NHS
Blood and Transplant

2020/21
Annual Report and Accounts

HC 500
SG/2021/159

NHS Blood and Transplant

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Introduction from the Chair

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

This last year has been tumultuous for our organisation. I have been incredibly proud of the immense hard work and sustained effort from everyone across NHS Blood and Transplant (NHSBT) as we have confronted the significant challenges and opportunities we have faced.

It is hard to believe that in a single year we have safely managed the impact of a pandemic, implemented opt-out legislation for organ donation, collected thousands of units of potentially life-saving convalescent plasma and taken what we have learned to build a whole new programme for the collection of Plasma for Medicines. We are also developing our role in the future of genomics treatments, building our donor base and creating a new donor experience which includes a fairer approach to donor deferrals based on individual risk, opening the way for more gay men to become blood donors. We also managed to open a brand new centre in Barnsley, managing the logistics of moving in despite COVID-19 restrictions. Working through the most testing of circumstances we have maintained our essential services and stayed safe, provided the world with answers on COVID-19 treatments, seen a new era dawn for organ donation, worked tirelessly to make NHSBT a great place to work for everyone and taken real steps to scope our future direction.

I am exceptionally proud and appreciative of all that our staff and donors have done during the last year. The dedication of our colleagues and donors to save and improve lives continues to be inspirational to both myself and everyone who works at NHS Blood and Transplant.

NHSBT at its best during a challenging but successful year

The COVID-19 pandemic has tested the NHS like never before and our organisation has responded magnificently. Blood stocks have remained strong throughout this period due to good operational and strategic management and we have worked exceptionally hard to keep our staff and donors safe.

Whilst there was an inevitable fall in transplant numbers, many of our specialist nurses turned their skills to supporting colleagues in Intensive Care Units across the country.

We have supported the national response by providing sophisticated testing equipment and participating in national testing programmes. We have utilised the skills and empathy of colleagues, all too familiar with providing end of life care and support, to establish a bereavement advice line.

And perhaps most significant of all is the huge effort that went in to develop a programme of collecting convalescent plasma, which was thought to have the potential to help treat patients suffering from COVID-19 by transfusing them with the antibody rich plasma collected from donors who have recovered from the disease. We were disappointed that the clinical trials we contributed to proved no overall patient benefit – but this shouldn't undermine the achievement nor the enormous contribution of our plasma donors. We made a significant contribution to understanding COVID-19 and our findings will help clinicians across the world refine their treatments.

Our efforts in respect of convalescent plasma began from scratch last Spring, and we soon had over 1,700 members of staff committed to the programme over some 40 plus sites. We scaled at enormous pace, increased diversity and reimagined donor recruitment in new and bold ways.

We are taking what we have learned from this programme to build a new donation programme – collecting blood plasma for the production of important medicines (Plasma for Medicines - PFM) which will help thousands of UK patients with compromised immune systems. This hasn't been possible since restrictions were placed on the use of UK plasma following the Creutzfeldt Jakob Disease (vCJD) crisis of the 1990s. An independent expert review has now found that UK plasma is safe to use. The Government has asked us to develop this programme over the next year, and we are now progressing at pace with the opportunities that this presents to us and to the health sector.

Managing risk to retain trust

There is no doubt that NHS Blood and Transplant operates in an area of significant risk, even more so over the last year as our organisation has played a key part in the response to the COVID-19 pandemic. We continue to believe that we have an excellent record in managing risk and we are confident that our management of the blood supply and our approach to organ donation are amongst the safest in the world. The Board has continued to place a great emphasis on governance and risk over the last year and will continue to do so in the year ahead. We must be assured that we can retain the complete trust and total confidence of the public, our donors and recipients as well as our Government sponsors, and our customers across the NHS.

We continue to work closely with our Executive Team to clarify our strategic risks and we have also restructured our risk management system and processes. Whilst adding capacity to our risk management function, the Audit, Risk and Governance Committee is now undertaking regular in-depth reviews of our strategic risks, providing greater objective challenge to the plans for mitigating and managing them.

The Board and I are reassured that we achieved 'moderate' assurance on our approach to governance, risk and financial control. The sense of stability is good, and we are confident that we will continue to see improvements.

As a result of our previous review, we have made some significant changes to our governance arrangements to streamline our approach and give much greater clarity and focus to the Board's oversight role. These changes are working well and align with the changes to NHSBT's operating model that the organisation is working through. I remain confident that they strengthen our governance and provide much clearer accountability for the key issues facing our organisation

This has been particularly important at a time when we have successfully implemented the most significant change to organ donation law for a generation. The introduction of 'deemed consent' placed an even greater need for us to give the public confidence that their donation decision and the views of their family will be respected, and that we are highly competent and capable of always acting in the public interest.

To achieve this aim the Board will continue to provide robust, objective challenge to the organisation and our approaches to the changes and challenges ahead of us.

One of the most significant priorities for NHSBT in the last year was to improve the diversity, inclusion and treatment of all our workforce, to make our organisation a much better place to work for everyone. This has been particularly important over the last year as we have responded to the independent report on the treatment of some of our ethnic minority colleagues at our Colindale Centre. We have recognised that the report was indicative of wider concerns of racism in the organisation. The issues and problems highlighted in the report were completely unacceptable to us and we have been working exceptionally hard to resolve these challenges. We are starting to see some progress – but these are challenging issues and there is much more to do. We recognise that we must go further and faster to make a real difference to the lived experience of our colleagues.

We are also totally committed to improving the diversity of our donor base to improve the equity of clinical outcomes for all patients, especially those from a Black, South Asian or Middle Eastern background. Too many patients wait too long or receive less effective treatments, because we haven't been able to provide them with the blood and organs that best meet their needs. This must change.

The Board are indebted to the hard working and dedicated staff of our organisation and, of course, to our donors without whom saving and improving lives would simply not be possible.

Millie Banerjee
Chair

Millie Banerjee stepped down as Chair on 6th August 2021. John Pattullo, NHSBT's former chair, became Interim chair on 7th August 2021 until a new Chair is appointed or until March 2022.

Overview

Introduction

The scale of the coronavirus pandemic and the changes this made to our donors, colleagues and operations, has been immense. We were fortunate to have already introduced a number of new technologies and ways of working which enabled us to transition, maintain performance and grow at a remarkable pace. We are extremely grateful to our donors who kept on donating so we could deliver the products that patients needed throughout the last year. We are very proud of our staff who kept each other safe and supported, so together we could deliver step changes in operations

Highlights of our year

April 2020

NHSBT begins leading a major new programme, on behalf of the Government, to collect convalescent plasma from people who have recovered from COVID-19, to supply two major COVID-19 trials.

May 2020

Max and Keira's Law – the Organ Donation (Deemed Consent) Act – came into effect on the 20th May 2020.

June 2020

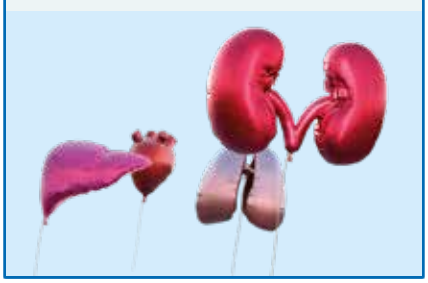
NHSBT takes over new Barnsley centre.

October 2020

NHSBT expands convalescent plasma collection by opening 14 more blood plasma donor centres across England.

November 2020

Data for the first six months after the new organ donation opt out law shows 134 more donations took place (taking the total to 341 organ donations).



December 2020

NHSBT and the National Blood Transfusion Committee publish Transfusion 2024, setting out priorities for transfusion practice in the NHS for the next five years.

and lead internationally important research studies in these challenging times. We are an essential part of the NHS. We take pride in making the most of absolutely every donation – from blood and organs to tissues and stem cells. Every day, when we break new scientific ground, when we connect with donors and families, when we help to save a life, we bring the values of caring, expert and quality to our roles. The donors who make our work possible do so selflessly, giving life and changing life for the better. It is because of them, and the people who need their life-saving and life-enhancing donations, that we strive to be the best in all we do.

Organ Donation

July 2020

Latest Transplant Activity Report shows England was on track for record numbers of organ donors before COVID-19 hit.

August 2020

NHSBT steps up appeal for Asian and older male convalescent plasma donors as research shows they are more likely to have highest antibody levels.

September 2020

NHSBT was awarded £1.125 million from the Medical Research Council and Japan Agency for Medical Research to conduct research into regenerative medicine at the Stem Cell Institute in Cambridge.

January 2021

FAIR Review on a more individualised way of assessing blood donation.

February 2021

NHS Blood and Transplant launches the 'Leave Them Certain' Campaign to urge families to talk about organ donation, and ban lifted on the use of UK plasma for the production of immunoglobulins.

Leave them certain

March 2021

NHSBT commissioned to collect Plasma for Medicines (PFM). Human Tissue (Authorisation) (Scotland) Act 2019 was implemented.

At a glance – the year in numbers

Organ and Tissue Donation and Transplantation:

Organ Donors:
1,179 people donated their organs after death and
384 people made living donations

3,386
deceased and living donor transplants

Over
350
people died waiting for a transplant last year

709,206 new registrations to the Organ Donor Register, giving a total of **26,746,406** registrants in the year

6,010
products issued – including skin for the treatment of burns, heart valves for bypass surgery, tendons for sports injury and many other clinical indications

2,514
corneas issued for transplantation, helping maintain or restore sight

3,291
serum eyedrop products 'tears' to treat patients with severely dry eyes

Blood Donation:

Blood issued:
1,291,000
red blood cells
↓6.5%
on same period past year

Blood donors:
761,000
regularly donating
of which
110,000
are O negative and
23,100
are Ro donors

Clinical Services:

Therapeutic Apheresis Service performed
9,390
treatments for
1,926 adult and child patients to remove unwanted aspects of the blood or replenish needed parts to improve patient health

British Bone Marrow Registry added
11,335
recruits to the donor panel and issued
117
units for patient use

Stem cells issued
45 units and added **49** cords to the bank

In Diagnostics, Red Cell Immunohaematology (RCI) service performed **67,855** investigations and Histocompatibility and Immunogenetics (H&I) performed **198,128** clinical tests

Meeting customer needs:

83%
of our hospital transfusion customers scored **9** or **10** out of **10** for satisfaction

We met our customer requests for blood products (excluding RO)
98.6% on time and in full.
Including RO and RO Kell we met requests **96.9%** on time and in full

Blood total stocks maintained above the
3 days
of stock level target all year

Our performance

Chief Executive's review

It has been a huge responsibility but also an enormous privilege to lead such an extraordinary organisation over the last year.

2020/21 is undoubtedly the most challenging and tumultuous year the NHS has ever faced. I am incredibly proud of the way our organisation has played its part in our response to the COVID-19 pandemic. Not only have we continued to deliver our life-saving services in the most testing circumstances, but we have also played a crucial role as part of the national effort to beat this dreadful disease.

I am in awe of the way our colleagues have faced this challenge. Never has our mission to save and improve lives been more important.

Staying safe and maintaining security of supply

From the start of the pandemic, we put in place extensive COVID-19 secure measures to ensure the safety of our donors and staff and, in turn, help maintain the security of supply. On blood donation sessions, this included triaging donors on entry, social distancing, enhanced cleaning and the wearing of PPE and face masks. We also introduced our own comprehensive COVID-19 helpline staffed by infection control experts and, when it became available, regular lateral flow testing.

Though blood donation fell during the first wave of the pandemic, so too did hospital demand for blood. As a result, blood stocks remained healthy (and did so throughout the year), allowing us to continue meeting the needs of patients.

Organ donation and transplantation were inevitably challenged by the pandemic. At the peak of infection in spring 2020 and again during the winter, a number of transplant units closed temporarily as services and staff, including many of our own nurses, were diverted to cope with a surge in COVID-19 cases. Surgeons also had to consider the added risks of COVID-19 to immunocompromised patients after a transplant. However, deceased donor referrals and life-saving transplants have continued through the pandemic – compared to the year 2019/20, we were able to maintain 71% of proceeding deceased donor activity and 79% of deceased donor transplants in 2020/21. This is testament to the magnificent response of the organ donation and transplant community, working together to ensure that as many patients as possible received the transplants they needed.

NHS England recognised NHSBT as an essential part of the NHS frontline, allowing staff to access the COVID-19 vaccination from the start of the national roll out. This was essential to staff safety and morale, as well as operational resilience.

Providing the world with answers on COVID-19 treatments

As the world sought answers to the COVID-19 pandemic, NHSBT set up the world's largest clinical trial to establish the potential benefits of treating seriously ill patients with antibody-rich convalescent plasma collected from donors who had recovered from COVID-19. Unlike other countries with established plasmapheresis collection facilities, we had to build ours from a standing start – recruiting and training over 1,700 staff and opening more than 40 new donation centres. This, together with a national donor recruitment campaign, allowed us to collect over 55,000 units of convalescent plasma (of which 29,143 were high titre), which went on to treat over 6,500 patients in 226 participating hospitals. This was a remarkable achievement and a testament to the dedication of our staff and the altruism of our donors. I will never cease to be amazed and uplifted by the generosity of the human spirit.

Sadly, the RECOVERY and REMAP-CAP trials concluded that there was no clear patient benefit from convalescent plasma. Though this was a disappointment for donors and staff, who were motivated by the opportunity to bring hope to people suffering from COVID-19, we were pleased to help provide definitive evidence, allowing clinicians to focus on alternative treatments.

Definitive evidence on the efficacy of convalescent plasma is just one of the many legacies from this major programme. Another is the national plasmapheresis collection infrastructure that can now be re-purposed for the collection of plasma for the manufacture of immunoglobulins, thanks to the Government's decision to lift the decades old ban on the use of UK plasma for these life-saving medicines. The Government has directed us to keep collecting plasma for medicines and provided funding until at least March 2022. This follows the success of a three-month pilot. Collection will establish a domestic supply of plasma medicines for NHS patients. These donations will reduce our reliance on imported plasma medicines and help save lives. Donations will continue at Stratford, Birmingham, Manchester, Twickenham, Croydon, Chelmsford, Reading, Bristol, Barnsley, Bolton and Stockton.

A new era for organ donation

This past year also marked a significant change to organ donation law in England. From 20th May 2020, people no longer have to opt in to become a donor but are assumed to be one unless they register a decision otherwise. A public awareness campaign helped ensure that the change in the law was widely understood and our latest campaign is now encouraging everyone to discuss their donation wishes with their family to 'leave them certain'.

It is too early to say what the impact will be in England, but similar legislation in Wales (enacted in 2015) has led to improved consent rates, donor numbers and thus more lives saved. Scotland implemented its version of opt-out in March 2021.

As we look to the future, we believe these law changes will be a major factor in improving outcomes for patients awaiting life-saving transplants. Additional improvements, including how new technologies can improve organ utilisation, are set out in our new strategy (*Organ Donation and Transplantation 2030: Meeting the Need*) which was developed in collaboration with clinicians, patient groups and wider stakeholders.

A great place to work *for everyone*

NHSBT prides itself on our mission to save and improve lives. For the most part, people see it as a great place to work. Over the last year, however, we have had to come to terms with the fact that this experience is not shared by all colleagues. This was underscored in June 2020, when we published the findings from an externally conducted organisational diagnostic which identified evidence of systemic racism, as well as instances of bullying, harassment and micro aggressions, at one of our sites. We acknowledged that these issues extended to other parts of our organisation and committed to taking action.

Diversity and inclusion is soul searching work. It requires a commitment to listen to, and learn from, uncomfortable truths. It also requires a willingness to challenge the status quo and review our policies, processes and systems from first principles. As we go on this journey as an organisation, we will continue to be guided by expert advice as well as constructive feedback from internal and external stakeholders – no matter how hard it can sometimes be to hear. I want NHSBT to be a great place to work for everyone and will not rest until this is a reality.

Looking to the future

As we come out of lockdown, we have started to turn our heads to Recovery and Transformation. The pandemic has tested us personally and professionally but NHSBT has risen to the challenge. Indeed, it has taught us a lot as an organisation. We have embraced new technologies and learned to work in a more flexible and agile way.

We have shown that we can innovate and adapt to keep essential services running. And we have demonstrated to ourselves and others that we can deliver large scale programmes at speed and in the most challenging of circumstances.

All this and more will be critical in responding to our external environment which is rapidly changing around us. Over the course of the coming year, we will be developing a new corporate strategy and associated transformation roadmap which will set our direction for the next five years.

And finally

I would like to thank colleagues across NHSBT for their hard work and commitment during what was an extraordinary year. I couldn't ask for a more dedicated team – you have done yourselves proud. I know everyone would also want me to extend our collective thanks to our amazing donors, without whom we would not be able to deliver on our mission to save and improve lives.

Betsy Bassis
Chief Executive and Accounting Officer

Our corporate 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 for providing UK-wide services in support of Organ Donation and Transplantation.

Our Mission and Strategic Ambition

Our mission is to save and improve lives.

To save and improve even more lives in the years to come, we will adopt four corporate strategic objectives:

- Diversify and strengthen our donor base;
- Modernise and extend our established services;
- Develop and grow new and high-potential services; and
- Make NHSBT a great place to work for everyone.

NHSBT has also recognised that, as a national provider of specialist products and services operating in a system of local Trusts, we have a responsibility to provide system leadership to improve clinical outcomes, reduce health inequalities and optimise resources. We look forward to working more proactively with our NHS colleagues on delivering these improvements.

Our values

Three small words, one big difference.

Our challenges

Our risks are linked to our strategic objectives and KPIs. To provide an overview of risks that might affect us, we group all risks under ten themes against delivery of objectives.

The 10 risk themes with residual risk (RR) score, description and planned mitigations

Risk themes	RR	Description of the risk theme	Further planned mitigations
Safety & Quality of Clinical Care	10	There is a risk that the quality or safety of NHSBT's products or services provided to donors, donor families or patients, does not support or provide appropriate standards of care, and therefore puts donors or patients at risk of harm.	Learning from all incidents. Improving the use of automation and technology.
Staff Establishment & Recruitment	12	There is a risk that NHSBT will not be able to recruit staff with sufficient skills, qualifications and experience, to meet NHSBT's requirements, especially where there is a known shortage in a specific staff group or expertise required by the NHS.	Workforce planning and targeted recruitment events. Informed succession planning
Failure of the Provision of Blood & Blood Components	9	There is a risk that NHSBT fails in the collection, analysis, processing, testing and supply of regulatory compliant and clinically appropriate blood components in sufficient quantity to meet demand, leading to patient harm.	Development of strategies for marketing and blood collection.
Strategic Development Capacity	9	There is a risk that NHSBT fails to react to changes in the wider healthcare environment, regulatory framework or developments in research and/or technology, caused by NHSBT failing to foresee, adapt appropriately or with sufficient agility, resulting in a failure to maintain position or make strategic change.	Gather intelligence from our R&D experts, from advisory groups and from international peers. Improving the use of technology and marketing platforms.
Functionality of Critical ICT Systems & Technology	16	There is a risk that critical NHSBT business services are impacted because digital and technology solutions are not available or providing the right functionality.	Significant investment planned in replacing legacy infrastructure, improving the resilience of systems and additional cyber security capability.
Supplier of Critical Product will fail to provide	12	There is a risk that a supplier of critical product will fail to provide at the expected level, caused by supplier failure, poor performance, changes in regulation or poor contract/specification.	Strategic stocks maintained for key consumables at both NHSBT and suppliers. Procurement strategies and contracts designed to mitigate risks. Supply chain risk management function that continually assesses and manages risk. Increasing collaboration with other blood services.
Confidentiality, Accessibility & Integrity of Data	15	There is a risk that the confidentiality, integrity and availability of our system, services and/or data is compromised, caused by the exploitation of weak security culture, vulnerable legacy services and systems, and an immature security controls regime from malicious actors and accidental insider actions, leading to regulatory penalties, operational impacts and a threat to life.	Significant investment in cyber capabilities, continuous improvement of Information Governance process and the development and implementation of an organisation wide data strategy.

Risk themes	RR	Description of the risk theme	Further planned mitigations
Loss of a Key Facility	12	There is a risk that the loss of a key facility will cause a failure to deliver key products or services to customers, causing delays to treatment or harm to patients.	Donor Centre and Blood Centre resilience to be improved with key improvement projects scheduled. e.g. Liverpool Cleanroom refurbishment. Electrical infrastructure reviews underway to identify work required to improve resilience.
The reputation of NHSBT is adversely affected	12	There is a risk that a significant event(s) impacts on the reputation of the organisation, such that NHSBT may lose the confidence and trust of the public, resulting in donors stop coming forward.	Crisis communication plans are in place and regularly tested. Professional in-house public relations advice is an inherent part of risk mitigation plans. Regular horizon scanning identifies potential issues as early as possible and routine monitoring of the media, social media, customer satisfaction and public attitudes measures trust and reputation.
Grant In Aid (GIA) Funding	12	There is a risk that Grant in Aid (GIA) funding for organ donation may be adversely affected by political or policy decisions in Government.	Engagement with DHSC and the Devolved Administrations.

Below is how we manage the relative risk scores:

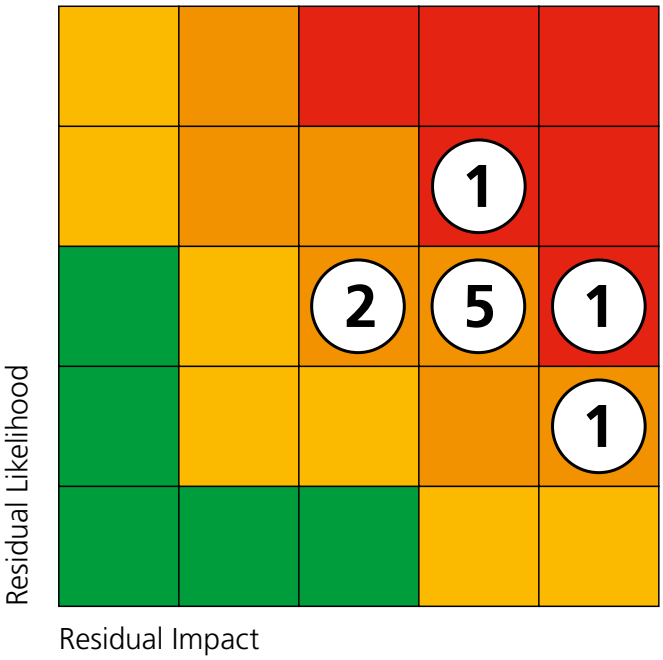
High Risks (score 15-25) are almost certain or highly likely to occur and could have a catastrophic or major impact if they do so. These risks are unacceptable and require urgent review and action.

Moderate Risks (score 8-12) are highly likely or possible to occur and which could have a major or moderate impact. These risks are unacceptable and requires action and review.

Low Risks (score 4-6) are possible or unlikely to occur and which could have a moderate or minor impact. These can be acceptable which are subject to possible action and remain subject to review.

Very Low Risks (score 1-3) are unlikely or rare to occur and which could have a minor or insignificant impact. These are an acceptable level of risk which are subject to review.

Our 10 risk themes residual risk scores shown in our risk appetite grid



For more about how we manage risks see page 58.

Big opportunities – The future of plasma, cell therapies and genotyping

The UK Government has lifted the ban on the use of UK plasma to produce antibodies (also known as immunoglobulins). Immunoglobulins are used to treat various conditions either supplementing or counteracting the immune response by a patient. For example, a patient with arthritis can receive antibodies which suppress the patient's immune system and reduce further damage to joints, or a leukaemia patient whose immune system is compromised can receive antibodies to supplement their immune system and protect them from other diseases.

For our donors, this will mean that the excess plasma recovered from whole blood donations will no longer be discarded or sold for non-clinical issue. Instead, this plasma will be provided to commercial manufacturers (fractionators) who will use the plasma to produce plasma-derived medicinal products (PDMPs), such as immunoglobulins. These domestically-sourced PDMPs will be supplied exclusively to the NHS for the benefit of UK patients. We are planning to repurpose our convalescent plasma collection capacity to meet more of the UK's need for immunoglobulins and other PDMPs (see page 29).

Our Cellular and Molecular Therapies (CMT) team has been awarded grants of £4.5m over 5 years by the UK Governments' Medical Research Council and associated charities, to support the development of viral vector manufacturing for early phase academic-led gene therapy trials and to facilitate the provision of cost-effective viral vectors and plasmid DNA to stimulate the UK's gene therapy sector. In gene therapy a 'faulty' disease causing gene in a human's DNA is identified. Viruses (viral vectors) or plasmids (small DNA molecules found in bacteria) can be manufactured to contain replacement genes. When the virus or plasmid with the replacement gene is introduced into the patient, it replicates, and the 'faulty' genes are replaced sufficiently that the disease is reduced or cured. Viral vectors have been used to treat cancer, diabetes, heart defects, Alzheimer's and dementia. This is a vital area of research for the future of healthcare.

There is also research being funded in the UK to translate theoretical benefits into new patient treatments, using stem cells and immunotherapy, which NHSBT could manufacture and support. We are updating our strategies to reflect this rapid emergence of cell therapies.

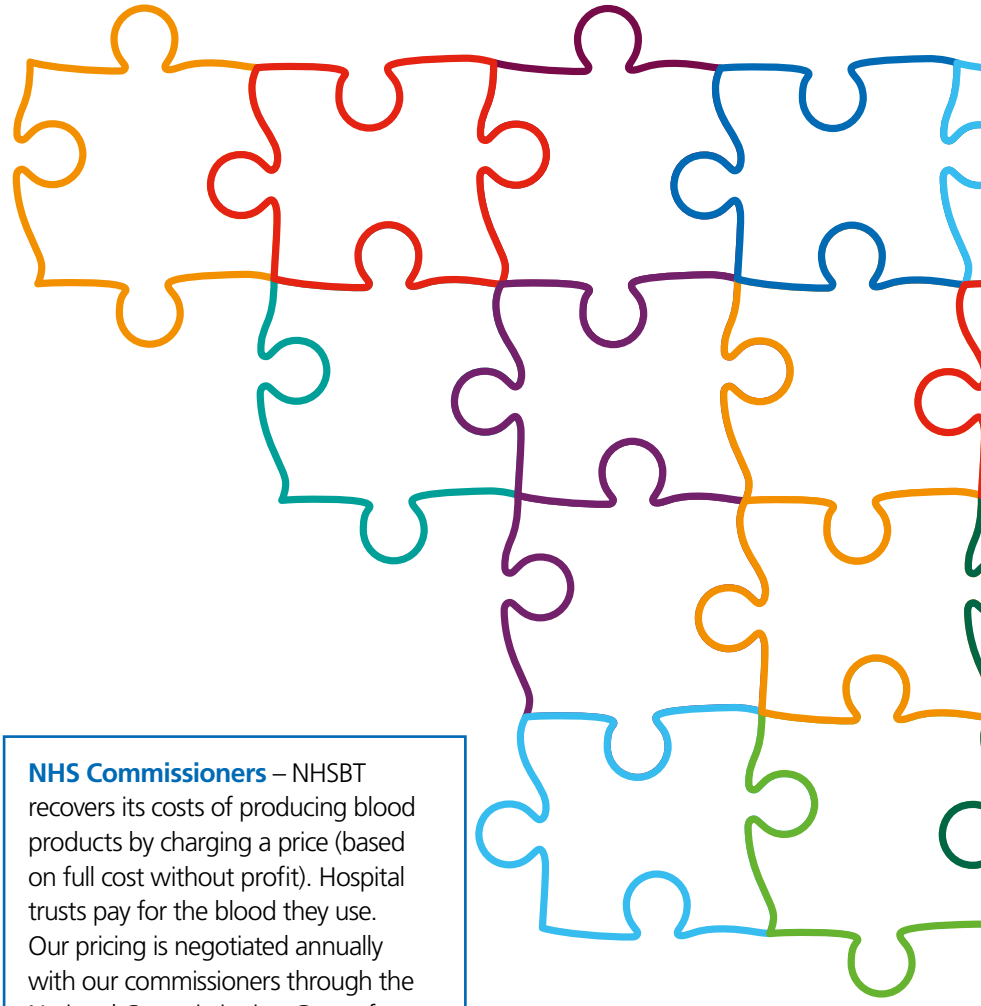
The UK Government is investing heavily in genomics via its 2020 Genome UK strategy. This aims to create the most advanced genomic healthcare system in the world. Genomics will be used to support earlier disease detection, faster diagnoses and target interventions to specific groups of patients. This will enable predictive and preventative care to improve public health and wellness. As a result, patient testing across the NHS is increasingly moving to genotyping. We are already a leading provider of genotyping in the UK, across a number of areas in our Diagnostics function within Clinical Services. We also have some of the leading global expertise on genotyping, diagnostic and blood donation testing. We are exploring opportunities to provide system leadership and opportunities to partner with existing genomic programmes, to access external investment to scale up our genomics capability. Genotyping is proven to lead to better patient outcomes in both stem cell and organ transplantation, and could lead to better patient outcomes in blood transfusion too.

Our approach to working in partnership

NHS Blood and Transplant operates in a complex environment and improving the experience of donors and positive outcomes for patients cannot be achieved in isolation. We are a collaborative organisation and we depend upon deep strategic relationships with our partners to work towards shared strategic goals.

Our patients – we provide life-saving patient care through our Therapeutic Apheresis Service. Specialist treatments remove harmful, disease-forming proteins, chemicals, or cells from patients' blood. We treat over 1,900 adults and children every year from eight dedicated therapeutic units across the country.

Our donors – without our donors NHS Blood and Transplant could not function. We communicate regularly with over 200,000 registered blood donors about their donation and how the blood they provide is used. We provide ongoing support to the families of those whose loved ones have donated their organs and tissues to save and improve the lives of others.



Government – We are accountable to the four Health Departments in the UK for the delivery of organ donation and transplantation, and to the English Health Department for providing a blood service.

Our regulators – are responsible for the safety of our donors, patients and our workforce and operate in a highly regulated environment. The Care Quality Commission (CQC) monitors, inspects and regulates our services to make sure they meet fundamental standards of quality and care. The Medicines and Healthcare Products Regulation Agency (MHRA) is responsible for the regulation of medical devices and medicines used in healthcare and the regulation of blood establishments. The Human Tissue Authority regulates the removal, storage and use of tissue and cells; and organs for transplantation. As specialists, our clinicians and scientists also advise the policy making bodies in the UK (e.g. SaBTO, the UK Advisory Committee on the Safety of Blood, Tissues and Organs), in Europe and internationally on the safe use of all of our products and services.

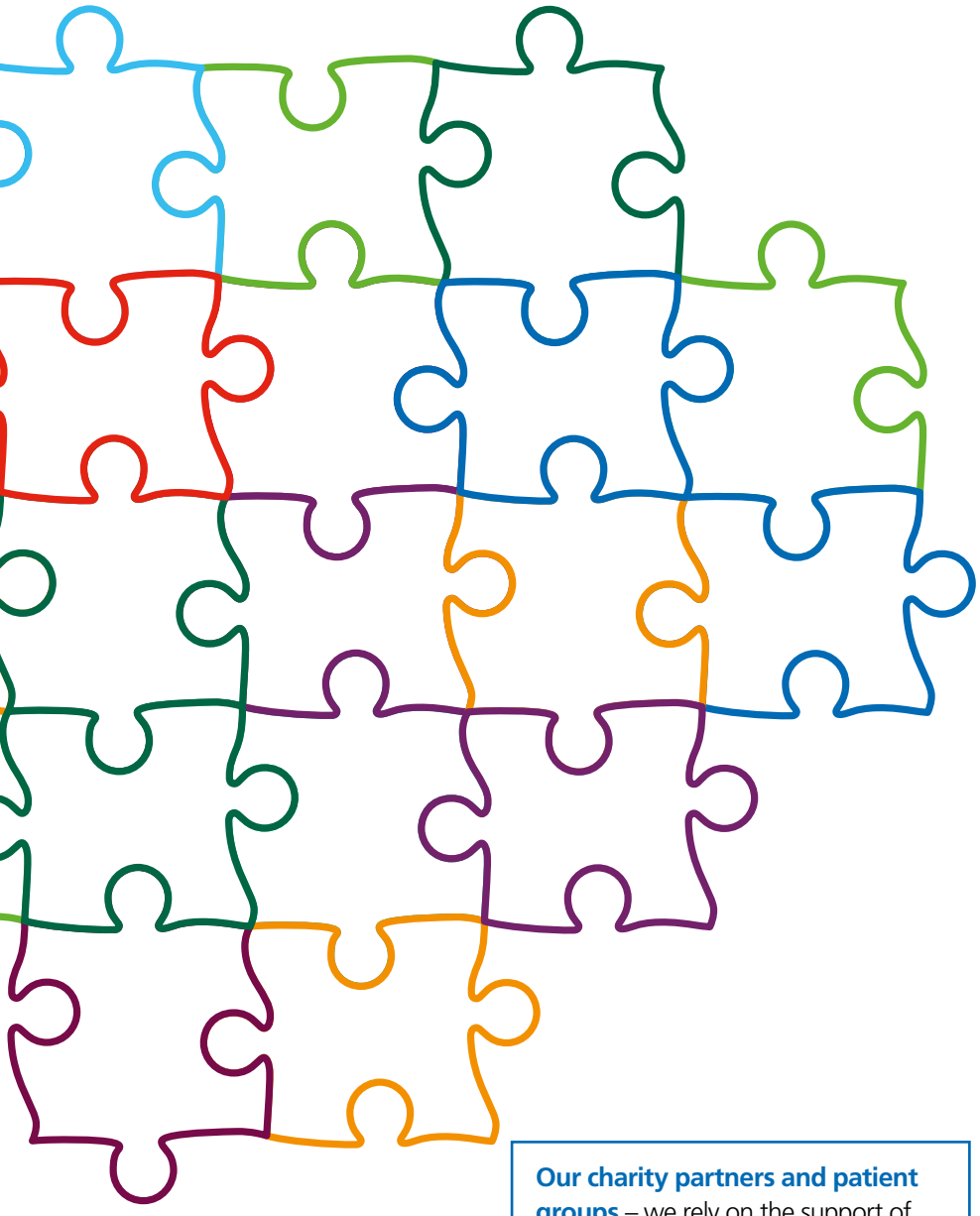
NHS Commissioners – NHSBT recovers its costs of producing blood products by charging a price (based on full cost without profit). Hospital trusts pay for the blood they use. Our pricing is negotiated annually with our commissioners through the National Commissioning Group for Blood (NCG). Following a review of the impact of COVID-19 on demand for blood products, it was agreed by the Department of Health and Social Care(DHSC) that NHS Trusts would pay a fixed monthly block price based on their pre pandemic expected levels of demand. This aligned with the interim funding changes for NHS Trusts who in turn were funded on a fixed block basis by their Commissioners.(see page 65).

NHS customers – we supply blood products, solid organs, tissue and stem cells to hospital trusts and other NHS bodies. We also supply private hospitals. We communicate closely on demand and supply issues to ensure that hospitals can meet the needs of their patients. We want to build stronger and deeper relationships with our customers, so we work together on shared strategic aims.

Our people – NHS Blood and Transplant has a highly engaged and dedicated workforce committed to saving and improving lives. Our colleagues work from many different sites across the UK and it is vital that we communicate openly and regularly through a range of appropriate channels to suit the needs and circumstances of each team.

Our communities – we recognise that we have not always been effective at engaging ethnic minority communities in donation. We are increasingly working at a grass roots level with community groups who are best placed to share the message. Last year we launched a community investment scheme with grants totalling around £600,000. These will be given to ethnic minority and faith organisations to help promote organ and blood donation.

The public – we always need new donors to replace those who can no longer donate blood and we need more donors with certain blood types than others to match changing patient needs. We need more organ and stem cell donors too. We run ongoing donor recruitment campaigns to explain the benefits of donation. Last year we also ran a high-profile campaign to explain changes to organ donation law and ensure everyone knows what it means for them.



Our Trade Unions – we enjoy a robust and constructive partnership with our Trade Unions. This is essential, particularly during a time of considerable change in our organisation.

Our suppliers – delivering our services is dependent on a wide range of suppliers, and we work hard to ensure the security of our supply chain to avoid disruption to services. These relationships have been tested through the pandemic and we have been able to avoid disruption to our services.

Our peers – we work with bodies who provide similar products and services to us across the world. We benchmark our productivity, learn best practice and procure key products in collaboration with them.

Scientific and research organisations – we work collaboratively on a range of research projects with academic and research organisations providing leading-edge expertise in blood, organ and stem cells. We have extensive laboratory facilities and clean rooms, and good manufacturing processes which play an important role in research programmes.

NHS clinical community – NHSBT plays a unique role in transplant and transfusion medicine, and we are well placed to encourage collaboration and best practice sharing in these fields.

Our charity partners and patient groups – we rely on the support of a wide range of charity partners to help promote all forms of donation. We have established blood and organ campaign forums to bring our partners together to share campaigning ideas and best practice.

Performance report

Our objectives, operational review and KPIs

We set ourselves strategic targets and measure our performance against these for each of our 3 operating divisions (Blood Supply, Organ and Tissue Donation and Transplantation and Clinical Services) as shown below. We also had a fourth, new, Plasma operation in the year.

Blood Supply

STRATEGIC OBJECTIVE:

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

KEY PERFORMANCE INDICATORS:

PILLAR/ THEME	BLOOD STRATEGIC TARGET	Target	Actual
Blood Donation/ Donor Experience	Blood Donors Donating in Last 12 Months – All Groups	807,366	753,550
	O Negative Blood Donors Donating in Last 12 Months	117,124	110,440
	Ro Blood Donors Donating in Last 12 Months	23,675	23,362
Supply Chain Operations	Percentage of product supplied meeting customer requirements on time and in full (OTIF) excluding Ro YTD	98.0%	98.6%
	% of hospitals scoring 9 or 10 out of 10 for overall satisfaction	70%	82%
	% of donors scoring 9 or 10 out of 10 for overall satisfaction	79%	83%

Note: Donor numbers have been impacted by the COVID-19 pandemic.

OPERATIONAL REVIEW:

The COVID-19 pandemic has placed extraordinary pressures on our supply chain during 2020-21. We have adapted the way we work on our blood sessions and manufacturing halls to make our working environments COVID-secure and keep our colleagues and donors safe. Coupled with changing donor behaviours during the pandemic, this has made blood collection and production levels more variable than usual. Our hospital customers have also been substantially impacted by the pandemic, resulting in greater variability in blood component demand as compared with pre-pandemic expectations. While this variability in both demand and supply has created challenges, we have emerged from 2020-21 with record levels of donor and customer satisfaction and On Time, In Full (OTIF) performance.

Additionally, we have delivered some significant strategic changes during the year. This included starting the journey of modernising our blood sessions with the live trial of the Session Solution project, and delivery of important milestones in the Logistics Review Programme, which aims to generate £3.8m annual savings.

Bhaveshree Chandegra

Bhaveshree was diagnosed with Acute Myeloid Leukaemia when 19 years old. She started chemotherapy and needed blood and platelet transfusions throughout the treatment.

Bhaveshree says: "Having platelet and blood transfusions throughout my 8 months of treatment saved my life. After each transfusion I'd feel a boost of energy to get through the day, before chemotherapy treatment put me back down again. But I never gave up, somehow I got the strength to keep on going. I'm so lucky and grateful to all those amazing people who donated platelets and blood. Without them I wouldn't be alive today. Thank you."

The safety and wellbeing of our colleagues and donors is of paramount importance. At the outset of the COVID-19 pandemic, we responded rapidly to ensure our operating environments were made COVID-secure and have continuously adopted new measures over the course of the year to enhance our controls.

Across our supply chain, we have introduced greater distancing between areas of activity, provided Personal Protective Equipment (PPE) and enhanced cleaning processes to minimise the risk of transmission through touchpoints. In our Manufacturing, Testing and Hospital Services environments, we have constructed Perspex screens between workstations where required, particularly in areas where achieving a minimum two metre distance is not possible due to space constraints. For Blood Donation teams, we have introduced a triage process where colleagues and donors have their temperature checked, colleagues follow good hand hygiene practice and check that everyone entering our blood sessions is wearing a face-covering.

For all of our front-line roles, we have recently introduced lateral flow testing to identify asymptomatic colleagues with COVID-19. We are also encouraging all colleagues in Blood Supply to get vaccinated at the earliest opportunity and continue to monitor uptake for the vaccine.

While most colleagues in Blood Supply are front-line, we have also put support in place to protect the health and wellbeing of colleagues who are able to perform their roles from home. We have offered access to equipment to improve the ergonomics of home workspaces and have adopted a Home Working Pledge. Among other things, this pledge encourages colleagues to take breaks from screen working and to be respectful of the challenges that many experience when working from home.

In the year, we recruited and trained a record-breaking number of Session Nurses and Donor Carers to replace leavers, scale-up our convalescent plasma collection programme and to create supply resilience (see page 29).

The impact of the pandemic on the wider NHS has had a consequential effect on blood component demand in 2020-21. Three common themes are evident:

- **Overall demand reduction** – Demand for all blood components decreased compared to pre-pandemic expectations, as hospitals have adjusted their activity to cope with the impact of COVID-19 hospitalisations. Actual red cell issues over 2020-21 were c1.280m compared to a pre-COVID-19 expectation of c1.380m (c7% below expectation). Similar reductions have been observed for platelets and plasma components.
- **More variable demand profile** – In addition to this decline in total annual demand, the demand profile over the past 12 months has been more variable than in previous years. Red cell demand initially declined by approximately a third in March and early April, before increasing to c90% of pre-COVID-19 levels by late April. Over the remainder of the spring and summer, the demand trend generally increased as there were fewer COVID-19 hospitalisations. Demand stopped increasing over the winter months as COVID-19 admissions began to rise again, but did not decline to the same extent as observed during the first wave of the pandemic, aside from the usual decreased levels over the Christmas and New Year bank holiday periods (see Fig. 1).
- **Differential demand by segment** – While total demand has reduced, some segments of demand have not reduced proportionally. For instance, hospitals adjusted their stocks to favour increased proportions of universal components, e.g. O D negative red cells and A D negative platelets. During periods of acute pressure in hospitals (during peak of first and second wave hospitalisations), demand for O neg red cells peaked as high as 17% of total demand (see Fig. 2), whereas only 7-8% of the UK general population has this ABO group.

Fig. 1 – Total Red Cell Demand vs Forecast (7 Day Moving Total)

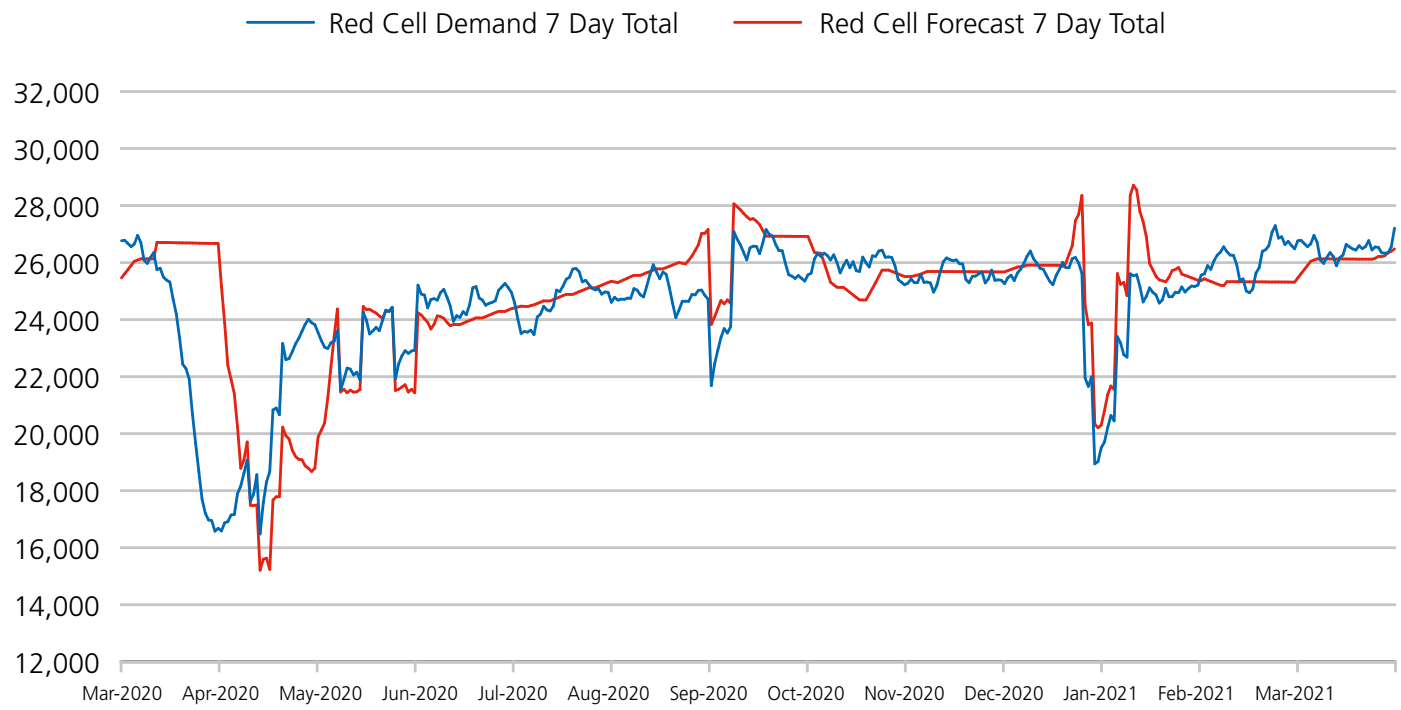
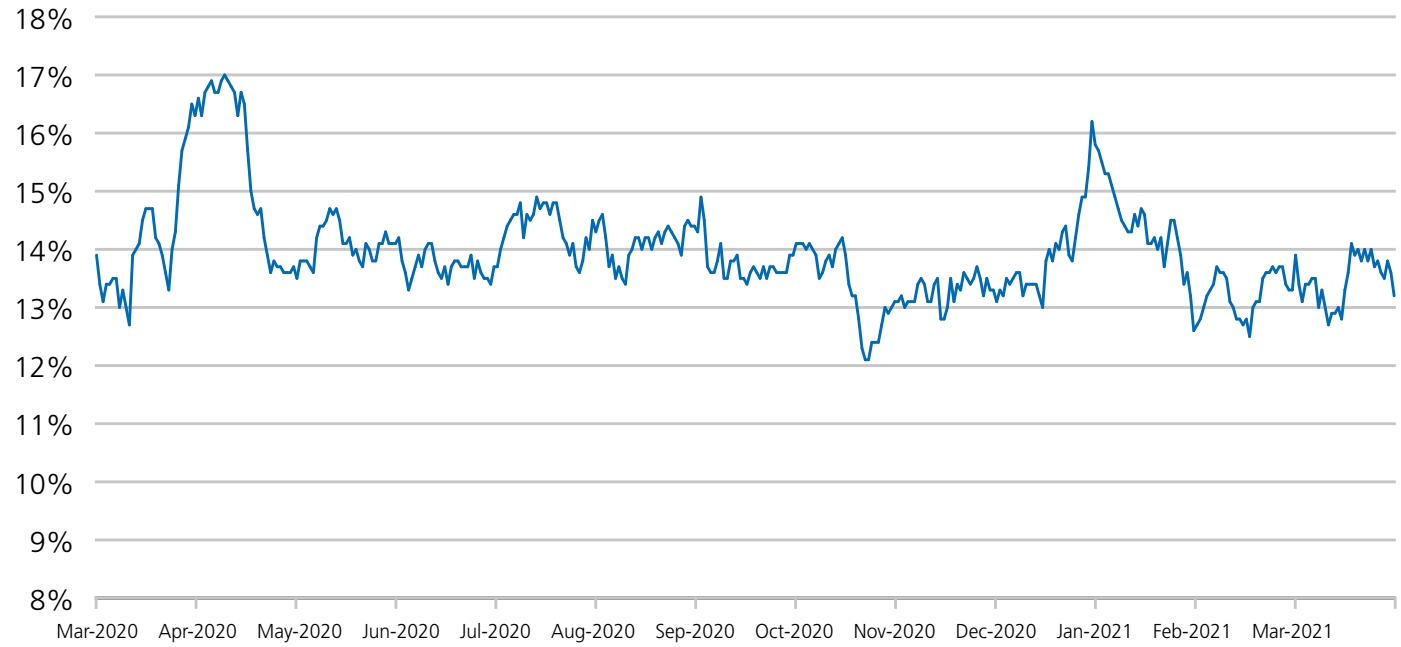


Fig. 2 – O D negative Red Cell Demand as a % of Total Red Cell Demand (7 Day Moving Total)



The main supply impacts during the pandemic have been:

- **Blood Donation venues** – We visit approximately 1,600 community venues, with varying frequency, for mobile blood donation sessions across England in a normal year. The introduction of social distancing measures on blood sessions led to a reduction in donation chairs and donor throughput at many of these venues. To retain as much capacity as safely possible, we consolidated activity into the largest available locations and stopped using around one third of (typically smaller) venues. Additionally, around 70 of our venues were contacted by the National Vaccination Programme to be used for extended periods as local COVID-19 vaccination hubs. We worked closely with local Public Health leads responsible for the vaccine rollout to minimise the impact on our operations.

- **Workforce absence** – We experienced absence levels as high as 15% during periods of 2020-21, with some colleagues who have been categorised as extremely clinically vulnerable entering periods of shielding on government advice. We completed individual risk assessments with all colleagues categorised as vulnerable, and implemented control measures to ensure as many colleagues as possible could continue safely working. Some colleagues have unfortunately caught COVID-19, which has resulted in sickness absence, in most cases short-term.
- **Donor base** – A combination of reduced donation opportunities, lower levels of demand and changes to donor attitudes/behaviours, all led to a reduction in new donors donating, and an increase in existing donors becoming inactive during 2020-21. The combined effect of these factors was a 6.7% decline in the overall active donor base in the last 12 months (from 807,805 to 753,550 at March 2021). We have focussed on minimising the loss of known O neg and Ro donors and, as such, these donor bases have decreased to a lesser extent by 2.1% and 3.3% respectively. This donor base reduction has generally not impacted our ability to meet lower levels of demand in 2020-21, but will require attention in the event of a sustained demand increase (e.g. forecast Ro demand growth).

Due to the variability in demand and supply, overall red cell stock fluctuated between 5 to 10 days of stock over 2020-21. The Blood Operations Leadership Team (BOLT) oversaw an action plan to improve stocks from their lowest point during August-October 2020, which included recruitment of more blood donation colleagues to mitigate the impact of capacity lost due to venue and staffing constraints. Throughout this period, BOLT acted to strike a balance between safe levels of red cell stocks, and diverting resource to concurrently scale-up convalescent plasma collection capacity.

Consequently, overall red cell stocks never fell below minimum safety levels of 4.5 days of stock during 2020-21. Additionally, levels of service to our hospital customers improved with 83% of hospitals scoring 9 or 10 out of 10 for Overall Hospital Satisfaction (from 79% in 2019-20). Our On Time, In Full (OTIF) performance (excluding Ro requests) reached a record high level of 98.6% (from 98.4% in 2019-20). The percentage of donors scoring 9 or 10 out of 10 for Overall Donor Satisfaction is also at the highest on record at 83.1% (from 79.0% in 2019-20).

Ginny Walker

Ginny Walker lost 3 litres of blood after a traumatic birth in June 2018. She was rushed into surgery and received 3 transfusions of O negative blood in total, which saved her life.

"The blood I received was like liquid gold. As soon as I received it I could feel myself starting to improve. The blood transfusions were a lifeline for me and my son."

The pandemic and the subsequent recovery period is likely to shape hospital demand over 2021-22 and beyond, although to exactly what extent is currently unclear. Two long-term supply challenges are almost certain to remain over the coming years:

- O negative blood is often called the 'universal blood type' because people of any blood type can receive it. This makes it vitally important in an emergency or when a patient's blood type is unknown. Approximately 7% of the UK population have O neg blood, but hospital orders for O neg over the past 12-month period have been growing and now represent approximately 14% of total red cell demand. Additionally, we issue O neg red cells as a clinically acceptable substitute component (often for unmet Ro demand), meaning that actual issues of O neg are now typically 15-16% of total red cell issues, more than double the population prevalence
- Ro Kell neg red cell (a type of blood – see glossary) demand continues to grow as more patients with sickle cell anaemia are being offered more regular and automated blood exchanges. Demand in 2019-20 reached c65.6k, representing growth of 9.0% vs the previous year. Further annual growth of 5% had been expected in 2020-21 and, despite the impact of the pandemic, Ro demand remained strong at c65.9k. The growth in demand is forecast to continue over the next few years, reaching 85.8k by year-end 2023-24. As we are currently unable to meet all demand, because we do not have enough Ro donors, we issue a clinically acceptable alternative (usually O neg red cells) for almost half of the Ro requests we receive.

During 2020-21 we have also been delivering a large programme of change. Most significantly, we rapidly established a convalescent plasma collection programme (see page 29).

At the start of the financial year, we successfully moved to a single UK-sourced plasma supply for Fresh Frozen Plasma (FFP) and Cryoprecipitate components, stopping the import of plasma for transfusion and saving the NHS a forecast £3.2m per year.

We have also been working to deliver the Session Solution project. This project will equip our blood collection teams with the software, hardware and connectivity to ensure they can do their job more easily and safely, with fewer manual process steps. Following a pause due to the COVID-19 response, work on this project has restarted including live trials and we are planning to have completed the full roll-out of Session Solution to all blood collection teams by October 2021.

Our Logistics Review Programme (LRP) remains on track to achieve total forecast savings of approximately £3.8m per year, while maintaining existing service level agreements for both our internal and external customers. In the first quarter of 2020-21, the National Rota Parameters, agreed in consultation with Trade Unions, were approved through a ballot of their members. Despite the delay due to COVID-19, new rotas were successfully implemented which has enabled us to optimise our transport operation through both more efficient deployment of our driver workforce and use of third-party suppliers. The Logistics Management Review (LMR) Consultation concluded in December 2020. Recruitment for the LMR project has progressed well and the changes are all on-track to have been implemented during the first quarter of 2021-22.

The implementation of an automated and integrated rostering and pay system for Blood Donation Teams and Donor Centres is underway, with roll-out to all teams expected to be complete by autumn 2021. This solution will see our teams move from a paper-based system to an automated electronic solution, reducing the risk of pay errors associated with manual transcription, removing manual work for our Pay Support team and providing increased and more timely access to roster and pay information for frontline colleagues. The integrated software will also provide opportunities for improved management information within Blood Supply.

Organ and Tissue Donation and Transplantation (OTDT)

STRATEGIC OBJECTIVES:

- To match world class performance in organ donation and transplantation
- To be recognised by the NHS as the preferred provider of high quality, ethically sourced and cost-effective tissue allografts in England, Wales and Northern Ireland.

KEY PERFORMANCE INDICATORS:

OTDT STRATEGIC TARGET – Organs	Target	Actual
Overall consent/ authorisation rate (%)	72%	69%
Number of deceased donors	1,668	1,179
Number of deceased donor transplants	4,358	2,950
% adults in England who have had a conversation about organ donation	43%	39%

Note: the metrics were established by the "Taking Organ Transplantation to 2020" strategy in 2013. Targets were set for 2020/21 based on those metrics until the metrics are refreshed as part of the new strategy. The numbers of donors and transplants have been negatively impacted by COVID-19.

OTDT STRATEGIC TARGET – Tissues	Target	Actual
Tissues and Eye Services (TES) Sales Income £000	16,100	8,700
TES On Time in Full (OTIF)	98.0%	99.7%

Note: the number of elective operations using Tissues products reduced in the year so the income performance against target has been negatively impacted by COVID-19.

Kevin Ferdinand, Heart Transplant Recipient

"It was so sudden – I was normally fit and well and I began to feel sick. I had breathlessness, a loss of appetite and was so tired.

"I thought it was simply a case of just flu or something so continued forcing myself into work, even as things got continually worse.

"As days turned into weeks, things began to get worse. It got to the point where I couldn't get out of bed, get dressed; the things you take for granted.

"It was during another visit to the GP when it was noticed that my eyes were turning yellow, indicating something was wrong with my kidneys. I was immediately referred to Bradford Royal Infirmary.

"When tests came back after nearly five hours, they indicated I had major organ failure.

"My kidneys and liver were shutting down and my heart was damaged – with only 7 per cent of it working. Things were quickly deteriorating.

"I was rushed into intensive care and put on to a lot of drips. Doctors told me and my parents that I would be lucky to make it through the night.

"My daughter, Lacie-Rose, was two at the time and I was worried but tried to keep positive. Throughout the journey I wanted to stay alive for my loved ones.

"Once I was clinically stable, I was placed on the transplant waiting list.

"It was overwhelming when I got the news that there was a matching heart: very emotional and very frightening. You don't know if you're going to make it through or not.

"Following a successful 19-hour operation I was kept asleep for nine days.

"Now I have got to be a father again and can play an active role with Lacie-Rose.

"No-one likes to talk about these issues. I think it's very important that people have that conversation with their family about organ donation, unfortunately death is a part of life. If you donate your organs you will be saving someone's life – giving the gift of life."

OPERATIONAL REVIEW

Tania Mortimer-Fennell

Tania Mortimer-Fennell's mother, Caroline, gave the decision to donate Tania's kidneys and liver & lungs, when Tania passed away from a brain haemorrhage on Mother's Day aged just 17. Tania had discussed with Caroline about her wish to save someone's life and had added it to her 'life-list'.

"Tania had discussed her wishes with me and added 'saving someone's life' to her 'life list'. That made it easier to action her donation. It wasn't my decision it was hers – I just carried out her wishes; the last act I could do for her. It was so important we'd discussed it and I know that three other families have been spared the sadness of losing someone they love because of her brave decision and that brings comfort."

Caroline (Tania's Mum)

We are hugely grateful to the 1,532 people and families who consented to solid organ donation in 2020/21 – 1,179 of whom proceeded to donation – and to the many people who made the courageous decision to become living donors.

In 2020/21 we set out to build on previous years' progress with an ambitious annual target of 1,668 deceased solid organ donors. However, the pandemic had an unprecedented impact on the UK's organ donation and transplantation system, because we rely on intensive care and other acute hospital facilities. Nonetheless, we maintained 71% of the deceased donors and 79% of transplants in 2020/21 compared to 2019/20.

We are still working to understand the full impacts of the pandemic. At the time of writing, our latest assessment is that the transplant waiting list may grow to levels last seen in 2013/14 – mainly as a result of lost donation and transplantation opportunities during the last year. We therefore worked tirelessly to restore services during 2020/21 and now look to recover strongly during the coming year.

Quarter one 2020/21 saw us overcoming challenges during the early months of the pandemic to support 195 proceeding donors. Our Recovery programme laid foundations for a return to pre-COVID-19 activity levels during summer 2020, resulting in 392 deceased donors overall in Q2. During Q3 306 deceased donors proceeded, exceeding numbers in the first wave of the pandemic, despite immense pressure on hospitals.

In early 2021 the number of proceeding donors fell again. We were nonetheless growing in confidence that strong foundations had been lain to enable further recovery, and we indeed ended Q4 with a strong number of deceased donors in March (286 in total in Q4), taking us into 2021/22 in a good position. 2020/21 saw higher than ever public support for organ donation (consent/authorisation rate 69%) partly due to changes in law.

The UK's Critical Care capacity remains under enormous pressure, and consideration with regards to risk and benefit is particularly important when marginal organs are offered to potential recipients during the pandemic. The fact that 2,950 deceased donor transplants have been performed in 2020/21 is a credit to the whole of the transplantation community as they adapt to these ever-changing challenges.

Despite some strong individual months, the consent/authorisation rate from Black and Asian donors continues to be a challenge (36% in 2020/21). However, we continue to see increases in the number of Black and Asian patients transplanted due to organ offering scheme changes implemented in recent years. Overall, 84 deceased donors and 683 Black and Asian transplants have been facilitated. This represents 7% of deceased donors and 23% of all deceased donor transplants.

Dishna donated a kidney to her Mum to save her from going onto dialysis in 2018. She believes saving someone's life is very powerful in the Hindu teaching. Dishna is mother to two young boys.

Dishna says, "Donating an organ is an incredible and life changing gift one can give to a patient in need.

"My kidney donation has given my mum a new lease of life, she looks and feels so amazingly well."

Dishna Hirani, organ donor

We are also very grateful to the 444 living donors in the 12 months to March 2021. We saw a large decrease in living donation in Q1 due to the suspension of the UK's living donation programmes in response to COVID-19, with just

29 living donor transplants taking place. This increased to 161 in Q2 and 164 living donor transplants in Q3. The UK Living Kidney Sharing Scheme quarterly matching runs were cancelled in April and July 2020, but the October matching run went ahead as scheduled. However, with 75% of the 92 identified transplants from the October run yet to proceed, a risk-based approach resulted in the January 2021 matching run being cancelled. A further reduction in numbers was anticipated in Q4. However, despite these challenging conditions, 90 transplants have been reported so far as having taken place during Q4 (one month in arrears and larger delays than usual in reporting living donor transplants). As with deceased donation, we are encouraged by signs that activity accelerates strongly once centres begin to recover. The UK Living Kidney Sharing Scheme quarterly matching run is due to take place in April 2021 as planned.

England's move to an opt out system, as a result of Max and Keira's law in May 2020, has seen 344 cases of support for deemed consent in England in 2020/21 from the 516 patients where deemed consent applied (67%). We will make the most of this new legislation and new ways of working adopted during this unprecedented year, along with the rest of the vision for the next ten years, in the upcoming Strategy – *Organ Donation and Transplantation 2030: Meeting the Need.*

Jo's life turned upside down when her sight began to deteriorate at an alarming rate.

Numerous treatments failed and Jo thought she may never be able to regain her vision.

But then a serum made from the plasma of male blood donors gave her hope. NHSBT has been providing serum eye drops from 2003 and is the only accredited production facility in the UK.

"Without these drops my life would be so different. I can't imagine not seeing my children's faces as they grow, missing out on the details of their lives. I'm so grateful to all those who donate blood, these drops help me to live my best life and appreciate the beauty of my life.

"I was so worried for so long and in so much pain. I tried everything until I was finally offered these drops and I went from living a life in the dark, feeling so hopeless to embracing life again."

Dr. Jo Daniels, Serum Eye Drops recipient

Tissue & Eye Services

OPERATIONAL OVERVIEW

Unlike ODT (which is funded by Grants), our Tissue and Eye Services are funded by product sales. We have experienced challenges in both donation and product sales, as COVID-19 led to significant cancellations in the orthopaedic and ophthalmic elective surgery in the NHS. We have facilitated 1,384 ocular donors this year, compared to 2,389 in 2019/20, and 290 heart valve donations, compared to 320 in the previous year. Our overall income position was £9,723k, against a target of £13,308k, a year-on-year decline of 22%.

Despite the challenges, we have had many successes including: ensuring that the supply of serum eyedrops was maintained for patients during the pandemic (income for this product was £672k (24.4%) ahead of 2019/20); introducing a new innovative heart valve product which allows more patients to be treated from a single heart donation (income for these was £271k (45%) ahead of 2019/20): and we also met the increased NHS demand for skin during the pandemic (income for skin is £115k (31.8%) ahead of previous year).

We also supported the wider NHS response to COVID-19 by seconding around 100 nurses from across the Organ Tissue Donation and Transplantation Directorate to an NHS Bereavement Helpline at very short notice.

Sonia Beard

"I was 17 when I had my heart valve transplant.

"I know it's a cliché, but it is like having a new lease of life after transplant – you become so accustomed to being unwell and unable to do everyday activities, so being able to do all the things I loved doing before, such as tap dancing, was amazing. "I tap-danced for 12 years before my op and had to give up due to illness. I'm dancing again now and five months after my transplant I ran a 10k race!"

Clinical Services

STRATEGIC OBJECTIVES:

Within the Stem Cell and Therapeutics Function we have the following strategic objectives:

- The Stem Cell Donation and Transplantation Teams (SCDT) aim to maximise the number of patients offered a potentially curative stem cell transplant by providing an effective, affordable and financially sustainable supply of well-matched unrelated donor stem cells
- The Cellular and Molecular Therapies teams (CMT) aim to establish NHSBT as the preferred provider of cell therapies to the NHS, and of innovative cellular and DNA-based therapies for academic and commercial organisations
- The Therapeutic Apheresis teams (TAS) aim to become the NHS preferred provider of high quality, cost effective services.

During 2020 we started updating our strategy in this area. This will be completed in 2021/22 and aligned to the UK Stem Cell Strategic Forum outcomes. We play a key role delivering workstreams for the forum. Our progress in the year was impacted by the COVID-19 pandemic, as we and our NHS colleagues supported the national response.

Our Red Cell Immunohaematology (RCI), Histocompatibility and Immunogenetics (H&I) and International Blood Group Reference Laboratory (IBGRL) teams, in our Diagnostic Services function, aim to provide an innovative, integrated, technologically enabled service, saving patients' lives by ensuring they have access to precisely matched blood, stem cells and organs when needed. Over the next year we will be working with academics and others in the NHS to understand the benefits of widescale genomic typing of both donors and patients, and how this could improve the services we provide and how we can support the national genotyping effort.

KEY PERFORMANCE INDICATORS:

CLINICAL STRATEGIC TARGET	Target	Actual
Sales Income £000 YTD	£71m	£66m

Note: the Income KPI above has been adversely impacted by the COVID-19 pandemic.

OPERATIONAL REVIEW

Our Clinical Services strategic business units (SBU's) aim to be preferred national suppliers to the NHS, ensuring a not for profit supply from within the NHS. Overall, we look to deliver growth in activity each year, through provision of more high-quality products and services for patients, which will be fed back to the NHS by keeping future prices as low as possible and investment to develop new and improved therapies.

In 2020/21, the COVID-19 pandemic has driven a material reduction in service demand, particularly during the first wave of the pandemic in quarter one, but also during the second wave in quarters three and four. The pandemic also required us to adapt our Clinical Service operations to effectively manage risks relating to staff absence, maintaining a COVID-secure environment and consumables supply, as well as the risks posed by the Winter flu season, bad weather and the end of the transition period with the European Union. Clinical Services successfully maintained the provision of our diagnostic, therapeutic apheresis, stem cell and advanced therapy medicinal (ATMP) products and services to hospitals throughout the pandemic.

We also responded to requests for additional help in support of the national response, with our Research and Development function providing support to several clinical trials, including provision of more than 60k samples for Public Health England's seroprevalence study and support to the REALIST Advanced Therapy Medicinal Products (ATMP) study.

The **NHS Cord Blood Bank**, maintained by our Stem Cell Donation and Transplantation (SCDT) function, aims to store unrelated stem cells to ensure that all patients, whatever their ethnicity, have access to a curative stem cell transplant should they need it. We collect more samples to supply patients from ethnic groups who have less chance of receiving stem cells from other sources. By March 2021 we had 18,601 units in the bank, just under our target of 19,000. Pandemic related restrictions in NHS hospital maternity wards have restricted our cord collection activities this year.

The NHS Cord Blood Bank issued 45 units for patients in the year, a reduction from the 49 issued last year. Just under half of the units issued (22) were sent to non-UK customers, with UK provision increasing from 15 to 23 this year.

During 2021/22, we will update our Cord Blood strategy as part of the broader Stem Cells and Therapeutic functions strategy work. We remain committed to maintaining this unrelated stem-cell bank. We also support clinical trials that seek to expand the use of cord blood for both stem cell transplants and other advanced cell therapies. Going forward, the costs of the blood bank will reduce as the bank transitions from growing to maintaining stock levels.

SCDT also manages the **British Bone Marrow Registry** (BBMR). Activity was also lower than plan with 117 units issued to patients versus a target of 240 (and 193 last year). This was driven by the COVID-19 pandemic restricting the number of stem cell transplants performed in the UK, and export provision being impacted by application of a 'US donors first filter' on searches for US Transplant Centres (to reduce the risk on their supply chain during the pandemic). Actions will be progressed as part of the updated Stem Cell and Therapeutics Strategy to optimise the BBMR registry to meet patients' needs more often from the UK. In December 2020 the NHS Cord Blood Bank issued its 800th cord and the bank reached its 25th anniversary.

Mark was diagnosed with severe aplastic anaemia in 2008. He had 104 blood and platelet transfusions along with a bone marrow transplant followed by a stem cell transplant at the Sheffield Hallamshire Hospital in 2013. Following his second stem cell transplant in 2013, Mark finally recovered, he now has a young family (Iona 7 & Magnus 5) and is doing very well. Mark runs his own technology business and also now works as a patient advocate and a director and trustee of Anthony Nolan to help other patients going through blood cancer and blood disorders.

Mark keeps fit by playing tennis and running; in 2016 he ran the London Marathon to raise funds for Anthony Nolan and in 2019 ran a half marathon with his Bone Marrow Donor.

"The blood and platelet transfusions kept me alive and the stem cell transplant saved my life. Without the work of NHSBT, all the blood donors and of course my selfless stem cell donor I would not have the chance to see my children grow up".

Mark Ritson, Stem Cell recipient

Routine service activity grew by 12% this year in our **Cellular and Molecular Therapies Service** (CMT) despite the pandemic, with a strong recovery seen after an initial reduction in quarter one. Advanced cell therapies income was, however, down year-on-year (-20%) due to pandemic driven delays. The Clinical Biotechnology Centre activity and income was in line with plan (level year-on-year).

CMT manufactured Mesenchymal Stromal Cells (MSC), from NHSBT umbilical cord tissue, for the REALIST Clinical trial to treat patients in intensive care with acute respiratory distress syndrome (ARDS). MSCs were supplied for the phase 2a trial that was repurposed solely for COVID-19 patients with ARDS. A second REALIST trial, for non-COVID patients in ICUs with ARDS, is due to start soon.

The latest CMT customer survey scored 100% for customer satisfaction in 3 key areas for stem cell transplantation activity, and CMT completed the successful relocation of Leeds and Sheffield laboratories to Barnsley, with new capacity for Advanced Cell Therapy Work coming on-line.

Our **Therapeutic Apheresis Services** (TAS) national function treated 1,926 patients (compared to 1,933 the previous year), performing 9,390 procedures. Patient satisfaction increased from 92% to 97%. Procedure levels fell to 20% below plan during the first wave of the pandemic, but steadily rose during the months after, ending the year 6% below plan and 1% ahead of last year. TAS provided extra resilience support to (non-contracted) services across many parts of the country. Within the London region, the nursing and medical workforce was stretched during the pandemic by a combination of vacant posts and increased referral levels in that area, impacting our ability to treat patients. This required support from nurses and Consultants from across the wider TAS establishment, and the situation will remain fragile until Q1 2021/22 when newly recruited staff commence in-post.

In our Diagnostic Services functions, demand for our **Histocompatibility and Immunogenetics** (H&I) service was materially affected by reduced NHS activity. This was driven by the initial suspension of elective work in hospitals during the first phase of the COVID-19 pandemic, the gradual pace of activity restoration and by the second wave of the pandemic. Income was down on plan by 23% and 20% behind last year.

Red Cell Immunohematology (RCI) activity was also below plan, mostly on pre-transfusion patient investigations (down 10% on last year). The **International Blood Group Reference Laboratory** (IBGRL) also saw a reduction in molecular diagnostics support to NHS patients, with referral volumes down by 4% in-year, due to the pandemic. In IBGRL we experienced challenges obtaining consumables needed for fetal screening as global demand rose for these driven by the pandemic response. We continue to manage this proactively to mitigate any impacts on our services.

IBGRL hosts and manages the International Rare Donor Panel (IRDP) on behalf of the global transfusion community, which is used to locate and facilitate the exchange of rare blood between a collaboration of 27 countries. A project to replace the limited and outdated database with a new web-based platform within Microsoft Dynamics 365 CRM was completed successfully in December 2020, with very positive feedback from the user community. This has also reduced the risk of transcription errors.

Our customer satisfaction scores were above target in all services. Within our Diagnostic functions we exceeded 95% for RCI and H&I, and in IBGRL we exceeded 98% for Fetal RhD screening and 99% for Patient Genotyping.

The COVID-19 pandemic resulted in five of our six SBU's being below income budget for the year. In Stem Cells, Therapeutic Services and Cellular and Molecular Therapies, income was just below plan, but Stem Cell Donation and Transplantation income was 22% below budget. Therapeutic Apheresis income was also close to plan, protected in part by a block contract commissioning arrangement in-year with NHS England and Improvement (NHSEI). In Diagnostic Services, Red Cell Immunohematology income was 7% behind plan as income was partly protected by a fixed cost plus variable recharge mechanism in place; Histocompatibility and Immunogenetics income was 23% below budget; and IBGRL was 9% below plan.

Overall, this resulted in a £7.0m, 10%, adverse variance for Clinical Services against the income budget (including both invoiced sales and DHSC funding in support of stem cell donation / cord blood banking). This was offset, in part, by expenditure savings of £3.5m across the directorate, generating an adverse impact on Clinical Services financial contribution of £3.5m. In 2021/22 we will mitigate the demand risk to our income by introducing fixed and variable billing arrangements in both Cellular and Molecular Therapies and Histocompatibility and Immunogenetics.

In Clinical Services we received zero "major" and zero 'critical' regulatory non-compliances (compared with two reported in DTS during 2019/20). There was one Serious Incident relating to a transcription error (see page 56) compared to one in 2019/20.

Clinical Service projects

The Clinical Services Directorate is leading a major project to replace the Clinical Biotechnology Centre in Bristol and house it within an extension to our Filton Centre. The planned investment will require around £8.7m of capital funding and will increase the capacity of NHSBT to manufacture small batches of plasmids for use in clinical trials on stem cell therapies in the UK. The project was approved by the NHSBT Board and DHSC during 2019 and is proceeding to plan. The building has been constructed and the internal fit-out is now underway. This project represents a major investment in the UK's capabilities in regenerative medicine and will enable us to support nationally important research and industry development.

Research and Development

Our innovative translational research, clinical trials and development projects inform international best practice in transfusion, transplantation and regenerative medicine. The evidence our scientists and clinicians produce improves outcomes for patients who rely upon our products and services.

Achievements:

- We have collaborated with the two national trials (RECOVERY and REMAP-CAP) testing convalescent plasma among other treatments for COVID-19. 5,796 patients received convalescent plasma at 226 hospitals in the RECOVERY trial and 1,040 patients received plasma at 122 hospitals in the REMAP-CAP trial (see page 29)
- Our organisation wide randomised-controlled trial of interventions aiming to reduce the number of donor faints (STRIDES) continues. The trial is one of the largest ever conducted in the UK and is testing four different strategies to determine which is the most cost-effective; the main trial (involving all blood donors over 3 years) continued to recruit throughout the pandemic, and is ongoing, whilst the associated BioResource involving a subset of donors was paused in March 2020 to allow staff to focus on blood stock. The BioResource recommenced towards the end of 2020
- Following on from our work to improve understanding of barriers to and facilitators of blood and organ donation for BAME communities, we have secured £600,000 from the government to fund a Community Investment Scheme to address the issues. Community groups may apply to this scheme to fund projects
- The universal platform for genotyping our blood donors, allowing a complete profile of their blood groups to be determined in a single test, has now been successfully validated. The next stage is to recruit blood donors to the UK 5 Million Early Disease Detection Research Project, leading to a significant increase in the number of donors being typed with this new test
- Under Transfusion 2024, the Haem-Match programme, looking at ways to better match blood for transfusion to patients with haemoglobinopathies, is getting underway
- Received funding for a large trial in organ donors to see whether administering a dose of a statin to the donor will improve the quality of the donated organs. The data collection for this study will be from the organ donation and transplantation registry and this will be the world's largest trial of an organ donor intervention and will pave the way for further organ donation trials
- Published the results of our research in 185 scientific papers in national and international journals.

Plasma

Convalescent plasma

Building from scratch to 1,700+ staff and 40+ sites.

When the COVID-19 pandemic swept the world in early 2020, NHSBT moved quickly to supply two trials testing convalescent plasma (CVP) as a treatment for COVID-19. This meant building an entirely new plasma operation from scratch. This research work was shared widely and informed decisions made in medical treatment of COVID-19 around the world.

The first trial, RECOVERY, started in April 2020, and treated early-stage patients. RECOVERY is the largest CVP trial for COVID-19 treatment in the world to date. A second trial, REMAP-CAP, began in June 2020, treating patients in intensive care with CVP.

NHSBT established CVP collection capacity across more than 40 donor centres. This included the opening of 21 new CVP donor centres. We were able to provide enough plasma to supply both trials, which combined had over 16,000 randomised patients.

The enormous scale of building the CVP Programme meant that we could not 'go it alone'. We worked closely with organisations across the Life Sciences and industry such as Superdrug, with our regulators (MHRA and CQC) and with other public health organisations. By helping to deliver the largest CVP trial in the world, NHSBT played a key part in placing 'Global Britain' on the map, helping to strengthen the UK's reputation as a global scientific leader.

While interim results from the trials have shown that there are no clear patient benefits of CVP for COVID-19 treatment, our work has provided clear answers to the international scientific community. Researchers have used trial findings to pivot to exploring alternative, life-saving treatments. RECOVERY trial analysis is ongoing, and international trials on the use of plasma to treat COVID-19 continue. We are hopeful that outcomes will show patient benefits through CVP treatment, for example in the earliest stage of the disease.

Scaling at pace, while increasing our diversity

In under a year, NHSBT recruited over 1,700 staff to the Convalescent Plasma Programme. From the outset, NHSBT emphasised increasing BAME and youth representation. We did this by using new recruitment channels to reach BAME communities and young people, and expanding interview candidate metrics to include values, behaviours and passion for NHSBT's work. We were able to increase the percentage of BAME nurses from 13% (NHSBT average) to 42%. For Donor Carers, we increased this percentage from 9% (NHSBT average) to 26%. We were proud to win the HR Excellence 2020 Award for Best Recruitment Strategy.

We transformed our online training, reducing the training programme from 12 to 6 weeks, whilst ensuring the highest level of quality and patient safety.

Setting up a major programme at pace involved every part of our organisation – from HR and IT to donor experience, clinical services, marketing, blood supply and quality assurance. We worked across NHSBT's Directorates to deliver, while in the process smoothing operational procedures, increasing flexibility and engraining an entrepreneurial mindset across the organisation.

Thinking innovatively about donor recruitment

Imam Sayed Jafar Baraka encourages plasma donation through our Turn to Love campaign

To reach the donor cohort with high antibody levels, we developed a highly targeted Community Engagement Programme concentrating on regions with the highest number of hospitalised patients. We worked with clinical staff to recruit still-hospitalised plasma donors, as well as primary care providers, religious organisations and community groups.

Our BAME-specific partnerships and campaigns also helped us to reach BAME communities.

In just six weeks, we hired a team of 50 field-based donor recruiters from diverse backgrounds, many recently furloughed or made redundant, and identified 60 'NHSBT Ambassadors,' to encourage plasma donation.

We built a new donor base of 80,000 unique donors (who had attended at least one convalescent plasma donation session). Of these, 82% had never attended an NHSBT blood or plasma donation session before.[1]

What's next for UK plasma

In March 2021 the Government approved the use of UK plasma for the production of immunoglobulins, also known as plasma-derived medicinal products (PDMPs), which will be used to treat conditions such as trauma, congenital deficiencies, immunologic disorders and infections.

The UK's PDMP supply is currently completely dependent on plasma collected internationally. Plasma from NHSBT's donors can now be used to meet part of the UK market demand, benefitting thousands of UK patients.

In June 2021, we received confirmation of funding, until at least March 2022, for us to collect plasma to meet 20% of the UK's patient need for PDMPs.

Key stats (as at end February 2021)

42	Convalescent plasma donation sites opened.
88,179	Unique donors attending at least one session with the intention of donating CVP or giving a CVP sample. Of these, 83% were new to blood donation (had never attended a session before).
49,163	donating CVP or giving a CVP sample. Of these, 83% were new to blood donation (had never attended a session before).
55,192	Total donations collected.
29,143	High titre units (validated and potentially validated) produced from these donations.
14,100	Patients randomised through the RECOVERY trial.
5,796	Patients who received CVP through the RECOVERY trial.
226	Hospitals reached through the RECOVERY trial.
1,930	Patients recruited to the REMAP-CAP trial.
122	Hospitals reached through the REMAP-CAP trial.

1 As at end February 2021.

Case study 1

Darren Buttrick, 49 years old, married with three daughters from Coven in the West Midlands

Darren Buttrick contracted COVID-19 in March 2020. His situation quickly deteriorated, and was placed on a ventilator. Darren placed a call home to his family on 20 March, on what he calls a "*very dark day in March when (I) was told to fight for my life.*" Fortunately, Darren recovered.

When NHSBT called Darren to ask if he would consider donating his plasma, he says it was a "*no brainer.*".

NHSBT allows a maximum of 24 plasma donations per year. Darren reached the 24 donations milestone on 12 February, making him the person in England who has donated plasma the most times.

Darren says, "*For me it was about giving back. The NHS saved me; I know how very ill I was. (…) Donating my plasma has helped me get over the emotions of having COVID-19 and the bad way I had it – it has helped my emotional recovery. It's the feeling of giving back – and helping others.*"

Case study 2

Dr Wassim Shamsuddin, 40 years old, married with three children and from Bicester, Oxfordshire

Dr Wassim Shamsuddin is a consultant anaesthetist at Milton Keynes hospital. He caught COVID-19 in April 2020. Wassim first donated his plasma in June when NHSBT's first appeal went out seeking more male donors (due to higher antibodies in male plasma). He continued donating regularly, and reached double donation figures.

Wassim played a key role in encouraging more Asian donors to donate plasma, including by speaking on the BBC Asian Network.

He says, "*I have seen how the virus has disproportionately affected the Black and Asian communities. (…) Knowing that people have lost their lives to the virus and seeing this for myself at work, (I think that) if plasma could be the difference between life or death, I'm glad that I have been able to play my part in helping others.*"

Group Services

Our group services are Strategy and Transformation, Donor Experience, Digital Data and Technology Services (DDTS), Quality, People, and Finance. The objectives for our group services are shown below. The Strategy and Transformation, Donor Experience[2] and DDTS reviews are below. The Quality activity is reflected in the governance statement page 55. The People activity is reflected on pages 37-49. The Financial review is at page 34.

- Strategy and Transformation: Developing our corporate strategy, the transformation roadmap to deliver, and frameworks to manage and govern progress.
  - Collaboration across the organisation to develop our strategic vision.
  - Prioritised transformation portfolio that supports our vision.
  - Frameworks to manage risk and govern our progress and manage challenges.

- Donor Experience: Deliver the volume and mix of donors to meet patients' needs.
  - Strengthen our donor base to meet patients' needs.
  - Diversify our donor base to help reduce health inequalities.
  - Increase donor satisfaction across all segments by improving our donors' experience.
  - Grow a new plasma donor base to support the UK's self-sufficiency in plasma products.
  - Develop a resilient, diverse and engaged workforce by updating the way we work together.

- Digital Data and Technology Services: Deliver quality digital, data and technology services through an expert community of staff and supplier partners. Our digital vision is underpinned by 7 strategic objectives.
  - Improve the digital experience for donors.
  - Modernise blood technology.
  - Build new technology for plasma.
  - Design inclusive and human-centred services.
  - Protect, secure and create insight from our data and information.
  - Stabilise and future-proof our infrastructure and operational services.
  - Develop our community of people, adopt new ways of working and deliver change at pace.

- Quality: Support the delivery of donor and patient safety and the achievement of world-class regulatory performance through innovation and continuous improvement.
  - Support regulatory compliance and quality standards across NHSBT.
  - Develop enhanced digital and user-centric Quality systems and processes.

- People: Driving the best employee experience now, and for future NHSBT colleagues and partners, enabling our NHSBT people to thrive in order to save and improve more lives.
  - Make NHSBT a diverse and inclusive organisation to achieve equity for our workforce and the communities we serve.
  - Put health, wellbeing and safety at the heart of our organisation.
  - Support a culture of leadership, education and learning.

- Finance: Delivers finance, procurement, estates & facilities and contract management services.
  - Ensures that our critical services are financially secure.
  - Provides efficient and effective financial services and meet procurement needs.
  - Provides high quality facilities, operating to the highest regulatory standards and support NHSBT in being a great place to work.
  - Leads our sustainability strategy and supports the national and NHS goal for net zero carbon emissions.

2 Donor Experience is a donor facing operational service but is allocated as a group service overhead to the 3 income generating Operating Divisions.

Strategy and Transformation

The Strategy and Transformation Directorate was being established throughout the year. The directorate brings together a number of corporate functions that collectively facilitate the creation of our corporate strategy and transformation portfolio, and support the way we deliver, including our governance and risk frameworks. The directorate also leads our diversity and inclusion agenda, working closely with the People function. Work is underway to refresh our corporate strategy and this work will complete in 2021/22, setting out our vision for transforming services to save and improve even more lives.

Donor Experience

The new Donor Experience directorate was created at the start of the year by bringing together the teams responsible for the recruitment and retention of our donors: Marketing, Communications and Donor Relationship Services. A new senior management team was in place for 2021/22. Re-organisation continues to align teams to their new functions and invest where more resource and capability is required for the future.

Throughout the year our donors continued to deliver their amazing support to the NHS and patient needs. Collections for blood and platelets were sufficient to meet the highly variable demand. Necessary investment in donor engagement and collection capacity was made to ensure stock levels were maintained, or returned quickly after a period of high demand. Despite the impact of COVID-19 our marketing campaigns continued where necessary, in particular to support the Organ Donation legislation change, where we achieved the necessary 75% awareness level as required.

We continue to invest and prioritise the diversification of our donor base to better support the changing demographics of NHS patients and help reduce health inequalities. Increasing the supply of Ro Kell Neg blood is one such priority and is being supported through increased investment into the marketing and engagement of donors of Black Caribbean and Black African ethnicity, who are more likely to have this blood type. Further investment into increasing awareness and willingness to donate across ethnic minorities is also part of our Organ campaign, where awareness is lower than the population average. The pandemic brought new barriers to our efforts generally so limited improvement was possible during the year. 2021/22 plans have been adjusted accordingly with further investment and prioritising the improvement of donation experience for our priority donors.

And finally, to further support our donors, and our minority ethnic donors in particular, we have formalised a multi-year programme of change to improve our donors' experience across the end-to-end journey in donation. Initial focus has been on whole blood donation experience, and specific development of new products and services that support online self-service, better transparency on available appointments and the first steps in personalisation of content and engagement.

Digital Data and Technology Services DDTS

2020/21 has been a pivotal year for DDTS with significant progress being made across all strategic objectives.
To respond to the COVID-19 pandemic we had to rapidly change our ways of working to respond at pace, deliver many new capabilities, enable a third of the workforce to work productively from home and continue to deliver in-flight strategic programmes.

Throughout the year we delivered changes to our digital donor experience, delivering new donor registration pathways to cater for an increased volume of blood and convalescent plasma donors, and implemented accessibility improvements to make our products more inclusive.

We made solid progress towards modernising blood technology, legacy infrastructure was replaced, the conversion of our critical blood supply system to a modern code base commenced and board approval was received for a 5-year modernisation programme of work.

We have reduced cyber vulnerabilities through the establishment of a cyber programme, a cyber operations team and the implementation of new capabilities. This programme of work takes maximum advantage of NHS Digital cyber capabilities with risk reduction measures continuing to be delivered over the next year. We continue to monitor our compliance against evolving NHS Digital cyber requirements.

In order to deliver effectively we introduced new ways of working, created multi-disciplinary product centres, increased our focus on human centred design and hired staff into new critical roles. These foundations will enable us to continue working at pace in the future.

Learning from compliments, comments and complaints

Our complaints procedures are in line with best practice published by the Parliamentary and Health Ombudsman. We aim to provide excellent customer satisfaction where 60-72% of our customers rate our service as 9 or 10 out of 10. We encourage compliments and complaints from hospitals, blood donors, from organ donor families and from our patients. We make it easy to give us feedback and we review every complaint and our lessons learned from them as part of our clinical governance in our CARE committees (see page 56). If our customers are not satisfied with how their complaints are resolved they can complain

to the Parliamentary and Health Ombudsman. In 2020/21 there were three requests for information made through the Ombudsman, we met these requests and had no complaints (two 2019/20).

Customer	Compliments		Complaints	
	2020/21	2019/20	2020/21	2019/20
Hospitals	196	283	919	908
Blood donors	7,590	13,219	6,258	5,428
Organ donor families, public, transplant recipients and hospitals	165	132	104	93
TAS patients/ referring clinicians	250	224	2	4

In our latest half-year satisfaction survey, 100% of our hospital transfusion customers were satisfied or very satisfied with NHSBT overall, and 100% were satisfied or very satisfied with the range and quality of our blood components, the service provided by NHSBT drivers, the provision of matched platelets and the service provide by Hospital Customer Service Managers.

83.9% of our blood donors (78.4% 2019/20) scored us nine or ten out of ten for overall satisfaction. The improvement in donor experience was as a result of continual improvements to the session environment and communications to ensure donors felt safe donating, despite the impact of COVID-19.

However, COVID-19 saw wide ranging challenges to our Blood Supply activity, smaller and reduced frequency of sessions due to safety restrictions and an increase in session cancellations for reasons such as venue suitability and staff sickness absence. These 20/21 results reflect the significant impact that arose from and still impacts our service due to COVID-19.

As a result of the increases seen, a comprehensive complaints review was undertaken in 20/21 and we are currently implementing a root and branch review of the department to transform the way we listen and act upon this feedback and deliver a best-in-class customer experience.

In ODT we have seen an overall increase in complaints linked to legislation changes but clinical complaints have reduced on prior years. Despite the pandemic, we received a large number of compliments, an increase on prior years.

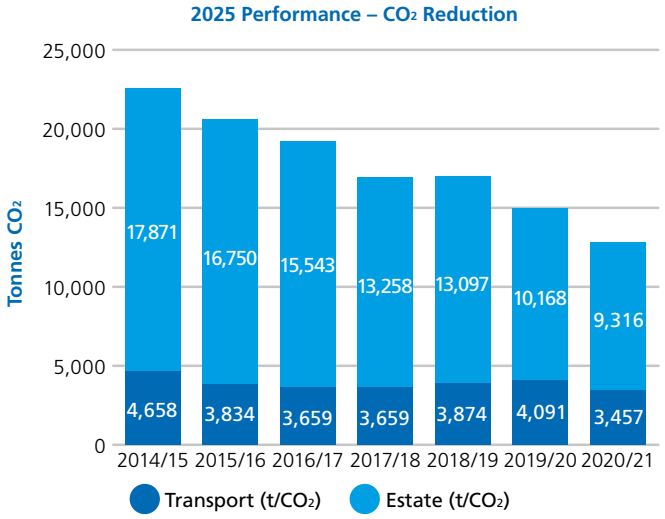
In 2020, 97% of our patients rated our overall service 9 or 10 out of 10.

Our approach to sustainability

Our current Sustainability Strategy was published in 2015. It covers the period through to 2025 and, along with embedding sustainability into our organisational culture, it includes the following key objectives:

- A 50% reduction in our direct carbon emissions
- Delivering zero waste to landfill (excluding clinical waste)
- A resilient business creating a sustainable supply chain.

We continue to see good progress with a 44% reduction in carbon emissions to date versus the 2014/15 baseline. Although there has been a positive impact on energy usage as a result of COVID-19, the underlying trend continues to be positive. This is being delivered as a result of the rationalisation of our old Leeds and Sheffield sites and continued implementation of low energy schemes, including the installation of Solar PV electrical generation at Manchester and our new Barnsley site.



We remain on course to deliver our strategic target with further benefits to come from:

- The full year effect of Leeds and Sheffield site closures and opening of the new Barnsley site
- Installation of a Solar PV system at Newcastle
- Implementation of a lighting replacement scheme at the Filton site
- Development of designs for a further Solar PV renewable electricity scheme at our Liverpool Centre
- Commencement of the electrification of NHSBT's fleet and installation of the necessary charging infrastructure.

With regard to our "zero waste to landfill" our performance was less encouraging and, although our waste contractor ensured that all waste produced on our sites was diverted from landfill sites, it was found that a proportion of waste from some of these treatment facilities was still found to be going to landfill. As a result, we have worked with the contractor to identify the waste streams involved and install dry mixed recycling bins. This will now enable all waste to be truly diverted from landfill and for us to commence external certification of our "Zero Waste to Landfill" credentials.

Our objective to be a resilient business is focused on our compliance with ISO14001:2015 (Environmental Management System) certification. We have been certified for the last 6 years, and have seen continued improvement in our assessment scores, demonstrating that our system for managing and improving sustainability and environmental performance is resilient and robust.

The objective for a sustainable supply chain is underpinned by the adoption of ISO20400 by NHSBT. ISO20400 is the International Standard that provides guidance to organisations for integrating sustainability within procurement (as described in ISO26000, the standard that provides guidance on how organisations can operate in a socially responsible way). All actions from the previous assessment in 2019 are either complete or close to completion. It is anticipated that, with the work completed so far, and the adoption of robust sustainability measures required to calculate and maintain our carbon footprint data, we will be ready for a positive and improved re-assessment to ISO20400 in late 2021.

Looking forward we will renew our strategy in order that we align with the NHS commitment to a Carbon Net Zero strategy. Due to the work completed over the last five years, NHSBT is already someway along the path to meeting the challenge. As part of the new strategy, a baseline carbon footprint, based on 2019/20 figures, will be established, along with a life cycle analysis of key products, that will support all areas of NHSBT to plan towards a Carbon Net Zero objective. In support of this process we have engaged with BSI to put in place a system for measuring Green House Gases, based on ISO14064-1 'International Standard for GHG Emissions Inventories and Verification'. The use of this system will allow us to use carbon as an accountancy tool and ensure that all figures are compiled using agreed standards and verified annually by a recognised external body.

Financial review

Trading performance

In line with the Treasury's Financial Reporting Manual (FReM) we are required to publish our primary accounts on a ***Net Expenditure*** basis. This further requires that the programme funding received by NHSBT (mostly in support of organ donation and transplantation) 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 and with programme funding reported as income. ***Note 2*** provides NHSBT's financial results on an Income and Expenditure basis, consistent with the format of our management accounts, and reconciles this to the Net Expenditure basis shown in the SoCNE.

On an income and expenditure basis NHSBT is reporting a deficit of £13.0m in 2020/21 compared to a budgeted deficit of £19.5m, and a surplus of £6.1m in 2019/20.

During March 2020, when the NHS announced a suspension of elective procedures in response to COVID-19 pressures, NHSBT saw an immediate drop in red cell demand of 20% – 30%. In order to protect income, and consistent with practice across the NHS, NHSBT agreed with DHSC and NHS England that "block contracting" arrangements with NHS Trust should be implemented for blood supply. Although, later in the year, demand improved to around 5% less than pre-pandemic levels, given ongoing demand uncertainty these arrangements applied through the whole of 2020/21. In addition, rebates for blood that were due to Trusts were not paid and provided a contingency of £15.5m against additional COVID-19 costs. These costs included the loss in contribution from our specialist services, due to a reduction in demand and where block contracts did not apply. As a result of these actions, ***the financial impact of COVID-19, on a net trading basis, was broadly neutral to NHSBT***.

The improved outcome versus budget expectations was therefore driven primarily by:

- Reduced costs in Organ Donation and Transplantation, due to the much lower transplant activity during the pandemic, whereas the programme funding provided by DHSC and the Devolved Governments was provided in full. The surplus generated in 2020/21 is therefore being carried forward as cash to fund activities in 2021/22

- A one-off supplier rebate within Organ Donation and Transplantation (also carried forward in cash)
- Lower spending on transformational change projects in Blood and Group
- Partly offset by a one off non-cash book loss arising from the disposal of the Leeds and Sheffield sites.

Expenditure on the convalescent plasma Project was not budgeted. The costs of £55.4m were, however, fully funded by DHSC and there was no net impact on financial performance in the year.

In our Operating Segments (as described in Note 2), the following movements from last year should be noted:

- The significant increase in the deficits reported in ***Diagnostics, Tissues and Stem Cells*** are directly related to the reduction in demand from COVID-19 and its associated impact on elective procedures within Trusts. The lost contribution is offset at NHSBT level by the blood price related contingencies provided in Blood Supply
- The reduction in the deficit reported for ***Organ Donation and Transplantation*** is due to the reduction in activity (and related costs) as a result of COVID-19, whereas funding continued to be provided in full by the four UK Health Departments. It was also supported by a one-off supplier rebate of £2.5m. We report persistent deficits in organ donation and transplantation because funding is only provided for the direct additional costs of the activity but does not cover the allocated costs of the NHSBT group services functions. This implies that the service is cross subsidised by blood and specialist services prices by around £10m pa.
- The reduction in the surplus reported in ***Blood Supply*** reflects a combination of the COVID-19 contingencies noted above, increased expenditure on transformation projects (£3.8m) and the one off impact of the disposal of our Leeds/Sheffield sites (£4.6m), partly offset by lower variable costs as a result of lower demand/activity as a result of COVID-19.

Capital spend

Capital funding of £22.5m was provided by DHSC in 2020/21(£22.6m in 2019/20) which we received from the DHSC in the year, along with the £4.1m received in April 2020 from the 2019/20 allocation. Capital projects included construction of a new site at Barnsley (now complete) and a new Clinical Biotechnology Centre at Filton.

Property losses on disposal, revaluation and other revaluation movements

In March 2021 we disposed of 3 properties. The title of Fox Den Road in Stoke Gifford was transferred to the Government Property Agency (GPA) as a compulsory inter-governmental book transfer for £2.8m. This property transfer has no operational impact. We will continue to operate ODT functions from this site and will pay a rental to GPA for this use (see notes 7 and 9). Following the opening of our new centre at Barnsley, we disposed of our Sheffield and Leeds sites. Sheffield was sold to the Sheffield Hospitals Trust. The property was previously valued at £4.2m, with a revaluation reserve of £1.8m and revalued prior to sale at £0.8m. We received and paid over £0.8m proceeds from the sale to DHSC and report an impairment of £1.7m and a loss on disposal of £0.8m in the SoCNE. The Leeds site was transferred to Homes England under the Public Land for Housing Programme.. Prior to the disposal, Leeds was valued at £4.7m with a revaluation reserve of £2.6m. We received no consideration and hence an impairment of £1.2m and a loss on disposal of £0.9m is reported.

Of our £211m property assets (land, building and assets under construction), £190m has been valued by the Valuation Office. The remaining £21m includes assets under construction of £17.5m, with the balance due to additions in the last quarter for owned and finance leased properties, and cumulative additions to operating leased assets (all valued at historic cost under IAS17). The Valuation Office professionally re-values properties with an onsite inspection, every 5 years, in line with our accounting policy and the Treasury's FReM guidance. The last full valuation was in March 2019. A desktop revaluation has been performed by the Valuation Office as at 31 March 2021. Additions to the properties, since the 2019 on-site inspection, have been reported to the valuer for assessment in the valuation (excluding those added in the final quarter) to arrive at the final valuation at March 2021.

Net assets

The Statement of Financial Position reports that net assets reduced to £288.9m at 31 March 2021 from £291.3m at 31 March 2020. The most significant movements were:

Non-current assets increased to £236.3m from £229.6m, due to increased capital spend in the year and the net impact of the desktop revaluation. Barnsley, which moved from Asset Under Construction to Buildings as it came into use, was valued with an on-site visit by the valuer and resulted in an upward revaluation of £5.7m.

Inventories reduced to £17.3m from £20.1m. This included a planned reduction of £0.8m in Tissues and reduction of £0.5m in warehouse stores as EU Exit contingencies were released. Harnesses procured for the collection of convalescent plasma have been valued at nil value (see note 11) resulting in an overall reduction of harness stock versus prior year.

Trade and other receivables increased from £41.8m at 31 March 2020 to £44.6m at March 2021, with £4m being due from DHSC (funding for the 2019/20 pay settlement and convalescent plasma) and an increase in VAT reclaimable on convalescent plasma and capital spend. Trade receivables are lower than last year, due to reduced activity in specialist services and reduced overdues.

Trade and other payables increased from £41.8m in March 2020 to £52.7m in March 2021. This movement includes £2m more owed to employees for leave not taken, £3m paid to NHS Pensions in April and an increase in accruals reflecting higher spend during the year not yet billed by our suppliers.

Cash increased by £2.7m from £50.5m to £53.2m. This notionally comprises £31.7m attributable to Blood Supply, £5.9m to Clinical Services and £15.6m to ODT. Cash balances in Blood Supply and our specialist services have been accumulated over several years as we are normally required to set our prices to generate a break-even position. Estimations involved in price setting (e.g. forecasting demand, costs and the timing of large non-recurring revenue investments) have generated cumulative surpluses and cash. These funds will be spent on transformation, including improving the ICT infrastructure, renewing the Pulse blood management system and funding ODT projects.

For contingent liabilities refer to note 18 in the financial statements. There are no other significant contingent liabilities to report as of 31 March 2021.

NHSBT is the corporate trustee for NHSBT Trust Funds. The total net assets of the trust funds as at 31 March 2020 were £0.112m (compared to £0.161m in March 2019). The 2019/20 Trust Fund Accounts were published in January 2021 and are available at https://www.nhsbt.nhs.uk/who-we-are/transparency/accounts/trust-fund-accounts/. 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 financial returns for the charity are also available on the Charities Commission website.

Going concern

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

On the basis of this process, and in agreement with DHSC and NHSE&I, we have revised our prices for blood and specialist services in 2021/22. Along with the funding that has been confirmed by DHSC and the devolved governments for organ donation and transplantation, NHSBT will have sufficient income to meet its operational plans and exit 2021/22 with contingency cash reserves.

Looking beyond 2021/22, we continue to expect that sufficient funding will be available to meet NHSBT objectives and operating requirements, we therefore continue to adopt the going concern basis in the preparation of these financial statements.

I hereby sign the Performance Report from pages 18 to 36

Betsy Bassis
12 October 2021

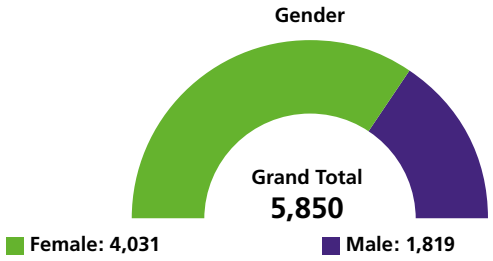
Our accountability

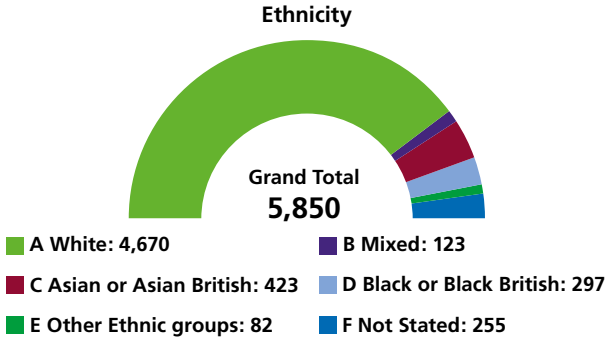
In this section we explain how we remain accountable to parliament and in line with best practice on corporate governance.

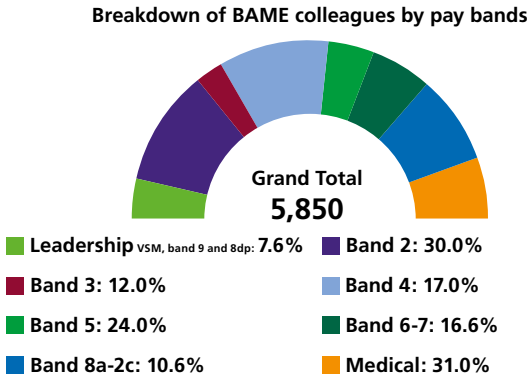
Accountability report – Our people

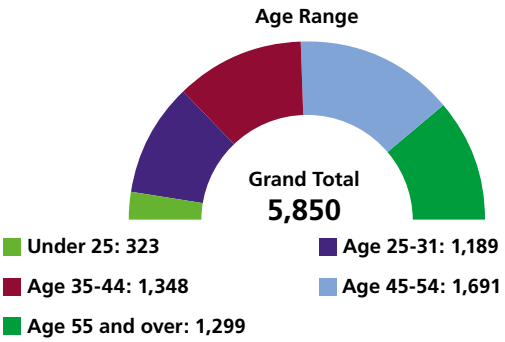
Every day our people work tirelessly at the heart of the NHS, showing dedication and a determination to make a difference. We are proud of our people. Because of what they do we want to attract the best talent, nurture, develop, engage and motivate them so they can continue to save and improve more lives. In this section we describe what we do to achieve that.

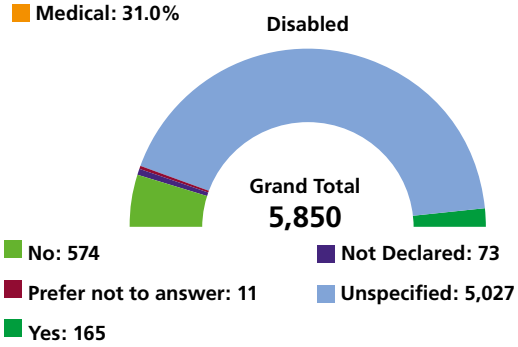
Our people and rewards











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

Our turnover rate at March 2021 is 11.26% (13.08% 2020) and is higher than the NHS average of 8.8%. Our rates are improving year-on-year from a peak of 17% in 2016.

Staff numbers and costs

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

This is subject to audit.

			31 March 2021	31 March 2020
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	180,276	34,596	214,872	178,519
Social security costs	17,571	1,192	18,763	16,947
Employer contributions to NHS Pensions Agency	33,110	1,530	34,640	22,360
Notional cost of NHS Pension increase	–	–	–	9,776
Total	**230,957**	**37,318**	**268,275**	**227,602**

On 1 April 2019, the employer contribution rate for the NHS Pension Scheme increased by 6.3%. The additional cost, funded by DHSC, was £10,534k for the year and is included in Employer contributions to NHS Pensions Scheme above (2019/20 £9,776k shown as Notional cost of NHS Pension increase).

Whole-time Equivalents	Permanent Number	Other Number	Total Number
Period Ended 31 March 2021	**4,641**	**759**	**5,400**
Period Ended 31 March 2020	4,540	231	4,771

The significant increase in headcount and staff costs relates mainly to staffing for the new convalescent plasma operation.

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of their workforce. The banded remuneration of the highest paid director (both including contractors and excluding contractors) in 2020/21 is shown in the table below, together with the remuneration ratios compared to the midpoint of the banded remuneration of the highest paid director's pay. This shows the pay multiple excluding contractors is 6.3 compared to 6.8 last year due to the highest paid director's pay increasing slightly more than the median remuneration for employees.

	2020/21	2019/20
Highest Director Banded Remuneration (including contractors)	£250k to £255k	£300k to £305k
Highest Director Banded Remuneration (excluding contractors)	£205k to £210k	£200k to £205k
Lowest Banded Remuneration	£0k to £5k	£0k to £5k
Median Remuneration	£32,939	£29,966
Remuneration Ratio (including contractors)	7.7	10.1
Remuneration Ratio (excluding contractors)	6.3	6.8

In 2020/21, 0 (2019/20, 0) employees received remuneration in excess of the highest-paid director.

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

This is subject to audit.

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 2020 to December 2020 the total number of whole-time equivalent days lost to sickness absence was 46,102 days (2019 43,265 days). This equates to an average of 9.4 days per whole-time equivalent (2019 9.1 days) and a sickness absence rate of 2.6% (2019 2.5%).

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 1.11.

Early retirements and redundancies

During 2020/21 there were 59 payments for early retirements and/or redundancies from NHSBT. The sum of £2,783k has been paid out in 2020/21 in respect of these redundancies and/or early retirements (2019/20 14 early retirements and/or redundancies and payments of £529k).

There is currently a £119k provision held for redundancy costs, (none held in 2019/20).

The total charge (including accruals) of £3,615k for early retirements and redundancies is included within other staff-related costs in note 5 (2019/20 £374k).

The table below discloses the number and value by cost band of compensation packages paid during 2020/21.

Exit Package cost band	Number of compulsory redundancies	Cost of compulsory redundancies (£000s)	Number of other departures agreed	Cost of other departures agreed (£000s)	Total number of exit packages	Total cost of exit packages (£000s)	Number of departures where special payments made	Cost of special payment included in exit package
Less than £10,000	2	13	–	–	2	13	–	–
£10,001 – £25,000	4	78	3	52	7	130	–	–
£25,001 – £50,000	21	783	4	141	25	924	–	–
£50,001 – £100,000	19	1,333	6	383	25	1,716	1	57
£100,001 – £150,000	–	–	–	–	–	–	–	–
£150,001 – £200,000	–	–	–	–	–	–	–	–
Totals for 2020/21	**46**	**2,207**	**13**	**576**	**59**	**2,783**	**1**	**57**
Totals for 2019/20	**14**	**529**	**–**	**–**	**14**	**529**	**–**	**–**

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

This is subject to audit.

Ill health retirement

Two individuals retired early on ill-health grounds in the year generating additional pension liabilities of £59,201.00 (2019/20 3 individuals £86,933.00). These costs are met by the NHS Pension Scheme.

The Remuneration Committee and senior manager rewards

Membership and purpose of the Committee is shown on page 53. The Chief Executive and Director of People also attend but excuse themselves when their remuneration is being discussed.

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

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

Senior management contract information

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

Betsy Bassis, Chief Executive. NHS start date 4 March 2019, appointed 4 March 2019. Accounting Officer from 29 March 2019. Full time permanent appointment with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Dr Gail Miflin, Chief Medical Officer and Director of Clinical Services. NHS start date 1 August 1991, appointed 1 June 2016. Permanent full-time post with three months' notice by the employee, and three months' notice period by NHSBT.

Greg Methven, Director of Blood Supply. NHS start date 6 February 2017, appointed 6 February 2017. Permanent full-time post with three months' notice by the employee, and six months' notice period by NHSBT.

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

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

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

Wendy Clark, Chief Digital Information Officer. NHS start date 10 September 2018, appointed 6 January 2020. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Officers appointed during the year 2020/21:

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

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

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

Rosna Mortuza, Chief Diversity and Inclusion Officer. NHS start date 26 November 2007, appointed 27 July 2020. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT.

Leavers in the year:

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

Katherine Robinson, Director of People. NHS start date 25 July 1994 appointed to the Executive team on 1 July 2017. Permanent full-time post with three months' notice of termination by the employee, and six months' notice period by NHSBT. Katherine Robinson left the Board and Executive Team on 7 October 2020.

The remuneration and pension benefits of the most senior officials of NHSBT are shown in the tables on pages 41 and 42. The tables on pages 41 and 42 are subject to audit.

Remuneration and pension entitlement of senior managers

a) Remuneration

	2020/21					2019/20				
Name and title	Salary In £5k bands £000	Performance pay and bonuses £000	Non-cash benefits To nearest £00	All pension related benefits bands of £2.5k £000	Total In £5k bands £000	Salary In £5k bands £000	Performance pay and bonuses £000	Non-cash benefits To nearest £00	All pension related benefits bands of £2.5k £000	Total In £5k bands £000
Ms B Bassis (Chief Executive)	175-180	5-10	–	40-42.5	220-225	170-175	–	–	35-37.5	205-210
Ms M Banerjee (Chair)[1]	60-65	–	–	–	60-65	60-65	–	–	–	60-65
Lord Oates (NED)	–	–	–	–	–	5-10	–	–	–	5-10
Prof P Vyas (NED)	5-10	–	–	–	5-10	5-10	–	–	–	5-10
Prof D Kelly (NED)[2]	5-10	–	–	–	5-10	-	–	–	–	–
Mr K Rigg (NED)[3]	0-5	–	–	–	0-5	5-10	–	–	–	5-10
Mr C St John (NED)	5-10	–	–	–	5-10	5-10	–	–	–	5-10
Mr J Monroe (NED)[4]	5-10	–	–	–	5-10	5-10	–	–	–	5-10
Mr P White (NED)	10-15	–	–	–	10-15	10-15	–	–	–	10-15
Ms H Fridell (NED)	5-10	–	–	–	5-10	5-10	–	–	–	5-10
Ms J Lewis (NED)[5]	–	–	–	–	–					
Mr P Huggon (NED)[6]	–	–	–	–	–	–	–	–	–	–
Dr Gail Miflin (Chief Medical Officer and Director of Clinical Services)	205-210	–	–	52.5-55	255-260	200-205	–	–	57.5-60	260-265
Mr G Methven (Director of Blood Supply)	145-150	–	1	35-37.5	180-185	130-135	–	–	30-32.5	160-165
Mr R Bradburn (Director of Finance)	145-150	–	31	-	150-155	145-150	–	63	65-67.5	215-220
Mr A Clarkson (Director of Organ and Tissue Donation and Transplantation)	135-140	5-10	21	65-67.5	210-215	135-140	–	38	210-212.5	350-355
Mr I Bateman (Director of Quality)	110-115	–	1	27.5-30	140-145	110-115	–	25	10-12.5	120-125
Mr M Stredder (Director of Donor Experience)[7]	135-140	–	–	–	135-140	130-135	–	–	32.5-35	160-165
Mrs K Robinson (People Director)[8]	60-65	–	23	17.5-20	80-85	120-125	–	32	20-22.5	145-150
Ms W Clark (Chief Digital Information Officer)[9]	145-150	0-5	–	32.5-35	180-185	30-35	–	–	7.5-10	40-45
Ms R Mortuza (Chief Diversity and Inclusion Officer)[10]	55-60	–	–	172.5-175	230-235	–	–	–	–	–
Ms K Robinson (Director of Strategy and Transformation)[11]	100-105	–	–	275-277.5	375-380	–	–	–	–	–
Mr D Rose (Director of Donor Experience)[12]	105-110	–	–	15-17.5	120-125	–	–	–	–	–
Ms P Grealish (Interim Chief People Officer)[13]	120-125	–	–	–	120-125					
Mr H Williams (Director of Diagnostics and Therapeutic Services)	–	–	–	–	–	225-230	–	–	20-22.5	245-250
Mrs C Rose (Interim Director of Marketing and Communications)	–	–	–	–	–	70-75	–	1	32.5-35	105-110
Ms S Johnson (Interim Chief Executive)	–	–	–	–	–	10-15	–	–	–	10-15
Mr B Henry (Interim Technology Director)[14]	–	–	–	–	–	225-230	–	–	–	225-230

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 £1,000's.

[1] Ms M Banerjee – left on 6 August 2021. Replaced by Mr J Pattullo appointed as Interim Chair 7 August 2021.
[2] Prof D Kelly – appointed on 1 July 2020. Full year salary (£5k bands) £5-10
[3] Mr K Rigg – left on 20 June 2020. Full year salary (£5k bands) is £5-10
[4] Mr J Monroe – left on 10 February 2021. Full year salary (£5k bands) is £5-10
[5] Ms J Lewis – appointed as NED on 1 March 2021. Full year salary (£5k bands) is £5-10
[6] Ms P Huggon – appointed as NED on 1 March 2021. Full year salary (£5k bands) is £5-10
[7] Mr M Stredder – left on 12 July 2020. Full year salary (£5k bands) is £165-170 of which, £90-95k is exit costs (see Early Retirements and Redundancies table)
[8] Mrs K Robinson – left the Board and Executive Team on 7 October 2020 and left the organisation on 31 March 2021. Full year salary (£5k bands) is £120-125
[9] Ms W Clark – prior year salary part year from 6 January 2020
[10] Ms R Mortuza – appointed as Chief Diversity and Inclusion Officer on 27 July 2020. Full year salary (£5k bands) £85-90
[11] Ms K Robinson – appointed as Director of Strategy and Transformation on 11 May 2020. Full year salary (£5k bands) £115-120. Left on 20 June 2021
[12] Mr D Rose – appointed as Director of Donor Experience on 20 May 2020. Full year salary (£5k bands) £145-150
[13] Ms P Grealish – appointed as Interim Chief People Officer on 8 October 2020 – engaged full time as a contractor. Full year salary (£5k bands) is £250-255. Left on 31 August 2021. Replaced by Ms D McKenzie appointed as Chief People Officer 1 September 2021
[14] Mr B Henry – left on 31 December 2019. Engaged full-time as a contractor. Full year salary (£5k bands) is £300-305.

b) Pension benefits

Name and title	Real increase / (decrease) at pension age (bands of £2,500) £000	Real increase in lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real increase in Cash Equivalent Transfer Value £000
Ms B Bassis (Chief Executive)	2.5-5	–	5-10	–	81	40	15
Dr Gail Miflin (Director of Clinical Services)	2.5-5	0-2.5	60-65	125-130	1,197	1,098	55
Mr G Methven (Director of Blood Supply)	2.5-5	–	10-15	–	137	98	16
Mr R Bradburn (Director of Finance)	0-2.5	–	30-35	–	577	541	5
Mr A Clarkson (Director of Organ and Tissue Donation and Transplantation)	2.5-5	2.5-5	50-55	120-125	946	852	60
Mr I Bateman (Director of Quality)	0-2.5	5-7.5	25-30	75-80	0	578	–
Mr M Stredder (Director of Donor Experience)[1]	0-2.5	–	10-15	–	167	148	–
Mrs K Robinson (People Director)[2]	0-2.5	0-2.5	40-45	85-90	679	620	18
Ms W Clark (Chief Digital Information Officer)	2.5-5	–	5-10	–	88	51	14
Ms R Mortuza (Chief Diversity and Inclusion Officer)[3]	7.5-10	15-17.5	10-15	20-25	173	0	110
Ms K Robinson (Director of Strategy and Transformation)[4]	12.5-15	–	15-20	–	117	0	90
Mr D Rose (Director of Donor Experience)[5]	0-2.5	–	0-5	–	17	0	1
Ms P Grealish (Interim Chief People Officer)[6]	–	–	–	–	–	–	–

[1] Mr M Stredder – left on 12 July 2020

[2] Mrs K Robinson left the Board and Executive Team on 7 October 2020

[3] Ms R Mortuza – appointed as Chief Diversity and Inclusion Officer on 27 July 2020

[4] Ms K Robinson – appointed as Director of Strategy and Transformation on 11 May 2020

[5] Mr D Rose – appointed as Director of Donor Experience on 20 May 2020

[6] Ms P Grealish – appointed on 8 October 2020 – Engaged full time as a contractor therefore is not signed up to the NHSBT Pension Scheme.

Pension table figures explained

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

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

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

Off-payroll engagements and their tax arrangements

HM Treasury require all public-sector bodies to report on their high value off-payroll engagements. These are arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements) and are not classed as employees.

The table below identifies all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	16
Of which, the number that have existed:	
for less than one year at the time of reporting	8
for between one and two years at the time of reporting	4
for between 2 and 3 years at the time of reporting	3
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	0

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

The table below identifies all new off-payroll engagements, or those that reached six-month duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements or those that reached 6 months duration during the time period	15
Of which number for whom:	
Assessed as caught by IR35	9
Assessed as not caught by IR35	6
Engaged directly (via PSC) and are on the payroll	0
Of engagements reassessed for consistency/ assurance purposes during the year	0
Of engagements that saw a change to IR35 status following the consistency review	0

The table below identifies off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2020 and 31 March 2021:

	Number
The number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, during the financial year	1
The 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	22

An Interim Chief People Officer was engaged to bolster senior leadership capacity within the People Directorate.

Our approach to diversity and inclusion in our workforce

Equality, Diversity and Inclusion (EDI) is a strategic priority at NHSBT. We want a culture in which all our people, patients, carers and donors feel valued. We want our organisation to reflect the communities we serve and for there to be more proportionate representation of all protected characteristics across all levels of the organisation.

With the events of last year, including the Black Lives Matter movement, the publication of our own Organisational Diagnostic Report and the disproportionate effect of COVID-19 on BAME communities, highlighting the

devastating consequences of health inequalities, the EDI agenda has been a key focus at NHSBT in the conversations we're having, the way we design and deliver our services and equally, in the way we make this organisation a great place to work, where everyone can thrive.

We have appointed a Chief Diversity Inclusion Officer, established an EDI Council with Board and Executive sponsorship, enhanced our EDI Networks and identified Executive Directorate sponsors for each staff network group. We have also put structures in place to build on pace and momentum, create greater scrutiny and accountability in delivering real and meaningful change. We have promoted our whistleblowing process and established a complex case unit to investigate complaints promptly. We are reviewing and updating all our EDI Inclusion policies to ensure they are just and fair. A large proportion of our marketing spend is targeted at recruiting the blood and organ donors we need to help us address unacceptable health inequalities for Black and Asian Minority Ethnic patients.

The Organisational Diagnostic Report – June 2020

Following poor engagement scores in our staff survey, a number of grievances and concerns raised by Black, Asian and Minority Ethnic (BAME) colleagues at our site in Colindale, we commissioned an independent organisation diagnostic report to explore the experience of colleagues at the Colindale centre. The report was published in June 2020 and provided evidence of systemic racism and instances of bullying, harassment and micro aggressions experienced by BAME colleagues, along with a number of recommendations for urgent action. Concerns were echoed by an external advisor working on national projects at NHSBT, which showed this to be a wider concern than a single centre.

The report has deeply impacted all colleagues at all levels of our organisation. For some, it was a welcome recognition of long-standing workplace issues they have experienced. For others the report came as a shock and the realisation that this had happened in their organisation was deeply distressing. Colleagues continue to process the findings with many committed to learning more about all equality issues to ensure no one ever feels this way again at NHSBT. Some other colleagues may still not fully accept that they need to change or that this applies to them and others are struggling to come to terms with all the findings.

NHSBTs Board and Executive Team have accepted the report's findings and recommendations in full. This has been recognised as a 'mission critical' matter to resolve. Many of the biggest opportunities for improving our delivery against our mission, to save and improve lives, involve the BAME community, by encouraging more donations to save more BAME lives. We understand that making NHSBT a great place to work for BAME colleagues is intrinsically linked to building trust in these communities. We will continue to do the hard work to achieve a culture which embraces diversity and is a great place to work for everyone.

Since the initial report we have:

- strengthened the supervisory and leadership team at Colindale centre;
- reviewed and improved development opportunities;
- held behavioural commitments workshops;
- provided better support and mentoring for managers; introduced a stakeholder review of key people processes;
- commenced a national review of how we recruit and promote across the organisation.

We have also commissioned an independent follow up review to evaluate progress. This report was published in September 2021. It confirmed that good progress has been made on most of the nine priority recommendations, but with more to do, especially with regard to further improving recruitment processes and how the learnings and progress can be applied to all parts of our organisation.

Organisational engagement

Since the report we have had a focus on creating safe spaces for all colleagues to have the conversations needed to share experiences and learn of the impact of these. We have also focussed on education, raising awareness and getting engagement from colleagues across a range of diversity and inclusion matters.

We were fortunate to have Dr Robin DiAngelo, bestselling author of 'White Fragility' to host an exclusive webinar attended by 377 colleagues on 'Why it's so hard for white people to talk about racism'. Dr DiAngelo encouraged us to recognise race inequality and talked us through how we can take responsibility, act and change things going forward.

A series of organisational wide 'Let's Talk About Race' webinars, hosted by Business in the Community facilitators throughout the year, helped to educate and raise awareness of Race Equality in the workplace. These sessions enabled over 500 colleagues to join workshops to talk openly and comfortably about race. We continue to work closely with leaders to ensure all colleagues, particularly those who are not office-based or do not have regular access to a computer, have the same opportunities to take part in sessions like this.

As part of National Inclusion Week in September-October, we continued to have open, challenging and meaningful discussions around inclusive policies and practice, the diversity of our workplace and the way that our people felt about working at NHSBT. Bringing in expert guest speakers to share best practice from across the wider NHS also helped to establish open and honest dialogue about areas and ways in which to drive improvement.

We also launched a programme of 'Let's Talk About Diversity and Inclusion' webinars in the Autumn, with Executive Directors sharing first-hand their challenges and experiences with diversity and inclusion, creating greater ownership of the agenda. These webinars have helped to increase dialogue

and visibility with the Executive Team. 684 colleagues in total joined across all webinars and the recordings are available on our internal media channel, for colleagues to re-watch.

Our directorate senior management teams have developed Inclusion plans and continue to work collaboratively in and across teams to (for example) set clear inclusion objectives for all colleagues, plan interactive workshops to engage and educate colleagues and to undertake reviews of the experience of women at NHSBT. Initial feedback is that culture is shifting and things are improving but we do not underestimate the work needed to engage all colleagues and shift our culture to be Inclusive for all.

Re-imagining Inclusive Recruitment

Improving our recruitment process was a key recommendation of the Organisational Diagnostic Report and we therefore launched a 'Re-imagining Inclusive Recruitment' workstream to drive rapid improvement in our recruitment process and practices, from attraction and selection to inductions and training, both in the short term and longer-term. We are also seeking to improve the diversity of our workforce in all sections of the organisation. Our efforts in recruitment are showing small and impactful improvements with major recruitment drives over the last six months and new methods of practice resulting in greater diversity of appointments made, from which we are learning as part of our wider drive to improve inclusivity and diversity.

There has been an improvement in Black Asian and Minority Ethnic representation at senior levels of the organisation with 36 BAME employees at Band 8a-9 in December 2020 compared with 32 this time last year. The convalescent plasma recruitment drives resulted in 22 Black Asian and Minority Ethnic Nurses, 46% (compared with 26 White Nurses, 54%) and 60 ethnic minority Donor Carers, 23% (compared with 157 White Donor Carers whilst 49 Preferred not to say).

To aid development into senior positions, we are also offering the Leadership Academy Stepping Up Programme for aspiring Black Asian and Minority Ethnic colleagues. Managed by NHS Leadership Academy, this will run in-house exclusive to 42 colleagues over the coming year.

Employee Network Groups

We have continued to work closely with our Employee Network Groups, supporting them in the fantastic opportunities they provide to our people in raising issues and ensuring all voices are heard. In October 2020, we worked in partnership with our Black, Asian, and Minority Ethnic (BAME) Staff Network to deliver an exciting and thought-provoking calendar of events in celebration of Black History Month. The range of events were topical and informative, covering a range of areas including:

- Black Lives Matter – a panel discussion regarding mental health in the Black community.
- Black is Beautiful – exploring the media perceptions of Black women.
- Queer. Black. Here.– discussing the taboos existing about being queer in the Black community.

We also held our first Table Talk session with a panel of BAME colleagues who discussed the D&I agenda, navigating their careers at NHSBT, sharing lived experiences and personal strategies.

Throughout the month there were also weekly cooking events and a Let's Get Physical session each Friday morning with Mr Motivator. The feedback from the Mr Motivator sessions was so positive, as they provided a fun and energising end to the week during the COVID-19 lockdown, that the sessions were continued through to the end of January 2021.

Similarly, we have worked in partnership with our LGBT Staff Network to help deliver LGBT History Month, raising awareness and dialogue by hosting seven virtual events including a trans awareness workshop with award-winning charity, Birmingham LGBT; three workshops with Stonewall, exclusive to NHSBT colleagues covering trans issues, mental health and being a better ally to People of Colour. The network also promoted a further 13 external events covering a broad range of topics including intersectionality, LGBT disability, pronouns and wellbeing. Over 250 colleagues have attended our internal LGBT+ Ally training. We are also working in partnership with our Network this year to support the submission of the Stonewall Workplace Equality Index (WEI) for the third consecutive year.

We have supported the relaunch of our Disability and Wellbeing Network (DAWN) and submitted NHSBT's data to the first Workplace Disability Equality Scheme (WDES) in November 2020. The WDES is comprised of 10 specific measures, enabling NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

We marked International Day of People with Disabilities on 3 December 2020 with a webinar hosted by the Interim Chief People Officer, Patricia Grealish. A panel of guests from across the NHS shared their lived experiences with both visible and non-visible disabilities. Chief Digital and Information Officer and Executive Sponsor for DAWN, Wendy Clark, also organised a webinar with Apple to share iPad tips and discuss accessibility.

Assistant Director for Manufacturing Operations (North), Debbie Richards, hosted an Inclusive Minds webinar during National Inclusion Week 2020, providing an introduction to Neurodiversity for our colleagues. Debbie was joined by neurodiversity expert and founder of Creased Puddle, Caroline Turner. Creased Puddle is an organisation empowering neurodiversity in the workplace.

We have also provided support and online resources to all employees around mental health and wellbeing through digital toolkits, access to wellbeing apps and regular mindfulness and 'wobble room' sessions – this has been more relevant this year during the pandemic as many colleagues

have had to adapt to different ways of working, some under consistent and extreme pressures working from home or in our centres or collection sessions.

Our Executive Sponsors have promoted and supported key events like Black History Month, LGBT+ History Month and Disability Awareness days, by attending webinars and workshops and in some cases hosting online webinars too.

National progress

FAIR (For the Assessment of Individualised Risk) is a collaboration of UK blood services, PHE, University of Nottingham and LGBT+ charities led by our organisation. FAIR are advocating the review of blood donation criteria for gay men. The Department of Health and Social Care accepted the FAIR steering group recommendations and will move to individualised risk assessment. Donors will no longer be asked to declare if they have had sex with another man, making the criteria for blood donation gender neutral and more inclusive. The FAIR recommendations came into effect from 14 June 2021.

Forward plan

The last year has focussed on engagement across the organisation, building awareness and tackling live issues. Whilst we continue to build on organisational level engagement, education and culture change, we need to accelerate delivery and impact.

To achieve that, we have put in place structures to facilitate action at a corporate level alongside implementation plans across directorates to change how we work and tackle specific challenges and opportunities in different teams. We are working closely with senior leaders to ensure that this can be translated into tangible impact in each directorate. We are wholly committed to making NHSBT a great place to work for everyone.

Gender pay gap

Our latest gender pay gap reporting is as at 31 March 2020 when NHSBT employed 5,870 staff members (including 12 directors) of whom 4,045 were female (of which five are directors) and 1,825 were male (of which seven 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 reversed for higher banded roles, at Band 8c and above.

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

Our mean GPG shows women's pay is 7.8% lower than men's. This compares well to the Office for National Statistics mean GPG figure for the public sector, which was 15.5% (October 2020). NHSBT therefore compares favourably with the wider public sector and other NHS Arm's Length Bodies.

Our median figure 6.7% (also showing women's pay is lower than males) had increased from 5.6% in the previous year. We are developing our action plan to reduce our GPG further over the coming year.

Supporting and engaging our people

Below are the key ways we support and engage our colleagues to play a full role in shaping our organisation so together we can save and improve more lives.

Engagement

We carried out a pulse survey in May 2020, which showed a small increase in our engagement score from 7.6 (in 2018) to 7.8 (out of 10).

We have recently introduced an innovative Employee Experience platform, which serves as an everyday team tool to drive engagement and cultural change by empowering and enabling teams at a local level. We will also be using it to gain deep insights that can help proactively identify best practice, risk and hotspots across the organisation. Our aim is that the platform empowers teams and leaders to make significant cultural improvement and changes, provide unconditional feedback mechanism and, through anonymity, offer unprecedented transparency. We are consulting on plans to run regular surveys throughout the year.

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 in:

- Collaboration,
- Delivering Everyday,
- Developing People,
- Inspirational Leadership,
- Going the Extra Mile,
- Innovation, Living our Values,
- Supporting our Health and Wellbeing,
- Supporting Diversity and Inclusion, and our Charity Support, as well as celebrating professional development achievements.

People Development

Colleagues are encouraged to have personal development plans; this remains an essential part of our appraisal process.

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

Pre-COVID-19 our courses were all face to face events. The pandemic enabled us to accelerate our plans to shift to 'point of need' learning and convert these to either blended or digital learning products. Our efforts ensured that, despite

COVID-19 restrictions, colleagues could access development on demand.

Apprenticeships form an essential part of the way we minimise skills gaps and support and develop our people. Our current apprentices are entry level recruits joining NHSBT as well as existing employees. We have ambitious plans to expand our Apprenticeships to support both individuals' development and organisational effectiveness. Over the last 12 months:

- 140 people are active 'in-learning' (64 new starts over the last 12 months)
- 21 people have raised an expression of interest – having suitability assessed
- 22 people are on our waiting list,
- 20 people are in a break in learning, our highest number to date, a reflection of COVID-19
- 7 people withdrawn – this is the lowest number recorded yet.

The apprentice salary paper was approved and implemented on 1st April. Recruitment requests now prompts managers to justify why band 2, 3 and 4 requests could not be an apprenticeship.

Scientific and clinical training:

2020 saw our first Higher Specialist Scientist Trainee (HSST) qualify and we have 16 in training. 513 delegates completed our science courses:

- (5 days) Essential Transfusion Medicine (ETM) Total 106
- (15 days) Intermediate Transfusion Medicine (ITM) Total 73
- (5 days) Practical Introduction to Transfusion Science (PITS) Total 115
- (5 days) RCPath Pre-Exam Revision Total 146
- (5 days) Specialist Transfusion Science Practice (STSP) Total 73
- These are a mix of internal and external candidates.

Later in 2021 we are launching an MSc for Transfusion that we have developed in partnership with the University of the West of England. This will enable us to continue to develop our own workforce and the wider transfusion community.

In March we launched our new Digital Learning Platform that will enable us to transform colleagues' learning experience, develop an EPortfolio and also generate income by providing access to our learning to our partners and customers. In the first 24 hours we had over 270 logins, with the most visited content being Mandatory Training, Transfusion Science, Business Skills, Nursing and People Skills.

Leadership development

We introduced quarterly conferences for senior leaders, to build the leadership community. These conferences, which are now delivered virtually, provide an opportunity for the group to consider key organisational challenges and develop as a leadership group.

In recognition of the pressures senior leaders were experiencing early in the pandemic, our coaching faculty proactively provided coaching support for this group.

We have piloted our Blended Learning Leadership programmes, to date 108 leaders attended these newly converted programmes.

We work collaboratively to develop our leadership programmes, to ensure they reflect our diversity and inclusion ambitions, for example by piloting an 'Inclusive Leadership' programme.

We have launched an innovative leadership development tool 'Magpie' (that 275 leaders are regularly using) that, as well as providing access to nearly 500 online resources, learns your preferences and areas of interest and offers suggestions for topics and resources to support development.

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

1. "The Effective Leader" (Level 1): for an aspiring or new leader (completed by 128 leaders)
2. "The Engaging Leader" (Level 2): for leaders who manage people or are senior leaders (completed by 40)
3. "The strategic leader" (Level 3): for leaders developing and leading strategy (completed by 5).

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

Coaching and mentoring is encouraged across NHSBT. We have 12 fully qualified executive level coaches and have programmes planned to expand the faculty and increase diversity. The first cohort, with 50% of the delegates from the BAME community, started in March.

We are developing ambitious plans to develop the senior leadership group throughout 2021/22 and beyond.

Talent management and succession planning

We have continued our efforts on this important area and will continue to expand our efforts to ensure we fulfil our ambitions.

Organisational Diagnostic report

In response to the Organisational Diagnostic, we worked closely with colleagues in Colindale and stakeholders in the wider organisation, to create a series of interventions to address the prevalent issues, these included:

- Coaching for those affected
- Onsite counselling by a specialist trauma counsellor
- Civil Teams workshops, that uncovered some deep rooted cultural and systemic issues, that having been surfaced, we are now developing Organisational Development interventions to support
- PDPR workshops, for both colleagues and managers, to improve both the quality and volume of effective appraisals. As a result we saw a 20% increase in PDPR's. We are currently evaluating the quality of PDPR's
- Reciprocal Mentoring – NHS Leadership Academy, we are developing a programme, which will be piloted in Q1. NHSLA have met with our Chair and CEO to share the approach. A project team are planning the pilot
- Communicating in the Context of Racial Harm – Equality Academy, we are developing a programme, which will be developed so as to synchronise and complement the Reciprocal Mentoring programme. EA have met with our Chair and CEO and shared the methodology. A project team are developing the pilot and rollout plan for Q1
- Blood Supply – Culture programme – the People directorate are working in partnership with the Blood Supply SMT to develop a programme of work, following and utilising the learning from interventions in Colindale. This will form part of our Great Place to Work ambitions.

Trade Union relationships

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

NHSBT enables 111.19 whole-time equivalent Trade Union representatives to carry out national consultation/partnership working duties. These representatives collectively spent 12,335 hours on these duties this year, reflecting the scale of change consultation within NHSBT and geographic spread of employees. Please see below for details of Union Officials:

Relevant Union Officials	
No. of employees who were relevant union officials during the relevant period	**Full-time equivalent employee number**
126	111.19
Percentage of time spent on facility time	
Percentage of time	**Number of employees**
0%	15
1-50%	104
51-99%	4
100%	3
Percentage of pay bill spent on facility time	
Description	**£000**
Total of cost facility time	290
Total pay bill	268,275
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	8%

Health, Safety and Wellbeing

Our Health, Safety and Wellbeing (HSW) five-year corporate plan has completed its second year, with further good progress on the four themes: prevention culture, visible leadership, wellbeing and communications. Our management system was successfully migrated to the international standard ISO45001 in February 2021 bringing wellbeing into the system and moving from consultation with our colleagues on HSW to active participation.

Our HSW team supports our response to COVID-19 providing advice and risk assessment support to frontline operations to ensure colleagues feel safe and supported. Ensuring that our vulnerable colleagues continue to work safely in COVID-19 secure premises. The focus on Black, Asian and Minority Ethnic (BAME) colleagues at greater risk of COVID-19 is met with a successful manager led risk approach to ensure support for their immediate safety and also longer term wellbeing.

Patient facing colleagues successfully supported the wider NHS during the first wave of the pandemic and have returned to our duties with appropriate ongoing critical incident debriefing and psychological support to help them cope with any potential trauma they have suffered. Our collections teams work incredibly hard to provide a safe working and donor environment in our donor centres and mobile sessions and not only keep to operational targets but successfully implemented a whole new product of convalescent plasma. Outbreaks on teams are well managed by our internal test and trace system with lessons learnt and implemented in other areas on breaks, touch point cleaning and travel to sessions. Laboratory services, aided by Estates and Facilities in shared areas, continue to meet COVID-19 secure status with only one large outbreak in CMT Birmingham.

This year our plan is to keep up the good work on vaccination, implement more wellbeing initiatives on mental health and musculoskeletal risks, thereby to help support the people strategy of a great place to work.

NHS Charities Together grants funded by public donation wellbeing

In the year our charity arm, the NHSBT Charity Fund, received grants of £240,000, mostly from NHS Charities Together, which had in turn been funded by donations from the public. As required, we spent these grants on staff wellbeing, including funding workshops to help our colleagues recover from the trauma of caring for intensive care patients and bereaved relatives. Thank you on behalf of our colleagues to all who donated.

Accountability report – our governance and accountability structure

Directors' report

Chief Executive

Betsy Bassis
Chief Executive

Betsy has extensive experience leading complex, customer-facing organisations across the private and public sectors. She is also a non-executive director of the housing association London and Quadrant.

Board Directors (Voting Members)

Dr Gail Miflin
Chief Medical Officer and Director of Clinical Services

Gail joined 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.

Greg Methven
Director of Manufacturing and Logistics

Greg has had senior roles within ICI and Akzo Nobel. He was latterly Chief Operating Officer of McBride Plc, Europe's leading supplier of private label household and personal care products.

Rob Bradburn
Director of Finance

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

Anthony Clarkson
Director of Organ Donation and Transplantation

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

Directors (Non-Voting Members)

Ian Bateman
Director of Quality

Became a Director in 2015. He has over 25 years of experience in senior national and international Quality and Regulatory Compliance roles in both public and private sectors.

Wendy Clark
Chief Digital Information Officer

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

David Rose
Director of Donor Experience

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

Katie Robinson
Director of Strategy and Transformation

Joined us May 2020 from NHS England and NHS Improvement where she held a number of roles, most recently Deputy Director, Provider Policy. Prior to joining NHS England Katie held a number of roles across the Civil Service, including as a Senior Civil Servant at the Department for Business, Innovation and Skills.

Patricia Grealish
Chief of People

A fellow of the CIPD and experienced HR and People leader and HR Director. Over 25 years, Patricia has held board positions in the private and public sector and has a track record of delivering across the people agenda to deliver strategic and system change.

Rosna Mortuza
Chief Diversity and Inclusion Officer

Previously Director of Implementation for the International Consortium of Health Outcome Measurement and a Trustee of The School of Oriental and African Studies. Rosna has delivered transformational change across a range of sectors.

Our Board

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

Board Members serving during the period 1 April 2020 to 31 March 2021:

Chair

Millie Banerjee

Chair

Millie Banerjee has had a long and varied career in the private and public sectors with extensive experience in corporate governance in both sectors. Currently she is also the Chair of the South West London Integrated Care System. Served on the Board until 6 August 2021.

Non-Executive Directors

Helen Fridell

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

Joanna Lewis

Jo was most recently People Director at Sky and joins us with 25 years' experience in Human Resources. She is also a Trustee for Middlesex Learning Partnership Multi-Academy Trust and the London School of Mosaic.

Professor Paresh Vyas

Professor Vyas is a Professor of Haematology at Oxford University, he runs a research laboratory at the Weatherall Institute of Molecular Medicine. (Chair of the Research and Development Committee).

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.

Piers White – MBE

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.

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 NED with the Lancashire and South Cumbria NHS FT.

Professor Deidre 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).

Leavers and secondees

Keith Rigg

Non-Executive Director

Served on the Board from October 2013 to June 2020.

Jeremy Monroe

Non-Executive Director

Served on the Board from February 2013 to February 2021.

Mike Stredder

Interim Director of Donor Experience

Served on the Board from to June 2015 to July 2020.

Katherine Robinson

Director of People

Served on the Board from 1st July 2017 to 7 October 2020. On secondment from 11 January 2021.

New Board members between 31 March and Authorised for issue date

John Patullo Interim Chair

Deborah McKenzie Chief People Officer

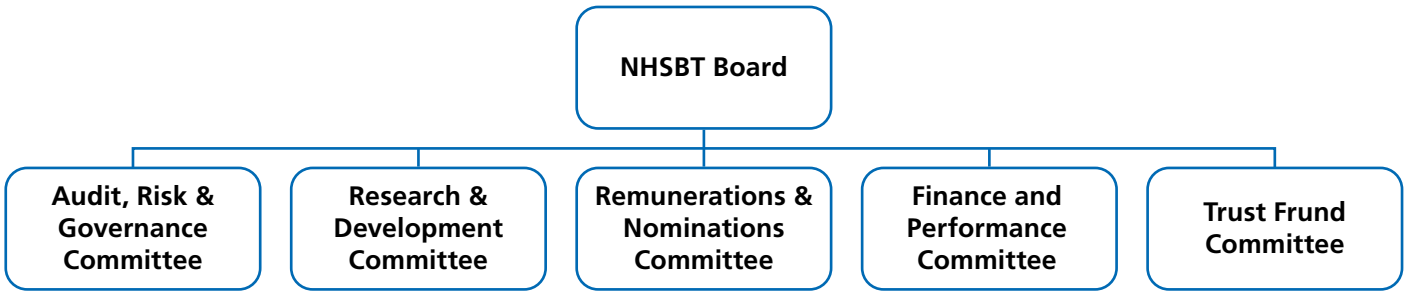
Details of the remuneration of senior managers of NHSBT can be found in the Remuneration and Staff Report at pages 41-42.

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

http://www.nhsbt.nhs.uk/who-we-are/transparency/accounts/board-expenses-and-interests/

Our governance structure

NHSBT Governance Structure has undergone a substantial review in 2020/21 – the membership and duties of all Committees have been reviewed and amended in year and ratified by the Board. The Audit, Risk and Governance Committee (ARGC) reviews governance arrangements on behalf of the Board and a new assurance map and Board Assurance Framework are in development to support ARGC in overseeing the delivery of NHSBT's statutory, regulatory and strategic objectives and the effectiveness of its internal controls and risk management processes. The key assurance strands are described further below.



Committee	Role	Membership and attendance (as a proportion of meetings held while appointed)
The Board	Oversees the strategic direction and the delivery of objectives and ensures that the core purpose and values of the organisation are upheld. The Board is led by the Chair and comprises Non-Executive Directors (NEDs) and Executive Directors, including the Chief Executive, Chief Medical Officer and Director of Clinical Services and Finance Director.	**Non-Executive** Millie Banerjee (Chair) 6/6 Helen Fridell 6/6 Jeremy Monroe 5/5 Keith Rigg 1/1 Charles St John 6/6 Prof. Paresh Vyas 5/6 Piers White 6/6 Prof. Deirdre Kelly 5/5 Joanna Lewis 1/1 Phil Huggon 1/1 **Voting Member Directors** Betsy Bassis 6/6 Rob Bradburn 6/6 Anthony Clarkson 6/6 Greg Methven 5/6 Dr Gail Miflin 6/6 **Non Voting Members** Ian Bateman 6/6 Wendy Clark 6/6 Katie Robinson 6/6 Rosna Mortuza 4/4 Katherine Robinson 3/3 Patricia Grealish 3/3 David Rose 5/6

Committee	Role	Membership and attendance (as a proportion of meetings held while appointed)
Remuneration & Nominations Committee	Consolidates the duties of both a Renumeration and Nominations 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 determines remuneration, conditions of service and termination arrangements of those very senior managers currently paid under the terms of the Executive Senior Manager (ESM) Framework 2016 and any other management posts with a base salary in excess of £100,000 per annum. The Committee also oversees and advises the Board on termination and severance arrangements in relation to the Chief Executive and NHSBT Directors and determining which Executive Directors are members of the NHSBT Board.	Jeremy Monroe (Chair) 4/4 Millie Banerjee 4/4 Betsy Bassis 4/4 Helen Fridell 4/4 Joanna Lewis 0/0 Katherine Robinson 1/2 Patricia Grealish 2/2
Trust Fund Committee	Oversees NHSBT's charitable funds which are used to support staff welfare and small research and development projects. NHSBT is the corporate trustee of the Trust Fund. The Board of NHSBT acts on behalf of the corporate trustee and Board members are not individual trustees.	Charles St John (Chair) 4/4 Rob Bradburn 4/4 Dr Gail Miflin* 2/3 Katherine Robinson 2/2 Patricia Grealish 2/2 *Revised terms of reference ratified at January 2021 Board removed Gail Miflin.
Finance & Performance Committee	Responsible for scrutinising NHSBT financial and planning reports, making recommendations to the NHSBT Board on financial performance, planning and pricing issues and providing assurance that these are being managed effectively.	Charles St John (Chair) 5/5 Jeremy Monroe 4/5 Prof. Paresh Vyas 4/5 Rob Bradburn 5/5 Dr Gail Miflin 0/1* Katie Robinson 3/4* Joanna Lewis 0/0 *Revised terms of reference at April Finance & Performance Committee and ratified at January 2021 Board appoint Katie Robinson as member and remove Gail Miflin.
Audit Risk and Governance Committee (ARGC)	Formally the Governance and Audit Committee (GAC) Provides the Board assurance that governance, risk management and internal control processes across all clinical and non-clinical activities are effective. The reports to ARGC are from Directors and Managers and Internal and External Auditors. The internal auditors are GIAA. The ARGC also approves the Annual Report and Accounts on behalf of the Board and reviews the work and findings of the National Audit Office.	Piers White (Chair) 6/6 Keith Rigg 1/1 Jeremy Monroe 5/5 Professor Deirdre Kelly 3/5 Rob Bradburn 6/6 Gail Miflin 6/6 Ian Bateman 6/6 Wendy Clark 6/6 Phil Huggon 1/1

Committee	Role	Membership and attendance (as a proportion of meetings held while appointed)
Research and Development Committee	Provides strategic advice to the Board on the NHSBT research programme. It approves and allocates available funding for research projects within the delegated financial limits of NHSBT. It receives annual reports and monitors progress on funded projects and commissions research from external sources where appropriate. It also seeks assurance that appropriate arrangements are in place for staff development, research governance, agreements with academic and commercial collaborators, and protection of Intellectual Property. It further receives and considers the Annual Report of Research that is required by the DHSC.	Prof Paresh Vyas (Chair) 2/2 Dr Gail Miflin 2/2 Rob Bradburn 2/2 Greg Methven 1/2 Jeremy Monroe 2/2 Anthony Clarkson 2/2 Piers White 2/2 Prof Deirdre Kelly 1/1 Prof Ellen van der Schoot (Head of Department Experimental Immunohaematology, Sanguin) 2/2 Prof Dana Devine (Chief Scientist, Canadian Blood Services) (1/2) Prof Hans L Zaaijer (Head of Dept Blood-Borne Infections, Sanquin Research) (1/2) Associate Professor Andreas Zuckermann, (Director of Cardiac Transplantation, University of Vienna in Austria) (1/2) Prof Alessandro Rambaldi (Director of the Department of Oncology and Haematology-Oncology, Bergamo) (1/2)

Statement of Accounting Officer's responsibility

Under the National Health Service Act 2006, the Secretary of State for Health and Social Care has directed NHS Blood and Transplant to prepare a statement of accounts for each financial year in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Blood and Transplant and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

- observe the Accounts Direction issued by the Secretary of State for Health and Social Care, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- prepare the accounts on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The Principal Accounting Officer of DHSC has designated the Chief Executive as Accounting Officer of NHS Blood and Transplant. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding NHS Blood and Transplant's assets, are set out in *Managing Public Money* published by the HM Treasury.

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Blood and Transplant's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Corporate Governance Report – Governance Statement

Board and Accounting Officer scope of responsibility

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

NHSBT's accountabilities to the Department of Health and Social Care and the devolved Governments

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

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

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

Following our review of governance structures the assurance processes, set out in our Board Assurance Framework, will be reviewed by the Audit, Risk and Governance Committee (ARGC). The Framework was last reviewed in November 2018. 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 50. The Board undertook two development days in the year and a review of Board effectiveness and corporate governance is planned for 2021/22.

Strategic management and reporting

The Board approves the business plan and strategies across the organisation, which include the objectives and targets we aim to achieve. Our Executive Team and Board receive a monthly 'Board report' which shows performance including trend data, progress on strategic projects and a summary of key issues for attention. The content of this report is reviewed periodically to ensure that it provides sufficient information and assurance to the Board. Both the business plan and 'Board report' format and design were reviewed and refreshed during 2020/21. There is also a more detailed quarterly performance review for each Director with the Chief Executive. During 2020/21, not all quarterly review processes were possible (5 have happened with 4 further reviews scheduled out of 16) due to the need to prioritise resources to support the emergency response to the COVID-19 pandemic.

Clinical governance

The Chief Medical Officer and Director of Clinical Services has responsibility for all aspects of clinical governance and effectiveness across NHSBT and reports regularly to the Executive Team, Audit, Risk and Governance Committee (ARGC) and the Board on all matters of clinical governance. The Director's Clinical Governance report covers clinical risks, risk management, clinical audits, policy and safety, information governance, regulatory issues, new external guidance and alerts, clinical service developments, incidents including serious incidents (SIs) and Never Events (see definition below), clinical complaints/commendations and clinical claims.

To oversee clinical governance there is a Clinical Audit, Risk and Effectiveness Committee (CARE). This meets bi-monthly and receives reports from CARE groups embedded within each of the operational directorates. Each operational Senior Management Team meeting also has a standing clinical governance agenda item as do the Quarterly Performance reviews by Directorate.

Clinical governance activity includes:

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

Never Events/Serious Incidents

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

Serious Incidents (SIs) are adverse events, where the consequences to patients, families and carers, staff, donors, 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. During 2020/21 a total of two incidents were identified as being SIs versus five in 2019/20. The two incidents related to:

- A donor heart was unsuitable for both solid organ transplant and heart valve donation but was temporarily removed to facilitate lungs retrieval. However, during Post-Mortem examination (PM), the heart was not present within the body
- A transcription error, where a single digit error was made, when NHSBT staff manually entered a patient's human leucocyte antigen (HLA) type into the database to search for the best stem cell match from registered donors to be transplanted to the patient.

Each incident was formally investigated and reported to the relevant Director who oversaw the completion of the action plan. Each incident was also reviewed at CARE to ensure organisational learning and minimise the risk of a similar incident occurring in other parts of NHSBT.

Infected Blood Inquiry

The Infected Blood Inquiry 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 blood products. 2,009 people who are infected and affected have been appointed as core participants.

NHSBT is a Core Participant (CP) in the Inquiry. This generally refers to a participant who will play a key role in the inquiry process. As an organisation NHSBT is supporting former colleagues who have been asked to provide evidence to the Inquiry.

NHSBT has cooperated fully with the Inquiry from the start and is doing whatever it can to assist the Inquiry in order that answers can be provided to the questions asked by the infected and affected. NHSBT has provided a significant volume of information/records to the Inquiry and is committed 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, 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).

NHSBT has repeated its review of the DHSC guidance published in December 2013 *Protecting and promoting patients' interests. Licence exemptions: guidance for providers* and determined that, due to increased demand for our apheresis based therapies, we are awaiting confirmation from NHSEI, as to whether we require a licence.

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 marked as medical devices, denoting they have been made to appropriate standards.

Quality Management System (QMS)

We operate a single, comprehensive quality management system (QMS) with detailed process documents and compliance records held in an electronic system (QPulse). The records ensure continued, demonstrable compliance with our regulatory requirements, licences and accreditations. Our processes also ensure that staff are adequately trained and competent. We operate a robust process of self-inspection (see below); and a risk-based quality system which provides assurance that controls are in place and risks are managed within the critical operational areas of NHSBT.

Self-inspections of NHSBT facilities are programmed on a 2-yearly cycle, cover all regulated activities at our licensed sites and include:

- Internal Quality Audit, undertaken by a team of approved auditors independent of the site or activity being inspected. They provide assurance on effective closure of external inspection findings and identify areas for regulatory and quality improvement
- Risk based process audits which are scheduled throughout the year and are focussed on critical processes and their improvement. The focus of risk-based process audits is agreed with each directorate leadership team based on previous quality incidents, audit findings and directorate risks
- Ad-hoc audits that are commissioned at the discretion of Senior Management, often in response to individual adverse events, trends or changes to our operational configuration.

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

- A quarterly Management Quality Review (MQR) Report to the Executive Team and ARGC
- An annual summary MQR report to the Board
- Monthly reporting of supporting key operational KPIs, designed to monitor that key processes remain in control, via the Board Performance Report.

Our Quality activity and reporting is regularly reviewed to identify improvements. For example, during the year improvements have been made to our Quality Incident and Supplier Management systems.

Non-compliance with regulatory requirements

NHSBT aims to have no "critical" and no "major" non-compliances identified during any external regulatory inspections. During 2020/21, many regulatory inspections were carried out remotely, although there were a number of on-site inspections of NHSBT facilities carried out by the MHRA. In total there were 23 external regulatory and accreditation inspections of NHSBT's facilities and systems across Quality, Business Continuity and H&S. There were no critical or major non-compliances raised in any of these inspections. All recommendations raised in the inspections concerned have or are being addressed.

During 2020/21 and mainly due to operational pressures due to the COVID-19 response, we have seen variability in the number of overdue events within the quality management system. An overdue event is, for example, when a policy or procedure has exceeded its review date and not been reviewed by the owner; or when an element of a corrective and preventive action plan goes past its due date. Following an increase in overdue events at the end of Q3 a number of improvement initiatives were implemented which resulted in improved performance through Q4 and beyond year end.

Risk management and control

NHSBT has maintained its focus during 2020/21 on risk management activity across the organisation. Additional focus has been required as a result of the pressures created by the End of the Transition period and also COVID-19.

The risk management process across NHSBT is scrutinised by two key Governance and Oversight Committees (1) the Risk Management Committee (RMC) is responsible for the oversight of NHSBT's risk management framework ensuring the suitability, adequacy and effectiveness of NHSBT's risk management process and (2) the Audit and Risk Governance Committee (ARGC) who seek assurance on the status and management of NHSBT's strategic risks.

To support the governance requirements of the Risk Management Committee, a sub-group, the Risk Leads Forum (RLF) has been introduced with clear aims and objectives. This group provides challenge and debate on pre agreed classification of risk, with output from the meeting informing discussions held at the RMC.

During 2020/21 NHSBT has undertaken an internal review of its risk management framework and risk reporting structure. The review of the risk management used the ISO risk management standard (ISO31000) as the measure. The review has resulted in two comprehensive updates:

1. The production and implementation of a revised Risk Management Manual.

   This document provides detailed information regarding NHSBT's risk management framework and also the risk management process, which staff at all levels are required to follow. To provide additional support and guidance, a number of supporting 'bite size' guides have been produced and made available on the risk management intranet page.
2. The development and rollout of risk management training and education courses:

   (a) A general risk awareness online training course available to all colleagues.

   (b) A detailed course for Risk Leads covering all aspects of our process, including risk assessment, scoring and overall management.

   (c) A risk awareness course is in development aimed at Board and Director level.

To ensure visibility of risk across the organisation we use a risk management system. In the year we have completed a deep dive review of each Strategic Risk (see pages 13-14) with the responsible Directors. There is work ongoing to develop the strategic plans and objectives which will then identify related risks and management plans.

Business continuity

Many of our products and services are unique and critical to the wider health community and patients. This year, more than ever the organisation's resilience has been tested and the importance of robust business continuity arrangements have been re-emphasised.

The Business Continuity Team moved directorates this year and now report to the Director of Strategy and Transformation.

Aims for the coming year include:

- Continued certification of the blood supply chain to ISO22301
- Closer integration with the DDTS response framework and the wider Business Continuity system
- Understanding the 'new normal' regarding COVID – specifically what lessons can be learned, how can we better embed Business Continuity and what does this Business Continuity look like in the future?

- Review of the organisation's exercise programme to deliver a full review of our plans and procedures and how they should change under the new circumstances we find ourselves in
- To work alongside the supply chain team to better examine supplier resilience.

Much of this will be dependent on the longevity of the COVID-19 pandemic and the impact it continues to have on NHSBT and wider society.

Information Governance and Security

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

In the year we reported three incidents to the Information Commissioners Office. The Information Commissioners Office (ICO) has closed one of the incidents with no further action required and two are ongoing.

We also reported 381 data incidents in the year, most involved mishandling of paper documents including Blood Donor Health Check forms (DHCs), nearly all of which were subsequently recovered. We review each incident and the trends. We identify the lessons learned and share these with the teams responsible and nationally to avoid repeats. We are also introducing systems which will remove the need for paper forms to address this.

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

Whistleblowing policy and Freedom to Speak up Guardian

We have a Freedom to Speak Up guardian which is a valuable element in providing a safe working environment for our colleagues, and safe services for our customers. In the financial year of 2020/21 109 concerns were raised. These concerns, and the trends, outcomes and learnings, are reported to the Chief Executive and other forums including the Equality and Diversity Consultative Committee, where our union colleagues review the data, each month. We are working to simplify how to raise a concern. We're improving our reporting to show themes and trends from Freedom To Speak Up, Whistleblowing, HR Cases and other indicators. We are working very closely with the Diversity and Inclusion programme and our heads of centre to address the root causes of concerns raised.

Organisational Diagnostic report

As reported on page 44, an Organisational Diagnostic report was published in June 2020 that evidenced systemic racism, instances of bullying, harassment and micro aggressions experienced by BAME colleagues and made nine recommendations for urgent action. We have reset our governance arrangements for EDI. We created the EDI Council, chaired by our Chief Executive. This includes members of the Executive Team, the Chairs of our Employee Network Groups as well as Trade Union representatives, allowing for regular and direct dialogue in setting the strategic agenda, holding the organisation to account and to flag any areas of concern.

The establishment of the EDI Partnership Consultative Committee provides a forum for our trade union colleagues and operational leads to push forward with our NHS Equality Standard measures, including the Workforce Race Equality Standards, Workforce Disability Equality Standards and our Equality Delivery System.

Our Executive Champions for Network Groups support by raising awareness, championing issues throughout the organisation and escalating or problem-solving where there may be institutional barriers.

Counter Fraud policy

The Anti-Fraud, Bribery and Corruption policy explains how staff must conduct business and report suspected fraud. We also have a risk-based counter fraud action plan. We plan preventative and detective work in areas of risk and investigate any suspected cases raised with our Local Counter Fraud Specialists. We report on our plans and actual work undertaken to ARGC and they also receive our self-assessment against the NHS and Cabinet Office counter fraud standards. During 2020/21 three cases have been reviewed. The first was related to false appointments and has been the subject of a broader internal audit, the second was an allegation against a supplier which has been concluded and the third was an ongoing police prosecution case where a false claim was made that a charity had provided funds to NHSBT.

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 CO_2 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

Through the COVID-19 pandemic our first priority has been the safety and wellbeing of our donors, patients and colleagues. Health Safety and Wellbeing (HSW) is covered in our Accountability report (pages 49).

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

	19/20				20/21			
Level	**HSE Rep**	**Lost time**	**Serious Acc**	**Minor/ Near Miss**	**HSE Rep**	**Lost time**	**Serious Acc**	**Minor/ Near Miss**
Blood Supply	17	9	83	1,078	26	14	104	1,194
Clinical Services	1	2	10	75	1	1	8	71
OTDT	0	3	12	91	0	0	10	49
Donor Experience	0	0	0	1	0	0	0	0
Group Services	1	0	1	97	0	0	2	75
Total	**19**	**14**	**106**	**1,342**	**27**	**15**	**124**	**1,389**

HSE Reportable (HSE Rep) – Over 7 days lost time injuries or specified injuries reported to the Health and Safety Executive (HSE) e.g. fractures or injuries requiring an over 24 hours stay in hospital.

Lost Time – Over 3 but less than 8 day lost time injuries.

Serious Accident (Serious Acc) – Injuries or near miss incidents graded as serious by Health Safety & Wellbeing (HSW) Department based on their severity and likelihood of reoccurrence, excluding road traffic incidents and violence.

Minor/Near Miss – Minor injuries or all other near miss incidents where no injury to staff.

The table above shows full year figures for 2020/21 compared to the previous two years. We have seen an increase in near miss reporting in Blood Supply which we welcome and learn from. Other areas near miss reporting has decreased which we believe is related to increased homeworking. We also report an increase in the number of HSE reported, lost time and serious accidents in Blood Supply.

Further analysis of the Blood Supply Lost Time cases (1 day or more) shows incidence rate, as a proportion of hours worked, actually reduced to 2.0 (vs 2.4 the prior year). This reduced rate happened despite more hours being worked with more new starters during the pandemic. We are pleased with this rate reduction.

The Blood Supply Serious Accidents increased due to more blood exposures and needlesticks accidents (68 in 2019/20 to 90 in 2020/21) which we attribute to the proportion of new starters this year.

To keep our Blood Supply colleagues safe we have recruited an extra HS&W advisor in London to coach managers (half of Accidents were in London and SE). We will also be trialling peer-to-peer safety observations across Blood Supply collection teams in 2021/22.

We have a national Health Safety and Wellbeing five-year plan to continuously improve our practices and keep our colleagues safe.

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 2020/21 programme of work agreed by the ARGC covered 16 work areas. Three further reviews were removed or deferred to 2021/22. Of the 16 audits, 15 were completed and reported on in the period. Six of the reports were advisory, of the remaining 9:

- 1 report received a "substantial" assurance
- 7 received a "moderate" assurance
- 1 received a "limited" assurance.

The limited assurance report related to Donor Centre Appointment Management.

The two audits deferred to 2021/22 planning were: Blood Safety – detecting emerging infections and Cyber Security and Records Management. The audit of HR corporate responsibilities was removed from the plan.

ARGC monitors the completion of all medium and high outstanding audit recommendations. In May 2021 ARGC were informed that there were no overdue medium or high recommendations from the 2020/21 audit programme. The ARGC have been informed that one recommendation from 2019/20 has been given an extension due to the impacts of COVID-19 and is carried over into 2021/22.

The Internal Audit opinion in 2019/20 was moderate as we completed changes following a fundamental review of governance and risk management to address identified weaknesses. We are now embedding these changes and have maintained a moderate opinion in 2020/21.

Internal Audit – opinion of the Head of Internal Audit

In 2020/21 Internal Audit has 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 our independent view on NHSBT's risk profile.

Our opinion is based solely on our assessment of whether the controls in place support the achievement of management's objectives as set out in our 2020/21 Internal Audit Plan and Individual Assignment Reports. "In accordance with the requirements of the UK Public Sector Internal Audit Standards, I am required to provide the Accounting Officer with my annual opinion of the overall adequacy and effectiveness of the organisation's risk management, control and governance processes."

My opinion is based on the outcomes of the work that Internal Audit has conducted throughout the course of the reporting year. There have been no undue limitations on the scope of Internal Audit work and the appropriate level of resource has been in place to enable the function to satisfactorily complete the work planned. Therefore, in summary, my overall opinion is that I can give Moderate assurance to the Accounting Officer that NHSBT has had adequate and effective systems of control, governance and risk management in place for the reporting year 2020/21.

Review of effectiveness

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

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

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

Accountability report – Parliamentary accountability and audit report

Basis for accounts preparation

These accounts for the year ending 31 March 2021 have been prepared as directed by the Secretary of State for Health and Social Care in accordance with section 232 (Schedule 15, Paragraph 3) of the National Health Service Act 2006, and in a format as instructed by the DHSC with the approval of Treasury.

External audit

The Comptroller and Auditor General (C&AG) is appointed by statute to audit NHSBT and report to Parliament on the truth and fairness of the annual financial statements and regularity of income and expenditure. The cost of audit work performed is £102k (£98k 2019/20). There were no payments to the C&AG for non-audit work during 2020/21 and 2019/20.

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).

	31 March 2021		31 March 2020	
Losses Statement	**No. Cases**	**£000**	**No. Cases**	**£000**
Cash losses	5	1,100	6	–
Bookkeeping losses	0	0	1	–
Exchange rate fluctuations	1	0	3	–
Losses of pay, allowance and superannuation benefits	40	55	40	27
Losses of accountable stores	74	227	97	147
Claims waived or abandoned	21	5	9	8
Fruitless payments and constructive losses	13	2,387	1	13
Total	**154**	**3,774**	**157**	**195**

	31 March 2021		31 March 2020	
Special Payments	**No. Cases**	**£000**	**No. Cases**	**£000**
Compensation payments	31	69	29	89
Ex gratia payments	13	74	9	10
Total	**44**	**143**	**38**	**99**

Cash losses contains £1.1m representing the unsettled claim value in a contractual dispute with a supplier.

The above table includes £0.743m for Session Solution fruitless payments for leased hardware which was paid for but not used due to the programme being delayed due to COVID-19.

The CVP Programme was halted in March following the results of the two main research trials. The total spend on this programme in the year was £55.4m. At the same time the UK government has permitted the use of UK plasma for fractionation and the production of plasma derived medicinal products (PDMPs). In June 2021, DHSC commissioned and funded NHSBT to collect plasma until at least March 2022 while funding is reviewed for the longer-term. At 31 March NHSBT held harnesses for collecting convalescent plasma which was purchased for £5.2m (see note 11). Of this £1.59m of stock cannot be repurposed for collecting PDMPs or platelets and so has been disclosed as a constructive loss in the statement above. Following the extension of funding for plasma, and results of early validation by our Quality teams which commenced in June 2021, we are confident that £3.46m of the stock can be used prior to its expiry. We are evaluating options for the £0.15m balance of harnesses. Where options are exhausted and if stocks are wasted further losses will be disclosed.

Expenditure on consultancy

Consultancy expenditure during 2020/21 is £2,237k (2019/20 £567k).

Remote contingent liabilities

This is subject to audit.

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

Notation of gifts

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 (for blood), on behalf of the NHS. Prices are national, and set per unit, calculated using forecast sales volumes for the coming year. Prices include the full cost of providing products and services to the NHS (including a return on the cost of capital employed). In 2020/21 blood prices were calculated per unit but charged to hospital customers in a block contract based on pre – pandemic expected usage volumes.

As a block contract arrangement was in place for blood 2020/21 there was no calculation of rebate to customers based on lower usage than planned. The amount that would have been payable to customers under this rebate £11.6.m (£3.9m 2019/20) was retained, as agreed by DHSC and NCG as a contingency for COVID-19 costs. Note 2 shows the contribution per business unit and is subject to audit.

I hereby sign the Accountability Report (including the Governance Statement) from pages 37 to 64.

Betsy Bassis 12 October 2021
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 2021 under the National Health Service Act 2006. The financial statements comprise the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. The financial reporting framework that has been applied in their preparation is applicable law and International Accounting Standards as interpreted by HM Treasury's Government Financial Reporting Manual.

I have also audited the information in the Our Accountability report that is described in that report as having been audited.

In my opinion, the financial statements:

- give a true and fair view of the state of NHS Blood and Transplant's affairs as at 31 March 2021 and of NHS Blood and Transplant's net expenditure for the year then ended;
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects, the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2019. I have also elected to apply the ethical standards relevant to listed entities. I am independent of NHS Blood and Transplant in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the 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 Board and 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 applicable law and International Accounting Standards as interpreted by 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 is 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 parts of the Our Accountability report described in that report as having been audited, the financial statements and my auditor's certificate thereon. The Accounting Officer is responsible for the other information. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge 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, based on the work undertaken in the course of the audit:

- the parts of the Our Accountability report to be audited have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Our Performance report and Our Accountability report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

In the light of the knowledge and understanding of NHS Blood and Transplant and its environment obtained in the course of the audit, I have not identified material misstatements in the Our Performance report and Our Accountability report. I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Our Accountability report to be audited are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Report Manual are not made; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

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:

- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error.
- 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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Inquiring of management, NHS Blood and Transplant's Head of Internal Audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS Blood and Transplant's policies and procedures relating to:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - 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 the National Health Service Act 2006 and Managing Public Money.
- discussing among the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, posting of unusual journals, accounting for estimates and other areas of management judgement such as provisions and the valuation of inventory; and

- obtaining an understanding of NHS Blood and Transplant's framework of authority as well as other legal and regulatory frameworks that NHS Blood and Transplant operates in, focusing on those laws and regulations that had a direct effect on 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 Service Act 2006, Managing Public Money, pensions legislation, tax legislation and employment law.

In addition to the above, my procedures to respond to identified risks included the following:

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

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists 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.

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

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 20 October 2021
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 2021

	Note	2020/21 £000	2019/20 £000
Gross Income			
Income from sale of goods and services	2 & 3	348,505	340,699
Other operating income	2 & 3	28,551	27,693
		377,056	**368,392**
Expenditure			
Staff costs	4	(268,275)	(227,602)
Operating expenses	5	(230,435)	(190,821)
Depreciation, amortisation & impairment charges	9 & 10	(13,553)	(9,933)
Other operating expenditure	6	(31,037)	(25,074)
		(543,300)	**(453,430)**
Net operating expenditure before interest		**(166,244)**	**(85,038)**
Finance expense		(865)	(381)
Net operating expenditure after interest	2	**(167,109)**	**(85,419)**
Other comprehensive net expenditure Items which will not be reclassified to net operating costs:			
Net gain on revaluation of Property, Plant and Equipment	9 & 10	513	5,519
Total comprehensive net expenditure		**(166,596)**	**(79,900)**

Notes 1 to 22 form part of these accounts.

All income and expenditure is derived from continuing operations.

Statement of financial position as at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Property, plant and equipment	9	233,143	225,962
Intangible assets	10	2,732	3,579
Financial assets	12	397	77
Total non-current assets		**236,272**	**229,618**
Current assets			
Inventories	11	17,312	20,122
Trade and other receivables	12	44,578	41,854
Cash and cash equivalents	13	53,211	50,549
Total current assets		**115,101**	**112,525**
Current liabilities			
Trade and other payables	14	(52,688)	(41,836)
Provisions for liabilities and charges	15	(566)	(464)
Other liabilities	16	(266)	(230)
Total current liabilities		**(53,520)**	**(42,530)**
Total assets less current liabilities		**297,853**	**299,613**
Non-current liabilities			
Provisions for liabilities and charges	15	(419)	(409)
Financial liabilities	16	(8,551)	(7,935)
Total non-current liabilities		**(8,970)**	**(8,344)**
Total assets less employed		**288,883**	**291,269**
Financed by			
General fund		200,927	199,504
Revaluation reserve		87,956	91,765
Total taxpayers' equity		**288,883**	**291,269**

Notes 1 to 22 form part of these accounts.

The financial statements on pages 68 to 93 were recommended by the Audit Risk and Governance Committee on 1 July 2021 and approved by the Board in accordance with powers within the NHSBT Standing Orders and are signed by the Accounting Officer, Betsy Bassis.

Betsy Bassis
Date: 12 October 2021

Statement of changes in taxpayers' equity for the year ended 31 March 2021

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

Statement of changes in taxpayers' equity for the year ended 31 March 2020

	Note	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2019		176,661	89,435	**266,096**
Changes in taxpayers' equity for 2019/20				
Net expenditure for the financial period		(85,419)	–	**(85,419)**
Net gain on revaluation of property, plant and equipment	9 & 10	–	5,519	**5,519**
Transfer between reserves		3,189	(3,189)	**0**
Total recognised income and expense for 2019/20		**(82,230)**	**2,330**	**(79,900)**
IFRS 15 adjustment		(2)	–	**(2)**
Revenue Grant from DHSC		72,699	–	**72,699**
Notional funding for pension increase		9,776	–	**9,776**
Capital Grant from DHSC		22,600	–	**22,600**
Balance at 31 March 2020		**199,504**	**91,765**	**291,269**

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 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Net operating costs		(166,244)	(85,038)
Adjustments for non-cash transactions	17	15,492	19,955
(Increase)/decrease in trade and other receivables		(3,044)	(5,195)
(Increase)/decrease in inventories		2,810	1,694
Increase/(decrease) in trade and other payables		10,852	18,170
(Increase)/decrease in capital creditors (not in SoCNE)		(636)	345
Provisions utilised	15	(100)	(124)
Movement in financial lease liabilities		881	–
Net cash (used in) operating activities		**(139,989)**	**(50,193)**
Cash flows from investing activities			
Purchase of plant, property & equipment		(23,098)	(21,291)
Purchase of intangible assets		(161)	(1,156)
Proceeds from disposal of non-current assets		2	–
Net cash (used in) investing activities		**(23,257)**	**(22,447)**
Cash flows from financing activities			
Grant from DHSC		166,960	95,299
Capital element paid in respect of finance leases	16	(227)	(185)
Interest paid in respect of finance leases		(825)	(369)
Net cash generated from financing activities		**165,908**	**94,745**
Increase in cash and cash equivalents		2,662	22,105
Cash and cash equivalents at 01 April		50,549	28,444
Cash and cash equivalents at 31 March	13	**53,211**	**50,549**

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 2020/21 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM comply with IFRS to the extent that they are meaningful and appropriate to the public sector context as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the FReM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS body for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 Accounting convention

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

1.1.2 Going concern

The organisation's annual report and accounts have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for the service in published documents.

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 below) that management has made in the process of applying NHSBT's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Charities consolidation

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

1.2.2 Sources of estimation uncertainty

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

- Use of depreciated replacement cost to value land and buildings (see accounting policy note 1.6)
- Use of amortised cost as a proxy for fair value for intangible assets (see accounting policy note 1.7)
- The estimation assumptions used in the calculation of provisions for liabilities and charges (see accounting policy note 1.13)
- Measurement of the accrual for employee leave liability. We apply the average number of days carried forward per employee to the average weekly basic pay bill for the year.

1.3 Revenue from contracts with customers

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

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

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

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 contract value adjusted for activity monthly in arrears. In 2020/21 block contracts were in place where customers were billed a monthly contract value based on expected (pre-pandemic) demand and no adjustments were made for actual demand variations.

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

Revenue from project contracts

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

1.3.1 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 should read 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.

1.3.2 Other income

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

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

1.4 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 fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.5 Capital charges

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

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

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

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

1.6 Property, plant and equipment

Note 1.6.1 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 cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.6.2 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 expenses immediately, as allowed by IAS 23 for assets held at fair value.

1.6.3 Subsequent expenditure

Depreciation

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

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

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

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

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

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

Revaluation

All land and buildings are professionally revalued in accordance with IAS 16 every five years. Professional valuers undertake a desktop valuation for each of the interim years except for where cumulative additions since the last full valuation is greater than £2m and represent a greater than 20% increase in the net book value, in which case a full on-site valuation is carried out. The change in valuations are reflected in the accounts. A full valuation of NHSBT land and buildings was last carried out in March 2019.

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

- Non-specialist operational assets – Existing Use Value (EUV)
- Specialist operational assets – Depreciated Replacement Cost (DRC). This is the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

Equipment assets are indexed annually in accordance with the appropriate categories within the publicised Health Service Cost Index. The carrying value of existing assets at that date will be written off over their remaining useful lives. New fixtures and equipment are carried at depreciated historic cost, as this is not considered to be materially different from fair value.

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 income (expenditure) in the Statement of Comprehensive Net Expenditure.

Impairments

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

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

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

1.6.4 De-recognition

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.

1.7 Intangible Assets

1.7.1 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.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is charged to the Statement of Comprehensive Net Expenditure in the period in which it is incurred. NHSBT does not hold any internally generated intangible assets.

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

1.7.2 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.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IFRS 5.

1.7.3 Amortisation

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

1.7.4 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

Software licences	3 to 26 years

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

1.8 Inventories

Inventories are valued as follows:

- Raw materials and work in progress are valued on a weighted average cost basis
- Blood products are valued at the lower of cost, on a full recovery cost basis, or net realisable value, which represents the expected future selling price

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

The plasma collected under the Convalescent Plasma Programme held at 31st March is held at nil value. This was the net recoverable value, at the time, as this plasma was issued to hospitals free of charge under the research trials. At 31 March whether this plasma could be repurposed for use in PDMPs was subject to ministerial approvals, donor consent and further validation and testing. The likelihood of using this plasma is therefore subject to material uncertainty and hence it continues to be carried at nil value.

1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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.

1.10 Foreign exchange

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

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

1.11 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension 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 schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

National Employment Savings Trust (NEST) Pension Scheme

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

1.12 Leases

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

NHSBT as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Subsequently, property, plant and equipment held under finance leases are revalued as described in 1.6.3 above. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating NHSBT's net operating cost.

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

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

1.13 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.

Clinical Risk Pooling

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

Non-clinical Risk Pooling

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

1.14 Financial Instruments

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

Financial assets

In accordance with IFRS 9 and FReM, NHSBT is required to recognise a loss allowance representing expected credit losses on trade receivables. NHSBT has applied the simplified approach, as required, and measured the loss allowance at an amount equal to lifetime expected credit losses.

1.15 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain events not wholly within the 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.

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

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

The following have not been adopted early in these accounts:

- **IFRS 16 – Leases:** The change in the accounting treatment for leases has been deferred until 1 April 2022. The impact of IFRS 16 is dependent on the leases that NHSBT holds at the time of implementation. However, work has already commenced to the extent of identifying current leases and contracts containing a lease that are expected to be in place, at the time of transition to the new standard, and understanding the future accounting treatment of all leases, held as lessee, and their impact on the assets and liabilities in the Statement of Financial Position. This standard is expected to lead to a material increase in property assets resulting from assets currently disclosed in the operating lease note being valued and added to the assets of the organisation. There is also expected to be a material impact in the accounts for operating leases that are expected to be transferred to the Statement of Financial Position as a lease liability
- **IFRS 17 – Insurance Contracts:** This standard is effective for accounting periods beginning on or after 1 January 2021. A preliminary assessment indicates there will be no material changes as NHSBT does not enter into insurance contracts.

Note 2 Operating segments – 2020/21

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

Note 2.1 Operating segments – 2019/20

For the year 1 April 2019 to 31 March 2020	Total £000	Blood Components (incl R&D) £000	Diagnostics £000	Tissues £000	Organ Donation & Transplant £000	Therapeutic Apheresis Services £000	Stem Cells £000
Revenue							
Provision of Products and Services	**340,699**	268,887	30,864	15,040	-	11,223	14,685
Income from Scottish Parliament	**6,145**	–	–	–	6,145	–	–
Income from National Assembly for Wales	**3,526**	–	–	–	3,526	–	–
Income from Northern Ireland Assembly	**2,101**	–	–	–	2,101	–	–
Other Income	**15,922**	8,323	1,531	1	1,957	385	3,725
Programme Funding from the DHSC	**72,699**	–	–	–	68,537	–	4,162
Total Revenue	**441,092**	**277,210**	**32,395**	**15,041**	**82,266**	**11,608**	**22,572**
Expenditure							
Variable costs	**(57,199)**	(38,108)	(5,748)	(2,153)	(3,773)	(3,882)	(3,535)
Direct costs	**(215,503)**	(111,828)	(16,899)	(9,835)	(61,085)	(4,301)	(11,555)
Direct support costs	**(106,699)**	(79,282)	(7,343)	(3,169)	(9,714)	(1,306)	(5,885)
Movement in value of stocks	**(1,421)**	(881)	–	(540)	–	–	–
Other support costs	**(33,943)**	(20,388)	(2,364)	(1,241)	(7,387)	(773)	(1,790)
Total Expenditure	**(414,765)**	**(250,487)**	**(32,354)**	**(16,938)**	**(81,959)**	**(10,262)**	**(22,765)**
Operating surplus/(deficit) for the financial period	**26,327**	**26,723**	**41**	**(1,897)**	**307**	**1,346**	**(193)**
Transformation costs	(20,222)	(8,888)	(868)	–	(10,466)	–	–
Operating surplus for the financial period	**6,105**	**17,835**	**(827)**	**(1,897)**	**(10,159)**	**1,346**	**(193)**
Add: Notional cost of capital included in expenditure above	**8,463**						
Less: Notional cost of pension increase	**(9,776)**						
Less: Programme Funding from DHSC	**(72,699)**						
Less: Capital charges paid to the DHSC	**(17,512)**						
Net expenditure	**(85,419)**						

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

We report our financial performance in operating units as follows:

Blood Supply provides blood and blood components, primarily to NHS hospitals and includes research and development activity. In 2020/21 £55.4m of expenditure was incurred on the CVP Programme which was fully funded by DHSC programme funding.

Clinical Services includes:
Diagnostics which provides specialist laboratory services (Red Cell Immunohematology and Histocompatibility & Immunogenetics) and also reagents.

Stem Cells includes Cellular and Molecular Therapies, the British Bone Marrow Registry (BBMR) and the Cord Blood Bank (CBB).

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

Organ and Tissue Donation and Transplantation includes:

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

Tissues retrieves and provides human tissue products.

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

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

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

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 2020/21 block contracts were in place. No adjustments were made for actual demand variation and no rebates were paid (see page 84).

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

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

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

3.1 Income by nature

	2020/21 £000	2019/20 £000
Blood and Components	292,361	277,210
Diagnostic and Therapeutic Services	29,222	32,395
Tissues	11,994	15,041
Stem cells	17,134	18,410
Organ Donation and Transplantation	14,138	13,728
Therapeutic Apheresis Services	12,207	11,608
Total Income from activities per SoCNE	**377,056**	**368,392**

3.2 Income by source

	2020/21 £000	2019/20 £000
Department of Health and Social Care	10,838	11,089
NHS Trusts	115,870	–
NHS Foundation Trusts	211,415	–
NHS CCGs	31	–
Other NHS bodies	–	319,602
Other Government bodies	15,820	15,957
Non-NHS	23,069	21,633
Trust Funds	13	111
Total Income from activities per SoCNE	**377,056**	**368,392**

£15,793k of the Other Government bodies income shown above is contractual income and grant funding from devolved administrations (2019/20 £11,772k).

3.3 Revenue grant-in-aid from DHSC

	2020/21 £000	2019/20 £000
Programme funding – Organ Donation and Transplantation	62,327	62,338
Programme funding – Organ Donation Deemed consent	11,509	6,199
Programme funding – Diagnostic and Therapeutic services	4,173	4,162
Programme funding – Convalescent Plasma*	55,390	–
Programme funding – Corporate/Notional pension funding	11,061	9,776
Total Revenue grant from DHSC per SoCTE	**144,460**	**82,475**

DHSC grant-in-aid is recorded directly as a change in taxpayers' equity.
*In 2020/21 we received £55.4m of CVP Programme funding from DHSC (see page 29).

Note 4 Staff costs

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	214,872	178,519
Social security costs	18,763	16,947
Employer contributions to NHS Pensions scheme	34,640	22,360
Notional cost of NHS Pension increase	–	9,776
Total	**268,275**	**227,602**

On 1 April 2019, the employer contribution rate for the NHS Pension Scheme increased by 6.3%. The additional cost, funded directly by DHSC, was £9,776k for the year. In 2020/21, the additional cost (£10,534k) which was paid by NHSBT and was matched by programme funding from DHSC, has been reported in Employer contributions to NHS Pensions Scheme.

Note 4.1 Pension costs

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

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on an assessment of liabilities at 31 March 2020, updated to 31 March 2021 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 its recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contributions rate payable from April 2019 at 20.68% of pensionable pay from this date. In 2019/20 14.38% of this has been paid and accounted for by NHSBT and the balance charged directly to DHSC. The cost directly paid by DHSC in 2019/20 was £9,776k and was included in NHSBT accounts as a notional cost and notional funding. In 2020/21, the additional cost has been paid and accounted for by NHSBT and was funded by DHSC.

The 2016 funding valuation was also expected to test the costs of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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

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

NEST is a defined contribution scheme managed by a third-party organisation. It carries no possibility of actuarial gain or loss to NHSBT and there are no financial liabilities other than payment of the employers' contribution. The minimum combined contribution for 2020/21 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 2021 there were 159 employees enrolled in the NEST scheme (131 at 31 March 2020).

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Note 5 Operating expenses

	2020/21 £000	2019/20 £000
Other staff related costs	10,832	12,183
Consumable supplies	68,938	64,884
Maintenance of buildings, plant and equipment	20,139	16,866
Rent and rates	13,833	12,245
Transport costs	14,193	19,934
External contractors	50,940	25,877
Purchase and lease of equipment and furniture	8,992	5,343
Utilities and telecommunications	10,460	10,039
Media advertising	4,124	1,967
Organ Donation Transplant Scheme payments	21,070	18,136
Professional fees*	6,812	3,249
External Auditors remuneration: Audit fees**	102	98
Total	**230,435**	**190,821**

* 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	2020/21 £000	2019/20 £000
Capital charges paid over as cash to DHSC		17,970	17,512
Capital non-cash: Loss on disposal of fixed assets*	8	1,768	47
Miscellaneous**		11,299	7,515
Total		**31,037**	**25,074**

* Loss on disposal of fixed assets includes the book losses of two property sales: Leeds (£945k) and Sheffield (£770k) with proceeds going to DHSC as owner of estate.
** Amount includes £4.9m (2019/20 £3.4m) relating to IT software licence fees and £1.6m (2018/19 £1.4m) to insurance costs.

Note 7 Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where NHSBT is the lessee.

NHSBT's operating lease commitments relate to property rents and vehicles. The vehicle commitments are based on 379 staff lease cars and 324 fleet vehicles.

The property commitments are based on 66 properties which include 15 short term premises leases to support the Convalescent Plasma Programme, the remaining lease payments being recorded as falling due within one year.

The amounts recognised in these accounts are:

	2020/21 £000	2019/20 £000
NHSBT as lessee		
Payments recognised as an expense		
Lease and rental payments*	10,267	8,228
Total future minimum lease payments payable		
Not later than one year	5,572	4,611
Later than one year and not later than five years	9,953	9,056
Later than five years	249	446
Total	**15,774**	**14,113**

* 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.

Note 8 Other gains/(losses)

	2020/21 £000	2019/20 £000
Profit/(loss) on disposal of non-current assets		
Loss on disposal of plant and equipment	(53)	(47)
Loss on disposal of buildings	(847)	–
Loss on disposal of land	(868)	–
	(1,768)	**(47)**

Losses recorded on land and buildings relate to the property movements outlined at Note 6.

Note 9 Property, plant and equipment – 2020/21

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/cost at 1 April 2020	27,651	158,019	22,226	52,590	10	9,028	269,524
Additions purchased	–	1,117	16,351	4,751	–	1,515	23,734
Reclassification	–	20,816	(21,033)	217	–	–	–
Indexation	–	–	–	1,258	–	–	1,258
Other in year revaluations	(250)	(4,760)	–	–	–	–	(5,010)
Impairments	(232)	(2,634)	–	–	–	–	(2,866)
Transfer of assets to other government bodies	(825)	(1,925)	–	–	–	–	(2,750)
Disposals	(868)	(847)	–	(1,642)	–	–	(3,357)
Valuation/cost at 31 March 2021	**25,476**	**169,786**	**17,544**	**57,174**	**10**	**10,543**	**280,533**
Accumulated depreciation at 1 April 2020 – brought forward	–	1,686	–	38,397	9	3,470	43,562
Provided during the year	23	5,652	–	3,180	1	825	9,681
Indexation	–	–	–	918	–	–	918
Other in year revaluations	–	(5,183)	–	–	–	–	(5,183)
Disposals	–	–	–	(1,588)	–	–	(1,588)
Accumulated depreciation at 31 March 2021	**23**	**2,155**	**–**	**40,907**	**10**	**4,295**	**47,390**
Net book value at 1 April 2020	27,651	156,333	22,226	14,193	1	5,558	225,962
Net book value at 31 March 2021	**25,453**	**167,631**	**17,544**	**16,267**	**0**	**6,248**	**233,143**
Net book value at 31 March 2021 comprises:							
Owned assets	15,733	85,158	17,002	16,267	–	6,248	140,408
Subsequent expenditure on or relating to assets acquired under a Finance Lease	–	44,277	542	–	–	–	44,819
Held on Finance Lease	9,720	38,196	–	–	–	–	47,916
	25,453	**167,631**	**17,544**	**16,267**	**–**	**6,248**	**233,143**
Revaluation reserve	**14,021**	**71,585**	**–**	**881**	**–**	**687**	**87,174**

Note 9.1 Property, plant and equipment – 2019/20

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/cost at 1 April 2019	27,503	157,226	7,382	52,776	10	5,670	250,567
Additions purchased	–	432	14,844	2,312	–	3,358	20,946
Reclassification	–	–	–	–	–	–	–
Indexation	–	–	–	1,294	–	–	1,294
Other in year revaluations	148	286	–	–	–	–	434
Impairments	–	75	–	–	–	–	75
Disposals	–	–	–	(3,792)	–	–	(3,792)
Valuation/cost at 31 March 2020	**27,651**	**158,019**	**22,226**	**52,590**	**10**	**9,028**	**269,524**
Accumulated depreciation at 1 April 2019 – brought forward	–	1,429	–	37,957	9	2,678	42,073
Provided during the year	–	4,978	–	3,254	–	792	9,024
Indexation	–	–	–	931	–	–	931
Other in year revaluations	–	(4,721)	–	–	–	–	(4,721)
Disposals	–	–	–	(3,745)	–	–	(3,745)
Accumulated depreciation at 31 March 2020	**–**	**1,686**	**–**	**38,397**	**9**	**3,470**	**43,562**
Net book value at 1 April 2019	27,503	155,797	7,382	14,819	1	2,992	208,494
Net book value at 31 March 2020	**27,651**	**156,333**	**22,226**	**14,193**	**1**	**5,558**	**225,962**
Net book value at 31 March 2020 comprises:							
Owned assets	17,908	98,431	2,170	14,193	1	5,558	138,261
Subsequent expenditure on or relating to assets acquired under a Finance Lease	–	20,713	15,650	–	–	–	36,363
Held on Finance Lease	9,743	37,189	4,406	–	–	–	51,338
	27,651	**156,333**	**22,226**	**14,193**	**1**	**5,558**	**225,962**
Revaluation reserve	**14,404**	**74,498**	**–**	**883**	**–**	**923**	**90,708**

Note 10 Intangible assets – 2020/21

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

Note 10.1 Intangible assets – 2019/20

	Software Purchased	Total
	£000	£000
Valuation/cost at 1 April 2019 – brought forward	9,324	**9,324**
Additions	1,156	**1,156**
Revaluations	–	**–**
Disposals	(2,755)	**(2,755)**
Valuation/cost at 31 March 2020	**7,725**	**7,725**
Amortisation at 1 April 2019 – brought forward	5,917	**5,917**
Provided during the year	984	**984**
Revaluations	–	**–**
Disposals	(2,755)	**(2,755)**
Amortisation at 31 March 2020	**4,146**	**4,146**
Net book value at 1 April 2019	3,407	**3,407**
Net book value at 31 March 2020	**3,579**	**3,579**
Net book value at 31 March 2020 comprises:		
Purchased	3,579	**3,579**
Asset financing	**3,579**	**3,579**
Revaluation reserve	**1,057**	**1,057**

Note 11 Inventories

	31 March 2021	31 March 2020
	£000	£000
Raw materials and consumables	4,826	6,394
Work in progress	3,292	2,204
Finished processed goods	9,194	11,524
Total	**17,312**	**20,122**

In year losses of stock items are included in the Losses and Special Payments disclosure in the Accountability Report. Each case is reported to the Audit, Governance and Risk Committee with an explanation of how they occurred.

At 31st March, NHSBT held 67,660 units of plasma collected under the Convalescent Plasma Programme. These have a nil value and do not appear in the note above.

At 31st March, NHSBT held 122,034 harnesses for the collection of plasma under the Convalescent Plasma Programme. They are held at nil value and do not appear in the note above. These harnesses were purchased at a cost of £5.2m and were charged to expenditure under the programme in 2020/21. £1.59m of these harnesses cannot be repurposed or refunded and a loss has been recorded (see page 64). There is a high level of confidence that £3.46m of these harnesses can be repurposed for either platelet or plasma collection. At the 31st March these were held at nil value but these will now be revalued to purchase value in June 2021 or shortly thereafter. Options are being evaluated for the balance £0.15m of stock.

Note 12 Trade and other receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade receivables	21,235	28,392
Allowance for impaired contract receivables	(14)	(104)
Other debtors	170	183
VAT	8,213	3,729
Prepayments and accrued income	14,974	9,654
Subtotal	**44,578**	**41,854**
Non-Current		
Other prepayments and accrued income	397	77
Subtotal	**397**	**77**
Total trade and other receivables	**44,975**	**41,931**

	2020/21	2019/20
Allowances for credit losses	£000	£000
At 1 April	(104)	(127)
New allowances arising	(14)	(104)
Utilisation of allowances (written off)	21	4
Reversed unused (recovered)	83	123
At 31 March	**(14)**	**(104)**

Note 13 Cash and cash equivalents

	2020/21	2019/20
	£000	£000
At 1 April	50,549	28,444
Net change in year	2,662	22,105
At 31 March	**53,211**	**50,549**
Broken down into:		
Cash in hand	1	1
Cash with the Government Banking Service	53,210	50,548
Total cash and cash equivalents as in SoFP and SoCF	**53,211**	**50,549**

Note 14 Trade and other payables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables – revenue	7,535	9,388
Trade payables – capital	664	29
Tax and social security costs	15	12
Accruals and deferred income*	44,474	32,407
Total current trade and other payables	**52,688**	**41,836**

*Accruals include £4.1m (2019/20 £2.1m) representing annual leave earned but not taken, the increase being due to a temporary change in policy in response to the COVID-19 pandemic, and £1.1m for annual leave overtime correction following an agreement reached by the NHS Staff Council to resolve claims linked to pay entitlements, in respect to holiday pay under the NHS terms and conditions of service.

Note 15 Provisions for liabilities and charges

	PAYE	Employee Benefits	Redundancy	Product Liability & Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	–	436	–	437	873
Provisions arising in the year	25	–	119	110	254
Utilised during the year	–	(27)	–	(73)	(100)
Reversed unused	–	(3)	–	(80)	(83)
Unwinding of discount	–	41	–	–	41
Balance at 31 March 2021	**25**	**447**	**119**	**394**	**985**
Expected timing of cash flows:					
– not later than 1 year;	25	28	119	394	566
– later than one year and not later than five years;	–	148	–	–	148
– later than five years	–	271	–	–	271
Total	**25**	**447**	**119**	**394**	**985**

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.

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.

At 31 March 2020 £19,129,670 (is included in the provisions of NHS Resolution (formerly NHS Litigation Authority) in respect of clinical negligence liabilities of NHSBT (31 March 2020: £20,683,911).

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

Note 16 Finance leases

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

Minimum lease payments	31 March 2021 £000	31 March 2020 £000
Not later than one year	1,214	959
Later than one year and not later than five years	4,857	3,432
Later than five years	18,885	18,817
	24,956	**23,208**
Less future finance charges	(16,138)	(15,043)
Present value of future lease obligations	**8,818**	**8,165**

Present value of minimum lease payments	31 March 2021 £000	31 March 2020 £000
Not later than one year	267	230
Later than one year and not later than five years	1,454	1,190
Later than five years	7,097	6,745
Present value of future lease obligations	**8,818**	**8,165**
Analysed as:		
Current borrowings	267	230
Non-current borrowings	8,551	7,935
	8,818	**8,165**

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

Note 17 Other cash flow adjustments (non-cash)

Other cash flow adjustments	2020/21 £000	2019/20 £000
Depreciation (note 9)	9,680	9,024
Amortisation (note 10)	1,007	984
Impairments* (note 9)	2,866	(75)
Loss on disposal (note 8)	1,768	47
Provisions arising in year (note 15)	254	234
Provisions reversed in year (note 15)	(83)	(35)
Notional pension cost	–	9,776
Total	**15,492**	**19,955**

*Impairments comprise £1,182k for Leeds and £1,682k for Sheffield centres following revaluation prior to sale.

Note 18 Contingent assets and liabilities

A contingent liability of £35,903 (31 March 20 £56,363) relates to potential costs associated with donor claims, personal injury claims and other employee liability and public liability claims.

A contingent liability of £1,375,000 (31 March 2020 £1,375,000) relates to Hepatitis C cases brought under an action for product liability.

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

Note 19 Capital commitments

At 31 March 2021 the value of contracted capital commitments was £690,826 (31 March 2020 £10,223,592).

Note 20 Related parties

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

The Department of Health and Social Care is regarded as a controlling, related party. During the year NHSBT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department, including:

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

During the year these transactions were valued at £505m in income (2019/20 £426m) and £29m of expenditure (2019/20 £27m). Of this income, NHSBT received £144.5m (2019/20 £72.7m) from the DHSC in relation to operational grant-in-aid and £22.5m (2019/20 £22.6m) funding for capital programme.

In addition, NHSBT has had several material transactions with other government departments, central and local government bodies, NHS bodies of Scotland, Wales and Northern Ireland. These transactions amounted to £16m of income (2019/20 £16m) and £58m of expenditure (2019/20 £44m).*

**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	Value of goods and services provided by NHSBT to Related party* £000	Value of goods and services purchased by NHSBT from Related party* £000
Ms M Banerjee	Chair	South-West London Integrated Care System	Chair	11,453	–
Prof P Vyas	Non-Executive Director	University of Oxford	Clinical Professor of Haematology	737	573
Prof P Vyas	Non-Executive Director	Oxford University Hospitals NHS Foundation Trust	Consultant Haematologist	5,452	2,105
Mr I Bateman	Director of Quality	The Pirbright Institute	Trustee Director	3	–
Prof Deirdre Kelly	Non-Executive Director	Birmingham Women's and Children's NHS Foundation Trust	Consultant Paediatric Hepatologist	2,680	23
Prof Deirdre Kelly	Non-Executive Director	University of Birmingham	Professor of Paediatric Hepatology	6	129
Mr Phil Huggon	Non-Executive Director	Liverpool Women's Hospital FT	Non-Executive Directorship	5	–

*the figures in the table are payments between the two corporate organisations over which the NHSBT Board Member or senior manager has influence.

In June 2021 we received confirmation that we had funding to collect plasma for medicines until at least 31 March 2022, while this is a significant event it does not materially impact the accounts at the time of signing. There are no other events after the reporting date which would have a material effect on these accounts.

Note 21 Events after the reporting date

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

In June 2021 we received confirmation that we had funding to collect plasma for medicines until at least 31 March 2022, while this is a significant event it does not materially impact the accounts at the time of signing. There are no other events after the reporting date which would have a material effect on these accounts.

Note 22 Financial instruments

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that NHSBT has with customers and the way they are financed, NHSBT is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies to which the financial reporting standards may apply. NHSBT has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing NHSBT in undertaking its activities.

NHSBT's treasury management operations are carried out by the finance department, within parameters defined within the Standing Financial Instructions and policies agreed by the Board. The treasury activity is subject to review by internal audit.

Currency risk

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

Interest rate risk

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

Credit risk

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

Liquidity risk

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

Glossary

Term	Definition
Allografts	A surgical transplant of tissue between genetically different individuals of the same species.
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.
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.
Creutzfeldt–Jakob disease (vCJD).	The human variant of Bovine spongiform encephalopathy (BSE), commonly known as mad cow disease. The collection of UK plasma was banned in 1998 due to concerns over the spread of vCJD.
Donation after circulatory death (DCD)	Donation after circulatory death refers to the retrieval of organs for the purpose of transplantation from patients whose death is diagnosed and confirmed using cardio-respiratory criteria.
Fetal RHD screening	Women who are **Rhesus D negative** (RhD-) exposed to fetal RhD+ erythrocytes can develop anti-Rh antibodies (Rh-isoimmunization), which have the potential to permeate the placenta and cause hemolytic disease.
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.
Haemoglobinopathies	A group of recessively inherited genetic conditions affecting the haemoglobin component of blood. They are caused by a genetic change (mutation) in the haemoglobin. Some may cause a significant clinical condition resulting in illness and potential death including Sickle Cell Disease and Thalassaemia.

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

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.
Ro	Ro is a blood type (see above). When the Rhesus group D and DHCE genes combine there are 8 possible outcomes – one of which is Dce – also known as Ro subtype. Only 2.99% of our donors in 2019/20 had this Ro subtype. We do not currently collect enough Ro blood to meet demand for this type.
Ro Kell negative blood	Ro Kell negative blood is especially important for treating the rare, inherited condition sickle cell disease. Only around 2% of donors have this rare combination of two blood types. Donors of any ethnicity can be Ro Kell negative although Black people are 10 times more likely to have the Ro subtype than white people. People with Ro Kell negative blood are being urged to talk to family members about donation, because they may also share this rare combination of types.
Serology (serological)	The scientific study or diagnostic examination of blood serum, which looks at the response of the immune system to pathogens or introduced substances.
Statin	a group of medicines that can help lower the level of low-density lipoprotein (LDL) cholesterol in the blood.
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.
TNC	Cord units are graded based on the numbers of viable stem cells contained in the unit. TNC = Total Nucleated Cells.

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