NHS
Blood and Transplant

Annual Report and Accounts
2022-23

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SG/2023/136

NHS Blood and Transplant Annual Report and Accounts 2022-23

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Introduction from the Chair

NHSBT is an amazing organisation that plays a unique role within the NHS. We collect and supply a wide range of blood products, stem cells as well as a range of diagnostic and therapeutic services across England and our organ and tissue services reach across the UK. We are, on the whole, self funding with around three quarters of our income from the sales of products and services to the NHS. The remainder is provided through the Department of Health and Social Care (DHSC) and the devolved governments.

We have a long and proud history of cutting-edge research and development and are continually developing new products, treatments and advancements to save and improve patients' lives – many of which you will read about in this report.

We are particularly excited about the work we are doing to start to produce immunoglobulin medicine from UK plasma, that around 17,000 patients rely on. The NHS currently relies on imports of these lifesaving medicines but by taking donations and recovering plasma here we will bolster the supply chain and improve the self-sufficiency of the UK in producing our own treatments. And we are delighted to have opened the doors this year to our new Clinical Biotechnology Centre (CBC) in Bristol that will manufacture treatments for currently incurable diseases.

We wouldn't be able to save and improve thousands of lives a year without the support of our amazing donors. Just under 800,000 people are active blood donors. With each donation they help up to three patients. We now have 6,000 plasma donors – an increase of a third compared to the previous year. And there are nearly 30 million people signed up to the organ donation register. We've seen a reduction in consent rates for organ donation so it's more important than ever for people to register a decision so loved ones know that they wanted to donate their organs if faced with making that very difficult decision. One of our big focuses next year will be on raising awareness of the need for more people to sign the organ donation register.

We also wouldn't be able to save and improve lives without our great people at NHSBT. We've faced some big and difficult challenges over the past few years with the pandemic, blood stocks and supporting a large, diverse workforce located in many different roles in many different locations. It is really important to us to have an intentionally inclusive team and that is something we will continue to work hard to achieve.

I would like to take this opportunity to thank Wendy Clark who took over as interim Chief Executive last August. Wendy has been a fantastic leader of our organisation and I'm very pleased she will be supporting our new Chief Executive as her deputy. I would also like to thank our non-executive directors who retired from the board during the year – Charles St.John, Jo Lewis and Helen Fridell. And welcome to our new non-executive directors Rachel Jones and Caroline Serfass. We have also created two new associate non-executive director roles to champion diversity and promote an inclusive culture within NHSBT.

And finally, I would like to welcome our new Chief Executive, Dr Jo Farrar who joined us in June. Jo is a very experienced Chief Executive and brings new perspective and a wealth of knowledge to NHSBT.

Peter Wyman Chair NHSBT

Our performance

Chief Executive's review

I am proud to have been appointed Chief Executive and took up the role on 1 June 2023. I would like to thank Wendy Clark who acted as the interim Chief Executive from August last year and I'm delighted she will now take up the role of Deputy Chief Executive.

Wendy led the organisation through some difficult challenges but also celebrated some great achievements and innovations, which you will read about in this report. We have much to look forward to as we move into the second year of delivering our ambitious strategy to save and improve even more lives and create a world where every patient receives the donation they need.

Stabilising blood supplies

Our blood supply chain faced big challenges in 2022-23. This included workforce shortages caused by unfilled vacancies, donor and staff illness in the winter months and industrial action. This meant, at times, we weren't able to collect enough blood. In the autumn, this led to NHSBT calling its first ever amber alert on whole blood. Hospitals were asked to reduce ordering by holding lower stocks and rescheduling non-urgent elective activity. This was not a situation anyone at NHSBT wanted to find ourselves in. Thanks to our hardworking staff we managed to stabilise operations quickly and were able to stand down from the alert after four weeks.

I would like to thank our colleagues across the NHS and in the Department of Health and Social Care (DHSC) for their support and working with us to stabilise stocks.

Over the past year we have focussed intensively on building our workforce and supply chain resilience and we have been working closely with the DHSC. Ministers have given their support for investing in a comprehensive programme of work to future-proof our blood supply operations to increase whole blood collection capacity and smooth platelet stocks – as they have a particularly short shelf-life.

New products, developments and innovation

We've had an incredibly exciting year and have much to look forward to in terms of innovation. We built up our plasma collection capability following the decision in 2021 by Ministers to lift the ban on UK plasma for fractionation into immunoglobulin medicines. We have been supporting NHS England in the procurement process for a fractionator which we hope will be awarded in early summer. This will mean the UK can develop our own life saving and life changing medicines for patients with weak immune systems, for example people with genetic disorders, immune systems damaged by cancer and people whose immune system is attacking itself. Plasma collection for research and immunoglobulins, both through apheresis and recovered from whole blood, has become a core part of our operations.

In March, we opened our state-of-the-art Clinical Biotechnology Centre (CBC) in Bristol which will make a great contribution to the UK's ability to develop and manufacture new gene and cell therapies. The CBC will manufacture products for the development of potentially curative therapies for currently incurable diseases, such as some forms of cancer, sickle cell disease, and cystic fibrosis. It was built with a near £10m Government grant and was designed to expand the UK's ability to make the clinical grade products required for the research and development of new cell and gene therapies. It will support early phase clinical trials and pre-clinical work, providing a route to eventual commercial scale production.

When it comes to innovation for our donors, we have continued to upgrade our digital experience by launching self-service bookings for existing plasma donors, who can now book online or use the NHS Give Blood App. In partnership with NHS Digital, we explored new channels to recruit donors to both the Organ Donor Register and for plasma donation. Two million people managed and registered their decision on organ donation using the NHS App, and 3,000 registered to become plasma donors after a push notification on the app.

And, having successfully enrolled 30,000 new donors, we trialled a new way of investigating which of those donors had the vital O negative blood type – the universal blood type that can be used in emergencies. For the first time we sent out home typing kits so new donors could check their type and register it online so we could prioritise bringing them in to give blood. We recruited 1,000 new O negative

donors through this innovative route, and we have now also launched a similar pilot for recruiting donors to the Stem Cell Register with an ambition recruit 5,000 new donors from home.

A challenging organ and cornea landscape

As ever, we are hugely grateful to the many people and families who consented to organ donation and to everyone who chose to become living donors. They are truly heroes who save and improve the lives of many patients and families.

We are proud to have increased the number of donors by 2% and the number of transplants by 5% in 2022-23 compared to 2021-22. This is a credit to the whole of the transplantation community. Unfortunately, we did not meet the targets we had set for the year. A reduction in eligible deceased donors and continuing NHS pressures had a major impact on our organ donation and transplantation system, because we rely on intensive care and other acute hospital facilities.

While we had previously seen year-on-year increases in the public's support for organ donation, the consent rate has fallen in 2022-23 to 2015-16 levels (61%). Some families are telling us of delays and mixed NHS experiences prior to those very difficult end-of-life conversations. We have adapted our colleagues' training and clinical practices so that we can utilise more organs from donors that would not have proceeded in the past. This means that transplants grew faster (5% increase) than

donors (2% increase) in 2022-23 compared to 2021-22.

We have also faced challenges this year with cornea donations. Donations are still substantially behind pre-pandemic levels, and this has resulted in the number of corneas being issued for transplantation being nearly 25% behind target. We've put in place a programme of work to address this.

Our work to tackle health inequalities

Reducing health inequalities is a key focus of our work across NHSBT. We have put a determined focus on increasing the diversity of our blood donor population – particularly the recruitment of donors of Black African and Black Caribbean heritage. This is because Ro is most commonly found in people of Black African and Black Caribbean heritage and is the blood type most essential to reduce health inequalities as it is needed to treat sickle cell patients. There has been a rapid rate of growth in demand for this blood type. Our new donor recruitment activity has strongly focussed on these communities and I'm very pleased to say, because of this, last year we saw the strongest ever growth of donors with the Ro blood sub-type. There is, of course, a lot more to be done but we are making progress.

The UK faces similar challenges in organ donation and transplantation. 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. They will also wait longer than someone who is white. However, due to

organ offering scheme changes implemented in recent years, and an increase in organ utilisation overall, we continue to see increases in the number of ethnic minority patients transplanted.

We have made good progress on the Genomics Programme that we established in 2021-22 to develop and implement genomics technology to enable quicker and more accurate testing, which will improve health outcomes and reduce health inequalities in transfusion and transplantation. As a partner in the Blood transfusion Genomics Consortium (BGC), we supported the validation of a 'simple-to-use' DNA test for typing clinically relevant red cell blood groups. Our Colindale laboratory genotyped over 2,000 samples to support the validation and work will continue next year to secure regulatory accreditation. Our Colindale laboratory has also started to genotype the recruited STRIDES (STRategies to Improve Donor ExperienceS) donors with this new DNA test and expects to genotype up 80,000 blood donors over the next 18 months. And this year, NHS England approved a 12-month programme to genotype sickle cell and thalassemia patients with this new DNA-based testing – we are mobilising the capacity to undertake this over the next year.

Alongside this, the HAEM-MATCH Consortium started its 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.

Our People and Culture

Our people are critically important. They work hard everyday to improve and save lives – and are amazing. We want to ensure NHSBT is a place where we celebrate diversity and foster inclusion and treat everyone with dignity and respect. We have been working hard – and will continue to do so – to ensure everyone across NHSBT can reach their full potential.

Dr Jo Farrar CB OBE
Chief Executive and Accounting Officer

Our mission, purpose, values and strategy

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. We employ 6,180 people across the UK, with a total income and funding of over £561 million.

Our mission

Our 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.

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.

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

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 strategic priorities, 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:
https://www.nhsbt.nhs.uk/who-we-are/performance-and-strategy/our-strategy/

Our 5 strategic 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 report against these strategic priorities, and our sustainability, finances and strategic risks, in the Performance Report.

Performance report

Grow and diversify our donor base

Diversify and strengthen our donor base

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Whole blood donor base	814k	799k	Below target
O neg donor base	119k	112k	Below target
Ro donor base	29.5k	26.0k	Below target
BBMR donor registrations	30k	15.5k	Below target
Organ donor registrations (England/Wales)	746k	737k	Below target
Organ donor registrations (UK)	1 million	850k	Below target

An increasing shortage of front-line staff led us to reduce the number of appointments available to new donors, which enabled increased conversion rates for bookings to donations, and reduced the time asked of staff on-session to guide first time donors through their initial donation. Mid-year we changed emphasis to increasing the diversity of our donor population, and particularly the recruitment of donors of Black African and Black Caribbean heritage. As a result we finished the year with just under 800,000 active whole blood donors; this represented a 1% increase in donor numbers during the year.

The diversity of our donor base improved throughout the year. The O negative donor base grew by 1.5% compared to 2021-22, and we finished the year strongly with the introduction of a new off-session testing service to identify

more. Platelet donor numbers have been affected by reduced commuter and visitor numbers in city centres, and we saw donor numbers fall by 2.5% during the year. Despite a consolidation to three centres for plasma for medicine collection, we have seen plasma donor numbers grow by 1,500 to reach 6,000 at the end of the year.

Reflecting our priority, the growth of donors with the Ro blood sub-type was the strongest. This blood type is essential in reducing health inequalities via treatment of sickle cell patients. Growing Ro donor numbers presents our most essential supply task because of the rapid rate of growth in demand for this blood type. Ro donor numbers grew by more than 5% in 2022-23, and reached 26,000 active donors by the end of the year. The Ro subtype is most commonly found in people of Black African and Black Caribbean heritage, and our new donor recruitment activity in 2022-23 was strongly focussed on these communities. This has driven particularly strong growth in the number of donors of Black heritage, which increased by 10% during 2022-23 and exceeded 19,000 by the end of the year.

Calvin experienced his first sickle cell crisis at six months old.

“From that point onwards, I’ve spent most of my life in hospital rather than outside of it. As a child, I was constantly in pain, so it didn’t seem strange to me to be in hospital more than at home.

“I started having regular blood transfusions when I was 18 and had three to five units of blood each week, until around 15 years ago when I started having red cell exchanges every three to four weeks.

“I receive ten to 11 units each time, automated in a cell separator, mainly because I sickle so much.

“Having regular exchanges has made a massive difference and has given me back my life as it reduces the time I’m in hospital.

“Before the exchange programme I was spending an average of seven to eight months a year as an inpatient and frankly had no social life.

“Until my daughter was six, she didn’t realise that I lived in the same house as her because I was always in hospital and she thought that was where I lived.

“On a brighter note, the exchange transfusions have allowed me to do so much more with my life, including joining the B Positive Choir.

“We are a choir that is made up of people from across England, whose lives are affected by the lifesaving power of blood. Our members include blood donors and blood recipients, people who have blood-related medical conditions such as sickle cell, our families, friends and people who work with blood.

“I can’t stress enough how grateful I am to all who donate blood. Because of blood donations, my life has changed in ways I could have never imagined.”

Grow and diversify our donor base

Improve our donors' experience

Our 2022-2023 Targets

Performance measure	Target	Results	Performance
Improve our donors' experience	Net Promoter Score 86 (for blood and plasma)	86	On target

Our ongoing investment in the donor experience saw our Net Promoter Score achieve a 1-point uplift year on year, even though November saw a dip due to the amber alert.

We continued to upgrade our digital experience by launching self-service for existing plasma donors, who can now book online or use the NHS Give Blood App. Since its introduction over 50% of bookings for plasma are now made via digital channels, and we have also seen an improvement in booking conversion with 1 in 2 people now making an appointment when logging on.

Following donor feedback, we have enhanced how we recognise donors with new digital badges and milestone achievements. This feature lets donors track their donation history and share progress via social media with over 30 shares a month across Facebook.

We enriched our donor base with more O negative donors as we successfully recruited more than 1,000 new donors through home blood typing. Over 30,000 newly registered donors received typing kits through the post and registered their blood type online which enabled us to prioritise key groups in becoming a donor. We also launched a similar

pilot for recruiting donors to the Stem Cell Register aiming to recruit 5,000 new donors from home.

In partnership with NHS Digital, we explored new channels to recruit donors to both the Organ Donor Register and for plasma donation. 2 million people managed and registered their decision on organ donation using the NHS App, and 3,000 registered to become plasma donors after a push notification on the app.

Grow and diversify our donor base

Grow the foundation of a new plasma donor base

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Plasma Active Donor Base	12.5k	6k	Below target

Our plasma donor base for plasma for medicines has grown during 2022-23, with over 6,000 donors now registered. This has been supported by innovations such as enabling regular plasma donors to book their own appointments via the NHS Give Blood App, and the 'Life Saving Medicine, It's In You' local campaign to support plasma donation around our plasma donor centres. Growth has been impacted by staffing capacity, the requirement to prioritise whole blood collection during the amber alert in the autumn, and the re-purposing of some plasma capacity to support whole blood collection activity.

2023-24 will see a renewed focus on sustainable donor base growth, as well as maturing our current donor base by encouraging our existing donors to donate more frequently.

(For more on our activity around plasma, please see the section later in the report, under **4. Collaborate, develop and scale new services – support the Government ambition for a domestic supply of plasma for medicines)**.

Eva needed a blood transfusion to help her recover after the birth of her son.

"Christmas Day 2021 was the best Christmas ever... at 9.12am I met my baby boy at Bassetlaw Hospital in Worksop.

"He weighed 9lb 4oz and arrived safely. However, not everything went to plan, and I lost a lot of blood during an emergency C-section. I needed two units of blood to recover.

"I had plans to give blood before I became pregnant, but it was difficult for me to donate during the pandemic. I wish I had donated before, as I will not be able to now after receiving blood, but I want to say thank you to everyone who gives blood – you are all wonderful.

"My little boy celebrated his 1st birthday last Christmas and is now 18 months old! He is growing so fast. He now has almost 14 teeth and is walking and starting to talk – he repeats everything he hears and also loves telling me animal noises, with dogs and ducks being his favourite!

"It is wonderful to watch him grow, and this is with thanks to blood donors."

Modernise our operations, improve resilience and efficiency

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

Customer Satisfaction

During 2022-23, 76% of our hospital customers scored us 9 or 10 out of 10 for overall satisfaction. This is a slight improvement on the 75% scored in the previous year despite the challenges of the 'amber alert' for red cell stocks during October 2022, and this reflects the collaboration that took place between NHSBT and hospitals during this challenging period. Meanwhile 79% of donors scored us 9 or 10 out of 10 for overall satisfaction, which was a decrease as compared with 81% scored in the previous year. This lower score reflects the impact of the staffing challenges experienced on blood donation teams this year caused by high staff turnover (peaking in some months >30%) combined with high sickness absence (peaking at c8%), which regrettably led to high levels of cancelled donor appointments and long waiting times on many blood sessions.

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.

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Meet customer requirements for product on time and in full (OTIF) including Ro	97.4%	96.2%	Below target
Improve customer satisfaction – % of hospitals scoring 9 or 10 out of 10 for overall satisfaction	80%	76%	Below target
Improve donor satisfaction – % of donors scoring 9 or 10 out of 10 for overall satisfaction	84.5%	79.3%	Below target

The 2022-23 year has been one of challenges for the blood supply chain. We faced workforce shortages, industrial action, and continued variability in both demand and supply for our products.

During the year, we declared our first-ever formal red cell stock shortage (amber alert) for a four-week period during October-November 2022. This was due to the sustained lower levels of collection as a consequence of the challenges we faced, which resulted in red cell stocks, particularly O negative, falling to low levels. As a result, hospitals were asked to reduce ordering by holding lower inventory and rescheduling non-urgent elective activity for this period. Having declared the amber alert on 12 October, red cell stocks subsequently improved quickly, and while staffing levels have improved, subsequent industrial action meant that we remained in 'pre-amber' alert status with hospitals for platelets (a short shelf life product) for the remainder of 2022-23. The recovery in stock levels was in no small part due to the thousands of donors, both existing and new, who responded to the

urgent call for more donations.

Our focus during the year and our plans for next year have been therefore on building additional workforce and supply chain resilience. Unfortunately, we experienced high levels of turnover in front-line roles, with some blood collection teams turning over around 60% of their staff in a 12-month period. This was compounded at points by peaks in sickness absence caused by seasonal illness and continued COVID-19 waves. The resulting staff shortages have been acute in some locations, resulting in lower collection capacity, regrettably high levels of donor cancellations and long waiting times on many blood sessions.

As a result of both the amber alert and the subsequent industrial action, we have invested heavily in recruiting and training more colleagues to strengthen the resilience of our blood donation teams. Alongside this, we have accelerated the training process for new donor carers, meaning instead of taking around eight weeks we can now train a full-time colleague in just four weeks. We have also recruited above budgeted levels on donation teams to ensure that we have enough staff to maintain our operations and to counter-act the effects of high turnover and absence. We have worked closely with colleagues, local trade union representatives, and hospital customers to mitigate the impacts of industrial action disruption, which created increased variability in hospital demand. The impact of industrial action on collection capacity was partly mitigated through the commitment of colleagues willing to work, including changing shifts to cover those colleagues who wanted to

participate in the industrial action.

These targeted interventions helped stabilise collections and reduce staff turnover, which fell to c17% by the end of 2022-23 across the Blood Supply directorate (compared to more than 30% earlier in the year).

As a consequence of these prolonged challenges, we have secured Department of Health and Social Care support for investing in a comprehensive programme of work to future-proof our blood supply operations by delivering additional collection capacity and smoothing the collection and processing of short-life products to eliminate the mid-week dip we see in inventory. These investments will be delivered during 2023-24 through our Future Proofing Blood Programme.

Additionally, we have made progress in modernising our operations through the procurement of a range of new blood testing equipment as part of our Testing Development Programme (TDP).

Modernise our operations

Modernise our pathology services

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Pathology Services income	£38.5m	£40.2m	Above target
Sample turnaround times – core services	95% within SLA	99%	Above target
No of major regulatory non-compliances	Zero	Zero	On target

Our Pathology services provide specialist diagnostics to support safe transfusion and transplantation for patients, completing approximately 300,000 investigations every year. When patients need a transfusion, further investigations are sometimes required to identify antibodies developed by the patient so that the clinical teams can transfuse safe blood components for these sensitised patients. Our services also include Human Leukocyte Antigen (HLA) typing, which is a genetic test used to match patients and donors for bone marrow, cord blood, or organ transplants. HLA are proteins, known as markers, that the immune system uses to identify which cells belong in your body and which do not, and are more complex than blood groups.

These specialist services are delivered by a team of approximately 450 scientists across 16 different laboratories in England grouped into three specialties: Red Cell Immunohematology (RCI), Histocompatibility and Immunogenetics (H&I), and IBGRL (International Blood Group Reference Laboratory).

The £40.2m income earned during 2022-23 can be broken down into approximate income streams follows: RCI and reagents – £19.9m, H&I – £18.6m, IBGRL and other miscellaneous income such as training services – £1.7m.

2022-23 saw Pathology Services growing in all areas, with the exception of antenatal (due to lower birth rate), with income £1.7m ahead of budget. Sample turnaround times were above target and we received zero 'major or critical' regulatory non-compliances. We have also made good progress in the he development of a new Pathology Services strategy, which we will complete in the first quarter of 2023-24.

This year we have made good progress on the Genomics Programme that we established in 2021-22 to develop and implement genomics technology to enable quicker and more accurate testing, which will improve health outcomes and reduce health inequalities in transfusion and transplantation. We are investing in the development of low-cost array-based genotyping technologies, to enable better matched blood components for transfusion-dependant patients to prevent them from developing antibodies. We are also investing in long-read sequencing technologies, like Oxford Nanopore, to achieve less ambiguous results for HLA types. These more accurate

results will enable more personalised matching of donations to patients for stem cells and solid organ transplants.

We have been working with Our Future Health (OFH) to recruit blood donors to this research programme, and have now developed a plan to recruit up to 500,000 donors into OFH over five years. 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. At present, we are aiming to start this recruitment in the summer of 2023. Our Future Health is expected to be the UK's largest health research programme, aiming to recruit up to 5 million people. It is designed to help people live healthier lives for longer through the discovery and testing of more effective approaches to prevention, earlier detection and treatment of diseases.

As a partner in the Blood transfusion Genomics Consortium (BGC), we supported the validation of a 'simple-to-use' DNA test for typing clinically relevant red cell blood groups. Our Colindale laboratory genotyped over 2,000 samples with this array to support the validation and work will continue next year to secure regulatory accreditation. Our Colindale laboratory has also started to genotype the recruited STRIDES (STRategies to Improve Donor ExperienceS) donors with this new DNA test and expects to genotype up 80,000 blood donors over the next 18 months. In addition, this year, NHS England approved a 12-month programme to genotype sickle cell and thalassemia patients with this new DNA-based testing; we are mobilising the capacity to undertake this in 2023-24.

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.

In the final quarter of 2021-22, we established our Transfusion 2024 programme, aiming to improve patient outcomes through delivering improved infrastructure to support transfusion best practice. In 2022-23, we have engaged with a number of hospitals and laboratory information management systems (LIMS) providers to undertake pilots of new services, including electronic requesting and reporting of tests results directly into the hospitals' LIMS, and remote interpretation of test results by our Red Cell Immunohematology labs.

In 2022-23, we specifically started to implement electronic requesting and reporting for our foetal RhD screening test. This is a high throughput molecular test (c50,000 per year) that predicts the RhD status of the baby (positive or negative) from the mother's blood sample. This information allows determination of whether anti D prophylaxis injection is necessary for each individual woman, providing better personalised care.

Drive innovation

Investing in the development of cutting-edge therapies

On 10 March 2023, we opened our state-of-the-art Clinical Biotechnology Centre (CBC) in Filton, north Bristol, which will contribute greatly to the UK's ability to develop and manufacture new gene and cell therapies.

It will manufacture products for the development of potentially curative therapies for currently incurable diseases, such as some forms of cancer, sickle cell disease, and cystic fibrosis. Some of these will be personalised therapies, aimed at treating just one person.

The CBC is designed to expand the UK's ability to make the clinical grade products required for the research and development of new cell and gene therapies. It will support early phase clinical trials and pre-clinical work, providing a route to eventual commercial scale production.

It will help give patients quick access to the latest treatments by increasing the number of UK patients with incurable diseases who are able to take part in clinical trials and also bring new treatments into the NHS faster.

Cell and gene therapy is a cutting-edge area of medical development. Therapies are based on the idea that living cells or genetic material can be used to cure a wide range of acquired and inherited diseases, by altering their DNA or using them as a vehicle to deliver treatments. Gene and cell therapy can be used to treat

illnesses such as leukaemia, haemophilia, autoimmune disorders, cancer, HIV, melanoma, and cystic fibrosis.

- Gene therapy works by fixing a genetic problem at its source. Genetic material, usually in a carrier such as a modified and inactivated virus, is transferred to cells, and the faulty DNA is replaced, inactivated, or repaired – for example, gene therapy is being used by the NHS to treat Spinal Muscular Atrophy.
- In cell therapy, the patient receives cells which then act with a therapeutic benefit. These cells are often genetically modifie for example, CAR T-cell therapy, where immune cells are modified to recognise and attack cancer cells.

Such advances in biotherapies offer new hope for patients for whom all other treatment options have been exhausted. CAR T-cell therapies have now been used to treat hundreds of patients.

Nitya, 22, had lifesaving CAR-T cell therapy for acute lymphoblastic leukaemia.

Nitya become the first person to receive CAR-T therapy at the Bristol Haematology and Oncology Centre in February 2019.

Nitya has now been free of the disease for four years.

She said: “I felt really excited to be able to receive CAR-T cells given they were new to the NHS. CAR-T was absolutely lifesaving for me. Without it, I don’t think I would be here.

“I think it’s just so exciting to see other new cell and gene therapies being developed at the CBC that can help other people too.

“I now feel great, I’m at university and I am living my life as normal, four years on from receiving CAR-T cells, because I’m in complete molecular remission with no evidence of disease now.

“I feel lucky that I got it when I did, and I hope more people also now get the chance to have new treatments. I hope the new CBC can help other new treatments to reach patients faster.”

Drive innovation

Increase organ donors and transplants through opt-out and utilisation

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Improve overall organ consent/authorisation rate (%)	72%	61%	Below target
Number of deceased organ donors	1,646	1,430	Below target
Number of deceased organ donor transplants	3,872	3,598	Below target
Organ donor families, public, transplant recipients and hospitals' satisfaction	0 complaints; high-level of compliments	53 complaints; 103 compliments	Below target

We have increased the number of deceased donors by 2% and the number of transplants by 5% in 2022-23 compared to 2021-22. This was made possible by those who made the life-saving decision to donate their organs, and the continued determination of the UK's donation and transplantation community.

Nonetheless the transplant list continues to grow, and by the end of the year had returned to levels last seen in 2013-14.

We are working across the system to take action, and had aspirational targets to recover to even higher levels of donation and transplantation than before the pandemic.

Sadly, a continuing reduction in the deceased donor pool (19% compared to 2019-20) and emerging NHS pressures

had a major impact in 2022-23, because we rely on intensive care and other acute hospital facilities.

In addition, the public's support for organ donation came under sustained pressure and the consent and authorisation rate has fallen in 2022-23 to 2015-16 levels (61%).

We responded by adapting our colleagues' training and clinical practices so that we can utilise more organs from donors that would not have proceeded in the past. This means that transplants grew faster (+5%) than donors (+2%) in 2022-23 compared to 2021-22, and we had more of both despite the reduction in consent and authorisation rates.

The recovery of the UK Living Kidney Sharing Scheme has been sustained. Together with deceased organ donation and transplantation, we will confirm all activity in an Annual Activity Report during summer 2023.

Reducing health inequalities is a key focus our work. Around 30% of people on our transplant waiting list are from an ethnic minority while representing 14% of the UK population, and the proportion of ethnic minority donors was 8% in 2022-23. This has meant that an ethnic minority recipient will wait longer than someone who is white. This is partly because the consent and authorisation rate from ethnic minority donors continues to be a challenge (35% in 2022-23), falling by 3 percentage points compared with the previous year.

We were therefore pleased to see increases in the number of ethnic minority patients transplanted (950 in total, a 1% increase compared with last year). This is because of changes to organ offering schemes that were made recent years, and a welcome increase in organ utilisation overall.

26% of all deceased donor transplant recipients in 2022-23 were black, Asian, mixed race or of an ethnic minority. This means that while ethnic minority patients remain at a disadvantage, we are closing the gap across ethnicities as detailed in our Annual Report on Ethnicity Differences (https://www.odt.nhs.uk/statistics-and-reports/annual-report-on-ethnicity-differences/).

"When **Rachael** entered a room, it was as if a light had been switched on, she was always laughing and joking. She completed her PGCE with her dream to become a teacher; she also volunteered with the Girl Guides and enjoyed giving her time to others.

"Rachael was a very compassionate person, so it came as no surprise to us that at 16 she signed up to become an organ donor. When Rachael passed at the age of 22, we honoured her wishes, and it gives us great comfort that Rachael has given the precious gift of life to others."

Rachael's family

Collaborate, develop and scale new services

Build capacity in the UK cellular therapies supply chain

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Cell, Apheresis and Gene Therapies income	£38.3m	£39.3m	Above target
Number of major regulatory non-compliances	Zero	Zero	On target
NHS Cord Blood Bank size	19,000	18,660	Below target
NHS British Bone Marrow Registry growth	+30,000	+16,000	Below target[1]

1 Due to prioritisation of existing donors on blood collection sessions due to amber alert and preceding low-stock management

In 2022-23, demand across our Cell, Apheresis and Gene Therapies (CAGT) product/service lines was variable, with some areas seeing demand above predicted levels and some below. The NHS Cord Blood Bank issued 31 units for patients (50 last year) which is below target, although activity, in particular international issues, increased towards the end of the year. The British Bone Marrow Registry activity was below plan, with 162 donors matched to patients (175 last year). In Cellular and Molecular Therapies, service activity above plan, supporting 1,849 stem cell transplants (1,817 last year). Our Therapeutic Apheresis Service activity was ahead of plan, treating 2,087 patients (1,934 last year) and performing 11,148 procedures (10,075 last year). New services were started supporting NHS Trusts with critical red-cell exchange

treatments for sickle cell patients under the MedTech Funding Initiative. In CAGT we received zero ‘major or critical’ regulatory non-compliances.

During the year, we obtained a Medicines and Healthcare products Regulatory Agency (MHRA) licence for Good Manufacturing Practice (GMP) and completed commissioning of the Clinical Biotechnology Centre (CBC) extension to our Bristol site. The project was delivered to budget and provides new capacity for Advanced Cell and Gene Therapy work – a c£10m investment in UK regenerative medicine capability. Operations ceased at the old Langford site and GMP manufacturing started at the new site in Q4. CBC income remained stable compared to last year despite resources required to manage two sites and commissioning the new site.

Work continued at CBC 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. The products manufactured by CBC are used to make gene therapy medicines that can treat a range of diseases from cancer, to inherited genetic disorders such as sickle cell disease and cystic fibrosis. CMT continued to support the RESTORE clinical trial with manufacturing of red cells from adult stem cells and the AMELIE H2020 EU consortium with the development of GMP manufacturing of autologous muscle cells to restore the function of the sphincter that can be damaged in childbirth.

In 2022-23, NHSBT supported the delivery of the UK Stem Cell Strategic Forum (UKSCF) report published in June 2022 which contains several recommendations for the UK in the areas of stem cell transplantation and advanced therapy products. We also finalised a new five-year strategy which is aligned with the UKSCSF report.

Deborah met Tatton exactly 10 years to the day after Tatton donated his stem cells to her through the British Bone Marrow Registry. He'd signed up through donating blood and was aged 32 when he donated – there is a need for more young stem cell donors. Debs needed the transplant for chronic lymphocytic leukaemia.

Tatton said: "Because of this small thing I did, another person is alive today and that is mind-blowing. Her family have already had ten more years with her, ten more birthdays, ten more Christmases.

"If someone was in the middle of the road and a car was coming, you'd try to save them, wouldn't you? Well, a car is coming for people like Debs — and you can save them. This is the best thing I will ever do in my life."

Debs said: "When I actually set eyes on him for the first time, I could hardly take in the magnitude of the whole thing — he was a stranger, yet the fact I am alive today is entirely thanks to him. It was surreal yet wonderful at the same time."

Collaborate, develop and scale new services

Expand our tissue and eye service offering to patients

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Tissues and Eye Services income	£18.5m	£17.2m	Below target
Number of cornea donors	3,650	2,382	Below target
Number of corneas issued for transplant	4,730	3,592	Below target

As the NHS continues with the recovery plan for elective surgery following the pandemic, Tissue and Eye Services (TES) have supported this activity by supplying products for the Ophthalmic, Orthopaedic & Sports Injury, Cardiovascular, and Burns and Wound Care specialities. Due to the nature of the recovery plan, there have been a number of adjustments to the type of products that have been required, with items such as tendons being used much less and processed bone products being in high demand. This fluctuation in demand has required TES, and the services and suppliers who support them, to be very flexible in their response to this changing environment.

The largest challenge faced this year has been the level of cornea donors, with the number of donations being 2,382, which is a 4.2% increase on the previous year, but still 18.8% behind pre-pandemic levels (2018-19). This has resulted in the number of corneas being issued

for transplantation being 24% behind the 2022-23 target. Due to demand for corneas being higher than our ability to supply, a number of hospitals are importing corneas from overseas establishments. To respond to this low performance position, a programme of work has been completed to provide a set of improvement recommendations that will be implemented within the next financial year. We have started importing corneas to bolster NHSBT stock levels, to assist in meeting demand whilst we work on these improvement recommendations.

We also provides Serum Eyedrops to the Ophthalmic speciality, for patients with severe Ocular Surface Disease (OSD). There has been a significant increase in patients being prescribed this product this year, with issues being ahead of target by 2.9%, and 14.9% ahead of 2021-22 actual.

Bharat lived for 35 years with little to no vision. Part of his eye had grown into a cone shape due to a condition named keratoconus, which meant that light couldn't reflect on to his retina to form images.

That all changed in 2021 when an organ donor gave him the 'ultimate gift', as Bharat says: the gift of sight.

Bharat: "It is the ultimate gift – there are no words. My donor, whoever he or she is, has given me the gift of sight.

"Straight after the transplant I could see the shape of my surgeon's face, and my vision has been improving since the surgery.

"That is all thanks to someone being on the NHS Organ Donor Register and consenting to donating their eye so that the cornea can be transplanted.

"It is the ultimate gift a person can give."

Collaborate, develop and scale new services

Support the Government ambition for a domestic supply of plasma for medicines

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Litres collected of source plasma	15,816	8,830	Below target
Litres collected of recovered plasma	87,185	79,895	Below target

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 on Human Medicines (CHM). From April 2022 we established a Plasma Directorate within NHSBT.

NHSBT supported NHS England in the procurement process for a fractionator. The first shipments of collected plasma will start to be manufactured into immunoglobulin medicines for the UK in mid-2024, and this will contribute to a level of self-sufficiency for these medicines.

During 2022-23 a major recovered plasma transformation was delivered across our three manufacturing sites. An industrial scale frozen plasma operation was established. This entailed recruitment, training, infrastructure, process redesign, digital development and workflow changes. These developments fundamentally change our manufacturing operations. Whilst the volume of recovered collection for plasma for medicines was impacted during 2022-23 by the lower than anticipated levels of whole blood collection, we ensured that any plasma not suitable for clinical use was still used in other ways for patient benefit, such as for diagnostic purposes.

A key objective remains ‘test and learn’, ensuring that we identify the right operational model, donor recruitment approach and retention activities to enable future expansion, as global supply constraints increase.

Collection from our three donor centres of source plasma achieved 8,830 litres. There was a need to establish both collection capacity and build a new plasma donor base during the year. Performance was impacted by both the need to prioritise red blood cell collection during the amber alert in the autumn, and the requirement to build plasma clinic collection capacity. Blood stocks have now stabilised, and staffing challenges have been addressed through enhanced recruitment, training and forecasting of future staff turnover.

During 2022-23 a new type of apheresis donation machine was introduced which is much more flexible and makes it safer for people with a smaller physique to donate, enabling more women to donate, and in a shorter time. Female donors now make up 39% of our donor base, up from 11% in May 2022. We have also simplified the online process for regular donors to book their own appointments which reduces impact on session time and supports higher donation frequency

Plasma collection for medicines, both through apheresis and recovered from whole blood, has become a core part of our operations.

Stephanie's mum, Yvonne, received medicine made from plasma which has helped her to live with cancer for 20 years. It was her experience which inspired Steph to become a plasma donor in Birmingham.

Her mum was diagnosed with small-cell lung cancer 20 years ago and given six weeks to live.

Today Yvonne receives immunoglobulin, a medicine made from plasma donations, every six weeks.

The medicine contains antibodies, part of the immune system, which help reduce the effects of her neuropathy – nerve damage from her own immune system mistakenly attacking her nerves.

Neuropathy can be caused by cancer or its treatment.

The antibodies in the donor medicine help Yvonne's immune system to self-regulate and calm down.

Stephanie said: "Mum suffers very severe nerve pain. She struggles to walk. She can only pick things up if she is looking at them.

"The immunoglobulin relieves the pain and improves her co-ordination."

She had never donated any form of blood before until she saw a plasma donor centre in New Street, Birmingham.

Stephanie and her sister Sarah booked in to donate. Sarah was not able to donate on the day but Stephanie, a senior admin worker, was able to make her first donation. Since then she has continued to donate, and featured in a special Mother's Day campaign to get more people donating plasma.

She said: "We wanted to give something back. We went down and it was smooth and painless.

"The whole visit was an hour which could save someone's life, so I would 100 per cent say to other people 'go for it'. There's nothing to worry about.

"When you have that personal connection, it means that little bit more, but it's nice to do anyway."

Invest in people and culture

At all levels our workforce reflects the diversity of the population

Our 2022-23 Targets

Performance measure	Target	Results	Performance
At all levels our workforce reflects the diversity of the population	15% BAME representation Band 8+	13.8%	Below target[1]
	27% disability declaration rate	27.3%	Above target[2]
	96% sexual orientation declaration rate	72.4%	Below target[3]

[1] Over the course of the 2022-23 year, our BAME representation at band 8a and above has fluctuated. To get to green, we have agreed specific actions to improve inclusive recruitment practices across the organisation in response to our Workforce Race Equality Standard and work on our Intentional Inclusion Programme.

[2] Currently 27.3% of our workforce have shared their disability status (an increase of 13% from last year).

[3] 72.4% of our workforce have shared their sexual orientation (an increase of 8% from last year), but we did not achieve the target we set ourselves at the start of the year. To get to green, we have reset the target for the 2023-24 financial year to 80% sexual orientation declaration rate. To raise awareness and improve declaration rates, we have launched our Count Me In campaign, and this will help inform future plans.

Our ambition is to be a great place to work. We want to ensure at NHSBT 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.

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 and Inter-Faith Week, with educational

events, podcasts, panel discussions and webinars.

In the past year, we have achieved LGBTQ+ Inclusive Employer Gold and a Top 100 in Stonewall's Workplace Equality Index; been awarded first across all NHS bodies for our Accessible Information Standard work; acted to improve our gender pay gap – at 5.25% it is approximately a third of the national average (14.9%).

We have made progress with a new and improved approach to inclusive recruitment, which has delivered better quality data across the recruitment pathway and a significantly improved recruitment experience.

Covering the year of 2021-22, in March 2023 we published our Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap Reports. Each of these reports are available on the NHSBT website and include the action plans we will take forward.

Invest in people and culture

Our workforce feels motivated, valued and engaged

Our 2022-23 Targets

Performance measure	Target	Results	Performance
Our workforce feel motivated, valued and engaged	7.7 overall engagement score	7.5	Below target[1]

[1] We ran the Our Voice survey over the months of January, February and March 2022. No further surveys have taken place over the course of the year and engagement score has therefore remained static. In April 2023, we ran the next Our Voice survey, and are now in the process of reviewing the feedback received to prepare publication of the results.

In 2022-23 we sought to improve the employee experience by developing and implementing a Corporate Action Plan to respond to the insights generated from the Our Voice survey. Additionally, each directorate developed their own tailored plan.

HR Direct is the formal gateway for all HR related queries. Recognising the importance of excellent responsiveness, the function gained formal Customer Service Excellence accreditation in 2016 and has retained that accreditation every year since. Following the assessment in February 2023 we gained our highest accreditation rating to date, in recognition of our commitment to continuous improvement. HR Direct will continue to be an integral part of our future model of ensuring we respond first time to resolve queries and direct workplace issues for resolution at the earliest opportunity.

During 2022-23 we have continued our work to review a range of our policies, particularly focussing on our intention to introduce a culture of informal resolution and to

promote informal resolution at the earliest opportunity for issues arising in the workplace. This work is ongoing and has been supported through changes resulting from our People Directorate restructure.

In September 2022 we launched a transformation programme to identify and implement key initiatives to enable our organisation to become intentionally inclusive and anti-racist. In the first phase of the programme, a multidisciplinary team was stood up and we committed to 21 key deliverables, ranging from compliance with the Public Sector Equality Duty to providing anti-racism coaching for executives and the Board, and psychological safety training for the senior leadership community.

Building on the insights and feedback gathered during phase one, phase two of the programme has focused on four key workstreams to:

1. co-create and implement an anti-racist framework
2. conduct a systemic review of our policy systems and practices
3. raise awareness, understanding, and capability across the organisation to become intentionally inclusive and anti-racist
4. develop an organisational-wide behaviour framework to define what good looks like at NHSBT

By taking these steps, we are laying the foundation for our organisation to become more diverse, equitable, and inclusive. We will continue to monitor our progress and make necessary adjustments to ensure that we are meeting our goals and fulfilling our commitment to creating a culture where our people feel seen, heard, valued and safe.

Our sustainability

We emitted 11,101 tCO_2e (tonnes of carbon dioxide equivalent) of Scope 1 (direct) emissions and Scope 2 (indirect) emissions in 2022-23 (2021-22: 11,661 tCO_2e). When Scope 3 (value chain) emissions are added, this brings the estimated total emissions to 14,174 tCO_2e (2021-22: 13,697 tCO2e). This estimate of Scope 3 does not include all supply chain emissions*.

Emissions data April 2022 to March 2023

Emissions source	Carbon (tCO_2e) 2022-23	*Re-presented*** Carbon (tCO2e) 2021-22
Natural gas	3,008	3,170
CO_2	445	277
Gas oil	162	109
Diesel	2,505	2,556
Fugitive refrigerant gases	44	159
Total Scope 1	**6,164**	**6,271**
UK national grid electricity	4,937	5,390
Total Scope 1 & 2	**11,101**	**11,661**
Transport	792	859
Transmission, distribution and generation loss ***	1,740	791
Flights	74	22
Regular taxi, motor bike and bus	15	9
National rail	117	49
Waste	62	66
Small car (EV)	5	n/a
Commuting	29	n/a
Working from home	239	240
Total Scope 3*	**3,073**	**2,036**
Total Scope 1, 2 & 3	**14,174**	**13,697**
Less self-generated renewables	**(78)**	**(34)**

* 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, an external specialist estimated in 2021-22 that our total Scope 3 emissions were 58,056 tCO2e. We are currently in the process of re-assessing that estimate.

** Our 2021-22 figures have been re-presented to match the headings used in the 2022-23 report. The total emissions for Scope 1, 2 and 3 have not changed, only the split of the figures within the categories has changed. Where 'n/a' is shown this is due to additional information being reported in 2022-23 which was not available in 2021-22; we are constantly seeking to enhance our understanding and reporting of our emissions.

*** Full-year data for transmission, distribution and generation loss was available for the first time in 2022-23; a full-year figure was not available for 2021-22, which used the best available data.

Scope 1 direct emissions are those from activities owned or controlled by the organisation.

Scope 2 energy indirect emissions are those released into the atmosphere that are associated with the consumption of purchased electricity. These are a consequence of the organisation's energy use but occur at sources we do not own or control.

Scope 3 other indirect emissions are a consequence of the organisation's actions that occur at sources that we do not own or control and which are not classed as Scope 2 emissions.

We continue to make good progress towards our current 2015-25 strategic goals. The five targets, within the current strategy, are largely completed, as described below:

Target by 2025	Progress
50% cut in carbon emissions	Completed in 2022-23 with 50.35% reduction.
Zero waste to landfill	Completed in 2021-22 with continued certification to ValPak scheme.
A resilient business	Completed in 2020-21 with continued certification to ISO14001 and ISO22301.
A sustainable supply chain	In progress. Reassessment to ISO20400 due in 2023, an increase in score of 0.24 will take us to 4/5 and completion.
Sustainability built into organisational culture	Reassessed during 2022-23, and status moved from 'Completed' back to 'In progress'. Further work required to build sustainability into business case processes and accounting.

Our finances

Overall financial performance

The total income received by NHSBT in 2022-23 was £561.0m (£514.1m in 2021-22). Around 70% of our income is provided through sales of products and services to the NHS, with the remainder provided as programme funding from the Department of Health and Social Care (DHSC) and the devolved governments. The reasons for the increase in income in 2022-23 were the higher level of fees and charges being recovered through prices from the sale of Blood and Specialist Services, and additional funding (close to year-end) from DHSC to restore working capital.

In line with the HM Treasury 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 also stem cells, 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*** of the financial statements provides the 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 £561.0m received in 2022-23, on a total income and expenditure basis, NHSBT reported a surplus of £15.2m. This compares to a planned budgeted deficit of £8.1m, and a deficit of £8.8m that was reported in 2021-22. It is common for NHSBT 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).

Excluding the additional funding from DHSC, the underlying improved financial outcome in 2022-23 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 2022-23 is therefore being carried forward as cash to fund activities in 2023-24.
- Activity in Clinical Services being close to pre-Covid levels and higher than the conservative 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.

Financial performance by segment compared to 2021-22

All funding and costs relating to the Plasma for Medicines Programme are now reported as a discrete segment this financial year, having been reported as a project within the Blood Components segment the previous year. This is due to this programme of work evolving into a core business operation.

The overall income for Blood Components (including transport charges) was £310.4m in the year. This was 5.8% higher than 2021-22 (£293.4m) due to an underlying average price per unit increase of 6% and includes reduced non-clinical issues of £2.5m (plasma derived) which are now also reported within Plasma income. Overall, the NHSBT operating surplus is £15.2m for the year, and is significantly higher than the £8.8m deficit recorded in 2021-22. The current year position includes additional funding from DHSC of £18m to restore working capital. Previous year deficits were also planned, with expenditure budgets set for transformation projects funded by cash reserves.

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 (£10m). ODT funding overall has increased by £6.9m, which includes non-recurring funding for DCD Hearts project (£3.6m) and Opt-out (£2m deferred from 2021-22), plus an increase in recurring funding from Scotland and Wales devolved administrations of £1.1m. Although the number of organ donations and transplants was higher than 2021-22, they remained some 9% below pre-pandemic levels. Direct costs were therefore £3.4m lower than funding and this is therefore carried forward as cash reserves into 2023-24.

Income in Tissue and Eye Services (TES) was lower than planned at £16.3m, particularly when compared to the improvements seen in 2021-22. There are, however, firm expectations for growth in 2023-24, with a cash break even position planned for the year.

Demand in Clinical Services (pathology, stem cells and therapeutic apheresis) has now mostly returned to pre COVID-19 levels in 2022-23. Total income (including programme funding from DHSC in support of the NHS Cord Blood Bank and the British Bone Marrow Registry) therefore recovered to £79.5m in 2022-23, 6.9% higher than the £74.7m seen in 2021-22.

Capital expenditure

DHSC provided funding for capital expenditure of £10.5m in 2022-23, versus £12.0m in 2021-22. 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. During the year our capital expenditure was £11.5m. Of this, £3.8m was spent on the continuation of 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. Other capital expenditure included various IT projects that support the organisation's strategy to modernise core technology (£1.3m), additional right of use assets acquired under leases (£0.8m), and £5.6m spent on a range of critical business equipment across Blood Supply and Clinical Services laboratories including platelet incubators, centrifuges, controlled rate freezers and flow cytometers.

Net assets

Net assets increased to £314.4m at 31 March 2023 from £291.2m at 31 March 2022. The increase was mostly driven by:

- Non-current assets increasing from £247.1m to £276.5m due primarily to the impact of the adoption of IFRS 16 bringing many 'right of use' assets on to the Statement of Financial Position, and also to capital expenditure during the year and the net impact of the desktop-based revaluation on our property assets.
- Trade and other receivables increasing by £32.0m from £43.4m to £75.4m, due primarily to increases in trade receivables balances from £29.6m to £47.0m, and an increase in prepayments and accrued income from £10.0m to £23.9m.
- Trade and other payables increasing from £71.5m in March 2022 to £75.5m in March 2023, due primarily to a £7.8m increase in accruals and deferred income, partially offset by a reduction in trade payables of £3.8m.
- Other financial liabilities (current and non-current) increased by £21.1m from £8.6m to £29.7m, mainly due to the lease liabilities recognised as a consequence of the adoption of IFRS 16.
- Cash decreased by £14.0m from £64.7m at March 2022 to £50.7m at March 2023. The balance notionally comprises £13.4m attributable to Blood Supply, £8.5m to Clinical Services, £12.7m

to ODT and £16.1m 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 19 of the financial statements describes NHSBT's contingent liabilities. There are no other significant contingent liabilities to report, as at 31 March 2023.

NHSBT is the corporate trustee for the NHS Blood and Transplant Trust Fund. The total net assets of the trust fund at 31 March 2023 were £118k (compared to £81k at March 2022). The 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.

The Trust fund accounts can be found here:

https://register-of-charities.charitycommission.gov.uk/charity-details/?regid=1061771&subid=0

https://www.nhsbt.nhs.uk/who-we-are/transparency/accounts/trust-fund-accounts/

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 costs 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 planning and pricing models, and in agreement with DHSC and NHS England, we have revised our prices for blood and specialist services in 2023-24. Along with funding from DHSC and the devolved governments for organ donation, transplantation and stem cells, we have a funding envelope which is sufficient to meet our operational plans in 2023-24.

Looking beyond 2023-24, 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 take into consideration 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.

Our strategic risks

The Board manages and monitors the status of strategic risks through the Board Assurance Framework and monthly performance reporting. Risks are 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.

Strategic risks are monitored in line with the agreed risk appetite process (which is aligned to the HM Treasury Orange Book), where we have different appetites or tolerance for risks with different types of impact.

The table below shows the risks, indicating the score against risk appetite, showing 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	15	Donor and Patient Safety	Risk Limit[1]
Linked with the strategic objective "Modernise our operations to improve safety, resilience and efficiency"				
2A	Disruptive Event (Internal Failure)	20	Service Disruption	Risk Limit[1]
Linked with the strategic objective "Modernise our operations to improve safety, resilience and efficiency"				
2B	Disruptive Event (External Failure)	16	Service Disruption	Risk Limit[1]
Linked with the strategic objective "Modernise our operations to improve safety, resilience and efficiency"				
3	Scale and pace of Change Programme	16	Innovation and Development	Judgement Zone
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

No.	Risk Title	Residual Score	Impact Area	Risk Appetite
Linked with the strategic objectives "Grow and diversify our donor base", "Modernise our operations" and "Collaborate with partners"				
5A	Finance	12	Financial	Within Tolerance
Linked with the strategic objectives "Develop and scale new services to provide additional support to the NHS"				
5B	Support for Strategic Delivery	15	Innovation and Development	Within Tolerance
Linked with the strategic objective "Develop and scale new services to provide additional support to the NHS"				
6	Accessibility of Data	8	Innovation and Development	Optimal
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	16	People	Judgement Zone
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"				

[1] Risks at the risk limit included **Risk 1, Patient and Donor Harm**. This score was driven by an operational risk issue regarding a data management system in one of the clinical operating areas. The risk was about the need to use a paper-based system rather than the preferred IT system, and was therefore about operational management rather than directly related to patient safety. The risk was reviewed in April 2023 and re-scored to a 12, which is within the Judgement Zone. An action plan has been defined for mitigation. The other risks at risk limit are **Risks 2a** and **2b**, **Service Disruption**, which have been affected by blood stock shortages and industrial action through the 2022-23 year. Both of these

risks were reviewed in May 2023 and re-scored to a 9, which is within the Judgement Zone, as a result of the improved ability to manage the impact of industrial action.

I hereby sign the Performance Report from pages 19 to 70

Dr Jo Farrar CB OBE **5 July 2023**
Chief Executive and Accounting Officer

Our accountability

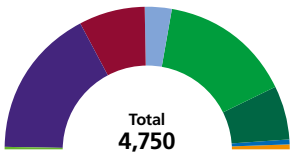
Our Accountability report covers the three required sections. Our people (see page 72) covers remuneration and staff report requirements, Our governance and accountability structure (see page 106) and Our governance statement cover the corporate governance report requirements and we have a parliamentary accountability report (see page 163). 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.

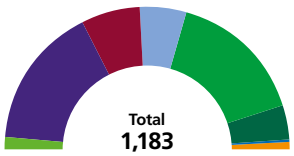
The top three graphs add together to form our total headcount of 6,180:

Headcount by band: white



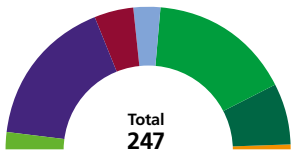
Band 2: [0.9%, 44]
Band 3: [34.1%, 1,618]
Band 4: [14.5%, 690]
Band 5: [6.5%, 311]
Band 6/7: [30.0%, 1,427]
Bands 8a-c: [11.9%, 565]
Leadership: [1.3%, 61]
Medical: [0.7%, 34]

Headcount by band: BAME



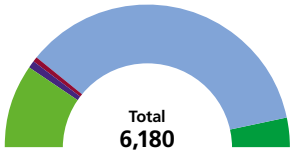
Band 2: [3.0%, 35]
Band 3: [32.4%, 383]
Band 4: [13.2%, 156]
Band 5: [10.4%, 123]
Band 6/7: [31.4%, 372]
Bands 8a-c: [7.5%, 89]
Leadership: [0.9%, 11]
Medical: [1.2%, 14]

Headcount by band: not specified



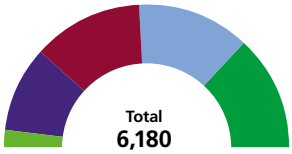
Band 2: [4.0%, 10]
Band 3: [34.0%, 84]
Band 4: [8.9%, 22]
Band 5: [6.1%, 15]
Band 6/7: [32.4%, 80]
Bands 8a-c: [13.8%, 34]
Leadership: [0.0%, 0]
Medical: [0.8%, 2]

Headcount: disability



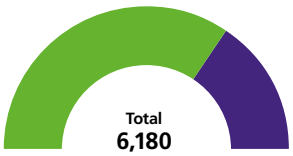
No: [19.39%, 1,198]
Not Declared: [1.5%, 97]
Prefer not to answer: [1.20%, 74]
Unspecified: [71.28%, 4,405]
Yes: [6.57%, 406]

Headcount: age



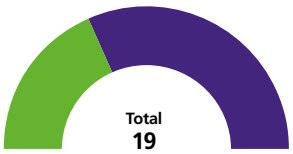
Under 25: [4.40%, 272]
25-34: [19.39%, 1,198]
35-44: [24.74%, 1,529]
45-54: [25.57%, 1,580]
55 & above: [25.91%, 1,601]

Headcount: gender



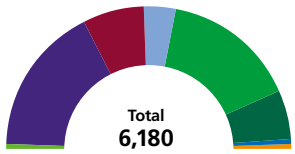
Female: [68.92%, 4,259]
Male: [31.08%, 1,921]

Executive and Board: gender



Female: [37.0%, 7]
Male: [63.0%, 12]

Headcount: overall by pay band



Band 2: [1.4%, 89]
Band 3: [33.7%, 2,085]
Band 4: [14.0%, 868]
Band 5: [7.3%, 449]
Band 6/7: [30.4%, 1,879]
Bands 8a-c: [11.1%, 688]
Leadership: [1.2%, 72]
Medical: [0.8%, 50]

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

Staff turnover

In March 2022 organisational turnover stood at 18.1%, and at the end of March 2023 reduced to 15.4%. A key area of focus are our front-line Blood Donation teams. For these teams, turnover in March 2022 was reported as 28.5%, and in March 2023 reported as 22.6%. This remains a concern and we have work planned for the 2023-24 financial year to further reduce turnover in our Blood Donation teams.

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 information is also disclosed in Note 4 of the financial statements.

This is subject to audit.

	Permanent	Other	Total 2022-23	Total 2021-22
	£000	£000	£000	£000
Salaries and wages*	210,855	25,743	236,598	225,521
Social security costs**	23,353	1,308	24,661	19,123
Employer pension contributions***	37,334	1,502	38,836	34,394
Total	**271,542**	**28,553**	**300,095**	**279,038**

* Includes temporary staff (including agency) £25.7m (2021-22 £35.0m) and termination benefits £0.5m (2021-22 £1.7m), and is net of recoveries in respect of outward secondments £1.2m (2021-22 £1.5m).
** Includes apprenticeship levy £1.0m (2021-22 £1.0m).
*** Includes contributions to NHS Pensions £38.8m (2021-22 £34.3m) and to NEST £93k (2021-22 £66k).

On 1 April 2019, the employer contribution rate for the NHS Pension Scheme increased by 6.3%. The additional cost of £11.8m in 2022-23 (2021-22 £11.0m) was paid by NHSBT and matched by programme funding from the Department of Health and Social Care. An actuarial valuation of the NHS Pension Scheme is currently underway and will set the new

employer contribution rate due to be implemented from April 2024.

In addition, staff costs of £1.1m (2021-22 £2.8m) were capitalised as directly attributable to the development of the new Pulse system (intangible asset) under the 'Blood Technology Modernisation' project (£0.7m NHSBT staff and £0.4m agency).

	Permanent	Other	Total
Whole Time Equivalents	**Number**	**Number**	**Number**
Period Ended 31 March 2023	**4,891**	**490**	**5,381**
Period Ended 31 March 2022	4,721	688	5,409
Of which: Number of employees (WTE) engaged on capital projects:	**20**	**4**	**24**

The note above shows average number of whole-time equivalent staff.

Pay multiples

This is subject to audit.

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, for both total pay and benefits, and separately for the salary component of total pay and benefits. The banded remuneration of the highest paid director (both including contractors and excluding contractors) in 2022-23 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 total pay and benefits pay multiple excluding contractors is 6.2 compared to 6.5 last year due to the highest paid director's pay increasing by less than the increase in the median for employees. A pay offer was proposed on 16 March 2023, as a result of discussions between the government and the NHS Staff Council, and following consultation by the unions of their members, the NHS Staff Council accepted this pay offer on 2 May 2023. The pay offer included non-consolidated additional backdated pay for 2022-23, equivalent in total to an additional 4% on average for staff on Agenda for Change terms and conditions. Since the additional backdated pay relates to 2022-23, and is non-consolidated, it has been shown in the 'total pay and benefits' and 'performance pay and bonuses' figures in the tables.

	2022-23	2021-22
Highest director banded remuneration (including contractor directors)	**£225k to £230k**	£280k to £285k
Highest director banded remuneration (excluding contractor directors)	**£225k to £230k**	£220k to £225k
Lowest banded remuneration	**£0k to £5k**	£0k to £5k
25th percentile remuneration (total pay and benefits)	**£28,475**	£25,348
25th percentile remuneration (salary component of total pay and benefits)	**£26,748**	£25,348
50th percentile (median) remuneration (total pay and benefits)	**£36,550**	£33,952
50th percentile (median) remuneration (salary component of total pay and benefits)	**£34,672**	£33,952
75th percentile remuneration (total pay and benefits)	**£51,183**	£48,908
75th percentile remuneration (salary component of total pay and benefits)	**£48,969**	£48,908
Remuneration ratio (including contractor directors, total pay and benefits)	**6.2**	8.4
Remuneration ratio (including contractor directors, salary component of total pay and benefits)	**6.6**	8.4
Remuneration ratio (excluding contractor directors, total pay and benefits)	**6.2**	6.5
Remuneration ratio (excluding contractor directors, salary component of total pay and benefits)	**6.6**	6.5

Year	25th percentile pay ratio	50th percentile (median) pay ratio	75th percentile pay ratio
(including contractors directors)			
2022-23 total pay and benefits	8.0:1	6.2:1	4.4:1
2022-23 salary component of total pay and benefits	8.5:1	6.6:1	4.6:1
2021-22 total pay and benefits	11.2:1	8.4:1	5.8:1
2021-22 salary component of total pay and benefits	11.2:1	8.4:1	5.8:1
Excluding contractor directors			
2022-23 total pay and benefits	8.0:1	6.2:1	4.4:1
2022-23 salary component of total pay and benefits	8.5:1	6.6:1	4.6:1
2021-22 total pay and benefits	8.7:1	6.5:1	4.5:1
2021-22 salary component of total pay and benefits	8.7:1	6.5:1	4.5:1

Highest Director	2022-23	*Restated* 2021-22	% change from prior year
salary and allowances (including contractor directors)	£225k to £230k	£280k to £285k	-19%
performance pay and bonuses	-	-	-
salary and allowances (excluding contractor directors)	£225k to £230k	£220k to £225k	2%
performance pay and bonuses	-	-	-
For employees of the entity taken as a whole, the average percentage changes from the previous financial year of:			
salary and allowances	£39,196	£37,679[1]	4%
performance pay and bonuses	£1,939[3]	£4.34[2]	44,536%[3]

In 2022-23, no employees (2021-22: nil) received remuneration in excess of the highest-paid director. Total pay and benefits include 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.

1 The 2021-22 salary and allowances figure in the table above has been restated to show the average per full-time equivalent employee (the figure previously reported in 2021-22 was £199,462k, which was the total cost of salary and allowances).

2 The 2021-22 performance pay and bonuses figure in the table above has been restated to show the average per full-time equivalent employee (the data previously reported in 2021-22 was £20k – £25k, which was the banding of the total cost of performance pay and bonuses).

3 The increase in 2022-23 is due to the backdated non-consolidated pay award.

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 2022 to December 2022 the total number of whole-time equivalent days lost to sickness absence was 66,237 days (2021: 55,928 days). This equates to an average of 12.9 days per whole-time equivalent (2021: 10.9 days) and a sickness absence rate of 5.7% (2021 *restated:* 4.9%).

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, on page 214.

Early retirements and redundancies

This is subject to audit.

During 2022-23 there were 14 payments for early retirements and/or redundancies from NHSBT. The sum of £0.9m has been paid out in 2022-23 in respect of these redundancies and/or early retirements (2021-22 32 early retirements and/or redundancies, and payments of £1.9m).

There is currently a £279k provision held for redundancy costs (2021-22 £25k).

The total charge (including accruals) of £0.5m for early retirements and redundancies was expensed over the period 2022-23, and it is adjusted for opening and closing accruals which are included within salaries and wages in Note 4 of the financial statements (2021-22 £1.7m). The actual exit packages payment during 2022-23 amounts to £0.9m

The table below discloses the number and value by cost band of compensation packages paid during 2022-23.

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	1	6	-	-	1	6	-	-
£10,001 – £25,000	5	94	-	-	5	94	-	-
£25,001 – £50,000	1	46	1	46	2	92	-	-
£50,001 – £100,000	-	-	1	96	1	96	-	-
£100,001 – £150,000	1	117	3	368	4	485	-	-
£150,001 – £200,000	-	-	1	160	1	160	-	-
Totals for 2022-23	**8**	**263**	**6**	**670**	**14**	**933**	**-**	**-**
Totals for 2021-22	**15**	**780**	**17**	**1,131**	**32**	**1,911**	**1**	**8**

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 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.

Ill health retirement

Three individuals retired early on ill-health grounds in the year generating additional pension liabilities of £349,794 (2021-22 two individuals £57,399). These costs are met by the NHS Pension Scheme.

The People Committee and senior manager rewards

Membership and purpose of the Committee is shown on page 124. The Chief Executive and Chief People Officer 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 Department of Health and Social Care (DHSC) guidance, the nationally negotiated changes to medical and dental pay, and the Executive Senior Management (ESM) Framework, and any cost-of-living pay increases are paid in line with DHSC Remuneration Committee recommendation as they relate to the ESM pay framework. Remuneration for the Chair and 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 (ESM) 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. The start date is the date of commencement of continuous NHS service for pension purposes.

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 9 August 2022.

Dr Gail Miflin, Chief Medical Officer and Director of Clinical Services. NHS start date 1 August 1991, 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. Retired 28 October 2022.

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. Appointed Interim Chief Executive Officer 9 August 2022. NHS start date 10 September 2018, NHSBT start date and 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.

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.

Gerard Gogarty, Director of Plasma for Medicines. 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.

Deborah McKenzie, Chief People Officer. Appointed 1 September 2021. On secondment from the UK Health Security Agency for 2 years and 7 months, full-time post with three months' notice of termination by the employee, and three months' notice period by NHSBT.

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.

Rebecca Tinker, Interim Chief Digital Information Officer. NHS and NHSBT start date 7 September 2020. Appointed to the role 15 August 2022. Permanent full-time contract with 12 weeks' notice of termination by the employee, and 12 weeks' notice period by NHSBT.

Paul O'Brien, Interim Director of Blood Supply. NHS and NHSBT start date 25 July 2022. Fixed-term contract with eight weeks' notice by NHSBT in the first six months, and then after six months in post six months' notice of termination by the employee, and six months' notice period by NHSBT.

Carl Vincent, Chief Financial Officer. NHS start date 1 October 1996, NHSBT start date 10 October 2022. Permanent contract with six months' notice of termination by the employee, and six months' notice period by NHSBT.

Janet Kidd, General Counsel and Company Secretary. NHS and NHSBT start date 5 September 2022. Permanent full-time contract. Left the role on 31 March 2023.

Officers appointed during the year 2022-23:

Wendy Clark, appointed Interim Chief Executive 9 August 2022.

Carl Vincent, Chief Financial Officer, appointed 10 October 2022.

Rebecca Tinker, appointed Interim Chief Digital and Information Officer 15 August 2022.

Janet Kidd, General Counsel and Company Secretary, appointed 5 September 2022.

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

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).

Leavers in the year:

Betsy Bassis, Chief Executive. Left on 9 August 2022.

Rob Bradburn, Director of Finance. Left on 28 October 2022.

Stephen Cornes, Director of Blood Supply. Left on 31 July 2022.

Janet Kidd, General Counsel and Company Secretary. Ceased role 31 March 2023.

The remuneration and pension benefits of the most senior officials of NHSBT are shown in the tables on pages 86 to 90. The tables are subject to audit.

Remuneration and pension entitlement of senior managers

a) Remuneration

	Year to 31 March 2023					Year to 31 March 2022				
Name and title	Salary (in £5k bands) £000	Performance pay and bonuses (in £5k bands) £000	Non-cash benefits (to nearest) £00	All pension related benefits (to nearest) £000	Total (in £5k bands) £000	Salary (in £5k bands) £000	Performance pay and bonuses (in £5k bands) £000	Non-cash benefits (to nearest) £00	All pension related benefits (to nearest) £000	Total (in £5k bands) £000
Ms B Bassis (Chief Executive)[1]	65-70	-	-	1	70-75	170-175	5-10	-	41	220-225
Ms W Clark (Interim Chief Executive/ Chief Strategy, Digital and Information Officer)[2]	160-165	5-10	1	40	210-215	145-150	5-10	-	35	185-190
Mr J Pattullo (Interim Chair)[3]	-	-	-	-	-	40-45	-	-	-	40-45
Mr P Wyman (Chair)[4]	60-65	-	-	-	60-65	-	-	-	-	-
Ms M Banerjee (Chair)[5]	-	-	-	-	-	20-25	-	-	-	20-25
Prof P Vyas (NED)[10]	-	-	-	-	-	5-10	-	-	-	5-10
Prof D Kelly (NED)	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr C St John (NED)[6]	5-10	-	1	-	5-10	5-10	-	-	-	5-10
Prof C Craddock (NED)[7]	5-10	-	-	-	5-10	-	-	-	-	-
Mr P White (NED)	10-15	-	-	-	10-15	10-15	-	-	-	10-15
Ms H Fridell (NED)[8]	0-5	-	-	-	0-5	5-10	-	-	-	5-10
Ms J Lewis (NED)[9]	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Mr P Huggon (NED)	5-10	-	-	-	5-10	15-20	-	-	-	15-20
Dr Gail Miflin (Chief Medical Officer and Director of Clinical Services)	225-230	-	-	85	310-315	220-225	-	-	59	280-285
Mr G Methven (Director of Blood Supply)[17]	-	-	-	-	-	80-85	-	1	7	85-90
Mr R Bradburn (Director of Finance)[11]	90-95	-	31	16	110-115	145-150	-	31	35	185-190
Mr C Vincent (Chief Financial Officer)[12]	65-70	-	-	19	85-90	-	-	-	-	-
Mr A Clarkson (Director of Organ and Tissue Donation and Transplantation)	140-145	5-10	21	37	185-190	135-140	5-10	21	31	175-180
Mr I Bateman (Director of Quality)[21]	-	-	-	-	-	125-130	5-10	2	41	175-180

	Year to 31 March 2023					Year to 31 March 2022				
Name and title	Salary (in £5k bands) £000	Performance pay and bonuses (in £5k bands) £000	Non-cash benefits (to nearest) £00	All pension related benefits (to nearest) £000	Total (in £5k bands) £000	Salary (in £5k bands) £000	Performance pay and bonuses (in £5k bands) £000	Non-cash benefits (to nearest) £00	All pension related benefits (to nearest) £000	Total (in £5k bands) £000
Ms H Gillan (Director of Quality) [22]	110-115	-	1	97	205-210	10-15	-	1	3	10-15
Mr G Gogarty (Plasma Director) [23]	115-120	-	-	92	205-210	10-15	-	-	11	20-25
Ms R Mortuza (Chief Diversity and Inclusion Officer) [18]	-	-	-	-	-	70-75	-	-	33	100-105
Ms K Robinson (Director of Strategy and Transformation) [19]	-	-	-	-	-	25-30	-	-	-	25-30
Mr D Rose (Director of Donor Experience and Communications)	145-150	5-10	-	36	190-195	140-145	-	-	36	180-185
Ms P Grealish (Interim Chief People Officer) [20]	-	-	-	-	-	95-100	-	-	-	95-100
Mr S Cornes (Director of Blood Supply) [13]	40-45	-	-	-	40-45	140-145	-	-	-	140-145
Ms D McKenzie (Chief People Officer) [24]	210-215	-	-	-	210-215	110-115	-	-	-	110-115
Ms R Tinker (Interim Digital & Information Officer) [14]	70-75	-	-	14	85-90	-	-	-	-	-
Mr P O'Brien (Director of Blood Supply) [15]	105-110	-	1	-	105-110	-	-	-	-	-
Ms Janet Kidd (General Counsel) [16]	75-80	-	1	5	80-85	-	-	-	-	-

	Year to 31 March 2023					Year to 31 March 2022				
	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)	(to nearest)	(in £5k bands)	(in £5k bands)	(in £5k bands)	(to nearest)	(to nearest)	(in £5k bands)
Name and title	£000	£000	£00	£000	£000	£000	£000	£00	£000	£000

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

1 Ms B Bassis – left on 9 August 2022. Full year salary (£5k bands) is £170-175k.

2 Ms W Clark – Chief Strategy, Digital and Information Officer to 8 August 2022. Full year salary (£5k bands) is £145-150. Appointed as Interim Chief Executive on 9 August 2022. Full year salary (£5k bands) is £165-170k.

3 Mr J Pattullo – appointed as Interim Chair 7 August 2021, left on 31 March 2022.

4 Mr P Wyman – appointed as Chair 1 April 2022.

5 Ms M Banerjee – left on 6 August 2021. 2021-22 full year salary (£5k bands) is £60-65k.

6 Mr C St John – left on 31 March 2023.

7 Prof C Craddock – appointed as NED 8 June 2022. Full year salary (£5k bands) is £5-10k.

8 Ms H Fridell – left on 29 July 2022. Full year salary (£5k bands) is £5-10k.

9 Ms J Lewis – left on 31 January 2023. Full year salary (£5k bands) is £5-10k.

10 Prof J Vyas – left on 31 March 2022.

11 Mr R Bradburn – left 28 October 2022. Full year salary (£5k bands) £145-150k.

12 Mr C Vincent – appointed as Chief Financial Officer 10 October 2022. Full year salary (£5k bands) £145-150k.

13 Mr S Cornes – appointed as Director of Blood Supply on 4 October 2021. 2021-22 contractor full year salary (£5k bands) £280-285k, appointed to a permanent part-time post from 1 April 2022, left on 31 July 2022. Full year salary (£5k bands) is £125-130k.

14 Ms R Tinker – appointed as Interim Chief Digital Information Officer 15 August 2022. Full year salary (£5k bands) is £105-110k.

15 Mr P O'Brien – appointed as Interim Director of Blood Supply 25 July 2022. Full year salary (£5k bands) is £160-165k.

16 Ms J Kidd – appointed as General Counsel 5 September 2022, ceased role 31 March 2023. Full year salary (£5k bands) is £130-135k

17 Mr G Methven – left on 31 October 2021. 2021-22 full year salary (£5k bands) is £145-150k.

18 Ms R Mortuza – left on 1 December 2021. 2021-22 full year salary (£5k bands) is £90-95k.

19 Ms K Robinson – left on 20 June 2021. 2021-22 full year salary (£5k bands) is £115-120k.

20 Ms P Grealish – left on 1 September 2021. 2021-22 full year salary (£5k bands) is £235-240k.

21 Mr I Bateman – retired on 28 February 2022 and took his pension. 2021-22 full year salary (£5k bands) is £125-130k.

22 Ms H Gillan – appointed as Director of Quality on 28 February 2022. 2021-22 full year salary (£5k bands) is £90-95k.

23 Mr G Gogarty – appointed as Plasma Director on 1 March 2022.

24 Ms D McKenzie – appointed as Chief People Officer on 1 September 2021. Seconded from the UK Health Security Agency (UKHSA). Costs represent the recharge from UKHSA, including employer's national insurance and pension contributions, but excluding VAT. Figures for 2021-22 have been restated to be on the same basis as 2022-23. Full year equivalent for 2021-22 (£5k bands) was £190-195k.

b) Pension Benefits

Name and title	Real increase/ (decrease) at pension age (in £2.5k bands) £000	Real increase in lump sum at pension age (in £2.5k bands) £000	Total accrued pension at pension age at 31 March 2023 (in £5k bands) £000	Lump sum at pension age related to accrued pension at 31 March 2023 (in £5k bands) £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Real increase in Cash Equivalent Transfer Value £000
Ms B Bassis (Chief Executive)[1]	0-2.5	-	10-15	-	148	124	(1)
Dr Gail Miflin (Chief Medical Officer and Director of Clinical Services)	5-7.5	2.5-5	70-75	140-145	1,452	1,294	91
Mr R Bradburn (Director of Finance)[2]	0-2.5	-	40-45	-	720	642	23
Mr A Clarkson (Director of Organ and Tissue Donation and Transplantation)	2.5-5	-	60-65	125-130	1,092	1,002	39
Mr C Vincent (Chief Financial Officer)[3]	0-2.5	-	20-25	-	308	253	14
Ms W Clark (Interim Chief Executive/Chief Strategy, Digital and Information Officer)	2.5-5	-	10-15	-	173	126	21
Ms R Tinker (Interim Digital & Information Officer)[4]	0-2.5	-	0-5	-	42	24	2
Mr P O'Brien (Director of Blood Supply)[5]	-	-	-	-	-	-	-
Ms Janet Kidd (General Counsel)[6]	0-2.5	-	0-5	-	18	-	-
Mr D Rose (Director of Donor Experience and Communications)	2.5-5	-	5-10	-	77	46	9
Mr S Cornes (Director of Blood Supply)[8]	-	-	-	-	-	-	-
Ms D McKenzie (Chief People Officer)[7]	-	-	-	-	-	-	-
Ms H Gillan (Director of Quality)	5-7.5	7.5-10	40-45	75-80	739	615	90

Name and title	Real increase/ (decrease) at pension age (in £2.5k bands) £000	Real increase in lump sum at pension age (in £2.5k bands) £000	Total accrued pension at pension age at 31 March 2023 (in £5k bands) £000	Lump sum at pension age related to accrued pension at 31 March 2023 (in £5k bands) £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Real increase in Cash Equivalent Transfer Value £000
Mr G Gogarty (Plasma Director)[9]	2.5-5	7.5-10	35-40	95-100	n/a	749	-

1 Ms B Bassis – left on 9 August 2022.
2 Mr R Bradburn – left 28 October 2022.
3 Mr C Vincent – appointed as Chief Financial Officer 10 October 2022.
4 Ms R Tinker – appointed as Interim Chief Digital Information Officer 15 August 2022.
5 Mr P O'Brien – appointed as interim Director of Blood Supply 27 July 2022.
6 Ms J Kidd – appointed as General Counsel 5 September 2022, ceased role 31 March 2023.
7 Ms D McKenzie – appointed as Chief People Office on 1 September 2021. Seconded from the UK Health Security Agency. Not part of NHS pension scheme.
8 Ms S Cornes – left on 31 July 2022.
9 Mr G Gogarty – reached normal pensionable age during the year, a CETV at 31 March 2023 is therefore not available.

Pension table figures explained

The total accrued pension figures are the benefits of all years' membership of the scheme, not just 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.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

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.

Off-payroll engagements and their tax arrangements

HM Treasury requires all public-sector bodies to publish information about the number of off-payroll engagements that are in place where individual costs exceed £245 per day.

Table 1: Off-payroll engagements as at 31 March 2023, for more than £245 per day	Number
Number of existing engagements earning £245 per day or greater as of 31 March 2023	**62**
Of which, the number that have existed:	
for less than one year at time of reporting	50
for between one and two years at time of reporting	6
for between two and three years at time of reporting	5
for between three and four years at time of reporting	1
for four or more years at time of reporting	-

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: Off-payroll workers engaged at any point during the year ended 31 March 2023, earning £245 per day or greater	Number
Number of new engagements earning £245 per day or greater, between 1 April 2022 and 31 March 2023	**50**
Of which, the number:	
not subject to off-payroll legislation	48
subject to off-payroll legislation and determined as in-scope of IR35	2
subject to off-payroll legislation and determined as out-of-scope of IR35	-
Number of engagements reassessed for compliance or assurance purposes during the year	-
Of which, the number of engagements that saw a change to IR35 status following review	-

Table 3: Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	-
Total number 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	21

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, and this is a matter the Board keeps under constant review.

Our Equality, Diversity and Inclusion Council is responsible for overseeing our commitment to develop an intentionally inclusive and anti-racist culture and deliver our EDI objectives. The Council makes recommendations to the NHSBT Executive Team to fulfil our responsibilities and ambition on equality, diversity and inclusion and provide oversight of the EDI programme. It is responsible for agreeing its objectives and monitoring progress to ensure delivery and impact of a programme of cultural change to generate improvements in employee morale and engagement. Additionally, the Council is responsible for tracking and ensuring NHSBT's compliance with legislative, mandatory, and regulatory requirements.

We are investing in a People and Culture Programme to deliver on our strategic priorities in this area. The programme is developing workstreams to deliver an anti-racist and intentionally inclusive culture. We have published our EDI objectives, Workforce Equality Standards and Gender Pay Gap on our website.

Disability confident employer

We are recognised as a disability confident employer by the government's Disability Confident Scheme. Applicants 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, and we have published our organisational Workplace Adjustments policy. Support is also provided by Access to Work and our occupational health provider. We aim to improve the numbers of colleagues self-identifying their disability status, ensure adjustment needs are met and monitoring of career development and progression. Feedback from our 2023 staff survey is yet to be released, however we will use the insight as a source insight to monitor and track progress of disabled colleagues' working experiences and engagement. We continue to monitor and measure ourselves against the NHS Workforce Disability Equality Standard.

Gender pay gap

Our latest gender pay gap reporting as at 31 March 2022, when NHSBT employed 5,735 'relevant' staff members (including 11 directors) of whom 3,922 were female (of which six are directors) and 1,813 were male (of which five are directors).

NHSBT's overall ratio of male to female employees is approximately 32:68, which is broadly in line with the ratio in the wider NHS. However, the ratio of male to female employees is 34:66 for the upper quartile of pay.

In line with government requirements we publish our gender pay gap (GPG) figures each year on our website here:
https://www.nhsbt.nhs.uk/who-we-are/transparency/accounts/organogram-and-salaries/

Our mean gender pay gap for ordinary pay has been reduced to 5.3%, which is significantly better than other public sector organisations (NHS England 16.2%), and well below the national average of 15.4% (Office of National Statistics report, 2021). This translates into the fact that for every £1 we pay to men we pay 94.7p to women. Our median pay gap for ordinary pay has reduced to 0.2% from 3.8% (2021). This translates into the fact that for every £1 we pay to men we pay 99.8p to women.

Engagement

Our ambition is to explore shifting to a continuous listening approach. In 2022-2023 this was supported by the Senior Leadership Team regularly visiting sites across the organisation and hearing from colleagues. Our engagement score remains above 7 (out of 10): 7.6 in 2018, 7.8 in 2020, 7.7 in 2021 and 7.5 in 2022.

We are carrying out our annual survey starting in April 2023 using our Employee Experience Platform. This will give us an updated benchmark, allowing us to see the progress made on the priorities we identified in 2022. The platform we are using enables teams to use their scores to address the actions that they consider are most important for them, as well as providing an organisational picture for our executive team. In 2022 directorates also generated a range of actions to address the priorities they identified from their results. The three organisational priorities, taken from our 2022 results are:

1. Harassment, bullying and abuse
2. Disability support
3. Reward and recognition

Colleagues' contributions and achievements are recognised through a variety of schemes including Recognition of Excellence. We hold a yearly award ceremony to celebrate our colleagues' achievements.

People development

We provide our learning and development for all colleagues, including personal skills development, scientific training, and management and leadership development.

Apprenticeships

In pursuit of retaining and attracting talented colleagues our Apprenticeship Programme offers a valuable solution by providing a wide range of structured training programmes that combine on-the-job learning with classroom instruction. This year we have developed an apprenticeship strategy to align our programmes of work to deliver strategic value, maximise use of the apprenticeship levy and continue to deliver great programmes of development for our people.

We offer a wide range of apprenticeships, from level 2 to level 7 and across 48 programmes.

Over the last 12 months:

- 237 people are active 'in-learning' (49 new starts over the last 12 months)
- 9 people are in a break in learning, due to personal circumstances
- 20 people withdrew, due to either leaving the organisation or personal reasons

The apprenticeship levy carry-over into 2023-24 is £2.2m.

Scientific and clinical training

We rely on a breadth of specialists with expertise in differing scientific and clinical disciplines. During 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 support a number of Clinical Fellows and actively support training of HSSTs and other colleagues hosted within the wider NHS.

We actively supported approximately 130 other NHSBT learners through a selection of professional qualifications to achieve progress towards Biomedical Science Registration.

In addition, we supported many internal and external delegates in our scientific and transfusion medicine and pathology courses.

- 581 delegates completed our science courses (compared to 687 in 2021)
- Five-day Essential Transfusion Medicine, 101 delegates, now blended with mixture of training packages and virtual classrooms, all accessed remotely
- Fifteen-day Intermediate Transfusion Medicine, 91 delegates, now blended with days online (small number of packages with more in development and remote delivery) and two days face-to-face practical

- Five-day Practical Introduction to Transfusion Science, 179 delegates, now blended, three days accessed remotely, two days in practical face-to-face
- Five-day RCPath Pre-Exam Revision, 117 delegates, delivered fully online
- Five-day Specialist Transfusion Science Practice, 80 delegates, blended delivery, four days accessed remotely, one day practical face-to-face
- One-day Advanced Transfusion Masterclass, 13 delegates

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. The first cohort we had 37 students, 34 of which are NHS employees from across the UK, and the second cohort has 34 students. We received 92% overall student satisfaction in the National Professional Taught Experience Survey which is a huge achievement for its first year.

As we also try and raise the profile of NHSBT as a place to work, and transfusion and transplantation as exciting fields to work in, we have increased our outreach work. We have supported 26 placement students on an 11-month placement (15 in 2021-22 academic year and 11 in 2022-23), held 18 days of school age work experience placements for 18 different students at 3 different NHSBT centres, held school visits in Healthcare Science week, and reintroduced some face-to-face tours (mainly at Filton).

Our virtual blood centre tour received almost 3,000 hits in the last year. Our Bloody History of Transfusion module is also freely available. We have also developed a combined virtual reality package on blood identification and a crossmatch package, to increase the range of learning products available to staff and course participants and raise the profile of transfusion science with college and school age students. In addition, we have created a catalogue of new on-line modules to complement our courses.

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.

Our blood transfusion research units support post-graduate researchers, and many colleagues actively participate in research and development as part of their professional roles within the organisation.

Leadership development

We have continued regular conferences for senior leaders, to build the leadership community. These conferences, which are now delivered either virtually or face-to-face, provide an opportunity for the group to consider key organisational challenges and develop as a leadership group.

In recognition of the pressures senior leaders face, our coaching faculty continue to proactively provide coaching support for this group, and we are currently scoping the use of an online learning and collaboration tool for this community.

Middle manager leadership and management development

Throughout 2022-23 we continued to deliver a blended approach to developing all leaders and managers, both current and aspiring. This approach delivers a recognised standard for leadership and management skills and behaviours. During 2022-23, 903 managers from across NHSBT completed one or more of these programmes.

In support of building our middle managers capability to deliver increasingly complex operational roles, we created the online Leadership and Management Toolkit as a single point of access for key management knowledge and information, this is used regularly by 40% of the target stakeholder group.

In September 2022 we proposed to NHSBT's Executive Team an evolving transformation strategy that recognises that managers and leaders face an extraordinary challenge to rebuild an organisation that has been impacted by the pandemic, regulatory criticism and the distrust of significant colleague groups. We are now in the process of building and rolling out a high-quality package of development products and services that will enable managers and leaders to thrive in their roles and create high performing, inclusive teams.

This strategy has already improved the engagement of middle managers through the following initiatives:

- Open House for Leaders, where managers of all levels come together for short sessions to discuss, share and learn to effectively build practical solutions to tackle "wicked problems". To date over 150 managers have engaged in this initiative since its creation in November 2022
- we are currently testing the viability of a learning platform that provides direct access to managers key bite size learning. This 90-day pilot which commenced in January 2023 is already demonstrating that managers value the instant access nature of the materials and the opportunity to learn as a community of practice. It is proving to be an extremely popular approach to learning, in the first 3 weeks of the pilot over 1,200 individual items of learning were used

- our transformation strategy also recognised the value of enabling managers and leaders to access the opportunity to follow a more structured approach to their professional development. To support this, we have built close links with the NHS Leadership Academy and are currently supporting a cohort of 22 managers to test the suitability of the 15-week Edward Jenner online accredited programme

Talent management and succession planning

In exploring these areas, we identified an absence of a clear set of organisational behaviours and recognised that this is a key foundation needed to support this work. We have created a set of behaviours that are being tested in Blood Donation, Plasma and Quality, and we will learn from the testing and use this to create resources and tools that enable behaviours to be embedded throughout the employee lifecycle. We will then turn our attention to talent management, succession planning and career pathways in quarter 2 of 2023.

Trade Union relationships

NHSBT has a robust Partnership Framework with Trade Union colleagues underpinning a productive and effective approach to partnership working. Our directors meet with our lead reps and full-time officers on a quarterly basis, and the Executive Team meets with them 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 96 (81.66 whole time equivalent) Trade Union representatives to carry out national consultation/ partnership working duties. These representatives collectively spent 14,384 hours on these duties this year, reflecting the scale of change consultation within NHSBT and the 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**
96	81.66

Percentage of time spent on facility time	
Percentage of time	**Number of employees**
0%	21
1-50%	68
51-99%	2
100%	5

Percentage of pay bill spent on facility time	
Description	**£000**
Total of cost facility time	309
Total pay bill	287,877
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	20.4%

Health, safety and wellbeing

Implementation of our five-year occupational health, safety and wellbeing plan continued into the final year enabling us to meet the ISO45001 quality management standard, delivering a 12% reduction in accidents over the five years. A new strategy and plan are being developed on the basis of continual improvement, with the aim to further decrease accidents, increase wellbeing and meet regulatory requirements. Partnership working continues with Unions to identify improvements in the system, such as a training officer with responsibilities including menopause awareness and working together on accident investigations.

COVID-19 controls have focused on maintaining good ventilation in our centres and mobile collection venues, with continued good hand and respiratory hygiene. The relaxation of mask wearing and social distancing has not affected the number of absence cases. Mask wearing was re-introduced for patient and donor facing teams in October to provide extra controls, owing to a surge of infection in the community, and was relaxed again in November. We continue to support a small number of long covid absence cases.

Accountability report – our governance and accountability structure

The Directors' Report

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 this to set strategy and constructively challenge the organisation to perform at its best.

Board Members serving during the period 1 April 2022 to 31 March 2023:

Our Non-Executive Directors

Peter Wyman

Peter 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. He was a partner at PricewaterhouseCoopers LLP until 2010 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, since January 2016, as Chair of the Care Quality Commission (CQC).

Piers White

Piers has held a number of executive roles in financial services including Barclays UK and Flemings. He was awarded an MBE for public service in 2009. He currently chairs two Housing Associations, Halesworth Ltd and West Kent, and a not for profit logistics business, Courier Facilities Ltd.

Phil Huggon

Phil has held a number of executive commercial, marketing and transformation roles including with BP, MARS and Shell. He is also the Chair of the NHS Transformation Unit, Vice Chair of Healthwatch England and a Non-executive Director with the Lancashire and South Cumbria NHS FT.

Professor Deirdre Kelly

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

Charles Craddock

Charles is Professor of Haemato-oncology at the University of Birmingham, and Director of the Blood and Marrow Transplant Programme at University Hospitals Birmingham. As well as extensive research interests, he has significant Board experience, including the UK Stem Cell Strategic Oversight Committee and Anthony Nolan. He was awarded the CBE for services to medicine and medical research in 2016.

Charles St John

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

Rachel Jones (from 1 May 2023)
Rachel brings a breadth of skills and experience to the board, having held strategy, digital, transformation, data and technology executive posts in the private, public and charity sectors. In her current role as Chief Information Officer in central government she specialises in innovating operating models and continuous improvement. Previously an IBM and Deloitte management consultant, Rachel shaped and led global technical transformation programmes of scale in financial services, sporting events and retail for brands such as London 2012 Olympics, RBS, Royal London, Swinton Insurance, Aviva, Barclays, Cooperative Bank and Lookers.

Caroline Serfass (from 1 May 2023)
Caroline brings significant business, technology and transformational leadership experience gained across a range of industries including pharmaceutical, medical devices, consumer electronics and IT services. She has been a non-executive board member at NNIT since 2018.

Executive Directors

Jo Farrar – Chief Executive Officer
(from 1 June 2023)

Jo is an experienced public servant and chief executive whose early career was spent in the Home Office and Cabinet Office undertaking work around public service reform. She has held a number of leadership roles across local government and the civil service. She joins NHSBT from the Ministry of Justice where she was the Second Permanent Secretary and before that Chief Executive HM Prison and Probation Service, responsible for delivering prison, probation and youth custody services in England and Wales. Jo has been the Chief Executive of two councils – firstly Bridgend in Wales and secondly Bath and North East Somerset. Jo has a PhD in public service reform.

Wendy Clark – Interim Chief Executive (to 31 May 2023), Deputy Chief Executive (from 1 June 2023)

Wendy joined our organisation in January 2020 and became the Interim Chief Executive in August 2022. Wendy is an experienced strategy, digital and transformation leader and has worked across the private and public sectors and multiple industries, including as Chair of The Board of Trustees at Breast Cancer UK.

Helen Gillan – Director of Quality

Helen is an experienced leader within NHSBT and was General Manager of Tissue and Eye Services for 12 years. She has a track record of delivering innovation and modernising services. She was previously an auditor for the British Standards Institute, assessing quality management systems across both the public and private sector.

Carl Vincent – Chief Financial Officer

Carl joined our organisation in October 2022 from NHS Digital, where he was Chief Financial Officer from 2013-2022, leading their finance and estates functions. Before this Carl worked at the Department of Health and Social Care (DHSC) for 17 years, where he worked as an economic adviser before training as a Chartered Global Management Accountant and transitioning to finance and commercial roles. Prior to his career in the DHSC Carl studied for a MSc in Health Economics, and before becoming a student he trained and worked as a Registered General Nurse.

Rebecca Tinker – Interim Chief Digital Information Officer

Rebecca joined as Digital Delivery Director in 2020, having previously spent her career working in strategy and transformation leadership roles for global brands in retail and leisure industries – specialising in digital and commercial change.

Anthony Clarkson – Director of Organ Donation and Transplantation/Tissue and Eye Services

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.

Deb McKenzie – Chief People Officer

Deborah joined us from Public Health England where she was Chief People Officer. She has experience developing and implementing leadership programmes for the Department of Health and Social Care. As an associate partner with Accenture, she led a number of large-scale change programmes. Deborah was also Senior Responsible Officer for the Public Health Reform consultation, leading a transfer of 11,500 colleagues to the new UK Health Security Agency.

Gail Miflin – Chief Medical Officer

Dr Gail joined NHSBT in 2010 and became a Director in 2016. Previously she was a Consultant Haematologist at hospitals and NHS Trusts, specialising in treating patients with red cell disorders.

Paul O'Brien – Interim Director of Blood Supply

Paul joined us after a long career with Procter and Gamble in a variety of manufacturing and quality roles. He has worked in multiple countries across the globe where he has developed a wealth of supply chain and leadership experience.

David Rose – Director of Donor Experience and Communications

David 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.

Gerry Gogarty – Director of Plasma for Medicines

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.

Non-Executive Directors leaving in the year

Joanna Lewis – Served on the Board until 31 January 2023.
Helen Fridell – Served on the Board until 29 July 2022.
Charles St John – Served on the Board until 31 March 2023.

Details of the remuneration of senior managers of NHSBT can be found in the Remuneration and Staff Report at pages 86 to 90.

A full register of interests, updated each year, is available from the NHSBT website here: http://www.nhsbt.nhs.uk/who-we-are/transparency/accounts/board-expenses-and-interests/

Our governance structure

A review of the organisation's governance structure was undertaken following the Campbell Tickell Board Effectiveness Review report issued in October 2021, to address the recommendations pertaining specifically to the operation of Board committees. Following the review, a new governance structure was approved by the Board at its meeting in September 2022.

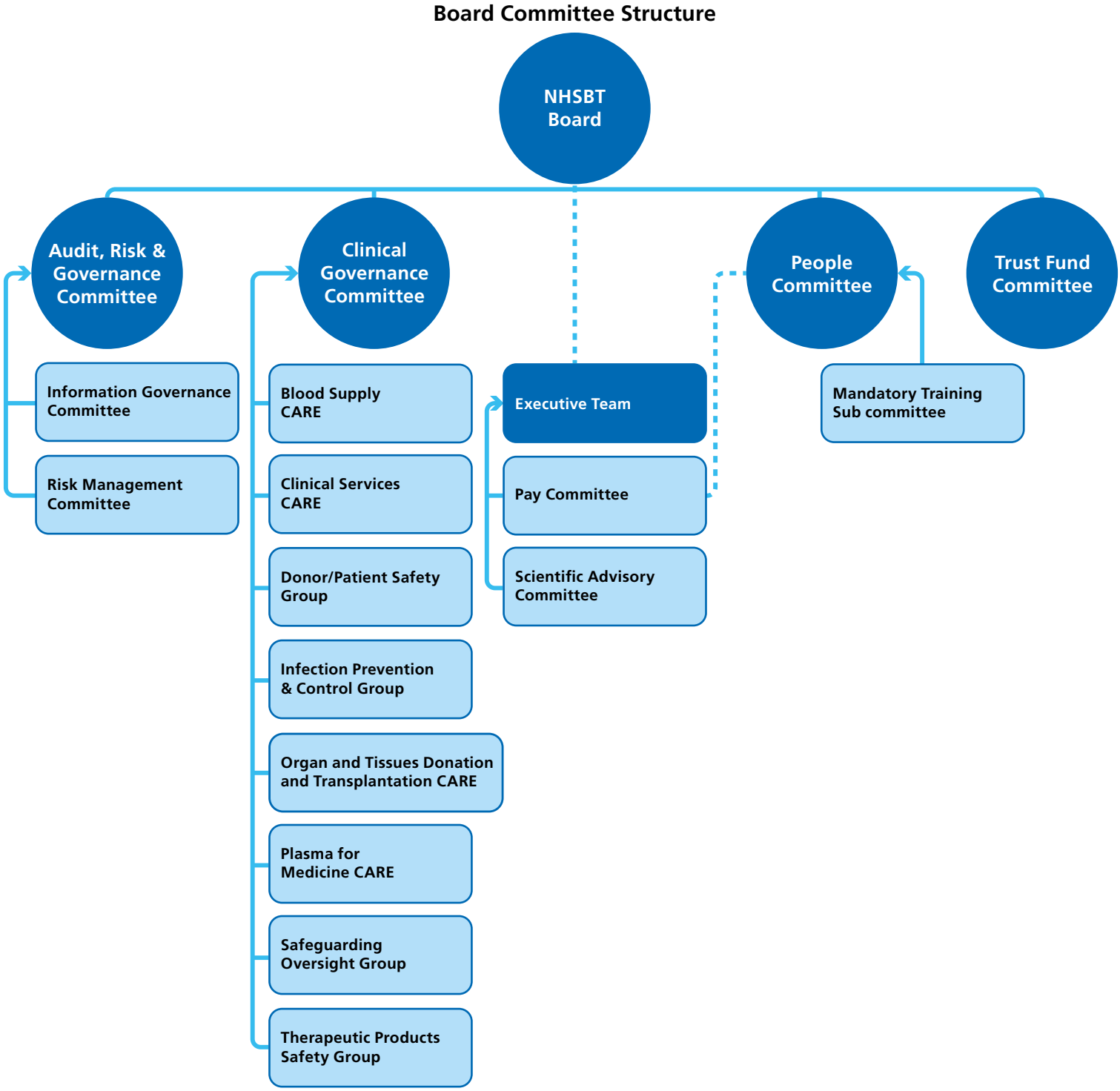
The objectives of the review were to:

- provide a consistent, high-quality service to the Board in support of its NHSBT governance responsibilities
- create a Clinical Governance Committee, directly accountable to the Board, in line with the majority of NHS boards
- reduce the amount of time attending and supporting multiple sub-committees
- streamline effective decision-making by creating a clear line of sight from the Board to the committees responsible for audit, finance, risk and clinical governance

The Board agreed to establish a Clinical Governance Committee reporting into the Board, to take over the responsibilities of the CARE Committee which was disbanded. The Clinical Governance Committee is chaired by a clinical NED.

The Board also agreed to disband the Finance and Performance Committee with certain responsibilities transferred to the Audit, Risk and Governance Committee.

The Research and Development (R&D) Committee was replaced by Scientific Advisory Board which now reports to the Executive Team. Oversight of R&D governance remains with the Chief Medical Officer and Clinical Governance Committee as part of Clinical Governance Framework assurance.



The Board

Chair: Peter Wyman

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, Director of Clinical Services, and Chief Financial Officer.

The Board met six times in the past year and attendance was as follows:

Name	Title	Total attendance/ possible attendance
Peter Wyman	NHSBT Chair	6/6
Phil Huggon	Non-Executive Director/Senior Independent Director	6/6
Charles St John	Non-Executive Director	6/6
Professor Charles Craddock (appointed 8 June 2022)	Non-Executive Director	5/5
Professor Deirdre Kelly	Non-Executive Director	4/6
Joanna Lewis (served on the Board until 31 January 2023)	Non-Executive Director	4/5
Piers White	Non-Executive Director	4/6
Wendy Clark (joined the Board January 2020, appointed Interim Chief Executive 9 August 2022)	Interim Chief Executive Officer	6/6
Carl Vincent (appointed 10 October 2022)	Chief Financial Officer	3/3
Dr Gail Miflin	Chief Medical Officer and Director of Clinical Services	6/6
Anthony Clarkson	Director of Organ and Tissue Donation and Transplantation	4/6
Helen Gillan	Director of Quality	5/6
Paul O'Brien (appointed 25 July 2022)	Interim Director of Blood Supply	4/4
Deborah McKenzie	Chief People Officer	6/6
David Rose	Director of Donor Experience and Communications	6/6
Gerry Gogarty	Director of Plasma for Medicines	6/6
Rebecca Tinker (appointed 15 August 2022)	Interim Chief Digital and Information Officer	4/4
Betsy Basis (served on the Board until 9 August 2022)	Chief Executive Officer	2/2
Rob Bradburn (served on the Board until 28 October 2022)	Director of Finance	3/3
Helen Fridell (served on the Board until 29 July 2022)	Non-Executive Director	1/2
Stephen Cornes (served on the Board until 31 July 2022)	Director of Blood Supply	0/2

Audit, Risk and Governance Committee

Chair: Piers White

The purpose of the Committee is to support the Board and Accounting Officer by reviewing assurances on governance, risk management and the control environment to ensure that they are comprehensive and reliable. The Committee is responsible for providing assurance of an effective system of corporate governance, risk management and internal control, across the whole of the organisation's activities.

This Committee comprises of independent Non-Executive Directors. Additionally, an independent Non-Executive Member was appointed in November 2022.

The Committee met five times in the year and attendance was as follows:

Name	Total attendance/possible attendance
Piers White	5/5
Professor Deirdre Kelly	5/5
Phil Huggon	4/5
Niamh McKenna (independent Non-Executive Member)	3/3
Carl Vincent	3/3
Helen Gillan	4/5
Rob Bradburn	2/2
Wendy Clark	4/4
Betsy Basis	1/2
Janet Kidd	3/3

The significant issues that the Committee considered during the year related to:

- 2021-22 Annual Report and Accounts received and considered by the committee prior to being submitted to the Board of Directors for approval
- 2021-22 Internal Audit Annual Report, including the Head of Internal Audit Opinion received and noted
- the effectiveness of risk management systems, including deep dives into strategic risks, and review of the Board Assurance Framework
- plans for internal and external audit were examined and agreed
- internal audit progress reports
- external audit progress reports
- counter fraud progress reports
- the going concern assumption was examined and recommended for approval

Clinical Governance Committee

Chair: Professor Charles Craddock

The purpose of the Committee is to provide assurance to the Board that the NHSBT has a robust framework for the management of all critical clinical systems and processes. This is a framework through which NHSBT is accountable for continuously improving the quality of services and safe-guarding high standards of care by creating an environment in which excellence in care will flourish.

The Committee held its first meeting in January 2023, and attendance was as follows:

Name	Total attendance/possible attendance
Professor Charles Craddock	2/2
Peter Wyman (ex-officio attendee)	2/2
Gail Miflin	2/2
Helen Gillan	2/2
Paul O'Brien	2/2
Anthony Clarkson	2/2
Gail Miflin	2/2

People Committee

Chair: Peter Wyman (interim)
(chaired by Joanna Lewis until 31 January 2023)

The purpose of the Committee is to support the Board in its responsibility to discharge its regulatory duties in respect of employee relations matters, to provide assurance on the board composition and organisational climate, and to approve recommendations for external recognition. The Committee fulfils the role of the Remuneration and Terms of Service Committee described in EL(94)40 of the Code of Conduct and Accountability 2004.

The Committee met four times during the year, and attendance was as follows:

Name	Total attendance/possible attendance
Jo Lewis	4/4
Helen Fridell	1/1
Deborah McKenzie	3/4
Betsy Bassis	1/1
Peter Wyman	3/3
Wendy Clark	3/3

Trust Fund Committee

Chair: Charles St John
(Phil Huggon will chair the Committee from 1 April 2023)

The Committee has responsibility for the management of funds held on trust by NHSBT, keeping the Board advised of its deliberations and actions and making recommendations to the Board on policy matters and where it has no delegated executive powers.

The Committee met three times during the year, and attendance was as follows:

Name	Total attendance/possible attendance
Charles St John	3/3
Rob Bradburn	1/1
Jo Lewis	2/2
Deb McKenzie	1/3
Carl Vincent	2/2

Research and Development Committee

The Committee was stood down in September 2022. The purpose of the Committee had been to provides strategic advice to the Board on the NHSBT research programme, approve and allocate available funding for research projects within the delegated financial limits of NHSBT. The Committee also sought assurance that appropriate arrangements were in place for staff development, research governance, agreements with academic and commercial collaborators, and protection of intellectual property. It was replaced by Scientific Advisory Board.

Finance and Performance Committee

The Committee was stood down in September 2022. It had been 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 were being managed effectively. Its responsibilities transferred to the Audit, Risk and Governance Committee.

Statement of Accounting Officer's Responsibility

Under section 29A of 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 must give a true and fair view of the state of affairs as at the end of the financial year, and the expenditure and income, total recognised gains and losses, and cash flows during the 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 financial statements

- prepare the accounts on a going concern basis, unless it is inappropriate to do so; and
- confirm that the Annual Report and Accounts as a whole are 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.

The Principal Accounting Officer of the Department of Health and Social Care 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.

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 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.

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.

Board arrangements

Information on our Board and its Committees is set out from page 117.

The Board Assurance Framework

The Board manages risk through the Board Assurance Framework (BAF). This is a document demonstrating the link between strategy, risk and assurance and is a tool for the Board to hold the organisation to account and gain assurance that the organisation can meet its objectives. The risks are established against the corporate strategy and were agreed in January 2022, and remain the organisation's strategic risks. These are the risks outlined on the BAF. The risk appetite framework was agreed in March 2022, and was reviewed at a Board workshop in March 2023. Board Committees review the risks aligned to their area at each meeting and advise the Board on

the outcome. Further details of our strategic risks, and our assessment of their status, can be found in the **Our strategic risks** section on page 68.

Board Effectiveness review

The Board commissioned an external organisation, Campbell Tickell, to undertake a Board Effectiveness review in September 2021. The report, which was issued in October 2021, made several recommendations regarding improvements which could be made both at Board level and at Audit Risk and Governance Committee level.

The Government Internal Audit Agency (GIAA) conducted an audit of the Campbell Tickell Board Effectiveness Review Report, to provide assurance on the implementation of the recommendations made. During their audit, several areas for improvement were noted, and these were reported in September 2022. The Board reviewed the action tracker in full at its meeting in March 2023, and agreed that implementing the recommendations had been completed and the actions could be closed, although it was acknowledged that the GIAA were still to review the evidence to support the closure of the actions.

The GIAA acknowledged that the key changes to the Corporate Governance arrangements could trigger a fresh Board Effectiveness review in due course and may therefore impact how the organisation chose to take forwards the findings from their audit.

An internal Board Effectiveness Review was undertaken in December 2022. The Board considered the report of findings of the review at a Board seminar on 28 March 2023. A further Board effectiveness review will be carried out later in 2023, alongside the Board Committees' effectiveness review.

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 performance 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 2022-23.

Delegations

NHSBT is designated as a Public Corporation by the Office for National Statistics. NHSBT operated on an interim set of delegations issued by our sponsor department DHSC during 2021-22, which have remained in place throughout 2022-23. These will be further reviewed during 2023-24.

Clinical governance

The Chief Medical Officer is the responsible director for clinical governance.

During 2022-23 the clinical governance structure has been reconfigured and is now overseen by the Clinical Governance Committee (CGC), which is chaired by a non-executive director, Professor Charles Craddock. The CGC is now a subcommittee of the NHSBT Board, which oversees all matters relating to clinical governance. The committee meets bi-monthly, and reviews reports and updates from directorate Clinical Audit, Risk and Effectiveness (CARE) groups embedded within three operational directorates (Clinical Services, Blood Supply, and Organ and Tissue Donation and Transplantation), 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:

- reviewing of Corporate and Directorates clinical risks, actions and mitigations
- reviewing of never events, serious incidents and other incidents involving patients, donors, and staff, ensuring that investigations are appropriate. and learning is shared
- reviewing of clinical audit strategy, plans, reports and actions

- reviewing of clinical workforce data including training compliance
- ensuring compliance with national guidance
- reviewing data collection and reporting on infectious diseases in collaboration with the UK Health Security Agency (UKHSA)
- reviewing data collection and reporting on transfusion complications
- reviewing 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 oversee organ allocation policy, which is approved 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 and Serious Incidents

A Never Event is defined by NHS England as a 'serious, largely preventable patient safety incident that should not occur if the available preventable measures have been implemented by the healthcare provider'.

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 was one never event, and four serious incidents, reported during 2022-23 (6 SIs were recorded in 2021-22) as follows:

Never Event

In September 2022, there was a 'Never Event', where unintentional ABO mismatched solid organ transplantations (kidneys and liver) for three recipients occurred. NHSBT has completed its internal investigation, but this incident is still open and currently being investigated in conjunction with the hospital and NHS England. The shared learning will be disseminated once the joint investigation has concluded.

Serious Incidents

1) In April 2022, an incorrect ABO blood group was manually entered onto the DonorPath system leading to three incorrect offers of organs (liver and kidneys) for transplantation. Although the patients had been called in for the transplants, the errors were discovered before they went to the theatre and transplants did not occur. Actions to mitigate this risk have been put in place.
2) In May 2022, a cornea was transplanted, but later a growth was identified in microbiology samples that were still being incubated in the eye bank. The patient subsequently developed an infection in the transplanted cornea and required another transplant. The source of contamination could not be identified but assurance was provided that all NHSBT processes had been followed. To reduce this risk, it was recommended that an additional antimicrobial/anti fungal rinse during cornea processing should be introduced. This is currently being reviewed by the Human Tissue Authority for approval before implementation.
3) In December 2022, deficiencies were identified in the NHSBT handover process of a patient's central line care back to the hospital referring team. These deficiencies had contributed to issues with the management of the line care, and the patient subsequently developed sepsis and a clot. Several areas for improvement are being addressed including improving documentation and communication processes. A joint investigation of the incident with the referring hospital team is ongoing.

4) In January 2023, as the result of a blood analyser machine fault, there were potentially several high titre blood products being wrongly labelled as low titre, which, if transfused, could potentially cause serious blood transfusion reaction. A lookback investigation was completed to ascertain the fate of the blood units potentially implicated, and whether any patient harm happened. A total of 694 units were identified as potentially implicated, and fortunately no patient harm occurred. The fault happened because of the machine's age, and further checks have been added to mitigate risks whilst this and other similar machines across relevant sites are being replaced, which is already ongoing as part of the Testing Development Programme.

Approach to Never Events and Incidents Management

We embrace our responsibilities for the effective management and learning from Never Events and Serious Incidents. All members of staff including agency workers and contractors are required 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. Furthermore, the Freedom to Speak Up service is also available to promote an open, trusting culture in NHSBT, and is another safe and confidential route to let the organisation know when something is not right.

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

The Duty of Candour legislation sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. We are committed to our Duty of Candour and maintaining honesty and transparency when things go wrong in line with a Just Culture.

The Patient Safety Incident Response Framework (PSIRF) is a new framework developed by NHS England, which replaces the current Serious Incident (SI) Framework. It has a much broader scope than the SI Framework and sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient/donor safety incidents, with a focus on learning and improvement. Organisations are expected to complete transition to PSIRF by Autumn 2023. We are currently planning the implementation of PSIRF at NHSBT to ensure that the organisation meets national patient/donor safety incident response standards as set in the PSIRF.

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 the Clinical Governance Committee (CGC) bi-monthly.

Eight audits have been completed during 2022-23. Risk assessment of clinical audit outcomes is similar to that used by the NHSBT internal audit function, and highlights the level of assurance provided by the findings of each clinical audit. The four potential assurance ratings are substantial, moderate, limited and unsatisfactory. Where relevant, the risk assessment is also linked to risks included in the NHSBT Risk Register.

Two clinical audits were rated as giving substantial assurance, indicating that no issues were found, these were Audit of Donor Registry Searches and Audit of Quality Incidents and Input from the Patient Blood Management Team.

Five clinical audits were rated as giving moderate assurance, indicating a small number of low impact issues had occurred. These were: Audit of On-Session Pain Management During Blood Donation; Audit of the Reporting of Infectious Disease Markers in CMT; Audit of the Use of FRM400 in Pre-Procedure Assessment for Therapeutic Apheresis Patients; Audit of Referrals of Anti-D Antibodies During Pregnancy; and Audit of IBGRL Fetal RhD Screening. All actions that arose from three of the audits have been closed, and the actions for the

remaining two audits are ongoing and being monitored through the NHSBT Quality Management System.

The Audit of Missing Information in Tissue Donor Referrals was risk assessed as providing limited assurance, highlighting either issues of low impact potentially occurring frequently, or more significant issues occurring infrequently. A working group reviewed the systems and processes for referring potential ocular tissue donors, and completed its work in December 2022. A re-audit is planned in October 2023 to assess the impact of the changes made following the original audit.

None of the clinical audits were risk assessed as 'unsatisfactory', indicating a high risk to patient or donor safety.

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. Throughout 2022-23 NHSBT continued to engage with the Inquiry, including the preparation of initial and final written submissions. The initial submission outlined recommendations that NHSBT wished the Inquiry Chair

to consider, to decide whether any additional evidence was required. The final written submission included the conclusions and recommendations that NHSBT suggested the Chair might make. On 24 January 2023, NHSBT's final oral submissions, were made by Charlie Cory-Wright KC. In addition, work continued in preparing witness statements in response to formal requests for information, supporting former colleagues in giving written and oral evidence, providing and reviewing significant volumes of information/records, both hard copy and digitised, and reviewing presentations written by the Inquiry team and expert reports.

The hearings of oral evidence by the IBI are now complete, but evidence (including statements by new and existing witnesses) is still being submitted. The Inquiry may send letters of warning to individuals and organisations likely to be criticised.

The second interim report, concerned with the framework for compensation, was published on 5 April 2023. The final report is unlikely to be published before Autumn 2023.

NHSBT has sought throughout to assist and cooperate fully with the IBI, and to fulfil its commitment to openness and transparency.

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.

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

During 2022-23 there were 29 external regulatory and accreditation inspections of our facilities, services and systems across Quality, Business Continuity and Health and Safety. Regulators such as Medicines and Healthcare products Regulatory Agency (MHRA), Human Tissue Authority (HTA), Care Quality Commission (CQC), European Federation for Immunogenetics (EFI), and accreditors for medical laboratories, occupational health and safety, business continuity, environmental and Underwriters Laboratory. The overall assessment of these inspections demonstrated that NHSBT is a safe organisation, delivering quality products and services.

Whilst it is noted that most of these inspections produced positive outcomes, six major non-compliances were raised against NHSBT following the CQC Well-Led and Regulated Activities inspections in the summer of 2022. An action plan was agreed by the Board in November 2022 and submitted to, and accepted by, the CQC in December 2022. Delivery progress against the action plan for all regulatory findings is being monitored and communicated with the inspectorate at quarterly engagement meetings.

We assure ourselves and our regulators of staff, donor and patient safety by operating a single, comprehensive quality management system (QMS) with detailed process documents and compliance records held in an electronic system (Q-Pulse). 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 proactive approach to safety and continuous improvement by implementing a robust process of self-inspection; 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. Our audit process is subject to Government Internal Audit Agency (GIAA) review.

Self-inspections of NHSBT facilities are programmed on a two-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.
- 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 (CEO) and delivers assurance to the Board, Audit Risk and Governance Committee (ARGC), Clinical Governance Committee (CGC) and Executive Team (ET) through:

- a quarterly Management Quality Review (MQR) Report to the Executive Team and ARGC
- a semi-annual Quality Performance Review (QPR) to the CEO office
- 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

As previous years, we continue to see variability in the number of overdue major incidents and events within our QMS. These are activities not closed by the agreed target date. Following an upward trend in overdue events, a number of improvement initiatives were implemented, and continue to be explored, which have resulted in improved performance.

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.

Our strategic risks are shown on page 68. 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.

As an organisation we continue to work on Government Functional Standards. Each Functional Standard has an Executive Lead and a senior management Subject Matter Expert assigned. Regular reviews are conducted on the compliance with the standards, and on the action plan to meet compliance when this is relevant. The organisation has action plans in place to meet the “shall” statements in the Functional Standards, or has made a statement to indicate that the standard is not applicable in particular instances.

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 are terms of reference for the Risk Management Committee, and a policies and procedures guide for its work.

Business continuity

We are the sole supplier for many products and services to the healthcare sector in England for Blood, and across the UK for Organs. These products and services are critical to the wider health community and patient treatment.

Key actions in the last year have been to manage blood stock challenges and industrial action. Blood stock shortage has been a concern for a considerable time during the year, but judicious management of stock, cooperation with hospitals, and careful management of donor attendance, meant that NHSBT continued to provide blood to hospitals to cover all requirements. However, in October, NHSBT called its first amber alert in its history, restricting the issue of blood, and ensuring that stock was used for non-elective procedures. This amber alert continued for a month, and service then returned to normal levels. By the end of the financial year, overall blood stock was at target levels.

Industrial action took place in the healthcare sector from January 2023, and whilst NHSBT was not initially affected, we did put in place plans for response, and worked with

the Department of Health and Social Care and NHS England to create a system-wide response to the action. When affected in February, NHSBT had Executive-level leadership in place and was working with Trade Union colleagues to understand the potential impacts. Despite the potentially fragile blood stock situation, the industrial action did not affect the recovery of blood stock.

The external audit on NHSBT's Business Continuity Management System (ISO22301) resulted in the organisation's first major non-conformity, which was raised against the risk management system. The recommendation covered some inconsistencies and gaps in the information in the risk management system, improvements in the documentation of assurances, rationale for scoring being inconsistently applied, and mitigation actions not being documented. A plan to address the issues raised has been approved by the Audit, Risk and Governance Committee, and the auditors intend to re-audit six months after the initial audit.

Data Security, Privacy, and Records Management

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 Data Security, Privacy, and Records Management (DSPR) (formerly known as the Information Governance) Team support these owners and test the

compliance and controls of their management of the assets to all relevant regulations, legislation and NHS best practice.

During the year we reported two incidents to the Information Commissioners Office (ICO), relating to information sent to the wrong individual as part of a Subject Access Request, and confidential disciplinary documents leaked to an external news service. No action was taken by the ICO on either incident, due to the satisfactory actions and controls that had been put in place by NHSBT to both manage and prevent such incidents occurring again. We also continue to 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 205 data incidents during 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 during the period. There were a number of High Severity alerts issued by NHS Digital (now NHS England), which we responded to in a compliant and timely manner. Throughout the year we have made continued progress

in augmenting and strengthening our cyber security capabilities and maturity, including the on-boarding of additional data feeds into our security monitoring platform, rolling out enhanced cyber defences across our server estate, significantly increasing our use of multi-factor authentication to access NHSBT services, bolstering our email security policy and posture, and further strengthening our external and internet facing services. This is supported by a dedicated Cyber Operations team, a security governance structure, and a Chief Information Security Officer post.

Whistleblowing policy and Freedom to Speak Up Guardian

The Freedom to Speak Up service (FTSU) is expanding to increase both capacity and diversity, to ensure we continue to work at removing barriers to speaking up. Guardian resource will increase from May 2023, with the internal recruitment of two new Guardians each spending half of their time on this role, bringing the total number of Guardians to three. The FTSU Champion network is also being expanded from five to 30, creating a diverse network of colleagues who can raise awareness and signpost concerned colleagues to the support available. Each Champion has one day of protected time to use each month as and when needed.

During the year, 137 concerns were raised through FTSU and escalated for appropriate resolution. 100% of those who fed back after being supported by the service reported that they were ‘as or more likely’ to speak

up again. 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, are launching a comprehensive management development programme, to ensure managers and leaders at all levels have the required capability. In order to ensure the Speak Up service is fully accessible to all colleagues, the FTSU Guardian attends Diversity and Inclusion 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. To ensure all employees are aware of, and have easy access to, the FTSU service, including frontline staff, a new app will be introduced in the first quarter of 2023-24, which colleagues will be able to use on their work or personal devices.

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 Specialist. We report on our plans

and work undertaken to ARGC and it also receives our self-assessment against the counter fraud standards. During 2022-23 three new cases have been reviewed and one previous case has been followed up. The three new cases comprised two cases of attempted fraud which were prevented, and one case of identity fraud where the agency worker was immediately suspended. We continue to 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.

Health and safety

Health Safety and Wellbeing (HSW) is covered in our Accountability report on page 105.

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

	2022-23				2021-22			
	HSE report	3-7 lost time	Other harm	Near miss	HSE report	3-7 lost time	Other harm	Near miss
Blood Supply	28	11	581	1,054	21	9	720	784
Clinical Services	-	-	52	53	1	-	59	61
OTDT	-	-	38	90	-	-	49	69
Donor Experience	-	-	3	1	-	-	1	1
Group Services	-	-	19	55	-	-	13	37
Plasma	1	-	9	3	-	1	32	9
Total	29	11	702	1,256	22	10	874	961

HSE report: 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.

Near miss: near miss incidents where no injury to staff.

We are pleased to see a continued reduction in harm incidents, with good progress in Blood Supply, Plasma and OTDT. The implementation of the corporate HS&W plan

has succeeded in reducing accidents over the five-year period by 12%.

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 2022 23 programme of work agreed by the ARGC covered 17 work areas, comprising 16 assurance engagements and one advisory review. During the year the plan was reviewed to ensure that it remained relevant, and six reviews were removed from the initial plan, and four additional reviews were added. Of the six that were removed, four were deferred for consideration in 2023-24, one was replaced by a broader review, and one was cancelled. Of the 17 activities, all have been completed and reported on in the period. There were a higher number of activities during 2022-23 than recent years (13 in 2021-22, 15 in 2020-21). One report was advisory (2021-22: five), of the remaining 16:

- none received a ‘substantial’ assurance opinion

(2021-22: 2)

- 8 received a ‘moderate’ assurance opinion (2021-22: 4)
- 8 received a ‘limited’ assurance opinion (2021-22: 2)

The limited assurance reports were:

1. Clinical Information Sharing

The review noted that although the organisation has a formal, structured and documented process for post donation file reviews, no management checks are performed to provide assurance that new clinical information and voice recording procedures are being complied with.

2. IT Acceptable Use Policy/Asset Management

The review identified that greater clarity could be provided to staff as to what is classified as acceptable ‘limited use’ of mobile devices, which would enable greater compliance with the policy and the effective monitoring of violations.

3. Campbell Tickell Recommendations – Follow Up

The review in September 2022 noted that the actions taken often did not directly address the recommendations in the Board effectiveness report. Additionally, there were not adequate arrangements in place to monitor, track and evidence implementation of the recommendations. As set out on page 132, the Board reviewed progress in March 2023, and were comfortable that the actions were closed,

although it was acknowledged that the GIAA were still to review the evidence to support the closure of the actions.

4. Transformation Portfolio – Portfolio Governance and Benefits Management

The review identified in particular the need for the development and implementation of a portfolio management oversight strategy along with greater clarity of roles and responsibilities to align with the governance framework.

5. Grievance Processes

The review identified a number of weaknesses in the control framework to manage grievances. The overall control framework needs to be strengthened to ensure a fair and consistent approach to the management of grievances.

6. Coroners Information Sharing

Although NHSBT takes a proactive approach to comply with coroner requirements and embed and improve coroner decision procedures, the review found that there were data integrity issues with the information system used to document compliance and communication, and there was therefore a risk of failing to respond credibly and effectively to any regulatory or legal challenges.

7. Freedom of Information/Subject Access Requests

The review found that the control framework needs be strengthened, with clearer accountability for the end-to-end process and improved processes and procedures.

8. Risk Management

The review found that risk management processes do not currently create an overarching framework for the effective and efficient oversight of risks. The design and systematic implementation of policies, procedures and practices for risk identification, assessment, treatment, monitoring and reporting require improvement.

During 2022-23, 122 recommendations were made across the 16 assurance engagements. 11 of those recommendations were closed in year. Of the 111 which remain outstanding at the 31 March 2023, 86 were not yet due and 25 were overdue. The number of recommendations made during the year exceeds the number of recommendations made in previous years, partly due to a higher proportion of assurance reviews in 2022-23 than in previous years, and partly due to the increased number of issues found during audits that require remediation. Of the 25 overdue recommendations, four were high priority and 15 were medium priority. Of the four high priority recommendations, three related to the Campbell Tickell Recommendations – Follow Up review and one related to the Transformation Portfolio – Portfolio Governance and Benefits Management review.

The Annual Report and Opinion from the Head of Internal

Audit was discussed by the Audit, Risk and Governance Committee, and based on the feedback from the committee the Executive Team discussed and agreed actions for improvement:

1. Directors will take responsibility for agreeing the scope and Terms of Reference for audits in their areas
2. all internal audit reports will be on the Executive Team agenda, for discussion if the opinion is 'Limited', or for information if the opinion is 'Moderate' or Substantial'
3. our internal auditors will be asked to arrange training for senior management teams, with a masterclass to be arranged for directorate leads
4. the list of outstanding internal audit recommendations will be reviewed monthly at an Executive Team meeting focussing on governance and performance

In addition, progress to address outstanding internal audit recommendations will be reported to every meeting of the Audit, Risk and Governance Committee for review.

Internal Audit – opinion of the Head of Internal Audit

In 2022-23, 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 that at the start of the year, the Head of Internal Audit assessed the risks to the achievement of the organisation's objectives, reviewed its risk management arrangements and the risk register, and consulted senior stakeholders. During the year, the Head of Internal Audit reviewed the plan to ensure it remained relevant, and presented recommended changes to the Audit, Risk and Governance Committee for approval.

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 and Audit, Risk and Governance Committee 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 overall opinion is that I can give Limited assurance that NHS Blood and Transplant has had adequate and effective systems of control, governance and risk management in

place for the reporting year 2022-23. This reflects the work required going forwards to ensure that the organisation is built on firm foundations. This represents a decline in opinion rating compared with previous years."

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.

The GIAA can only provide us with limited assurance for the areas covered by the reviews they completed during the year. We have started to address the recommendations from their reviews, and as set out above I can rely on several other sources of assurance

around our controls, including the Audit, Risk and Governance Committee's work during the year reviewing the effectiveness of risk management systems, deep dives into strategic risks and review of the Board Assurance Framework. Additionally, the work of other Board committees, inspections by our external regulators and clinical audits, self-inspections and internal quality audits of our regulated activities, and regular reporting on delivery and financial matters to the Executive Team provide a wide range of alternative sources of assurance which lead me to believe that we have maintained effective control throughout the period.

Accountability report – Parliamentary accountability and audit report

Basis for accounts preparation

The financial statements for the year ended 31 March 2023 have been prepared as directed by the Secretary of State for Health and Social Care in accordance with section 29A of the National Health Service Act 2006, and in a format as instructed by the Department of Health and Social Care with the approval of HM 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 on the regularity of income and expenditure. The cost of audit work performed was £106,000 (2021-22: £110,050). There were no payments to the C&AG for non-audit work during 2022-23 or 2021-22.

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.

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 2023		31 March 2022	
	No. Cases	£000	No. Cases	£000
Cash losses	-	-	-	-
Exchange rate fluctuations	-	-	-	-
Losses of pay, allowance and superannuation benefits	56	8	43	23
Losses of accountable stores	74	597	65	165
Claims waived or abandoned	23	-	36	4
Fruitless payments and Constructive losses	-	-	8	(10)
Total	**153**	**605**	**152**	**182**

The rise in losses of accountable stores was mainly due to the write-off of time expired harnesses, originally purchased during the ramp-up of convalescent plasma activities during the pandemic and subsequently used elsewhere in the business where possible, and the write-

off of test kits on the introduction of new test machines, where continuity of testing during the changeover had to be ensured.

Special Payments	31 March 2023		31 March 2022	
	No. Cases	£000	No. Cases	£000
Compensation payments	6	31	12	32
Ex gratia payments	10	139	7	80
Total	**16**	**170**	**19**	**112**

Expenditure on consultancy

Consultancy expenditure during 2022-23 was £nil (2021-22: £150k). As required, this disclosure uses the definition of consultancy set out in the HM Treasury Financial Reporting Manual, and therefore 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 19 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 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 using forecast sales volumes for the coming year, to underpin a fixed capacity plus variable cost. Prices include the full cost of providing products and services to the NHS (including a return on the cost of capital employed). Note 2 of the financial statements shows the contribution per business unit and is subject to audit.

This accountability report was previously agreed by Wendy Clark as Interim Chief Executive, and on the basis of the assurances provided to me I hereby sign the Accountability Report (including the Governance Statement) from pages 74 to 166.

Dr Jo Farrar CB OBE **5 July 2023**

Chief Executive and Accounting Officer

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of NHS Blood and Transplant for the year ended 31 March 2023 under the National Health Service Act 2006. The financial statements comprise NHS Blood and Transplant's:

- Statement of Financial Position as at 31 March 2023;
- Statement of Comprehensive Net Expenditure, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows 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 2023 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.

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 for 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 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.

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 of the 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.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If 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.

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 Our Performance and Our Accountability Reports.

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

- adequate accounting records have not been kept by NHS Blood and Transplant or returns adequate for my audit have not been received from branches not visited by my staff; or
- I have not received all of the information and explanations I require for my audit; or
- the financial statements and the parts of the 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;
- providing the Comptroller and Auditor General with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the Comptroller and Auditor General with additional information and explanations needed for his audit;
- providing the Comptroller and Auditor General with unrestricted access to persons within NHS Blood and Transplant from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error;
- ensuring that the financial statements give a true and fair view and are prepared in accordance with Secretary of State directions made under the National Health Service Act 2006;

- ensuring that the annual report, which includes the Our People Report, is prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- 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.

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, I:

- considered the nature of the sector, control environment and operational performance including the design of NHS Blood and Transplant's accounting policies;
- inquired 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;
  - detecting and responding to the risks of fraud; and

- 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 with the National Health Services Act 2006 and Managing Public Money;
- inquired of management, NHS Blood and Transplant's Head of Internal Audit and those charged with governance whether:
  - they were aware of any instances of non-compliance with laws and regulations;
  - they had knowledge of any actual, suspected, or alleged fraud;
- discussed with 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. I focused 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, employment law, pension legislation and tax legislation.

Audit response to identified risk

To respond to the identified risks resulting from the above procedures:

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management and the Audit, Risk and Governance Committee concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the Board and internal audit reports; and
- in addressing the risk of fraud through management override of controls, I tested the appropriateness of journal entries and other adjustments; assessed whether the judgements on estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

I 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.

Report

I have no observations to make on these financial statements.

Gareth Davies **Date: 10 July 2023**

Comptroller and Auditor General

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

Our finances

Statement of Comprehensive Net Expenditure for the year ended 31 March 2023

	Note	2022-23 £000	2021-22 £000
Gross Income			
Income from sale of goods and services	2 & 3	394,469	370,812
Other operating income	2 & 3	41,325	31,386
		435,794	**402,198**
Expenditure			
Staff costs	4	(300,095)	(279,038)
Operating expenses	5	(208,547)	(213,426)
Depreciation, amortisation & impairment charges	9, 10 & 11	(19,054)	(11,589)
Other operating expenditure	6	(30,065)	(30,071)
		(557,761)	**(534,124)**
Net operating expenditure before interest		**(121,967)**	**(131,926)**
Finance expense		(1,106)	(955)
Net operating expenditure after interest	2	**(123,073)**	**(132,881)**
Other comprehensive net expenditure Items which will not be reclassified to net operating costs:			
Net gain on revaluation of property, plant and equipment	9	7,320	11,290
Net gain on revaluation of right of use assets	10	3,213	-
Total comprehensive net expenditure		**(112,540)**	**(121,591)**

Notes 1 to 23 form part of these accounts.

All income and expenditure is derived from continuing operations.

Statement of Financial Position as at 31 March 2023

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Property, plant and equipment	9	191,372	240,479
Right of use assets	10	73,728	-
Intangible assets	11	10,954	6,445
Financial assets	13	437	198
Total non-current assets		**276,491**	**247,122**
Current assets			
Inventories	12	18,331	17,276
Trade and other receivables	13	75,387	43,359
Cash and cash equivalents	14	50,685	64,676
Total current assets		**144,403**	**125,311**
Current liabilities			
Trade and other payables	15	(75,485)	(71,463)
Provisions for liabilities and charges	16	(995)	(866)
Obligations under leases	17	(5,407)	(298)
Total current liabilities		**(81,887)**	**(72,627)**
Total assets less current liabilities		**339,007**	**299,806**
Non-current liabilities			
Provisions for liabilities and charges	16	(304)	(395)
Obligations under leases	17	(24,332)	(8,253)
Total non-current liabilities		**(24,636)**	**(8,648)**
Total assets less employed		**314,371**	**291,158**
Financed by			
General Fund		211,208	194,779
Revaluation Reserve		103,163	96,379
Total taxpayers' equity		**314,371**	**291,158**

Notes 1 to 23 form part of these accounts.

The financial statements on pages 180 to 185 were recommended by the Audit Risk and Governance Committee on 29 June 2023 and approved by the Board in accordance with powers within the NHSBT Standing Orders, and are signed by the Accounting Officer, Dr Jo Farrar as Chief Executive.

Dr Jo Farrar CB OBE **5 July 2023**

Chief Executive and Accounting Officer

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2023

	Note	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2022		194,779	96,379	**291,158**
Changes in taxpayers' equity for 2022-23				
Net expenditure for the financial period		(123,073)	-	**(123,073)**
Net gain on revaluation of property, plant and equipment	9	-	7,320	**7,320**
Net gain on revaluation of right of use assets	10	-	3,213	**3,213**
Transfer between reserves		3,749	(3,749)	**-**
Total recognised income and expense for 2022-23		**(119,324)**	**6,784**	**(112,540)**
Revenue Grant from DHSC		125,253	-	**125,253**
Capital Grant from DHSC		10,500	-	**10,500**
Balance at 31 March 2023		**211,208**	**103,163**	**314,371**

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**

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.

Statement of cash flows for the year ended 31 March 2023

	Note	2022-23 £000	2021-22 £000
Cash flows from operating activities			
Net operating costs before interest		(121,967)	(131,926)
Adjustments for non-cash transactions	18	19,353	12,040
(Increase)/decrease in trade and other receivables	13	(32,267)	1,418
(Increase)/decrease in inventories	12	(1,055)	36
Increase in trade and other payables	15	4,022	18,775
Decrease in capital accruals	15	389	233
Provisions utilised	16	(160)	(168)
Net cash (used in) operating activities		**(131,685)**	**(99,592)**
Cash flows from investing activities			
Purchase of plant, property and equipment		(6,213)	(6,875)
Purchase of right of use assets		(1,109)	-
Purchase of intangible assets		(4,934)	(4,719)
Proceeds from disposal of non-current assets		-	-
Net cash (used in) investing activities		**(12,256)**	(11,594)
Cash flows from financing activities			
Grant from Department of Health and Social Care		135,753	123,866
Capital element paid in respect of finance leases		(4,667)	(267)
Interest paid in respect of finance leases		(1,136)	(948)
Net cash generated from financing activities		**129,950**	122,651
(Decrease)/increase in cash and cash equivalents		(13,991)	11,465
Cash and cash equivalents at 1 April		64,676	53,211
Cash and cash equivalents at 31 March	14	**50,685**	**64,676**

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 2022-23 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 NHSBT for the purpose of giving a true and fair view has been selected. The particular policies adopted follow. 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, right of use assets, intangible assets, inventories and certain financial assets and financial liabilities.

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.

1.2.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see 1.2.2), 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 Fund, 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).
- On implementation of IFRS 16, management had to make assumptions over the estimated lease term of several properties whose contracts were due to expire within the next three years, and those which were under review at the time of implementation. In line with IFRS 16 paragraph 18 and B34,

management had to consider the commercial reality and business plans as the basis to estimate the potential lease term on a case by case basis.

1.3 Subsidiaries, associates and joint arrangements

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 31 March 2023.

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 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.

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 31 March 2023.

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 31 March 2023.

1.4 Operating segments

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

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 and services provided is recognised when (or as) performance obligations are satisfied by transferring the promised goods or 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.

1.5.1 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 2022-23 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.

1.5.2 Revenue from project contracts

NHSBT receives income from contracts for projects. For example, research and development, and clinical trials. The customers are mainly 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 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 Other income, funding and grants

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; and is measured as the sums due under the sale contract 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.

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, except right of use assets acquired under a lease, where the irrecoverable VAT is not included in the value of the non-current asset, but is expensed at the point at which it falls due in line with IFRIC 21. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Capital charges

An annual charge, reflecting the cost of capital utilised by NHSBT, is payable to the Department of Health and Social Care (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 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 financial statements. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the financial statements.

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.

1.11 Property, plant and equipment

Note 1.11.1 Recognition

Property, plant and 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 costWhere 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.

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.

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 an expense 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.

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.

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 is 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 31 March 2023.

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 appropriate ONS indices. 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.

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.

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.

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, where is meets the criteria for capitalisation.

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.

1.13 Depreciation, amortisation and impairments

1.13.1 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 assets, and residual values, are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.13.2 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 the service potential of the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the general 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 general 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.

1.13.3 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 below:

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

The estimated useful lives of 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 in the same way as 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.

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

1.16.1 Transition from IAS 17 and IFRIC 4 to IFRS 16

In accordance with the FReM, NHSBT adopted IFRS 16 on 1 April 2022. Previously, under IAS 17 and IFRIC 4, each lease contract was recognised either as a finance lease or an operating lease, with the appropriate accounting treatment dependent on the recognised category of lease.

On 1 April 2022, most lease contracts were recognised on the Statement of Financial Position as right-of-use assets and lease liabilities. For leases previously classified as operating leases, the lease cost changed from an in-period operating lease expense, to recognition of depreciation of the right-of-use asset and an interest expense on the lease liability.

The transition to IFRS 16 has been completed in accordance with paragraph C5(b) of the standard, applying IFRS 16 requirements retrospectively and recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These were as follows:

- NHSBT has applied the practical expedient offered in paragraph C3 of the standard to apply IFRS 16 to only contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 and IFRIC 4, and not to those that were identified as not containing a lease under previous leasing standards.
- NHSBT has measured the right-of-use assets for leases previously classified as operating leases per IFRS 16 C8(b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments. A lease liability was recognised equal to the present value of the remaining lease payments discounted using an incremental borrowing rate. The discount rate applied at the transition date was based on the HM Treasury incremental borrowing rate of 0.95%.
- No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9(a) of the standard, low value for NHSBT being below £5,000.

- The transitional provisions have not been applied to operating leases whose term ends within 12 months of the date of initial application, in accordance with paragraph C10(c) of the standard. Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with paragraph C10(e) of the standard.

Due to transitional provisions employed, the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 were not employed for leases in existence at the initial date of application. Leases entered into on or after the 1 April 2022 were assessed under the requirements of IFRS 16.

1.16.1.1 Elections and expedients

Following transition, NHSBT has applied the following elections and expedients in applying IFRS 16:

- The measurement requirements under IFRS 16 were not applied to leases with a term of 12 months or less under paragraphs 6 – 8 of the standard.
- The measurement requirements under IFRS 16 were not applied to leases where the underlying asset was of a low value, which for NHSBT is considered to be those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5(b) of the standard.
- In alignment with other DHSC bodies, NHSBT will not apply IFRS 16 to intangible assets, but will apply the treatment described in accounting policy 1.12.

HM Treasury has adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16. NHSBT is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. NHSBT is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

1.16.1.2 NHSBT as lessee

At the commencement date of a leasing arrangement the lessee recognises a right-of-use asset and corresponding lease liability. Subsequently, property, plant and equipment held under finance leases are revalued as described in accounting policy 1.11.2, except where the frequency of rent reviews serve as a suitable proxy for ensuring that the cost of the lease reflects market value.

NHSBT considers that the cost model (measurement of the value of right-of-use assets by reference to the lease

liability) is a reasonable proxy for fair value for non-property leases, due to their short lease terms, and for property leases of less than 15 years which have rent reviews at regular intervals of three to five years. Such regular rent reviews ensure that the lease, and the associated right-of-use assets, reflect market conditions. Additionally, right-of-use assets generally have shorter lives and lower values than the associated underlying assets and, as set out in the HM Treasury Financial Reporting Manual, cost is an acceptable proxy for assets with shorter economic lives or lower values.

Right-of-use assets are depreciated on a straight-line basis from the date of transition, or the lease commencement date if later, to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive net expenditure.

Irrecoverable VAT is expensed in the period to which it relates and therefore is not included in the measurement of the lease liability and consequently not included in the value of the right-of-use asset.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or where the lease contained a low value underlying asset.

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

Disclosures regarding right-of-use assets and lease liabilities, and other required disclosures, can be found in Note 10 and Note 17. The impact of the first-time application of IFRS 16 on the 2022-23 financial statements can be found in Note 10.

1.16.2 Prior-year IAS 17 and IFRIC 4

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

1.16.2.1 NHSBT as lessee

Property, plant and equipment held under finance leases was 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 was revalued as described in accounting policy 1.11.2. Lease payments were 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 were recognised in calculating NHSBT's net operating cost.

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

Where a lease was for land and buildings, the land and building components were 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.

At 31 March 2023 a very small number of units remained for the Convalescent Plasma (CVP) programme, which are expected to be used for clinical trials, and are therefore held at nil value. Plasma for Diagnostics (PFD) is held at cost. Plasma for Medicines (PFM) continues to be held at nil value, as at 31 March 2023 no sales contracts are in place.

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 Net Expenditure in the period in which they arise.

1.20 Expenditure on employee benefits

1.20.1 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.

1.20.2 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.

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

1.20.3 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 1.70% (2021-22: minus 1.30%) 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:

A nominal short-term rate of 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

A nominal medium-term rate of 3.20% (2021-22: 0.70%) 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 3.51% (2021-22: 0.95%) 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 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

1.21.1 Clinical Risk Pooling

NHS Resolution operates a risk pooling scheme under which NHSBT pays an annual contribution to NHS Resolution, 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 are disclosed in Note 16 but is not recognised in NHSBT accounts.

1.21.2 Non-clinical Risk Pooling

NHSBT also participates in NHS Resolution's Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk 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

NHSBT only has 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.

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 or 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 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 164)

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

IAS 8 requires disclosure in respect of new accounting standards, amendments and interpretations that are, or will be, applicable after the accounting period.

These Standards are still subject to HM Treasury FReM adoption:

IFRS 14 Regulatory Deferral Accounts

Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016, and therefore not applicable to NHSBT.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM, and is expected to be adopted from April 2025. We do not anticipate any significant impact from this standard.

Note 2 Operating segments – 2022-23

For the year 1 April 2022 to 31 March 2023	Total	Blood Components (inc. R&D)	Tissue and Eye Services	Organ Donation & Transplant	Pathology	Therapeutic Apheresis Services (TAS)	Cell, Apheresis and Gene Therapies (excl. TAS)	Plasma
	£000	£000	£000	£000	£000	£000	£000	£000
Revenue								
Provision of products and services	**394,469**	310,446	16,269	-	36,034	13,398	17,846	476
Income from Scottish Parliament	**6,823**	-	-	6,823	-	-	-	-
Income from National Assembly for Wales	**4,721**	-	-	4,721	-	-	-	-
Income from Northern Ireland Assembly	**2,178**	-	-	2,178	-	-	-	-
Other income	**27,603**	7,141	29	4,107	1,665	473	4,210	9,978
Programme funding from the DHSC	**125,254**	36,670	886	74,731	2,506	268	3,057	7,136
Total revenue	**561,048**	**354,257**	**17,184**	**92,560**	**40,205**	**14,139**	**25,113**	**17,590**
Expenditure								
Variable costs	**(59,722)**	(37,749)	(2,798)	(3,521)	(6,224)	(4,208)	(4,212)	(1,010)
Direct costs	**(275,866)**	(145,755)	(10,587)	(70,544)	(21,442)	(5,964)	(13,793)	(7,781)
Direct support costs	**(148,183)**	(112,830)	(3,583)	(11,293)	(7,892)	(1,503)	(7,781)	(3,301)
Movement in value of stocks	**1,701**	1,078	(342)	-	-	-	-	965
Other support costs	**(43,394)**	(26,183)	(1,495)	(7,971)	(3,147)	(1,040)	(2,283)	(1,275)
Total expenditure	**(525,464)**	**(321,439)**	**(18,805)**	**(93,329)**	**(38,705)**	**(12,715)**	**(28,069)**	**(12,402)**
Operating surplus/ (deficit) for the financial period before transformation	**35,584**	32,818	(1,621)	(769)	1,500	1,424	(2,956)	5,188
Transformation costs	(20,337)	(7,929)	-	(6,900)	(871)	(364)	(636)	(3,637)
Operating surplus/ (deficit) for the financial period	**15,247**	**24,889**	**(1,621)**	**(7,669)**	**629**	**1,060**	**(3,592)**	**1,551**
Add: notional cost of capital included in expenditure above	7,807							
Less: programme funding from DHSC	(125,253)							
Less: capital charges paid to the DHSC	(20,874)							
Net expenditure	**(123,073)**							

Note 2.1 Operating segments – 2021-22

For the year 1 April 2021 to 31 March 2022	Total	(Re-presented)* Blood Components (inc. R&D)	Tissues and Eye Services	Organ Donation & Transplant	Diagnostics	Therapeutic Apheresis Services	Stem Cells	(Re-presented)* Plasma
	£000	£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**	7,647	20	2,253	1,370	458	4,795	2,224
Programme funding from the DHSC	**111,866**	7,179	398	71,320	742	243	4,724	27,260
Total revenue	**514,063**	**308,213**	**15,461**	**86,191**	**35,731**	**13,208**	**25,775**	**29,484**
Expenditure								
Variable costs	**(53,574)**	(36,157)	(2,586)	(3,270)	(5,618)	(3,383)	(3,944)	1,384
Direct costs	**(266,594)**	(126,087)	(10,153)	(63,554)	(17,534)	(5,267)	(13,256)	(30,743)
Direct support costs	**(125,148)**	(97,362)	(3,157)	(9,999)	(7,398)	(1,288)	(5,944)	-
Movement in value of stocks	**(2,090)**	(2,306)	(860)	-	-	-	-	1,076
Other support costs	**(51,211)**	(29,883)	(2,020)	(11,244)	(3,871)	(1,259)	(2,934)	-
Total expenditure	**(498,617)**	**(291,795)**	**(18,776)**	**(88,067)**	**(34,421)**	**(11,197)**	**(26,078)**	**(28,283)**
Operating surplus/ (deficit) before transformation	**15,446**	16,418	(3,315)	(1,876)	1,310	2,011	(303)	1,201
Transformation costs	(24,209)	(12,074)	-	(10,499)	(704)	(294)	(513)	(125)
Operating surplus/ (deficit) for the financial period	**(8,763)**	**4,345**	**(3,315)**	**(12,375)**	**606**	**1,717**	**(816)**	**1,075**
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)**							

* Plasma was reported as part of Blood Components in 2021-22, but has been shown separately above to enable comparison with the reporting segments for 2022-23.

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 Components provides blood and blood components, primarily to NHS hospitals and also includes research and development activity.

Organ and Tissue Donation and Transplantation includes:-

Tissues and Eye Services retrieves and provides human tissue products.

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.

Clinical Services includes:

Pathology which provides specialist diagnostic laboratory services (Red Cell Immunohematology and Histocompatibility & Immunogenetics) and also reagents.

Therapeutic Apheresis Services provide a range of therapeutic apheresis services (e.g. plasma exchange, photopheresis) direct to patients.

Cell, Apheresis and Gene Therapies includes Cellular and Molecular Therapies, the British Bone Marrow Registry (BBMR) and the Cord Blood Bank (CBB).

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.

Plasma. In 2022-23 Plasma was funded partially through the remaining non-recurring DHSC programme funding for Plasma for Medicines, and also through sales of Plasma for Diagnostics.

Group Services expenditure, including Finance, People, ICT and Quality, is reported within 'Other support costs'. The costs of these services are allocated on the basis of activity in costing and pricing calculations.

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

Note 3 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 2022-23 a fixed and variable pricing arrangement was in place, which alleviates the requirement for rebates. 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 DHSC and other UK 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

	2022-23 £000	2021-22 £000
Blood and components	317,587	303,258
Pathology	37,699	34,989
Tissues	16,298	15,063
Stem cells	22,056	21,051
Therapeutic apheresis services	17,829	12,965
Organ donation and transplantation	13,871	14,872
Plasma	10,454	-
Total income from activities per SoCNE	**435,794**	**402,198**

3.2 Income by source

	2022-23 £000	2021-22 £000
Department of Health and Social Care	13,405	10,769
NHS Trusts	133,096	126,644
NHS Foundation Trusts	238,044	222,841
NHS Clinical Commissioning Groups/Integrated Care Boards	114	38
Other Government bodies	19,002	17,891
Non-NHS	32,133	24,015
Total income from activities per SoCNE	**435,794**	**402,198**

£18.4m of the Other Government bodies income shown above is contractual income and grant funding from devolved administrations (2021-22: £16.6m).

3.3 Revenue Grant in Aid from DHSC

	2022-23 £000	2021-22 £000
Programme funding – organ donation and transplantation	70,633	71,320
Programme funding – organ donation deemed consent	2,041	-
Programme funding – pathology and stem cells	4,162	5,709
Programme funding – convalescent plasma	-	6,871
Programme funding – plasma for medicine	6,807	20,391
Programme funding – corporate	41,110	7,177
Programme funding – tissue and eye services	500	398
Total revenue grant from DHSC per SoCTE	**125,253**	**111,866**

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

Note 4 Staff costs

	2022-23 £000	2021-22 £000
Salaries and wages*	236,598	225,521
Social security costs**	24,661	19,123
Employer pension contributions***	38,836	34,394
Total	**300,095**	**279,038**

* Includes temporary staff (including agency) £25.3m (2021-22 £35.0m) and termination benefits £0.5m (2021-22 £1.7m), and is net of recoveries in respect of outward secondments £1.2m (2021-22 £1.5m).
** Includes the apprenticeship levy £1.0m (2021-22 £1.0m).
*** Includes contributions to NHS Pensions £38.8m (2021-22 £34.3m) and to NEST £0.9m (2021-22 £0.1m).

On 1 April 2019, the employer contribution rate for the NHS Pension Scheme increased by 6.3%. The additional cost £11.8m (2021-22 £11.0m) was paid by NHSBT and matched by programme funding from DHSC.

In addition, £1.1m (2021-22 £2.8m) of staff costs were capitalised as directly attributable to the development of the new Pulse system (an intangible asset) under the 'Blood Technology Modernisation' (BTM) project (£0.7m NHSBT staff and £0.4m agency staff).

Note 4.1 Pension costs

NHS Pension Schemes

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/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 for Health and Social Care 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 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 and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability at 31 March 2023, is based on valuation data at 31 March 2022, updated to 31 March 2023 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. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

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.

National Employment Savings Trust

Under the terms of the Pensions Act 2008 NHSBT is required to provide a pension scheme for employees not enrolled in the NHS Pension Schemes. 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 2022-23 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 2023 there were 201 employees enrolled in the NEST scheme (195 at 31 March 2022).

Note 5 Operating expenses

	2022-23 £000	2021-22 £000
Other staff related costs	11,971	8,382
Consumable supplies	68,847	64,105
Maintenance of buildings, plant and equipment	18,313	17,794
Rent and rates	10,752	15,171
Transport costs	21,121	17,742
External contractors	30,339	41,081
Purchase and lease of equipment and furniture	6,492	8,732
Utilities and telecommunications	13,577	9,851
Media advertising	2,662	2,494
Organ Donation Transplant Scheme payments	21,183	21,111
Professional fees *	3,184	6,852
External auditors' remuneration: audit fees **	106	111
Total	**208,547**	**213,426**

* 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	2022-23 £000	2021-22 £000
Capital charges paid over as cash to DHSC		20,874	20,367
Capital non-cash: loss on disposal of fixed assets *	8	66	14
Capital non-cash: impairments **	9	581	-
Miscellaneous ***		8,544	9,690
Total		**30,065**	**30,071**

* Loss on disposal of fixed assets relates to the book losses of plant and machinery (£66k) due to the annual asset verification exercise.
** Impairment relates to an issue involving reinforced autoclaved aerated concrete at our Southampton site.
*** Includes £5.2m (2021-22 £4.9m) relating to IT software licence fees and £1.3m (2021-22 £1.5m) to insurance costs.

Note 7 Operating leases

This note discloses costs and commitments incurred in lease arrangements which did not meet the criteria to be recognised under IFRS 16 Leases.

Our operating lease commitments relate to property, rents and vehicles. The vehicle commitments are based on 327 staff lease cars. The property commitments are based on four properties.

NHSBT as lessee	2022-23 £000	2021-22 £000
Payments recognised as an expense		
Lease and rental payments *	4,733	12,275
Total future minimum lease payments payable		
Not later than one year	1,022	6,983
Later than one year and not later than five years	977	10,485
Later than five years	29	529
Total	**2,028**	**17,997**

* 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.

The reduction in operating lease expenses and future minimum lease payments is mainly driven by the adoption of IFRS 16 from 1 April 2022, which has resulted in most leases being reclassified as finance leases. Only those leases where the underlying asset have a value of £5k or less, or which have term of 12 months or less, or those where substantially all the economic benefits of the assets will not be obtained by NHSBT over the period of the lease, are now treated as operating leases.

Note 8 Other gains/(losses)

	2022-23 £000	2021-22 £000
Loss on disposal of non-current assets	(66)	(14)
Loss on disposal of plant and equipment	**(66)**	**(14)**

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

Note 9 Property, plant and equipment – 2022-23

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/cost at 1 April 2022	26,253	176,305	8,396	59,543	10	20,045	290,552
Adoption of IFRS 16 – reclassification to Right of Use Assets	(10,107)	(39,689)	-	-	-	-	(49,796)
Restated balance at 1 April 2022	**16,146**	**136,616**	**8,396**	**59,543**	**10**	**20,045**	**240,756**
Additions purchased	-	119	-	5,603	-	102	5,824
Reclassification*	-	8,395	(8,396)	(68)	-	68	(1)
Indexation	-	-	-	560	-	-	560
Other in year revaluations	(100)	2,773	-	-	-	-	2,673
Impairments	-	(581)	-	-	-	-	(581)
Disposals	-	-	-	(2,008)	-	-	(2,008)
Valuation/cost at 31 March 2023	**16,046**	**147,322**	**-**	**63,630**	**10**	**20,215**	**247,223**
Accumulated depreciation at 1 April 2022	-	2,211	-	42,539	10	5,312	50,072
Provided during the year	-	4,792	-	3,371	-	3,643	11,806
Reclassification	-	-	-	(2)	-	2	-
Indexation	-	-	-	407	-	-	401
Other in year revaluations	-	(4,494)	-	-	-	-	(4,494)
Disposals	-	-	-	(1,940)	-	-	(1,934)
Accumulated depreciation at 31 March 2023		**2,509**	**-**	**44,375**	**10**	**8,957**	**55,851**
Net book value at 1 April 2022	26,252	174,094	8,396	17,004	-	14,733	240,479
Net book value at 31 March 2023	**16,046**	**144,813**	**-**	**19,255**	**-**	**11,258**	**191,372**

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2023 comprises:							
Owned assets	16,046	108,668	-	19,255	-	11,258	155,227
Subsequent expenditure on or relating to assets acquired under a Finance Lease	-	36,145	-	-	-	-	36,145
Held on Finance Lease	-	-	-	-	-	-	-
	16,046	**144,813**	**-**	**19,255**	**-**	**11,258**	**191,372**
Revaluation reserve	**5,944**	**62,800**	**-**	**428**	**-**	**98**	**69,270**

*Reclassified to Note 11 Intangibles

Note 9.1 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	23	2,155	-	40,907	10	4,295	**47,390**

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
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**	**-**	**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**

Note 9.2 Revaluation of property, plant and equipment

NHSBT undertook a desktop revaluation of land and buildings as at 31 March 2023. 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 2019. We commissioned and used a desktop revaluation at the end of March 2023.

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. There are two exceptions, Gloucester Oak House and London West End which are valued at their Existing Use Value (EUV), as these are non-specialised assets where market-based evidence can be used for valuations.

The revaluation of NHSBT owned land and building resulted in an increase in value of £9.8 million, after impairments.

The carrying amount of land and buildings that would have been recognised had the assets been carried under the cost model is £97.4m for buildings, and £16m for land.

Note 10 Right of use assets – 2022-23

	Land £000	Buildings £000	Transport Equipment £000	Total £000
Valuation/cost at 1 April 2022	-	-	-	**-**
Effect of adoption of IFRS 16:				
Leases previously treated as operating leases	29	21,471	4,932	**26,432**
Reclassification of finance leases from property, plant and equipment	10,107	39,689	-	**49,796**
Additions	-	472	313	**785**
Rent reviews	-	324	-	**324**
Other in year revaluations	189	1,514	-	**1,703**
Valuation/cost at 31 March 2023	**10,325**	**63,470**	**5,245**	**79,040**
Accumulated depreciation at 1 April 2022	-	-	-	**-**
Provided during the year	29	4,963	1,830	**6,822**
Other in year revaluations	(23)	(1,487)	-	**(1,510)**
Accumulated depreciation at 31 March 2023	**6**	**3,476**	**1,830**	**5,312**
Net book value at 1 April 2022	-	-	-	**-**
Net book value at 31 March 2023	**10,319**	**59,994**	**3,415**	**73,728**
Net book value at 31 March 2023 comprises:				
Finance leased assets	10,319	59,994	3,415	**73,728**
Revaluation reserve	**8,988**	**24,877**	**-**	**33,865**

10.1 Amounts recognised in Statement of Comprehensive Net Expenditure

	2022-23 £000	2021-22 £000
Depreciation expense on right-of-use assets	6,822	-
Interest expense on lease liabilities	1,136	-
Expense relating to low value, short-term leases and leases where substantially all the economic benefits of the assets will not be obtained over the period of the lease	4,733	-
Non-recoverable VAT	704	-
	13,395	**-**

10.2 Amounts recognised in Statement of Cash Flows

	2022-23 £000	2021-22 £000
Total cash outflow on interest expense on leases	1,136	-
Total cash outflow on repayment on lease liabilities	4,667	-
	5,803	**-**

10.3 Transition impact

Statement of financial position	31 March 2022 £000	First time application of IFRS 16 £000	1 April 2022 £000
Total assets as at 31 March 2022	372,433	-	372,433
Right-of-use assets recognised	-	26,432	26,432
Prepaid lease payments	-	(1,737)	(1,737)
Total assets on 1 April 2022	**372,433**	**24,695**	**397,128**
Total liabilities as at 31 March 2022	(81,275)	-	(81,275)
Lease liabilities	-	(24,695)	(24,695)
Total liabilities on 1 April 2022	**(81,275)**	**(24,695)**	**(105,970)**
Total assets less total liabilities	**291,158**	**-**	**291,158**

10.4 Reconciliation from IAS 17 to IFRS 16

	£000
Closing operating leases disclosed at 31 March 2022	**17,997**
Impact of discounting	(1,525)
Other rent adjustments	11,622
Non-recoverable VAT not included in the lease liability	(1,544)
Low value, short-term leases and leases where substantially all the economic benefits of the assets will not be obtained over the period of the lease	(1,855)
Lease liability recognised at 1 April 2022	**24,695**

Note 11 Intangible assets – 2022-23

	Software Purchased	Assets Under Construction	Total
	£000	£000	£000
Valuation/cost at 1 April 2022	6,558	4,512	**11,070**
Additions	1,167	3,767	**4,934**
Reclassification*	-	1	**1**
Valuation/cost at 31 March 2023	**7,725**	**8,280**	**16,005**
Amortisation at 1 April 2022	4,625	-	**4.625**
Provided during the year	426	-	**426**
Amortisation at 31 March 2023	**5,051**	**-**	**5,051**
Net book value at 1 April 2022	1,933	4,512	**6,445**
Net book value at 31 March 2023	**2,674**	**8,280**	**10,954**
Net book value at 31 March 2023 comprises:			
Purchased	2,674	**8,280**	**10,954**
Asset financing	**2,674**	**8,280**	**10,954**
Revaluation reserve	**28**	**-**	**28**

*Reclassification from Note 9 Property, plant and equipment

Research and development expenditure associated with intangible asset development has been recognised as an expense in Note 4 and Note 5, and is categorised by the nature of the expenditure incurred.

Note 11.1 Intangible assets – 2021-22

	Software Purchased	Assets Under Construction	Total
	£000	£000	£000
Valuation/cost at 1 April 2021	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	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**

	Software Purchased	Assets Under Construction	Total
	£000	£000	£000
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**

Note 12 Inventories

	31 March 2023 £000	31 March 2022 £000
Raw materials and consumables	6,234	6,880
Work in progress	2,740	2,754
Finished processed goods	9,357	7,642
Total	**18,331**	**17,276**

At 31 March 2023, we held 42,978 units plasma for diagnostics, these were valued at £2.04m (31 March 2022 £nil). We also held 116,234 units of plasma for medicine, these were valued at nil value (31 March 2022 £nil). At 31 March 2023, we held 493 units (31 March 2022: 59,632 units) of plasma collected under the convalescent plasma programme. This has been retained due to its high-titre nature, making it ideal for clinical trials. Since no clinical trials are currently planned, and if they were to occur would be likely to be undertaken by NHSBT, this stock has been valued at £nil (31 March 2022: £1.08m).

At 31 March 2023, we held finished processed blood and component stocks valued £6.19m (31 March 2022 £4.98m). In 2022-23 we are seeing blood and component stock holding restored back to normal levels.

In the prior year we held 18,132 harnesses valued at

£1.15m which were purchased under the CVP programme, throughout 2022-23 we have worked to use the CVP harness within the organisation, returning the overall harness stock holding to normal levels, although £0.2m of the stock was written-off as it was out of date, and this is included in Losses and Special Payments on page 164.

Note 13 Trade and other receivables

	31 March 2023 £000	31 March 2022 £000
Current		
Trade receivables	47,035	29,603
Allowance for impaired contract receivables	(36)	(7)
Other debtors	149	133
VAT	4,348	3,622
Prepayments and accrued income	23,891	10,008
Subtotal	**75,387**	**43,359**
Non-Current		
Other prepayments and accrued income	437	198
Subtotal	**437**	**198**
Total trade and other receivables	**75,824**	**43,557**

Allowances for credit losses		
	2022-23 £000	**2021-22 £000**
At 1 April	(7)	(14)
New allowances arising	(36)	(6)
Utilisation of allowances (written off)	-	10
Reversed unused (recovered)	7	3
At 31 March	**(36)**	**(7)**

Note 14 Cash and cash equivalents

	31 March 2023 £000	31 March 2022 £000
At 1 April	64,676	53,211
Net change in year	(13,991)	11,465
At 31 March	**50,685**	**64,676**
Comprising:		
Cash in hand	1	1
Cash with the Government Banking Service	50,684	64,675
Total cash and cash equivalents	**50,685**	**64,676**

Note 15 Trade and other payables

	31 March 2023 £000	31 March 2022 £000
Current		
Trade payables – revenue	6,325	9,710
Trade payables – capital	42	431
Tax and social security costs	22	18
Accruals *	43,350	28,311
Deferred income	25,746	32,993
Total current trade and other payables	**75,485**	**71,463**

* The main increase in accruals in 2022-23 relates to £11.9m anticipated back dated non-consolidated additional pay settlement for 2022-23, based on the pay deal proposed by the Department of Health and Social Care.

Note 16 Provisions for liabilities and charges

	PAYE	Employee benefits	Redundancy	Product liability & other	Total
	£000	£000	£000	£000	£000
At 1 April 2022	51	423	25	762	1,261
Provisions arising in the year	57	21	279	297	654
Change in discount rate	-	(87)	-	-	(87)
Utilised during the year	(51)	(29)	(25)	(55)	(160)
Reversed unused	-	-	-	(374)	(374)
Unwinding of discount	-	5	-	-	5
Balance at 31 March 2023	**57**	**333**	**279**	**630**	**1,299**
Expected timing of cash flows:					
– not later than 1 year	57	29	279	630	995
– later than one year and not later than five years		112	-	-	112
– later than five years	-	192	-	-	192
Total	**57**	**333**	**279**	**630**	**1,299**

The PAYE provision is in respect of the probable value that will be due to HMRC under the annual PAYE Settlement Agreement process.

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 plus 1.70% as published by HM Treasury in April 2023.

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.

NHSBT has recognised a provision of £279k in relation to two redundancies at 31 March 2023 (31 March 2022: £25k).

At 31 March 2023 £13,017,499 is included in the provisions of NHS Resolution in respect of the clinical negligence liabilities of NHSBT (31 March 2022: £36,286,602).

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

Note 17 Obligations under leases

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

Minimum lease payments	31 March 2023 £000	31 March 2022 £000
Not later than one year	6,492	1,214
Later than one year and not later than five years	16,344	4,857
Later than five years	21,958	17,671
	44,794	**23,742**
Less future finance charges	(15,055)	(15,191)
Present value of future lease obligations *	**29,739**	**8,551**
Present value of minimum lease payments		
Not later than one year	5,407	298
Later than one year and not later than five years	12,952	1,642
Later than five years	11,380	6,611
Present value of future lease obligations	**29,739**	**8,551**
Analysed as:		
Current borrowings	5,407	298
Non-current borrowings	24,332	8,253
	29,739	**8,551**

* The material increase in the present value of future lease obligations in 2022-23 arises from the adoption of the IFRS 16 Leases accounting standard.

Note 18 Other cash flow adjustments (non-cash)

Other cash flow adjustments	Note	2022-23 £000	2021-22 £000
Depreciation	9 & 10	18,628	10,694
Amortisation	11	426	895
Impairments*	9 & 10	581	-
Loss on disposal	8	66	14
Provisions arising in year	16	654	591
Provisions reversed in year	16	(374)	(154)
Prepaid leases on first time adoption of IFRS 16		1,737	-
In year additions of right of use assets	10	1,109	-
Total		**19,353**	**12,040**

* The impairment in 2022-23 relates to an issue detected with the utilisation of reinforced autoclaved aerated concrete in the construction of our Southampton site. There were no impairments to report in 2021-22.

Note 19 Contingent assets and liabilities

A contingent liability of £112,212 (31 March 2022: £179,467) 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 2022: £1,375,000) relates to Hepatitis C cases brought under an action for product liability.

A contingent liability of £165,000 (31 March 2022: £165,000) 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 NHS England.

In April 2023, a detailed structural survey of our Southampton site revealed widespread issues with the roof of part of the building, which was constructed from reinforced autoclaved aerated concrete, and which

necessitated closing this area of the building. A detailed assessment of the work required to bring the site back into full use is just beginning. It is not currently possible to estimate the associated costs reliably.

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 20 Capital commitments

At 31 March 2023 the value of contracted capital commitments was £276,855 (31 March 2022 £145,347).

Note 21 Related parties

During the period none of the Department of Health and Social Care Ministers, 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 (DHSC) 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
- NHS Foundation Trusts
- NHS Trusts
- Health Education England

During the year these transactions were valued at £520m in income (2021-22: £484m) and £35m of expenditure (2021-22: £42m). Of this income, NHSBT received £125.3m (2021-22: £111.9m) from the DHSC in relation to operational grant-in-aid and £10.5m (2021-22: £12m) funding for its capital programme.

In addition, NHSBT has had several material transactions with other government departments, central and local government bodies, and NHS bodies of Scotland, Wales and Northern Ireland. These transactions amounted to £22m of income (2021-22: £19m)* and £74m of expenditure (2021-22: £66m).**

* reported as £12m last year, now corrected to £19m

** expenditure figures inclusive of pensions and social security costs of permanently employed staff.

NHSBT Board member or senior manager	NHSBT appointment	Related party	Related party position held	Receipts from Related party*	Payments to related party*	Amounts due from related Party	Amounts owed to related Party
				£000	£000	£000	£000
Charles Craddock	Non-Executive Director	Anthony Nolan	Advisor	875	27	284	(40)
Charles Craddock	Non-Executive Director	Accelerating Clinical Trials Ltd	Trustee and Founding Member	-	438	-	-
Deirdre Kelly	Non-Executive Director	Birmingham Women's and Children's NHS Foundation Trust	Consultant Paediatric Hepatologist	1,452	11	117	(3)
Gail Miflin	Chief Medical Officer and Director of Clinical Services	Accelerating Clinical Trials Ltd	Non-Executive Directorship	-	438	-	-

*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 (2021-22: £nil) and the Trust Fund had no outstanding debtors at 31 March 2023 (31 March 2022: £nil).

Other Related Parties

	2022-23		2021-22	
	Income £000	Expenditure £000	Income £000	Expenditure £000
Accelerating Clinical Trials Ltd grant funding	-	438	-	375
NHS and DHSC bodies	384,661	34,626	360,293	42,171
Other Whole of Government Accounts bodies	22,241	73,627	19,008	66,189

Other Related Parties

	2022-23		2021-22	
	Receivables £000	Payables £000	Receivables £000	Payables £000
NHS and DHSC bodies	36,124	41,405	17,651	34,203
Other Whole of Government Accounts bodies	2,321	6,387	8,053	422

Note 22 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.

In April 2023, a structural review of our Southampton site revealed an issue with the roof, related to the presence of reinforced autoclaved aerated concrete, and as a consequence it has been necessary to close some areas of the building. Our assessment of the impact on the value of the asset is £581k, and an impairment in respect of this has been included in the accounts.

A pay offer was proposed on 16 March 2023, as a result of discussions between the government and the NHS Staff Council. This included additional pay for 2022-23, comprising a 2% non-consolidated award plus a backlog bonus, equivalent in total to an additional 4% on average for staff on Agenda for Change terms and conditions (for further details see: https://www.nhsemployers.org/system/files/2023-03/Offer%20in%20principle%20pay%20structure_March%202023_6.pdf). Following consultation by the unions of their members, the NHS Staff Council accepted this pay offer on 2 May 2023, and it will be paid to staff in June 2023. Since the additional pay costs relate to 2022-23, and the pay offer was proposed prior to the end of the financial year, the costs have been accrued in the financial statements.

Note 23 Financial instruments

Financial risk management

Due to the continuing service provider relationship that NHSBT has with its customers, and the way they are financed, NHSBT is not exposed to the degree of financial risk faced by business entities. Financial instruments therefore play a much more limited role in creating or changing risk than would be typical of non-public sector bodies. 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.

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 financed from resources voted annually by Parliament. NHSBT's capital expenditure is funded from resources made available from the Department of Health and Social Care. NHSBT is not, therefore, exposed to significant liquidity risks.

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.

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.

Term	Definition
Fractionators/ Fractionation	Fractionation is the separation into component parts. Plasma fractionators 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.

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.

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.

Term	Definition
OTDT	Organ and Tissue Donation and Transplantation – the part of NHSBT which co-ordinates organ donation and transplantation in the UK and also manages tissue donation, production and supply.
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.

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.

Term	Definition
Ro	Ro is a blood type. When the Rhesus group D and DHCE genes combine there are 8 possible outcomes – one of which is Dce – also known as 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.

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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