NHS
Blood and Transplant

Annual Report and Accounts
2021-22

HC 1097

SG/2023/26

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NHS Blood and Transplant Annual Report and Accounts 2021-22

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Introduction from the Chair


Peter Wyman

NHSBT is an amazing organisation. We play a unique role in the NHS, providing blood, organs, tissues and stem cells, as well as a range of related diagnostic and therapeutic services. We are respected internationally for our productivity, research and development and trusted nationally for safety and reliability.

It has been a challenging couple of years. But even under the intense pressure of a global pandemic, our teams continued to break new boundaries with research and development – including through the plasma for medicine programme – and ensured we were able to supply our products to the NHS and patients so we could save and improve lives every day.

This is thanks to the loyalty of our amazing donors, dedication of our people and the support of partners and stakeholders.

We are very proud of the scale of our operations. Our teams throughout the UK provide 4,000 patients with lifesaving organ transplants every year. Our two world class tissue banks, supported by our four regional tissue and eye donation teams, provide 6,000 human tissue products and 2,000 corneas for transplant.

Thanks to more than 800,000 people who regularly donate blood,

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plasma and platelets and to our dedicated staff, each year we provide 1.4 million units of red cells, and 450,000 units of platelets and plasma across England. Our 50 regional and 25 fixed donor centre teams collect blood before being manufactured and tested in labs in Filton, Manchester and Colindale. It is then sent to our 14 stock holding units which distribute our products to 260 hospitals helping countless patients – including in our eight regional Therapeutic Apheresis Units where our highly trained staff provide 10,000 apheresis procedures annually to 2,000 patients and donors.

Our expertise and ability to contribute to the health and care system reaches way beyond blood and organs. Our teams also push boundaries and expand medical knowledge.

Our medical, nursing and scientific teams advise on the care of donors and patients and set national policies and guidelines for clinical care. Our world-class research and development programme guides international transfusion and transplantation practice to benefit healthcare in the UK and beyond. And we are dedicated to improving patient outcomes, donor health, transfusion, transplantation and regenerative medicine as well as having a clear focus on tackling health inequalities.

The CQC carried out their first inspection of NHSBT in June 2022. This was a reactive focussed inspection of the leadership and governance of the organisation. Following the “Well-Led” inspection of NHSBT, CQC also

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completed an inspection of our regulated activities, Blood Donation and Therapeutic Apheresis Services. CQC found that our services were safe and provided good care to donors and patients. The three reports (organisational wide and 2 service level reports) were published on 27th October 2022. The reports did identify areas for improvement. The action plans in response to these findings have been considered at the NHSBT Board meeting on the 29th November 2022 and having been reviewed were returned to CQC, following the meeting. Progress against the action plans will be monitored by the Board and the CQC, during regular and routine engagement meetings with the organisation. Looking more broadly, we continue to implement the lessons and changes recommended by the "Organisation Diagnosis Report for the Services at NHS Blood and Transplant" (2019). So, while we are making progress, like every good organisation we should always be challenging ourselves to do even better. In particular, I want to ensure we have a culture that enables each of us to be our best, that encourages everyone to speak up without fear or favour if they see something wrong or something which might be done better. I want a culture where everyone is valued for who they are and what they contribute".

That is just a snapshot of the work we do and why I am incredibly proud to have been appointed Chair in April 2022. NHSBT owes a huge debt of gratitude to John Pattullo who stepped in as interim Chair and

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> “ our organisation has played a key part in the response to the COVID-19 pandemic ”

who did far more than just keep things ticking over until the permanent Chair was appointed. I would also like to acknowledge Millie Banerjee’s work during the period she was Chair. Betsy Basis, resigned from NHSB on the 9th August 2022. Wendy Clark, formerly Chief Strategy, Digital and Information Officer, has now been appointed Interim Chief Executive, effective from the 9th August 2022.

In March 2022, shortly before I joined, we published our strategy. This was a defining moment for NHSBT. It sets the direction and ambition for the organisation we will become and the increased role we will play in the health and care system as we change the way we work to treat more patients with more specialist products and services.

The strategy sets a very clear direction for us as an organisation and for the many partners and stakeholders we work with to deliver for the thousands of patients and their families who rely on us every day. Together we will save and improve even more lives in the years ahead.

Peter Wyman Chair NHSBT

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Overview

Introduction

NHS Blood and Transplant (NHSBT) is a Special Health Authority dedicated to saving and improving lives.

We employ over 6,400 people across the UK, with a total income and funding of over £514 million. We are responsible for blood supply in England, and organ donation across the UK. We also provide a range of specialist diagnostic and therapeutic services, including international reference laboratories.

At a glance

Where we operate

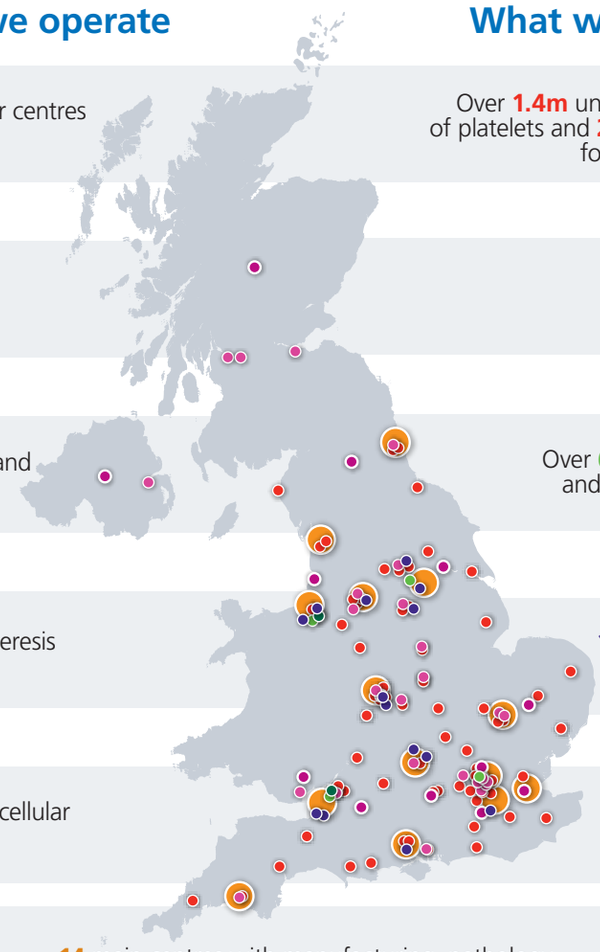
28 blood and plasma donor centres and **50** mobile teams

12 regional organ donation teams

2 world-class tissue banks and **4** regional donation teams

8 regional Therapeutic Apheresis Service (TAS) units

6 specialist laboratories for cellular and molecular therapies



14 main centres with manufacturing, pathology, donation and other specialist facilities

What we deliver*

Over **1.4m** units of red cells, **250,000** units of platelets and **200,000** plasma components for transfusion to **260** hospitals

4,000 life-saving organs to **29** UK Transplant Centres

Over **6,000** human tissue products and **2,000** corneas for transplant

10,000 procedures to around **2,000** patients and donors

Over **1,800** life-saving stem cell transplants

*every year

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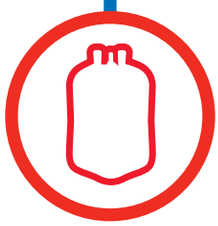
Our donors



Blood

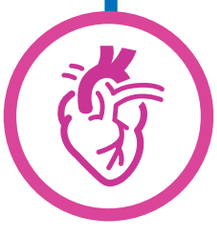
Over **800,000** people donate blood, plasma and platelets each year in England

We need at least **5,000** blood donations every day to meet patient need

To grow and diversify our donor base we need **150,000** new blood donors every year, including:

40,000 donors of Black heritage

30,000 donors with priority blood groups including Oneg



Organs and Tissues

30 million people have recorded a donation decision on the **NHS Organ Donor Register**

1 million people record their donation wish each year for the first time

Each year around **1,500** people donate their organs after death and over **1,000** people make living organ donations

Around **2,500** people donate their eyes, **250** donate bone, tendons and skin, and **350** donate heart tissue after death

We need **2,000** more organ transplants every year to meet demand

Stem cells

The British Bone Marrow Registry (BBMR) includes **380,000** potential stem cell donors, and connects us to **39 million** potential stem cell donors through a global network of registries

Stem cells are found in bone marrow and umbilical cord blood, and can be used to treat a wide range of blood cancers and disorders

The **NHS Cord Blood Bank** includes **19,000** clinical grade cord blood units for potential live-saving transplant

We need to recruit **30,000** new potential stem cell donors each year

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Our performance Interim Chief Executive's review

Wendy Clark

On 9th August 2022 I was appointed Interim CEO following the departure of Betsy Bassis who was CEO throughout the financial year 2021/22.

This year marked the 75th anniversary of the National Blood Service which came together in 2005 with UK Transplant to form NHSBT. It has been a year of many challenges due to the ongoing pandemic but I am incredibly proud of our performance. We have not only ensured continuity of supply of our critical products and services to the NHS, but have looked beyond the current crisis to develop a new strategy that will see us driving innovation and collaborating with partners to save and improve even more lives in the years to come.

> "I am in awe of the way our colleagues have faced this challenge...."

The second year of the pandemic

Thanks to the dedication of our staff and the altruism of our donors, we have continued to

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deliver for patients. This has not been without its challenges. Multiple waves of the pandemic have led to periodic increases in staff absence and donor availability, impacting supply. We have also seen variations in demand as hospitals have had to cancel elective surgeries and then put in place catch up programmes to deal with the backlog.

Our teams worked hard to manage these peaks and troughs, improving donor journeys and introducing new channels – such as our new app, concierge service and WhatsApp chat – to make it easier for donors to keep and re-arrange their bookings. On two occasions, we had to stand up a national emergency team to recover critically low blood stocks which threatened the continuity of blood supply. Thanks go out to our donors for helping us to avoid this 'never event' scenario. A key priority in 2022-23 will be to improve stock stability and avoid the need for these recovery efforts.

The pandemic continued to impact organ donation and transplantation activity, as well. We saw a 25 per cent reduction in the pool of eligible deceased donors, the causes of which we are still working to understand. Despite the introduction of Opt Out legislation in England, support for organ donation also fell during the same period as fewer families had access to loved ones in hospital. By working collaboratively with colleagues across the NHS, we were successful in mitigating the impact of these challenges and reached 90 per cent of pre-pandemic activity this last year – making the UK's

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recovery amongst the strongest internationally. Given the increase in the transplant waiting list, however, we must redouble our efforts to increase consent and improve organ utilisation in the months and years to come.

Plasma for the future

One of our strategic priorities as an organisation is to collaborate with partners to develop and scale new services for the NHS. A prime example of this is our plasma for medicine programme which sees us working alongside NHS England to develop a degree of national self-sufficiency in immunoglobulins. For many years, the UK has had to rely on imported immunoglobulins, bought on the international market and manufactured from plasma collected overseas. This has left us exposed as a country to increases in global demand, as well as supply shocks such as those caused by the pandemic.

But no more. Now that the Government has lifted the restriction on the use of plasma from UK donors, we have started to collect plasma in advance of NHS England appointing a fractionator who will manufacture it into immunoglobulins and return it for use in the NHS. In addition to recovering plasma from whole blood, we operate three plasma donor centres and have 4,000 active donors. Over the next few years we hope to recruit more than 10,000 regular donors and improve our productivity. If we are successful, we will be looking to scale this 'start up' operation even further, which will allow the NHS to achieve even higher levels

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of national self-sufficiency in this critical lifesaving medicine.

Advancing healthcare

We continue to run a comprehensive research and development programme, driving innovation to improve patient outcomes. One of our key areas of focus is genomics, which offers the opportunity to significantly improve donor and patient matching. This year, as one of the key members of the international Blood transfusion Genomics Consortium, we supported the validation of a simple-to-use DNA test for typing clinically relevant red blood cell groups. Our Colindale laboratory genotyped more than 1,000 samples and we will continue to work to secure regulatory accreditation next year. This will pave the way to introduce faster, cost-effective red cell genotyping into our routine services.

In addition, our HAEM-MATCH Consortium started its research to assess the role of extended matching in transfusion to improve outcomes for patients with sickle cell disease using genotyping results and precision medicine, with the ultimate aim of reducing immunisation against transfused blood. We also ran a pilot to recruit blood donors into Our Future Health. Based on its success, we will be working to recruit 500,000 donors over the coming years, supporting what is expected to be the UK's largest ever health research programme, discovering more effective ways to prevent, detect and treat diseases.

We have worked with

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the National Institute of Health Research to launch five new five-year Blood and Transplant Research Units. With a collective investment of £20 million, these multi-disciplinary centres of excellence will pursue cutting edge research in donor health and behaviour, improve transfusion practice in hospitals, increase the number of organs available and improve long-term outcomes after solid organ transplant, develop new kinds of cell therapies for blood disorders and blood cancer and, reduce the risks of transmitting infections through the work that we do.

During the year we also completed construction of our new Clinical Biotechnology Centre. This £9 million extension to our Bristol site will provide additional state-of-the-art capacity for advanced cellular and gene therapy work for healthcare, academic and commercial customers.

Attracting new donors

The demand for Ro red cells continues to increase due to more patients being treated for blood conditions such as sickle cell, which largely affects people of Black heritage. Sickle cell can be truly debilitating so it is incredibly important that we meet the clinical demand for approximately matched blood. Ro is a rare subtype which is 10 times more common in people of Black heritage. I am very pleased that we increased the number of Black heritage and mixed ethnicity donors from 12,900 to 17,400 – 43 per cent of whom were Ro subtype. But there is more

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to do as we are still not meeting clinical demand, which is why one of our five strategic priorities as an organisation is to grow and diversify our donor base.

And finally

Without our people, this organisation would not be able to deliver for our donors and the patients we collectively serve. Throughout this second year of the pandemic, they have demonstrated a level of resilience and determination that cannot be under-estimated or taken for granted. It is for this reason that we have and will continue to invest in our people and culture to ensure a high performing, and inclusive organisation. My aim is to make NHSBT a great place to work for everyone, and a destination of choice for top talent.

Together, our ambition is to save and improve even more lives in the years ahead and ultimately deliver our vision of a world where every patient receives the donation they need.

Wendy Clark
Interim Chief Executive and Accounting Officer

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Our mission, purpose, values, strategy and risks

NHS Blood and Transplant (NHSBT) is a Special Health Authority in England and Wales and is also accountable to the Scottish and Northern Ireland Health Departments for providing UK wide services in support of Organ Donation and Transplantation.

Our mission

NHSBT's mission is to save and improve lives. This inspires and motivates us every day.

As we look to the future, our ambition is to save and improve even more lives, creating a world where every patient receives the donation they need. This is an ambitious vision which will require significant change to what we do and how we work. But we must be ambitious on behalf of the patients who rely on our critical products and services.

Our core purpose

To provide a safe and sustainable supply of blood components, organs, stem cells, tissues and related diagnostic services to the National Health Service.

Our values

Caring about our donors, their families, our staff and the patients we serve

Being **expert** in meeting the needs of our customers and partners

Providing **quality** products, services and experiences for donors, staff and patients

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Our strategy

Our strategy sets out how we will deliver against our mission, while adhering to both our core purpose and values. The strategy is summarised via our 5 key priorities, and describes what we will do to achieve each of these priorities and how we will know when we have succeeded. For full details of our strategy, please read our Strategy document in full here.

Our 5 Key priorities:

Grow and diversify our donor base

to meet clinical demand and reduce health inequalities

Modernise our operations

to improve safety, resilience and efficiency

Drive innovation

to improve patient outcomes

Collaborate with partners

to develop and scale new services for the NHS

Invest in people and culture

to ensure a high performing, inclusive organisation

We will track our progress against these priorities in future annual reports.

In 2021-22 we managed our performance against our Annual Business Plan, which is outlined below (page 21).

Our Strategic Risks

In 2021-22 we created a Board Assurance Framework, deriving risks from a review of the new strategic priorities and assessing the risk to the delivery of those priorities. The Board Assurance Framework was formally adopted

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by the Board and risks continue to be scored on a five by five matrix, meaning that risks can be scored from 1 (lowest possible score) to 25 (highest possible score) by multiplying the impact and likelihood scores. We consider 1-3 as “very low”, 4-6 as “low”, 8-12 as “moderate” and 15 and above as “high” risk.

Toward the end of the year, the Board approved a new risk appetite process (aligned to the HM Treasury Orange Book), where we have different appetites or tolerance for risks with different types of impact. For example, we have minimal risk appetite for donor and patient safety matters but an open appetite for innovation and development.

The table below shows the risks, the scores with colours indicating whether the risk is very low, low, moderate or high, and the impact area and risk appetite, with colours indicating whether the risk is below or at the risk appetite level, at the tolerance level, in the judgement zone or at the risk limit. Each risk is linked to a strategic objective.

No.	Risk Title	Residual Score	Impact Area	Risk Appetite
1	Patient and Donor Harm	8	Donor and Patient Safety	Within Tolerance
Linked with the strategic objective “Modernise our operations to improve safety, resilience and efficiency”				
2A	Disruptive Event (Internal Failure)	12	Service Disruption	Judgement Zone
Linked with the strategic objective “Modernise our operations to improve safety, resilience and efficiency”				
2B	Disruptive Event (External Failure)	16	Service Disruption	Risk Limit
Linked with the strategic objective “Modernise our operations to improve safety, resilience and efficiency”				
3	Scale and pace of Change Programme	8	Innovation and Development	Below Optimal Score
Linked with the strategic objectives “Grow and diversify our donor base”, “Modernise our operations”, “Collaborate with partners”				
4	Number and Diversity of Donors	16	Innovation and Development	Judgement Zone
Linked with the strategic objectives “Grow and diversify our donor base”, “Modernise our operations” and “Collaborate with partners”				

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No.	Risk Title	Residual Score	Impact Area	Risk Appetite
5A	Finance	10	Financial	Optimal
Linked with the strategic objectives "Develop and scale new services to provide additional support to the NHS"				
5B	Support for Strategic Delivery	16	Innovation and Development	Judgement Zone
Linked with the strategic objective "Develop and scale new services to provide additional support to the NHS"				
6	Accessibility of Data	12	Innovation and Development	Within Tolerance
Linked with the strategic objective "Develop and scale new services to provide additional support to the NHS"				
7	Capacity, capability and flexibility of workforce	16	People	Judgement Zone
Linked with the strategic objective "Invest in people and culture to ensure a high performing and inclusive organisation"				
8	Leadership Capacity	9	People	Optimal
Linked with the strategic objective "Invest in people and culture to ensure a high performing and inclusive organisation"				
9	Regulatory Compliance	12	Legal, Regulatory & Compliance	Judgement Zone
Linked with the strategic objectives "Modernise our operations to improve safety, resilience and efficiency", "Innovate to improve patient outcomes" and "Collaborate with partners to develop and scale new services for the NHS"				

Risk 2B is shown as outside the risk tolerance due to a child risk about staffing, recruitment and annual leave. It links closely with risk 7 and risk 5B as our workforce capacity has been a constraining factor limiting our pace of change and why investing in our people is a key priority. We describe the impacts of the number and diversity of donors (Risk 4) in our performance section and the progress we have made in the year.

Two specific risks arose during the year which are closely related to the impacts of the pandemic. First, to mitigate potential supply chain disruptions we chose to extend the contracts for some key suppliers. The most significant impact of this decision has been on test kits, services and other contracts that support the testing of blood donors. The knock-on consequence is that re-procurement

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of several key supplies have needed tendering at the same time, placing considerable pressure on subject matter experts who work across key contracts. This is exacerbated as the technology we use is now outdated and will become unsupported, so we have very tight timescales to implement new solutions. This risk and related issues are now significant and under close scrutiny by the Board and Executive team.

A second impact was the disruption to blood supply. Blood stocks have fluctuated through the year due to the impact of COVID-19 on both our donors and our colleagues. On two occasions it became necessary to manage the risks by activating the critical incident plan managed by a National Emergency Team. Action taken included increased and more targeted marketing activity to increase the number and diversity of donors, management to mitigate sickness absence and increasing capacity by using plasma centres. We also asked hospitals to optimise blood use. The actions taken were successful and rebuilt stocks.

Other risks are reviewed in the performance section below and our assurance processes for risk are explained in the governance statement.

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Performance report

Our objectives, operational review and KPIs

Our NHSBT Business Plan 2021-2022, sets out what we intended to do over the course of the year to fulfil this mission. Our Business Plan was structured around 4 business plan objectives, each with priorities underpinning it. The plan also included detailed targets and activities from each area of our organisation that outlined how directorates would contribute to our business plan objectives.

The four business plan objectives and their corresponding priorities were as follows:

A. Modernise and extend our established services (see page 24)

Our priorities in achieving this in 2021-22 were to

- Modernise supply chains to protect and sustain a safe supply of blood;
- Increase organ donors and transplants through opt-out and utilisation;
- Modernise our pathology services.

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B. Develop and grow new and high-potential services (see page 38)

Our priorities in achieving this in 2021-22 were to

- Build capacity in the UK cellular therapies supply chain;
- Expand our tissue and eye service offering to patients;
- Support the Government ambition for a domestic supply of plasma for medicines.

C. Diversify and strengthen our donor base (see page 45)

Our priorities in achieving this in 2021-22 were to

- Reduce the Ro Kell Neg gap in blood donation;
- Improve our donors' experience by upgrading our digital services;
- Grow the foundation of a new plasma donor base.

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D. Make NHSBT a great place to work (see page 51)

Our priorities in achieving this in 2021-22 were to

- Increase diversity and inclusion amongst our workforce at all levels;
- Improve our employee experience;
- Support post-pandemic recovery across NHSBT.

This performance report will summarise how we have performed against this business plan. The report is divided into three sections:

1. **Our products and services (see page 24),** where we discuss performance against our business plan objectives to
   - Modernise and extend our established services
   - Develop and grow new and high-potential services
2. **Our donors and people (see page 45),** where we discuss performance against our business plan objectives to
   - Diversity and strengthen our donor base
   - Make NHSBT a great place to work for everyone
3. **Our Finances (see page 58),** where we report on the financial activity of note over the past year.

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Our products and services

2021-2022 business plan objective A:

Modernise and extend our established services

Priority 1: Modernise our supply chains to protect and sustain a safe supply of blood

Customer Satisfaction

75% of our hospital transfusion customers scored us 9 or 10/10, with the vast majority (98%) being satisfied or very satisfied. 80.5% (2021-22) of our blood donors scored us nine or ten out of ten for overall satisfaction, compared to 83.9% in 2020-21. As in previous years, the number of compliments received from our blood donors far outweighed the number of complaints. 11,009 (2021/22) compliments were received. (We received 7,590 compliments in 2020-21). In 2021-22 there were three requests for information made through the Parliamentary and Health Ombudsman, we met these requests and had no complaints. (In 2020-21 we had two complaints). We have improved how we manage complaints and use the feedback to improve the donor experience.

Our overall aim is to ensure all patients, including those with complex needs, receive the right blood components at the right time, and are supplied via an integrated, cost efficient and best in class supply chain and service.

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Our 2021-22 Targets

Performance Measure Aim	Target	Results	Performance
Meet customer requirements for product on time and in full (OTIF) including Ro	96.9%	96.9%	On-target
Improve customer satisfaction – % of hospitals scoring 9 or 10 out of 10 for overall satisfaction	75%	75%	On-target
Improve donor satisfaction – % of donors scoring 9 or 10 out of 10 for overall satisfaction	83%	81%	Off-target

Our Achievements

In the second year of the COVID-19 pandemic, we have continued to meet the needs of our customers while providing safe and positive experiences for our donors and colleagues.

We have made progress in modernising our operations by rolling out three key projects – Blood Technology Modernisation, Session Solution and Electronic Rostering. Blood Technology Modernisation, a project to re-write our 'Pulse' blood management system in modern code, delivered a first release of converted code. This is a significant step towards the stabilisation and security of our blood systems. The other two projects involve moving from paper-based to digital systems and have had an immediate impact in reducing administration time and effort for our blood donation teams, allowing them to deliver an even more efficient and safe service. These systems will also provide better management insight and enable us to continually improve our services and safely increase efficiency in future.

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We have delivered strong On Time, In Full (OTIF) performance despite high levels of variability in demand and supply of blood products during the year. We have also supplied over 4,000 blood components to other blood services in the United Kingdom and Republic of Ireland when their stocks have run low.

More blood components were issued to hospitals than the previous year with increases of 6% for red cells, 6% for platelets, 24% for cryoprecipitate and 14% for fresh frozen plasma, demonstrating a recovery from the impact of the pandemic on our supply volumes. However, we still saw peaks and troughs in demand for blood products by hospitals during 2020-21 as hospitals cancelled elective surgery to cope with COVID-19 pressures and, when able, tried to catch up on elective backlogs. The charts below demonstrate this level of volatility by showing the total weekly demand levels for red cells (Fig. 1) and the demand for the 'universal' O D negative red cells (Fig. 2). Meeting such volatile demand whilst ensuring we minimise wastage is challenging, and has required us to make every effort to predict demand shifts and flex our collection capacity as best we can.

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Fig. 1 – Overall Red Cell Demand 2021-22 (7-day moving total)

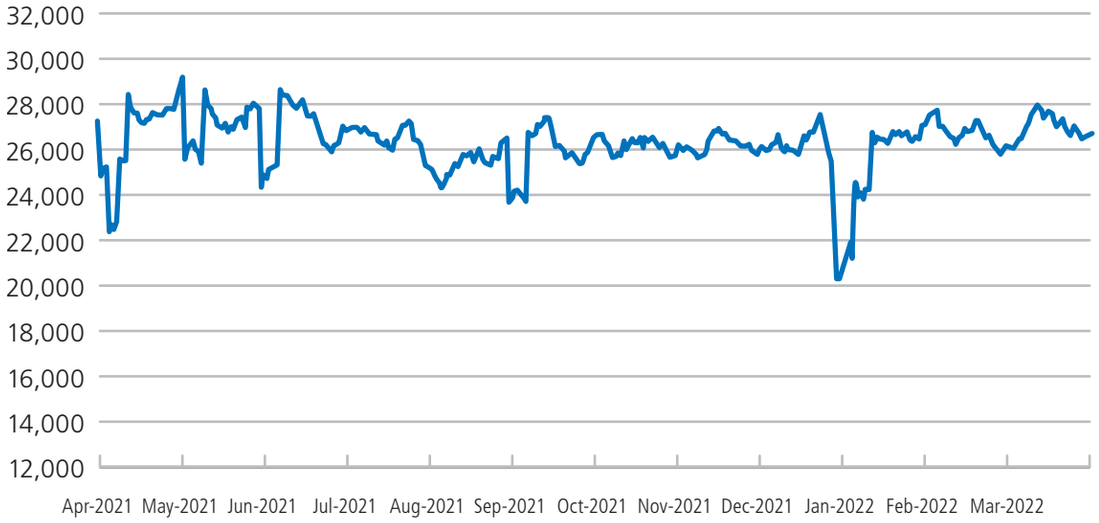
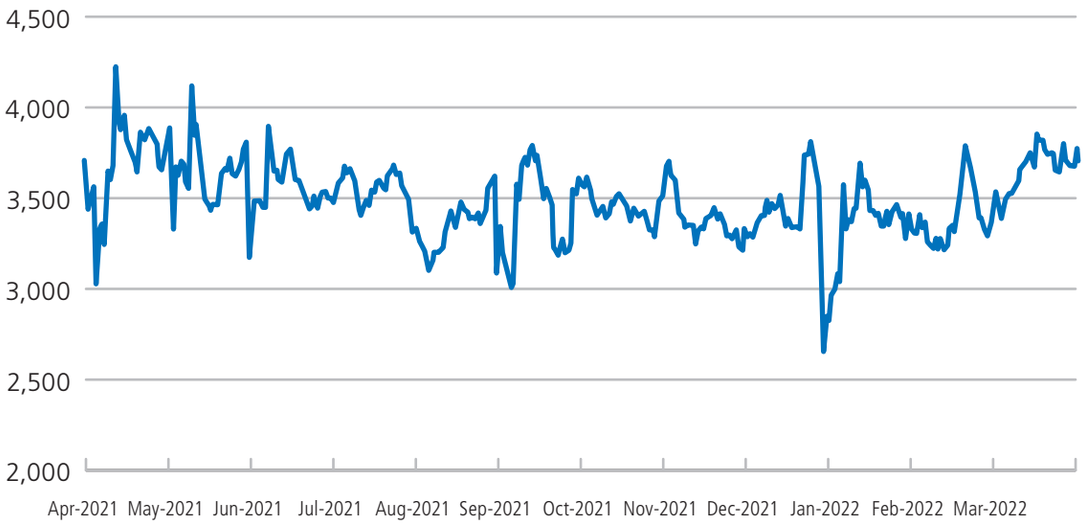


Fig. 2 – O D negative Red Cell Demand 2021-22 (7-day moving total)



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Our ability to collect and supply blood components has also been variable because:

- Donor attendance patterns changed through the year. At the peak of the Omicron wave in December 2021, only 84% of our donor appointments were booked (vs. 90% annual average). The percentage of booked appointments where a donor did not attend also varied significantly reaching 22% of all booked appointments at times (vs. 18.6% annual average) (see Fig 3).
- Increased rates of absence among our blood collection staff due to Covid-related sickness and quarantine also had a major impact on our ability to operate. For example, in December 2021 almost 20% of our blood collection staff were not at work, forcing us to cancel some appointments and impacting our customer satisfaction levels, with appointment cancellation or management – related issues being the leading cause of complaints from donors.

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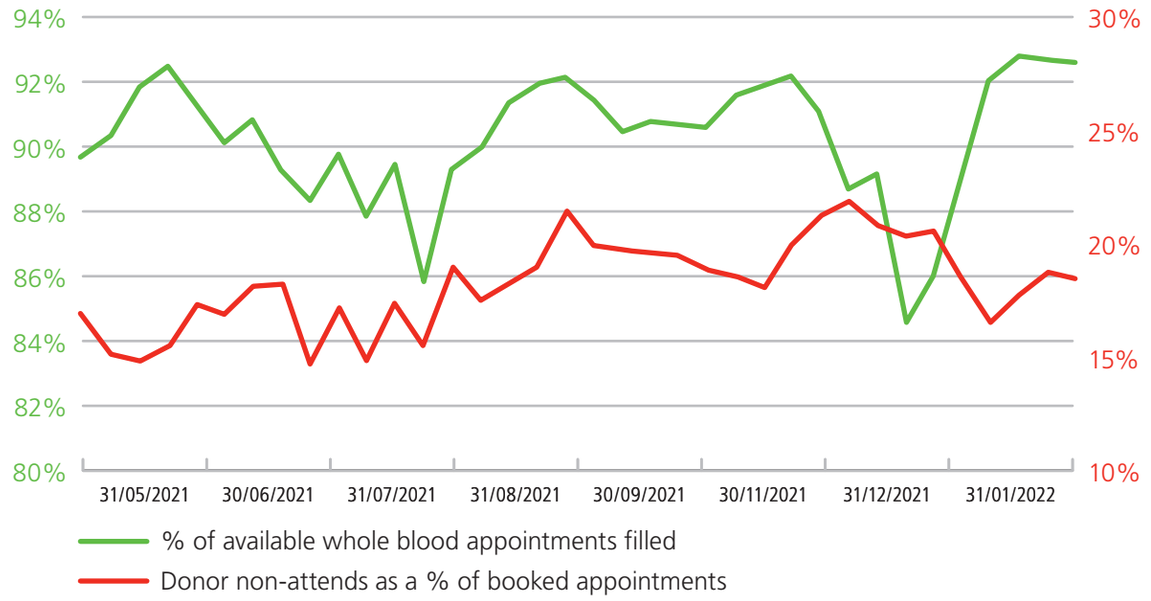
Fig. 3 – Percentage of blood donation appointments filled and percentage of donors not attending by week 2021-22



This variability in both demand from hospitals and supply from donors has caused fluctuations in our stock levels. Total red cell stocks fluctuated between five and nine days of stock over 2021-22, when our target levels are to have enough stock for six days' supply. At some points, stocks of O D negative and B D negative red cells fell to below 3 days of stock. To ensure this did not affect the supply of blood to hospitals, we stood-up a national emergency team to manage the situation on two separate occasions (first in late-July 2021 and again in late-October 2021). This approach ensured we recovered quickly and avoided falling below two days of stock, the level at which we would formally consider declaring a stock-shortage.

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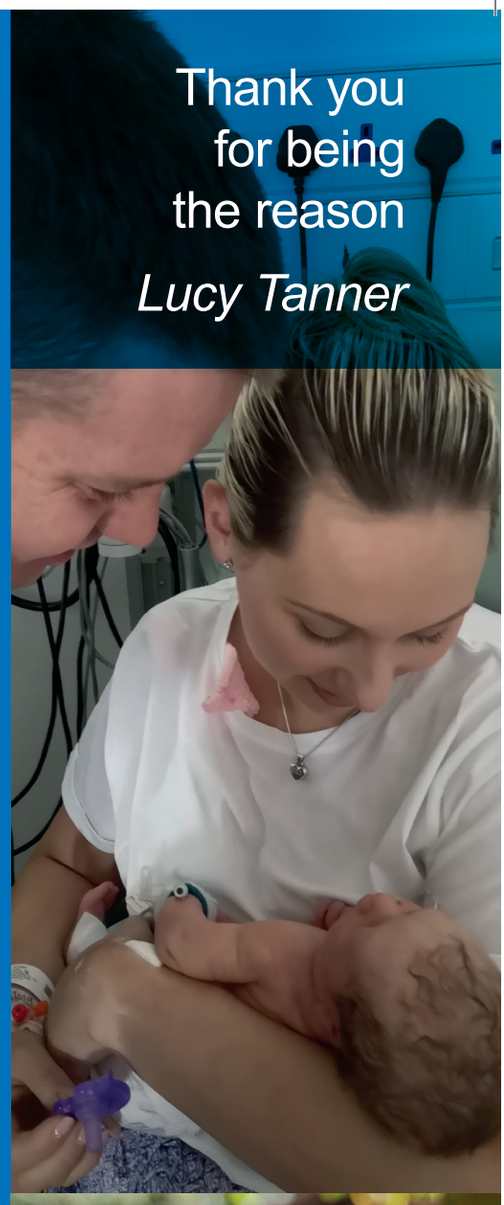
Blood Recipients

Lucy Tanner required a lifesaving blood transfusion after complications during an emergency C-section. Lucy was rushed to The Rosie Hospital in August 2019 after a low-lying placenta caused her to have a severe bleed at home, 36 weeks into the pregnancy. In order to successfully perform the C-section, surgeons had no choice but to cut into the placenta, which unfortunately caused massive haemorrhaging. Lucy needed 6 units of blood as a result of the haemorrhage.

"I'm so grateful to the donors who give up their time to donate blood. If they hadn't donated, I wouldn't be here," said Lucy. "Thank you for being the reason that my children still have their mum."



Theo has sickle cell and has received blood transfusions and exchanges to treat sickle cell complications in emergency situations. Theo also faces the daily challenges of sickle cell such as overcoming fatigue, crippling pain, and preventing complications that lead to needing hospitalisation. Theo does not need frequent transfusions but in times that he has received transfusions and exchanges they have enabled a quick recovery and he has quickly been able to return to activities that he enjoys.

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2021-2022 business plan objective A:

Modernise and extend our established services

Priority 2: Increase organ donors and transplants through opt-out and utilisation

Our 2021-22 Targets

Performance Measure Aim	Target	Results	Performance
Improve overall organ consent/authorisation rate (%)	74%	66%	Off-target
Number of deceased organ donors	1,697	1,397	Off-target
Number of deceased organ donor transplants	4,295	3,419	Off-target
Organ donor families, public, transplant recipients and Hospitals' satisfaction	0 complaints; high-level of compliments	57 complaints; 82 compliments	Off-target

Our Achievements

We are hugely grateful to the many people and families who consented to solid organ donation and to those who made the courageous decision to become living donors.

We publish a report on Organ Donation and Transplantation activity annually, which details transplantation rates by organ and ethnicity of recipients and of those who remain on the transplant waiting list. Below is a high-level summary of our year.

We had ambitious targets to recover quickly in 2021-22 to even higher levels of donation and transplantation than before the pandemic. Sadly, the pandemic continued to have a major impact on the UK's organ donation and transplantation system, because we rely on intensive care and other acute hospital facilities. Nonetheless, we are

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proud to have increased the number of deceased donors by 18% and the number of transplants by 16% in 2021-22 compared to 2020-21. This is a credit to the whole of the transplantation community as they adapt to these ongoing and ever-changing challenges.

While we have previously seen year-on-year increases in the public's support for organ donation, in 2021-22 the consent/authorisation rate fell to 2017/18 levels (66%). We believe this is in part due to restrictions on hospital visitors.

Reducing health inequality is a key focus of the work of NHSBT. Someone who is black, Asian, mixed race or of an ethnic minority is more likely to be on the transplant list than someone who is white. Around 30% of our transplant waiting list is from an ethnic minority but these populations only represent around 14% of the UK population. They will also wait longer than someone who is white. The consent/authorisation rate from ethnic minority donors continues to be a challenge (38% in 2021-22). However, we continue to see increases in the number of ethnic minority patients transplanted due to organ offering scheme changes implemented in recent years. Overall, 8% of deceased donors were black, Asian, mixed race or of an ethnic minority. 27% of all deceased donor transplant recipients in 2021-22 were BAME, while BAME patients represent 30% of transplant demand. This means that while BAME patients remain at a disadvantage, we are closing the gap across ethnicities as detailed in our BAME annual report.

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The UK Living Kidney Sharing Scheme quarterly matching runs went ahead as scheduled in 2021-22 and we have seen a strong recovery in living donation transplants.

England's move to an opt-out system, as a result of Max and Keira's law in May 2020, has seen 459 cases of support for deemed consent in England in 2021-22 from the 794 patients where deemed consent applied (58%). We also saw 935 families supporting their loved ones' opt-in decision in England (92%) and 123 consents where the deemed legislation did not apply.

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2021-2022 business plan objective A:

Modernise and extend our established services

Priority 3: Modernise our pathology services

Our 2021-22 Targets

Objective / KPI's	Target	Results	Performance
Pathology Services Income	£34.9m	£35.0m	Better than plan
Sample turnaround times – core services	95% within SLA	@99%	Better than plan
No of major regulatory non-compliances	Zero	Zero	Equal to plan

Our Pathology services provide specialist diagnostics to support safe transfusion and transplantation for patients completing approximately 300,000 investigations every year. These specialist services are delivered by a team of approximately 450 scientists across 16 different laboratories in England grouped into 3 three specialties: Red Cell Immunohematology (RCI), Histocompatibility and Immunogenetics (H&I) and IBGRL (International Blood Group Reference Laboratory).

The £35m income earned during 2021-22 can be broken down into approximate income streams follows: RCI – £18m, H&I – £15m, IBGRL and other miscellaneous income such as Training services – £2m.

2021-22 saw Pathology Service demand move back towards pre-pandemic levels for most service lines, with income just ahead of budget. Sample turnaround times were above target and we received zero 'major or critical' regulatory non-compliances. We also started the development of a new Pathology Services strategy, which we will complete during 2022-23.

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This year we established a change programme to develop and implement genomics technology to enable quicker, more accurate and complete testing, which will improve health outcomes and reduce health inequalities in transfusion and transplantation. As part of the programme, we piloted the recruitment of blood donors into the Our Future Health research programme (OFH) and, based on the learnings, are planning to scale-up in future years to recruit 500k donors into OFH. This will give us more detail on blood groups and iron levels which will enable better matches for recipients and improved checks on donor health.

As a partner in the Blood transfusion Genomics Consortium, we supported the validation of a 'simple-to-use' DNA test for typing clinically relevant red cell blood groups. Our Colindale laboratory genotyped over 1,000 samples with this array and work will continue next year to secure regulatory accreditation. Alongside this, the HAEM-MATCH Consortium started their research to assess the role of extended matching in transfusion to improve outcomes for patients with sickle cell disease. In the coming years, we will continue to collaborate with the NHS, academia, and Industry to progress our Genomics Programme.

During 2021-22, the National Institute of Health Research, in partnership with NHSBT, awarded a second round of funding to five new (five-year) Blood and Transplant Research Units, spanning the broad scope of NHSBT that started in April 2022.

In the final quarter of 2021-22, we established our

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Transfusion 2024 programme, aiming to improve patient outcomes through delivering improved infrastructure to support transfusion best practice. Next year, we will collaborate with NHS colleagues to pilot the remote interpretation of test results and electronic requesting/reporting.

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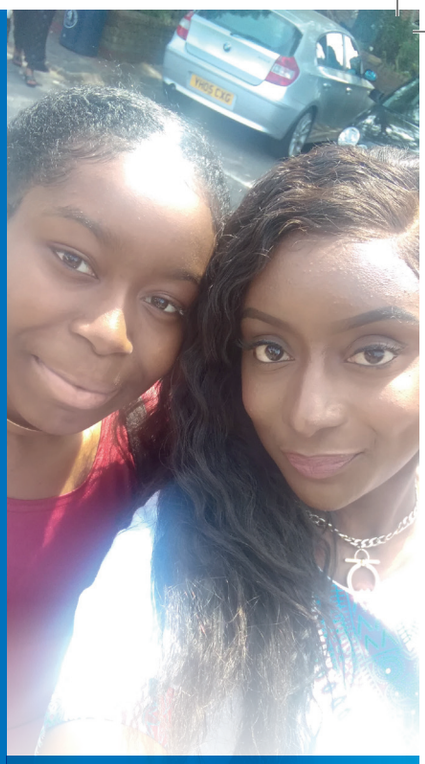
Blood Donors

Samantha says “Signing up to give blood is one of the best decisions I’ve made to help others. I was inspired by both my friend David, who is a regular donor, and my little sister who has sickle cell.”

“When I found out there are a shortage of black donors, this also inspired me to encourage my friends and family to sign up and donate. In 2019, I went on a mission to sign up one person per month and managed to get 14 friends and family that year. As an O negative blood donor, I understand the importance of donating regularly. I also look forward to receiving the text message to say where my blood has been used. 13 donations and counting!”

Johnny says “I gave blood for the first time in this country in October last year during Black History month. I am originally from Ghana and work as a registered nurse in Cumbria. I had seen on social media that NHS Blood and Transplant needed more black blood donors to come forward.

“I was happy to do it and a few days after the donation, I received a letter disclosing that I had a rare but important blood subtype – Ro. I was taken aback because I have donated blood several times in Ghana but I never knew of Ro blood. I have now made the pledge to donate blood regularly and I will continue to promote the movement to friends



When I found out there are a shortage of black donors

Samantha

I gave blood for the first time

Johnny

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2021-2022 business plan objective B:

Develop and grow new and high-potential services

Priority 1: Build capacity in the UK cellular therapies supply chain

Our 2021-22 Targets

Objective / KPI's	Target	Results	Performance
CAGT Income	£36.0m	£38.3m	Better than plan
No of major regulatory non-compliances	Zero	Zero	Equal to plan
NHS Cord Blood Bank Size	@19,000	@18,660	Just below target
NHS British Bone Marrow Registry Growth	+30,000	+18,730	Below target due to prioritisation of blood stock collection on session, plans to expand in 2022-23 to 30,000 goal

In 2021-22, demand returned to pre-pandemic levels across most of our Cell, Apheresis and Gene Therapies (CAGT) product/service lines. The NHS Cord Blood Bank issued 50 units for patients (45 2020-21) and the British Bone Marrow Registry activity was above plan with 175 donors matched to patients (117 last year). In Cellular and Molecular Therapies, service activity was 15% above plan, supporting 1,817 stem cell transplants (1,367 last year). Our Therapeutic Apheresis Service treated 1,934 patients (1,606 last year), performing 10,075 procedures (9,390 last year). In CAGT we received zero 'major or critical' regulatory non-compliances.

During the year, we completed the construction of the Clinical Biotechnology Centre (CBC) extension to our Bristol site, on time and to budget, providing new capacity for Advanced Cell and Gene Therapy Work – a ca £9m

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investment in UK regenerative medicine capability. CBC income also grew by 16% to £3.1m in-year. During 2022-23 we will cease operations at the old Langford site, secure the regulatory licence to manufacture Good Manufacturing Practice (GMP)-grade gene therapies and relocate to our new facility.

Work also began in relation to the grants awarded by the UK Governments' Medical Research Council and associated charities (£4.5m over 5 years), to support the development and manufacture of viral vectors and plasmid DNA for the UK's gene therapy sector.

In 2021-22, NHSBT continued to support the workstreams of the UK Stem Cell Strategic Forum, culminating in delivery of an interim report in Autumn 2021. The full report is due by the Summer of 2022, which will be incorporated into our new CAGT strategy due later this year.

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2021-2022 business plan objective B:

Develop and grow new and high-potential services

Priority 2: Expand our tissue and eye service offering to patients

Our 2021-22 Targets

Performance Measure	Target	Results	Performance
Tissues and Eye Services Sales Income	£14,297k	£15,038k	Above target
Number of Cornea Donors	3,650	2,279	Below target

Our Achievements

Tissue and Eye Services supply products to the Ophthalmic, Orthopaedic & Sports Injury, Cardiovascular, and Burns & Wound Care specialities, many of which have had much lower levels of activity during 2021-22 due to the pandemic. Despite the challenging environment, we reacted to the demand for products from the Ophthalmic and Orthopaedic sectors as they restarted surgery, and income has increased over the levels seen in the previous year, finishing £741k over target (£15,038k vs. £14,297k).

Thanks to the generosity of our donors and their families we have also seen an increase in the levels of donation this year, over 2021-22, with 2,279 Ocular donations, 360 Cardiovascular donations and a further 329 donors donating bone, skin and tendons.

As well as supplying products used for surgery, Tissue and Eye Services also produce and issue Serum Eyedrops to patients to relieve the chronic discomfort caused by their conditions. Patients receive 3 months' supply in each batch and this year 3,564 batches have been issued to patients, an increase of 251 batches over the previous year.

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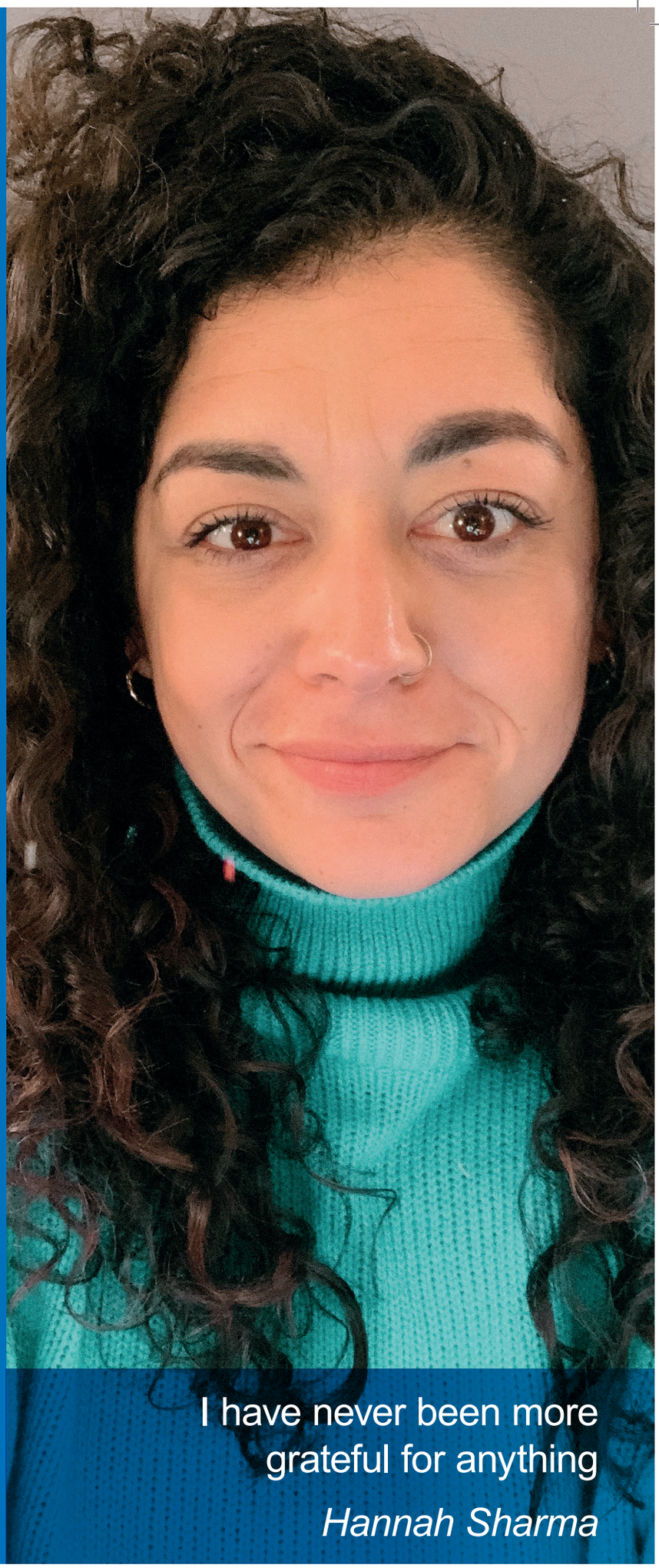
Organ Recipient

Hannah Sharma received a heart transplant in 2019 after suddenly becoming very ill with Dilated Cardiomyopathy. A very serious condition that meant Hannah's heart was enlarged, scarred and unable to pump blood around her body effectively.

Six weeks after being listed Hannah receive her heart. Hannah adds "I have never been more grateful for anything and I'm incredibly thankful for my donor's family from the bottom of 'our heart' for giving me a second chance and for honouring their loved one's wishes to save lives through organ donation. Organ donation is the greatest gift to those who are waiting."



I have never been more grateful for anything

Hannah Sharma

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2021-2022 business plan objective B:

Develop and grow new and high-potential services

Priority 3: Support the Government ambition for a domestic supply of plasma for medicines

Our 2021-22 Targets

Performance Measure Aim	Target	Results
Litres collected of source plasma	**To maximise collection**	**14,707**
Litres collected of recovered plasma	**To maximise collection**	**7,931**

Our Achievements

In April 2021 NHSBT started the collection of plasma for medicine (PFM), utilising infrastructure originally established for convalescent plasma. This followed the decision by ministers to lift the ban on UK plasma for fractionation following a review by the Medicines and Healthcare products Agency (MHRA) and the Commission Human Medicines (CHM).

NHSBT supported DHSC with the development of a business case to collect PFM on a longer-term basis and in December 2021 we received a ministerial instruction directing us to retain three plasma donation clinics on a permanent basis, and to continue to collect recovered plasma. We started to store plasma ahead of a fractionator being appointed by NHS England, and collected approximately 20k litres of PFM in 2020-21.

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We pivoted from collecting plasma for the globally significant trials of RECOVERY and REMAP-CAP, to collecting plasma for fractionation into immunoglobulin medicines. From April 2022 we established a Plasma Directorate within NHSBT. This Directorate will create a UK-based supply of plasma-derived medicines for NHS patients.

Over the past two years plasma collection for research and immunoglobulins, both through apheresis and recovered from whole blood, has become a core part of our operations.

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Living Donor

Prafula Shah says
"I donated my left kidney to my niece Shakti. She had suffered from chronic kidney disease from birth. In late 2017 Shakti's condition deteriorated dramatically. We were told she would need a transplant. A number of family members took the test including me.

Unfortunately, there were no matches but after talking through our options with experts at the Royal Free Hospital, we made the decision to join the National Living Donor Kidney Sharing Schemes (NLDKSS) as a 'paired donation'.

Our details were included in the national database and after a short time a match was found! Nine weeks after surgery we both returned to work and it has been the biggest joy for me to see Shakti happy, healthy, thriving, and able to live her life to the fullest.

I donated my left kidney to my niece Shakti

Prafula Shah

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Our donors and people

2021-2022 business plan objective C:

Diversify and strengthen our donor base

Priority 1: Reduce the Ro Kell Neg gap in blood donation

Our 2021-22 Targets

Performance Measure Aim	Target	Results	Performance
Whole Blood Donor base	807k	790k	Off-target
O neg Donor base	122k	110k	Off-target
Ro Donor base	27.7k	24.8k	Off-target
BBMR donor registrations	97.1k	94.3k	Off-target
Organ donor registrations	684k	885k	Above-target

Our Achievements

2021-22 proved to be a second challenging year for our donors due to the impact of COVID-19 and the preventative measures introduced across the country. Overall, our active donor base (those donating at least once a year) increased from 753,600 at the end of 2020-21 to 790,000.

During the year we welcomed 110,600 new donors to our service. Not just the 108,000 who donated blood or platelets for the first time, but also the 2,600 who answered our new call for plasma. 683,000 new members of the public recorded their donation wish with the Organ database, with 128,000 recording their decision through the NHS app. We bid farewell to 74,000 donors who stopped donating due to illness, retirement, or other permanent reasons. Our huge thanks for their lifetime of service, many have donated for decades.

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Patients who need regular transfusions often rely on specially matched blood, in particular Ro blood, which is 10x more common in people of Black African or Black Caribbean heritage. Through increased investment and support from our partners we increased the number of active donors with the Ro sub-type from 22,100 to 24,800, the highest ever, with 5,170 new donors welcomed. The total representation from donors of Black heritage and mixed ethnicity has increased from 12,900 to 17,400 this year, of which 43% were of the Ro subtype. There has been an increase in the proportion of opt-in registrations to the Organ Donor Register from Black, Asian, Mixed Race and Minority Ethnic communities in England and Wales too, from 10% in 2020-21 to 11.2%.

We ran dedicated marketing campaigns to increase donations from people of Black African and Black Caribbean heritage and address the ongoing health inequalities. Charity and commercial partnerships were established to underpin the activity across all services, including the African Caribbean Leukaemia Trust, Sky Sports, Aviva, Waitrose & Partners, Unilever and Next.

When the independent advisory committee on the Safety of Blood, Tissues and Organs (SaBTO) changed the guidelines For the Assessment of Individualised Risk (FAIR), we supported the education of the population on the changes and celebrated the more inclusive donor experience. This improved opportunities for gay men and those with links to sub-Saharan Africa to donate.

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2021-22 saw the third year of the highly successful NHSBT Community Investment Scheme with £400,000 invested across 35 projects (with investment up 106% on 2020-21). Initially established to support organ donation awareness within minority ethnic communities, this year the Scheme was extended to include whole blood too.

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2021-2022 business plan objective C:

Diversify and strengthen our donor base

Priority 2: Improve our donors' experience by upgrading our digital services

Our 2021-22 Targets

Objective	Target	Results	Performance
Improve our donors' experience by upgrading our digital services	85% of blood bookings online	78%	Off-target
	Net Promoter Score 85 (2021-22 Target 85 vs 83 since 2017)	85	On-target

Our Achievements

With the pandemic continuing and the increased asks of our donors, our Net Promotor Score fell slightly to 85, 2 points down year-on-year. Donor satisfaction and consent rates worsened, with the most frequent complaints covering appointment cancellations and availability of appointments as we managed the impacts from the pandemic. Several improvements have been launched this year to answer our donors' feedback

We launched a new NHS Give Blood app in the year which has an improved user experience and facial recognition. Donors are 2 times more likely to book an appointment due to the improved experience. For plasma donors we launched a new digital registration process which enables interested donors to sign up to donate, since launch in September we've seen over 10,000 new registrations. To help reduce donors being deferred we also refreshed our "Check you can give tool" giving a chance for donors to rebook if they know they won't be eligible to donate.

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To support stock challenges due to the pandemic we implemented two new channels for donors, a concierge team and WhatsApp chat to help book or amend appointments. Donors called by the concierge team 3 days ahead of appointment ensured 93% attended as planned. This service has worked especially well for donors from non-White backgrounds as receiving a Concierge call resulted in higher attendance than those who did not receive a Concierge call.

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2021-2022 business plan objective C:

Diversify and strengthen our donor base

Priority 3: Grow the foundation of a new plasma donor base

Our 2021-22 Targets

Objective	Target	Results	Performance
Plasma donor base	56k*	4.8k	Not applicable

*Original Plasma target assumed 11 venues but today's results are based on a reduction to 3 venues

Our Achievements

Our Plasma donor base for Plasma for Medicines has grown steadily once more towards the end of 2021-22, with almost 5,000 donors now registered and an aggressive growth plan in place for 2022-23. (For more on our activity around Plasma, see the preceding section: 2021-2022 business plan objective B: Develop and grow new and high-potential services – Priority 3: Support the Government ambition for a domestic supply of plasma for medicines).

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2021-2022 business plan objective D:

Make NHSBT a great place to work for everyone

Priority 1: Increase diversity and inclusion amongst our workforce at all levels

Our 2021-22 Targets

Objective	Target	Results	Performance
Increase diversity and inclusion amongst our workforce at all levels	Increase ethnic minority representation at Band 8a and above from 9% to 10%	We achieved with increases made across all Bands above Band 8a to average 13.4% excluding medics and 14.6% including medics	On-target

Our Achievements

Our ambition is to be an inclusive place to work and to be cared for. We want to ensure NHSBT is a place where we celebrate diversity and foster inclusion through a culture of dignity and respect.

Our journey to inclusion involves colleagues being encouraged to make a positive difference to each other, to stakeholders, and to patients using collective and corporate learning opportunities. Our executives are sponsoring our staff networks; our directorate diversity leads are shaping services and developing policies with a co-design mindset, and our Diversity and Inclusion team is steering our action plan for workforce and service inclusion that includes network specific support.

Our corporate focus has been on improving recruitment processes, training and career development opportunities, and dignity at work.

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Thanks to excellent support from our staff networks (The Women's Network, LGBT+ Network, GRacE Network, and the Disability and Wellbeing Network) we have made real progress. The networks, in partnership with the Diversity and Inclusion team, have marked key events in the inclusion calendar, including international women's day; LGBT+ History Month, Black History Month; Disability History Month; Staff Networks Day; Inter-Faith Week, and Hate Crime week, with educational events, podcasts, panel discussions and webinars. We run regular lunch and learn sessions on topics including Ramadan and the menopause to increase understanding among middle managers and staff.

In the past year, we have attained silver standard in Stonewall's Workplace Equality Index; been placed second across all NHS bodies for our Accessible Information Standard work; ; acted to improve our gender pay gap – at 8% it is half the national average (15.4%) and lower than all DHSC Arm's Length Bodies.

In response to NHS England's Model Employer standard – which aims to improve the representation of ethnic minority staff at every grade – we set a goal to have our leadership representation mirror the UK's ethnic minority population as recorded in 2011 Census. This means having 15% of our workforce at Band 8a and above from ethnic minorities. It's anticipated that the target figure will rise once 2021 Census data is published in October 2022.

At this point our 8a and above representation is 14.6% (9.83% in April 2021).

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2021-2022 business plan objective D:

Make NHSBT a great place to work for everyone

Priority 2: Improve employee experience

Our 2021-22 Targets

Objective	Target	Results	Performance
Improve employee experience	People Policy Review – training programme commence in Q3 complete by end of Q4	Launched our new Code of Conduct in December 2021	On-target

Our Achievements

In 2021-22, we commenced work to move to a resolution culture, with the intent of resolving colleague to colleague issues early and creating a more appreciative culture. A key part of this initiative has been the development and launch of a new Code of Conduct Policy across the workforce.

We worked with an independent organisation to redesign our dignity at work, grievance and disciplinary processes and place an emphasis on early intervention and resolution. We also commenced training for managers in our new approach, as well as engagement with staff groups to seek feedback.

In the coming year we will continue to focus on working collaboratively to identify and resolve concerns speedily.

We undertook a whole-organisation staff survey, this gave us a rich range of insights and an organisational benchmark for Engagement. Each directorate has developed a plan to respond to the survey results and we have tools in place to enable every manager to generate meaningful actions for their teams.

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2021-2022 business plan objective D:

Make NHSBT a great place to work for everyone

Priority 3: Support post-pandemic recovery across NHSBT

Our 2021-22 Targets

Objective	Target	Results	Performance
Support post-pandemic recovery across NHSBT	Staff vaccination rollout comparable to other NHS Trusts. Comparable Trust selected: London Ambulance Trust due to it being a geographically spread organisation, not concentrated at a few sites and does not have its own vaccination centres, ESR double vaccinated rate = 89.9% (NHS-wide rate = 93%).	NHSBT ESR double vaccinated rate = 86% at highest and available to all staff.	On-target (within comparable range)

Our Achievements

Our COVID-19 vaccination project delivered comparable rate of staff vaccination levels to London Ambulance to February 2022, against which we benchmarked our performance. London Ambulance was selected as an appropriate benchmark because like NHSBT its staff are geographically spread across many sites and it does not have its own vaccination programme. This is in contrast to the vast majority of NHS trusts that are based in a small number of large sites with dedicated vaccination programmes. An additional challenge was the significant proportion of NHSBT staff that do not have patient or donor facing roles, which was a reason some gave for not feeling that vaccination was imperative.

The project provided availability of vaccines for all staff including England, Scotland, Wales and Northern Ireland – based colleagues and a national staff campaign encouraged everyone to come forward for vaccination whilst respecting individual's decisions.

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Our Sustainability

We emitted 11,661 tCO_2e (tonnes of carbon dioxide equivalent) of Scope 1 (direct) emissions and Scope 2 (indirect) emissions in 2021-22 (2020-21 12,448 tCO2e). When Scope 3 (value chain) emissions are added, this brings the estimated total emissions to 13,697 tCO_2e (13,661 tCO_2e in 2020-21). This estimate of Scope 3 does not include all supply chain emissions which could be 58,056 tCO_2e*. We will work with our suppliers in 2022-23 to improve estimates of our total emissions.

Emissions data April 2021 to March 2022

Emissions source	Carbon (tCO_2e) 2021-22	Carbon (tCO_2e) 2020-21
Natural gas	3,170	3,260
CO2	277	252
Gas oil	109	367
Diesel	2,556	2,604
R-410A	159	-
Total Scope 1	**6,271**	**6,483**
UK National Grid electricity	5,390	5,965
Total Scope 1 & 2	**11,661**	**12,448**
Average car (Unknown fuel)	859	645
Transmission and distribution of UK national grid electricity	477	513
Flights (Domestic and short haul)	22	7
Regular taxi, motor bike and bus	9	18
National rail	49	12
Commercial and industrial waste (Recycled)	14	22
Commercial and industrial waste (Combustion)	40	25
Paper and board: board (Recycled)	12	8
Working from Home	240	-
UK National Grid electricity	314	-

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Emissions source	Carbon (tCO_2e) 2021-22	Carbon (tCO_2e) 2020-21
Total Scope 3*	**2,036**	**1,250**
Total Scope 1, 2 & 3	**13,697**	**13,698**
Less Self-generated renewables	**(34)**	**(37)**
Net estimated emissions	**13,663**	**13,661**

* Note our scope 3 above does not include all supply chain emissions. Using the Defra EEIO dataset, the Axiom platform and our supply chain spend for 2021-22 (£212,187,015), we estimate our scope 3 emissions to total 58,056 tonnes CO2e.

Spend on sustainability matters

	2021-22 £000	2020-21 £000
gross expenditure on the purchase of energy	5,165	4,772
expenditure on accredited offset purchases	0	0
total expenditure on official business travel	3,158	2,306
total expenditure on transport costs	17,742	14,193
spend on waste to landfill, recycled or incinerated	1,330	1,001

Waste in Tonnes:

	2021-22 tonne
Metals (Recycled)	1
Organic: garden waste (Composting)	25
Commercial and industrial waste (Recycled)	664
Commercial and industrial waste (Combustion)	1,856
Paper and board: board (Recycled)	241
Paper and board: paper (Recycled)	342
Wood (Recycled)	2
WEEE – fridges and freezers (Recycled)	0
WEEE – mixed (Combustion)	2

We have been certified as sending zero waste to landfill. We are collating total water consumption figures for our net zero plan. We purchased approximately 21,100 reams of A4 Paper in the year.

Great progress has been made on our current 2015-25 strategic goals. We expect to complete these in 2022-23, two years ahead of plan, when we will publish our new sustainability strategy Net Zero 2040, aligned to the wider NHS.

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The five targets, within the current strategy, are largely completed, as described below:

Target by 2025	Progress	Percentage met
50% cut in carbon emissions	If current trends continue we anticipate achieving this target (nearly 3 years early) in June 2022.	98.5%
Zero Waste to Landfill	NHSBT is currently undergoing an external certification of this objective and we are likely to be certified as 'Zero Waste to Landfill' by the end of this financial year.	100%
A resilient business	This target was completed in 2020, through our continued compliance with ISO14001, the International Standard for Environmental Management Systems (EMS).	100%
A sustainable supply chain	We aim to achieve a score of 4 out of 5 against ISO20400, the International Standard for Sustainable Procurement. Our latest assessment gave us 3.56 on our last assessment. We anticipate achieving our target in our assessment during 2022-23.	89%
Sustainability embedded into organisational culture	The progress we have made to meet our sustainability objectives, so far ahead of the end of the strategy end date, shows a clear positive shift in organisational culture. This will be used as a springboard towards a Net Zero future.	100%

During construction projects we consider climate change adaptation, rural proofing and biodiversity. There were no considerations to report in 2021-22 or 2020-21. All construction undertaken complies with BREEAM standards.

Net Zero by 2040

To prepare for Net Zero by 2040 we are measuring our emissions (see above). We have also commissioned advisors to produce a Net Zero Road Map, including Science Based Targets, that will be used to produce a Net Zero plan. This plan is due to be completed, agreed and published by September 2022.

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Our finances

Overall Financial Performance

The total income received by NHSBT in 2021-22 was £514.1m (£521.5m in 2020-21). Around 72% of our income is provided through sales of products and services to the NHS with the remainder provided as programme funding from DHSC and the Devolved Governments. The primary reason for the decline in income in 2021-22 was due to the higher level of funding provided by DHSC in 2020-21 for the Convalescent Plasma Programme during the height of the national pandemic response.

In line with the Treasury's Financial Reporting Manual (FReM), we publish our primary accounting statement on a ***Net Expenditure*** basis. This requires that the programme funding received by NHSBT, mostly in support of organ donation and transplantation, and more recently plasma as well, is included in reserves, rather than in the Statement of Comprehensive Net Expenditure (SoCNE).

The Board and management of NHSBT, however, manage the financial performance of NHSBT on an ***Income and Expenditure*** basis, with programme funding reported as income. **Note 2** provides NHSBT's financial results on an Income and Expenditure basis, consistent with the format of our management accounts, and reconciles this to the Net Expenditure basis shown in the SoCNE.

Consistent with the total income of £514.1m received in 2021-22, on a total income and expenditure basis, NHSBT reported a deficit of £8.8m. This compares to a planned budgeted deficit of £23.0m, and a deficit of £13.0m that

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was reported in 2020-21. It is common for NHBST to plan for an income and expenditure deficit as a result of using cash reserves to fund some of its planned activities (especially in respect of non-recurring revenue projects).

The improved outcome in 2021-22 versus our planning expectations was driven primarily by:

- Reduced costs in Organ Donation and Transplantation, due to a lower number of organ donations and transplants. Programme funding provided by DHSC and the Devolved Governments was, however, provided in full. The surplus generated in 2021-22 is therefore being carried forward as cash to fund activities in 2022-23.
- Activity in Clinical Services and Tissue and Eyes Services (TES) being close to pre-COVID levels and higher than the conservation assumptions that were made in the budget.
- Lower spending than planned in IT and transformation, including the reclassification transfer of certain revenue costs incurred on our Blood Technology Modernisation Project to capital.
- All of the above more than offsetting adverse cost variances in Blood Supply, due to the need for additional spending on temporary labour and overtime in blood collection, in order to maintain blood stock levels.

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Financial Performance by Segment compared to 2020-21

Within the Blood Component segment, we also include the funding received from DHSC for the Convalescent Plasma project, and its associated costs. We now also include funding and costs for the Plasma for Medicines initiative which the Convalescent Plasma project has now evolved into. The revenue and costs for both plasma projects balance out, with unused funding carried forward as cash reserves.

Excluding plasma, the overall income for Blood Components was £293.4m in the year. This was 3.6% higher than 2020-21 (£283.2m) due to an underlying price per unit increase of 5%, offset by the loss of income from plasma sold for non-clinical use (as a result of it now being retained for the plasma for medicines project). The operating surplus of £5.4m for the year was higher than the £2.4m recorded in 2020-21 as our overall expenditure was lower than that assumed by the price increase that was applied to blood. The lower expenditure was a result of lower spending on IT and transformation, including reclassification of costs to capital. These positive variances more than offset the increased costs in blood collection that were needed to sustain stocks during the pandemic.

The direct cost of Organ Donation and Transplantation (ODT) is funded by DHSC and the three devolved UK governments. Indirect overheads are not funded, however. As such, ODT is effectively subsidised by revenue generated by other parts of NHSBT (by £11.2m). Excluding funding for non-recurring projects the underlying funding

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for normal operating expenditure in 2021-22 was broadly flat at £86.2m. Although the number of organ donations and transplants was higher than 2020-21, it remained some 20% below pre-pandemic levels. Direct costs were therefore £6.4m lower than planned and this is therefore carried forward as cash reserves into 2022-23. The increased deficit reported for ODT of £12.4m in 2021-22 is higher than the £4.9m deficit reported in 2020-21 due to:

- Underlying inflation in operational costs, versus funding that remained flat.
- A higher number of organ donations and transplants, and hence related costs, in 2021-22 versus 2020-21.
- An exceptional supplier rebate of £2.5m that was received in 2020-21.

Income in Tissue and Eye Services (TES) improved to £15.0m versus the abnormally low level of income of £12.0m seen in 2020-21, when the impact of the pandemic was at its peak. As a result, the deficit reduced from £5.5m to £3.3m. Further post-covid recovery, plus real demand growth, is now expected in 2022-23 with TES is expected to operate at cash break even as a result.

As with the other segments of NHSBT, Covid-19 continued to impact demand in Clinical Services (Pathology, Stem Cells and Therapeutic Apheresis) in 2021/22, but with overall demand in Clinical Services returning close to normal levels. Total income (including programme funding from DHSC in support of the NHS Cord Blood Bank and the British Bone Marrow Registry) therefore recovered to £74.7m in 2021/22, 19% higher than the £62.7m seen

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in 2020/21. A surplus of £1.5m was therefore recorded, versus the Covid-19 impacted deficit of £5.0m that was seen in 2020/21.

Capital spend

DHSC provided funding for capital expenditure of £12.0m in 2021-22, versus £22.5m in 2020-21. Expenditure is now reducing to more historic norms, following the exceptional expenditure of previous years involved with the construction of the new Barnsley Centre and the Clinical Biotechnology Centre at Filton. Expenditure in 2021-22 saw the completion of the construction stage for each of these major projects. It also included the re-classification of £4.5m of revenue to capital, related to the Blood Technology Modernisation project. This project is engaged in rewriting the underlying code of the Pulse blood management system, in order to preserve its long-term future and resilience.

Net assets

Net assets increased to £291.2m at 31 March 2022 from £288.9m at 31 March 2021. The increase was mostly driven by:

- Non-current assets increasing from £236.3m to £247.1m due to capital expenditure and the net impact of the desktop-based revaluation (£5.4m) on our property assets.
- Trade and other payables increasing from £52.7m in March 2021 to £71.5m in March 2022 due largely to a £16.8m increase in accruals and deferred income. Accruals increased because of increased activity relating

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to plasma and some delays in supplier billing. Deferred income was significantly higher at £32.9m, primarily due to £22.9m of Treasury funding (via DHSC) that has been approved for carry over to support Plasma for Medicines in 2022-23. £7.2m of deferred income was ODT funding.

- Cash increased by £11.5m from £53.2m at March 2021 to £64.7m at March 2022. The balance notionally comprises £16.6m attributable to Blood Supply, £11.3m to Clinical Services, £13.9m to ODT and £22.9m to Plasma. Cash balances in Blood Supply and Clinical Services have been accumulated over recent years due to under expenditure versus plan, mostly in respect of non-recurring transformational projects.

Note 18 describes NHSBT's contingent liabilities. There are no other significant contingent liabilities to report, as at 31 March 2022.

NHSBT is the corporate trustee for NHSBT Trust Funds. The total net assets of the trust fund at 31 March 2022 were £81k (compared to £134k in March 2021). The 2021/22 Trust Fund Accounts are published on the NHSBT and Charity Commission websites. Although the Trust Fund assets are controlled by NHSBT, consolidated accounts are not produced as the Trust Fund is not financially material to NHSBT.

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Going concern

We operate a rolling five-year financial planning process which is regularly refreshed to reflect assumptions about product demand, funding from the four UK Health Departments, operating costs and the projected cost and benefits of our investment programme. We use this process to adjust prices for blood and specialist services and provide our Board with assurance that we can generate adequate income and cash resources, to meet our expected costs, over the coming five-year period.

We have refreshed our forecasts, and in agreement with DHSC and NHSE&I, we have revised our prices for blood and specialist services in 2022-23. Along with funding from DHSC and the devolved governments for organ donation and transplantation and stem cells, we will have enough funding to meet our operational plans in 2022-23.

Looking beyond 2022-23, we continue to expect that sufficient funding will be available to meet NHSBT objectives and operating requirements. We are not aware of any pending changes to NHSBT functions but also consider the HMT Financial Reporting Manual assumption that services would continue to be provided. Taking this into account, we continue to adopt the going concern basis in the preparation of these financial statements.

This report was reviewed and approved by Betsy Bassis in the role of Chief Executive during 2021/22 and until 9th August 2022.

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As one of NHSBT's Executive Director's during the financial year 2021/22 and now Interim Chief Executive I am satisfied and assured that the above represents a sound record of the year.

I hereby sign the Performance Report from pages 21 to 65.

Wendy Clark **7 February 2023**

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Our accountability

Our Accountability report covers the three required sections. Our people (see page 66) covers remuneration and staff report requirements, Our governance and accountability structure (see page 95) and Our governance statement cover the corporate governance report requirements and we have a parliamentary accountability report (see page 140). In line with best practice on corporate governance, our governance structures oversee assurance mechanisms through the year and are summarised in this accountability report to Parliament.

Accountability report – Our people

Every day our people work tirelessly at the heart of the NHS, showing dedication and a determination to make a difference. We are proud of our people. We want to attract the best talent, nurture, develop, engage and motivate them so they can continue to save and improve more lives. In this section we describe what we do to achieve that. (the top 3 graphs adds together to NHSBT total headcount of 5,831)

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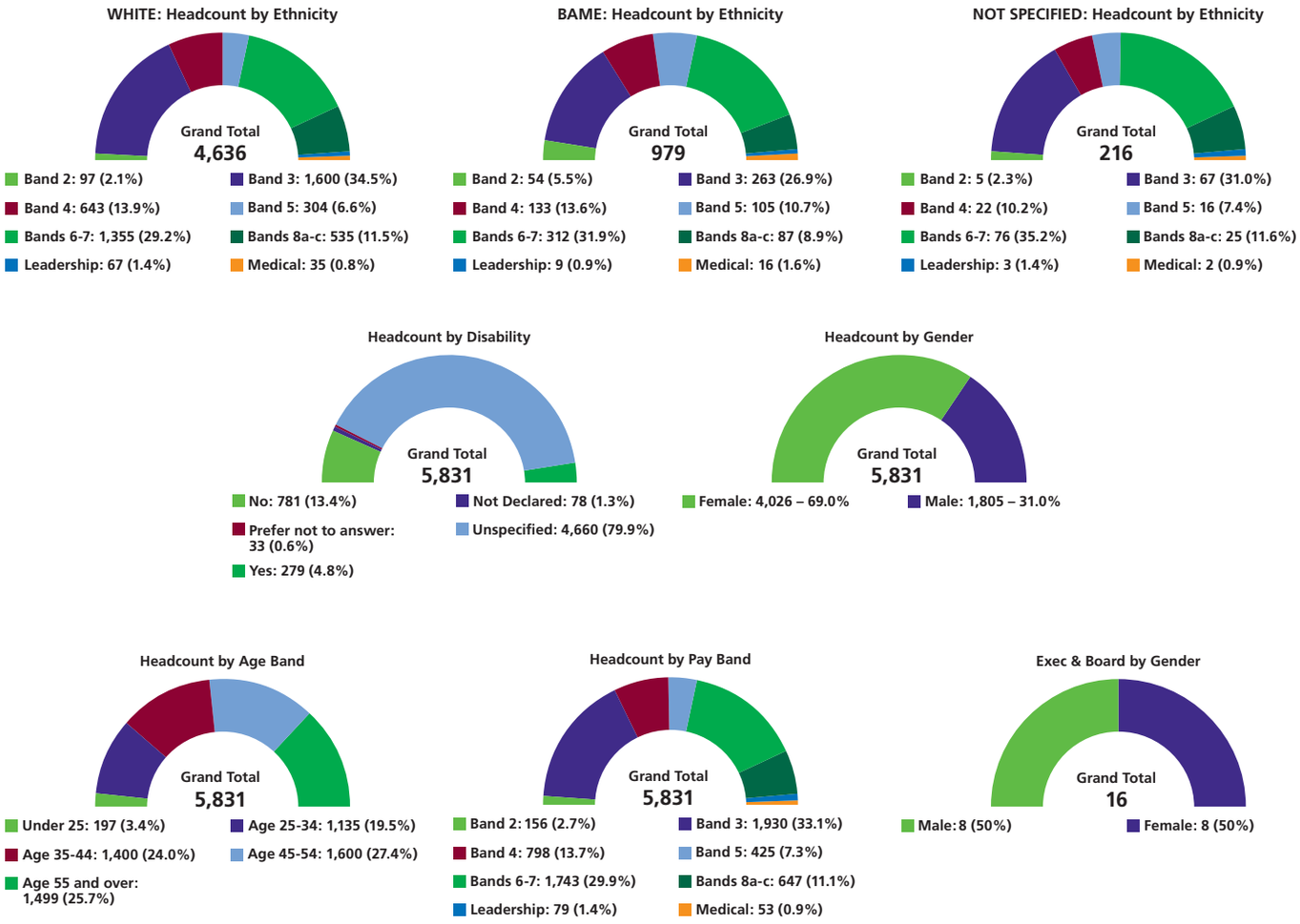

Note: Headcount above is the total number of people employed at NHSBT. Whole time equivalent below adjusts for part-time workers showing people as a proportion of a whole-time equivalent employee.

Our turnover rate at March 2022 is 17.40% (11.26% in 2020-21). While this is in line with trends in the UK we are monitoring this closely.

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Staff numbers and costs

The table below shows a breakdown of staff numbers and costs, and distinguishes between staff permanently employed and other staff engaged on the objectives of NHSBT, such as agency staff. This exact information is also disclosed in note 4 of the financial statements.

This is subject to audit.

	Permanent	Other	Total 2021-22	Total 2020-21
	£000	£000	£000	£000
Salaries and wages*	190,442	35,079	225,521	214,872
Social security costs**	17,900	1,223	19,123	18,763
Employer pension contributions***	32,809	1,585	34,394	34,640
Total	**241,151**	**37,887**	**279,038**	**268,275**

* Includes temporary staff (including agency) £35m (2020-21 £34.6m) and termination benefits £1.7m (2020-21 £3.7m) and is net of recoveries in respect of outward secondments £1.5m (2020-21 £1.4m).
** Includes apprenticeship levy £1m (2020-21 £0.8m).
*** Includes contributions to NHS Pensions £34.3m (2020-21 £34.6m) and to NEST £66k (2020-21 £63k).

On 1 April 2019, the employer contribution rate for the NHS Pension Scheme increased by 6.3%. The additional cost, funded directly by DHSC, was £9.8m for the year 2020-21. In 2021-22, the additional cost (£11m) was paid by NHSBT and matched by programme funding from DHSC.

In addition to note 4 staff costs £2.8m of staff costs were capitalised as directly attributable to the development of the new Pulse system (intangible asset) under the “Blood Technology Modernisation” (BTM) project (£0.6m NHSBT staff and £2.2m agency) (£nil in 2020-21).

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	Permanent	Other	Total
Whole Time Equivalents	**Number**	**Number**	**Number**
Period Ended 31 March 2022	**4,721**	**688**	**5,409**
Period Ended 31 March 2021	4,641	759	5,400
Of which: Number of employees (WTE) engaged on capital projects:	**18**	**31**	**49**

The note above shows average number of whole-time equivalent staff. There was a higher temporary staffing level at the start of the year on the plasma programme. This temporary headcount was reduced through the year and staff were recruited on a permanent basis to meet the lower collection needs of plasma for medicine.

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 (both including contractors and excluding contractors) in 2021-22 is shown in the table below, together with the remuneration ratios compared to the midpoint of the banded remuneration of the highest paid director's pay. This shows the pay multiple excluding contractors is 6.5 compared to 6.3 last year due to the highest paid director's pay increasing more (up 7%) than the median (up 3%) for employees.

The highest paid director, including contractors, is a different director to the prior year. As required, the pay for the 5-month contract, is extrapolated to the full-time equivalent pay. This leads to a 19% increase in pay which results in larger changes in the ratios between the years.

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Contractor directors are used to cover short term needs while permanent directors are appointed. The highest paid contractor director in 2020-21 was recruited to a permanent pay scale in April 2022.

From 2021-22 Reporting bodies are required to include additional Fair Pay disclosure for the top to median, lower quartile and upper quartile staff pay multiples (ratios).

	2021-22	2020-21
Highest Director Banded Remuneration (including contractor Directors)	**£280k-£285k**	£250k-£255k
Highest Director Banded Remuneration (excluding contractor Directors)	**£220k to £225k**	£205k to £210k
Lowest Banded Remuneration	**£0k to £5k**	£0k to £5k
Median Remuneration	**£33,952**	£32,939
Remuneration Ratio (including contractor Directors)	**8.4**	7.7
Remuneration Ratio (excluding contractor Directors)	**6.5**	6.3

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
(Including contractors Directors)			
2021-22	11.2:1	8.4:1	5.8:1
2020-21	10.2:1	7.7:1	5.6:1
(Excluding contractors Directors)			
2021-22	8.7:1	6.5:1	4.5:1
2020-21	8.4:1	6.3:1	4.6:1

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Highest Director	2021-22	2020-21	% change from prior year
salary and allowances (Includes Contractor Directors)	£280k to £285k	£250k to £255k	19%
performance pay and bonuses	0	0	0%
salary and allowances (Excludes contractor Directors)	£220k to £225k	£205k to £210k	7%
performance pay and bonuses	0	0	0%
'For employees of the entity taken as a whole, the average percentage changes from the previous financial year of:			
salary and allowances	£199,462k	£178,474k	12%
performance pay and bonuses	£20k to £25k	£15k to £20k	45%

In 2021/22, (nil) (2020/21, nil) employees received remuneration in excess of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

This is subject to audit.

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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 2021 to December 2021 the total number of whole-time equivalent days lost to sickness absence was 55,928 days (2020 46,102 days). This equates to an average of 10.9 days per whole-time equivalent (2020 9.4 days) and a sickness absence rate of 3.0% (2020 2.6%).

Our pension schemes

Most of our employees are members of the NHS Pension Scheme which is an unfunded, defined benefit scheme. We are not able to identify the shares of the underlying assets and liabilities related to our organisation and so the scheme is accounted for as a defined contribution scheme. See Accounting policy 1.20.

Early retirements and redundancies

During 2021-22 there were 32 payments for early retirements and/or redundancies from NHSBT. The sum of £1.9m has been paid out in 2021-22 in respect of these redundancies and/or early retirements (2020-21 59 early retirements and/or redundancies and payments of £2.8m).

There is currently a £25k provision held for redundancy costs, (2020-21 £119k).

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The total charge (including accruals) of £1.7m for early retirements and redundancies was expensed over the period 2021/22 and it is adjusted for opening and closing accruals which is included within salaries and wages in note 4 (2020/21 £3.6m). The actual exit packages payment during 2021/22 amounts to £1.9m.

The table below discloses the number and value by cost band of compensation packages paid during 2021-22.

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	2	9	2	8	4	17	-	-
£10,001 – £25,000	3	52	-	0	3	52	-	-
£25,001 – £50,000	4	153	6	218	10	371		-
£50,001 – £100,000	4	246	4	297	8	543	1	8
£100,001 – £150,000	-	-	4	427	4	427	-	-
£150,001 – £200,000	2	320	1	181	3	501	-	-
Totals for 2021-22	**15**	**780**	**17**	**1,131**	**32**	**1,911**	**1**	**8**
Totals for 2020-21	**46**	**2,207**	**13**	**576**	**59**	**2,783**	**1**	**57**

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.

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Ill health retirement

Two individuals retired early on ill-health grounds in the year generating additional pension liabilities of £57,399 (2020-21 2 individuals £59,201). These costs are met by the NHS Pension Scheme.

The People Comittee and senior manager rewards

Membership and purpose of the Committee is shown on page 109. The Chief Executive and Director of People also attend but excuse themselves when their remuneration is being discussed.

In deciding the remuneration of the Chief Executive and Executive Directors, the committee follows all relevant DHSC guidance and the Executive Senior Management (ESM) Framework and any cost-of-living pay increases are paid in line with DHSC Remuneration Committee recommendations. Remuneration for Non-Executive Board Members is set by the Secretary of State for Health.

All senior managers are appraised annually, 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 in NHSBT are reported below. The start date is the date of commencement of continuous NHS service for pension purposes.

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Betsy Bassis, Chief Executive. NHS start date 4 March 2019, appointed 4 March 2019. Full time permanent appointment with three months' notice of termination by the employee, and six months' notice period by NHSBT. Resigned on 9th August 2022.

Dr Gail Miflin, Chief Medical Officer and Director of Clinical Services. NHS start date 21 February 2005, NHSBT start date 1 June 2010 and appointed to the role 1 June 2016. Permanent full-time post with three months' notice by the employee, and three months' notice period by NHSBT.

Rob Bradburn, Director of Finance. NHS and NHSBT 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.

Anthony Clarkson, Director of Organ and Tissue Donation and Transplantation. NHS start date 16 September 1991, NHSBT start date 1 September 1997 and appointed to the role 11 February 2019 having previously covered the role on an Interim basis from 30 July 2018. Full time permanent appointment with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Wendy Clark, Chief Strategy, Digital and Information Officer. Wendy's portfolio expanded in September 2021 to include Strategy and Transformation. NHS start date 10 September 2018, NHSBT start date appointed to the role 6 January 2020. Permanent full-time post with 12 weeks' notice of termination by the employee, and 12 weeks' notice period by NHSBT (appointed Interim Chief Executive 9th August 2022).

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David Rose, Director of Donor Experience and Communications. NHS and NHSBT start date 20 May 2020, appointed to the role 20 May 2020. Permanent full-time post with six months' notice of termination by the employee, and six months' notice period by NHSBT.

Performance pay and bonuses

Our Executive Team members fall under the executive and senior manager (ESM) pay guidance issued by DHSC. There is an annual review process to assess performance and award bonuses with a cap on what individuals and the whole team can receive. The people committee decide on the bonuses in line with the guidance.

Officers appointed during the year 2021-22:

Stephen Cornes, Director of Blood Supply. Interim full time post from 4 October 2021 to 31 March 2022 then joined on a permanent basis on 1 April 2022. NHS start date 1 April 2022. Permanent part time post with six months' notice by the employee, and six months' notice period by NHSBT (left 31 July 2022).

Paul O'Brien, was appointed as Interim Director of Blood Supply – 25 July 2022.

Helen Gillan, Director of Quality. NHS and NHSBT start date 30 June 2003. Appointed to the Executive Team 28 February 2022. Permanent full-time post with six months' notice by the employee, and six months' notice period by NHSBT.

Deb McKenzie, Chief People Officer. Appointed 1 September 2021. On Secondment from the UK Health and Security Agency for 2 years and 7 months, she holds

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a full-time post with three months' notice of termination by the employee, and three months' notice period by NHSBT.

Gerard Gogarty, Plasma Director. NHS and NHSBT start date 1 December 1998. Appointed to the Executive Team 1 March 2022. Permanent full-time post with six months' notice by the employee, and six months' notice period by NHSBT.

Leavers in the year:

Greg Methven, Director of Blood Supply. 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. Left 31 October 2021

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 six months' notice by the employee, and six months' notice period by NHSBT. Left NHSBT on 28 February 2022.

Patricia Grealish, Interim Chief People Officer. Appointed 8 October 2020. Temporary post with 4 weeks' notice of termination by the post holder, and 4 weeks' notice period by NHSBT Left 1 September 2021

Katie Robinson, Director of Strategy and Transformation. NHS start date 4 June 2013, appointed 11 May 2020. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT. . Left 20 June 2021

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Rosna Mortuza, Chief Diversity and Inclusion Officer. NHS start date 26 November 2007, appointed 27 July 2020. Permanent full-time post with 12 weeks' notice of termination by the employee, and 12 weeks' notice period by NHSBT. Left on the 1 December 2021 on secondment to NHSEI.

The remuneration and pension benefits of the most senior officials of NHSBT are shown in the tables on pages 79 and 81. The tables on pages 79 and 81 are subject to audit.

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Remuneration and pension entitlement of senior managers

a) Remuneration

	Year to 31 March 2022					Year to 31 March 2021				
	Salary	Performance pay and bonuses	Non-Cash Benefits	All Pension Related Benefits	Total	Salary	Performance pay and bonuses	Non-Cash Benefits	All Pension Related Benefits	Total
	In £5k bands	In £5k bands	To nearest	Bands of£2.5k	In £5k bands	In £5k bands	In £5k bands	To nearest	Bands of£2.5k	In £5k bands
Name and title	£000	£000	£00	£000	£000	£000	£000	£00	£000	£000
Ms B Bassis (Chief Executive) 1	170-175	5-10	0	40-42.5	220-225	175-180	5-10	0	40-42.5	220-225
Mr J Pattullo (Interim Chair) 2	40-45	0	0	0	40-45	0	0	0	0	0
Ms M Banerjee (Chair) 3	20-25	0	0	0	20-25	60-65	0	0	0	60-65
Prof P Vyas (NED) 4	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Prof D Kelly (NED)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Mr K Rigg (NED) 5	0	0	0	0	0	0-5	0	0	0	0-5
Mr C St John (NED)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Mr J Monroe (NED) 6	0	0	0	0	0	5-10	0	0	0	5-10
Mr P White (NED)	10-15	0	0	0	10-15	10-15	0	0	0	10-15
Ms H Fridell (NED)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Ms J Lewis (NED) 7	5-10	0	0	0	5-10	0	0	0	0	0
Mr P Huggon (NED) 8	15-20	0	0	0	15-20	0	0	0	0	0
Dr Gail Miflin (Chief Medical Officer and Director of Clinical Services)	220-225	0	0	57.5-60	280-285	205-210	0	0	52.5-55	255-260
Mr G Methven (Director of Blood Supply) 9	80-85	0	1	5-7.5	85-90	145-150	0	1	35-37.5	180-185
Mr R Bradburn (Director of Finance)	145-150	0	31	35-37.5	185-190	145-150	0	31	0	150-155
Mr A Clarkson (Director of Organ and Tissue Donation and Transplantation)	135-140	5-10	21	30-32.5	175-180	135-140	5-10	21	65-67.5	210-215
Mr I Bateman (Director of Quality) 10	125-130	5-10	2	40-42.5	175-180	110-115	0	1	27.5-30	140-145
Mr M Stredder (Director of Donor Experience) 11	0	0	0	0	0	135-140	0	0	0	135-140
Mrs K Robinson (People Director) 12	0	0	0	0	0	60-65	0	23	17.5-20	80-85

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	Year to 31 March 2022					Year to 31 March 2021				
	Salary	Performance pay and bonuses	Non-Cash Benefits	All Pension Related Benefits	Total	Salary	Performance pay and bonuses	Non-Cash Benefits	All Pension Related Benefits	Total
	In £5k bands	In £5k bands	To nearest	Bands of£2.5k	In £5k bands	In £5k bands	In £5k bands	To nearest	Bands of£2.5k	In £5k bands
Name and title	£000	£000	£00	£000	£000	£000	£000	£00	£000	£000
Ms W Clark (Chief Strategy, Digital and Information Officer) 13	145-150	5-10	0	35-37.5	185-190	145-150	0-5	0	32.5-35	180-185
Ms R Mortuza (Chief Diversity and Inclusion Officer) 14	70-75	0	0	32.5-35	100-105	55-60	0	0	172.5-175	230-235
Ms K Robinson (Director of Strategy and Transformation) 15	25-30	0	0	0	25-30	100-105	0	0	275-277.50	375-380
Mr D Rose (Director of Donor Experience and Communications)	140-145	0	0	35-37.5	180-185	105-110	0	0	15-17.5	120-125
Ms P Grealish (Interim Chief People Officer) 16	95-100	0	0	0	95-100	115-120	0	0	0	115-120
Mr S Cornes (Director of Blood Supply) 17	140-145	0	0	0	140-145	0	0	0	0	0
Ms D Mckenzie (Chief People Officer) 18	80-85	0	0	27.5-30	110-115	0	0	0	0	0
Ms H Gillan (Director of Quality) 19	10-15	0	1	2.5-5	10-15	0	0	0	0	0
Mr G Gogarty (Plasma Director) 20	10-15	0	0	10-12.5	20-25	0	0	0	0	0

NED = Non-Executive Director. Performance pay and bonuses relates to pay earned in the previous year.
Non-cash benefits were in.
in relation to the provision of cars and reimbursement of business mileage and are stated in round £100's not £1000's.

1 Ms B Bassis – left on 9 August 2022 – Full year salary (£5k bands) is £170-175k.
2 Mr J Pattullo – appointed as Interim Chair 7 August 2021. Full year salary (£5k bands) is £60-65k.
3 Ms M Banerjee – left on 6 August 2021. Full year salary (£5k bands) is £60-65k.
4 Professor P Vyas – left on 31st March 2022 – Full year salary (£5k bands) is £5-10k.
5 Mr K Rigg – left on 20 June 2020. Full year salary (£5k bands) is £5-10k.
6 Mr J Monroe – left on 10 February 2021. Full year salary (£5k bands) is £5-10k.
7 Ms J Lewis – appointed as NED on 1 March 2021. Full year salary (£5k bands) is £5-10k.
8 Mr P Huggon – appointed as NED on 1 March 2021. Full year salary (£5k bands) is £5-10k.
9 Mr G Methven – left on 31 October 2021. Full year salary (£5k bands) is £145-150k.
10 Mr I Bateman – Retired on 28 February 2022 and took his pension. Full year salary (£5k bands) is £125-130k.
11 Mr M Stredder – left on 12 July 2020. Full year salary (£5k bands) is £165-170k of which, £90-95k is exit costs (see Early Retirements and Redundancies table).
12 Mrs K Robinson – left the Board and Executive Team on 7 October 2020, left the organisation on 31 March 2021. Full year salary (£5k bands) is £120-125k. In April 2022 she received a redundancy package totalling £180-185k. This is reported in the exit packages for 2021/22.
13 Ms Wendy Clark – appointed Interim Chief Executive on 9th August 2022.
14 Ms R Mortuza – left on 1 December 2021. Full year salary (£5k bands) is £90-95k.
15 Ms K Robinson – left on 20 June 2021. Full year salary (£5k bands) is £115-120k.
16 Ms P Grealish – left on 1 September 2021. Full year salary (£5k bands) is £235-240k.
17 Mr S Cornes – appointed as Director of Blood Supply on 4 October 2021. Contractor Full year salary (£5k bands) £280-285k, S Cornes has been appointed to a permanent part time post as at the 1 April 2022 with a full year salary (£5k band) £125-130k.
18 Ms D Mckenzie – appointed as Chief People Officer on 1 September 2021. Full year salary (£5k bands) is £145-150k (Pension figures for the year have been estimated based on pension data provided up to 30 September 2021).
19 Ms H Gillan – appointed as Director of Quality on 28 February 2022. Full year salary (£5k bands) is £90-95k.
20 Mr G Gogarty – appointed as Plasma Director on 1 March 2022. Full year salary (£5k bands) is £110-115k.

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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 pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real increase in Cash Equivalent Transfer Value £000
Ms B Bassis (Chief Executive) 1	2.5-5	0	10-15	0	124	81	17
Dr Gail Miflin (Chief Medical Officer and Director of Clinical Services)	2.5-5	0-2.5	65-70	130-135	1,294	1,197	63
Mr G Methven (Director of Blood Supply) 2	0-2.5	0	10-15	0	157	137	3
Mr R Bradburn (Director of Finance)	2.5-5	0	35-40	0	642	577	41
Mr A Clarkson (Director of Organ and Tissue Donation and Transplantation)	2.5-5	0	55-60	120-125	1,002	946	31
Mr I Bateman (Director of Quality) 3	0	77.5-80	20-25	160-165	0	0	0
Ms W Clark (Chief Strategy, Digital and Information Officer) 4	2.5-5	0	5-10	0	126	88	16
Ms R Mortuza (Chief Diversity and Inclusion Officer) 5	0-2.5	0-2.5	10-15	25-30	216	173	19
Ms K Robinson (Director of Strategy and Transformation) 6	0-2.5	0	15-20	0	166	157	0
Mr D Rose (Director of Donor Experience and Communications)	2.5-5	0	0-5	0	46	17	7
Ms P Grealish (Interim Chief People Officer) 7	0	0	0	0	0	0	0
Mr S Cornes (Director of Blood Supply) 8	0	0	0	0	0	0	0
Ms D Mckenzie (Chief People Officer) 9	0-2.5	0	20-25	0	307	267	12
Ms H Gillan (Director of Quality) 10	0-2.5	0-2.5	30-35	65-70	615	572	3
Mr G Gogarty (Plasma Director) 11	0-2.5	0-2.5	30-35	85-90	749	665	7

1 Ms B Bassis – left on 9 August 2022.
2 Mr G Methven – left on 31 October 2021.
3 Mr I Bateman – retired on 28 February 2022. Increase in 21/22 due to lump sum paid on retirement.
4 Ms Wendy Clark – appointed as Interim Chief Executive on 9 August 2022.
5 Ms R Mortuza – left on secondment to NHSEI 1 December 2021.
6 Ms K Robinson – left on 20 June 2021.
7 Ms P Grealish – left on 1 September 2021. Engaged full time as a contractor therefore is not signed up to the NHSBT pension scheme.
8 Mr S Cornes – appointed as Director of Blood Supply on 4 October 2021. Engaged full time as a contractor therefore is not signed up to the NHSBT pension scheme – left on 31 July 2022.
9 Ms D Mckenzie – appointed as Chief People Officer on 1 September 2021 seconded from UKHSA. Pension figures for the year have been estimated based on pension data provided up to 30 September 2021.
10 Ms H Gillan – appointed as Director of Quality on 28 February 2022.
11 Mr G Gogarty – appointed as Plasma Director on 1 March 2022.

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Pension table figures explained

The total accrued pension figures are the benefits of all their years membership of the scheme, not just their service in a senior capacity.

The Cash Equivalent Transfer Value (CETV) figure is a cash value placed on the pension benefits and is the amount available to transfer to an alternative plan if a member leaves the scheme. The value reflects contributions paid by the employee and employer, inflation, the scheme benefits, and any benefits transferred in from other schemes or additional years of pension purchased by the member. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV is approximating the increase funded by the employer. The calculation of this figure removes the increase due to inflation and contributions paid by the employee.

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Off-payroll engagements and their tax arrangements

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.

Table 1: Highly paid off-payroll worker engagements as at 31 March 2022, earning £245 per day or greater.	Number
Number of existing engagements as of 31 March 2022	27
Of which...	
No. that have existed for less than one year at time of reporting.	12
No. that have existed for between one and two years at time of reporting.	12
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	2
No. that have existed for four or more years at 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.

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2022, earning £245 per day or greater.	Number
No. of new engagements, between 1 April 2021 and 31 March 2022	36
Of which...	
Not subject to off-payroll legislation	35
Subject to off-payroll legislation and determined as in-scope of IR35	1
Subject to off-payroll legislation and determined as out-of-scope of IR35	0
No. of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review.	0

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Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	Number
No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	2
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	24

An Interim Chief People Officer and an Interim Director of Blood Supply were appointed to cover these roles while more permanent appointments could be made.

Our approach to diversity and inclusion in our workforce

Investing in our people and culture is a strategic priority at NHSBT, ensuring that we are a high performing and inclusive organisation.

Corporate

Our EDI Council sets our D&I agenda. Our D&I Programme Board oversees the Senior Responsible Officers (SRO) and directorate-level D&I plans and ensure momentum on delivery. Our EDI Partnership Consultative Committee oversees plans to improve Equality measures, including the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and Stonewall WEI (Workforce Equality Index). Our Networks represent protected groups and promote and support key initiatives and awareness days. We support our networks with an Executive Sponsor, budget and admin support and we work closely with staff side colleagues in this work.

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Directorate

Each directorate has developed an EDI plan with actions and targets. These plans have been reviewed by the D&I Programme Board who oversee the progress and delivery against them.

Individual

All our colleagues will have individual Diversity and Inclusion objectives. We have encouraged all our colleagues to declare their data so we can accurately measure our progress to inclusion. Currently only 14% of our workforce have declared their disability status and only 64% of our workforce have declared their sexual orientation.

Progress and next steps

Following two independent reports, we have broadened the scope of our Inclusion work to the whole organisation. Our business plan objective D, priority one was to increase diversity and inclusion amongst our workforce at all levels. In early 2022 the Diversity and Inclusion team reviewed our Directorate D&I plans and concluded that Inclusion work is being prioritised and we are making good progress against the recommendations. See page 51 for further achievements.

Disability confident employer

We are recognised as a disability confident employer by the government's Disability Confident Scheme. We plan to become a 'disability confident leader', by having our self-assessment validated, and by encouraging other employers to become Disability Confident. Applicants

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for job vacancies are encouraged to be open so we can meet their needs and provide an inclusive experience. We operate the guaranteed interview scheme for those who meet the minimum criteria. Adjustments are regularly made in recruitment, in induction training and throughout employment as required. Support is also provided by Access to Work and NHSBT's occupational health provider. We aim to improve the levels of disability declaration, adjustment needs met and monitoring of career development and progression. Feedback from our 2022 staff survey indicated some employees with disabilities were reluctant to progress from supportive teams. We monitor ourselves against the Workforce Disability Equality Standards.

Gender pay gap

Our latest gender pay gap reporting is as at 31 March 2021 when NHSBT employed 5,828 'relevant' staff members (including 10 directors) of whom 4,008 were female (of which five are directors) and 1,820 were male (of which five are directors).

NHSBT's overall ratio of male to female employees is approximately 31:69, which is broadly in line with the ratio in the wider NHS. However, the ratio of male to female employees is reversed for higher banded roles, at Band 8c and above.

We publish our gender pay gap (GPG) figures each year on our website, in line with government requirements.

Our mean GPG shows women's pay is 8.1% lower than men's. This compares well to the Office for National

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Statistics mean GPG figure, which was 15.4% (2021). NHSBT therefore compares favourably with the wider public sector and other DHSC Arm's Length Bodies.

Our median figure % (also showing women's pay is lower than males) had reduced from 6.7% in the previous year. We are developing our action plan to reduce our GPG further over the coming year.

Engagement

We carried out a full organisation survey to measure employee engagement, with questions split into three monthly surveys, these ran from January to March 2022. We used a platform which captures scores and comments anonymously and allows detailed analysis of results and action planning at a team, directorate and organisational level. We are utilising the platform's ability to analyse the results by protected characteristic.

We will run an annual survey for the whole organisation and we will develop mechanisms to receive regular feedback from our people. We will celebrate our successes, and address areas in need of our attention. Our engagement score remains stable following surveys held in 2020 (7.5/10) and 2022 (7.5/10).

Colleagues' contributions and achievements are recognised in a variety of ways including our Recognition of Excellence scheme which culminates in an annual Award Ceremony.

People development

Personal development plans remain an essential part of our appraisal process. We provide our learning and

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development framework ‘SHINE’ for all colleagues, including personal skills development, scientific training and management and leadership development.

Pre-COVID-19 our courses were all face-to-face events. The pandemic enabled us to accelerate our plans to shift to ‘point of need’ learning and convert these to either blended or digital learning products, further details are included in subsequent paragraphs.

Our efforts have ensured that, despite COVID-19 restrictions, colleagues could access high quality development on demand, we are continuing to develop our blended learning portfolio and leverage the benefits of the 70/20/10 model of learning, 70% obtained from job-related experiences, 20% from interactions with colleagues and managers, and 10% from formal development events.

Apprenticeships

Apprenticeships are used to train entry level recruits and to upskill existing employees. We offer a wide range of apprenticeships, from level 2 to level 7 and across 42 programmes. Over the last 12 months:

- 235 people are active ‘in-learning’ (95 new starts over the last 12 months)
- 17 people are in a break in learning, due to COVID-19
- 8 people withdrawn

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We encourage managers to consider taking on an apprentice instead of a normal band 2, 3 and 4 role. We worked with The Princes Trust on 'The Ignite Your Future' initiative to recruit a cohort of apprentices in September/ October 2021.

National Apprenticeship Week was a great success with considerable engagement across the organisation and ended with the annual celebration event with awards for those going above and beyond and the first Apprentice of the Year winner.

Scientific and clinical (S&C) training

In the year our Higher Specialist Scientist Trainees (HSST) programme had 15 trainees across four disciplines (H&I; transfusion, bioinformatics and virology) and two trainees qualified becoming Consultant Clinical Scientists.

We trained 139 other learners primarily leading to Biomedical Science Registration.

We also trained hundreds of internal and external delegates in our science, transfusion medicine and Pathology courses.

In September 2021 we launched an MSc in Applied Transfusion and Transplantation Science that we have developed in partnership with the University of the West of England. In the first cohort we have 37 students, 34 of which are NHS employees from across the UK. This course will enable us to continue to develop our own workforce and the wider transfusion and transplantation community, developing scientists and leaders for the future.

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Our virtual blood centre tour received 14k hits in its first 12 months of going live, and we have added the Bloody History of Transfusion to our freely available catalogue of learning materials. We have also developed a combined virtual reality package on blood identification to increase the range of learning products available to staff and course participants

This training will enable us to continue to develop our own workforce and the wider transfusion and transplantation community, developing scientists and leaders for the future.

Leadership development

We have continued regular conferences for senior leaders, to build the leadership community and allow the group to consider key organisational challenges together. We provided coaching support for this group. We have delivered blended learning leadership programmes for 373 leaders in the year including the Effective Line manager completed by 65 leaders and the Inclusive Leader completed by 320 leaders. We have provided Leaders with 'Magpie', a platform with online leadership development resources. 505 leaders are regularly using this resource.

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We have an online structured learning tool for all leaders and managers, both current and aspiring, called the Leadership Ladder. The Ladder supports NHSBT's values and behaviours. It provides a recognised standard for leadership and management across 3 levels:

1. "The Effective Leader" (Level 1): for an aspiring or new leader (completed by 675 leaders)
2. "The Engaging Leader" (Level 2): for leaders who manage people or are senior leaders (completed by 154 out of 642 leaders)
3. "The strategic leader" (Level 3): for leaders developing and leading strategy (completed by 33 out of 78 strategic leaders).

We play a key part in the DHSC Healthcare Sector leadership programme and the DHSC Talent Board and, whilst these programmes remain paused due to COVID-19, we are in continued dialogue the NHS Leadership Academy and will ensure that we fully utilise these courses once they restart.

Coaching and mentoring is encouraged across NHSBT. We have 12 fully qualified executive level coaches and have expanded the faculty and increased diversity of the faculty. We are developing ambitious plans to develop the senior leadership group throughout 2022-23.

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Talent management and succession planning

To realise the new ambitious strategy, we have carried out an initial gap analysis to understand the Talent and Succession needs that will enable us to become a high performing inclusive organisation. This will require our managers and leaders to have the capabilities for now and the future, with our manager's having an even greater requirement to help bring about the changes whilst ensuring their people adapt, grow and thrive.

During the forthcoming year we will redefine and relaunch our approaches to performance, talent, succession, and career management. These will be designed in collaboration with colleagues from across the organisation to ensure diversity of thought and inclusivity is at the heart of our people practices. These will be embedded with supporting development, ensuring that the right capabilities and language are in place to support meaningful conversations between managers and their people enabling them to be more effective and valued.

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Trade Union relationships

NHSBT has a robust Partnership Framework with Trade Union colleagues underpinning a productive and effective approach to partnership working. The Executive Team meets with the national representatives annually to share plans for the year ahead. This demonstrates our open and transparent approach and allows for earlier discussion of some strategies.

NHSBT enables 113 (93.72 whole time equivalent) Trade Union representatives to carry out national consultation/ partnership working duties. These representatives collectively spent 12,529 hours on these duties this year, reflecting the scale of change consultation within NHSBT and geographic spread of employees. 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**
113	93.72

Percentage of time spent on facility time	
Percentage of time	**Number of employees**
0%	56
1-50%	51
51-99%	2
100%	4

Percentage of pay bill spent on facility time	
Description	**£000**
Total of cost facility time	281
Total pay bill	266,704
Percentage of the total pay bill spent on facility time	0.11%

Paid Trade Union activities	
Time spent on trade union activities as a percentage of the total paid facility time hours	23%

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Health, Safety and Wellbeing

Our plan is to effectively manage our occupational safety risks and build on our wellbeing strategy, which was enhanced to consider the Promotion, Prevention and Protection of individuals wellbeing. The introduction of the on-line wellbeing hub and campaign to ensure staff are aware of the interventions and support available is going well. Our management system continues to meet the requirements of the ISO45001 standard for all our activities.

The COVID-19 response has continued with maintenance of effective controls in our centres and collection sessions. Partnership working with our unions has been successful throughout the year, working together to maintain the best possible safety and assurance for our staff and donors. Homeworking is supported through a hybrid working policy and an electronic display screen equipment risk assessment system. Enabling staff to return to centres has been achieved with the introduction of an electronic desk booking system. We are continuing to review our controls with the measurement of ventilation levels in our centres and sessions using CO2 monitors. This work is helping us prepare to relax restrictions on social distancing.

The year ahead will continue to focus on wellbeing to ensure that we meet the support requirements of staff who have been affected by the pandemic.

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Accountability report – our governance and accountability structure

Directors' report

Betsy Bassis

Chief Executive

Betsy has extensive experience leading complex, customer-facing organisations across the private and public sectors. Before joining NHSBT in March 2019, she was the Chief Operating Officer at the Department for Environment, Food and Rural Affairs. Betsy spent 12 years at Centrica/British Gas in a range of senior roles, including Strategy Director for British Gas. Served on the Board until 9 August 2022

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John Pattullo

Chair

John has extensive experience in the fast-moving consumer goods and logistics sectors, working for companies including Procter & Gamble and DHL. He has been a non-executive with eight organisations and has been Chairman of four of these, including In Kind Direct (a Prince's Charity), and V Group, a PE owned Marine Service business. He was previously Chairman of NHSBT between 2013 and 2017. Interim role (commenced 7 August 2021) completed 31 March 2022

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Board Directors (Voting Members)

Dr Gail Miflin

Chief Medical Officer and Director of Clinical Services

Gail is NHSBT's Chief Medical Officer and responsible for the organisation's delivery of R&D, Cell Apheresis & Gene Therapies, and Pathology Services. She led the NHSBT Convalescent Plasma Project. Previously she has been a Consultant Haematologist at the Royal Free Hospital and UCLH Foundation Trust.

Stephen Cornes

Director of Blood Donation

Stephen has extensive experience across the supply chain, including business planning, manufacturing, distribution, supply and demand planning, customer service and customer logistics, working for large scale, complex companies including Procter & Gamble and Alliance Healthcare. Served on the Board until 31 July 2022.

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Rob Bradburn

Director of Finance

Rob is a Chartered Accountant.
He held a number of senior international leadership positions in ICI, Associated British Foods and Premier Foods before joining NHSBT in April 2008. Rob left NHSBT on 30 October 2022.

Anthony Clarkson

Director of Organ Donation and Transplantation

A Registered Nurse with over 25 years' NHS experience Anthony is a transformational leader who has held a number of leadership roles including in Blood Donation, Tissue and Eye Service and ODT.

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Directors (Non-Voting Members)

Wendy Clark

Chief Strategy, Digital and Information Officer

Wendy is an experienced digital technology leader and CIO with a track record of delivering transformation. Wendy has worked across the private and public sectors and multiple industries. Before joining NHSBT in January 2020, she was Executive Director of Product Development at NHS Digital and prior to that CIO for a National Security Agency. Appointed as Interim Chief Executive 9 August 2022.

David Rose

Director of Donor Experience

Joined as a Director in 2020 from Starbucks Coffee Company where he was responsible for digital customer experiences and engagement across EMEA. Previously he held a number of commercial leadership roles at Virgin Atlantic Airways in the UK, Kenya and China.

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Gerard Gogarty

Plasma Director

Experienced in transformation, strategy and operations, Gerry has held a number of leadership roles across manufacturing, collection, business transformation and marketing. Prior to joining NHSBT, Gerry led the commercialisation of several Local Government functions.

Helen Gillan

Director of Quality

Recently appointed to Director having served as General Manager for Tissue and Eye Services in NHSBT since 2012. Helen has worked in both the public and private sector in Quality and Regulatory Compliance roles.

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Deb McKenzie

Chief People Officer

Deb joined us from Public Health England where she was Chief People Officer. During 2020-2021 Deb played a key role in the Public Health Reform programme which led on the creation of the UKHSA and Office for Health Improvement and Disparities. She is an experienced public and private sector leader with a passion for supporting organisations and the people that work there to deliver outstanding outcomes and flourish. Prior to joining the public sector she was an associate partner with Accenture where she led a number of international large-scale change programmes. Deb is a scientist by background and spent her early career working in the private sector for consumer goods companies.

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Our Board

Our Board brings a diversity of skill, experience and approach, which underpins our decision-making. Our Board's purpose is founded on independence and diverse thinking, and using that to set strategy and constructively challenge the organisation to perform at its best.

Board Members serving during the period 1 April 2021 to 31 March 2022:

Millie Banerjee

Chair

Millie Banerjee has had a long and varied career in the private and public sectors with extensive experience in corporate governance in both sectors.Served on the Board until 6 August 2021.

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Peter Wyman

Chair

Peter was appointed on the 1 April 2022, and brings a wide breadth of skills and experience to the board having held a range of senior posts in the private, public and voluntary sectors over the course of his career. He was a partner at PricewaterhouseCoopers LLP and President of the Institute of Chartered Accountants in England and Wales from 2002 to 2003. In the health sector, he served for five years as Chair of the Yeovil District Hospital NHS Foundation Trust and was Chair of the Care Quality Commission (CQC), between January 2016-March 2022.

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Non-Executive Directors

Charles St John

Charles was a Partner at private equity investment firms Cognetas and Electra. He is also a Non-Executive Director of Capstone Fostercare, Van Elle plc and Whiteline Windows.

Professor Paresh Vyas

Professor Vyas is a Professor of Haematology at Oxford University, he runs a research laboratory at the Weatherall Institute of Molecular Medicine. (Chair of the Research and Development Committee). Served on the Board until 31 March 2022.

Professor Deirdre Kelly

Professor of Paediatric Hepatology at Birmingham University and Consultant Paediatric Hepatologist at Birmingham Children's Hospital, Deirdre has significant Board experience, notably in the Health Research Authority, General Medical Council, Care Quality Commission (CQC) and Safety of Blood, Tissues and Organs (SaBTO).

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Piers White

Piers was UK Chief Executive of Bank Insinger de Beaufort NV until the sale to BNP Paribas in 2008. Prior to that he was Chairman of Flemings Offshore Private Banking, a Director of the Save and Prosper Group Ltd and spent 15 years at Barclays where his last role was Service Director running all the UK branches and staff.

Over the last 20 years Piers has held numerous NED positions across public, private and third sector organisations. He currently chairs CFL Ltd and Halesworth Ltd.

Helen Fridell

Helen is the Transformation Director, Customer Experience at Cisco. She is on the UK Gambling Commission Digital Advisory Panel and participates in the Mentoring for Growth programme.

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Joanna Lewis

Jo was most recently People Director at Sky and joins us with 25 years' experience in Human Resources gained across financial services, media and technology businesses. She is also a Trustee for Middlesex Learning Partnership Multi-Academy Trust and the London School of Mosaic and has her own HR consulting business and is a Fellow of the Chartered Institute of Personnel and Development.

Phil Huggon

Phil has held a number of Executive commercial, marketing and transformation roles including with BP, MARS and Shell. He is also Vice Chair of Healthwatch England and NED with the Lancashire and South Cumbria NHS FT. He is also Chair of International House, a Global Language Provider, and RCU Limited, a Further Education Consultancy.

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Directors Leaving

Ian Bateman

Director of Quality

Served on the Board to 28 February 2022.

Rosna Mortuza

Chief Diversity and Inclusion Officer

Served on the Board to 1 December 2021.

Patricia Grealish

Interim Chief People Officer

Served on the Board to 1 September 2021

Katie Robinson

Director of Strategy and Transformation

Served on the Board to 20 June 2021

Greg Methven

Director of Manufacturing and Logistics

Served on the Board to 31 October 2021.

Details of the remuneration of senior managers of NHSBT can be found in the Remuneration and Staff Report at pages 79 to 81.

Rod Bradburn left his role of Director of Finance on 30 October 2022 and was replaced by Carl Vincent as Chief Financial Officer on 10 October 2022.

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/

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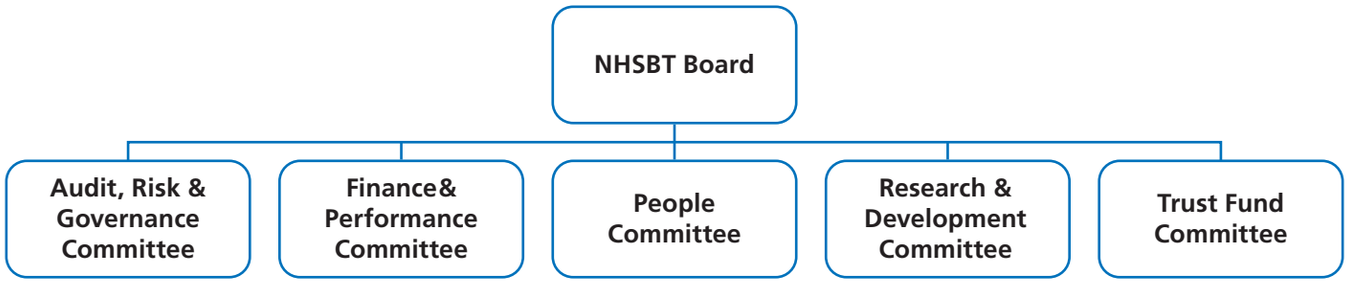
Our governance structure

Following the review of our governance structures last year, the structure, and duties of all committees remain broadly unchanged. There have been some small changes to membership. The terms of reference for the Remuneration and Nominations Committee were reviewed and broadened to reflect the need for a wider remit and NED oversight – this has also been renamed the People Committee. The Audit, Risk and Governance Committee (ARGC) reviews governance arrangements on behalf of the Board. A Board Assurance Framework has been approved by ARGC, and there has been substantial progress in assurance mapping in which ARGC has also been heavily involved. This supports ARGC's role in overseeing the effectiveness of internal controls and risk management processes on which the Board relies in overseeing the delivery of NHSBT's statutory, regulatory and strategic objectives. The governance structures and role of the committees are described further below.



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Committee	Role	Membership and attendance (as a proportion of meetings held while appointed)
The Board	Oversees the strategic direction and the delivery of objectives and ensures that the core purpose and values of the organisation are upheld. The Board is led by the Chair and comprises Non-Executive Directors (NEDs) and Executive Directors, including the Chief Executive, Chief Medical Officer and Director of Clinical Services and Finance Director.	Non Executive John Patullo (interim Chair 4/4) Millie Banerjee (Chair) 2/2 Helen Fridell 5/6 Charles St John 6/6 Prof. Paresh Vyas 4/6 Piers White 5/6 Prof. Deirdre Kelly 6/6 Joanna Lewis 4/6 Phil Huggon 4/6 Voting Member Directors Betsy Bassis 6/6 Rob Bradburn 6/6 Anthony Clarkson 6/6 Greg Methven 4/6 Dr Gail Miflin 6/6 Non Voting Members Ian Bateman 5/6 Wendy Clark 6/6 Katie Robinson 1/1 Rosna Mortuza 3/3 Patricia Grealish 1/2 David Rose 6/6 Deb McKenzie 4/4
People Committee (Formerly Remuneration & Nominations Committee)	The Committee terms of reference were reviewed and approved by the Committee on 22 Feb, and NHSBT Board on 29th March. The ToR were updated to reflect the necessary broadening of the Committee's remit to consider wider People issues beyond senior remuneration and appointments. The Committee still fulfils the role of the Remuneration and Terms of Service Committee. It determines remuneration, conditions of service and termination arrangements of those very senior managers currently paid under the terms of the Executive Senior Manager (ESM) Framework 2016 and any other management posts with a base salary in excess of £100,000 per annum. The Committee also oversees and advises the Board on termination and severance arrangements in relation to the Chief Executive and NHSBT Directors and determining which Executive Directors are members of the NHSBT Board.	Joanna Lewis (Chair) 5/5 Millie Banerjee 1/1 John Pattullo 4/4 Betsy Bassis 5/5 Helen Fridell 5/5 Patricia Grealish 1/1 Deb McKenzie 4/4
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.	Charles St John (Chair) 4/4 Rob Bradburn 4/4 Jo Lewis 4/4 Patricia Grealish 2/2 Deb McKenzie 2/2

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Committee	Role	Membership and attendance (as a proportion of meetings held while appointed)
Finance & Performance Committee	Responsible for scrutinising NHSBT financial and planning reports, making recommendations to the NHSBT Board on financial performance, planning and pricing issues and providing assurance that these are being managed effectively.	Charles St John (Chair) 5/5 Prof. Paresh Vyas 3/5 Jo Lewis 5/5 Phil Huggon 2/2
Audit Risk and Governance Committee (ARGC)	Provides the Board assurance that governance, risk management and internal control processes across all clinical and non-clinical activities are effective. The reports to ARGC are from Directors and Managers and Internal and External Auditors. The internal auditors are Government Internal Audit (GIAA). The ARGC reviews the Annual Report and recommends it to the Board, who approves it, and reviews the work and findings of Mazars LLP who perform the external audit on behalf of the National Audit Office.	Piers White (Chair) 7/7 Prof Deirdre Kelly 7/7 Phil Huggon 7/7
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.	Prof Paresh Vyas (Chair) 2/2 Piers White 2/2 Prof Deirdre Kelly 2/2 Prof Dana Devine (Chief Scientist, Canadian Blood Services) (2/2)* Prof Hans L Zaaijer (Head of Dept Blood-Borne Infections, Sanquin Research) (2/2)* Associate Professor Andreas Zuckermann, (Director of Cardiac Transplantation, University of Vienna in Austria) (0/2)* Prof Alessandro Rambaldi (Director of the Department of Oncology and Haematology-Oncology, Bergamo) (1/2)*

*External specialists

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Statement of Accounting Officer's Responsibility

Under the National Health Service Act 2006, the Secretary of State for Health and Social Care has directed NHS Blood and Transplant to prepare a statement of accounts for each financial year in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Blood and Transplant and of its income and expenditure, Statement of Financial Position and cash flows 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 for Health and Social Care, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements 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 accounts;
- prepare the accounts on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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The Principal Accounting Officer of DHSC has designated the Chief Executive as Accounting Officer of 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 NHS Blood and Transplant's assets, are set out in Managing Public Money published by the HM Treasury.

As the Accounting Officer, 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 NHS Blood and Transplant's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

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Corporate Governance Report – Governance Statement

Board and Accounting Officer Scope of Responsibility

The NHSBT Board must have appropriate governance arrangements in place to confirm that NHSBT is operating in accordance with the law, applicable regulations and that risks to the delivery of strategic objectives are managed. The Accounting Officer is responsible for maintaining a system of internal control to deliver the agreed aims and objectives. The Accounting Officer is personally responsible for safeguarding public funds and NHSBT's assets.

NHSBT's Accountabilities to the Department of Health and Social Care and the Devolved Governments

We are a Special Health Authority in England and Wales that was established by Statutory Instrument in 2005. Our statutory duties are described in our Directions that are published by the Secretary of State for Health and Social Care and the National Assembly for Wales.

Our relationship with the Department of Health and Social Care (DHSC) and our accountabilities to them are described in a 'Framework Document'. Our accountabilities to the Welsh Government, and to the Scottish and Northern Irish Health Departments relating to organ donation and transplantation are set out in Board arrangements and Income Generation Agreements.

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Duties of the Secretary of State for Health and Social Care

We must comply with the duties of the Secretary of State in the Health and Social Care Act 2012. A key duty is to "*to reduce inequalities between the people of England with respect to the benefits that may be obtained by them from the health service*" when providing our products and services. All our strategies for Blood, Organs and Stem Cells 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, organs and bone marrow transplants. We continue to work to reduce remaining health inequalities.

The governance framework

Our governance structures and assurance processes, set out in our Board Assurance Framework, have been reviewed by the Audit, Risk and Governance Committee (ARGC). The Framework gives assurance of the delivery of NHSBT's statutory and strategic objectives and the effectiveness of its internal controls and risk management processes. The framework was reviewed against best practice guidance (including "Corporate Governance in Central Government Departments"). The key assurance strands are described further below.

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Board arrangements

Information on our Board and its Committees is set out from page 108.

NHSBT undertook a Board Effectiveness review in September 2021. This was externally facilitated by Campbell Tickell, the review activities comprised the following:

- Engagement with a steering group, comprising the Chair of ARGC, Director of Quality, and the Company Secretary
- Conduct of an online survey comprising two key elements – a cluster of statements exploring various aspects of Board effectiveness, and a section providing the opportunity for respondents to offer commentary on learning from the past
- Interviews with all NEDs and with members of the Executive team;
- Observation of an ARGC meeting on 14th September 2021
- Various feedback meetings: a discussion of emerging headlines with the Chair and Chief Executive; attendance at an Away Day with NEDs and Executive staff on 29th September; and further discussions with NHSBT's Chair.

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The outcome report made recommendations to the Board on the following themes:

- Areas of focus for the interim Chair
- Recommendations to improve Committee and Governance Structure
- Better use of time
- Improvement of Board papers and reporting and support to presenters
- Non-Executive Director Induction
- Clarity on Strategic Direction
- Greater focus on risk
- Recommendations for ARGC.

The recommendations from the report and progress against them have been tracked and reported in the Public Board papers since December 2021. NHSBT has made positive progress in all areas and will continue to review performance and hold formal effectiveness reviews every 3 years.

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Strategic management and reporting

The Board approves the business plan and strategies across the organisation, which include the objectives and targets we aim to achieve. Our Executive Team and Board receive a monthly 'Board report' which shows performance including trend data, progress on strategic projects and a summary of key issues for attention. The content of this report is reviewed periodically to ensure that it provides sufficient information and assurance to the Board. Both the business plan and 'Board report' format and design were reviewed and refreshed during 2021-22.

Delegations

NHSBT is designated as a Public Corporation by Office for National Statistics. NHSBT operated on an interim set of ALB delegations issued by our sponsor department DHSC during 2021/22. These will be further reviewed during 2022/23. Due to an administrative oversight, we were required to apply for retrospective approvals for several consultancy, professional and temporary worker cases.

Three settlement agreements were issued in 2021/22 that contained confidentiality clauses, Ministerial approval was not sought at the time. In order to ensure full compliance, retrospective Ministerial approval for the use of confidentiality clauses in these cases was requested. Regarding the wording of the confidentiality clauses the Cabinet Office confirmed that the intent within all three confidentiality clauses was the same as that within their guidance and, importantly, that it did not restrict of stifle the individuals to talk about, or raise, any issues around mal-practice or whistleblowing (in line with the Public

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Interest Disclosure Act). As standard NHSBT do not use confidentiality clauses routinely, each case is given consideration and in these instances a decision was made by NHSBT that the use of the confidentiality clauses was necessary. The lack of approvals was an oversight from NHSBT. All approvals for the money paid as part of the settlement agreements (e.g., contractual redundancy payments) have already been obtained as necessary (including retrospective approval from HM Treasury for an £8k ex-gratia payment). The three settlement agreements have now received DHSC Ministerial approval on the 30 November 2022, with one of the agreements requiring Ministerial approval from the Cabinet Office due to the individual with one of the agreements being equivalent to a Senior Civil Servant. This was received on 23 January 2023. The CO Minister was content that NHSBT have undertaken a lessons learnt activity and new processes are now in place to ensure that all the correct approvals are sought in advance of using confidentiality clauses in the future. The default position remains in line with Cabinet Office Guidance that confidentiality clauses will only be used when necessary and not be included in settlement agreements as a matter of course.

Clinical governance

The Chief Medical Officer and Director of Clinical Services is also the responsible Director of Clinical Governance Clinical Effectiveness across NHSBT and reports regularly to the Executive Team, Audit, Risk and Governance Committee (ARGC) and the Board on all matters relating to Clinical Governance. The Director's Clinical Governance

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report cover: clinical risks and management; clinical audits; policy and patient/ donor safety; information governance; regulatory compliance; new external guidance and alerts; clinical services developments; incidents including serious incidents (SIs) and Never Events (see definition below); clinical complaints/patient and donor feedback and claims.

Corporate Clinical Audit, Risk and Effectiveness Committee (CARE) oversees all matters relating to clinical governance. CARE is a subcommittee to ARGC. The Committee meets bi-monthly, and reviews reports and updates from Directorate CARE groups embedded within three operational directorates (Clinical Services, Blood Supply and Organ, Tissues Donation and Transplant), seeking assurances, and providing recommendations proportionately as required. Clinical Governance is also a standing agenda item for each operational directorate's Senior Management Team meetings and the Quarterly Performance reviews by Directorate.

Clinical governance activity includes:

- Review of Corporate and directorates clinical risks and mitigations.
- Review of Never events, serious incidents and other incidents involving patients, donors, and staff, ensuring that investigations and learning is appropriate.
- Review of clinical audit strategy, plans, reports and actions.
- Review of clinical workforce data including training compliance.
- Compliance with National Guidance.

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- Data collection and reporting on infectious diseases in collaboration with Public Health England (PHE).
- Data collection and reporting on severe transfusion complications.
- Data collection and monitoring of organ data to ensure equity of access, to optimise the use of organs and monitor the outcomes of transplantation.
- Working with other health professionals, Department of Health and Social Care (DHSC) and specialist advisory groups to set organ allocation policy (for approval by the NHSBT Transplantation Policy Review Committee).
- Working with other health professionals, DHSC and specialist advisory groups (including Joint Professional Advisory Committee which oversees guidelines for all four UK Blood Services) to set policy for blood, stem cells and tissues.

Never Events / Serious Incidents

There were no Never Events reported within NHSBT during the year 2021-22. A Never Event is defined by NHS Improvement as a 'serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by the Healthcare provider'.

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Serious Incidents (SIs) are defined as adverse events, where the consequences to patients, donors, families and carers, staff, visitors, or other organisations are very significant, or the potential for learning is so great, or potential for reputational damage is high enough, that a heightened level of response is justified and warrants the use of additional resources.

There were six serious incidents reported during the year 2021-22 (2 in 2020-21) as follows:

1) April 2021 – Eye tissue was retrieved despite coroner's restriction. Consent was obtained from the donor family. Subsequently, the coroner 'restricted' permission for eye tissue donation due to the cause of death. Tissues were retrieved in error. The root causes were misalignment of paper and electronic records and a gap in knowledge of the terminology in use across all teams.
2) May 2021 – A heart was retrieved without the donor family's consent. A family gave consent for donation but excluded consent for the heart after it was explained that it might not be suitable for transplant. The retrieval team only checked the front sheet of the consent form. The learning included highlighting the importance of handover between teams.
3) July 2021-A pre-cut cornea graft was issued from NHSBT eye bank to a hospital in England. The Pre-cut tissue supplied had a thickness that met NHSBT release criteria (measured at the centre). However, the surgeon felt that the graft was not acceptable due uneven thickness. The surgeon had to stop surgery

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after removal of the patient's cornea. Equipment (Optical Coherence Tomography (OCT)) has now been purchased which measures thicknesses across the entire corneal graft.

4) Oct 2021-A customer ordered some granulocytes on the Online Blood Ordering System (OBOS) but failed request Cytomegalovirus (CMV) negative. CMV is a virus which many blood donors have developed antibodies to. These antibodies can be dangerous to immunosuppressed patients and babies so CMV negative must be used. The patient was transfused and was not harmed by this but later died. All hospital customers have been reminded of the importance of completing the specification on the Online Blood Ordering System.

5) Nov 2021 – A 'near-miss' occurred where incompatible red blood cell units were issued for a Sickle Cell Patient but were not transfused. This was investigated due to the potential for harm. Immediate mitigating actions and communications have taken place to prevent a repeat whilst the investigation takes place.

6) December 2021 – A cornea which was donated and consented for clinical use was incorrectly issued for Training and Development (T&D) to the Royal College of Ophthalmologists. Actions put in place have included reviewing of related documents to ensure robust checks are routinely completed, and retraining teams with regards to the requirements for non-clinical tissue to improve knowledge within the department.

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Approach to Never Events and Incidents Management

We embrace our responsibilities for the effective management and learning from Never Events and incidents. All members of staff including agency and contractors are encouraged to report all incidents when they occur. There are accessible policies, processes and systems to support the prompt reporting and investigation of incidents, risks, and other concerns.

All incidents are formally investigated. Each incident is also reviewed at Directorate and Corporate Clinical Audit, Risk and Effectiveness (CARE) groups to ensure organisational. Assurance from deep dives is provided through the CARE groups and reported to Audit, Risk and Governance Committee (ARGC).

We are committed to our Duty of Candour and maintaining honesty and transparency when things go wrong.

Approach to Clinical Audits

Our clinical approach is supported by a strategy and an annual schedule of audits. Clinical audit findings and recommendations are reported through the Directorate CARE groups with oversight from NHSBT CARE committee bimonthly.

During 2021-22, four clinical audits were completed relating to urgent referrals to therapeutic apheresis service (TAS), kidneys being declined after they have been transported, tissue donor referrals and corneal graft cutting. All recommended actions are in progress.

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Infected Blood Inquiry

The Infected Blood Inquiry (IBI) is a public inquiry established to examine the circumstances in which patients treated by the NHS, in particular since 1970, were given infected blood and/or blood products. The IBI is considering the impact on families; how the authorities responded; the nature of any support provided following infection; questions of consent; whether there was a cover up.

NHSBT is a Core Participant in the IBI. 2021-22 has been a very busy year in terms of engagement with the IBI. Activity has included preparing detailed statements, on behalf of the organisation, in response to formal requests for information; supporting former colleagues in giving written and oral evidence to the IBI; continuing to provide a significant volume of information/records.

NHSBT continues to fully cooperate with the IBI and is committed to openness and transparency.

The Government announced on the 17th August 2022 that the victims of the infected blood scandal will each receive an interim compensation payment of £100,000. The Government intends to make payments by the end of October 2022. These payments will be made by the Department and as such will have no impact on NHSBT or these accounts. All the relevant matters are being handled by the Department.

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Product safety, regulation and quality assurance

Our products and services must comply with various regulations and pieces of legislation which include the Blood Safety and Quality Regulations 2005, The Quality and Safety of Organs intended for Transplantation Regulations 2012, the Human Tissue Act 2004, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and the Health and Social Care Act 2012.

We also follow the Guidelines for Blood Transfusion in the UK and safety advice from the advisory committee for the Safety of Blood, Tissues and Organs (SaBTO).

We are regulated and inspected by several regulatory bodies including the Medicines Healthcare products Regulatory Agency (MHRA), the Human Tissue Authority (HTA), and the Care Quality Commission (CQC).

We also work to a number of professional standards and accreditations, including ISO15189 Medical Laboratories: the requirements for quality and competence is an international standard that specifies the quality management system requirements particular to medical laboratories. We are inspected regularly by several accreditation bodies such as United Kingdom Accreditation Service (UKAS) and the Joint Accreditation Committee (JACIE).

NHSBT's Reagent products must be CE/UKCA marked as medical devices, denoting they have been made to appropriate standards.

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Compliance with regulatory requirements through our quality management system (QMS)

We aim to have no “critical” and no “major” non-compliances identified in any external regulatory inspections. During 2021/22 there were 14 external regulatory and accreditation inspections of our facilities and systems across Quality, Business Continuity and Health & Safety. No critical or major non-compliances were raised in any of these inspections and all recommendations have or are being addressed. As a result of these inspections, we are assured that our processes are effective.

We maintain this performance by operating a single, comprehensive quality management system (QMS) with detailed process documents and compliance records held in an electronic system (QPulse). The records ensure continued, demonstrable compliance with our regulatory requirements, licences and accreditations. Our processes also ensure that staff are adequately, trained and competent. We operate a robust process of self-inspection (see below); and a risk-based quality system which 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, cover all regulated activities at our licensed sites and include:

- Internal Quality Audit, undertaken by a team of approved auditors independent of the site or activity being inspected. They provide assurance on effective closure of external inspection findings and identify areas for regulatory and quality improvement.

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- Risk based audits are focussed on critical processes and their improvement. The audits are agreed with directorate leadership teams based on quality incidents, audit findings and directorate risks.
- Ad-hoc audits are commissioned by Senior Managers, often in response to adverse events, trends or changes to our operations.

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

- A quarterly Management Quality Review (MQR) Report to the Executive Team and ARGC.
- An annual summary MQR 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.

Our Quality activity and reporting is regularly reviewed to identify improvements.

During 2021-22, we have seen variability in the number of overdue events. An overdue event is, when a policy or procedure has gone past its review date; or when an element of a corrective and preventive action plan goes past its due date. Following an upward trend in overdue events peaking in the first half of the year, a number of improvement initiatives were implemented which resulted in improved performance through the remainder of the year.

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In response to the CQC report, the Board approved a CQC Action Plan on 29 November 2022. The plan was subsequently submitted to the CQC on the 5 December 2022 in accordance with the agreed timescales. The CQC have accepted the action plan and will monitor progress at their quarterly engagement with NHSBT. The actions have been allocated to specific owners (Executive Directors) and are reviewed at their relevant SMTs.

Risk Management and Assurance

Risk management is an essential part of NHSBT improving and saving lives and ensuring that NHSBT is able to deliver on its strategic priorities. This year we have developed our risk management system so it aligns with our new corporate strategy.

Our strategic risks are shown on page 18. Each risk is linked to the strategic objective that it will most affect, and responsibility for each risk is owned by a member of the Executive Team. Each risk is also assigned an oversight committee that will be responsible for discussing and overseeing these risks on a regular basis, holding the relevant director to account and providing support if required.

We have also started work on the Government Functional Standards that we must complete. This work is at an early stage, we are in the process of evaluating the gaps to the mandatory requirements within the standards and are putting plans in place to address these gaps.

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Risk management and assurance is scrutinised by two key Governance and Oversight Committees (1) the Risk Management Committee (RMC) approves the risk management process and the relevant documents that govern that process and oversee the organisation's response to risk and (2) the Audit, Risk and Governance Committee (ARGC) which seeks assurance on behalf of the Board that the risk management system is functional and effective. The Board retains the responsibility for approving the organisation's Risk Policy and Risk Appetite statements and has regular reviews of the Board Assurance Framework.

In addition, we have a Risk Leads Forum (RLF), a sub-group of the Risk Management Committee, which reviews and challenges risk assessments and informs the RMC.

There is a Terms of Reference for the Risk Management Committee and policies and procedures guide our work.

Business continuity

We are the sole supplier for many of our products and services in our delivery areas. These are often critical to the wider health community and patients.

The last year was, of course, dominated by the response to the pandemic from Government, the NHS and for ourselves. We were dedicated to response. We worked closely with the Department of Health and Social Care and other key health responders during the pandemic. We ensured continuation of supply and also supported other services in UK and Ireland with blood stocks in times of shortage.

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Despite the challenges we have made significant improvement in risk of IT failure, and we have improved our methods for gaining assurance. This continues to be a significant field of development.

Recent years have tested the organisation's resilience and lessons learned from EU Exit and the Coronavirus Pandemic have been identified and need to be embedded into our systems. We have identified an increased risk of business continuity, in particular from external events (see strategic risks page 18) and we are working to improve our continuity planning for identified risks. We plan a continuity exercise programme to ensure that gaps are identified and mitigated.

We received positive feedback from an external audit against the business continuity management requirement (ISO22301) and will continue to seek external verification and use the feedback received to improve our approach.

Information governance and security

The Information Governance Committee (IGC) oversees the work to protect our digital systems, services, and information assets and ensures we are managing information in line with law and policy. Each identified information asset has an accountable Information Asset Owner, and the Information Governance and Security Teams support these Owners and test the compliance and controls of their management of the assets to all relevant regulations, legislation and NHS best practice.

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In the year we reported no incidents to the Information Commissioners Office (ICO) and in May 2022 closed an incident reported to the ICO in 2019, with no further action being taken or monetary penalty. We proactively collaborate with the ICO on complaints to ensure that NHSBT customers, patients and staff are appropriately informed on the processing and recording of information held by NHSBT.

We also reported 394 data incidents in the year, most involved loss of paper documents including Blood Donor Health Check forms (DHCs), nearly all of which were subsequently recovered. We continue to review all incidents and subsequent trends to identify lessons learned, and share these with the teams responsible, and across wider NHSBT operations nationally to help avoid repeats. We are working to introduce systems and reduce the need for paper forms to address this

There were no reportable cyber security incidents in the period. There were a number of High Severity alerts issued by NHS Digital which we responded to in a compliant and timely manner. Throughout the year we have made significant progress in augmenting our Cyber Security capabilities including the on-boarding of an NCSC Accredited Cyber Incident Response Partner, rolling out of Microsoft Advanced Threat Protection software, the standing up of a dedicated Threat Intelligence Platform and Service, the establishment of a Security Monitoring Platform, and the enhancement of our Secure-and-Privacy-by-Design approach across our architectural and software design lifecycle. This is supported by a dedicated

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security governance structure and the appointment of a Chief Information Security Officer.

Whistleblowing policy and Freedom to Speak up (FTSU) Guardian

In the financial year of 2021-22 100 concerns were raised. The data shows that staff feel able to raise any questions relating to safety directly with managers and generally use the Speak Up service for cultural, behavioural, and policy concerns. We are focussing on addressing the root causes of frequently raised concerns and, consequently, will be introducing a new Resolution Unit led by the Speak Up service. In order to ensure the Speak Up service is fully accessible to all colleagues, the FTSU Guardian attends Network meetings, Staffside Partnership Committee meetings and other forums where equality, diversity and inclusion concerns may be raised. The growing network of FTSU Champions encourages those protected by the Equality Act 2010 to raise concerns and is itself a very diverse group. Themes and trends of concerns are monitored, and potentially discriminatory conduct is highlighted and acted on.

Counter Fraud policy

The Anti-Fraud, Bribery and Corruption policy explains how staff must conduct business and report suspected fraud. We also have a risk-based counter fraud action plan. We plan preventative and detective work in areas of risk and investigate any suspected cases raised with our Local Counter Fraud Specialists. We report on our plans and work undertaken to ARGC and they also receive our self-assessment against the counter fraud standards.

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During 2021-22 two new cases have been reviewed and three previous cases have been followed up. The two new cases relate to external actors trying to obtain funds via emails and text messages. We work closely with our cyber teams to investigate and prevent future attempts.

Our supply chain ethics and sustainability

We are committed to upholding human rights, anti-corruption, anti-slavery and anti-bribery policies within NHSBT and our supply chain. We expect suppliers to comply with a code of conduct and our Modern Slavery Policy (Supply Chain). As part of tendering suppliers demonstrate how they meet these expectations. Grievance procedures are set out within terms and conditions for workers to raise concerns.

NHSBT is working towards a Sustainable Supply Chain for all significant goods and services purchased and uses the certification process of ISO14001 and assessment process of ISO20400 to drive continuous improvement within this area. We apply sustainability performance indicators relevant to contracts including ones for reducing CO2 and reducing waste. Contract reviews are carried out on an ongoing basis across the supplier base to ensure performance of the contract against these indicators.

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Health and Safety

Through the COVID-19 pandemic our first priority has been the safety and wellbeing of our donors, patients and colleagues, Health Safety and Wellbeing (HSW) is covered in our Accountability report (pages 94).

The table below shows the Health and Safety incidents, by directorate and level for the last two years, with definitions of each level shown.

	2020-21				2021-22			
Level	HSE Report	3-7 lost time	Other harm	Near miss	HSE Report	3-7 lost time	Other harm	Near miss
Blood Supply	26	14	831	560	21	9	720	784
Clinical Services	1	1	42	28	1	0	59	61
OTDT	0	0	43	57	0	0	49	69
Donor Experience	0	0	0	0	0	0	1	1
Group Services	0	0	14	18	0	0	13	37
Plasma*	0	-	-	-	0	1	32	9
Total	**27**	**15**	930	**663**	**22**	**10**	874	**961**

*Plasma shown separately for 2021-22, within Blood Supply for 2020-21
HSE Reportable (HSE Rep) – Over 7 days lost time injuries or specified injuries reported to the Health and Safety Executive (HSE) e.g. fractures or injuries requiring an over 24 hours stay in hospital.
Lost Time – Over 3 but less than 8 day lost time injuries.
Other Harm – Injuries or occupational ill health to staff and contractors, excluding road traffic incidents and violence.
Minor / Near Miss – Minor injuries or all other near miss incidents where no injury to staff.

We are pleased to see a reduction in harm incidents in Blood Supply especially at a time of increased controls for the pandemic. Increases in Clinical and OTDT are small and from low levels. The number of lost time accidents has reduced with the incidence rate per 100,000 workers at 484 from 608 last year, which compares favourably with the Labour Force Survey figure of 710 for the Public Health and Social Care Sector. We are pleased to see an increase in near miss reporting in all areas, reflecting

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an increase in the maturity of our HS&W management system, as people recognise the importance of reporting incidents so we can learn from them.

Control weaknesses identified during Internal Audit reviews

Our internal audit service is provided by Government Internal Audit (GIAA).

Definition of the assurance opinions:

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 2021-22 programme of work agreed by the ARGC covered 19 work areas. During the year 2 additional reviews were incorporated within the plan. As part of in-year prioritisation of work, 2 reviews were deleted as a result of changing risk profile across NHSBT, 3 were deferred and have been incorporated into our 2022-23 work programme and 2 (recruitment processes and pre-employment checks) were amalgamated into a single activity for logistical reasons. Of the 15 activities, all have been completed and reported on in the period. One of the activities involved providing direct support to NHSBT to develop their assurance mapping process and no output is appropriate. The other activities comprised a blend of advisory reports and formal assurance activities broadly in line with previous years outputs. Five reports were

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advisory, of the remaining 9:

- 2 reports received a “substantial” assurance opinion.
- 5 received a “moderate” assurance opinion.
- 2 received a “limited” assurance opinion.

The limited assurance reports related to compliance with Government Commercial Services Contract Pipeline requirements and Recruitment Processes and Pre-employment Checks. There were 3 medium priority recommendations in the commercial review: 1) to write a commercial strategy, 2) to change the format of the pipeline report to meet best practice and 3) to update the contract extension procedures, actions are planned to address all three in 2022-23. There were 6 medium priority recommendations in the Recruitment review, 1) deploy system changes to ensure data accuracy of training records, 2) improve completion rates of recruitment & selection training by hiring managers, 3) run campaign to build awareness of hiring manager responsibilities in the recruitment process, 4) develop a quality assurance mechanism to monitor hiring manager adherence to process, 5) record the current profile and capacity of recruitment team as a risk, 6) right size the recruitment team in relation to current and future demands. These actions will be completed in 2022-23.

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The 3 audits deferred to 2022-23 planning were:

- Corporate Governance / Board Effectiveness – NHSBT had external evaluation in this area during 2021-22 and we consider it appropriate that a reasonable period of time be allowed for the organisation to implement recommendations stemming from that activity.
- Programme and Project Management – organisational accountabilities and personnel changes have occurred during 2021-22 and the review will add more value once things have stabilised.
- Plasma Programme – the Plasma for Medicines Programme has now been incorporated as permanent Directorate within NHSBT. At the request of management our initial work examining the overarching governance arrangements has expanded significantly to incorporate some key clinical risk areas and we are working with NHSBT colleagues to define and scope this critical work.

The 2 audits deleted from the 2021-22 plan were:

- Data governance – key elements of the areas we would have expected to cover in this review were included in our advisory work on Records Management and in our mandatory independent assessment of NHSBT's Data Security and Protection Toolkit submission.
- Cabinet Office Spending Controls – NHSBT are officially categorised as a Public Corporation and compliance with CO spend controls policies is not a mandatory requirement.

ARGC monitors the completion of all medium and high risk outstanding audit recommendations. In May 2022 ARGC

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were informed that there were no overdue medium or high recommendations from the 2021-22 audit programme. The ARGC have been informed that a number of recommendations relating to work completed during 2020-21 have been given extensions to original implementation dates, or have been paused due to a combination of operational and resourcing challenges and the impact of COVID-19.

Internal Audit – opinion of the Head of Internal Audit

In 2021/22, our Internal Audit service was provided by the Government Internal Audit Agency (GIAA). GIAA have provided assurance over NHS Blood and Transplant's (NHSBT's) core business activities with individual reviews performed across operational, financial and other risk areas; all informed by the organisation's risk assessment and their independent view on NHSBT's risk profile.

The Internal Audit opinion for the year states, "*Our opinion is based solely on our assessment of whether the controls in place support the achievement of management's objectives as set out in our 2021/22 Internal Audit Plan and Individual Assignment Reports*".

The Head of Internal Audit confirmed in the opinion that in accordance with the requirements of the UK Public Sector Internal Audit Standards, they are required to provide the Accounting Officer with their annual opinion of the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

The Head of Internal Audit concluded that "*My opinion is based on the outcomes of the work that Internal Audit has*

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conducted throughout the course of the reporting year. There have been no undue limitations on the scope of Internal Audit work and the appropriate level of resource has been in place to enable the function to satisfactorily complete the work planned. Therefore, in summary, my overall opinion is that I can give Moderate Assurance to the Accounting Officer that NHSBT has had adequate and effective systems of control, governance and risk management in place for the reporting year 2021-22."

Review of Effectiveness

As the Accounting Officer I place reliance on the internal system of control. These include, but weren't limited to:

- oversight by the Board and its sub-committees including the Audit Risk and Governance Committee;
- the work and opinions provided by GIAA our internal auditors;
- clinical assurance provided by our CARE committees and clinical auditing process;
- quality assurance provided by our internal quality team and external regulators;
- senior managers within the organisation, who had responsibility for the development and maintenance of the system of internal control, and
- regular reporting to the Executive Team on performance and risk management.

Our systems of internal control lead me to believe that we have maintained effective control throughout the period.

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Accountability report – Parliamentary accountability and audit report

Basis for accounts preparation

These accounts for the year ending 31 March 2022 have been prepared as directed by the Secretary of State for Health and Social Care 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 £111k (£101.5k 2020-21). There were no payments to the C&AG for non-audit work during 2021-22 and 2020-21.

Regularity of expenditure: losses and special payments

This is subject to audit.

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.

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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).

Losses Statement	31 March 2022		31 March 2021	
	No. Cases	£000	No. Cases	£000
Cash losses	0	0	5	1,100
Exchange rate fluctuations	0	0	1	0
Losses of pay, allowance and superannuation benefits	43	23	40	55
Losses of accountable stores	65	165	74	227
Claims waived or abandoned	36	4	21	5
Fruitless payments and				
Constructive losses*	8	(10)	13	2,387
Total	**152**	**182**	**154**	**3,774**

Special Payments	31 March 2022		31 March 2021	
	No. Cases	£000	No. Cases	£000
Compensation payments	12	32	31	69
Ex gratia payments	7	80	13	74
Total	**19**	**112**	**44**	**143**

*2020-21 included £0.743m for Session Solution which was deemed fruitless due to roll out delays and £1.59m for harnesses purchased for collecting convalescent plasma which were not used.

At 31st March plans were in place to use remaining harnesses bought for convalescent plasma prior to their expiry dates. Some batches expired on 1st May 2022 and a minor loss of £3.7k will be reported in 2022-23.

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Expenditure on consultancy

Consultancy expenditure during 2021-22 is £150k (2020-21 £2.2m). This was a piece of advisory work to design the plasma operating model. To March 2021 we used Cabinet Office's high-level definition of Consultancy. Following adoption of our new delegations 1 April 2022, as agreed with DHSC, we will refer to the procurement common areas of spend guidance to determine the nature of spend. Spend falling within consultancy, professional services and contingent labour definitions, above agreed thresholds, requires approval by DHSC. This disclosure excludes professional services and contingent labour.

Remote contingent liabilities

This is subject to audit.

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

Notation of gifts

This is subject to audit.

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

Fees and charges

This is subject to audit.

We have a statutory duty to set prices to breakeven year-on-year. Accumulated cash balances have arisen from prior year surpluses which will be used to fund essential IT investments. Most of our income is from prices set

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to recover our costs. We set the prices of our products annually with the National Commissioning Group, on behalf of the NHS. Prices are national, and set per unit, calculated using forecast sales volumes for the coming year. Prices include the full cost of providing products and services to the NHS (including a return on the cost of capital employed).

During 2021/22 the National Commissioning Group, agreed that demand was sufficiently close to planned volumes that we did not need to calculate or pay a rebate to customer hospitals. In 2020/21, DHSC and NCG agreed that we could retain £11.6.m of rebate due to customers to offset our increased covid-19 costs. Note 2 shows the contribution per business unit and is subject to audit.

This accountability report was previously agreed by Betsy Bassis prior to her departure on the 9th August 2022. As noted above, I have been involved in the preparation of these accounts and the assurances that were provided and therefore, I hereby sign the Accountability Report (including the Governance Statement) from pages 66 to 143.

Wendy Clark
As Accounting Officer

7 February 2023

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The Certificate and Report of the Comptroller and Auditor General to the House 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 2022 under the National Health Service Act 2006.

The financial statements comprise NHS Blood and Transplant's

- Statement of Financial Position as at 31 March 2022;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the financial statements is applicable law and UK adopted International Accounting Standards.

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 2022 and its net operating expenditure after interest for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

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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 (UK) (ISAs UK), applicable law 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 2019. I have also elected to apply the ethical standards relevant to listed entities. I am independent of NHS Blood and Transplant in accordance with the ethical requirements that are relevant to my audit of 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.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that NHS Blood and Transplant's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

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Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on NHS Blood and Transplant's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for NHS Blood and Transplant is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report, but does not include the financial statements nor my auditor's certificate and report. The Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, 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

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obtained in the audit or otherwise appears to be materially misstated.

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. 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.

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Opinion on other matters

In my opinion the part of the Our People report to be audited has been properly prepared in accordance with Secretary of State directions issued under the National Health Service Act 2006.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Our Accountability Report subject to audit have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Our Performance and Our Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of NHS Blood and Transplant and its environment obtained in the course of the audit, I have not identified material misstatements in the Our Performance and the Our Accountability Report.

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

- I have not received all of the information and explanations I require for my audit; or
- adequate accounting records have not been kept by NHS Blood and Transplant or returns adequate for my audit

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have not been received from branches not visited by my staff; or

- the financial statements and the parts of the Our Accountability report subject to audit are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Our People Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for:

- maintaining proper accounting records;
- the preparation of the financial statements and Annual Report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the Annual Report and accounts as a whole is fair, balanced and understandable;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error; and

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- assessing NHS Blood and Transplant's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS Blood and Transplant will not continue to be provided in the future.

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.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. 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.

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Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, we considered the following:

- the nature of the sector, control environment and operational performance including the design of NHS Blood and Transplant's accounting policies;
- Inquiring of management, NHS Blood and Transplant's Head of Internal Audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS Blood and Transplant's policies and procedures relating to:
- identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
- detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and

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- the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS Blood and Transplant's controls relating to NHS Blood and Transplant's compliance relating to the National Health Services Act 2006 and Managing Public Money.
- discussing among the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within NHS Blood and Transplant for fraud and identified the greatest potential for fraud in the following areas: revenue recognition, posting of unusual journals, complex transactions and bias in management estimates. In common with all audits under ISAs (UK), I am also required to perform specific procedures to respond to the risk of management override of controls.

I also obtained an understanding of NHS Blood and Transplant's framework of authority as well as other legal and regulatory frameworks in which NHS Blood and Transplant operates, focusing on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of NHS Blood and Transplant. The key laws and regulations I considered in this context included the National Health Services Act 2006, Managing Public Money, pensions legislation, tax legislation and employment law.

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In addition, I considered novel and contentious payments requiring external approval to comply with Managing Public Money.

Audit response to identified risk

As a result of performing the above, the procedures I implemented to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit, Risk and Governance Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and internal audit reports.
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.
- Testing approvals for exit packages, consultancy and contingent labour.

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I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

Other auditor's responsibilities

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.

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.

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Report

I have no observations to make on these financial statements.

Gareth Davies **Date:** 9 February 2023
Comptroller and Auditor General

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

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Our finances

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £000	2020-21 £000
Gross Income			
Income from sale of goods and services	2 & 3	370,812	348,505
Other operating income	2 & 3	31,386	28,551
		402,198	**377,056**
Expenditure			
Staff costs	4	(279,038)	(268,275)
Operating expenses	5	(213,426)	(230,435)
Depreciation, amortisation & impairment charges	9 & 10	(11,589)	(13,553)
Other operating expenditure	6	(30,071)	(31,037)
		(534,124)	**(543,300)**
Net operating expenditure before interest		**(131,926)**	**(166,244)**
Finance expense		(955)	(865)
Net operating expenditure after interest	2	**(132,881)**	**(167,109)**
Other comprehensive net expenditure Items which will not be reclassified to net operating costs:			
Net gain on revaluation of Property, Plant and Equipment	9 & 10	11,290	513
Total comprehensive net expenditure		**(121,591)**	**(166,596)**

Notes 1 to 22 form part of these accounts.

All income and expenditure is derived from continuing operations.

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Statement of Financial Position as at 31 March 2022

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Property, plant and equipment	9	240,479	233,143
Intangible assets	10	6,445	2,732
Financial assets	12	198	397
Total non-current assets		**247,122**	**236,272**
Current assets			
Inventories	11	17,276	17,312
Trade and other receivables	12	43,359	44,578
Cash and cash equivalents	13	64,676	53,211
Total current assets		**125,311**	**115,101**
Current liabilities			
Trade and other payables	14	(71,463)	(52,688)
Provisions for liabilities and charges	15	(866)	(566)
Other liabilities	16	(298)	(266)
Total current liabilities		**(72,627)**	**(53,520)**
Total assets less current liabilities		**299,806**	**297,853**
Non-current liabilities			
Provisions for liabilities and charges	15	(395)	(419)
Financial liabilities	16	(8,253)	(8,551)
Total non-current liabilities		**(8,648)**	**(8,970)**
Total assets less employed		**291,158**	**288,883**
Financed by			
General Fund		194,779	200,927
Revaluation Reserve		96,379	87,956
Total taxpayers' equity		**291,158**	**288,883**

Notes 1 to 22 form part of these accounts.

The financial statements on pages 156 to 161 were recommended by the Audit Risk and Governance Committee on 14 September 2022 and approved by the Board in accordance with powers within the NHSBT

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Standing Orders and are signed by the Accounting Officer, Wendy Clark as Interim Chief Executive.

Wendy Clark
Date: 7 February 2023

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Statement of Changes in Taxpayers' Equity for the year ended 31 March 2022

	Note	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2021		200,927	87,956	**288,883**
Changes in taxpayers' equity for 2021-22				
Net expenditure for the financial period		(132,881)	-	**(132,881)**
Net gain on revaluation of property, plant and equipment	9 & 10	-	11,290	**11,290**
Transfer between reserves		2,867	(2,867)	-
Total recognised income and expense for 2021-22		**(130,014)**	**8,423**	**(121,591)**
Revenue Grant from DHSC		111,866	-	**111,866**
Capital Grant from DHSC		12,000	-	**12,000**
Balance at 31 March 2022		**194,779**	**96,379**	**291,158**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

	Note	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2020		199,504	91,765	**291,269**
Changes in taxpayers' equity for 2020-21				
Net expenditure for the financial period		(167,109)	-	**(167,109)**
Net gain on revaluation of property, plant and equipment	9 & 10	-	513	**513**
Transfer between reserves		4,322	(4,322)	**0**
Total recognised income and expense for 2020-21		**(162,787)**	**(3,809)**	**(166,596)**
Revenue Grant from DHSC		144,460	-	**144,460**
Capital Grant from DHSC		22,500	-	**22,500**
Adjustments for Transfer of assets to GPA		(2,750)	-	**(2,750)**
Balance at 31 March 2021		**200,927**	**87,956**	**288,883**

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Information on reserves

General Fund

The General Fund represents the net assets invested in NHSBT (stated at historical cost less accumulated depreciation at that date), the surplus or deficit generated from activities and grant-in-aid funding provided.

Revaluation Reserve

The Revaluation Reserve represents increases in asset values arising from revaluations, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

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Statement of cash flows for the year ended 31 March 2022

	Note	2021-22 £000	2020-21 £000
Cash flows from operating activities			
Net operating costs before interest		(131,926)	(166,244)
Adjustments for non-cash transactions	17	12,040	15,492
(Increase)/ decrease in trade and other receivables	12	1,418	(3,044)
(Increase)/ decrease in inventories	11	36	2,810
Increase/ (decrease) in trade and other payables	14	18,775	10,852
Movement in working capital not through SoCNE	14/17	233	(636)
Provisions utilised	15	(168)	(100)
Movement in financial lease liabilities	16	-	881
Net cash (used in) operating activities		**(99,592)**	**(139,989)**
Cash flows from investing activities			
Purchase of plant, property & equipment	9	(6,875)	(23,098)
Purchase of intangible assets	10	(4,719)	(161)
Proceeds from disposal of non-current assets		-	2
Net cash (used in) investing activities		**(11,594)**	**(23,257)**
Cash flows from financing activities			
Grant from DHSC		123,866	166,960
Capital element paid in respect of finance leases		(267)	(227)
Interest paid in respect of finance leases		(948)	(824)
Net cash generated from financing activities		**122,651**	**165,909**
Increase in cash and cash equivalents		11,465	2,662
Cash and cash equivalents at 01 April		53,211	50,549
Cash and cash equivalents at 31 March	13	**64,676**	**53,211**

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Notes to the Accounts

Note 1 Accounting policies and other information

1.1 Basis of preparation

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) as adapted and interpreted by the 2021-22 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM comply with IFRS to the extent that they are meaningful and appropriate to the public sector context as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the FReM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS body for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

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1.1.2 Going concern

The organisation's annual report and accounts have been prepared on a going concern basis. NHSBT is financed by grant-in-aid and draws its funding from the Department of Health and Social Care (DHSC). Parliament has demonstrated its commitment to fund DHSC for the foreseeable future, and DHSC has demonstrated its commitment to the funding of NHSBT.

1.2 Critical judgements and key sources of estimation uncertainty

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.

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1.2.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying NHSBT's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Charities consolidation

Management consider NHS Blood and Transplant Trust Funds, of which NHSBT is the corporate trustee, to have an immaterial impact on the group results. Therefore, these accounts do not include a consolidated position under the requirements of IFRS 10.

1.2.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Use of depreciated replacement cost to value land and buildings (see accounting policy note 1.11)

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1.3.1 Subsidiaries

Entities over which NHSBT has the power to exercise control are classified as subsidiaries and are consolidated. NHSBT has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines.

The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with NHSBT or where the subsidiary's accounting date is not coterminous.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

NHSBT has no subsidiaries to report at 31st March 2022.

1.3.2 Associates

Entities over which NHSBT has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in these financial statements using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect NHSBT's share of the associate's profit or loss and other gains or losses. It is also reduced when any distribution is received by NHSBT from the associate.

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Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

NHSBT has no material associates to report at 31st March 2022.

1.3.3 Joint arrangements

Arrangements over which NHSBT has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where NHSBT is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

NHSBT has no joint arrangements to report at 31st March 2022.

1.4 Operating segments

Income and expenditure are analysed in the Operating Segments note 2 and are reported in line with management information used within NHSBT.

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1.5 Revenue from contracts with customers

Income is recognised to the extent that it is probable that the economic benefits will flow to NHSBT and the income can be reliably measured.

Where income is derived from contracts with customers, it is accounted for under IFRS 15.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, NHSBT invoices for all income relating to performance obligations satisfied in that year. Where NHSBT's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

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Revenue from NHS contracts

The main source of income for NHSBT is contracts with NHS Trusts primarily for the supply of blood and components and diagnostic and therapeutic services. Products and services are normally accrued in month and billed in the month following delivery with the exception of blood and components where customers are normally billed a monthly fixed contract value and variable price based on activity monthly in arrears. In 2021-22 fixed contracts values were not adjusted for actual demand variations.

The customer in these contracts is the Trust and the customer benefits as products/services are provided. These are essentially separate performance obligations that are substantially the same and have a similar pattern of transfer. At the year end, NHSBT invoices for all income relating to activity delivered in that year. Revenue is recognised to the extent that collection of consideration is probable.

Revenue from project contracts

NHSBT receives income from contracts for projects. For example, research and development; and Clinical trials. The customers being mostly Universities and commercial entities. Where project contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that NHSBT's interim performance does not create an asset with alternative

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use for NHSBT, and NHSBT has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and NHSBT recognises revenue each year over the course of the contract.

1.6.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from NHS Trusts for the provision of services. NHSBT receives programme funding from the Department of Health and Social Care (DHSC) for the provision of transplant services. Such grants are taken directly to the General Fund and not counted as income. They are shown in note 2 to these accounts.

1.6.2 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met; is measured as the sums due under the sale contract and where NHSBT is permitted to retain the proceeds.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

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1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, NHSBT recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accrual basis.

1.9 Value added tax

Most of the activities of NHSBT are outside the scope of value added tax (VAT) and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

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1.10 Capital charges

An annual charge, reflecting the cost of capital utilised by NHSBT, is payable to DHSC. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of NHSBT. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- Donated assets
- Average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short-term working capital facility)

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets. In accordance with the requirements laid down by DHSC, the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

The notional charges are taken directly to the General Fund and shown in note 2. Cash payment to DHSC in respect of the previous financial year is included in operating expenses.

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1.11 Property, plant & equipment

Note 1.11.1 Recognition

Property, Plant & Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, NHSBT
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has a cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- 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, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.11.2 Measurement

All property, plant and equipment assets 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.

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Assets that are held for their service potential and are in use are measured at their current value in existing use.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction are carried at cost, less any impairment loss. Assets under construction costs are accumulated until the asset is completed and ready to be brought into service when the asset is transferred to the relevant asset class and depreciation commences. Costs include professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

All land and buildings are professionally revalued in accordance with IAS 16 every five years. Professional valuers undertake a desktop valuation for each of the interim years 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 last carried out in March 2019. The value of property plant and equipment on this report are based on a desktop revaluation carried out as at 31st March 2022.

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The revaluation of NHSBT's land and buildings assets by the Valuation Office Agency includes measurement approaches used to arrive at the current value of in use assets. These approaches are for:

- Non-specialist operational assets – Existing Use Value (EUV)
- Specialist operational assets – Depreciated Replacement Cost (DRC). 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.

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.

1.11.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

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1.11.4 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met: The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

- the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of NHSBT's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided, to NHSBT and where the cost of the asset can be measured reliably.

Intangible assets are capitalised when they have a cost of at least £5,000. Intangible assets acquired externally are initially recognised at cost.

Following initial recognition at historic cost, intangible assets are carried at amortised cost as a proxy for fair value.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition 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. NHSBT does not hold any internally generated intangible assets.

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Software which is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.12.2 Measurement

Intangible assets acquired are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition 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 current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

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1.13 Depreciation, amortisation and impairments

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless NHSBT expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

Depreciation is charged on a straight line basis over the estimated useful life of the asset as follows:

Freehold Buildings	Up to 109 years
Plant and machinery	3 to 20 years
Information technology	3 to 27 years
Transport	10 years

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

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Impairments

At each financial year end, NHSBT checks whether there is any indication that its property, plant and equipment have suffered an impairment loss. If there is indication of an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with FReM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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Amortisation

Intangible assets are amortised, on a straight-line basis, over the estimated lives of the assets. Lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

Software licences	3 to 26 years
Internally generated software	3 to 26 years

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

1.14 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

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1.15 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 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. Subsequently, property, plant and equipment held under finance leases are revalued as described in 1.11 above. Lease payments are apportioned between finance charges and reduction of the lease obligation 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.

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Where a lease is for land and buildings, the land and building components are separated and individually assessed.

1.17 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.

The carrying values of inventories are considered a proxy for fair value less costs to sell.

The plasma collected under the Convalescent Plasma (CVP) Programme was previously held at nil value, the net recoverable value, as it was issued to hospitals free of charge during the research trials. At 31 March 2022 we plan to sell excess and expired plasma for non-clinical use, so value the CVP at the expected recoverable value. We anticipate the plasma collected for medicines (PFM) will be used prior to expiry but without contracts in place, with fractionators or funders, we continue to value PFM at nil value.

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1.18 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.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of NHSBT's cash management. Cash, bank and overdraft balances are recorded at current values.

1.19 Foreign exchange

NHSBT's functional currency and presentational currency is pounds sterling and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of each transaction.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

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1.20 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill health. The full amount of the liability for the additional costs is charged to operating expenses at the time NHSBT commits itself to the retirement, regardless of the method of payment.

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The scheme is subject to a full actuarial valuation every four years and an accounting valuation every year.

National Employment Savings Trust (NEST) Pension Scheme

NHSBT provides certain employees, who are not enrolled into the NHS Pension Scheme, with a pension from the defined contributions scheme which is managed by the National Employment Savings Trust (NEST). The cost to NHSBT is taken as equal to the contributions payable to the scheme for the accounting period.

1.21 Provisions

Provisions are recognised when NHSBT has a present legal or constructive obligation as a result of a past event, it is probable that NHSBT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 1.30% (2020-21: negative 0.95%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

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A nominal short-term rate of 0.47% (2020-21: minus 0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

A nominal long-term rate of 0.95% (2020-21: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Clinical Risk Pooling

NHS Resolution (formerly NHS Litigation Authority) operates a risk pooling scheme under which NHSBT pays an annual contribution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with NHSBT. The value of provisions of NHSBT carried by NHS Resolution on behalf of NHSBT is disclosed at note 15 but is not recognised in NHSBT accounts.

Non-clinical Risk Pooling

NHSBT participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk

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pooling schemes under which NHSBT pays an annual contribution to 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 operating expenses as and when they become due.

1.22 Financial Instruments

We only have non-current financial assets (prepayments and accrued income), current payables and receivables. There are no other financial instruments held in scope of IFRS 9. We do not carry out any hedge accounting transactions.

Financial assets

In accordance with IFRS 9 and FReM, NHSBT is required to recognise a loss allowance representing expected credit losses on trade receivables. NHSBT has applied the simplified approach, as required, and measured the loss allowance at an amount equal to lifetime expected credit losses. NHSBT only has financial assets at amortised cost, there are no other financial assets at fair value through profit and loss neither through other comprehensive net expenditure.

1.23 Contingent liabilities and contingent assets

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 entity's control, or a present obligation that is not recognised because it is not probable that a payment will be required to settle

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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 entity's control. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.24 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. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, 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 – see page 141)

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1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

1.26 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.

These Standards are still subject to HM Treasury FReM adoption::

- **IFRS 16 – Leases:**

IFRS 16 Leases will replace IFRS 17 Leases and IFRIC 4 Determining whether an arrangement contains a lease and other interpretations. HM Treasury has confirmed that IFRS 16 Leases, as interpreted and adopted by the FReM is to be effective from 1 April 2022.

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The objective of IFRS 16 is to report information that faithfully represents lease transactions and provide a basis for users of financial statements to assess the amount, timing and uncertainty of cash flows arising from leases. To meet that objective, a lessee should recognise assets and liabilities arising from a lease. For lessees, IFRS16 removes distinctions between operating leases and finance leases. These are replaced by a model where a right of use asset and a corresponding liability are recognised for all leases, except for short-term leases and low-value assets.

NHSBT is not an intermediate lessor in material sublease arrangements at the end of the reporting period.

Work has been undertaken to identify current leases and arrangements containing a lease held at 1 April 2022, which will become assets and liabilities in the Statement of Financial Position at this date. This was achieved by the Finance team liaising with staff across the business, to identify arrangements that include a 'right of use asset' and therefore may be subject to the requirements of IFRS 16. The transition to IFRS 16 will be completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application. IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. NHSBT will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing arrangements contain a lease.

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For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the organisation's incremental borrowing rate. NHSBT's incremental borrowing rate defined by HM Treasury currently is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022-23, NHSBT will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

NHSBT has reviewed all existing arrangements and has assessed whether a lease exist and is progressing the implementation of IFRS 16 in a timely manner.

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The organisation has estimated the impact of applying IFRS 16 in 2022-23 on the opening statement of financial position and the in-year impact on the statement of comprehensive net expenditure and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	27,609
Additional lease obligations recognised for existing operating leases	(27,609)
Net impact on net assets on 1 April 2022	**0**
Estimated in-year impact in 2022-23	
Additional depreciation on right of use assets	(5,224)
Additional finance costs on lease liabilities	(240)
Lease rentals no longer charged to operating expenditure	5,359
Estimated impact on surplus / deficit in 2022-23	**(105)**
Estimated increase in capital additions for new leases commencing in 2022-23	**0**

The table above includes the impact of 64 additional property assets which will increase assets and liabilities by £22.8m on transition. Our fleet of 291 vehicles will increase assets and liabilities by a further £4.8m, so we estimate that the full financial impact on opening balances in the 2022/23 financial statements will be £27.6m. These assets were previously disclosed as operating leases and so the operating leases note will reduce in value accordingly. The impacts on the SOCNE are not expected to be material as illustrated by the £105k deficit in year 2022/23. The table above could vary with the actuals due to the timing of each individual contract, since the model assumes that all contracts are paid at the same time, either in arrears or in advance. Therefore, there could be unavoidable variances by the end of FY 2022/23, which are expected to be immaterial.

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IFRS 17 – Insurance Contracts: This standard is effective for accounting periods beginning on or after 1 January 2022. IFRS 17 is yet to be adopted by the FReM. We do not anticipate any significant impact from this standard.

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Note 2 Operating segments – 2021-22

For the year 1 April 2021 to 31 March 2022	Total	Blood Components (incl Plasma and R&D)	Tissues and Eye Services	Organ Donation & Transplant	Diagnostics	Therapeutic Apheresis Services	Stem Cells
	£000	£000	£000	£000	£000	£000	£000
Revenue							
Provision of Products and Services	**370,812**	293,387	15,043	-	33,619	12,507	16,256
Income from Scottish Parliament	**6,511**	-	-	6,511	-	-	-
Income from National Assembly for Wales	**3,936**	-	-	3,936	-	-	-
Income from Northern Ireland Assembly	**2,171**	-	-	2,171	-	-	-
Other Income	**18,767**	9,871	20	2,253	1,370	458	4,795
Programme Funding from the DHSC	**111,866**	34,439	398	71,320	742	243	4,724
Total Revenue	**514,063**	**337,697**	**15,461**	**86,191**	**35,731**	**13,208**	**25,775**
Expenditure							
Variable costs	**(53,574)**	(34,773)	(2,586)	(3,270)	(5,618)	(3,383)	(3,944)
Direct costs	**(266,594)**	(156,830)	(10,153)	(63,554)	(17,534)	(5,267)	(13,256)
Direct support costs	**(125,148)**	(97,362)	(3,157)	(9,999)	(7,398)	(1,288)	(5,944)
Movement in value of stocks	**(2,090)**	(1,230)	(860)	-	-	-	-
Other support costs	**(51,211)**	(29,883)	(2,020)	(11,244)	(3,871)	(1,259)	(2,934)
Total Expenditure	**(498,617)**	**(320,078)**	**(18,776)**	**(88,067)**	**(34,421)**	**(11,197)**	**(26,078)**
Operating surplus/ (deficit) before transformation	**15,446**	**17,619**	**(3,315)**	**(1,876)**	**1,310**	**2,011**	**(303)**
Transformation costs	(24,209)	(12,199)	-	(10,499)	(704)	(294)	(513)
Operating surplus/ (deficit) for the financial period	**(8,763)**	**5,420**	**(3,315)**	**(12,375)**	**606**	**1,717**	**(816)**
Add: Notional cost of capital included in expenditure above	8,114						
Less: Programme Funding from DHSC	(111,866)						
Less: Capital charges paid to the DHSC	(20,366)						
Net expenditure	**(132,881)**						

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Note 2.1 Operating segments – 2020-21

For the year 1 April 2020 to 31 March 2021	Total	Blood Components (incl Plasma and R&D)	Tissues and Eye Services	Organ Donation & Transplant	Diagnostics	Therapeutic Apheresis Services	Stem Cells
	£000	£000	£000	£000	£000	£000	£000
Revenue							
Provision of Products and Services	**348,507**	283,233	11,993	-	27,976	11,712	13,593
Income from Scottish Parliament	**6,438**	-	-	6,438	-	-	-
Income from National Assembly for Wales	**3,526**	-	-	3,526	-	-	-
Income from Northern Ireland Assembly	**2,115**	-	-	2,115	-	-	-
Other Income	**16,470**	9,128	1	2,059	1,246	495	3,541
Programme Funding from the DHSC	**144,460**	66,451	-	73,836	-	-	4,173
Total Revenue	**521,516**	**358,812**	**11,994**	**87,974**	**29,222**	**12,207**	**21,307**
Expenditure							
Variable costs	**(62,325)**	(45,645)	(2,080)	(2,754)	(5,150)	(3,474)	(3,222)
Direct costs	**(257,638)**	(159,797)	(9,682)	(55,070)	(17,083)	(4,647)	(11,359)
Direct support costs	**(118,434)**	(89,972)	(3,230)	(10,225)	(7,625)	(1,317)	(6,065)
Movement in value of stocks	**(1,242)**	(515)	(727)	-	-	-	-
Other support costs	**(66,602)**	(47,820)	(1,807)	(9,924)	(3,435)	(1,131)	(2,485)
Total Expenditure	**(506,241)**	**(343,749)**	**(17,526)**	**(77,973)**	**(33,293)**	**(10,569)**	**(23,131)**
Operating surplus/ (deficit) before transformation	**15,275**	**15,063**	**(5,532)**	**10,001**	**(4,071)**	**1,638**	**(1,824)**
Transformation costs	(28,291)	(12,701)	-	(14,860)	(340)	(142)	(248)
Operating surplus/ (deficit) for the period	**(13,016)**	**2,362**	**(5,532)**	**(4,859)**	**(4,411)**	**1,496**	**(2,072)**
Add: Notional cost of capital included in expenditure above	8,337						
Less: Programme Funding from DHSC	(144,460)						
Less: Capital charges paid to the DHSC	(17,970)						
Net expenditure	**(167,109)**						

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

We report our financial performance in operating units as follows:

Blood Supply provides blood and blood components, primarily to NHS hospitals. Also includes Plasma and research and development activity. In 2021/22 £9.0m (2020/21 £55.4m) of expenditure was incurred on the CVP programme and £20.4m (2020/21 Nil) of expenditure was incurred on the plasma for medicine programme. These plasma programmes were fully funded by DHSC programme funding.

Clinical Services includes:
Diagnostics which provides specialist laboratory services (Red Cell Immunohematology and Histocompatibility & Immunogenetics) and also reagents. This is also known as Pathology.
Stem Cells includes Cellular and Molecular Therapies, the British Bone Marrow Registry (BBMR) and the Cord Blood Bank (CBB).
Therapeutic Apheresis Services provide a range of therapeutic apheresis services (e.g. plasma exchange, photopheresis) direct to patients.

Organ and Tissue Donation and Transplantation includes:
Organ Donation and Transplantation is funded by DHSC, with contributions from the Devolved Health Administrations, to identify and refer potential organ donors and to increase actual donors so that more transplants are enabled.

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Tissues and Eye Services retrieves and provides human tissue products.

All of the above aim to recover their costs through prices set annually via a national commissioning process except Organ Donation, CBB and BBMR which are funded by DHSC and the other UK Health Authorities.

Group Services include Finance, People, ICT and Quality. The costs of these services are allocated on the basis of activity in costing and pricing calculations.

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.

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Note 3 Income

Income largely consists of revenue from contracts and service level agreements with customers, the majority of customers being NHS bodies. Contracts typically run for a period of 1, 2 or 3 years. In all cases, income is accounted for in the year in which performance obligations within the contract are met, as outlined in note 1.3. In 2021-22 a fixed and variable pricing arrangement was in place. In 2020-21 block contracts were in place. No rebates were paid in either year (see page 142).

NHSBT receives income from non-contractual supplies: this includes income from training and royalties as well as for ad-hoc supply of products or services. This income is likewise accounted for in the period in which the goods/ services are provided.

Other revenue is largely grant in aid funding from the DHSC and other departmental health authorities in line with funding agreements for the financial year.

The following tables break down income streams by their nature and source.

3.1 Income by nature

	2021-22 £000	2020-21 £000
Blood & Components	303,258	292,361
Diagnostics	34,989	29,222
Tissues	15,063	11,994
Stem cells	21,051	17,134
Therapeutic Apheresis Services	12,965	12,207
Organ Donation & Transplantation	14,872	14,138
Total Income from activities per SoCNE	**402,198**	**377,056**

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3.2 Income by source

	2021-22 £000	2020-21 £000
Department of Health and Social Care	10,769	10,838
NHS Trusts	126,644	115,870
NHS Foundation Trusts	222,841	211,415
NHS CCGs	38	31
Other Government bodies	17,891	15,820
Non-NHS	24,015	23,069
Trust Funds	-	13
Total Income from activities per SoCNE	**402,198**	**377,056**

£16.6m of the Other Government bodies income shown above is contractual income and grant funding from devolved administrations (2020-21 £15.8m).

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3.3 Revenue Grant in Aid from DHSC

	2021-22 £000	2020-21 £000
Programme funding – Organ Donation & Transplantation	71,320	62,327
Programme funding – Organ Donation Deemed consent	0	11,509
Programme funding – Diagnostic & Therapeutic services	5,709	4,173
Programme funding – Convalescent Plasma	6,871	55,390
Programme funding – Plasma for Medicine	20,391	
Programme funding – Corporate	7,177	11,061
Programme funding – Tissue and Eye Services	398	-
Total Revenue grant from DHSC per SoCTE	**111,866**	**144,460**

DHSC grant in aid is recorded directly as a change in taxpayers' equity.

Note 4 Staff costs

	2021-22 Total £000	2020-21 Total £000
Salaries and wages*	225,521	214,872
Social security costs**	19,123	18,763
Employer pension contributions***	34,394	34,640
Total	**279,038**	**268,275**

* Includes temporary staff (including agency) £35m (2020-21 £34.6m) and termination benefits £1.7m (2020-21 £3.7m) and is net of recoveries in respect of outward secondments £1.5m (2020-21 £1.4m)
** Includes the apprenticeship levy £1m (2020-21 £0.8m) is a tax applied to all employers whose annual wage bill is more than £3m a year. It amounts to 0.5% of their total payroll and can be used for apprentice training and assessment, but not salaries.
*** Includes contributions to NHS Pensions £34.3m (2020-21 £34.6m) and to NEST £66k (2020-21 £63k).

On 1 April 2019, the employer contribution rate for the NHS Pension Scheme increased by 6.3%. In 2020-21 the additional cost, funded directly by DHSC, was £9.8m. In 2021-22, the additional cost (£11m) was paid by NHSBT and matched by programme funding from DHSC.

In addition to note 4 staff costs £2.8m of staff costs were capitalised as directly attributable to the development of the new Pulse system (intangible asset) under the "Blood Technology Modernisation" (BTM) project (£0.6m NHSBT staff and £2.2m agency) (£nil in 2020-21).

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Note 4.1 Pension costs

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the scheme can be found on the pension website at: https://www.nhsbsa.nhs.uk/nhs-pensions

Both are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a)Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period.
This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership

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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 2022, is based on an assessment of liabilities at 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts.

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 schemes (taking into account its recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. This resulted in employer contributions rates of 20.68%. This was paid to NHS pension in full in 2021-22 with funding received from DHSC to cover the contribution increase (see above).

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Members can purchase additional service in the NHS Scheme and contribute to Money Purchase Additional Voluntary Contributions run by the scheme's approved providers or by other free standing additional voluntary contributions providers.

Under the terms of the Pensions Act 2008 NHSBT is required to provide a pension scheme for employees not enrolled in the NHS Pension scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme.

NEST is a defined contribution scheme managed by a third-party organisation. It carries no possibility of actuarial gain or loss to NHSBT and there are no financial liabilities other than payment of the employers' contribution. The minimum combined contribution for 2021-22 is 8% of earnings of which the employer must pay 3%. Employer contributions are charged directly to the Statement of Comprehensive Net Expenditure and paid to NEST monthly. At 31 March 2022 there were 195 employees enrolled in the NEST scheme (159 at 31 March 2021).

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Note 5 Operating expenses

	2021-22 £000	2020-21 £000
Other staff related costs	8,382	10,832
Consumable supplies	64,105	68,938
Maintenance of buildings, plant and equipment	17,794	20,139
Rent and rates	15,171	13,833
Transport costs	17,742	14,193
External contractors	41,081	50,940
Purchase and lease of equipment and furniture	8,732	8,992
Utilities and telecommunications	9,851	10,460
Media advertising	2,494	4,124
Organ Donation Transplant Scheme payments	21,111	21,070
Professional fees*	6,852	6,812
External Auditors remuneration: Audit fees**	111	102
Total	**213,426**	**230,435**

*Professional fees include legal and programme management costs
**No payment was made to the External Auditors for non-audit work

Note 6 Other operating expenditure

	Note	2021-22 £000	2020-21 £000
Capital charges paid over as cash to DHSC		20,367	17,970
Capital non-cash: Loss on disposal of fixed assets*	8	14	1,768
Miscellaneous**		9,690	11,299
Total		30,071	31,037

*Loss on disposal of fixed assets includes the book losses of IT equipment (£2k), Assets Under Construction (£2k) and Plant and Machinery (£10k) due to the annual asset verification exercise. (2020-21 included losses on sales of Leeds and Sheffield (see note 8)
**Amount includes £4.9m (2020-21 £4.8m) relating to IT software licence fees and £1.5m (2020-21 £1.6m) to insurance costs.

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Note 7 Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where we are the lessee.

Our operating lease commitments relate to property, rents and vehicles. The vehicle commitments are based on 335 staff lease cars and 292 fleet vehicles.

The property commitments are based on 72 properties, including 58 long term leases and 14 premises for which contracts have expired and are being renewed.

The total future minimum lease payments payable below includes £11.2m for land and buildings, based on the minimum lease term where an exit clause exist. However, if we applied the full lease terms of these contracts, the commitment would be around £24m.

The amounts recognised in these accounts are:

NHSBT as lessee	2021-22 £000	2020-21 £000
Payments recognised as an expense		
Lease and rental payments *	12,275	10,267
Total future minimum lease payments payable		
Not later than one year	6,983	5,572
Later than one year and not later than five years	10,485	9,953
Later than five years	529	249
Total	**17,997**	**15,774**

* Lease and rental payments are included in Note 5 – Operating Expenses under rent and rates, purchase and lease of equipment, transport and other staff related costs.

* This is the last accounting year where an "Operating Leases" table is produced. This is due to the implementation of the new accounting standard for leases "IFRS 16". Please see section 1.26 for full details.

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Note 8 Other gains / (losses)

	2021-22 £000	2020-21 £000
Profit / (Loss) on disposal of non-current assets		
Loss on disposal of plant and equipment	(14)	(53)
Loss on disposal of buildings	-	(847)
Loss on disposal of land	-	(868)
	(14)	(1,768)

Losses recorded on plant and equipment relate to the movements outlined at Note 6.

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Note 9 Property, plant and equipment – 2021-22

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/cost at 1 April 2021	25,476	169,786	17,544	57,174	10	10,543	**280,533**
Additions purchased	-	227	1,360	4,277	-	778	**6,642**
Reclassification	-	745	(10,143)	-	-	9,398	**-**
Indexation	-	-	-	(532)	-	-	**(532)**
Other in year revaluations	777	5,547	-	-	-	-	**6,324**
Impairments	-	-	-	-	-	-	**-**
Transfer of assets to AUC Intangibles	-	-	(363)				**(363)**
Disposals	-	-	(2)	(1,376)	-	(674)	**(2,052)**
Valuation/cost at 31 March 2022	**26,253**	**176,305**	**8,396**	**59,543**	**10**	**20,045**	**290,552**
Accumulated depreciation at 1 April 2021 – brought forward	23	2,155	-	40,907	10	4,295	**47,390**
Provided during the year	23	5,824	-	3,380	-	1,467	**10,694**
Reclassification	-	-	-	-	-	(25)	**(25)**
Indexation	-	-	-	(382)	-	-	**(382)**
Other in year revaluations	(46)	(5,768)	-	-	-	-	**(5,814)**
Disposals	-	-	-	(1,365)	-	(425)	**(1,790)**
Accumulated depreciation at 31 March 2022	**-**	**2,211**	**-**	**42,539**	**10**	**5,312**	**50,073**
Net book value at 1 April 2021	25,453	167,631	17,544	16,267	-	6,248	**233,143**
Net book value at 31 March 2022	**26,252**	**174,094**	**8,396**	**17,004**	**0**	**14,733**	**240,479**
Net book value at 31 March 2022 comprises:							
Owned assets	16,144	87,573	8,396	17,004	-	14,733	**143,850**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	-	46,832	-	-	-	-	**46,832**
Held on Finance Lease	10,108	39,689	-	-	-	-	**49,797**
	26,252	**174,094**	**8,396**	**17,004**	**-**	**14,733**	**240,479**
Revaluation reserve	**14,831**	**80,760**	**-**	**525**	**-**	**204**	**96,320**

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Note 9.1 Property, plant and equipment – 2020-21

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/cost at 1 April 2020	27,651	158,019	22,226	52,590	10	9.028	**269,524**
Additions purchased	-	1,117	16,351	4,751	-	1,515	**23,734**
Reclassification	-	20,816	(21,033)	217	-	-	**-**
Indexation	-	-	-	1,258	-	-	**1,258**
Other in year revaluations	(250)	(4,760)	-	-	-	-	**(5,010)**
Impairments	(232)	(2,634)	-	-	-	-	**(2,866)**
Transfer of assets to other government bodies	(825)	(1,925)					**(2,750)**
Disposals	(868)	(847)	-	(1,642)	-	-	**(3,357)**
Valuation/cost at 31 March 2021	**25,476**	**169,786**	**17,544**	**57,174**	**10**	**10,543**	**280,533**
Accumulated depreciation at 1 April 2020 – brought forward	-	1,686	-	38,397	9	3,470	**43,562**
Provided during the year	23	5,652	-	3,180	1	825	**9,681**
Indexation	-	-	-	918	-	-	**918**
Other in year revaluations	-	(5,183)	-	-	-	-	**(5,183)**
Disposals	-	-	-	(1,588)	-	-	**(1,588)**
Accumulated depreciation at 31 March 2021	**23**	**2,155**	**-**	**40,907**	**10**	**4,295**	**47,390**
Net book value at 1 April 2020	27,651	156,333	22,226	14,193	1	5,558	**225,962**
Net book value at 31 March 2021	**25,453**	**167,631**	**17,544**	**16,267**	**0**	**6,248**	**233,143**
Net book value at 31 March 2021 comprises:							
Owned assets	15,733	85,158	17,002	16,267	-	6,248	**140,408**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	-	44,277	542	-	-	-	**44,819**
Held on Finance Lease	9,720	38,196	-	-	-	-	**47,916**
	25,453	**167,631**	**17,544**	**16,267**	**-**	**6,248**	**233,143**
Revaluation reserve	**14,021**	**71,585**	**-**	**881**	**-**	**687**	**87,174**

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Note 9.2 Revaluation of property, plant and equipment

NHSBT carried out a desktop revaluation of land and buildings as at 31 March 2022. The valuation was performed by an independent RICS registered valuer from the Valuation Office Agency, DVS Property Specialists.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Land and buildings used to provide NHSBT services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – existing use value (EUV)
- Specialised buildings – depreciated replacement cost (DRC).

The last full revaluation of the estate was completed in March 2018. We commissioned and used a desktop revaluation at the end of March 2022. This was not subject to 'material valuation uncertainty' due to market disturbance related to the pandemic.

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All NHSBT properties are revalued at their “Depreciated Replacement Cost”. This technique involves assessing all the costs of providing a modern equivalent asset using pricing at the valuation date.

The revaluation of NHSBT owned land and building resulted in an increase in value of £5.4m million. The revaluation of the Finance leased properties resulted in an increase in value of £6.7m at the reporting date of 31 March 2022.

The carrying amount of land and buildings that would have been recognised had the assets been carried under the cost model is £116.3m for buildings, and £22.6m for land.

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Note 10 Intangible assets – 2021-22

	Software Purchased	Assets Under Construction	Total
	£000	£000	£000
Valuation/cost at 1 April 2021 – brought forward	7,886	-	**7,886**
Additions	15	4,705	**4,720**
Transfer from AUC tangibles	-	363	**363**
Disposals	(1,899)	-	**(1,899)**
Reclassification	556	(556)	**-**
Valuation/cost at 31 March 2022	**6,558**	**4,512**	**11,070**
Amortisation at 1 April 2021 – brought forward	5,153	-	**5,153**
Provided during the year	895	-	**895**
Reclassification	25	-	**25**
Disposals	(1,448)	-	**(1,448)**
Amortisation at 31 March 2022	**4,625**	**-**	**4,625**
Net book value at 1 April 2021	2,733	-	**2,733**
Net book value at 31 March 2022	**1,933**	**4,512**	**6,445**
Net book value at 31 March 2022 comprises:			
Purchased	1,933	**4,512**	**6,445**
Asset financing	**1,933**	**4,512**	**6,445**
Revaluation reserve	**59**		**59**

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Note 10.1 Intangible assets – 2020-21

	Software Purchased £000	Total £000
Valuation/cost at 1 April 2020 – brought forward	7,725	**7,725**
Additions	161	**161**
Revaluations	-	**-**
Disposals	-	**-**
Valuation/cost at 31 March 2021	**7,886**	**7,886**
Amortisation at 1 April 2020 – brought forward	4,146	**4,146**
Provided during the year	1,007	**1,007**
Reclassification	-	**-**
Disposals	-	**-**
Amortisation at 31 March 2021	**5,153**	**5,153**
Net book value at 1 April 2020	3,579	**3,579**
Net book value at 31 March 2021	**2,733**	**2,733**
Net book value at 31 March 2021 comprises:		
Purchased	2,733	**2,733**
Asset financing	**2,733**	**2,733**
Revaluation reserve	**782**	**782**

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Note 11 Inventories

	31 March 2022 £000	31 March 2021 £000
Raw materials and consumables	6,880	4,826
Work in progress	2,754	3,292
Finished processed goods	7,642	9,194
Total	**17,276**	**17,312**

At 31st March 2022, we held 59,632 units of plasma collected under the Convalescent Plasma Programme, these were valued at £1.08m (March 2021 £nil). We also held 99,007 units of Plasma for Medicine, these were valued at nil value (March 2021 £nil).

At 31st March 2022 we held 18,132 harnesses valued at £1.15m which were purchased under the CVP programme and had previously been held at nil value.

At 31st March 2022 we held finished processed blood and component stocks valued £4.98m (March 2021 £7.35m). Campaigns were in progress to re-build stocks at this time.

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Note 12 Trade and other receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade receivables	29,603	21,235
Allowance for impaired contract receivables	(7)	(14)
Other debtors	133	170
VAT	3,622	8,213
Prepayments and accrued income	10,008	14,974
Subtotal	**43,359**	**44,578**
Non-Current		
Other prepayments and accrued income	198	397
Subtotal	**198**	**397**
Total trade and other receivables	**43,557**	**44,975**

Allowances for credit losses		
	2021-22 £000	2020-21 £000
At 1 April	(14)	(104)
New allowances arising	(6)	(14)
Utilisation of allowances (written off)	10	21
Reversed unused (recovered)	3	83
At 31 March	**(7)**	**(14)**

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Note 13 Cash and cash equivalents

	31 March 2022 £000	31 March 2021 £000
At 1 April	53,211	50,549
Net change in year	11,465	2,662
At 31 March	**64,676**	**53,211**
Broken down into:		
Cash in hand	1	1
Cash with the Government Banking Service	64,675	53,210
Total cash and cash equivalents as in SoFP and SoCF	**64,676**	**53,211**

Note 14 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables – revenue	9,710	7,535
Trade payables – capital	431	664
Tax and social security costs	18	15
Accruals *	28,311	37,104
Deferred income **	32,993	7,370
Total current trade and other payables	**71,463**	**52,688**

* At March 2021 accruals were higher reflecting a higher level of plasma activity, some supplier billing delays, £4.2m NHS Pension employer's contribution was unpaid and more annual leave un-taken by NHSBT colleagues.
*The main increase in deferred income in 2021-22 relates to £22.9m for PFM.

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Note 15 Provisions for liabilities and charges

	PAYE	Employee Benefits	Redundancy	Product Liability & Other	Total
	£000	£000	£000	£000	£000
At 1 April 2021	25	447	119	394	985
Provisions arising in the year	51	(4)	25	519	591
Change in discount rate	-	13	-	-	13
Utilised during the year – cash	(22)	(21)	(77)	(42)	(162)
Utilised during the year – accruals	-	(6)	-	-	(6)
Reversed unused	(3)	-	(42)	(109)	(154)
Unwinding of discount	-	(6)	-	-	(6)
Balance at 31 March 2022	**51**	**423**	**25**	**762**	**1,261**
Expected timing of cash flows:					
– not later than 1 year;	51	28	25	762	866
– later than one year and not later than five years;	-	118	-	-	118
– later than five years	-	277	-	-	277
Total	**51**	**423**	**25**	**762**	**1,261**

The provision for employee benefits is in respect of permanent injury benefit awards which are payable over the lifetime of the individuals receiving the payments. The discount rate applied is minus 1.30% as published by HM Treasury in December 2021.

Product Liability and Other relates to legal actions brought against NHSBT by individuals arising from use of NHSBT products; legal claims for personal injury (employee); legal claims from donors and employees; and other employee liability and public liability claims.

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At 31 March 2022 £36,286,602 (is included in the provisions of NHS Resolution (formerly NHS Litigation Authority) in respect of clinical negligence liabilities of NHSBT (31 March 2021: £19,129,670).

Our accounts do not include any provisions related to infected blood. DHSC accounts include provisions for financial support related to contaminated blood.

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Note 16 Finance leases

Obligations under finance leases where NHS Blood and Transplant is the lessee.

Minimum Lease Payments	31 March 2022 £000	31 March 2021 £000
Not later than one year	1,214	1,214
Later than one year and not later than five years	4,857	4,857
Later than five years	17,671	18,885
	23,742	**24,956**
Less future finance charges	(15,191)	(16,138)
Present value of future lease obligations	**8,551**	**8,818**

Present Value of Minimum Lease	31 March 2022 £000	31 March 2021 £000
Not later than one year	298	267
Later than one year and not later than five years	1,642	1,454
Later than five years	6,611	7,097
Present value of future lease obligations	**8,551**	**8,818**
Analysed as:		
Current borrowings	298	267
Non-current borrowings	8,253	8,551
	8,551	**8,818**

Finance lease obligations relate to the blood centre in Speke, Liverpool acquired in 2003 with a primary lease term of 25 years; the site of the blood centre in Newcastle acquired in 1985 with a lease term of 125 years; and the new blood centre and offices in Barnsley acquired in 2018 with a primary lease term of 25 years.

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Note 17 Other cash flow adjustments (non-cash)

Other Cash Flow Adjustments	2021-22 £000	2020-21 £000
Depreciation (note 9)	10,694	9,680
Amortisation (note 10)	895	1,007
Impairments (note 9)*	0	2,866
Loss on disposal (note 8)	14	1,768
Provisions arising in year (note 15)	591	254
Provisions reversed in year (note 15)	(154)	(83)
Total	**12,040**	**15,492**

*There are no impairments to report in financial year 2021-22. Impairments from 2020-21 comprise £1.2m for Leeds and £1.7m for Sheffield centres following revaluation prior to sale.

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Note 18 Contingent assets and liabilities

A contingent liability of £179,467 (31 March 2021 £35,903) relates to potential costs associated with donor claims, personal injury claims and other employer liability and public liability claims.

A contingent liability of £1,375,000 (31 March 2021 £1,375,000) relates to Hepatitis C cases brought under an action for product liability.

A contingent liability of £165,000 (31 March 2021 nil) relates to contractual commitments to underwrite the impact on 11 of our Clinicians pensions relating to 2019/20. These liabilities are in turn underwritten by NHSE.

Due to the nature of the contingent liabilities it is difficult to predict with any degree of accuracy the final amounts due and whether they will crystallise.

Note 19 Capital commitments

At 31 March 2022 the value of contracted capital commitments was £145,347 (31 March 2021 £690,826).

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Note 20 Related parties

During the period none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, have undertaken any material transactions with NHS Blood and Transplant.

The Department of Health and Social Care is regarded as a controlling, related party. During the year NHSBT 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, including:

- NHS England and Improvement
- NHS Foundation Trusts
- NHS Trusts
- Health Education England.

During the year these transactions were valued at £484m in income (2020-21 £505m) and £42m of expenditure (2020-21 £29m). Of this income, NHSBT received £111.9m (2020-21 £144.5m) from the DHSC in relation to operational grant-in-aid and £12m (2020-21 £22.6m) funding for capital programme.

In addition, NHSBT has had several material transactions with other government departments, central and local government bodies, NHS bodies of Scotland, Wales and Northern Ireland. These transactions amounted to £12m of income (2020-21 £12m) and £66m of expenditure (2020-21 £58m).*

*Expenditure figures inclusive of Pensions and Social Security costs of permanently employed staff.

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NHSBT board member or senior manager	NHSBT appointment	Related party	Related party position held	Receipts from Related party* – £000	Payments to Related party* £000	Amounts due from Related Party £000	Amounts owed to Related Party £000
Mr I Bateman	Director of Quality	The Pirbright Institute	Trustee Director	3	0	1	0
Prof P Vyas	Non-Executive Director	University of Oxford	Clinical Professor of Haematology	183	1,750	14	390
Prof P Vyas	Non-Executive Director	Oxford University Hospitals NHS Foundation Trust	Consultant Haematologist	6,021	2,559	383	246
Prof Deirdre Kelly	Non-Executive Director	Birmingham Women's and Children's NHS Foundation Trust	Consultant Paediatric Hepatologist	2,895	0	97	0
Prof Deirdre Kelly	Non-Executive Director	University of Birmingham	Professor of Paediatric Hepatology	37	4	22	0
Mr Phil Huggon	Non-Executive Director	Liverpool Women's Hospital FT	Non-Executive Directorship	4	0	0	0
Urmila Banerjee	South-West London Integrated Care System	NHS Trust Partnership Management	Chair	10,749	110	573	0

*The figures in the table are transactions between the organisations over which the NHSBT Board Member or senior manager has influence.

In accordance with IAS 24 the NHS Blood and Transplant Trust Fund is regarded as a related party. Income received from the Trust Fund during the year totalled £ nil k (2020-21 £13k) and the Trust Fund had no outstanding debtors at 31 March 2022 (31 March 2021 £ nil).

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Other Related Parties

	2021-22 £000s		2020-21 £000s	
	Income	Expenditure	Income	Expenditure
ACT grant funding	0	375	0	0
Local Authorities				
NHS & DH bodies	360,293	42,171	338,154	29,299
NHSBT Trust Fund			13	0
WGA / Other CG Bodies (inc Councils)	19,008	66,189	15,820	57,927
Non NHS (including staff)	22,897	425,373	23,069	456,074
Accounts	**402,198**	**534,108**	**377,056**	**543,300**

Other Related Parties

	2021-22 £000s		2020-21 £000s	
	Receivables	Payables	Receivables	Payables
ACT grant funding	0	0	0	0
Local Authorities				
NHS & DH bodies	17,651	34,203	14,842	10,953
NHSBT Trust Fund				
WGA / Other CG Bodies (inc Councils)	8,053	422	2,134	409
Non NHS (including staff)	3,899	36,822	4,259	41,326
Accounts	**29,603**	**71,447**	**21,235**	**52,688**

Note 21 Events after the reporting date

In accordance with the requirements of IAS 10 events after the reporting period are considered up to the date on which the accounts are authorised for issue. The Accounting Officer authorised these financial statements for issue on the same date as the Certificate and Report of the Comptroller and Auditor General.

No events after the reporting date to report in financial year 2021-22.

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Note 22 Financial instruments

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that NHSBT has with customers and the way they are 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 listed companies to which the financial reporting standards may apply. NHSBT has limited powers 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's treasury management operations are carried out by the finance department, within parameters defined within the Standing Financial Instructions and policies agreed by the Board. The treasury activity is subject to review by internal audit.

Currency risk

NHSBT is principally a domestic organisation with the great majority of transactions, assets and liabilities being UK and sterling based. NHSBT has no overseas operations. NHSBT therefore has low exposure to currency rate fluctuations.

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Interest rate risk

All of NHSBT's financial assets and financial liabilities carry nil or fixed rates of interest. NHSBT is not, therefore, exposed to significant interest rate risk.

Credit risk

Since the majority of NHSBT's revenue comes from contracts with other public sector bodies, NHSBT has low exposure to credit risk.

Liquidity risk

The majority of NHSBT's operating costs are finances from resources voted annually by Parliament. NHSBT's capital expenditure is funded from resources made available from Government. NHSBT is not, therefore, exposed to significant liquidity risks.

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Glossary

Term	Definition
Antigen	An antigen is any substance that causes your immune system to produce antibodies against it. This means your immune system does not recognize the substance and is trying to fight it off. An antigen may be a substance from the environment, such as chemicals, bacteria, viruses, or pollen. An antigen may also form inside the body.
Apheresis	Apheresis is a medical procedure in which the blood of a person is passed through apparatus that separates out one particular constituent and returns the remainder to the circulation.
Blood Groups	There are 36 known blood groups. The main two groupings used are the ABO group and the Rhesus group (usually described as + or –). The rhesus group is made up of two genes, the D gene (which gives the + or –) and the RHCE gene (which gives four group variations Ce, ce, CE, cE). The Kell group is the 3rd main blood group.

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Term	Definition
British Bone Marrow Registry (BBMR)	The British Bone Marrow Registry (BBMR) is part of NHSBT that helps people find stem cell matches. We work in co-operation with the UK's other bone marrow and blood donor registries, the charity Anthony Nolan and the NHS Cord Blood Bank. We are also part of an international network that helps find matches for people across the world.
Clinical Services	An operating division of NHSBT that supply biological products and related services, mostly to the NHS in England. It includes Cellular and Molecular Therapies (CMT), Diagnostic Services (H&I and RCI) and Therapeutic Apheresis Service (TAS).
Convalescent Plasma	This plasma (containing antibodies) is taken from recovered patients and used as a therapeutic treatment for other patients.
Cryoprecipitate	Cryoprecipitate, also called cryo for short, is a frozen blood product prepared from blood plasma. Medical uses for cryoprecipitate include Haemophilia.

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Term	Definition
Fractionators/ Fractionation	Fractionation is the separation into component parts. Plasma Fractionators of plasma split the plasma into parts which can be used or manufactured into plasma derived medicinal products (PDMPs)
Genotyping	Genotyping uses technology to detect small differences in the genetic make-up of an individual (genotype) which can identify what makes us unique including underlying diseases we may have or may be likely to develop.
Haemophilia	An inherited disorder in which the blood does not clot due to insufficient clotting factors.
Histocompatibility	Histocompatibility, or tissue compatibility, means having the same, or sufficiently similar human leukocyte antigens (HLA). Histocompatibility testing is used prior to whole organ, tissue, or stem cell transplants, where the differences between the donor's HLA alleles and the recipients could trigger the immune system to reject the transplant.

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Term	Definition
Histocompatibility & Immunogenetics (H&I)	The business unit in NHSBT's Clinical Services Directorate which provides testing and advice ranging from Solid Organ and Stem Cell transplantation and donor selection to testing for potential genetic immune reactions to drugs.
Human leukocyte antigens (HLA)	Each individual expresses many unique HLA proteins on the surface of their cells, which signal to the immune system whether a cell is part of the self or an invading organism. T cells recognize foreign HLA molecules and trigger an immune response to destroy the foreign cells.
Immunoglobulins	An **immunoglobulin** (**Ig**), a type of **antibody** (**Ab**), is a large, Y-shaped protein used by the immune system to identify and neutralize foreign objects such as pathogenic bacteria and viruses.
Immunohematology	The study of the immunology and genetics of blood groups, blood cell antigens and antibodies and specific blood proteins. Important in blood banking and transfusion medicine.

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Term	Definition
International Blood Group Reference Laboratory (IBGRL)	Provides reference services related to blood transfusion. It is a designated collaborating centre for the World Health Organisation. IBGRL also: – maintains a database of donors with rare blood types which authorised laboratories can interrogate directly – performs research in blood transfusion science – generates a range of monoclonal antibodies, recombinant proteins and kits for the estimation of feto-maternal hemorrhage (FMH)which are available to researchers around the world. – provides specialist clinical diagnostic services for NHSBT providing expertise in red cell reference serology and blood group genotyping, including non-invasive fetal genotyping from maternal blood.

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Term	Definition
OTDT	Organ and Tissue Donation and Transplantation – the part of NHSBT which manages the Organ Donor Register and National Transplant Register (which matches donors to people who are waiting for a transplant) and co-ordinates organ transplants in the UK and also manages the tissue donation production and sales.
O negative red cells/ O D negative	All patients can receive O negative red blood cells. O negative donors are often called 'universal donors' because anyone can receive the red blood cells from their donations. Although about 8% of the population has O negative blood, it accounts for 12.5% of hospital requests for red blood cells. Hospitals can safely give O negative blood to patients in emergencies where the blood type is unknown.
Plasmids	A plasmid is a small DNA molecule within a cell that can replicate independently. Particular genes can be attached to these Plasmids to replicate and be used in gene therapies

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Term	Definition
Plasma for Medicines (PFM)	Plasma can be made into medicines to help people with genetic conditions and immune disorders. Plasma is a yellowish liquid in your blood that carries platelets, red blood cells and white blood cells around the body. It also contains more than 700 proteins and other substances. These proteins can be separated from the plasma and made into medicines.
Red Cell Immunohematology (RCI)	The business unit in NHSBT's Clinical Services division which investigates serological problems, investigates adverse transfusion reactions and provides antenatal screening services.
RECOVERY Trial	The Randomised Evaluation of COVID-19 Therapy (RECOVERY Trial) is a large-enrolment clinical trial of possible treatments for people in the United Kingdom admitted to hospital with severe COVID-19 infection.
REMAP-CAP Trial	A Randomised, Embedded, Multi-factorial, Adaptive Platform Trial for Community-Acquired Pneumonia

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Term	Definition
Ro	Ro is a blood type (see above). When the Rhesus group D and DHCE genes combine there are 8 possible outcomes – one of which is Dce – also known as Ro subtype. Only 2.99% of our donors in 2019-20 had this Ro subtype. We do not currently collect enough Ro blood to meet demand for this type.
Ro Kell negative blood	Ro Kell negative blood is especially important for treating the rare, inherited condition sickle cell disease. Only around 2% of donors have this rare combination of two blood types. Donors of any ethnicity can be Ro Kell negative although Black people are 10 times more likely to have the Ro subtype than white people. People with Ro Kell negative blood are being urged to talk to family members about donation, because they may also share this rare combination of types.
Serology (serological)	The scientific study or diagnostic examination of blood serum, which looks at the response of the immune system to pathogens or introduced substances.

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Term	Definition
Therapeutic Apheresis Service (TAS)	The business unit in NHSBT's Clinical Services division which treats patients with Apheresis.
Tissues and Eye Services (TES)	The business unit in NHSBT's Organ and Tissue Donation and Transplantation division which collects donations of tissues and eyes, prepares these for transplantation, stores and provides these to hospitals to meet patient need.

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