance

a) To address findings from Board Effectiveness Reviews and the GIAA Internal Audit of Corporate Governance, the Committee reviewed management's Corporate Governance Improvement Programme which comprised workstreams related to risk management, internal audit, policies and functional standards, assurance mapping and corporate governance. Throughout the year they received reports on progress leading to agreement that sufficient progress had been made by the end of the financial year to warrant the programme's closure and a move to a 'business-as-usual' approach to continuous improvement for future years.

b) The ARGC reviewed progress throughout the year in relation to delivery of improvement recommended by Board Effectiveness Reviews and Board Committee effectiveness reviews

and gap analysis against the delegations to these. In the main the recommendation were completed by the end of the financial year, however a number outstanding in relation to the Clinical Governance Committee will be picked up during a planned Clinical Governance review in 2025-26.

c) The Committee reviewed an approach to defining a set of overarching 'Board Level' policies and policy statements to be moved into new formats and to be reviewed on an annual basis. This approach was recommended to the Board by the Committee. In particular the Committee reviewed the following:

- Scheme of Delegations,
- Standing Financial Instructions,
- Conflicts of Interest policy
- Confidentiality and Data Protection policy
- Risk Management policy
- Anti-Fraud, Bribery and Corruption policy
- Modern Slavery Statement
- Environment and Sustainability Statement.

In addition, as a one off the Committee reviewed the Records Management Policy.

d) During the year the Committee received an assurance report in relation to the declaration of potential conflicts of interest and the receipt or giving of gifts and hospitality. Improvements to the process were identified and the Committee continues to monitor their delivery and the impact of this.

e) The Committee receives a number of regular reports either at every standard meeting, or annually, in order to gain assurance of various matters, these include:

- Counter Fraud, including bribery,
- Losses and Special Payments,
- Waivers,
- Debt Management,
- Business continuity including the findings of a BSI audit conducted.
- Equality, Diversity and Inclusion compliance (annually),
- Mandatory training (annually) - In view of the progress made the ARGC confirmed that they did not require further reports to be presented to them on the basis that the People Committee will continue to monitor compliance.

Minutes or reports from the executive committees (Risk Management Committee, Information Governance Committee and Security Governance Committee) after each of their meetings are received by the ARGC for information, and to highlight significant matters.

Annual assurance reports are also reviewed in relation to the other Board Committees (Clinical Governance Committee, People Committee and Trust Fund Committee) and for the executive committees that report into the Committee (Risk Management Committee, Information Governance Committee and Security Governance Committee) with the aim of seeking assurance for the organisation.

f) During the year the Committee has discussed matters of data retention following the lifting of restrictions during the Infected Blood Inquiry, to seek assurance on the approaches now being

adopted. Patient/Donor clinical records was confirmed to be within the remit of the Clinical Governance Committee and moving forward the ARGC will receive information in regard to this through its consideration of principal risk P-03 Critical IT System Failure.

g) The Committee has reviewed its own terms of reference and those of its Finance Oversight and Scrutiny Sub-Group and the Risk Management Committee during the year.

h) The Committee reviewed the skills and capabilities required of its membership during the year and those of its current members. During the year there was a change of Chair for the Committee and arrangements were in place to ensure a sufficient transition.

Committee Effectiveness Review

An externally facilitated effectiveness review of the Board and its Committees was conducted by BDO LLP between November 2024 and February 2025. The report of their findings was presented to the Board at their meeting on 1 April 2025. Whilst the findings related to the Board, rather than its committees, there were two elements that each committee should give consideration to.

The first relates to succession planning and development. During 2024-25 the ARGC considered the skills of its members and the fact that the Committee Chair would be retiring from the Board and hence the Committee on 17 February 2025. Discussions with the Department of Health and Social Care were advanced to gain confirmation of the appointment of Ian Murphy as Chair from 18 February 2025. Ian Murphy has been brought onto the Board early in 2024 with this appointment in mind and therefore a long period of collaboration and transition of the Chair role had been possible. After Pier's departure, the appointment of Caroline Serfass, non-executive director, to the Committee with effect from 1 April 2025 was approved by the Board.

In terms of development of the Committee it was noted, at the time of the review, that three members (Piers White, Ian Murphy and Niamh McKenna) had recent and relevant financial experience and competence in accounting and/or auditing. The Terms of Reference set out that there must be one member with such experience. It was considered whether other members would benefit from financial training for non-financial non-executive directors but was decided that this would not be progressed at the current time. With the departure of Piers White, the Committee ends the year with two members with recent and relevant financial experience.

The skills assessment process will be repeated annually to identify any gaps that could be filled through future appointments and to identify knowledge development that can be planned.

The second finding relates to the size of the committee/board. The Terms of Reference of the ARGC states that there will be no fewer than three Non-Executive Board members and up to two-additional Associate Non-Executive Director or Independent Committee Member appointments. The Committee meets this requirement and the size is considered to be effective. Any non-executive director is welcome to observe the Committee and this has happened on two occasions during the year with the NHSBT Chair, Peter Wyman and Penny McIntyre observing different meetings.

Assurance and Statement to the Board

The opinion of the ARGC is that its risk management, control and governance processes are adequate and effective and may be relied upon by the Board.

The Gap Analysis against the Committee's delegations as set out in Appendix 1 has highlighted:

a) Whilst the effectiveness of internal audit and the performance of GIAA in this regard was discussed during the year, no formal review of its effectiveness was undertaken. The Committee should consider whether a formal review would add value.

b) The Committee receives the minutes of the Risk Management Committee (RMC) however these are not received until after they have been confirmed by the RMC at their next meeting (approximately 2 months later). This means that there is some delay before the activities of the RMC are seen. Draft minutes could be presented once agreed by the RMC Chair, subject to confirmation of the RMC at their subsequent meeting.

Appendix 1

Gap analysis against Clinical Governance Committee delegations

Committee Delegation	Terms of Reference	Reviewed by Committee (evidence and date)
Risk Management		
Oversight of the systems that are in place for the identification and management of risks. This committee can discharge this oversight by reviewing risks, seeking evidence of the effectiveness of risk mitigation and making recommendations to the Board on acceptable levels of risk:	5.2.1	Each standard meeting of the Committee considers the Board Assurance Framework. Annual deep dives are undertaken of each principal risk including consideration of their contributory risks and mitigating actions. The Committee has been key in encouraging strategic risk reviews of the Board. Much of the work of the Committee is focused on seeking assurance in relation to risk to the organisation.
The Committee will review the adequacy of all risk and control related disclosure statements (in particular the Governance Statement and declarations of compliance with the Health and Social Care Act 2012), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.	5.2.2.i	The Committee received the draft internal audit annual opinion at their 16 May 2024 meeting. The Committee considered the Annual Report and Accounts, including the Governance Statement and completion report of the external audit at their meeting on 27 June 2024 meeting.
The Committee will review the adequacy of directorate risk management arrangements. This may be through risk owners presenting risk information, by review of horizon scanning mechanisms or any other mechanism decided by the committee. Where possible this will be managed by planning an organisational review over an annual cycle through an agreed Committee Risk Management Calendar but may be by exception as circumstances dictate.	5.2.2.ii	A schedule of principal risk deep dives was agreed by the Committee following consideration by the Risk Management Committee. Annual deep dives were presented to the Committee in line with this. The deep dives discussed each principal risk including consideration of their contributory risks and mitigating actions. During the year the Committee has overseen the development of an assurance map which gives a view of the three lines of defense in relation to the main processes undertaken by each directorate and considers current and future legislation and regulation to be complied with.

The Committee will review the adequacy of the underlying assurances that support corporate objectives, statutory compliance, regulatory compliance, government mandate (via DHSC or other Government Department) and organisational policy.	5.2.2.iii	The Committee has received a number of assurance reports, throughout the year as set out in the summary of activity section above.
The committee will ensure that the Internal audit programme is informed by organisational risk.	5.2.2.iv	In forming the annual internal audit programme, GIAA consider the principal risks as set out in the BAF. In the future the assurance map will also inform the area of focus for audits. The Audit Committee members separate to the Executive Team consider key risks which would benefit from assurance from the internal audit process or areas where advisory reviews would be beneficial. Such suggestions are then considered by GIAA.
Internal Audit		
The ARGC is responsible for ensuring that there is an effective internal audit function that operates to Public Sector Internal Audit Standards.	5.2.3	GIAA has been appointed as the outsourced internal audit provision for NHSBT.
ARGC shall have particular engagement with the work of internal audit by reviewing and approving the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation.	5.2.3.i	The internal audit plan for H1 of 2024-25 was approved by the ARGC at its meeting on 16 May 2024, with the plan for H2 of 2024-25 being approved by the Committee at its meeting on 12 September 2024.
Consideration of the major findings of internal audit work, the effectiveness of management's response and the timeliness of follow up actions	5.2.3.ii	At each of its standard meetings the ARGC receives a report from GIAA on progress towards the completion of internal audit reviews, the findings of reviews and where audits are rated limited or lower the full detail of the findings and agreed management actions.
Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation, including direct access to the board chair and the committee chair thus providing independence	5.2.3.iii	GIAA have direct access to the ARGC Chair and NHSBT Chair. At least twice a year the ARGC meets with the internal auditor without management present. This was the case ahead of the Committee's

from the executive and accountability to the committee		meetings on 12 September 2024 and 7 March 2025. The Committee discusses the progress of GIAA in completing audits when considering its reports at each standard meeting, and discusses any risks to delivery of the programme.
Annual review of the effectiveness of Internal Audit.	5.2.3.iv	Whilst there was not a formal evaluation of the effectiveness of internal audit during the year the Committee discussed this within the private meetings held with management. Confidence in delivery of the internal audit plan was discussed through consideration of the internal audit updates provided by GIAA.
External Audit		
The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.	5.2.4	The Committee considered the 2023-24 Annual Report and Accounts, including the Governance Statement and completion report of the external audit at their meeting on 27 June 2024 meeting. The Completion report was formally presented at the meeting on 18 July 2024 and 12 September 2024. Updates were also provided at the Committee's meeting on 16 May 2024. Discussion in relation to the 2024-25 year planning for the external audit has taken place at the Committee's meetings on 14 November 2024 and 6 January and 7 March 2025.
Consideration of the performance of the External Auditor/outsourced partner organisation. If an external auditor resigns, the Committee will investigate the issues leading to this and decide whether any action is required.	5.2.4.i	The Committee has discussed the performance of the external auditor both in meetings during the year and in private meetings with management after the July 2024 and January 2025 meetings. There has been no resignation of the external auditor in the year.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with	5.2.4.ii	Discussion in relation to the 2024-25 year planning for the external audit has taken place at the Committee's meetings on 14 November 2024 and 6 January and 7

other External Bodies within the Healthcare system.		March 2025. The formal audit plan is awaited.
Approve the terms of engagement, including any engagement letter issued if mandated by a change in auditing standards or for instance a new Accounting Officer.	5.2.4.iii	The Committee considers the engagement letter for the external auditor alongside the audit plan.
Approve the remuneration, for both audit and non-audit services of any outsourced partner and ensure level of fees is appropriate to enable an effective and high-quality audit to be conducted.	5.2.4.iv	The Committee considers the remuneration of the external auditor alongside the engagement letter and audit plan.
Discussion with the External Auditors of their local evaluation of audit risks and assessment of NHSBT and associated impact on the audit fee.	5.2.4.v	The expected Audit Risks on the 2024-2025 Financial Statements Audit were discussed by the Committee on 14 November 2024.
Review of all External Audit reports.	5.2.4.vi	Verbal and written reports are received from the external auditor and NAO at each standard meeting of the Committee.
Governance		
Clinical Governance - Seek assurance in the form of an Annual Report from the Clinical Governance Committee, which will include a report of work undertaken, providing positive assurance that clinical governance mechanisms are in place and effective, that regulatory compliance for licenced and regulated activity is in place and effective, meeting the terms of reference for the committee and supporting the annual Governance Statement. Seek assurance relating to the findings from the programme of audits and the proposed plan for the subsequent year.	5.2.5	The Committee received such a report at its meeting on 16 May 2024.
People Committee - seek assurance in the form of an Annual Report from the People Committee, which will include a report of work undertaken, providing positive assurance that people management mechanisms are in place and effective, meeting the terms of reference for the committee	5.2.6	The Committee received such a report at its meeting on 16 May 2024.

and supporting the annual Governance Statement.		
Board Assurance Framework and Assurance Map - receive regular reports on the Board Assurance Framework, which will include reporting on risks rated as outside risk tolerance and other issues of concern raised by the Chief Risk Officer.	5.2.7	The BAF has been received by the Committee at each of its standard meetings.
Assurance Map - receive regular reports on the Assurance Map. This will include reporting on legal and other mandatory compliance by exception, any risks against compliance and any issues of concern raised by General Counsel.	5.2.7	The Committee received an update on assurance mapping at each of its meetings from July 2024 onwards.
Risk Management Committee - receive and consider an annual report from the Risk Management Committee (RMC) which will include compliance with RMC Terms of Reference, findings from audits internal or external to the organisation, compliance with applied standards and performance during the year. Receive a report or the minutes of every RMC meeting.	5.2.8	The Committee received such a report at its meeting on 16 May 2024. The Committee receives the minutes of RMC meetings once they have been confirmed by the Committee. This generally means that ARGC is not receiving the most recent view of activity through the Committee. It is recommended that minutes are provided for the most recent meeting once approved by the RMC Chair, which can be marked that they remain subject to confirmation of the Committee.
Information Governance and Security Governance Committees - receive and consider annual reports from the Information Governance Committee (IGC) and Security Governance Committee (SGC) which will include compliance with Terms of Reference, findings from audits internal or external to the organisation, compliance with applied standards and performance during the year. Receive a report or the minutes of every IGC and SGC meeting.	5.2.9	The Committee received such a report at its meeting on 16 May 2024. The Committee receives a report following each meeting of the IGC and SGC.
External Assurance Functions - review the findings of external assurance functions and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arm's Length	5.2.10	The BSI Audit of Business Continuity was received by the Committee at its meeting on 7 March 2025.

Bodies or Regulators / Inspectors (e.g., Care Quality Commission, MHRA, HTA, NHS Resolution etc.); professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges, accreditation bodies, etc.).		
Management - review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control. Request specific reports from individual functions within the organisation, as they may be appropriate to the overall arrangements.	5.2.11	The assurance map will assist with this delegation. The Committee has requested a number of reports during the year, including in relation to mandatory training, supplier management, patient records management post IBI and indemnity risk. All have been delivered.
Financial Reporting		
The Committee is responsible to reviewing and making recommendations to The Board and CEO on NHSBT's Annual Report and Financial Statements including:	5.2.12	During the year the Committee considered the proposed form and detail of the 2023-24 Annual Report and Accounts including the Governance Statement, approving its final form and recommending this to the Board and Accounting Officer for signature. The final meeting to sign off the process was held on 27 June 2024 meeting.
The narrative and commentary including that of the Governance Statement in particular and any other disclosures.	5.2.12.i	
The clarity and completeness of disclosures in the statements and the context in which statements are made.	5.2.12.ii	
Methods used to account for significant or unusual transactions.	5.2.12.iii	
Changes in, and compliance with, accounting policies and practices and the appropriateness of these.	5.2.12.iv	
The report and opinion of the External Auditors including unadjusted misstatements in the financial statements. major judgmental areas and significant adjustments resulting from the audit.	5.2.12.v	
Its consistency with the narrative and financial information that have been presented to the Board within the NHSBT management accounts during the course of the financial year.	5.2.12.vi	
Undertaking a high-level review of the financial performance of NHBST and its constituent Divisions/Businesses.	5.2.12.vii	The Committee established a Sub-Group during the year to assist with their role in providing high level scrutiny of NHSBT's

Review, at high level, the development of the budget and subsequent performance against the budget.	5.2.12.viii	financial planning and performance against budget, business plan and strategy. The Committee has received reports from the sub-group and has considered significant issues raised by the Committee. Reports are received following each meeting of the Sub-Group held.
Review and scrutinise the Divisional five-year plans and flag to the Board any concerns with regard to funding gaps and/or pricing strategies.	5.2.12.ix	
Review the performance indicators.	5.2.12.x	
Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.	5.2.13	
Where the committee is not satisfied with any aspect of the proposed financial reporting, it shall report its views to the board.	5.2.14	This has not been the case during 2024-25.
The Committee will consider any other relevant matters where requested to do so by the Board.	5.2.15	There have been no additional requests during 2024-25.