NHS
Blood and Transplant

Annual Report and Accounts 2024-25

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HC 1095
SG/2025/107

Caring Expert Quality

NHS Blood and Transplant

Annual Report and Accounts 2024-25

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Peter Wyman,
Chair

Dr Jo Farrar CB OBE,
Chief Executive and Accounting Officer (until 30 June 2025)

Introduction from the Chair and Chief Executive

We are pleased to present this year's Annual Report for NHS Blood and Transplant (NHSBT), marking another year of extraordinary contributions from our staff, our donors, our partners and the public. Together, we have saved and improved lives through the power of donation.

All NHSBT products and services – organs, tissues, plasma medicines, platelets and transfusion services – are critical infrastructure for the NHS. Today, with over 6,500 people working across the UK, and a funding and income base of £654 million, we continue to deliver critical care and cutting-edge innovation, while supporting donors and patients with compassion, professionalism and purpose.

At the heart of everything we do are our donors – individuals and families who give selflessly to help others. Their generosity forms the foundation of our life-saving work, and this year we have continued to build on that generosity by growing and diversifying our donor base to better reflect the needs of NHS patients.

Responding to growing pressure on the UK's blood supply and transplant waiting lists, we stepped up efforts in 2024-25 to attract new donors and engage more communities. From our Community Grants Programme to dynamic partnerships with Disney, ITV, and a range of corporate and public sector organisations, we have worked hard to raise awareness and remove barriers to donation.

Our blood donor base grew year-on-year, with modest but meaningful increases in donors with critical Ro and O negative blood types. The new Brixton centre is helping to address longstanding health inequalities by attracting more young and Black heritage donors and reaching communities historically underrepresented in donation. But we know challenges remain. Donor deferrals are increasing, often due to temporary factors such as recent travel or minor health issues. To respond, we are investing in digital improvements, including online eligibility tools and the redesign of our donor network to ensure people can donate where and when it suits them. This will be key to rebuilding blood stocks and putting us on a sustainable footing following a lengthy period spent in an amber alert this year.

We also saw more people step forward to become stem cell donors after the renaming of the UK Stem Cell Register, and more patients benefiting from stem cell transplants. And while our plasma programme fell just short of regular donor targets, the continued collection of high volumes of plasma from whole blood donors has kept supplies on track.

We achieved a huge milestone in March with the first NHS patients in a generation receiving life-saving plasma medicines derived from UK sourced plasma. This was the result of a highly successful collaboration between NHSBT, NHS England and the Department of Health and Social Care.

Our ambition is to increase UK national immunoglobulin self-sufficiency much higher – we are aiming to build to 30-35 per cent self-sufficiency from 2026 then beyond 35 per cent from 2030. To expand the programme, we will need to increase plasma collection significantly beyond the three donation centres that are currently in operation. Doing so will mean patients are at far less risk from global shortages caused by rising demand and fluctuations in market prices, and it reduces our reliance on costly imports of US medicines.

More than 735,000 people registered their decision to donate their organs after death for the first time this year, with more than 28 million people now opted in to the NHS Organ Donor Register (ODR). These registrations matter – when a loved one's decision is known, family consent rates rise to 90 per cent, compared to 50 per cent when no decision is recorded. But with only one per cent of people dying in the circumstances that make organ donation possible, it is critically important we get more people to sign up. Our DVLA partnership is the most successful at encouraging registrations to the ODR, so we have been working hard to build more effective partnerships by embedding donor registration into public services like the NHS App and Passport Office journeys. We continue to work with Government to benefit from more touchpoints with the public and aim to make further progress over the next 12 months.

We are continuing to upgrade our sites for our staff and for donors. This year we completed a major site improvement in Milton Keynes, relocated services from Stoke Gifford to Filton, and the major multi-phase refurbishment at Colindale, one of our most complex and important operational sites, is underway to upgrade laboratories, staff areas and core infrastructure. We have also expanded our donor estate with new donor centres in Brixton and Southampton, with a new centre opening in Brighton in September 2025.

Alongside physical and digital transformation, we continue to prioritise our people. Last year marked the launch of our new three-year People Plan, focused on supporting wellbeing, improving inclusion and helping our staff to thrive. Through initiatives such as Forward Together and our new Anti-Racism Framework, we are building a more empowering culture and one that is representative of the donors, patients and families we serve. We are also investing in leadership development, flexible working, and career pathways to help everyone at NHSBT feel valued and thrive so we can deliver top quality services to the public and NHS.

Innovation continues to drive our mission forward. This year saw exciting developments in genomics, including molecular genotyping to improve blood matching for people with sickle cell disorder. Our RESTORE trial on lab-grown red blood cells continues to lead internationally, and our work in drone logistics, dried plasma for emergencies, and advanced organ preservation is helping keep us at the forefront of global leadership in our field.

None of this would be possible without the extraordinary commitment of our staff, partners and – above all – our donors. To every person who gave blood, plasma, platelets, organs, tissues or stem cells this year – thank you. Your selfless contribution is a gift of life, and it is the reason we do what we do.

To underline the importance of our work and of donation, we submitted a detailed response to the Government's 10 Year Health Plan. We made clear that NHSBT services are vital infrastructure to the NHS and set out four areas where we could save and improve even more lives with Government and NHS support:

- systemic changes that shift the dial on reducing the organ and tissue transplant waiting list
- a transformation in the way we speak to the public about donation to embed altruistic donation in the nation's psyche
- NHS-wide interoperability on blood supply to increase resiliency, efficiency and safety
- support for innovation and development – creating new treatments and services at scale for NHS patients and becoming more self-sufficient in blood and tissue products.

We look forward to working with the Government and NHS on the 10 Year Health Plan and supporting the ambitions to move care from hospitals to communities; making better use of technology; and focusing on preventing sickness, not just treating it.

After two years as Chief Executive, this will sadly be Jo's final annual report as she is leaving NHSBT for a promotion to Permanent Secretary at the Ministry of Justice. As you will read in this report, Jo has led the organisation to deliver so much and live our values – caring, expert, quality. We are pleased that Caroline Walker will be joining us as Interim Chief Executive while we recruit to the role permanently.

It has been our privilege to work together to serve NHSBT and the patients, donors and families who rely on us. As we look ahead as an organisation, we remain focused on growing our impact, building trust with all communities, and ensuring that every patient receives the donation they need.

Our work

Who we are and what we do

NHS Blood and Transplant formed in 2005 by bringing together the National Blood Service and UK Transplant. We employ over 6,800 people across the UK, with total income and revenue funding of £654 million.

First and foremost we are a healthcare organisation within the NHS providing front-line care services for donors and patients. NHSBT plays a unique role in the NHS – we produce life-saving and life-improving products and treatments from donated blood, organs, tissues and stem cells, and provide a range of related diagnostic and therapeutic services.

Thanks to the NHSBT team, which includes expert manufacturing and logistics capability, we provide a lifeline for patients who rely on us to deliver every day across the length and breadth of the UK. We are trusted nationally for our commitment to quality, safety and reliability, and respected internationally for our productivity, research and development.

At the heart of everything we do are our donors themselves, without whom these services would not be possible. Our teams care for the many thousands of blood, plasma and stem cell donors who turn up every day to make these valuable contributions. We also depend upon the extraordinary actions of families who, in the depth of grief, consent to organ or tissue donations from their loved ones to help those in greatest need.

Our vision

- A world where every patient receives the donation they need.

Our mission and ambition

- To save and improve even more lives.

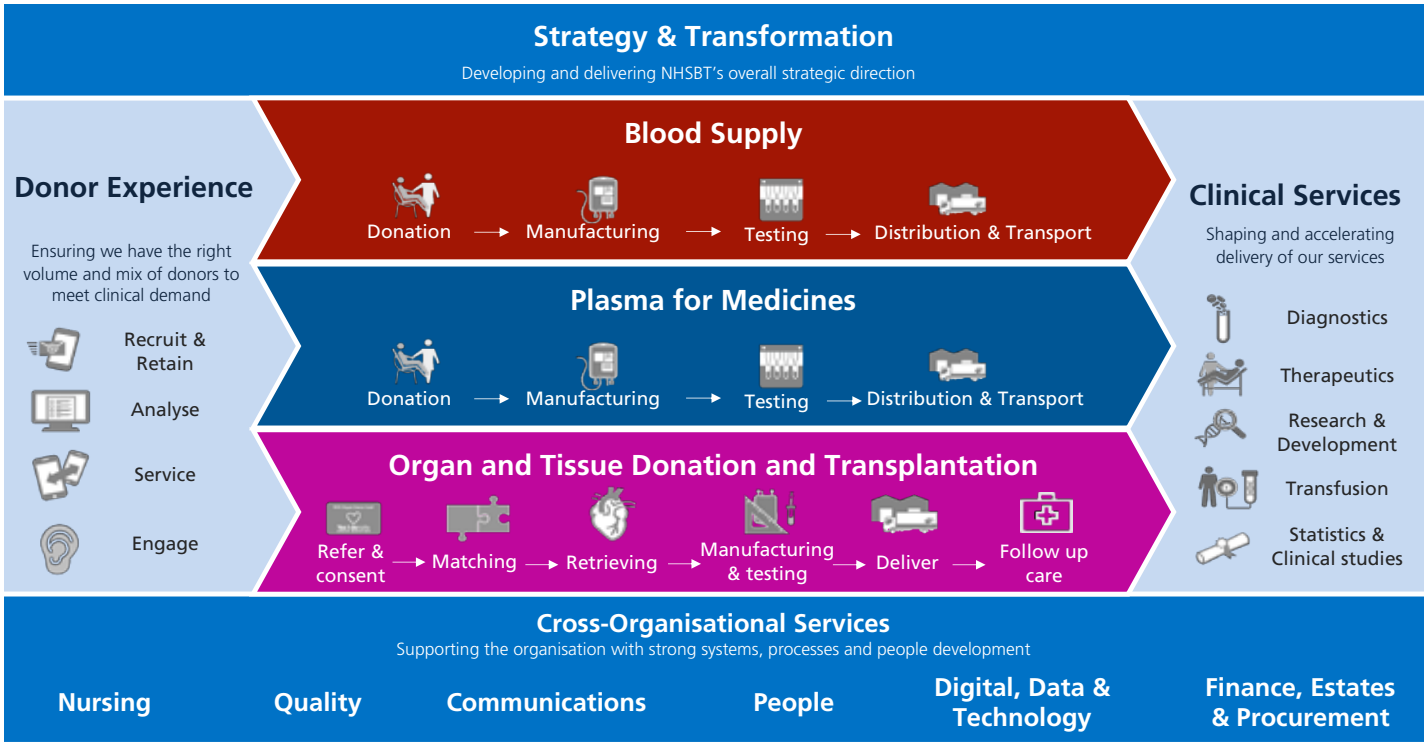
Our values

- caring about our donors, their families, our staff and the patients we serve
- being expert in meeting the needs of our customers and partners
- providing quality products, services and experiences for donors, staff and patients

Our organisation

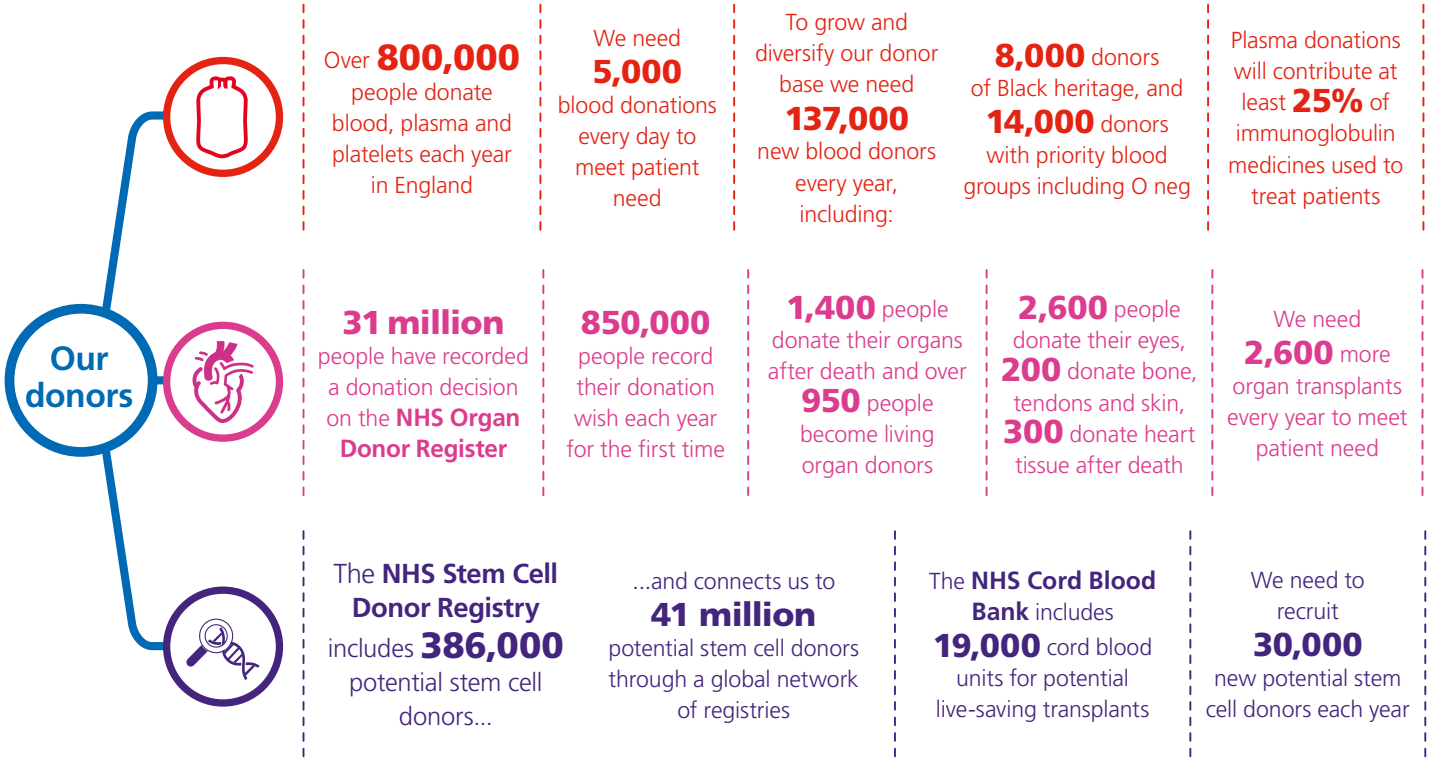
Our structure, functions, products and services

Our core products are blood, plasma, organs, tissues, cellular and gene therapies. Our core functions include donor engagement, collection, manufacturing, testing, distribution and treatment of patients.



Our donors

A diverse and active donor base is critical to meeting demand.



Our strategy

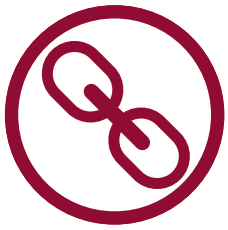
Our work is guided by our corporate strategy (https://www.nhsbt.nhs.uk/who-we-are/performance-and-strategy/our-strategy/), which consists of five strategic priorities. It sets out what we will do to achieve each of these priorities and how we will know when we have succeeded.

We first published the NHSBT strategy in March 2022, laying out our mission and ambition **to save and improve even more lives** in the years ahead and, ultimately, to deliver our vision of **a world where every patient receives the donation they need**. In our commitment to overseeing a living strategy we revisited our blueprint for NHSBT in 2023 and published an updated strategy document in 2024. It was plain to see that our strategic aspirations in 2022 remain relevant today and we have **recommitted to our vision, mission and ambition, values and five strategic priorities**.

This Annual Report is built around our five priorities and describes what we have achieved, what challenges we have faced, and how we have performed against the objectives we set in our 2024-25 business plan.

Grow and diversify our donor base

to meet clinical demand and reduce health inequalities



Modernise our operations

to improve safety, resilience and efficiency

Invest in people and culture

to ensure a high performing, inclusive organisation

Drive innovation

to improve patient outcomes

Collaborate with partners

to develop and scale new services for the NHS

Our performance

Strategic priority 1

Growing and diversifying our donor base

With ongoing pressures on the UK blood supply and transplant lists, it has never been more important to be 'the giving type'. Last year, thousands of people across the country answered our call – donating their blood, plasma, organs, tissue, and stem cells to help others in need.

Throughout 2024-25, we stepped up efforts to attract new donors, while also supporting those already part of our donor base. From opening a vibrant new blood donation centre in Brixton, to building exciting community partnerships around the country, our focus has been on building trust, breaking down barriers and increasing participation.

As a result, we have made encouraging progress in several areas. Our blood donor base grew slightly year-on-year, with modest increases in donors with critical blood types. The new Brixton donor centre has been a particular success, boosting engagement among Black heritage and younger donors and helping to address longstanding disparities.

We also recruited more stem cell donors and issued more life-saving units last year, although representation from minority ethnic communities declined slightly. And while we fell short of our target for regular plasma donors, high volumes of plasma recovered from whole blood donations kept overall supply on track.

Finally, it has been encouraging to see renewed public commitment to organ donation, with more people taking the important step of recording their decision to donate. This matters deeply, as when families know their loved one's wishes they are far more likely to support donation. Through our campaigns and partnerships with other public services, we are helping more people take that step – giving hope to those waiting for a life-saving transplant.

How we have performed: detailed analysis

Expanding our blood donor base

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
Total size of blood product donor base	804,910	796,572	+1.0%	820,085	Improving – below target
The proportion of people from Black heritage within the donor base	2.6%	2.6%	Unchanged	3.10%	Stable – below target
The number of registered donors with Ro blood type who are active donors	26,678	26,333	+1.3%	28,304	Improving – below target
The number of registered donors with O negative blood type who are active donors	110,946	108,283	+2.5%	116,372	Improving – below target

Note: The term 'active donor base' refers to the number of people who have successfully donated blood in the last 12 months.

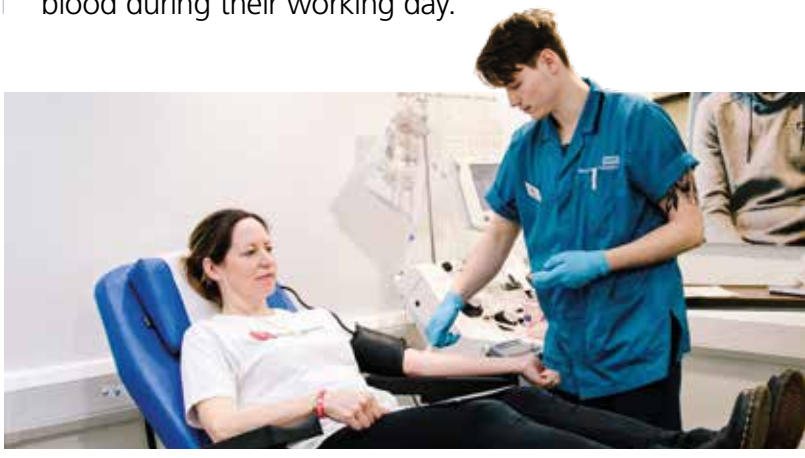
Regular donors are essential to our blood supply. Their generous contributions help us ensure the NHS has sufficient stocks in place to manage emergencies and surgeries, and can support patients with ongoing needs.

Last year, NHSBT managed to **increase the overall blood product donor base**, with 8,338 more active donors compared to the previous year. There was also an increase in the number of Black heritage donors, rising to 20,206 and remaining at 2.6 per cent of the total donor base. The number of active donors with the critical Ro (26,678) and O negative (110,946) blood types also rose slightly during the year, although both remained below target.

2024-25 saw important developments aimed at attracting the next generation of blood donors – most notably the opening of **a new donor centre in Brixton**. Located in the heart of the community, the centre is already drawing in large numbers of new donors, including a significantly higher proportion from Black heritage backgrounds than many other UK centres.

Meanwhile, as part of our donor marketing programme, we developed **new campaign partnerships with the BBC, and with The Walt Disney Studios Motion Pictures UK and Marvel Studios**, helping to build public awareness through high-profile celebrity endorsements.

NHSBT has also joined up with leading commercial organisations, including The Co-operative Bank, ITV and Alton Towers to give employees '**Donate Breaks**' – dedicated time off to donate blood during their working day.



However, NHSBT continues to face challenges that are limiting donor growth. For example, donor feedback suggests that our collection locations are not always optimally distributed, making it difficult to find appointments in some areas. The number of donor deferrals is also increasing – this is where individuals arrive for an appointment but are temporarily ineligible to donate, often because they are unaware of safety restrictions related to overseas travel or skin piercings, for example.

To help address these issues, we are taking forward plans to improve the donor experience. The aim is to make appointments easier to access through measures such as reviewing donor network design and digitising more of the appointment booking process. This will also include introducing an online eligibility check at the time of booking to reduce deferrals.

Blood donation media and campaign highlights for 2024-25 have included **a high-profile collaboration with The Walt Disney Studios Motion Pictures UK and Marvel Studios featuring Deadpool and Wolverine (top), and a BBC Casualty Christmas special tie-in (bottom)** which saw 5,000 new donors registering and 10,000 extra appointments booked in England the weekend after the episode aired.

The impact of the Brixton donor centre

Developed in partnership with local people, Brixton's first-ever permanent blood donor centre has been specifically designed to encourage donors to give blood by creating a friendly, laid-back environment rooted in the Brixton community.

Since opening in December 2024, the centre has received 5,350 donations from 5,207 donors in less than four months, already placing it among the top 10 most prolific donor centres in the UK. Of these, 1,747 (32.7 per cent) were new donors, compared to 14.2 per cent across all centres.

Brixton had also received over 600 collections from Black heritage donors by the end of March 2024, contributing 11 per cent of its total donations and far exceeding the four per cent average at other UK centres. It is also attracting younger donors, with an average donor age of 36 years – around a decade younger than other centres.

Scaling up plasma donation for use in medicines

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
Total size of plasma regular donor base	6,279	4,790	+31.1%	8,265	Improving – below target
The number of plasma for medicine units collected (source and recovered)	301,197	161,095	+87.0%	200,000	Improving – above target

2024-25 was also a significant year for NHSBT plasma collection programmes, as the first NHS patients in a generation began benefiting from new plasma-based medicines using the blood of UK donors.

NHSBT is building its domestic plasma supply in two ways: first, by establishing a base of regular plasma donors through **source plasma** collection, carried out at three dedicated centres in Birmingham, Twickenham, and Reading; and second, by extracting plasma from standard blood donations – this is known as **recovered plasma**.

Our **plasma donor base grew by 31.1 per cent** during 2024-25, and there was also an increase in donation frequency per donor – on average, each regular donor donated 3.27 times over a 12-month period, compared to 3.16 times in the previous year. These improvements led to **a 34 per cent rise in the volume of source plasma collected** last year.

Combined with a significant increase in the volume of plasma recovered from whole blood donations (page 39), this ensured that overall plasma supply remained healthy, allowing NHSBT to exceed production targets for plasma-based medicines in 2024-25.

In addition, we plan to increase plasma collection capacity across our three specialist centres in 2025-26 to create more opportunities for people to donate.

Jill's story

In March 2025, Jill Jones made history by becoming the first patient in a generation to be given UK-sourced plasma medicine as part of her cancer treatment at John Radcliffe Hospital in Oxford.

Since a longstanding ban on UK plasma was lifted in 2021, the UK has been building its own supply of plasma medicines amid a global shortage. This is intended to reduce reliance on imports, saving the NHS between £5 million and £10 million per year.

"Transfusions have been life-changing for me. I feel really privileged to be the first patient in a long time to be receiving immunoglobulin made from UK plasma."

Jill Jones, who receives regular infusions of immunoglobulin for non-Hodgkin lymphoma.

Growing our organ donor register

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
The number of people opting in to organ donor register during 2024-25 (UK)	735,046	699,195	+5.1%	750-800,000	Improving – below target

Last year, there was a five per cent increase in the number of people registering an 'opt-in' decision to be an organ donor, halting the decline seen in the previous year. Over 735,000 people registered the decision to be an organ donor for the first time, bringing the total number of people on **the NHS Organ Donor Register (ODR)** who have opted in to more than 28 million.

In addition, 115,000 people registered an 'opt-out' decision, with the total number of opt-outs now standing at 2.9 million – this means that around 31 million people in the UK have registered a decision about organ donation.

The ODR remains crucial to gaining support from a donor's family. When a loved one's decision is known, family consent rates are around 90 per cent. This drops significantly to around 50 per cent when no decision is recorded.

Alongside new registrations, there were also **2.7 million repeat opt-ins** in 2024-25, where people reconfirmed their decision to donate. Recent repeat registrations reinforce an individual's commitment and can help reassure families during difficult conversations.

Our priority remains increasing the number of people registering a decision to donate via the ODR. We continue to run public awareness campaigns about organ donation and are strengthening partnerships across government to embed opportunities to register into other public services. This includes **improving user journeys within the NHS App** and expanding our successful partnership with the **Passport Office**.

Activities to mark the 30th anniversary of the NHS Organ Donor Register included impressive sand art created on Scarborough beach by a specialist organ donation nurse and his team.

Ralph's story

Four-year-old Ralph received a multi-organ transplant after featuring in a ground-breaking campaign (by agency VML supported by NHSBT) to raise awareness of paediatric organ donation.

The Waiting to Live campaign ran in 2023-24 and drew attention to the hundreds of under-18s on the waiting list. By December 2024, half of the 16 children transformed into dolls for the campaign had received a life-saving transplant.

"Waiting was like living in a nightmare, waking up every day not knowing if this would be the day he would get the call and as each day went by hope slowly diminished. That all changed when Ralph received his incredible gift of life."

Ralph's mum, Katie Tatham, describing the impact of organ donation.

Recruiting new stem cell donors

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
The number of registered stem cell fit panel donors (SCDR Registry)	125,930	112,276	+12.2%	128,404	Improving – below target
The proportion of registered donors from ethnic minority backgrounds	17%	24%	-7.0% points	20%	Falling – below target

The number of registered stem cell donors on the **NHS Stem Cell Donor Registry (SCDR) Fit panel** finished the year at 125,930 – 4.2 per cent below our target.

Around 20,600 new donors were added to the register during the year. Nearly 29,000 new stem cell donors were recruited in total, which would have exceeded our target for the year. However, not all could be added immediately, as their tissue type testing (known as HLA typing) had not yet been completed – these donors will be added to the register in the first quarter of 2025-26 instead.

During the year, the registry was rebranded from the British Bone Marrow Registry to the NHS Stem Cell Donor Registry, and marketing efforts were refreshed and increased.

Following last year's successful pilot, **the recruitment criteria for joining the register was also expanded** to include Caucasian females aged 17-40. Their inclusion led to a drop in the percentage share of new donors from a minority ethnic background to 16.7 per cent, below the 20 per cent target.

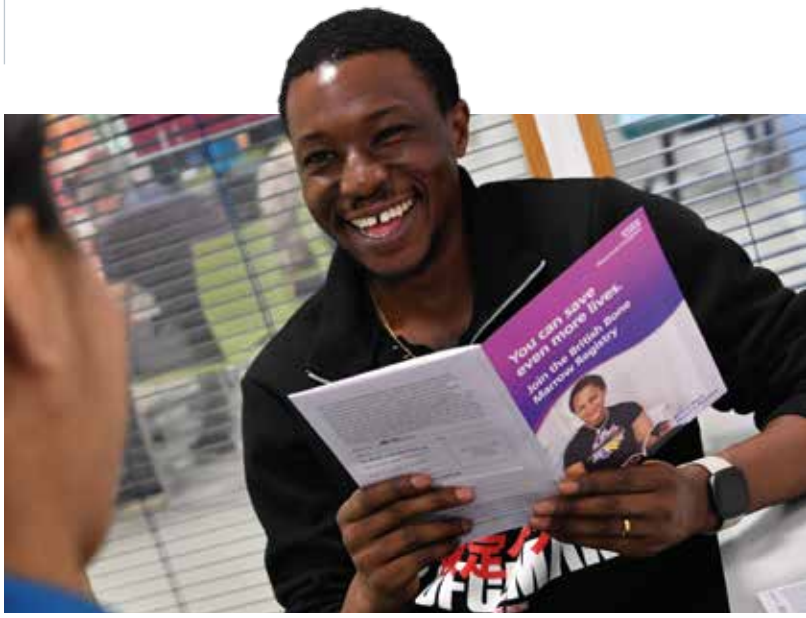
NHSBT also continued **piloting home sampling kits**, allowing potential donors to provide a simple cheek swab (buccal swab) from home. In addition, specially trained event assistants supported donor recruitment activities during blood donation sessions across the country.

During 2024-25, the SCDR successfully **matched 188 stem cell donors to patients requiring transplant** – up four per cent compared to the previous year, though just below our plan of 196.

Cord blood collection, meanwhile, exceeded targets for the year, with 152 high quality units added to our cord blood bank – a 30 per cent increase on last year. A total of 41 units were successfully issued to patients against a target of 35.

Despite these activities, **NHSBT's overall share of the total stem cell donors provided to UK patients** ended the year at six per cent, below the seven per cent target. This reflects wider challenges in securing enough UK-based donors.

While reciprocal arrangements with international registries help fill the gap, they are more expensive and complex than using UK donors. As a result, improving the domestic supply of stem cells remains a key priority, and we continue to work with our partners in the UK Stem Cell Strategic Forum and across the UK Aligned Registry to address the barriers.



Nirav and Kanan's story

A married couple were both called upon to donate life-saving stem cells last year after joining the NHS Stem Cell Registry – an event that has 1 in 4,000,000 odds of taking place.

Nirav and Kanan Chokshi individually signed up to the national registry, where each person has a 1 in 2,000 chance of being selected as a match. Against the odds, both were asked to donate, offering two cancer patients the chance of a cure.

"I didn't realise that us both donating was a one-in-four-million occasion and I feel really proud of us both. We encourage everybody to sign up to the register, but especially those of South Asian heritage."

Kanan Chokshi, stem cell donor.

The Community Grants programme

NHSBT's Community Grants programme helps to break down barriers to blood and organ donation by funding trusted community and faith-based organisations with deep local roots.

Last year, grants were awarded to 51 organisations delivering innovative, culturally tailored projects – ranging from podcasts and theatre productions to school events and art exhibitions – all focused on increasing awareness and understanding of the value of donation, particularly among Black heritage, Asian and minority ethnic communities.

Highlights include **the '56 Black Blood Donors' campaign by Black Blood Matters, sickle cell art exhibitions by Akanji Studio (pictured), a youth-focused donation education game by We Are Donors**, and **Imam-based training and awareness sessions run by the British Islamic Medical Association**.

These projects, backed by £600,000 in annual funding, are being supported by NHSBT's regional teams and ambassadors, and form part of wider efforts to build long-term partnerships that deliver impactful, community-led approaches to donation.

Strategic priority 2

Modernising our operations

Every year, NHSBT delivers safe, reliable services for thousands of patients, donors and clinicians across the country. As demand for these services continues to grow, we are committed to modernising our operations to ensure we maintain the highest standards of support.

Despite periods of increased pressure on blood stocks, NHSBT successfully met demand for blood products during 2024-25. To help achieve this, we called two amber alerts as part of a coordinated, system-wide approach to managing supply and demand.

Our teams also played a vital role in supporting the NHS during a major cyber event in London, and we have continued to build further resilience into the blood supply chain through the Future Proofing Blood programme.

Alongside this, NHSBT has made significant progress in modernising its physical estate. This included relocating operations from Stoke Gifford to Filton, refurbishing key sites in Milton Keynes and Colindale, and completing a new donor centre in Brixton. Further developments are underway in Southampton and Shepherds Bush, which should increase capacity and improve the donor experience.

Laboratory services also benefited from further improvements and upgrades. Through the Testing Development Programme, we secured funding for new equipment and facilities to support more modern, efficient and reliable testing processes – including essential upgrades for the Plasma for Medicines programme.

Modernising our digital and data infrastructure remains key to this work. In 2024-25, we took forward projects such as the Automated Results Transfer (ART) programme – which is improving the accuracy and efficiency of pathology test result processing – and the digitisation of the Therapeutic Apheresis Service which will help to reduce manual errors and drive efficiencies. We also supported the wider modernisation of transfusion services through the Transfusion 2024 programme.

Looking ahead, patient safety remains our highest priority, and we continue to make progress in responding to the recommendations of the Infected Blood Inquiry (page 87), working with other partners to learn lessons and ensure that our services are safe, transparent and accountable for the future.

How we have performed: detailed analysis

Future-proofing our blood services

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
Meet customer requirements for delivering product on time and in full including Ro	96.6%	96.9%	-0.3% points	96.3%	Falling – above target
Blood stock stability (days in stock)	6.2	6.6	-0.4	4.5-8.0 days	Falling – within target

There were several performance improvements across the blood supply chain over the past year, though work continues to strengthen donor and supply resilience – particularly for O negative and Ro red cells – and address ongoing vulnerabilities in platelet stocks.

NHSBT's overall reliability in supplying blood to hospitals remained strong, reflected in an **On Time In Full (OTIF) performance of 96.6 per cent against a target of 96.3 per cent**. However, to help us manage fluctuations in demand, we invoked two 'amber' stock alerts, allowing us to work closely with hospitals to co-ordinate supply and ensure continued delivery to patients.

The first alert occurred in summer 2024, triggered by a sharp and sustained increase in O negative red cell demand following a cyber-attack on an external NHS pathology provider. The second came after Christmas when a surge in platelet demand – linked to increased organ transplant activity – coincided with reduced production due to bank holiday staffing constraints. Beyond these alerts, meeting rising demand for the **Ro subtype** also remained a key challenge, with 48 per cent of Ro red cell demand unmet by Ro-type supply.

Short-notice donor cancellations initiated by NHSBT were also above target for much of the year, largely due to high vacancy levels and staff sickness in some collection teams.

However, performance improved towards the end of the year and this positive trend is expected to continue into 2025–26, supported by the introduction of a new staff planning process.

Planned improvements for 2025–26 include the continued rollout of the **Future Proofing Blood programme**, which has already delivered a new donor centre in Brixton and will add further appointment capacity in Brighton and across mobile community locations. Platelet resilience will also be strengthened through increased weekend and bank holiday working to boost collections and production during peak periods.

NHSBT continues to work in close partnership with the Department of Health and Social Care and NHS England to support long-term developments in blood supply, including through the newly established **Joint Blood Stocks Working Group**, chaired by the NHSBT Chief Executive.

Managing the London cyber-attack

In June 2024, a cyber-attack on Synnovis – a major pathology provider in London – disrupted access to critical laboratory systems for blood grouping, antibody screening, and crossmatching. This posed a serious risk to patient safety, as these tests are essential for ensuring that patients receive compatible blood products.

NHSBT's **Red Cell Immunohaematology (RCI) team** – which provides expert testing and advice for complex transfusion cases – responded rapidly to fill this urgent gap. It scaled up operations, extended working hours, and prioritised urgent cases, thereby ensuring continuity of care across affected hospitals. These actions ensured that clinicians could continue to safely transfuse patients in emergency and surgical settings, maintaining continuity of care despite the disruption.

The incident also led to a sustained surge in demand for O negative blood. Without access to crossmatching systems, hospitals had to rely more heavily on universal O negative units, placing pressure on already limited supplies. This contributed to an amber stock alert, as NHSBT worked closely with the NHS to manage and optimise use of this rare blood type.

Updating blood testing equipment and facilities

All blood donations undergo comprehensive safety screening, informed by international standards and lessons from the past. The **Testing Development Programme** brings together expertise from across NHSBT to modernise and future-proof our blood testing systems. During 2024-25, the programme secured funding to upgrade testing equipment for blood typing and disease screening at multiple sites. These upgrades will support more efficient, reliable testing and enable the introduction of new technologies.

A key milestone for 2024-25 involved expanding our plasma safety screening protocols to include additional viruses such as hepatitis A and parvovirus B19 at our new Manchester laboratory. This ensures every donation meets the highest standards of safety and reliability, reflecting our learning from past failings and our commitment to continuous vigilance.

To date, NHSBT's new Manchester laboratory has screened around two million donations as part of additional plasma safety protocols to support the Plasma for Medicines programme.

Transforming our digital and data services

Digital and data services play an important role in delivering safer, more efficient and more personalised care. Last year, we delivered important digital upgrades across pathology, therapeutic apheresis, marketing and organ matching services.

Highlights included:

Automated Results Transfer (ART) in pathology: The ART programme is transforming how pathology test results are processed by replacing manual data entry with automatic transfers from analysers into our Laboratory Information System (HAEMATOS). This reduces the risk of transcription errors, supports patient safety, and frees up valuable time for laboratory staff by eliminating tasks like typing in results or using USB sticks to move data between machines. Following an initial rollout involving two testing processes in 2023-24, we progressed with the automation of six more in 2024-25.

Digitising Therapeutic Apheresis Services: During 2024-25, NHSBT began a project to digitise its Therapeutic Apheresis Services (TAS). The goal is to implement a digitally-managed service that covers the entire patient pathway. Initial work is focused on electronic referrals, treatment planning, and care documentation. This initiative aims to improve efficiency and reduce administrative burdens for the TAS team, as well as decreasing the risk of errors due to manual data entry.

The project aims to launch a pilot focused on plasma exchange in the Bristol region in autumn 2025, and continue to implement across all procedures and regions through to summer 2026.

Marketing automation tool: NHSBT worked with a technology partner to modernise its donor communications by implementing a new marketing automation tool. The solution uses connected data from multiple sources – such as donor history, location, and blood type – to tailor messages to individual recipients. This has enabled a more coordinated, donor-focused approach to marketing activity: it is delivering targeted and relevant communications across email, SMS and digital platforms while significantly reducing the time needed to develop campaigns.

Organ Matching and Offering project: This is a multi-year programme designed to improve organ allocation through advanced data and digital matching tools. It aims to ensure more patients receive the best possible matches while addressing health inequalities and updating NHSBT systems to align with modern clinical practice. In 2024-25, we secured the necessary funding and Board approvals to launch the programme and begin recruitment in early 2025. Key priorities for 2025-26 include supporting the introduction of split liver transplants, expected to start in early 2026, and developing the new OrganPath system, scheduled for delivery later that year.

New liquid handling robots support donor-typing processes at NHSBT's stem cell testing laboratory in Colindale – just one example of how we are using automated technologies to streamline and improve services.

Harnessing AI to support our people and services

NHSBT has been actively exploring the potential of artificial intelligence (AI) to improve efficiency, support staff and enhance services.

Core platforms such as ServiceNow, Salesforce and Azure are gradually integrating AI capabilities that are helping boost productivity.

Several bespoke AI products are also in development, including:

- a virtual agent to support blood donor enquiries and appointment bookings
- a forecasting tool to predict daily donation session fill rates
- an AI assistant to help collection teams access policies and procedures.

To guide this work, we are establishing an AI governance group. The group will uphold clear standards, manage risks, and ensure that AI is introduced in a way that is legally, ethically and clinically sound.

Supporting the Transfusion 2024 programme

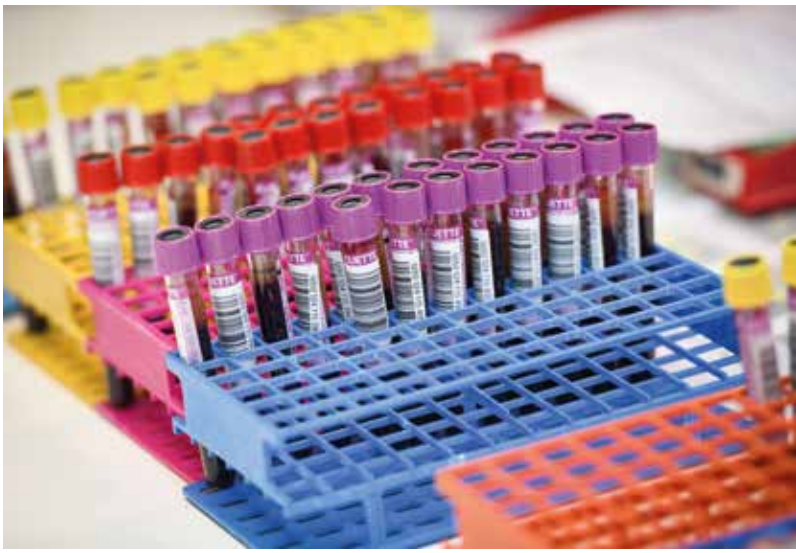
2024-25 also marked the final year of Transfusion 2024, a five-year plan aiming to modernise services and improve patient outcomes by strengthening digital infrastructure, data and professional training to support NHS transfusion units.

Key achievements over the last 12 months have included:

Fetal Rhesus D (RhD) electronic requesting and reporting: Thirty-six hospitals are now using the new system, surpassing the target of 30, while configuration and testing continue with several other hospitals. Fetal RhD screening is requested 55,000 times per year and is used to predict the RhD status of the baby, guiding clinical decisions about whether an anti-D prophylaxis injection is needed. Pathology has already exceeded its 2024-25 electronic ordering target of 1 per cent, reaching 1.96 per cent by the end of February 2025.

Red Cell Immunohaematology (RCI) Assist referral support tool: Following a successful pilot with eight hospitals, a business case has been approved for the full rollout of this referral support tool, which enables remote interpretation of test results by our RCI laboratories. Training has been delivered to hospital and RCI staff ahead of the tool going live in 2025-26.

Expanding the National Haemoglobinopathy Register (NHR): The NHR is a secure database that tracks patients with sickle cell disorder, thalassaemia and other rare anaemias to support better care, research and service planning. NHSBT is working to develop new digital solutions to bring together different datasets and improve access to up-to-date transfusion records. Both antibody and phenotype/genotype data went live during 2024-25, while a third phase of the project – involving NHSBT laboratory access to the NHR – is expected to progress in early 2025-26.



Modernising our estate

Throughout 2024-25, NHSBT made significant progress in modernising its estate to improve facilities for staff, create more welcoming spaces for donors, and drive efficiencies by making better use of our buildings.

In **Bristol**, we successfully relocated our Stoke Gifford operations to the nearby Filton centre, enabling us to consolidate office space and reduce costs by over £600,000 annually while creating a more collaborative and modern working environment. The transition also included important upgrades to our digital infrastructure.

In **Milton Keynes**, we moved into new premises and completed a full fit-out to create a bright, modern working environment tailored to the needs of our teams. The building includes improved heating and cooling systems and contemporary office layouts. Staff were closely involved in the design process, which has improved morale and wellbeing.

At **Colindale**, one of NHSBT's most complex and important operational sites, a major multi-phase refurbishment programme is underway to upgrade laboratories, staff areas and core infrastructure in a bid to create a more comfortable and sustainable working environment for staff.

Building on the success of Brixton (pictured above), we have also continued to invest in our donor centres. In **Southampton**, a new facility will provide additional capacity with nine donation beds, improved donor flow, and enhanced amenities, including a quiet space and dedicated communal areas for staff.

Plans are also underway to **relocate the Shepherd's Bush donor centre** within Westfield Shopping Centre. The new site will offer 50 per cent more space, excellent transport links, and long-term lease security – ensuring we can protect and grow this strategically important donor base.

The new canteen at Colindale forms part of a major multi-phase refurbishment to improve staff facilities and modernise this vital operational site.

Strategic priority 3

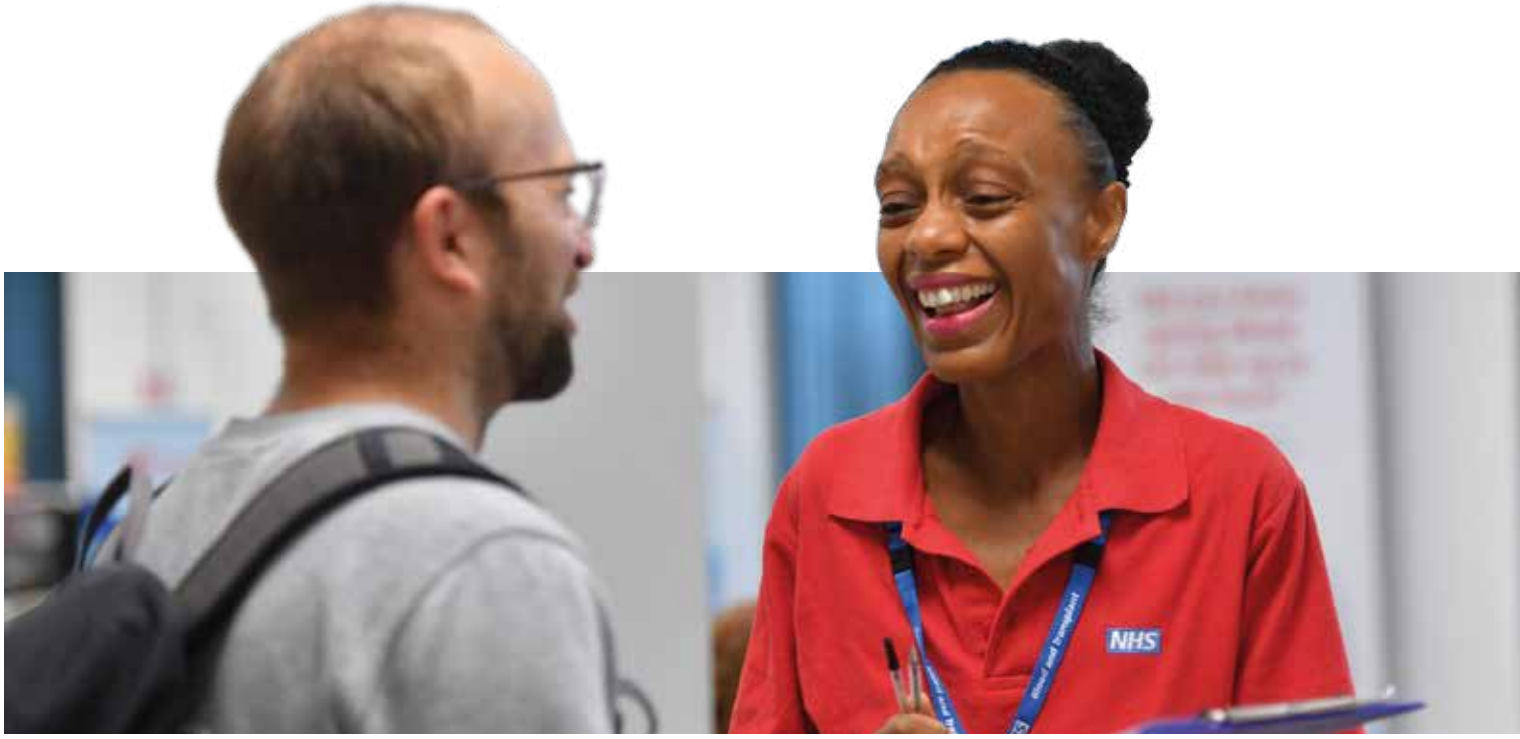
Investing in our people and culture

2024-25 marked the beginning of a new three-year People Plan describing our ambitions to make NHSBT a more supportive, empowering and inclusive employer. The plan includes a series of initiatives to improve the working environment, protect the health and wellbeing of our staff, and build a culture of dignity and respect.

During the past year, we have taken important steps forward in recruitment, flexible working, leadership development and support for underrepresented groups. Our Forward Together programme – now in its second year – has supported stronger action on intentional inclusion and anti-racism, including the launch of a new Anti-Racism Framework.

At the same time, we have implemented targeted measures to reduce sickness absence and workplace harm, while also introducing updated performance development tools to support more holistic, meaningful conversations between managers and staff – including a stronger focus on wellbeing and personal growth.

We are also investing in the future by nurturing talent at every level, from creating stronger entry routes via our successful apprenticeship programme to improving management and leadership development through tailored support. Together, these efforts reflect our commitment to help people 'join, stay and thrive' at NHSBT.



How we have performed: detailed analysis

Recruiting and retaining our people

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
Overall vacancy fill rate	88.8%	87.7%	+1.1% points	88%	Improving – above target
Staff turnover/ attrition – NHSBT as a whole	11.8%	13.9%	-2.1% points	14%	Improving – better than target

During 2024-25, we made several improvements to our recruitment processes to strengthen NHSBT's reputation as an employer and encourage candidates to apply.

These include:

- launching **a new dedicated careers site** to improve the quality of information for candidates
- embedding a **new business partnering model**, with talent and recruitment specialists working closely with business areas to reduce agency and off-payroll resourcing
- completing **a review into inclusive recruitment practices**, with key recommendations being taken forward
- developing a **new corporate induction programme**, providing joiners with better information about the organisation and exposure to different business areas.

Over the last 12 months, we have also focused on improving staff retention, notably launching new **agile and flexible working policies** to support our workforce, which is giving people more choice and flexibility in finding the most appropriate and effective way of carrying out their duties.

The three pillars of the People Plan

The new People Plan describes how we will support our people against three key pillars:

1. **Join** – which contains measures designed to improve the experience for prospective candidates and those joining NHSBT.
2. **Stay** – which looks at how we improve the working environment for our employees so that they want to stay within the organisation.
3. **Thrive** – which explores how we provide career and personal development opportunities to our people so that they can flourish professionally.

The plan also commits to wider improvements within the business, known as our **Foundations for Success**. These include ensuring our work is intentionally inclusive, making better use of data and information, enhancing leadership and management skills, and improving HR services.

Championing diversity and inclusion

2024-25 marked the second year of our **Forward Together** programme, which focuses on intentional inclusion and anti-racism. By March 2025, we had delivered the first phase of the programme, which included launching a new **Anti-Racism Framework**, reviewing inclusive recruitment policies and practices, and increasing staff awareness of inclusion and anti-racist behaviours.

In addition, NHSBT completed an **organisation-wide cultural diagnostic** to understand staff experiences and identify areas for improvement. We also partnered with the Mayor of London's **Workforce Integration Network Lab** to develop initiatives such as reverse mentoring and career kick-start conversations for Black heritage and minority ethnic staff. Supported by these initiatives, we saw representation of minority ethnic colleagues at Bands 8a-8c rise to 15.8 per cent – a record high.

Alongside this, the **Neurodiversity Network (NDN)** took forward several key initiatives. These included simplifying access to information on the NDN intranet pages, enhancing visibility across internal networks, and supporting the introduction of the Hidden Disabilities sunflower lanyard. The network also worked collaboratively across other staff networks and directorates to deliver change. A notable achievement was the successful testing and **rollout of the Open Dyslexic font** to all Microsoft Office users, supporting more inclusive digital access.

What is intentional inclusion?

As an organisation, we aim to reflect the communities we serve, with intentional inclusion at the heart of all we do. This means creating an environment where everyone feels seen, heard and safe, and where colleagues are supported to achieve their full potential – a key principle shaping our People Plan.

The **LGBT+ Network** also made significant progress. Highlights included delivering a series of anchor events, allyship training programmes and themed awareness days across NHSBT. The network also advised on policy development to tackle discrimination and supported public engagement by participating in Birmingham and Bristol Pride to promote donor registration. A major milestone was the completion of **the Sex Assigned at Birth (SaaB) project**, which involved working with internal and external stakeholders to help ensure an inclusive donation experience for trans and non-binary donors.

Finally, the **NHSBT Women's Network** remains an active and influential voice in championing gender equity, leadership and wellbeing. Last year, it represented women's priorities at the Equality, Diversity and Inclusion Council, delivered an annual #AccelerateAction conference, and hosted Safe Space sessions to support open dialogue. The network continues to lead several working groups and is currently helping to improve intranet resources to enhance access to information and support.

Supporting the health and wellbeing of our staff

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
NHSBT sickness absence rate	4.9%	4.8%	+0.1% points	4.0%	Increasing – worse than target
Incident harm rates per 1,000 staff members	7.5	8.7	-13.6%	7.6	Improving – better than target

NHSBT has continued to experience challenges with **staff sickness**. Throughout 2024-25, sickness absence remained consistently above the target of four per cent. The Health, Safety and Wellbeing team have worked with business areas on targeted plans to address this.

Reducing incidents of **workplace harm** has also been a particular focus. Key actions have included providing new mechanical tugs for mobile blood donation teams to decrease manual handling when setting up and packing down sessions.

As a result, we have seen an improving trend in workplace safety during the financial year. For example, by the end of March 2025, overall harm incidents had fallen to 6.6 per 1,000 employees, while incident rates specifically within Blood Supply teams fell below target at 10.8 per 1,000 for the first time since June 2024.

Helping our people to thrive

Last year, we also continued to strengthen the training and development opportunities available to staff at all levels. This has included running conferences for **senior leaders**, creating space to explore key organisational challenges and strengthen our leadership community. We have also introduced a new online learning and collaboration tool, alongside the launch of a refreshed senior leadership development programme.

For **middle managers**, we have created a blended development offer focused on building confidence, capability and engagement. This includes tailored programmes for new and aspiring managers, practical skills training, and structured inductions for those new to leadership roles (for more information, see page 64).

And finally, NHSBT is nurturing new talent through our successful **apprenticeships programme**. Last year, 136 people took part in apprenticeship schemes across the organisation, providing a range of entry-level opportunities and career pathways for people of all backgrounds.

Strategic priority 4

Driving innovation

NHSBT is committed to driving innovation across research, technology and clinical practice. From applying cutting-edge genomic science to improve blood matching, to supporting next-generation therapies, our work helps deliver better care for patients while supporting the UK's life sciences sector.

In 2024-25, we expanded our genomics programme, using molecular genotyping to support safer, more personalised transfusions. This includes pressing ahead with a ground-breaking collaboration with NHS England to offer extended blood group testing to all patients with sickle cell disorder and thalassaemia in England.

Innovation across the blood supply chain remains another important priority, with active collaborations to test the use of dried plasma in military settings, whole blood in trauma care, and drones to transport blood products. At the same time, our world-leading RESTORE trial – testing the viability of lab-grown red blood cells – has reached further key delivery milestones and continues to attract global interest.

To support organ donation and transplantation, we are helping to increase the use of advanced organ preservation technologies to maximise the number and quality of transplants and help manage the challenges of a changing organ donor pool. Our work with partners, including the new Joint Working Group on Organ Donation, reflects our determination to raise donation levels and improve the organ donation pathway.

Last year also saw the completion of NHSBT's Five-Year Review of Research Activities, which confirmed the exceptional quality of our research portfolio and its alignment with organisational priorities. The review called for a stronger focus on impact, translation, and governance – recommendations we will take forward this year to support greater innovation and impact across our programmes.

How we have performed: detailed analysis

Supporting advances in genotyping matching for blood transfusion

The use of genomic technology is transforming how we match blood for patients who need transfusions by applying advanced genotyping to better understand patients' blood types at a molecular level.

Around one in six patients (17 per cent) experience side effects from transfusions due to incomplete blood matching. These complications can be painful, distressing, and may limit future treatment options. By improving the precision of blood matching, genotyping helps reduce the risk of these complications and supports more effective, personalised care.

During 2024-25, NHSBT made progress in expanding access to our **extended blood group testing** for people with sickle cell disorder, thalassaemia, and other rare anaemias as part of a national programme.

Developed with NHS England, the initiative invites patients to provide a blood sample for DNA-based testing to establish their specific genotype and ensure more accurate blood matching. Last year, **more than 5,300 genotype tests** were successfully carried out, supporting safer and more effective transfusions for the future.

Tunde's story

Tunde Akintola, 52, a management consultant from Camden, was offered extended blood group testing at a routine NHS appointment last year. He has sickle cell and receives regular transfusions.

Tunde is pictured here with Bernadette Hylton, Lead Haemoglobinopathy Clinical Nurse Specialist at University College London Hospitals.

"I have a good friend who has developed antibodies and it has had a devastating effect on his life. If one little test can help people avoid these terrible complications, then it's well worth having."

Tunde Akintola, transfusion recipient.

Improving the blood component supply chain

In 2024-25, NHSBT continued to work with partners on key projects to strengthen the resilience and flexibility of the UK's blood component supply chain.

One of the most significant is **the Study of Whole Blood in Frontline Trauma (SWiFT)**, which investigates the clinical and cost-effectiveness of using whole blood transfusions compared with standard component therapy for patients experiencing traumatic haemorrhage. By the end of the year, over 900 participants had been enrolled across ten air ambulance trial sites. Findings from these trials are expected to inform future trauma care and transfusion practices.

NHSBT also made progress in its £5 million collaboration with the Ministry of Defence to develop a dried plasma product as part of its **Blood Far Forward programme**. The initiative aims to deliver life-saving blood components to injured personnel within 30 minutes of wounding, even in active war zones or remote environments. During 2024-25, specialist plasma drying equipment was successfully delivered, installed, and validated, while laboratory assessment of the dried plasma has also now begun.

Another major focus is our £1.6 million investment to support research and development into **universal plasma and universal platelets**. This programme aims to create clinically viable products that are compatible with any patient, regardless of blood group. However, we experienced a setback during 2024-25 as a key supplier withdrew: a potential new technology has now been evaluated and selected, pending contractual agreement.

We are also moving forward with our ground-breaking **RESTORE trial**, the world's first clinical trial of the in-person use of red blood cells manufactured from stem cells (mRBCs). Recruitment for the trial is now complete, and by the end of 2024-25, 19 doses had been administered to participants, with four additional batches in production and scheduled for administration during 2025. If proven safe and effective, both innovations could revolutionise treatment for patients with complex transfusion needs.

Using drone technology to transport blood products

In a UK first, NHSBT partnered with a medical logistics company to successfully transport blood packs by drone across a 68-kilometre route in Northumbria.

Ten units of packed red blood cells were flown between Wansbeck Hospital and Alnwick Infirmary – while an identical set was transported by road for comparison – in a trial to assess feasibility and safety of delivering medical supplies by drone.

It was the first time in the UK that blood packs have been delivered by drones flying 'beyond visual line of sight', meaning the pilot cannot see the physical drone as it travels, instead monitoring it remotely.

Laboratory analysis confirmed that drone transport did not affect the blood's quality or viability, demonstrating that drones could provide a safe, faster, and greener alternative to traditional transport methods. Further studies, including trials involving the transport of platelets, are now being planned.

Harnessing technology in organ donation and transplantation

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
Total number of organ transplants carried out (living and deceased)	4,581	4,680	-2.1%	4,768	Falling – below target
The number of organ transplants per deceased donor	2.56	2.47	+3.6%	2.43	Improving – above target
Overall organ consent rate	58.9%	60.0%	-1.1% points	60%	Falling – below target

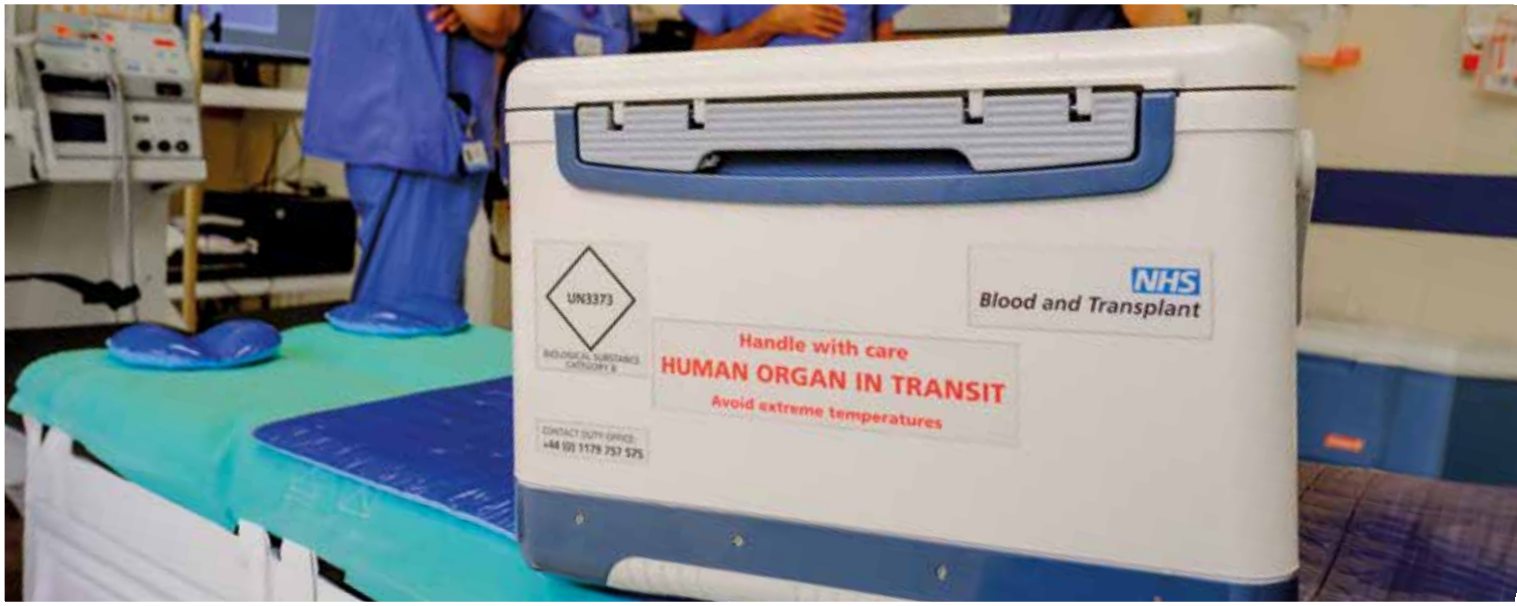
In 2024-25, NHSBT continued to adopt new technologies and digital tools to help more patients receive the life-saving transplants they need.

Despite a challenging year, 3,597 **deceased donor transplants** were carried out – equivalent to 95 per cent of the annual target. When combined with living donor transplants, the total reached 4,581 – a reduction of just over 2.1 per cent compared to last year (4,680). Although slightly below plan, this still represents a strong performance under difficult circumstances.

One of the key issues is the **continuing decline in donors after brainstem death (DBD)**, driven in part by a fall in neurological testing in intensive care units. In March 2025, just 63 per cent of potential donors received neurological testing, down from 72 per cent the previous year. As a result, donation after circulatory death (DCD) now accounts for 62 per cent of all deceased donors. This creates challenges since DCD donors typically yield fewer transplants and tend to have lower consent rates.

Despite this, NHSBT exceeded its **transplant-per-donor target**, achieving 2.56 transplants per donor against a target of 2.43. This was supported by ongoing investment in advanced organ preservation techniques such as normothermic regional perfusion and DCD heart transplant protocols.

The **overall consent rate for deceased donation** was 59 per cent, just short of our 60 per cent target. Encouragingly, we exceeded our consent target for donors from minority ethnic backgrounds (achieving 34 per cent against a 33 per cent target). However, the proportion of transplants going to minority ethnic patients fell slightly short of target.



During 2025-26, we will aim to improve consent rates through timely referrals, greater presence of specialist nurses in hospitals, and close collaboration with the National Organ Donation Committee to maximise referrals. We will also work with public and commercial partners to drive Organ Donor Register sign-ups.

In April 2025, we convened a Pathway Improvement Workshop and have since established a **Joint Working Group on Organ Donation**, co-chaired by the NHSBT Chief Executive and the Department of Health and Social Care. This group is tasked with identifying opportunities to raise donation levels to – and beyond – pre-pandemic rates. This will involve reviewing the entire donation pathway, including clinical practice, family conversations, public engagement, and the impact of legislative changes.

We are also mobilising an exciting programme to set the path for Assessment and Recovery Centres. This work will see cutting-edge organ preservation technologies deployed more widely, with the aim of increasing transplant numbers.

Understanding advanced organ preservation techniques

The increased use of new organ preservation technologies helps us increase the number of organs viable for transplant at a time when the overall donor pool is shrinking:

Normothermic regional perfusion is a technique that keeps donated organs at body temperature, helping to preserve their function after circulation has stopped. It involves blood circulation being temporarily restored to abdominal organs using a machine that mimics the body's normal temperature and function. This helps prevent organ damage, improves organ function, and increases the chances that more organs will be suitable for transplant.

DCD heart transplantation involves reanimating the donor heart outside the body using a portable perfusion machine. After the heart stops, it is removed, revived, and kept beating with warm, oxygenated blood until it can be transplanted. The process has enabled successful heart transplants from DCD donors, something previously not thought possible.

Tom's story

Tom Pinnock has had two organ transplants by the age of 29. After suffering a heart attack aged 26, Tom was placed on the 'urgent list' for a heart transplant and received a new heart in 6 days.

He later needed a kidney transplant as complications during his recovery led to kidney failure. Tom shared his story last year to mark the 30th anniversary of the Organ Donor Register.

"I was given a five per cent chance to live, but someone else's bravery gave me a life to go live – and gave my daughter a dad."

Tom Pinnock, organ transplant recipient.

The Five-Year Review of NHSBT research activities

Every five years, the Research Governance Office – part of the Clinical Services Directorate – conducts **a full review of NHSBT-funded and supported research activities**, assessing their quality, impact and alignment with organisational priorities.

In last year's review, a panel consisting of national and international experts and lay contributors praised our research programme as 'world-class' and 'an example to the rest of medicine', while recommending a sharper focus on impact, strategic alignment, and governance.

In response, NHSBT will maintain its core R&D funding and explore the potential for grants from the NHSBT Trust Fund to be used to support research bids.

Other key priorities include:

- strengthening the **translation of research** into practice
- improving **public and patient involvement** in research
- reviewing the role of **behavioural research**.

The Five-Year Review plays a crucial role in ensuring our research delivers maximum value – helping us to prioritise our investments and deliver innovative projects that will save and improve more people's lives in future. We are grateful to the researchers, scientists and clinicians that took part, and to the review panel for their invaluable insight.

Strategic priority 5

Collaborating with our partners

Throughout 2024-25, we have been proud to work alongside our partners across the NHS and life sciences to support a range of exciting developments that combine scientific progress with real-world impact for patients.

One of our most important achievements during 2024-25 was restoring the use of UK plasma to manufacture medicines for NHS patients – the first time in 25 years that English donors have contributed directly to the domestic supply of immunoglobulins and other plasma-derived therapies. We also made strong progress in improving the UK's self-sufficiency in albumin, further strengthening the domestic supply of critical plasma-based medicines.

Our Therapeutic Apheresis Service also continued to grow, launching new services in previously underserved regions and supporting the introduction of novel gene therapies for patients with rare inherited conditions.

Across cellular and molecular therapies, we expanded our manufacturing capacity and supported major clinical trials exploring new approaches to treating cancer, joint disease and other serious conditions.

Finally, although the landscape for ocular donation remains extremely challenging, our Tissue and Eye Service made encouraging progress in reducing cornea transplant waiting times across the NHS. We hope the new iOrbit programme – developed in partnership with NHS England – will lay the foundations for even greater improvements over time.

How we have performed: detailed analysis

Expanding our Therapeutic Apheresis Service (TAS)

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
The number of therapeutic apheresis procedures carried out	13,006	12,121	+7.3%	13,646	Improving – below target
The proportion of TAS service users rating 9 or 10 for overall satisfaction	95%	100%	-5% points	90%	Falling – but above target

Therapeutic apheresis is a medical procedure that involves removing blood from a patient, separating out specific components (such as plasma or certain blood cells), and then returning the remaining blood to the patient. It is used to treat a range of conditions, including certain autoimmune disorders, blood cancers, or complications of sickle cell disease, and to collect stem cells for stem cell transplants.

During 2024-25, NHSBT's Therapeutic Apheresis Service (TAS) carried out **just over 13,000 NHS procedures**. While this was 4.7 per cent fewer than our target (13,646), it is still 7.3 per cent more than the previous year (12,121). The shortfall was mainly due to fewer red-cell exchange procedures and stem cell collections than expected. This was largely the result of delays in the start of planned new or expanded services: for example, MedTech funding – which is used by Trusts to set up or expand red cell exchange services for sickle cell patients – was delayed by nearly a year.

Despite these challenges, TAS successfully launched two new services during the year: a plasma exchange service in the south west peninsula, an area previously underserved, and a new red cell exchange service in Middlesbrough. NHSBT also started supporting the delivery of the **Casgevy gene therapy for b thalassemia and sickle cell patients** through collecting starting material stem cells from patients in our Manchester unit.

Shaping the future of transfusion services

In July 2024, the Transfusion Transformation Symposium brought together senior leaders from NHSBT, NHS England, and the National Blood Transfusion Committee to discuss future priorities.

Key areas of discussion included:

- wider use of tranexamic acid in surgery
- smarter use of data and digital tools to track and manage blood supplies
- better patient involvement and consent processes
- improved staffing levels, training, and career pathway.

The event, which will help to shape a new five-year strategy, also highlighted the need for ongoing collaboration on addressing inequalities and strengthening resilience of blood supply and clinical services.

Advancing cellular and molecular therapies

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
The number of stem cell transplants supported by Cellular and Molecular Therapies (CMT)	1,737	1,787	-2.8%	n/a	n/a
Total income generated by the Clinical Biotechnology Centre (CBC)	£3.2m	£1.9m	£1.9m	£5.4m	Improving – below target
Total income generated by Advanced Therapies Unit (ATU)	£1.47m	£1.18m	+24.8%	£2.03m	Improving – below target

Cellular and gene therapies represent one of the most exciting frontiers in modern medicine. Cellular therapy often involves modifying or using a patient's own cells, such as T-cells, to fight disease, while gene therapy involves altering genes within a patient's cells to correct or prevent disease at the molecular level.

NHSBT helps to deliver these treatments by providing specialist services to collect, process, test and store cellular materials. It also manufactures cell and gene therapies for clinical trials.

Last year, we supported a total of **1,737 stem cell transplants** for patients, compared to 1,787 in 2023-24. The reduction was due to a decrease in demand for autologous transplants across NHS trusts. NHSBT also continued to process treatments known as CAR-T therapies, where a patient's own immune cells are specially modified to help fight cancer – supporting over 150 treatments for patients last year.

Income from our specialist **Advanced Therapy Units (ATUs)**, which manufacture these cell therapies, grew to £1.47 million. Highlights included a new partnership to produce CAR-T treatments at our Barnsley site for a UK clinical trial. Other major ATU projects included work in Filton growing red blood cells from stem cells to support the RESTORE project, and the manufacture of cell-based treatments in Liverpool for people with osteoarthritis.

At our **Clinical Biotechnology Centre (CBC)**, which focuses on delivery of components for gene therapies, income rose to £3.2 million, up from £1.9 million, but still short of a target of £5.39 million. This included the manufacture of key components such as plasmids – small DNA molecules used to deliver genetic instructions into cells.

As part of the **MRC/LifeArc-funded Gene Therapy Innovation Hub**, the CBC also continued developing technology for making viral vectors, which are used to safely carry therapeutic genes into the body. However, some of this work was delayed due to funding issues experienced by partner organisations.

Scaling up our plasma facilities

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
Total volume of plasma for medicine collected (source and extracted from whole blood)	301,197 ltrs	161,095 ltrs	+87.0%	200,000 ltrs	Improving – above target

Our **Plasma for Medicines (PfM)** division is currently delivering above expectations and has enabled UK patients to receive plasma-derived medicines from English donors for the first time in 25 years. This milestone is a culmination of intensive efforts by NHSBT, NHS England and the Department of Health and Social Care to create a new plasma supply chain and represents a major step forward in securing medicine supplies for the future.

In 2024-25, we **surpassed our overall collection targets by over 50 per cent**, delivering a combined total of over 301,000 litres of recovered and source plasma against a target of 200,000 litres – despite the number of plasma donors falling below target during the year.

Major regulatory, quality, technical and operational milestones have been delivered, including operationalising the fractionation agreement between NHSBT, NHS England and our commercial partner Octapharma. These achievements are delivering above our targets for 23 per cent UK self-sufficiency in immunoglobulin and 80 per cent albumin supply.

Establishing a stable and effective supply chain means that NHSBT can now dispatch UK-sourced plasma at weekly intervals to be processed and turned into medicines. **A total of 32 shipments comprising over 330,000 litres of plasma have been sent to date**, with seven more being ready for dispatch at the end of March 2025.

Our focus for 2025-26 will include restoring our Twickenham donor centre's full plasma appointment capacity (which was diverted last year into supporting blood supply with whole blood collection), building additional capacity across all three donor centres by increasing the number of chairs available for plasma collection, and increasing the retention and donation frequency of regular donors through our new donor loyalty scheme ('Plasma Perks').

We will also press ahead with our **Plasma Strategic Growth Programme** to develop options for long-term expansion and increased national self-sufficiency.

In summer 2024, NHSBT's plasma supply team dispatched the first pallet of UK plasma to be turned into life-saving medicines. Over a million litres of plasma have been recovered through blood and plasma donations since April 2021.

Extending access to tissue and eye services

Key measure	2024-25	2023-24	Year-on-year trend	2024-25 target	Performance
Number of corneas issued for treatment	3,929	3,854	+1.9%	3,816	Improving – above target
Total income generated by Tissue and Eye Services (TES)	£23.17m	£19.88m	+16.5%	£21.82m	Improving – above target

During 2024-25, NHSBT worked closely with NHS England on **the iOrbit programme** to reduce waiting times for cornea transplants. A key development has been the introduction of centralised funding, which is helping to deliver a more consistent and equitable allocation of corneas based on clinical urgency and length of wait.

As a result, we have made progress in bringing down the waiting times for transplants over the last 12 months, although we recognise that there is still more to do. We now offer corneas to patients who have been waiting in excess of 52 weeks for their transplant whereas last year we only accepted requests for patients who had been waiting in excess of 78 weeks.

Despite this progress, there are still many barriers to cornea donation, and we are working on a range of initiatives – including an ongoing partnership with Specsavers – to increase donor numbers and hence make more corneas available for transplant. We expect to make further progress on this in 2025-26.

The iOrbit programme

NHSBT is currently unable to meet the full demand for corneal tissue in the UK due to limited supply. To help address this, **the iOrbit project** was launched to build on the success of our existing Eye Retrieval Scheme (ERS). The aim is to set up dedicated eye retrieval teams in NHS hospitals, making it easier to collect donated eye tissue safely and efficiently.

During 2024-25, five NHS sites began running eye retrieval services, with staff undergoing training to support this work. A further site is due to start in July 2025, and four others are close to final agreement. The new services will help reduce the time patients have to wait for a corneal transplant – something that can have a significant impact on their quality of life.

Our **Serum Eyedrop Service** also continued to expand last year, with more patients treated than ever before. Demand for the service is expected to grow further in 2025–26.

Serum eyedrops are derived from blood products and are used as a treatment of last resort for patients with severe dry eye syndrome.

Dee's story

Last September marked the 20th anniversary of Dee Roberts-Molloy's cornea transplant, which she received after being diagnosed with keratoconus, a condition that causes the cornea to thin and bulge.

The transplant not only restored Dee's vision but also increased her confidence and independence, enabling her to complete a postgraduate degree and pursue a successful career.

By working closely with hospital partners, the iOrbit project is helping to improve the supply of donated tissue and support more patients, like Dee, who need sight-saving treatment.

"Every new year, I celebrate my donor in my own way, acknowledging the profound impact they've had on my life. I want my story to inspire others to consider donation and make a difference in someone's life."

Dee Roberts-Molloy, a transplant recipient, describes the value of corneal donation.

Our sustainability

We emitted 10,977 tCO_2e (tonnes of carbon dioxide equivalent) of Scope 1 (direct) emissions and Scope 2 (indirect) emissions in 2024-25 (2023-24: 10,700 tCO_2e). When Scope 3 (value chain) emissions are added, this brings the estimated total emissions to 110,411 tCO_2e (2023-24: 13,760 tCO_2e). (2023-24 Scope 3 emissions were estimated at 3,060 tCO_2e but did not include all supply chain emissions)*.

Emissions data April 2024 to March 2025

Emissions source	Carbon (tCO_2e) 2024-25	Carbon (tCO_2e) 2023-24
Natural gas	2,978	2,972
CO_2	332	18
Gas oil	49	103
Diesel	2,509	2,550
Fugitive refrigerant gases	133	389
Total Scope 1	**6,001**	**6,032**
UK national grid electricity	4,976	4,668
Total Scope 1 & 2	**10,977**	**10,700**
Transport	752	767
Transmission, distribution and generation loss	1,656	1,654
Flights	274	84
Regular taxi, motor bike and bus	32	15
National rail	202	180
Waste	19	67
Electric vehicles	19	12
Commuting	29	39
Working from home	235	239
Water	4	3
Purchased Goods and Services*	96,212	n/a
Total Scope 3*	**99,434**	**3,060**
Total Scope 1, 2 & 3	**110,411**	**13,760**
Less self-generated renewables	(71)	(73)

* Note the 2024-25 Scope 3 figures above have been calculated using our supply chain spend with minimal exceptions and caveats. No other reporting methodologies have changed.

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

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

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

We are now working with a consultant to produce a strategic plan to achieve Net Zero. A Net Zero governance group has been established, with Net Zero now recorded as a corporate risk.

Task Force on Climate-related Financial Disclosures (TCFD) compliance statement

NHSBT has reported on climate-related financial disclosures consistent with HM Treasury's TCFD-aligned disclosure application guidance, which interprets and adapts the framework for the UK public sector. NHSBT does not consider climate to be a principal risk, and has therefore complied with the TCFD recommendations and recommended disclosures relating to:

- governance – recommended disclosures (a) and (b)
- metrics and targets – recommended disclosure (b).

Since NHSBT does not consider climate to be a principal risk, the recommended disclosures for metrics and targets parts (a) and (c) are not considered material. This is in line with central government's TCFD-aligned disclosure implementation timetable for Phase 2. NHSBT plans to provide recommended disclosures for strategy in future reporting periods in line with the central government implementation timetable.

TCFD disclosures

Voluntary compliance

NHSBT is classified as a public corporation and is not consolidated into the Department of Health and Social Care's Group Accounts. As a consequence, compliance with the TCFD requirements is optional, although NHSBT has chosen to voluntarily comply.

Board oversight of climate-related issues

Our Board committee structure is shown on page 74.

The Board receives updates on compliance with NHSBT's Net Zero Sustainability Strategy. Board oversight covers all aspects of delivering the strategy:

- key changes
- activity in key areas of the organisation
- compliance
- progress on meeting the objectives of our Net Zero Sustainability Strategy
- environmental performance targets
- adequacy of resources
- communication from interested parties
- opportunities for continual improvement.

The reporting process is built around, and forms part of, our ISO14001:2015 certification, and the risk elements are also covered within the organisation's risk management processes.

Climate and other environmental considerations are considered as part of decision making. However, work is underway to formalise this process and bring it together under a detailed Net Zero Strategy that is owned by the Board.

Management's role in assessing and managing climate-related issues

NHSBT operates with delegated line management responsibility for managing risks (including climate change risks). This is expressed in the documented management and standard operating processes. However, the need to update job descriptions with specific responsibilities for carbon and environmental management will form part of the ongoing work to develop an overarching Net Zero Strategy.

All employees are made aware of their responsibilities for carbon and environmental management, through online training. Those employees whose actions can have a significant effect on risk and performance are provided with further role and task specific training.

The strategy is owned and led by the Board, with the Chief Financial Officer as lead sustainability champion. The Board receives updates on progress, and tracks performance against the net zero key performance indicator. Operational progress reports are fed into the Finance directorate senior management team, by the Estates and Facilities senior management team, on a monthly basis.

The responsible officer is the Head of Estates Transformation and Sustainability, who is responsible for developing and deploying the strategy, as well as the monitoring and reporting process. This work currently includes the development of the new Net Zero Strategy.

Metrics and targets

Our emissions data for 2024-25, together with comparative figures for 2023-24, is set out on page 42. This covers our Scope 1 and Scope 2 emissions, and an estimate of Scope 3 emissions. Our calculation methodology for Scope 1 and Scope 2 follows the Greenhouse Gas (GHG) Protocol and the basis for our Scope 3 estimates is set out under the emissions data table.

Our emissions reporting is audited by our external ISO14001:2015 certification body.

Our finances

Overall financial performance

The total income and revenue funding received by NHSBT in 2024-25 was £653.5m (2023-24: £578.6m). Around 70 per cent of our income is provided through sales of products and services to the NHS, 20 per cent is provided as programme funding from the Department of Health and Social Care (DHSC) and the devolved governments, with the remainder relating to other income sources such as NHS England funding for the supply of plasma, and grant and project income. The increase in income in 2024-25 of £74.9m was mainly due to a higher level of fees and charges being recovered through prices from the sale of blood and specialist services to cover inflationary pressures, additional funding received from DHSC in respect of inflation and indirect overheads for organ donation and transplantation, and for resilience in blood supply.

In line with the HM Treasury Financial Reporting Manual, we publish our primary accounting statements on a Net Expenditure basis. This requires that the programme funding received by NHSBT, mostly in support of organ donation, transplantation and stem cells, is included in reserves, rather than in the Statement of Comprehensive Net Expenditure (SoCNE).

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

The total income received in 2024-25 was £653.5m (2023-24: £578.6m), and NHSBT reported a surplus in the Income and Expenditure of £14.8m (2023-24: surplus of £0.7m) as seen on pages 122 to 123. The planned Income and Expenditure budget for the year was a deficit of £19.4m. In some reporting years, NHSBT will plan for a deficit as it uses cash reserves to fund planned transformation projects.

The underlying improved financial outcome in 2024-25 versus our planning expectations was driven primarily by:

- higher sales of plasma for diagnostics, and an increase in the plasma for medicines stock valuation which reflects the net realisable value under the supply agreement with NHS England
- lower spending than planned across group services, transformation projects and on the Future Proofing Blood programme
- additional funding from NHS England to mitigate the impact of the amber alert (from July 2024) which has driven cost overruns within blood supply due to the need for additional spending on temporary labour, overtime and marketing costs in order to maintain blood stock levels

Financial performance by segment compared to 2023-24

The overall income for Blood Components (including transport charges) was £357.6m in the year. This was 11 per cent higher than 2023-24 (£322.3m) reflecting the Blood Component Income uplift of 10.7 per cent agreed with the National Commissioning Group (NCG). The increase in direct and other support costs reflects the impact of higher inflation.

The direct cost of Organ Donation and Transplantation (ODT) is funded by DHSC and the three devolved UK governments. Indirect overheads are also now funded by DHSC, effectively reducing the subsidy in previous years provided by other parts of NHSBT. ODT funding overall has increased by £17.0m, which includes £11m for overheads, £5m for inflation and an increase in recurring funding from Scotland and Wales devolved administrations of £0.7m.

Sales income in Tissue and Eye Services (TES) was £3m higher than the previous year at £22.4m (2023-24: £19.4m), partially offset by higher variable and direct costs (which increased by £1.6m compared to the previous year), finishing the year with an overall surplus of £2.1m. This was an improvement against the previous year's deficit (£0.1m).

Clinical Services activity (Pathology, Stem Cells and Therapeutic Apheresis) increased overall by 5.7 per cent compared to the previous year. Total income (including programme funding from DHSC in support of the NHS Cord Blood Bank and the British Bone Marrow Registry) grew to £96.5m in 2024-25, 10.5 per cent higher than the £87.3m seen in 2023-24.

Following the signing of the Plasma Supply Agreement with NHS England during 2023-24, the revenue structure for Plasma has changed, and is now fully funded through the supply agreement with NHS England, and sales of plasma for diagnostics ('Other Income'). The net surplus relating to additional volumes of plasma for diagnostics will be carried forward as cash reserves to next year to support future transformation activities.

Capital expenditure

Capital funding can broadly be categorised as being required for a number of discrete purposes. For example, equipment is needed for replacement and replenishment to ensure NHSBT is able to deliver against agreed volumes and activity levels, and in doing so comply with its licensing and regulatory controls. The networked laboratories and production facilities require the estate to be maintained to specific levels. In totality, this is regarded as CNI (Critical National Infrastructure). In addition, the transformation programme, seen through the Investment Portfolio, is responsible for the bulk of the capital spend. This has routine oversight and review by the Executive Team and also periodically by the Board.

At a detailed level, DHSC provided a total of £17m funding for capital expenditure in 2024-25 (2023-24: £15.5m), with actual capital expenditure for the year higher at £18.3m due to reclassification of costs as part of the year end review process. £5.3m of this relates to the Blood Technology Modernisation Project, which is upgrading our core blood management system to preserve its long-term future and resilience. Other capital expenditure related to our estate (£6.3m) e.g. the Colindale Investment Programme, Brixton Donor Centre and Southampton Donor Centre, and various IT projects that support the organisation's strategy to modernise core technology (£1.4m). The balance of £5.2m was spent on a range of critical business equipment across Blood Supply, Clinical Services and TES laboratories.

Net assets

Net assets increased to £307.9m at 31 March 2025 from £287.6m at 31 March 2024. The key movements were:

- non-current assets increased from £253.7m to £255.1m due to a combination of the impact of the annual desktop revaluation of our property assets, indexation and asset additions
- trade and other receivables increased by £8.3m, from £70.5m to £78.8m. Trade and other payables increased by £10.1m, from £48.6m in March 2024 to £58.7m in March 2025. As there was a lower volume of payments at the year end compared with the previous year, this led to an increase in the trade payables and a higher cash balance as noted below.
- other financial liabilities (current and non-current) decreased by £2.8m from £31.2m to £28.4m, mainly due to consumption of lease liabilities in line with the requirements of the IFRS 16 accounting standard
- cash increased by £13.5m from £24.4m at the end of March 2024 to £37.9m at the end of March 2025, broadly matching the increase in trade and other payables

Note 19 of the financial statements describes NHSBT's contingent liabilities. There are no other significant contingent liabilities to report, as at 31 March 2025.

NHSBT is the corporate trustee for the NHS Blood and Transplant Trust Fund. The total net assets of the Trust Fund at 31 March 2025 were £160k (compared to £170k at 31 March 2024). The Trust Fund accounts are published on the NHSBT and Charity Commission websites. Although the Trust Fund assets are controlled by NHSBT, consolidated accounts are not produced as the Trust Fund is not financially material to NHSBT.

The Trust Fund accounts can be found here:

https://register-of-charities.charitycommission.gov.uk/en/charity-search/-/charity-details/3082011/accounts-and-annual-returns

Going concern

A rolling five-year financial plan is maintained and regularly refreshed. In high-level terms, and at a divisional level, this is designed to reflect assumptions about product and service demand, funding from the four UK health departments, assumed operating costs, and the projected costs and benefits of our investment programme.

The key principal risk for finance – P-05 (see next page) – is driven by the need to maintain a sustainable financial plan, both in the current year and also across a longer-term horizon. The financial plan is designed to provide the Board with assurance that there will be adequate income and cash resources generated to meet expected costs over the coming five-year period. As part of developing these plans, sustainability is balanced by an agreed Cost Improvement Programme.

NHSBT has a mixture of funding sources, and the five-year plan integrates these into a single coherent picture for the organisation. These funding sources can be broken down into i) fees and charges for blood and specialist services, with pricing agreed through a National Commissioning Group, and ii) programme funding (received from DHSC) for organ donation and transplantation, and stem cells, which is predominantly addressed through the periodic Spending Review rounds. As a UK-wide service, organ donation and transplantation also receives a proportionate amount of its funding from the other devolved governments.

Looking beyond 2025-26, it is expected that sufficient funding will be available to meet NHSBT objectives and operating requirements, underpinned by our ongoing Cost Improvement Programme. We are not aware of any pending changes to NHSBT functions but also take into consideration the HM Treasury Financial Reporting Manual assumption that services would continue to be provided. Taking this into account, we continue to adopt the going concern basis in the preparation of the financial statements.

Our principal risks

Principal risks are those that, if realised, will significantly impact the effective delivery of NHSBT's core responsibilities and / or strategic objectives. The score of principal risks is influenced by contributory risks, which are managed by the responsible business area.

The 11 principal risks, aligned to the corporate strategy, are owned and overseen by a named executive director. The principal risks are reviewed and challenged by the Risk Management Committee, and are also the subject of 'deep dives' presented at the Audit, Risk and Governance Committee.

The Board monitors the status of each principal risk through the Board Assurance Framework and monthly performance reporting, and also monitors the delivery of improvement actions designed to manage, control and reduce the risks.

Principal risks are monitored and managed in line with NHSBT's agreed risk appetite. The table below summarises the risks as at 31 March 2025 and illustrates the status in line with the appetite level.

Ref	Title	Residual Score	Change during the year	Impact Area	Risk Appetite
P-01	Donor and patient safety	4x3=12	↔	Donor and patient safety	Judgement Zone
	Linked with the strategic priority 'Modernise our operations'				
P-02	Service disruption	4x4=16	↓	Service disruption	Risk Limit
	Linked with the strategic priority 'Modernise our operations'				
P-03	Loss of critical ICT	5x4=20	↑	Service disruption	Risk Limit
	Linked with the strategic priority 'Modernise our operations'				
P-04	Donor numbers and diversity	4x4=16	↑	Service disruption	Risk Limit
	Linked with the strategic priorities 'Grow and diversify our donor base', 'Modernise our operations' and 'Collaborate with partners'				
P-05	Finance	4x5=20	↑	Financial	Judgement Zone
	Linked with each of the strategic priorities				
P-06	Clinical outcomes and health inequalities	4x3=12	↔	Innovation and development	Tolerable
	Linked with the strategic priority 'Drive innovation'				
P-07	Staff capacity, capability, recruitment and retention	4x3=12	↓	People	Tolerable
	Linked with the strategic priority 'Invest in people and culture'				
P-08	Managers and leaders' skills and capability	3x4=12	↔	People	Tolerable
	Linked with the strategic priority 'Invest in people and culture'				
P-09	Regulatory compliance (primary regulators)	4x2=8	↔	Legal, regulatory and compliance	Optimal
	Linked with the strategic priorities 'Modernise our operations', 'Drive innovation' and 'Collaborate with partners'				
P-10	Change programme scale and pace	4x3=12	↔	Innovation and development	Tolerable
	Linked with each of the strategic priorities				
P-11	Corporate governance	4x3=12	**New Risk**	Governance	Judgement Zone
	Linked with each of the strategic priorities				

Risk appetite explained

Optimal – the level of risk that NHSBT is aiming to achieve and operate for each agreed impact area. Risks reaching the optimal score are deemed acceptable, with continued monitoring of the risk and particular focus on its controls to ensure the risk's residual score does not change.

Tolerable – the boundaries which have been judged acceptable for the day-to-day management of the risk. Risks within this range may be deemed tolerable, with continued monitoring of the risk and particular focus on its controls to ensure the risk's residual score does not change, or ideally, within a given period, reaches the Optimal risk score where the risk can be fully accepted.

Judgment Zone – this is the range where risks need attention because its residual scores have breached the tolerance range. Specific risks may be tolerated at this level for a given period, based on the identified benefit, but regular review is required. Decisions must be made to either tolerate, treat, or transfer the risk.

Risk Limit – risks where their residual scores have breached this upper limit are deemed unacceptable, and must be addressed as soon as practicably possible. Decisions must be made to either treat, transfer, or terminate the risk. The risk cannot be accepted at this level.

Risks at the risk limit

During the year there have been three risks at the 'risk limit', and there are ongoing actions to address these.

P-02 Service disruption. The issue that was driving the score in 2023-24 – the structural issues in the roof of part of the building in Southampton – was resolved by removing staff and activity from the affected area, other than a small section which is fully propped and boarded. The current risk driving the score is the red blood cell stock, which has been below target for most of the 2024-25 year. There are short, medium and long-term plans to mitigate this risk, that have been discussed with the DHSC.

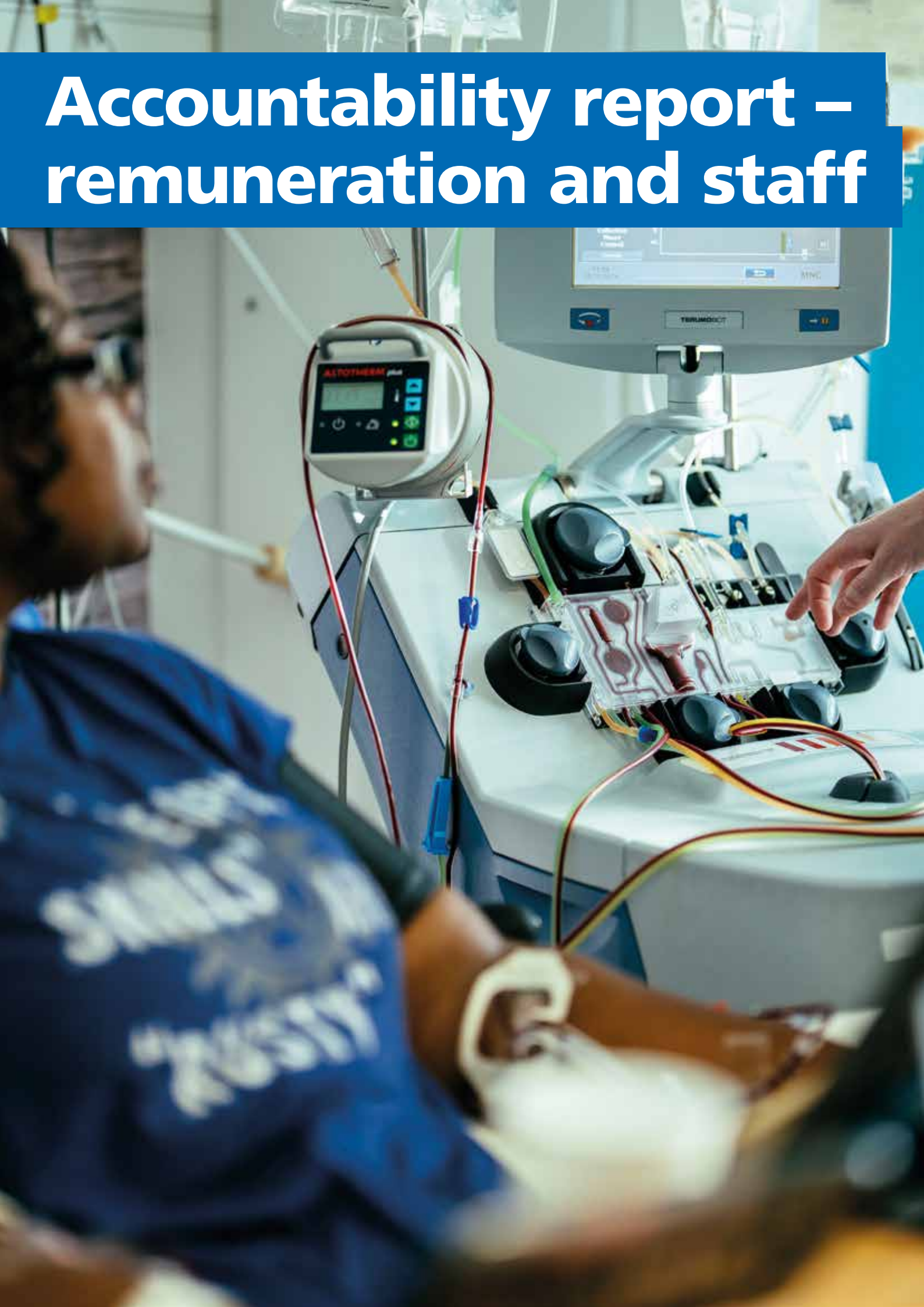
P-03 Loss of critical ICT. This risk is recorded at this level due to the critical requirement of the security of our systems, and the need to protect the data we hold and our operational capabilities. There has been considerable activity on system security during the year, with on-going plans to reduce the risk further.

P-04 Donor numbers and diversity. This risk is also affected by the blood stock issue that drives P-02.

I hereby sign the Performance Report from pages 12 to 48.

Caroline Walker **8 July 2025**
Interim Chief Executive and Accounting Officer

Accountability report – remuneration and staff



Our people

At NHSBT, our people are central to everything we do. Whether collecting blood and supporting donors, conducting cutting-edge research, or delivering life-saving transplants and transfusions, our workforce delivers for patients and the public every single day. We are committed to building a diverse, open and inclusive organisation – one that reflects the communities we serve and creates an environment where everyone can thrive.

In 2024-25, we launched a new three-year People Plan, setting out a series of actions to improve the working environment, protect health and wellbeing, and foster a culture of dignity and respect across the organisation – we want NHSBT to be a place where people want to join, are supported to stay, and have opportunities to grow.

To track our progress, we regularly monitor a range of workforce data. In this section we provide key information on staff turnover, sickness absence, senior leadership representation, workforce diversity and people development, as well as describing NHSBT's approach to remuneration, incorporating the latest staff numbers and costs.

Staff turnover

In the last three years we have seen our staff turnover reduce annually. In March 2024 we reported our annual turnover at 12.8 per cent, and at the end of March 2025 it was 11.2 per cent. We have continued to review the annual turnover in our Blood Donation teams. Annual turnover in the Blood Donation teams has reduced from 20.2 per cent reported at the end of March 2024, to 16.4 per cent at the end of March 2025.

Staff numbers and costs

The table below shows a breakdown of staff numbers and costs, distinguishing between staff permanently employed and other staff engaged on the objectives of NHSBT, such as fixed-term contract, bank and agency staff. This information is also disclosed in Note 4 of the financial statements.

This is subject to audit.

	Permanent	Other	Total 2024-25	Total 2023-24
	£000	£000	£000	£000
Salaries and wages*	244,706	25,917	**270,623**	**244,921**
Social security costs**	26,336	1,687	**28,023**	**26,214**
Employer pension contributions***	51,994	2,068	**54,062**	**42,521**
Total	**323,036**	**29,672**	**352,708**	**313,656**

* Includes temporary staff (including fixed term contracts, bank, and agency staff) £25.9m (2023-24: £19.8m) and termination benefits £0.05m (2023-24: £0.20m), and is net of recoveries in respect of outward secondments £0.1m (2023-24: £0.1m).
** Includes apprenticeship levy £1.3m (2023-24: £1.2m).
*** Includes contributions to NHS Pensions £54.00m (2023-24: £42.37m) and to NEST £0.06m (2023-24: £0.09m).

On 1 April 2019, the employer contribution rate for the NHS Pension Schemes increased by 6.3 per cent, and was increased by a further 3.1 per cent from April 2024. The additional cost of £21.3m in 2024-25 (2023-24: £12.9m) was paid by NHSBT and matched by funding from the Department of Health and Social Care. As a result of the completion of the actuarial valuation of the NHS Pension Schemes as at 31 March 2020, the total employer contribution rate was 23.7 per cent from April 2024.

In addition, staff costs of £1.1m (2023-24: £1.1m) were capitalised as directly attributable to the development of the new Pulse system (intangible asset) under the 'Blood Technology Modernisation' project (£0.9m NHSBT staff and £0.2m agency).

	Permanent	Other	Total
Full-time equivalents	**Number**	**Number**	**Number**
Year Ended 31 March 2025	**5,439**	**460**	**5,899**
Year Ended 31 March 2024	5,020	648	5,668
Of which: Number of full-time equivalent (FTE) employees engaged on capital projects:	**15**	**1**	**16**

The note above shows the average number of full-time equivalent staff for the year.

Expenditure on consultancy

Consultancy expenditure during 2024-25 was £177k (2023-24: £775k). As required, this disclosure uses the definition of consultancy set out in the HM Treasury Financial Reporting Manual, and therefore excludes professional services and contingent labour.

Pay multiples

This is subject to audit.

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of their workforce, for both total pay and benefits, and separately for the salary component of total pay and benefits.

The banded remuneration of the highest paid director in 2024-25 is shown in the table below, together with the remuneration ratios compared to the midpoint of the banded remuneration of the highest paid director's pay. This shows the total pay and benefits pay multiple was 6.7 compared to 6.5 in the previous year.

	2024-25	*Restated** 2023-24
Highest director banded remuneration	**£255k to £260k**	£235k to £240k
Lowest banded remuneration	**£5k to £10k**	£0k to £5k
25th percentile remuneration (total pay and benefits)	**£29,525**	£27,885
50th percentile (median) remuneration (total pay and benefits)	**£38,555**	£36,304
75th percentile remuneration (total pay and benefits)	**£52,809**	£50,056
Remuneration ratio (total pay and benefits)	**6.7**	6.5

Year	25th percentile pay ratio	50th percentile (median) pay ratio	75th percentile pay ratio
2024-25 total pay and benefits	8.7:1	6.7:1	4.9:1
2023-24 total pay and benefits (restated*)	8.5:1	6.5:1	4.7:1

* 2023-24 figures have been restated to show the position as at 31 March 2024, rather than the average for the whole year.

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

The salary and allowances of the highest paid director increased by 8.4 per cent from the previous year. During 2024-25, no employees (2023-24: nil) received remuneration in excess of the highest paid director.

The highest paid director did not receive any performance pay or bonuses during the year. For employees of the entity taken as a whole, the average performance pay and bonuses was £5 (2023-24: £4), a change of 25 per cent.

The increases in pay for the 25th, 50th and 75th percentile pay bands are in line with the NHS national pay award for 2024-25 of 5.5 per cent.

There has been a minor increase in the ratios of the percentile pay with the highest paid director due to the above noted increase, which was the result of the combination of the NHS pay award and the variable element of their pay as a medical consultant.

Sickness absence data

Sickness absence data is reported on a calendar year basis in line with national reporting requirements.

During the period January 2024 to December 2024 the total number of full-time equivalent days lost to sickness absence was 68,658 days (2023: 63,479 days). This equates to an average of 11.9 days per full-time equivalent (2023: 11.6 days) and a sickness absence rate of 5.3 per cent (2023: 5.2 per cent).

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 share of the liabilities related to our organisation and so the scheme is accounted for as a defined contribution scheme.

NHS Pension Schemes

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability at 31 March 2025, is based on valuation data at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7 per cent of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the three per cent cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

NHSBT made employer contributions to the NHS Pension Schemes of £53,998k during 2024-25, and estimates that its employer contributions for 2025-26 will be £55,888k.

National Employment Savings Trust

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

NEST is a defined contribution scheme managed by a third party organisation. It carries no possibility of actuarial gain or loss to NHSBT and there are no financial liabilities other than payment of the employer's contribution. The minimum combined contribution for 2024 25 is eight per cent of earnings of which the employer must pay three per cent. Employer contributions are charged directly to the Statement of Comprehensive Net Expenditure and paid to NEST monthly. At 31 March 2025 there were 122 employees enrolled in the NEST scheme (31 March 2024: 149).

Exit packages

This is subject to audit.

During 2024-25 there were five payments for departures from NHSBT which included one compulsory redundancy, and four other departures including pay in lieu of notice and special severance payments. The sum of £120k has been paid out in 2024-25 in respect of these exit packages (2023-24: 10 exit packages and payments of £575k).

There is currently a £125k provision held for exit packages costs (2023-24: £127k).

A total charge (including accruals) of £118k for exit packages was expensed over the period 2024-25, and it is adjusted for opening and closing accruals which are included within salaries and wages in Note 4 of the financial statements (2023-24: £452k). The actual exit packages payment during 2024-25 amounted to £120k.

The table below discloses the number and value by cost band of exit packages paid during 2024-25.

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	14	2	14	-	-
£10,001 – £25,000	-	-	1	23	1	23	1	23
£25,001 – £50,000	-	-	1	29	1	29	1	29
£50,001 – £100,000	1	54	-	-	1	54	-	-
£100,001 – £150,000	-	-	-	-	-	-	-	-
Totals for 2024-25	**1**	**54**	**4**	**66**	**5**	**120**	**2**	**52**
Totals for 2023-24	**3**	**369**	**7**	**206**	**10**	**575**	**4**	**92**

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

Ill-health retirement

Eight individuals retired early on ill-health grounds in the year generating additional pension liabilities of £183,272 (2023-24: ten individuals, £1,060,126). These costs are met by the NHS Pension Scheme.

The People Committee and senior manager rewards

The membership and purpose of the committee is shown on page 78. The Deputy Chief Executive and Chief People Officer also attend but excuse themselves when their remuneration is being discussed.

In deciding the remuneration of the Chief Executive and Executive Directors, the committee follows all relevant Department of Health and Social Care (DHSC) guidance, the nationally negotiated changes to medical and dental pay, and the DHSC Pay Framework for Executive and Senior Managers (ESM) in Arm's Length Bodies, and any cost-of-living pay increases or changes to remuneration are paid in line with DHSC Remuneration Committee recommendations and the appropriate guidance. Remuneration for the Chair and Non-Executive Board Members is set by the Secretary of State for Health.

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

Senior management contract information

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

Dr Jo Farrar, Chief Executive Officer. Appointed 1 June 2023. On secondment from the Ministry of Justice. Full-time post with three months' notice period by NHSBT.

Wendy Clark, Deputy Chief Executive. NHS start date 10 September 2018, NHSBT start date and appointed to the role of Chief Strategy, Digital and Information Officer 6 January 2020. Served as Interim Chief Executive Officer from 9 August 2022 until 31 May 2023, appointed to the role of Deputy Chief Executive from 1 June 2023. Permanent full-time post with 12 weeks' notice of termination by the employee, and 12 weeks' notice period by NHSBT.

Dr Gail Miflin, Chief Medical Officer and Director of Clinical Services. NHS start date 1 August 1991, NHSBT start date 1 June 2010 and appointed to the role 1 June 2016. Permanent full-time post with three months' notice by the employee, and three months' notice period by NHSBT.

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

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

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

Rebecca Tinker, Chief Digital Information Officer. NHS and NHSBT start date 7 September 2020. Appointed as Interim Chief Digital Information Officer on 15 August 2022, and Chief Digital Information Officer from 7 December 2023. Permanent full-time contract with six months' notice of termination by the employee, and six months' notice period by NHSBT.

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

Professor Denise Thiruchelvam, Chief Nursing Officer. NHS start date 1 November 2001, NHSBT start date 6 October 2023. Permanent full-time contract with six months' notice of termination by the employee, and six months' notice period by NHSBT.

Mark Chambers, Director of Donor Experience. NHS start date and NHSBT start date 6 June 2022, appointed as Deputy Director of Donor Experience on 1 July 2023, and Director of Donor Experience from 3 May 2024. Permanent full-time contract with six months' notice of termination by the employee, and eight weeks' notice by NHSBT during the first six months of the contract, and six months' notice by NHSBT thereafter.

Antony Tiernan, Director of Communications and Engagement. NHS start date 1 September 2003, NHSBT date 16 September 2024. Two year fixed-term contract with six months' notice of termination by the employee, and eight weeks' notice by NHSBT during the first six months of the contract, and six months' notice by NHSBT thereafter.

Julie Pinder, Chief People Officer. NHS start date 5 November 2018, NHSBT start date 23 September 2024. Permanent full-time contract with six months' notice of termination by the employee, and eight weeks' notice by NHSBT during the first six months of the contract, and six months' notice by NHSBT thereafter.

Deborah McKenzie, Chief People Officer. Appointed 1 September 2021. Seconded from the UK Health Security Agency until 27 September 2024.

Paul O'Brien, Director of Blood Supply. NHS and NHSBT start date 25 July 2022. Appointed as Interim Director of Blood Supply from 25 July 2022, and Director of Blood Supply from 10 July 2023. Permanent full-time contract with six months' notice of termination by the employee, and six months' notice period by NHSBT. Left NHSBT on 3 November 2024.

Officers appointed during the year 2024-25:

Julie Pinder, appointed Chief People Officer 23 September 2024.

Antony Tiernan, appointed Director of Communications and Engagement 16 September 2024.

Leavers in the year:

Deborah McKenzie, Chief People Officer, until 27 September 2024.

Paul O'Brien, Director of Blood Supply, until 3 November 2024.

The remuneration and pension benefits of the most senior officials of NHSBT are shown in the tables on pages 56 to 58. The tables are subject to audit.

Remuneration and pension entitlement of senior managers

Remuneration – Executive Directors

	Year to 31 March 2025					Year to 31 March 2024				
Name and title	Salary (in £5k bands) £000	Performance pay and bonuses (in £5k bands) £000	Non-cash benefits (to nearest) £00	All pension related benefits (to nearest) £000	Total (in £5k bands) £000	Salary (in £5k bands) £000	Performance pay and bonuses (in £5k bands) £000	Non-cash benefits (to nearest) £00	All pension related benefits (to nearest) £000	Total (in £5k bands) £000
Dr J Farrar (Chief Executive Officer)[1]	185-190	5-10	-	27	225-230	150-155	-	-	22	170-175
Ms W Clark (Deputy Chief Executive Officer)[2]	170-175	5-10	1	46	225-230	165-170	5-10	2	43	215-220
Mr A Clarkson (Director of Organ and Tissue Donation and Transplantation)	155-160	5-10	8	18	185-190	150-155	-	8	-	150-155
Mr C Vincent (Chief Financial Officer)	160-165	-	7	46	205-210	150-155	-	5	42	195-200
Dr Gail Miflin (Chief Medical Officer and Director of Clinical Services)[3]	255-260	-	-	-	255-260	235-240	-	-	-	235-240
Ms D McKenzie (Chief People Officer)[4]	80-85	-	-	30	110-115	155-160	0-5	-	60	220-225
Ms Julie Pinder (Chief People Officer)[5]	65-70	0-5	-	19	90-95	-	-	-	-	-
Mr P O'Brien (Director of Blood Supply)[6]	100-105	-	-	-	100-105	165-170	5-10	-	-	175-180
Mr G Gogarty (Plasma Director)	135-140	5-10	-	39	180-185	120-125	5-10	-	0	125-130
Ms D Thiruchelvam (Chief Nursing Officer)[7]	135-140	-	-	94	225-230	60-65	-	-	0	60-65
Ms H Gillan (Director of Quality)	125-130	-	5	17	140-145	120-125	-	2	0	120-125
Ms R Tinker (Chief Digital Information Officer)[8]	130-135	-	-	34	165-170	125-130	-	-	31	155-160
Mr M Chambers (Deputy Director of Donor Experience)[9]	110-115	-	2	28	135-140	75-80	-	1	17	95-100
Mr A Tiernan (Director of Communications and Engagement)[10]	70-75	-	-	-	70-75	-	-	-	-	-
Mr D Rose (Director of Donor Experience and Communications)[11]	-	-	-	-		50-55	-	-	12	65-70

1 Dr J Farrar – appointed Chief Executive Officer from 1 June 2023. Seconded from the Ministry of Justice (MoJ) and costs represent the payments made by the MoJ. Full year equivalent salary for 2023-24 (£5k bands) is £175-£180k and full year employer's pension contributions are (£2.5k bands) £25-27.5k.

2 Ms W Clark – Interim Chief Executive to 31 May 2023, full year equivalent salary for 2023-24 (£5k bands) £160-£165k; appointed Deputy Chief Executive from 1 June 2023, full year salary (£5k bands) £155-£160k.

3 Dr Gail Miflin took partial retirement on 12 March 2025. Her full year equivalent salary for 2024-25 (£5k bands) was £255-260k.

4 Ms D McKenzie – seconded from the UK Health Security Agency (UKHSA) until 27 September 2024, full time equivalent salary (5k bands) £160-165k.

5 Ms Julie Pinder – appointed Chief People Officer on 23 September 2024, full year equivalent salary (5k bands) £130-135k.

6 Mr P O'Brien – appointed Director of Blood Supply 10 July 2023, full year equivalent salary 2023-24 (£5k bands) was £160-165k; He left on 3 November 2024 full year equivalent salary (£5k bands) £160-£165k.

7 Ms D Thiruchelvam – appointed Chief Nursing Officer 6 October 2023, full year equivalent salary 2023-24 (£5k bands) was £125-£130k.

8 Ms R Tinker – appointed Chief Digital Information Officer 7 December 2023, full year equivalent salary (in £5k bands) £125-£130k; Interim Digital & Information Officer to 6 December 2023, full year equivalent salary (in £5k bands) £120-£125k.

9 Mr M Chambers – appointed Deputy Director of Donor Experience 1 July 2023, full year equivalent salary (£5k bands) £100-£105k.

10 Mr A Tiernan – appointed Director of Communications and Engagement 16 September 2024, full year equivalent salary (£5k bands) £130-£135k.

11 Mr D Rose – left 30 July 2023, full year equivalent salary (£5k bands) £145-£150k.

Remuneration – Non-Executive Board Members

	Year to 31 March 2025					Year to 31 March 2024				
Name and title	Salary (in £5k bands) £000	Performance pay and bonuses (in £5k bands) £000	Non-cash benefits (to nearest) £00	All pension related benefits (to nearest) £000	Total (in £5k bands) £000	Salary (in £5k bands) £000	Performance pay and bonuses (in £5k bands) £000	Non-cash benefits (to nearest) £00	All pension related benefits (to nearest) £000	Total (in £5k bands) £000
Mr P Wyman (Chair)	60-65	-	-	-	60-65	60-65	-	-	-	60-65
Mr P White[1]	10-15	-	-	-	10-15	10-15	-	-	-	10-15
Prof C Craddock	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms R Jones[2]	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms C Serfass[3]	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Prof L Marson[4]	5-10	-	-	-	5-10	0-5	-	-	-	0-5
Ms P McIntyre[5]	5-10	-	-	-	5-10	0-5	-	-	-	0-5
Mr I Murphy[6]	5-10	-	-	-	5-10	0-5	-	-	-	0-5
Prof D Kelly[7]	-	-	-	-	-	0-5	-	-	-	0-5
Mr Philip Huggon[8]	-	-	-	-	-	5-10	-	4	-	5-10

1 Mr P White – left on 18 February 2025. Full year equivalent salary (5k bands) £10-15k.
2 Ms R Jones – appointed on 1 May 2023. Full year equivalent salary (5k bands) £5-10k.
3 Ms C Serfass –appointed on 1 May 2023. Full year equivalent salary (5k bands) £5-10k.
4 Prof L Marson – appointed on 1 March 2024. Full year equivalent salary (5k bands) £5-10k.
5 Ms P McIntyre – appointed on 1 March 2024. Full year equivalent salary (5k bands) £5-10k.
6 Mr I Murphy – appointed on 1 March 2024. Full year equivalent salary (5k bands) £5-10k.
7 Prof D Kelly – left on 30 June 2023. Full year equivalent salary (5k bands) £5-10k.
8 Mr P Huggon – left on 29 February 2024. Full year equivalent salary (5k bands) £5-10k.

Pension Benefits

Name and title	Real increase/ (decrease) at pension age (in £2.5k bands) £000	Real increase in lump sum at pension age (in £2.5k bands) £000	Total accrued pension at pension age at 31 March 2025 (in £5k bands) £000	Lump sum at pension age related to accrued pension at 31 March 2025 (in £5k bands) £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Cash Equivalent Transfer Value at 31 March 2024 £000	Real increase in Cash Equivalent Transfer Value £000
Wendy Clark (Deputy Chief Executive)[1]	2.5-5	-	20-25	-	343	270	34
Anthony Clarkson (Director of Organ and Tissue Donation and Transplantation)	0-2.5	-	65-70	175-180	1,557	1,415	27
Carl Vincent (Chief Financial Officer)	2.5-5	-	30-35	-	520	431	41
Dr Gail Miflin (Chief Medical Officer and Director of Clinical Services)	-	-	0-5	-	61	124	-
Julie Pinder (Chief People Officer)[2]	0-2.5	-	15-20	-	273	216	14
Gerry Gogarty (Director of Plasma for Medicines)[3]	2.5-5	2.5-5	5-10	115-120	131	80	29
Helen Gillan (Director of Quality)	0-2.5	-	40-45	115-120	1,112	1,007	21
Rebecca Tinker (Chief Digital Information Officer)	0-2.5	-	5-10	-	124	87	15
Prof Denise Thiruchelvam (Chief Nursing Officer)	5-7.5	7.5-10	35-40	90-95	760	620	82
Mark Chambers (Deputy Director of Donor Experience)	0-2.5	-	5-10	-	75	42	16
Antony Tiernan (Director of Communications and Engagement)[4]	-	-	40-45	110-115	929	875	-
Ms D McKenzie (Chief People Officer)[6]	0-2.5	-	35-40	-	596	540	24

Notes

1 The Cash Equivalent Transfer Value reported is for the 2015 scheme only as Dr Miflin took partial retirement on 12 March 2025.

2 Appointed Chief People Officer 23 September 2024.

3 The Cash Equivalent Transfer Value reported is for the 2015 scheme only. A Cash Equivalent Transfer Value is not available in respect of the legacy scheme as normal retirement age has been reached.

4 Appointed Director of Communications and Engagement on 16 September 2024. The pension and Cash Equivalent Transfer Value take account previous NHS Service.

5 Dr Jo Farrar, Chief Executive Officer from 1 June 2023, is seconded from the Ministry of Justice, and is a member of the partnership pension scheme, and as such, does not accrue benefits in the Civil Service Pension Scheme. The employer contributions to her partnership pension account, to the nearest £000, relating to the year were £27,000 (2023-24 for the period 1 June 2023 – 31 March 2024: £22,000 with full year equivalent: £26,000).

6 Deborah McKenzie, Chief People Officer until 27 September 2024, was seconded from UK Health Security Agency and was a member of the Civil Service Pension Scheme.

7 Paul O'Brien, Director of Blood Supply, was not a member of the NHS Pension Scheme. He left NHSBT on 3 November 2024.

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgement. The Public Service Pensions Remedy applies to individuals that were members or eligible members of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

Pension table figures explained

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

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

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2025.

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

Off-payroll engagements and their tax arrangements

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

Table 1: Off-payroll engagements as at 31 March 2025, for more than £245 per day	Number
Number of existing engagements earning £245 per day or greater as of 31 March 2025	**13**
Of which, the number that have existed:	
for less than one year at time of reporting	11
for between one and two years at time of reporting	1
for between two and three years at time of reporting	-
for between three and four years at time of reporting	-
for four or more years at time of reporting	1

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

Table 2: Off-payroll workers engaged at any point during the year ended 31 March 2025, earning £245 per day or greater	Number
Number of engagements earning £245 per day or greater, between 1 April 2024 and 31 March 2025	**21**
Of which, the number:	
not subject to off-payroll legislation	-
subject to off-payroll legislation and determined as in-scope of IR35	20
subject to off-payroll legislation and determined as out-of-scope of IR35	1
Number of engagements reassessed for compliance or assurance purposes during the year	-
Of which, the number of engagements that saw a change to IR35 status following review	-

Table 3: Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025	Number
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	-
Total number of individuals on-payroll and off-payroll that have been deemed 'board members, and/or senior officials with significant financial responsibility' during the financial year	22

Our approach to diversity and inclusion in our workforce

Investing in our people and culture is a strategic priority to ensure that we are a high performing and inclusive organisation, and is a matter the Board keeps under constant review.

Our Equality Diversity and Inclusion (EDI) Council is responsible for overseeing our commitment to develop an intentionally inclusive and anti-racist culture and organisation, and monitors the NHSBT equality objectives. It provides oversight of equality diversity and inclusion initiatives, and is responsible for steering and monitoring progress in improving employee morale and engagement. The EDI Council oversee the following EDI frameworks and regulations:

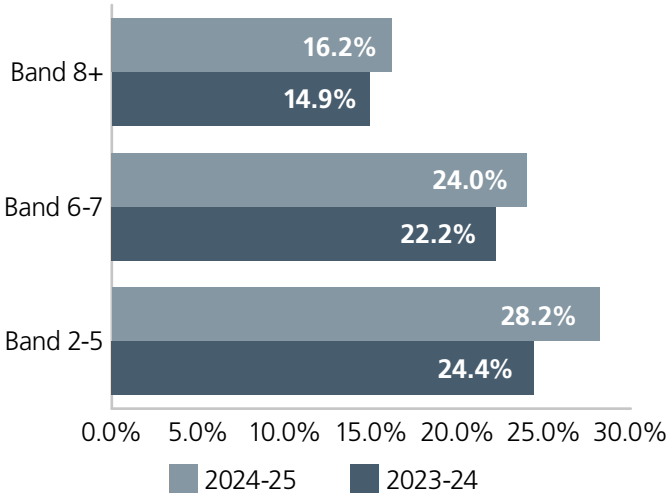
- Public Sector Equality Duty and Equality Objectives
- Equality Delivery System 2022
- Workforce Race Equality Standard
- Stonewall Workplace Equality Index
- Workforce Disability Equality Standard
- Gender Pay Gap reporting regulations

Our latest equality reports and information can be found on our website.

During 2024-25, we completed the first phase of the People and Culture Programme called Forward Together. This comprised three workstreams:

- Workstream 1 – co-creation and implementation of an anti-racism framework
- Workstream 2 – carrying out a review of our systems, processes and policies, linked initially to inclusive recruitment and retention
- Workstream 3 – to raise the awareness of intentional inclusion and anti-racism across our workforce, developing our colleagues' knowledge and providing applicable strategies and techniques to embed anti-racist and intentionally inclusive behaviours in everyday practice

Figure 1. Black and minority ethnic representation across paybands as a percentage of total workforce



Following the launch of Forward Together, we have seen an improvement in Black and minority ethnic representation across all pay bands. Figure 1 shows that the biggest increases in representation were seen among staff within Bands 2-5 (a 3.8 per cent point rise compared to 2023-24), with smaller improvements seen at Band 8 and above (up 1.3 per cent points year-on-year).

Figure 2. Sexual orentation across NHSBT as a percentage of total workforce

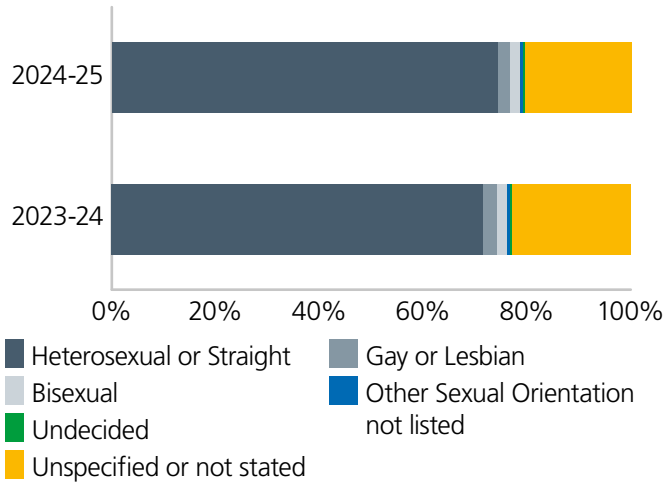


Figure 2 (above) shows the composition of the NHSBT workforce by stated sexual orientation. It is encouraging that the proportion of staff declaring their sexual orientation to the organisation increased from 76.9 per cent in 2023-24 to 79.5 per cent in 2024-25, suggesting progress in creating a more open and inclusive culture. We intend to build on this in 2025-26, supported by the work of our LGBT+ staff network (see page 28).

Disability Confident employer

We are recognised as a Disability Confident employer by the government's Disability Confident Scheme. Applicants for job vacancies are encouraged to be open so we can meet their needs and provide an inclusive experience. We operate a guaranteed interview scheme for those who meet the minimum criteria. Adjustments are regularly made in recruitment, in induction training, and throughout employment as required, and we have published our organisational Workplace Adjustments Policy. Support is also provided by Access to Work and our occupational health provider. We aim to improve the numbers of colleagues self-identifying their disability status, ensure adjustment needs are met, and that there is monitoring of career development and progression. We use feedback from our staff survey to monitor and track progress of disabled colleagues' working experiences and engagement. We continue to monitor and measure ourselves against the NHS Workforce Disability Equality Standard.

Figure 3. Proportion of NHSBT staff declaring as a percentage of total workforce

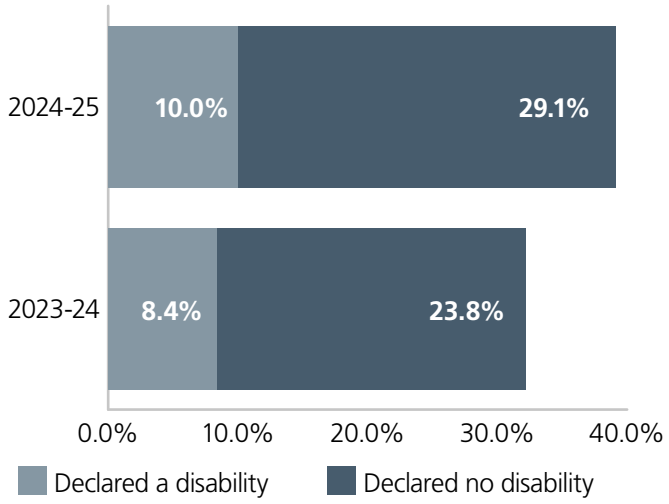


Figure 3 shows a rise in the percentage of NHSBT staff declaring a disability from 8.4 per cent in 2023-24 to 10.0 per cent in 2024-25. Although 60.9 per cent of NHSBT staff did not specify, did not declare or preferred not to answer last year, this proportion was slightly less than in the previous year (67.7 per cent) as we strive to encourage a more open and supportive environment around disability.

Gender pay gap

Our latest Gender Pay Gap Report (2024)[1] is available on our website. NHSBT employed 6,386 'relevant' staff members (including 12 directors) of whom 4,350 were female (of which seven were directors) and 2,036 were male (of which five were directors).

NHSBT's overall ratio of male to female employees is approximately 32:68, which is broadly in line with the ratio in the wider NHS. However, the ratio of male to female employees is 34:66 for the upper quartile of pay. Both these ratios remained the same as our previous report in 2023.

Our mean gender pay gap for ordinary pay has continued to reduce to 3.81 per cent from 5.04 per cent in 2023, which is significantly better than other public sector organisations, and well below the national average of 13.1 per cent (Office for National Statistics, 2024[2]). This means that for every £1 we pay to men we pay 96.19p to women. Our median pay gap for ordinary pay has reduced to 2.80 per cent from 3.57 per cent in 2023. In other words, for every £1 we pay to men we pay 97.19p to women.

[1] https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/35937/31957-0460tm-gender-pay-gap-report-2024.pdf

[2] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/genderpaygapintheuk/2024

Engagement

We completed our annual Our Voice survey in May 2024 using our Employee Experience Platform. Our engagement score remains above 7 (out of 10) at 7.2. Of the 14 drivers included within our 2024 survey, we saw an improvement in eight of these, with three staying the same compared to the benchmark of our 2023 survey. The overall improvement is attributed to directorate action planning focused on workload, enhanced speak-up opportunities including an expanded Freedom to Speak Up Service, dedicated directorate level EDI plans, the Forward Together Programme and the implementation of our new People Plan.

Organisationally, Growth and Development are identified as key priority areas for 2024-25, and a number of initiatives are in progress to raise awareness and signpost to opportunities. In addition, teams are able to access the data within the platform to identify and focus on their own priority.

People development

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

Apprenticeships

Our apprenticeship programme is an important way of attracting and retaining talented staff. It provides a wide range of structured training opportunities that combine on-the-job learning with classroom instruction to help people develop professionally.

We offer a wide range of apprenticeships, from level 2 to level 7, and across 51 programmes.

Over the last 12 months:

- 136 people are active 'in-learning' (70 new starts over the last 12 months)
- 16 people are in a break in learning, due to personal circumstances
- 15 people withdrew, due to either leaving the organisation or personal reasons.

The apprenticeship levy carry-over into 2025-26 is £2.6m.

Scientific and clinical training

We rely on a broad range of specialists with expertise across different scientific and clinical disciplines. In line with the People Plan, we help scientists in the organisation to 'join, stay and thrive'.

The training and support we provide for scientists within NHSBT and across the wider NHS enables us to continue to develop our workforce and the wider transfusion and transplantation community, creating scientists and leaders for the future.

During the year our Higher Specialist Scientist Trainees (HSST) Programme had 12 trainees (2023-24: 17) across four disciplines (H&I, transfusion, bioinformatics and virology) and five trainees (2023-24: three) qualified, becoming Consultant Clinical Scientists. We support a number of Clinical Fellows and actively support training of HSSTs and other colleagues hosted within the wider NHS.

We actively supported 158 other NHSBT learners through a selection of professional qualifications to achieve progress towards Biomedical Science Registration, and other learners including 20 biomedical scientist apprenticeships.

In addition, we supported many internal and external delegates in our scientific and transfusion medicine and pathology courses, in our role as one of the key providers of specialist transfusion training to the NHS:

- 973 delegates completed our science courses (compared to 581 in 2022 and 450 in 2023)
- the five-day Essential Transfusion Medicine course, was attended by 137 delegates (2023-24: 98 delegates), and is now a blended mixture of training packages and virtual classrooms, all accessed remotely
- our 15-day Intermediate Transfusion Medicine course, attended by 105 delegates (2023-24: 83 delegates), is now blended with 13 days online (a small number of packages with more in development and remote delivery) and two days face-to-face practical
- the five-day Practical Introduction to Transfusion Science course, 275 delegates (2023-24: 194 delegates), blended, with three days accessed remotely, and two days practical face-to-face
- a five-day RCPath Pre-Exam Revision course, with 156 delegates (2023-24: 153 delegates), which is delivered fully online
- a five-day Specialist Transfusion Science Practice course, attended by 137 delegates (2023-24: 113 delegates), with blended delivery, three days accessed remotely, two days practical face-to-face
- a one-day Advanced Transfusion Masterclass, 163 delegates (2023-24: 143 delegates).

In addition, we have re-launched our one-day Component Awareness course to support donor carers and employees from Blood Supply and 25 delegates have attended. We also reintroduced our one-day Basic Introduction to Transfusion Science and three online modules which have attracted 75 attendees. And we delivered transfusion / transplantation education talks to 416 attendees.

We operate an MSc in Applied Transfusion and Transplantation Science in partnership with the University of the West of England, and currently have 56 students across three cohorts studying towards this award. This course is maintaining its popularity and meets an NHS need.

During 2024-25, we have continued to support operational laboratories within NHSBT, with the successful development and delivery of cohort training of newly recruited Biomedical Scientists for the national network of Red Cell Immunohaematology laboratories. We assisted with the training of 208 scientists across two cohorts with excellent feedback from the participants involved.

It is also important we continue to raise the profile of NHSBT as an attractive place to work – and demonstrate that transfusion and transplantation, in particular, are exciting areas in which to build a career. One of the ways we are doing this is by increasing our outreach work. We have supported 23 Biomedical Science placement students on an 11-month placement (nine in the 2023-24 academic year and 14 in 2024-25), held six separate weeks of school age work experience for 28 different students at four different NHSBT centres, held school visits in Healthcare Science Week, along with face-to-face tours (mainly at Filton) for over 250 attendees, and run outreach events with schools and colleges and pathology network events reaching 3,550 attendees.

We have widened access to our virtual reality (VR) blood grouping software on the Meta apps store, with considerable interest from the transfusion community. We have continued to develop a combined VR package on blood identification and crossmatch. This is helping to increase the range of learning products available to staff and course participants, and raise the profile of transfusion science with college and school age students.

We developed an additional app for ABO blood grouping with a grant from the Institute for Biomedical Science, and received an accolade for the crossmatch VR app at an international award event. In addition, we have continued to create and maintain a catalogue of new online modules to complement our courses and widen access to transfusion education.

Leadership development

We have continued regular conferences for senior leaders to build our leadership community. These conferences provide an opportunity for the group to consider key organisational challenges and develop as a leadership group.

In recognition of the pressures that senior leaders face, our coaching faculty continues to provide coaching support for this group. The coaching offer has been refreshed this year to expand its reach, adding an online learning and collaboration tool to the resources available.

Middle manager leadership and management development

Throughout 2024-25, we continued to deliver a blended approach to developing all leaders and managers, both current and aspiring. This approach delivers a recognised standard for leadership and management skills and behaviours.

Our Leadership and Management Plan continues to improve the engagement, confidence and capability of middle managers across NHSBT, through the following initiatives:

- 77 aspiring and new managers engaged in the Edward Jenner management development programme
- 247 middle managers engaged in our Manager 101 and Art of Management programmes
- 408 leaders and managers engaged in our Open House for Leaders programme
- 700 leadership and management activities were accessed via the NHS Elect platform
- all new managers attended a manager induction within eight weeks of joining NHSBT.

Talent management and succession planning

Following the conclusion of the discovery work done into talent and performance at the start of 2024-25, we have used the insights gathered to progress this work throughout the rest of the year. This has resulted in the following:

1. **Performance management** – a new approach to performance being developed in collaboration with key stakeholders across the business. This brings together performance conversations, career conversations, wellbeing conversations and regular 1:1s, to enable colleagues to thrive at work. Following an initial pilot, we will be launching the new approach at the start of the 2025-26 year.
2. **Succession planning** – the initial work allowed us to start the conversation around talent and succession planning. There has been an initial focus on Executive Team roles, with emergency cover being identified and, towards the end of year, more conversations about longer-term succession plans. We have also started to identify business critical roles where succession plans may be needed. As we move into 2025-26, we are looking to further embed our approach to talent and succession planning across the organisation.

Health, safety and wellbeing

We have not achieved our harm incident reduction target for this year by 0.8 incidents per 1,000 employees. Blood Supply is focused on driving this down in the coming year. Details of health and safety incidents by directorate can be found on page 94.

Blood Donation has successfully implemented a mechanical tug to assist manual handling of cages on mobile sessions. This should reduce the number of serious musculoskeletal injuries on teams, help people on restricted duties take part in the unloading and loading of vehicles, and control their risk of injury. The project completed in March 2025 and was transitioned into business as usual, where the impact will be monitored at three and six months post implementation against accident figures in the coming financial year. Work has started at the National Health, Safety and Wellbeing Committee on our safety profile to identify improvements to the Health, Safety and Wellbeing management system.

We are pleased to see that all wellbeing scores in the annual Our Voice survey have increased for the second year in a row. Some scores now beat benchmarks for the sector, for example on stress.

Trade union relationships

NHSBT has a robust Partnership Framework with trade union colleagues underpinning a productive and effective approach to partnership working. Our directors and the Chief Executive meet with our lead representatives and full-time officers on a quarterly basis, and the Executive Team meets with them annually to share plans for the year ahead. This demonstrates our open and transparent approach and allows for earlier discussion and insight against our organisational strategic priorities.

NHSBT enables 97 (82.74 full-time equivalent) trade union representatives to carry out national consultation/partnership working duties. These representatives collectively spent 14,038 hours on these duties this year, reflecting the scale of change consultation within NHSBT and the geographic spread of employees. Please see opposite 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**
97	82.74

Percentage of time spent on facility time	
Percentage of time	**Number of employees**
0%	6
1-50%	83
51-99%	2
100%	6

Percentage of pay bill spent on facility time	
Description	**£000**
Total of cost facility time	336
Total pay bill	328,253
Percentage of the total pay bill spent on facility time	0.10%

Paid trade union activities	
Time spent on trade union activities as a percentage of the total paid facility time hours	41%

Accountability report – corporate governance

The Directors' Report

Our Board

The Board provides leadership and sets the tone for the organisation. As a unitary board, the non-executive directors share responsibility with the executive directors for ensuring that resources are in place to meet the objectives set. Our Board brings a diversity of skill, experience, and approach, which underpins our decision-making.

Board Members who served during the reporting year and up to the date of signing the accounts:

Our Non-Executive Directors

Peter Wyman

Peter brings a wide breadth of skills and experience to the board having held a range of senior posts in the private, public, and voluntary sectors. He was a partner at PricewaterhouseCoopers LLP until 2010, and President of the Institute of Chartered Accountants in England and Wales from 2002 to 2003. In the health sector, he served as Chair of Yeovil District Hospital NHS Foundation Trust from 2011 to 2016, and as Chair of the Care Quality Commission (CQC) from 2016 to 2022 before joining NHSBT. He was awarded a CBE in 2006 for services to the accountancy profession.

Piers White (until 17 February 2025)

Piers has held a number of executive roles in financial services, including with Barclays UK and Flemings. He was awarded an MBE for public service in 2009. Piers brings over 20 years' experience as a non-executive director and Chair of a variety of public purpose organisations.

Professor Charles Craddock

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

Rachel Jones

Rachel brings an extensive breadth of executive and board level experience in strategy, digital, transformation, and data and technology, taking a long term, commercial and health equality view. Previously an IBM and Deloitte management consultant, she has shaped and led global teams of scale in financial services, sporting events, academia, and retail. Rachel is also a non-executive director with the Northern Care Alliance Foundation Trust.

Caroline Serfass

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

Professor Lorna Marson

Lorna is Professor of Transplantation and Head of Deanery of Clinical Sciences at the University of Edinburgh. She is also an Honorary Consultant Transplant Surgeon at the Royal Infirmary of Edinburgh, and continues to contribute clinically to the renal transplant programme. She is past-President of the British Transplantation Society, and was Associate Medical Director, Research and Development, Organ and Tissue Donation and Transplant, until she took up post as a non-executive director of NHSBT in March 2024. She has recently been made a Fellow of the Royal Society of Edinburgh.

Penny McIntyre

Penny is currently Global Director of HR for Heriot Watt University, and her previous roles include HR Director for Fibre Network Delivery at Openreach, and HR Director of Infrastructure Projects at Network Rail.

Ian Murphy

Ian is Chief Operating Officer at IBC Buying Group and previous roles have included Trading Director at Travis Perkins and Chief Financial Officer at Copart and Jessops.

Our Associate Non-Executive Directors

Associate Non-Executive Directors are appointed by the Board, and the role can be on a voluntary or a remunerated basis. They sit on the Board, and Board committees, but are not legal directors and do not have voting rights. Their role helps in achieve a balance of board level skills, bringing additional expertise and diversity.

Bella Vuillermoz (until 2 July 2024)
Bella is an experienced senior leader with 25 years' experience, having worked at two FTSE100 companies, Marks & Spencer and Sky, as well as in City consultancy. She brings broad business experience, having led strategy, communications, sustainability, diversity and inclusion, commercial and operational areas.

Stephanie Itimi (until 5 June 2025)
Stephanie has a wealth of experience in cybersecurity, and has worked with the BBC World Service, the Home Office, and many other national and international organisations. She is the founder of Seidea, a community interest company addressing underrepresentation of women from ethnic minority backgrounds in cybersecurity.

Nicola Yates
Nicola is an experienced commercial leader, with a proven successful performance track record. She has led large businesses across Europe, most recently in her last role at pharmaceutical company GSK where she was Senior Vice President leading the P&L for 29 countries in Europe. She currently works as a Strategic Consultant working across healthcare industries.

Our Executive Directors

(* denotes voting member of the Board)

Dr Jo Farrar*
Chief Executive Officer (until 30 June 2025)
Jo is an experienced public servant and chief executive whose early career was spent in the Home Office, undertaking work around public service reform. In 2019 she was promoted to Chief Executive HM Prison and Probation Service, responsible for delivering prison, probation and youth custody services in England and Wales, before becoming the Second Permanent Secretary at the Ministry of Justice in March 2021.

Caroline Walker*
Interim Chief Executive Officer (from 1 July 2025)
Caroline is a highly experienced NHS leader. Most recently Caroline has been Interim Chief Executive Officer for the Trust group including Walsall Healthcare and the Royal Wolverhampton, whilst a permanent Chief Executive was being appointed. She was previously Chief Executive of North West Anglia Foundation Trust which she retired from in 2023, and prior to that has worked for the University Hospitals of Leicester NHS Trust, Great Ormond Street Hospital Foundation Trust and Barts Health NHS Trust. Caroline has also been Chief Operating Officer at Loughborough University. Caroline has operated at board level for 25 years and has a track record of improving patient care and developing high performing teams.

Wendy Clark*
Deputy Chief Executive Officer
Wendy is an experienced strategy, transformation and technology leader who has worked across the private and public sectors and multiple industries. Wendy joined NHSBT from NHS Digital where she was the Executive Director of Product Development, and before that held Executive Director roles in National Security. The initial part of Wendy's career was in the private sector leading technology change for organisations such as BP, Thomson Reuters and Astra Zeneca. Wendy has experience working as a trustee in the charity sector, including as Chair of the Board of Trustees at Breast Cancer UK.

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

Deborah McKenzie*
Chief People Officer (until 27 September 2024)
Deborah joined us from Public Health England where she was Chief People Officer. She has experience developing and implementing leadership programmes for the Department of Health. As an associate partner with Accenture, she led a number of large-scale change programmes. Deb was also Senior Responsible Officer for the Public Health Reform consultation, leading a transfer of 11,500 colleagues to the new UK Health Security Agency.

Dr Gail Miflin*
Chief Medical Officer and Director of Clinical Services
Gail is a Haematology Consultant and NHSBT's Chief Medical Officer. She previously worked at the Royal Free Hospital and University College London Hospitals for ten years, specialising in treating people with sickle cell disorder and thalassaemia. In NHSBT she also leads the pathology team who are looking at how best to provide genotyped blood for people with haemoglobinopathies, to reduce the complication of alloimmunisation. She leads NHSBT's cellular, apheresis and gene therapy services and is sponsor, on behalf of the Department of Health and Social Care, for the UK Stem Cell Strategic Forum. She was awarded an OBE in 2025 for services to blood and plasma.

Anthony Clarkson*
Director of Organ and Tissue Donation and Transplantation
A Registered Nurse with over 30 years' NHS experience, Anthony is a transformational leader who has held a number of roles across the organisation, including leading the creation of NHSBT as the UK's Organ Donation Organisation. In 2018 Anthony was awarded Health Service Journal Clinical Leader of the Year, and he was made a Fellow of the Royal College of Nursing in 2020.

Professor Denise Thiruchelvam (*from 30 July 2024)
Chief Nursing Officer
Denise joins NHSBT as an accomplished Chief Nursing Officer (CNO). Her progressive leadership experience includes serving as CNO, Director of Quality, and Director of Infection Prevention and Control (DIPC) for CSH Surrey (a social enterprise) since 2019. During this time, she also held the roles of Executive Lead for Quality and Assurance for the North West Surrey Alliance and Executive Director of Quality for Children and Family Health Surrey (CFHS). Earlier in her career, Denise worked nationally for England's CNO and gained public health expertise within the Health Protection Agency (now UKHSA), NHS commissioning, and local authorities.

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

Gerry Gogarty
Director of Plasma for Medicines
Experienced in transformation, strategy and operations, Gerry has held a number of leadership roles across manufacturing, collection, business transformation and marketing. Prior to joining NHSBT, Gerry led the commercialisation of several local government functions.

Paul O'Brien
Director of Blood Supply (until 3 November 2024)
Paul joined us after a long career with Procter & Gamble in a variety of manufacturing and quality roles. He has worked in multiple countries across the globe, where he has developed a wealth of supply chain and leadership experience.

Rebecca Tinker
Chief Digital and Information Officer
Rebecca joined as a director in 2020, having previously spent her career working in strategy and transformation leadership roles for global brands in retail and leisure industries specialising in digital and commercial change.

Julie Pinder
Chief People Officer (from 23 September 2024)
Julie is an experienced HR leader who has worked across the private and public sector, most recently as the Chief People Officer for NHS Digital. Prior to this, Julie was HR Director for the Department of Work and Pensions, where she spent 15 years working across a range of HR roles, with a focus on transformation programmes and driving employee engagement and cultural change.

Antony Tiernan
Director of Communications and Engagement (from 16 September 2024)
Antony is an award-winning Director of Communications who served over 20 years in the NHS, including at Guy's and St Thomas' NHS Foundation Trust and London Ambulance Service. Antony also served as a Director of Communications at NHS England, leading on a range of major initiatives, including the NHS's 70th and 75th anniversaries in 2018 and 2023 respectively. He most recently led communications for the London Fire Brigade and is a Trustee of the national charity, NHS Charities Together.

Mark Chambers
Deputy Director of Donor Experience (to 2 May 2024),
Director of Donor Experience (from 3 May 2024)
Mark has been a director in government bodies and government-funded organisations, and successfully ran his own marketing agency. He has delivered high profile, multi-million pound campaigns, is a Chartered Marketer, a Fellow of the Chartered Institute of Marketing, and holds a master's in marketing. Mark is also a non-executive director for a leisure company and has held a similar role for a charity.

Directors leaving in the year

Bella Vuillermoz, Associate Non-Executive Director, served on the Board until 2 July 2024.
Deborah McKenzie, Chief People Officer, served on the Board until 27 September 2024.
Paul O'Brien, Director of Blood Supply, served on the Board until 3 November 2024.
Piers White, Non-Executive Director and Senior Independent Director, served on Board until 18 February 2025.

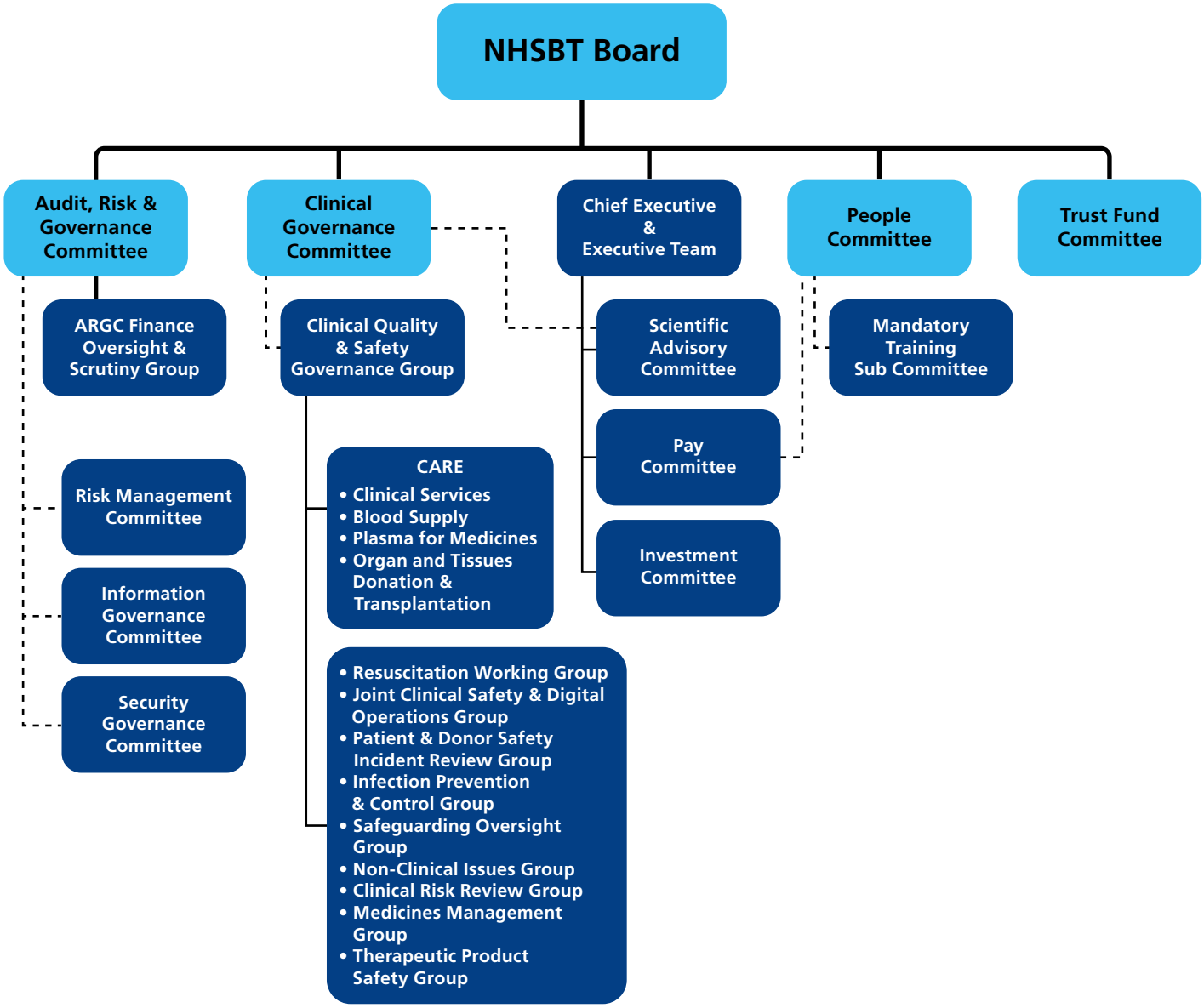
Details of the remuneration of senior managers of NHSBT can be found in the Remuneration and Staff Report at pages 49 to 65. A full register of interests, updated each year, is available from the NHSBT website here: http://www.nhsbt.nhs.uk/who-we-are/transparency/accounts/board-expenses-and-interests/

Our governance structure

The Board oversees the strategic direction and the delivery of objectives, and ensures that the core purpose and values of the organisation are upheld. It provides leadership and sets the tone for the organisation. As a unitary board, the non-executive directors share responsibility with the executive directors for ensuring that resources are in place to meet the objectives set.

The Board is supported by four committees to discharge its duties effectively, and each Committee is chaired by a non-executive director with relevant experience and qualification.

The governance structure is shown below:



The Board

Chair: Peter Wyman

The Board is led by a Non-Executive Chair, and is composed of six other Non-Executive Directors (NEDs), six voting Executive Directors, six non-voting Executive Directors, and two non-voting Associate NEDs.

The Board developed a skills and capability matrix to determine the composition of the Board and the experiences required for leading the organisation. This is to ensure that the Board is balanced and has the skills needed to meet the objectives of NHSBT. The NEDs are appointed by DHSC, and currently our NEDs have a wide range of experience including transplantation, human resources, governance, strategy, finance, and technology. All directors have declared their interests at public meetings of the Board. The Register of Interests is available on the NHSBT website (https://www.nhsbt.nhs.uk/who-we-are/our-board/). The Board reviews its effectiveness annually against best practice criteria. An externally facilitated review is undertaken every three years.

The Board met six times in the past year, including one extraordinary meeting of the Board. The NEDS also meet regularly without the Executive Directors present.

Attendance was as follows:

Name	Title	Total attended /Total possible
Peter Wyman	Chair	6/6
Caroline Serfass	Non-Executive Director	5/6
Professor Charles Craddock	Non-Executive Director	3/6
Piers White (to 17 February 2025)	Non-Executive Director	5/5
Rachel Jones	Non-Executive Director	4/6
Ian Murphy	Non-Executive Director	5/6
Professor Lorna Marson	Non-Executive Director	4/6
Penny McIntyre	Non-Executive Director	5/6
Stephanie Itimi	Associate Non-Executive Director	4/6
Bella Vuillermoz (to 2 July 2024)	Associate Non-Executive Director	0/1
Nicola Yates	Associate Non-Executive Director	4/6
Dr. Jo Farrar	Chief Executive Officer	6/6
Wendy Clark	Deputy Chief Executive Officer	6/6
Anthony Clarkson	Director of Organ and Tissue Donation and Transplantation	6/6
Carl Vincent	Chief Financial Officer	5/6
Deborah McKenzie (to 27 September 2024)	Chief People Officer	3/3
Dr. Gail Miflin	Chief Medical Officer and Director of Clinical Services	4/6
Professor Denise Thiruchelvam	Chief Nursing Officer	6/6
Gerry Gogarty	Director of Plasma for Medicines	6/6
Helen Gillan	Director of Quality and Governance	5/6
Paul O'Brien (to 3 November 2024)	Director of Blood Supply	3/3
Rebecca Tinker	Chief Digital and Information Officer	6/6
Julie Pinder (from 23 September 2024)	Chief People Officer	4/4
Antony Tiernan (from 16 September 2024)	Director of Communications and Engagement	4/4
Mark Chambers	Director of Donor Experience	6/6

Audit, Risk and Governance Committee

Chair: Piers White to 17 February 2025
Ian Murphy from 18 February 2025

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

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

The Committee is comprised of three Non-Executive Board Members, one Associate Non-Executive Board Member, and additionally, an independent Non-Executive Member from a source outside of the Board to ensure an appropriate level of skills and experience. To retain independence, the NHSBT Chair is not a member of the Audit, Risk and Governance Committee, although he has attended one meeting during the year as an observer. This complies with section 3.2 of the HM Treasury Audit and Risk Assurance Committee Handbook. The Committee Chair is appointed by the Department of Health and Social Care and has recent and relevant financial experience.

Executive Directors attend meetings of the Committee at the request of the Committee Chair. The Chief Financial Officer is the Lead Executive, and the Chief Executive Officer, Chief Nursing Officer, Chief Digital Information Officer and Director of Quality and Governance regularly attend meetings. Other Executive Directors and management staff are invited to attend meetings, to present to the Committee on specific areas of risk or operation that are within their area of responsibility. Representatives from the internal and external audit organisations attend each meeting. The Local Counter Fraud Specialist also attends the meeting to present the annual plan, quarterly updates, and the annual report on counter fraud.

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

Member	Title	Total Attended /Total Possible
Piers White	Non-Executive Director	6/6
Rachel Jones	Non-Executive Director	5/7
Ian Murphy	Non-Executive Director	6/7
Nicola Yates	Non-Executive Director	6/7
Niamh McKenna	Independent Non-Executive Member	7/7

Significant issues considered by the Committee during the year related to:

- a review of the Board Assurance Framework to provide a clearer overview of the strategic risks facing the organisation, any gaps in controls or assurance and the actions being taken to manage these risks or any gaps in controls or assurance including planning for, and follow-up from, the Board Risk Workshop held during the year
- deep dive reviews of principal risks within its remit, and receipt of assurance from the Clinical Governance Committee and People Committee in relation to the deep dives undertaken by them
- reviews of supplier management gaining assurance on measures in place and future direction
- reviews of key governance, finance, and risk management policies leading the establishment of a new form of Board Level Policies
- review of the Annual Report and Accounts for 2023-24, including the Governance Statement, and recommending the final draft to the Board
- the going concern assumption was examined and recommended for approval
- internal audit annual plan, reports and follow up reports on recommendations, and the internal auditors annual audit opinion that has moved from 'limited' to 'moderate' rating for the 2024-25 year

- monitoring of the completion of internal audit management actions in response to GIAA recommendations, seeing a marked improvement during the year, resulting in no overdue actions as year end
- review of clinical, quality assurance, regulatory and supplier audit plans and receipt of the Management Quality Review reports
- external audit plan, regular updates on progress, review of the external auditors' report, approval of external audit fees and monitoring of audit recommendations
- updates from the local counter fraud specialist, and in relation to losses and special payments, waivers and debt management
- monitoring progress in the Corporate Governance Improvement Programme, including progress in complying with Government Functional Standards and development of assurance mapping with all areas of the organisation mapped by year end, and completion of management actions from corporate governance audits and effectiveness reviews
- business continuity and disaster recovery
- the Data Security and Protection Toolkit Plan, and overall security (cyber, physical and people)
- indemnity cover and financial risk across NHSBT areas of operation
- via its Finance Oversight and Scrutiny Sub-Group, review of NHSBT's financial planning and performance against budget, business plan and strategy
- review of the Committee's effectiveness and gap analysis against delegations from the Board and consideration of the skills and capabilities required for the Committee.

Clinical Governance Committee

Chair: Professor Charles Craddock
to 17 February 2025
Professor Lorna Marson
from 18 February 2025

The Clinical Governance Committee is established by the Board of NHSBT with powers and responsibilities delegated to it within the NHSBT Standing Orders, Schedule of Delegations and its Terms of Reference.

The purpose of the Committee is to provide assurance to the Board that there is a robust framework for the management of all critical clinical systems and processes. This is a framework through which NHSBT is accountable for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. It sets the tone and direction for patient/donor safety, clinical effectiveness, patient outcomes and patient/donor experience and supports the organisation in the development, implementation and monitoring of robust frameworks for clinical governance.

This Committee is comprised of voting and non-voting members. Independent Non-Executive Directors with clinical experience and the Executive Directors with responsibility for nursing and medical/clinical services are voting members. The Director of Quality and Governance, Director of Plasma for Medicines, Director of Blood Supply and Director of Organ and Tissue Donation and Transplantation are non-voting members of the Committee.

Other Executive Directors and management staff are invited to attend meetings to present information on specific areas of risk or operation that are within their area of responsibility. The Chief Nursing Officer is the Lead Executive.

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

Name	Title	Total Attended /Total Possible
Professor Charles Craddock	Non-Executive Director	4/5
Professor Lorna Marson	Non-Executive Director	3/5
Professor Denise Thiruchelvam	Chief Nursing Officer	4/5
Dr. Gail Miflin	Chief Medical Officer and Director of Clinical Services	4/5
Helen Gillan	Director of Quality and Governance	5/5
Gerry Gogarty	Director of Plasma for Medicines	3/5
Anthony Clarkson	Director of Organ and Tissue Donation and Transplant	4/5
Paul O'Brien (to 3 November 2024)	Director of Blood Supply	1/3

Significant issues considered by the Committee during the year related to:

- monitoring of discussions and plans following the clinically facing findings and recommendations of the Infected Blood Inquiry
- the implementation of Patient Safety Incident Response Framework (PSIRF)
- patient and donor safety incident investigations
- review of manual processes and prioritisation of clinical records to curb data privacy incidents and reports following the London hospitals cyber-attack in summer 2024
- approval of the clinical audit plan and monitoring of progress against this, ensuring any action and response on recommendations
- deep dives into principal risks that fall within the remit of the Committee i.e. P-01 Donor and patient safety, and P-06 Clinical outcomes and health inequalities
- consideration of significant issues escalated from the Clinical Quality and Safety Governance Group including review of reports from CARE Groups
- review of the following annual assurance reports: Organ and Tissue Donation and Transplantation Biovigilance, Serious Hazard Of Transfusion, Safeguarding, Joint NHSBT/PHE Epidemiology, Medical Revalidations, Data Security and Information Governance, Privacy and Records Management, Infection Prevention and Control, Serious Incident and Never Events, Clinical Claims, Non Clinical Issues, Hepatitis E Virus Screening, Research and Development, Workforce and Therapeutics and Product Safety and Mandatory Training of Clinical Workforce
- approval of relevant policies
- review of the Committee's effectiveness and gap analysis against delegations from the Board and consideration of the skills and capabilities required for the Committee.

People Committee

Chair: Caroline Serfass

The People Committee is established by the Board of NHSBT as a non-executive committee of the Board with powers and responsibilities delegated to it within the NHSBT Standing Orders and its Terms of Reference.

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

This Committee is comprised of independent Non-Executive Directors. Executive Directors attend meetings of the Committee at the request of the Committee Chair. The Chief People Officer is the Lead Executive, and the Deputy Chief Executive Officer regularly attends meetings. The Director of Plasma for Medicine was a regular attendee until December 2024. From February 2025 the Chief Nursing Officer is a regular attendee. Other Executive Directors and management staff are invited to attend meetings, to present on specific areas within their area of responsibility.

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

Names	Title	Total Attended /Total Possible
Peter Wyman	Chair NHSBT	4/4
Caroline Serfass	Non-Executive Director	4/4
Penny McIntyre	Non-Executive Director	4/4
Lorna Marson (from 30 July 2024)	Non-Executive Director	3/3

Significant issues considered by the Committee during the year related to:

- determining the remuneration of individuals in substantive Executive Senior Manager posts in line with parameters and guidance set by DHSC, and approval of declarations in the Annual Report
- consideration of Board and Executive succession planning and talent management
- approval of the process for recruitment of, and endorsement of appointments to, Executive Director roles
- review of the Fit and Proper Persons Regulations (FPPR) Policy and assurance of application
- oversight of delivery of phase one of Forward Together programme and Anti-Racism Framework
- review and approval of reports, ahead of publication, in relation to Workforce Disability Equality Standard, Workforce Race Equality Standard, Gender Pay Gap, Ethnicity Pay Gap and Public Sector Equality Duty
- discussion of underlying themes and trends in health, safety and wellbeing
- review of mandatory training compliance
- review of organisational views through trends in Freedom To Speak Up cases; disciplinary, grievance and resolution cases; and Our Voice Survey findings
- monitoring of progress in delivery of the People Plan and review of the Workforce Dashboard
- principal risk deep dive reviews of P-07 Staff capacity, capability, recruitment and retention and P-08 Managers and leaders' skills and capabilities
- review of the Committee's effectiveness and gap analysis against delegations from the Board and consideration of the skills and capabilities required for the Committee.

Trust Fund Committee

Chair: Penny McIntyre

The Trust Fund Committee is established by the Board of NHSBT as a joint non-executive/executive committee with the powers and responsibilities delegated to it within the Trust Deed, NHSBT Standing Orders, Schedule of Delegations, the NHSBT Standing Financial Instructions and its Terms of Reference.

The purpose of the Committee is to administer the funds which are donated to the NHSBT Trust Fund, ensuring that they are kept distinct from the funds of NHSBT, and are used effectively to further the interests of the Authority, its staff, blood donors and other bodies and persons with whom NHSBT has a relationship as part of the NHS in England and Wales. The Committee is responsible for ensuring compliance with the requirements of the regulations applicable to charities in England and Wales, and any requirements or restrictions attached to funds received. The Committee is responsible for the development of the Trust Fund's funding strategy and oversight of its implementation and fundraising activities.

This Committee is comprised of both independent Non-Executive Director and Executive Director members. Other Executive Directors and management staff are invited to attend meetings, to present on specific areas within their area of responsibility. The Chief Financial Officer is the Lead Executive.

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

Members	Title	Total Attended / Total Possible
Penny McIntyre	Non-Executive Director	4/4
Rachel Jones	Non-Executive Director	3/4
Carl Vincent	Chief Financial Officer	3/4
Deborah McKenzie (to 27 September 2024)	Chief People Officer	0/1
Antony Tiernan (from 26 November 2024)	Director of Communications and Engagement	1/2

Significant issues considered by the Committee during the year related to:

- approval of the 2023-24 Annual Report and Accounts
- approval of the 2024-25 Annual Budget
- review of quarterly finance reports outlining the financial position and activities
- receipt of reports detailing progress on active Trust Fund supported projects (research and development, wellbeing, and professional nurse advocate grants)
- review of the Trust Fund Deed, Reserves Policy, Procedures and Guidelines
- consideration of strategic proposals to grow the Trust Fund
- review of the Committee's effectiveness and gap analysis against delegations from the Board and consideration of the skills and capabilities required for the Committee

Statement of Accounting Officer's Responsibility

Under section 29A of the National Health Service Act 2006, the Secretary of State for Health and Social Care has directed NHS Blood and Transplant to prepare a statement of accounts for each financial year in the form and on the basis set out in the Accounts Direction. The accounts must give a true and fair view of the state of affairs as at the end of the financial year, and the expenditure and income, total recognised gains and losses, and cash flows during the year.

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

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

The Principal Accounting Officer of 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 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.

Accountability 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 and 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 DHSC and our accountabilities to them are described in a Framework Agreement. Our Directions and the Framework Agreement are published on our website here: https://www.nhsbt.nhs.uk/who-we-are/transparency/policies-and-regulations/.

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. These include the duty for improvement in quality of services, which we address across all of our governance structures; duties towards research, education and training, all of which NHSBT undertakes for the betterment of our expert workforce and the services we are able to provide now and in the future for patients and service users; and the duty as to the NHS constitution.

Our business planning aligns with the DHSC Outcome Delivery Plan and the Secretary of State for Health and Social Care's priorities. To this end, NHSBT continues to play a vital role in supporting reductions in waiting times for emergency, cancer and elective treatments through the provision of blood components underpinned by a stronger donor base and modernised operations. We remain committed to enhancing financial efficiency, supporting NHS provider organisations in meeting cost-saving and productivity targets.

We also have a role in transforming healthcare through Change NHS: helping to build a health service fit for the future.

In October 2024, the Government launched a public engagement exercise asking people and organisations to share their experiences, views and ideas to help shape a 10 Year Health Plan for England. We aim to position ourselves at the heart of the government's thinking as a key enabler of the NHS's success. We are focused on influencing these health plans in four key areas:

1. systemic changes that shift the dial on reducing the organ and tissue transplant waiting list
2. a transformation in the way we speak to the public about donation
3. support for more innovation – we can create new treatments and services at scale for NHS patients and help the UK to become more self-sufficient in blood and tissue products
4. NHS-wide interoperability on blood supply to increase efficiency, productivity, safety and resilience.

You can read more about these plans in our response to the 10-Year Health plan (https://www.nhsbt.nhs.uk/who-we-are/transparency/10-year-health-plan/), which are aligned to our organisational Strategy and Business Plan for 2025-26.

Governance structure and assurance processes

Our governance structures and assurance processes are reviewed regularly by the Audit, Risk and Governance Committee (ARGC), to ensure that NHSBT's statutory and strategic objectives can be met, and that its internal controls and risk management processes remain effective. The key assurance strands are described further over the following pages.

Board arrangements

Information on our Board and its Committees is set out from page 74.

The Board Assurance Framework

The Board Assurance Framework (BAF) is used to refer to the document that brings together relevant information regarding the principal risks which influence the achievement of the Board's strategic priorities.

The BAF allows the Board to:

- maintain visibility and awareness of the principal risks faced by the organisation which could influence the delivery of strategic objectives
- understand the extent of the risk exposure (residual score) and the activity being undertaken to effectively manage the risks within the risk appetite levels agreed by the Board
- gain assurance that there are effective controls in place to manage the risk(s), including their appropriateness and effectiveness
- understand that in situations where weaknesses in controls exist, there are remedial actions in place to address these.

Responsibility for the production and maintenance of the BAF is held by the Corporate Risk Team.

Further details of our principal risks, and our assessment of their status, can be found in the 'Our principal risks' section on page 47.

Board effectiveness review

In line with corporate governance best practice, the Board has determined that externally facilitated reviews of its effectiveness, and the effectiveness of its committees, will be undertaken every three years, with internal reviews undertaken in the two intervening years.

Following two years of internal reviews, BDO LLP were engaged in 2024 to undertake an external review of board effectiveness, with their findings being presented to the Board at a seminar session in January 2025, and formally at their meetings on 1 April 2025. The review included a gap analysis against the 'Corporate Governance in Central Government Departments Code of Good Practice'.

The review found that overall, the structure, governance framework and arrangements in place at NHSBT support effective governance. BDO noted that NHSBT had some significant challenges in this area historically and has worked diligently to effect the changes necessary to address prior governance weaknesses and issues. In some areas, these improvements are still maturing, but solid foundations have been established, and good progress towards improvement has been made. Whilst the Board governance was generally effective, BDO's assessment highlighted some areas where further enhancements to approaches and thinking would be of benefit to the Board and, as a result, the organisation as a whole.

The findings have been considered by the Board and its committees, and actions determined to be beneficial in achieving continuous improvement of the Board's effectiveness are being agreed and will be tracked to ensure completion. The areas under consideration relate to strategy and ambition, succession planning and development, the size of the board and the structure of public board meetings.

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 receive a monthly performance report, which is received by Board on alternate months, coinciding with its meeting calendar (papers for which are published on our website here: https://www.nhsbt.nhs.uk/who-we-are/transparency/board-meetings-and-papers/). The content of this report is reviewed periodically to ensure that it provides sufficient information and assurance to the Board.

Delegations

NHSBT's sponsor department, the DHSC, issued updated delegations on 6 September 2024, which were duly implemented. NHSBT is designated as a Public Corporation by the Office for National Statistics and, unless otherwise covered by the delegations issued to us by DHSC, the spend control requirements relevant to Public Corporations are applicable.

Clinical governance

We are committed to ensuring that every patient, donor and family can have confidence in the safety of NHSBT services. This includes implementing strengthened safety procedures and testing protocols in direct response to the findings of the Infected Blood Inquiry.

The Chief Nursing Officer is the responsible director for clinical governance and safety.

During 2024-2025 the clinical governance structures have undergone transformation in line with the implementation of the Patient Safety Incident Response Framework. This has been a phased approach with a focus on undertaking incident investigations using systems methodologies.

The Clinical Governance Committee (CGC), which has been chaired by Non-Executive Director Professor Charles Craddock, has overseen the transformation planning which has culminated in the development of an organisation policy for Patient and Donor Safety Incident Management and an associated response plan.

The CGC, as a sub-committee of the NHSBT Board, oversees all matters relating to clinical governance. The committee met bi-monthly, and reviews reports and updates from directorate Clinical Audit, Risk and Effectiveness (CARE) groups embedded within four clinical operational directorates (Clinical Services, Blood Supply, Plasma for Medicine and Organ and Tissue Donation and Transplantation), seeking assurances and providing recommendations proportionately as required. The transformation activities have included the introduction of the Clinical Quality and Safety Governance Group (CQSGG) chaired by the Chief Nursing Officer.

The group has met bi-monthly prior to CGC. An integrated report which summarises the reports received has been developed, and through a focused approach has brought improvement to the oversight and assurance of clinical governance and patient and donor safety through CGC.

Clinical governance activity includes:

- reviewing of Corporate and Directorates' clinical risks, actions and mitigations
- reviewing of Never Events, Patient Safety Incident Investigations and other incidents involving patients, donors, and staff, ensuring that investigations are appropriate, proportionate and learning is shared
- reviewing of clinical audit policy, plans, reports and actions
- reviewing of clinical workforce data including training compliance
- ensuring compliance with national guidance, alerts and standards
- reviewing data collection and reporting on infectious diseases in collaboration with the UK Health Security Agency (UKHSA)
- reviewing data collection and reporting on transfusion complications
- reviewing data collection and monitoring of organ data to ensure equity of access, optimise the use of organs and monitor the outcomes of transplantation
- working with other health professionals, DHSC and specialist advisory groups to oversee organ allocation policy
- 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.

Approach to Patient Safety Incidents Investigations including Never Events

On 3 June 2024 NHSBT transitioned to the Patient Safety Incident Response Framework (PSIRF). The PSIRF replaced the Serious Incident Framework (2015). The PSIRF recognises that patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could or did cause harm. By removing the serious incident threshold, the PSIRF promotes a proportionate approach to responding to incidents and aims to embed patient safety incident response within a wider system of improvement. The PSIRF requires organisations to identify their own response plan based on their patient safety incident profile alongside the national mandated Patient Safety Incident Investigation (PSII) requirements including Never Events.

A PSII is undertaken when an incident or near-miss indicates significant patient or donor safety risks, or potential for new learning. The incident types identified by NHSBT are defined within the NHSBT Patient and Donor Safety Incident Response Plan which has been published alongside the PSIRF policy on the NHSBT website. The investigative method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

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

All incidents are formally investigated. Any potential PSIIs are discussed by a multidisciplinary team at the weekly Patient and Donor Safety Incident Review Group. Each incident is also reviewed at Directorate level and within Clinical Audit, Risk and Effectiveness (CARE) groups, as well as the organisation-wide Clinical Quality and Safety Governance Group (CQSGG) and Clinical Governance Committee (CGC). All PSIIs are approved by the Chief Medical Officer (CMO), Chief Nursing Officer (CNO) and Director of Quality and Governance.

We embrace our responsibility for learning when things go wrong and are committed to embracing the principles of the PSIRF by compassionately engaging with all those involved in a PSII, including staff, patients and donors. In addition, the Freedom to Speak Up service is also available to promote an open, trusting culture in NHSBT, and is another safe and confidential route to let the organisation know when something is not right.

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

Patient Safety Incident Investigations (PSII) including Never Events

PSIIs were introduced on 3 June 2024 and replaced the previous Serious Incident Framework.

During 2024-25, there were eight PSIIs, none of the incidents met the Never Event criteria or the NHS England national criteria for a PSII (compared to zero Never Events and six Serious Incidents in 2023-24).

Details of the PSIIs are as follows:

1. In July 2024, a sample error took place in one of the cellular molecular therapy laboratories, resulting in the administration of unnecessary medication to a healthy stem cell donor. No harm came to the donor. The investigation has strengthened practice relating to sample labelling, and a colour-coded pipette system has been introduced to support the BMS staff. There have also been improvements to the documentation of telephone communication between laboratories and hospitals.
2. Also in July 2024, it was found that corneas had been released for clinical use without sufficient serological results, following a potential sample mix up between two tissue donors. No adverse effects on the recipients have been reported. A full investigation was carried out and although it was not possible to identify how results were issued, five themes of system focused improvement were identified: the process of requesting an additional sample, the variability of personal identifiable data (PID), interoperability of IT systems, unclear courier process, and receipt of samples at the Colindale site. Shared learning has identified common themes, and the scope of improvement actions has increased, including a plan for a multi-stakeholder continuous improvement event at Colindale focused on sample handling.
3. A third incident in the same month involved a patient requiring treatment delivered by the Therapeutic Apheresis Service (TAS) team. It was identified during treatment that there was suboptimal communication of clinical information that impacted the patient's treatment plan. The patient sadly died of an intracranial haemorrhage unrelated to the treatment provided. A joint multidisciplinary investigation has been completed with the hospital. The investigation is complete, and improvements include changes to the referral forms and handover documentation, as well as improved access to the electronic patient records at the hospital for TAS nurses. The final investigation report is pending Director's approval.

4. In October 2024, it was identified that a pregnant lady was mistakenly treated as RhD positive instead of RhD negative. Initial testing by NHSBT's Red Cell Immunohaematology (RCI) laboratory was inconclusive, and the sample was referred to the International Blood Group Reference Laboratory (IBGRL), which confirmed the patient should be treated as RhD negative. However, the report was delayed and not shared with the hospital until after the patient had given birth. The hospital's laboratory system also lacked an alert to flag that the result was outstanding. As a result, the patient was managed as RhD positive, did not receive the recommended anti-D prophylaxis, and was transfused with RhD positive blood. A joint investigation with the hospital was completed and confirmed that the patient came to no harm. Improvements have since been implemented, including clearer interim clinical guidance, improved tracking of specialist reports, enhanced staff training, and updates to local systems to support safer care. The final investigation report has been submitted for Directorate level approval.

5. In November 2024, a plasma donor at Twickenham reported blood in their urine after donation, following a machine alert known as 'Hb in harness'. This can indicate red cell spillage or haemolysis (damage to red blood cells), with haemolysis considered likely due to the donor's symptoms. The incident triggered a national investigation by NHSBT. During the review, a second case was identified involving a May 2024 donation in Birmingham. In both cases, the donors had reported symptoms via a customer feedback survey, which was not designed for clinical monitoring and so their concerns were not initially escalated. A thematic analysis of 35 Hb in harness incidents from August to December 2024 highlighted issues around donor feedback oversight, inconsistencies in equipment tracking, and variation in how staff responded to alerts. Although no lasting harm was found, the investigation highlighted that donors lacked accessible information about haemolysis and its potential symptoms. In response, NHSBT has strengthened clinical guidance, staff training, escalation procedures, and equipment checks. A new donor leaflet is also being developed to explain Hb in harness, haemolysis, and post-donation symptoms. The final report, with recommendations, has been submitted for Directorate-level approval.

6. Another incident in November 2024 related to a sample mix up during routine testing at NHSBT's Red Cell Immunohaematology (RCI) laboratory. Two patient samples were accidentally swapped, resulting in incorrect test results being issued. One patient received unnecessary anti-D prophylaxis, while the other required additional follow-up to ensure appropriate care. The incident was identified through routine hospital follow-up and was escalated by NHSBT for formal investigation. Although no harm occurred, early review prompted immediate corrective actions. A PSII is underway, and the final report is being prepared, alongside an action plan to review verification processes and strengthen safeguards based on the investigation's findings.

7. In January 2025, as part of a transplant assessment, NHSBT failed to identify the presence of a very rare alloantibody. As a result, the patient went on to receive multiple incompatible transfusions during and after their transplant. The patient deteriorated as a result of transfusion-related haemolysis and died. The staff involved have been supported, processes have been updated to support onward referral of samples, and the terms of reference for regional multidisciplinary team meetings have been updated to include snap multidisciplinary meetings to rapidly bring clinicians together for complex cases. The final investigation report is pending Director's approval.

8. Finally, in February 2025 it was found that a blood sample tested in August 2024 had been reported as AB RhD positive. However, repeat testing by the hospital identified the patient as A RhD positive on two occasions. The patient did not receive a blood transfusion, and no harm came to the patient. NHSBT has completed all possible investigation into this incident including a lookback analysis. A process deviation was immediately put in place and continues to be necessary for the reduction of risk. Further investigation with the manufacturer is ongoing relating to the control wells, although this is outside of the scope of the PSII. The final investigation report is pending Director's approval.

Approach to clinical audits

Our clinical approach is supported by a strategy and an annual schedule of audits. Clinical audit findings and recommendations are reported through the Directorate CARE groups with oversight from the Clinical Governance Committee (CGC).

During 2024-25 four clinical audits were completed. Risk assessment of clinical audit outcomes is similar to that used by the NHSBT internal audit function, and highlights the level of assurance provided by the findings of each clinical audit. This framework includes: substantial assurance, indicating strong controls and no or minimal issues; moderate assurance, where minor, low impact issues are identified; limited assurance, highlighting either recurring minor issues or infrequent but more significant concerns; and unsatisfactory assurance, which denotes serious risks to patient or donor safety.

Of the audits completed during 2024-25, two were rated as providing substantial assurance: the Audit of Suspected Chlorhexidine Reactions and the Audit of Serious Incident Action Plans. These demonstrated sound practices and no areas of concern. Two further audits were rated as providing moderate assurance: the Audit of Confidentiality on Mobile Sessions and the Audit of Medical Deferrals in Eye Donation. These identified low risk issues which are being addressed through agreed actions.

In addition to these formal audits, small-scale clinical audit activity has continued throughout the year across services such as Plasma for Medicines (PfM) and Therapeutic Apheresis Services (TAS). These are delivered using tools such as Tendable and Online Surveys to support compliance monitoring and local quality improvement. Actions identified through audits are logged and tracked through the NHSBT Quality Management System (Q-Pulse), with oversight through directorate CARE groups.

Following a 2023 Government Internal Audit Agency (GIAA) review, which rated the clinical audit process as providing limited assurance, NHSBT implemented a structured action plan. By year-end 2024-25, 16 of 17 recommendations had been completed, with the final action on track for completion by 31 December 2025.

Infected Blood Inquiry

Introduction

The final report of the Infected Blood Inquiry, published on 20 May 2024 by Sir Brian Langstaff, stands as one of the most significant and painful investigations into healthcare failings in the history of the NHS. It exposed not only the physical harm caused by contaminated blood products administered during the 1970s and 1980s, but also the many years of silence, neglect, and institutional defensiveness that followed.

The seven-volume report lays out 12 key recommendations (with 57 sub-recommendations) that together form a call to action: for justice, transparency, support, and reform. These recommendations span a formal compensation scheme, public apologies, enhanced healthcare and support for victims, and strengthened governance and transparency across the healthcare system.

Seven of these recommendations relate directly to the NHS and health bodies, including those on patient records, safety, training, and transfusion governance. NHSBT's principal responsibility lies within Recommendation 7, which focuses on safety within the transfusion process – a responsibility we carry with solemn care.

The report acknowledges NHSBT's early decision to waive legal privilege on documents and issue a public apology. This was not a gesture of convenience, but a conscious decision to act with openness and respect from the outset. Our early stance has been recognised nationally and provided a benchmark for how organisations can lead with integrity.

We continue to reflect on the human cost behind every page of the Inquiry report. Our commitment now is to ensure these lessons are not only learned but embedded, so that such a tragedy never happens again.

NHSBT IBI implementation group

In May 2024, immediately following the Inquiry's publication, NHSBT established the Infected Blood Inquiry (IBI) Implementation Group, a dedicated body responsible for steering our internal response. This is chaired by the Chief Nursing Officer and supported by senior leaders across operations, science, clinical care, governance and digital systems to help drive forward implementation.

The group began with a detailed gap analysis, comparing NHSBT's current practice to the Inquiry's recommendations. This enabled us to identify areas requiring urgent action, particularly in relation to patient safety, workforce training, and governance of transfusion services.

The group reports into our Clinical Governance Committee and ultimately to the NHSBT Board, ensuring high-level scrutiny, accountability and transparency. Actions and progress updates are also cascaded through staff communications, webinars, and line management briefings, so that the wider organisation understands the changes underway.

Importantly, one of the sub-groups includes representation from staff who are themselves infected or affected by the scandal, as well as voices from donor communities. This inclusion ensures that decisions are shaped not just by policy expertise, but by lived experience.

National engagement and collaboration

NHSBT plays a leading role in the national implementation of the Inquiry's recommendations. We are core members of the Department of Health and Social Care's IBI Recommendations Programme Board and are represented across NHS England-led delivery boards and subgroups.

We co-chair the working group for Recommendation 7, which includes projects ranging from surgical blood use to national benchmarking and education reform. We also contribute to recommendation areas on record-keeping, training and digital infrastructure. Our specialists are helping shape new guidance, safety protocols, and national audit mechanisms.

Importantly, we collaborate with our blood service colleagues in Wales, Scotland and Northern Ireland to ensure alignment across the UK. This ensures that reforms to blood safety are consistent, equitable and informed by shared expertise.

A specific example is the national education curriculum under development, shaped by professionals and patient advocates from all four nations. This will equip clinicians, scientists and managers with the knowledge to prevent recurrence of past failings and to embed patient safety as an unwavering standard.

Openness and compassionate duty of candour

NHSBT continues to prioritise openness and candour at every level of the organisation. We acknowledge that trust was gravely damaged by the actions, and inactions, of past decades. Our response must therefore be more than words; it must demonstrate accountability, transparency, and humanity.

We have embedded Duty of Candour expectations into leadership development, governance structures and staff communications. We actively encourage disclosure, questioning and reflection, recognising that this is vital to learning and healing.

But candour must also be compassionate. We are acutely aware that behind every statistic lies a person, a family, a story. That is why our communication with families, victims and advocacy organisations is always approached with empathy, humility, and sensitivity. Whether in a formal letter or an internal staff forum, we strive to ensure that all voices feel heard and respected.

Stakeholder and employee engagement

Our engagement strategy recognises that the infected blood tragedy lives on in the lives of thousands of people, and within our own workforce. NHSBT has employees who have been personally affected, and we take this duty of care very seriously.

We provide direct support through one-to-one sessions, bereavement counselling referrals, and flexibility for staff wishing to attend Inquiry hearings or remembrance events. Regular webinars and briefings keep staff informed and provide a safe space to ask questions and express concerns.

We are also working closely with advocacy organisations, listening to their feedback and involving them in shaping ongoing work. The memorial project at our Filton site, for example, is being co-designed with victims and families. It is not merely a sculpture, but a statement of institutional remembrance and responsibility.

Financial and political context

The implementation of the Inquiry's recommendations will require sustained investment. NHSBT has submitted detailed business cases to the DHSC for areas requiring funding, such as modernising IT systems, enhancing workforce capacity and strengthening safety audit processes.

We are mindful of funding availability. While early discussions suggest that the government recognises the scale of investment required, we remain cautious and are planning within realistic constraints.

Recommendation 7 – Summary of workstreams

Recommendation 7 is a significant focal point for NHSBT. The subgroups and workstreams include:

- **7a(i) Tranexamic Acid Use:** reviewing surgical practice and checklists to improve safe prescribing and reduce unnecessary transfusions
- **7a(iii) Benchmarking:** building national dashboards to compare transfusion safety and improve oversight
- **7b Transfusion Transformation 2024:** redesigning transfusion governance and infrastructure
- **7c Staffing:** modelling and securing safe staffing levels across transfusion labs and services
- **7d Training and Education:** updating e-learning, curricula, and competencies across professions
- **7e SHOT Recommendations:** enabling consistent safety reporting and governance across NHS organisations
- **7f Digital and Data:** mapping and upgrading systems to better track transfusion outcomes.

These efforts form a blueprint for long-term systemic change and must be delivered with urgency and unwavering commitment.

Memorial art project

A permanent memorial is being commissioned at NHSBT's Filton headquarters. The design and commissioning process is being guided by those infected and affected, families, and staff members who have lost loved ones. This will be a space not only for remembrance but for education and organisational accountability, a daily reminder of the cost of failure and the need to uphold the highest standards.

Summary

The Infected Blood Inquiry has uncovered one of the most painful and far-reaching tragedies in the history of the NHS. Its findings have illuminated decades of harm, institutional denial and delayed justice. NHSBT recognises its responsibility, not only to respond with rigour and transparency, but to honour the humanity at the heart of this crisis.

We acknowledge, with the utmost humility, the lives lost, and lives changed forever. We carry the memories of those infected and affected with us in every action we take. Their voices, their stories and their resilience are guiding forces behind our work. We are committed to ensuring that this is not a moment of symbolic reckoning, but the foundation of permanent and meaningful change.

Our duty now is twofold: to deliver on every aspect of the Inquiry's recommendations with clarity, compassion and resolve, and to ensure that the principles of safety, candour, and justice endure in everything we do.

We stand with those who have suffered, not just in reflection but in action. With unwavering commitment, NHSBT pledges to support the full and faithful delivery of the Infected Blood Inquiry's vision. We will continue to listen deeply, act accountably, and learn relentlessly. We will work alongside government, regulators, patients and our own staff to make certain that the legacy of this Inquiry is not one of despair, but of healing, reform, and restored public trust.

We do this not because it is required, but because it is right. And we will not stop until every recommendation is delivered, every voice is heard, and every lesson is embedded, permanently, into the fabric of our service.

Product safety, regulation and quality assurance

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

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

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

We also work to several professional standards and accreditations, including ISO15189 Medical Laboratories: the requirements for quality and competence are 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), the British Standards Institution (BSI) and the Joint Accreditation Committee (JACIE).

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

Compliance with regulatory requirements through our quality management system

During 2024-25, there were 33 external regulatory and accreditation inspections of our facilities, services and systems across quality, business continuity and health and safety, by regulators such as the Medicines and Healthcare products Regulatory Agency (MHRA), the Human Tissue Authority (HTA), the European Federation for Immunogenetics (EFI), and accreditors for medical laboratories, occupational health and safety, business continuity, environment and Underwriters Laboratories. The overall assessment of these inspections demonstrated that NHSBT is a safe organisation, delivering quality products and services.

We assure ourselves and our regulators, of staff, donor and patient safety by operating a single, comprehensive quality management system (QMS) with detailed process documents and compliance records held in an electronic system (Q-Pulse). The records ensure continued, demonstrable compliance with our regulatory requirements, licences, and accreditations.

Our processes also ensure that staff are adequately trained and competent. We operate a proactive approach to safety and continuous improvement by implementing a robust process of self-inspection, and a risk-based quality system which provides assurance that controls are in place and risks are managed within the critical operational areas of NHSBT. Our audit process is subject to Government Internal Audit Agency review.

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

- **internal quality audits**, undertaken by a team of approved auditors independent of the site or activity being inspected. They provide assurance on effective closure of external inspection findings and identify areas for regulatory and quality improvement
- **risk-based audits** are focused on critical processes and their improvement. The audits are agreed with directorate leadership teams based on quality incidents, audit findings and directorate risks
- **ad-hoc audits** are commissioned by senior managers, often in response to adverse events, trends or changes to our operations.

The Director of Quality and Governance is an executive role that reports into the Deputy Chief Executive, and delivers assurance to the Board, Audit, Risk and Governance Committee (ARGC), Clinical Governance Committee, and the Executive Team through:

- a quarterly Management Quality Review (MQR) Report to the Executive Team and ARGC
- a semi-annual Quality Performance Review to the Chief Executive's office
- an annual summary MQR Report to the Board
- monthly reporting of supporting key operational KPIs, designed to monitor that key processes remain in control, via the Performance Report
- monthly reporting of performance, improvement, and risks to all relevant senior management and leadership teams.

In the previous 12 months, the organisation has focused on addressing the QMS activities that remain overdue within the system. Monthly executive performance review meetings have been introduced as the Chief Executive holds the team accountable for performance.

Risk management and assurance

Risk management is essential for improving and saving lives and supporting the organisation with the delivery of its strategic objectives.

Our principal risks are shown on page 47. Each risk is linked to the strategic objective that it will most affect. Accountability for each principal risk is assigned to a member of the Executive Team. Each principal risk is monitored and reviewed by an assigned oversight committee responsible for discussing and overseeing the risks and holding the relevant director to account and providing support where required.

Assurance mapping

In 2024-25, NHSBT completed the development and implementation of a simple, workable, assurance mapping model and framework. Assurance was mapped across the three lines of defence for key business processes within the organisation. NHSBT now has an assurance map and review process in place which has been supported by our internal auditors, the Government Internal Audit Agency.

The outputs can be viewed through a Power Bi report which allows users to drill through and view the full supporting data. NHSBT's overall assurance rating is currently 'moderate'.

Functional Standards

NHSBT has completed its annual review of compliance with the Government Functional Standards. NHSBT's compliance rating against the 'shall' mandatory elements is 'partially met'.

Of the 14 standards, one standard, GovS-015 Grants, was identified as not applicable to NHSBT. From the remaining standards, two of the functional standards have been rated as 'met', and 11 have been rated as 'partially met'. The 'partially met' standards each have agreed action plans in place, which, once completed, will result in compliance with the 'shall' mandatory elements.

Risk management and assurance is scrutinised by two key governance and oversight committees:

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

NHSBT is introducing a revised Risk Leads Forum, a sub-group of the Risk Management Committee, which will focus on reviewing and challenging risk and assurance management. The outputs from the Risk Leads Forum will be used to inform the RMC.

Business continuity

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

During the 2024-25 period, the Critical Incident process was stood up on 21 occasions, with the most common incidents involving estates and digital services. Delivery of key products and services was maintained throughout the year.

NHSBT was successfully used as a contingency during the cyber-attack on Laboratory Information Management Systems (LIMS) suffered by hospitals in south London. The organisation was able to support the wider NHS, although this did cause extra activity internally, which was not visible to outside observers. In the future, consideration as to how NHSBT assists hospitals if similar circumstances re-occur needs to be carefully considered, to achieve the balance of supporting the wider NHS and NHSBT being able to maintain stock levels and supply of its key products.

During 2024-25, NHSBT's Business Continuity Department was carrying 12 open minor non-conformities against its certification to ISO22301, although due to careful management of the situation this has now been reduced to four. There were two new minor non-conformities raised in the audit undertaken in January 2025, and it is anticipated the six outstanding non-conformities will be closed in advance of the next surveillance audit.

Data security, privacy and records management

The Data Security, Privacy, and Records Management (DSPR) team plays a crucial role in ensuring NHSBT data is safe and secure. During 2024-25, the DSPR team saw demand for their expertise continue to increase, with Data Processing Impact Assessments (DPIAs) and Data Subject Access Requests (DSARs) exceeding levels in previous years.

Over the past year, NHSBT has made notable strides in compliance with statutory disclosure requirements. Specifically, it has successfully addressed 202 Freedom of Information (FOI) requests and 597 Data Subject Access Requests (DSARs), achieving response rates of 889 per cent for FOIs and 91 per cent for DSARs within the designated target timelines, despite an approximate increase of 51 per cent in volume of DSARs year on year alone. Furthermore, the team has reviewed and assured 81 Data Processing Impact Assessments, a 33 per cent increase on the previous year, reviewing the data risks involved in the development of our systems and processes.

Our Information and Cyber Security teams have continued their work to augment and strengthen our security practices. In 2024-25, NHSBT achieved accreditation with DCB1596, the secure email standard to assure safe email communications with NHS organisations. Further significant process improvements include a new governance process for accessing NHSBT corporate IT from outside the UK, and a rigorous software approval process to mitigate external threats.

Seventeen cyber incidents were reported to NHS England as per the 'Respond to a Cyber Alert' service during the period. There were six High Severity alerts issued by NHS England, of which 94 per cent were responded to in a compliant and timely manner, an eight per cent compliance increase on last year.

During the year, we reported 276 data security incidents, marking a 12 per cent increase from last year. The predominant issue remains the loss of information, particularly Donor Safety Check forms (DSCs), most of which were recovered. We collaborated with the Blood Directorate and Donor Centres to review and improve the DSC process, aiming to reduce data loss incidents. Regular reviews of incidents and trends enable us to learn and share lessons, helping to prevent recurrence across NHSBT operations nationwide.

NHSBT experienced one serious data security incident necessitating notification to the Information Commissioner's Office (ICO) during 2024-25. This incident involved the misuse of sensitive information and was promptly addressed, with immediate and long-term measures implemented to mitigate the risk and enhance training and awareness. The ICO confirmed NHSBT's actions were appropriate and required no further intervention.

Whistleblowing policy and Freedom to Speak Up Guardian

The Freedom to Speak Up (FTSU) Annual Report was presented by the Head of FTSU at the Public Board in January 2025, highlighting the following key issues:

- management and leadership capability is having a negative impact on the willingness of workers to speak up about general and clinical concerns
- the main barriers to speaking up at NHSBT are fear of reprisal and lack of confidence that NHSBT will address their concern
- staff survey data indicates that some managers are refusing to support neurodiverse and disabled colleagues' rights to workplace adjustments under the Equality Act 2010, and that this is having a negative impact on colleagues' ability to speak up.

The Board agreed to support the recommendations to address the issues highlighted in the report.

In March 2025, compliance with mandatory requirements was at 98 per cent for both Speak Up training for all staff, and Listen Up training for managers.

FTSU service improvements included:

- establishing a Service Level Agreement detailing the scope and standards of the FTSU service, and NHSBT's responsibilities in the Speak Up process
- a new Guardian Procedures Handbook to further support consistency of practice and application of National Guardian's Office standards across the Guardian team
- guides for those raising or responding to concerns, to support the adoption in January 2024 of the National Speak Up Policy for the NHS
- work towards the procurement of a secure case management system. This will provide easier access to FTSU, enabling two-way communication between Guardians and anonymous concern raisers, and an efficient case management system for tracking actions planned by NHSBT, and the outcomes of concerns. Consequently, the potential to draw and apply learning from available data will be greatly improved.

During 2024-25, 139 concerns were shared with FTSU Guardians, of which 24 (17 per cent) were raised anonymously, an increase of six per cent from 2023-24.

The table below shows the types of concerns raised (note that each concern may include one or more element):

Concern included an element of:	Number of concerns with this element
Inappropriate attitudes or behaviours	49
Management/leadership of team/service	42
Worker mental health/wellbeing	40
Seeking advice or guidance	21
Indicated breach of NHSBT policy	20
Harassment or discrimination	17
NHSBT strategy/values/decision/ policy	17
Relationship with manager/lack of support	17
Indicated breach of Equality Act 2010	16
Team working conditions or culture	14
Bullying	9
Worker safety	8
Individual working/contractual arrangements	7
Indicated disadvantageous/ demeaning treatment following speaking up	6
Patient/donor safety/quality	6
Service improvement suggestion	6
Access to training/development	3
Formal process	3

Counter fraud policy

Our Anti-Fraud, Bribery and Corruption policy sets out clear roles and responsibilities, explains how staff must conduct business and report suspected fraud, and details how cases will be investigated.

2024-25 was the second year of our current Counter Fraud Strategy, which covers the period 2023-26. Within this we have made progress against our objectives and workplan for the year, including participation in the biennial National Fraud Initiative exercise, and reviewing and updating our Counter Fraud training module ready for relaunch during 2025. We continue to work towards full compliance with the GovS 013: Counter Fraud functional standard, and expect to achieve this during 2025-26. We have continued to build awareness of fraud, bribery and corruption risks across the organisation, through events such as webinars, an intranet article and quiz, and presentations to various teams. We report on our plans and ongoing work at each ARGC meeting.

During 2024-25:

- three cases were brought forward from the previous year, two were closed during 2024-25, and one remains ongoing
- two new cases were opened, investigated and concluded during the year
- five new cases were opened and were ongoing at the end of the financial year.

Our supply chain ethics and sustainability

We are committed to upholding human rights, anti-corruption, anti-slavery and anti-bribery policies within the NHSBT Commercial lifecycle and our supply chain. We expect suppliers to comply with a code of conduct and our Modern Slavery Policy (Supply Chain). As part of the tendering process 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 the assessment process of ISO20400 to drive continuous improvement within this area. As part of the tendering process suppliers demonstrate how they deliver sustainability benefits to NHSBT. 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

Health, safety and wellbeing is covered in our Accountability Report on page 64.

The table below shows the health and safety incidents by directorate, as an incidence rate per 1,000 employees:

	Blood Supply	Plasma for Medicines	Clinical Services	OTDT	Group Services	Donor Experience	Nursing	Grand Total
Apr	56	0	3	5	1	0	2	67
May	46	1	6	4	0	0	0	57
Jun	35	0	10	5	1	0	0	51
Jul	50	5	12	5	2	1	0	75
Aug	52	2	0	2	2	0	0	58
Sep	45	0	6	2	4	0	0	57
Oct	55	1	8	4	1	0	0	69
Nov	51	0	5	7	1	0	0	64
Dec	48	1	1	1	3	0	1	55
Jan	68	2	5	1	2	0	2	80
Feb	56	2	6	1	0	0	0	65
Mar	42	0	7	2	1	0	0	52
2024-25 Incidence Rate	**13.9**	**7.9**	**3.9**	**4.7**	**1.5**	**0.4**	**2.5**	**8.5**
2024-25 Target	**11.2**	**11.0**	**3.2**	**5.0**	**0.8**	**0.5**	**n/a**	**7.7**
2023-24 Incidence Rate	12.6	10.3	3.2	4.5	1.4	0.7	n/a	8.0
2022-23 Incidence rate	14.1	11.4	3.5	4.2	1.9	1.6	n/a	9.1

Definitions of the activities of the directorates shown in the table above can be found in Note 2 Operating Segments on page 122.

Control weaknesses identified during Internal Audit reviews

Our internal audit service is provided by Government Internal Audit Agency.

Definition of the assurance opinions:

Rating	Definition
Substantial	In the auditors' opinion, the framework of governance, risk management and control is adequate and effective.
Moderate	In the auditors' opinion, some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	In the auditors' 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 the auditors' 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 2024-25 audit programme agreed by ARGC covered 14 work areas, comprising 11 assurance engagements and three advisory reviews. The outcomes of the 11 assurance engagements were:

- two received a 'substantial' assurance opinion (2023-24: two)
- eight received a 'moderate' assurance opinion (2023-24: five)
- one received a 'limited' assurance opinion (2023-24: five)
- none received an 'unsatisfactory' assurance opinion (2023-24: one).

The limited assurance report was:

IT Disaster Recovery Planning for Key Systems – March 2025

The overall opinion rating of 'Limited' was based on identified risks and weaknesses in the controls in place for a critical ICT system in the event of a serious event.

Internal Audit – opinion of the Head of Internal Audit

In 2024-25, our Internal Audit service continued to be provided by the Government Internal Audit Agency (GIAA). GIAA has provided assurance over NHSBT's core business activities, with individual reviews performed across operational, financial and other risk areas, all informed by the organisation's risk assessment and their independent view on NHSBT's risk profile.

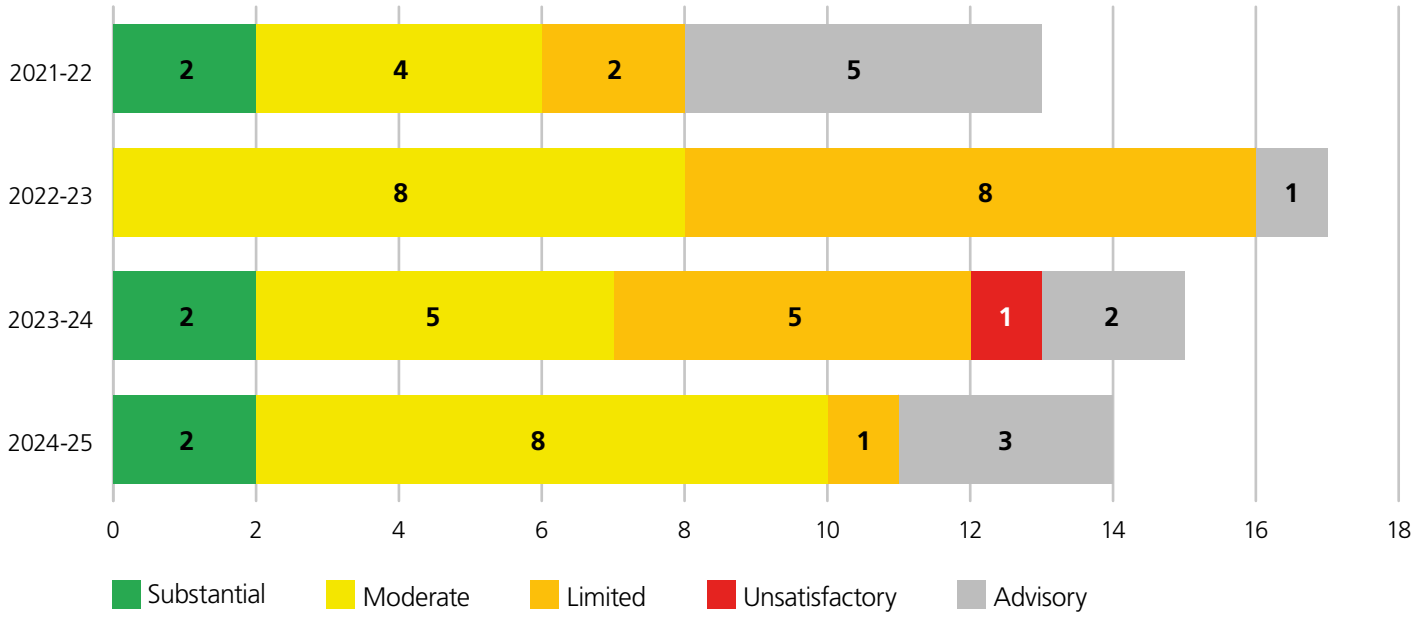
The internal audit opinion noted a consistent and positive trajectory in the advancements in assurance processes and governance frameworks, a more consistent approach to the treatment of strategic risk information across NHSBT, and good 'support and challenge' at executive level in various forums including the ARGC and the Risk Management Committee.

On governance, the internal audit opinion noted that a project-based approach had been adopted by the new Company Secretary to bring together various actions to improve the administration of the Board and main committees, providing momentum, whilst the creation of a principal risk for 'corporate governance failure' ensured traction.

And on internal control, significant progress and a major accomplishment was the creation of an Assurance Framework, underpinned by the mapping and evaluation of key business processes, making it easier for teams to identify controls, and demonstrate the effectiveness of their operation.

The Head of Internal Audit concluded that:

I am able to provide 'Moderate' assurance on the governance, risk management, and control framework at NHS Blood and Transplant (NHSBT) for the year ending 31 March 2025. This is an improvement on the 'Limited' opinion given in the last two years. My opinion recognises ongoing, dedicated efforts to establish and embed a stronger internal control framework. This year's Audit Plan was delivered successfully, without any limitations in scope. A summary of Engagement Level Opinions over the past four years highlights NHSBT's improvement journey:



Operational challenges

Operational challenges we have managed during the year include:

1. Risks at the risk limit

Principal risks are risks that could significantly affect the achievement or performance of NHSBT's corporate responsibilities or the effective delivery of strategic priorities. The score of principal risks is influenced by contributory risks, which are managed by the responsible business area. Principal risks are monitored and managed in line with NHSBT's agreed risk appetite. During the year there have been three risks at the 'risk limit', and there are ongoing actions to address these.

P-02 Service disruption. The issue that was driving the score in 2023-24, the structural issues in the roof of part of the building in Southampton, was resolved by removing staff and activity from the affected area, other than a small section which is fully propped and boarded. The current risk driving the score is the red blood cell stock, which has been below target for most of the 2024-25 year. There are short, medium and long-term plans to mitigate this risk, that have been discussed with the DHSC.

P-03 Loss of critical ICT. This risk is recorded at this level due to the critical requirement of the security of our systems, and the need to protect the data we hold and our operational capabilities. There has been considerable activity on system security during the year, with on-going plans to reduce the risk further.

P-04 Donor numbers and diversity. This risk is also affected by the blood stock issue that drives P-02.

2. London cyber-attack

In June 2024, a cyber-attack on Synnovis – a major pathology provider to NHS trusts in London – disrupted access to critical laboratory systems for blood grouping, antibody screening, and crossmatching. This posed a serious risk to patient safety, as these tests are essential for ensuring that patients receive compatible blood products.

NHSBT's Red Cell Immunohaematology (RCI) team responded rapidly to fill this urgent gap. The team scaled up operations, extended working hours, and prioritised urgent cases to support affected hospitals. These actions ensured that clinicians could continue to safely transfuse patients in emergency and surgical settings, maintaining continuity of care despite the disruption.

The incident also led to a sustained surge in demand for O negative blood. Without access to crossmatching systems, hospitals had to rely more heavily on universal O negative units, placing pressure on already limited supplies. This contributed to an amber stock alert, and NHSBT worked closely with the NHS to manage and optimise use of this rare blood type.

Review of effectiveness

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHSBT's aims and objectives, while safeguarding the public funds and assets for which I am personally responsible in accordance with 'Managing Public Money' and as set out in my Accounting Officer appointment letter. I have undertaken this responsibility by seeking a range of assurances, including assurances provided by my predecessor, Dr Jo Farrar.

In 2024-25, my predecessor was primarily informed by:

- oversight by the Board and its 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
- regular reporting to the Executive Team on performance and risk management, including regular monitoring of audit actions.

The Head of Internal Audit Opinion for the year was 'Moderate', showing a good improvement from the 'Limited' opinions of the previous two years, reflecting the hard work and improved process put in place to ensure that audit recommendations are managed and implemented effectively.

My predecessor also relied on several other sources of assurance around our controls, such as the Audit, Risk and Governance Committee's work during the year, which included a rolling programme of deep dives into strategic risks and regular review of the Board Assurance Framework. Additionally, the work of other Board committees, inspections by our external regulators and clinical audits, self inspections and internal quality audits of our regulated activities, and regular reporting on delivery and financial matters to the Executive Team provided a wide range of alternative sources of assurance. I am accordingly aware of any significant issues that have been raised by my predecessor. Our systems of internal control lead me to believe that we have maintained effective control throughout the period.

Accountability report – parliamentary accountability

Basis for accounts preparation

The financial statements for the year ended 31 March 2025 have been prepared as directed by the Secretary of State for Health and Social Care in accordance with section 29A of the National Health Service Act 2006, and in a format as instructed by the Department of Health and Social Care with the approval of HM Treasury.

External audit

The Comptroller and Auditor General (C&AG) is appointed by statute to audit NHSBT and report to Parliament on the truth and fairness of the annual financial statements, and on the regularity of income and expenditure. The cost of audit work performed was £130,000 (2023-24: £153,000, including £24,000 relating to additional audit work in respect of the valuation of two leased properties). There were no payments to the C&AG for non-audit work during 2024-25 or 2023-24.

Regularity of expenditure: losses and special payments

This is subject to audit.

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings, including losses which would have been made good through insurance cover had NHSBT not been bearing its own risk (with insurance premiums then being included as normal revenue expenditure).

Losses Statement	31 March 2025		31 March 2024	
	No. Cases	£000	No. Cases	£000
Losses of pay, allowance and superannuation benefits	17	4	18	12
Losses of accountable stores and vehicle damage	95	439	83	362
Claims waived or abandoned	18	16	13	8
Fruitless payments and constructive losses	-	-	1	4
Total	**130**	**459**	**115**	**386**

Special Payments	31 March 2025		31 March 2024	
	No. Cases	£000	No. Cases	£000
Compensation payments	3	5	5	3
Ex gratia payments	11	43	10	79
Total	**14**	**48**	**15**	**82**

Remote contingent liabilities

This is subject to audit.

There are no known material remote contingent liabilities.

For disclosable contingent liabilities see Note 19 in the financial statements.

Notation of gifts

This is subject to audit.

NHSBT 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. Most of our income is from prices set to recover our costs. We set the prices of our products annually with the National Commissioning Group on behalf of the NHS. Prices are national, and were set using forecast sales volumes for the year. Prices include the full cost of providing products and services to the NHS (including a return on the cost of capital employed), after any other elements of funding have been taken into account. Since prices are set using forecast volumes, actual volumes are monitored during the year. If volumes are higher than a planned tolerance, a rebate is calculated and paid to customers, to prevent over-recovery of costs by NHSBT. In 2024-25 the rebate paid to customers was £2.5m. Where accumulated cash balances have arisen from prior year surpluses, these are in the main used to fund essential IT and estate investments. Note 2 of the financial statements shows the contribution per business unit and is subject to audit.

This Accountability Report was previously agreed by Dr Jo Farrar as Chief Executive, and on the basis of the assurances provided to me I hereby sign the Accountability Report (including the Governance Statement) from pages 49 to 101.

Caroline Walker **8 July 2025**
Interim Chief Executive and Accounting Officer

Accountability report – audit certificate and report

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 2025 under the National Health Service Act 2006. The financial statements comprise NHS Blood and Transplant's:

- Statement of Financial Position as at 31 March 2025;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

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

In my opinion, the financial statements:

- give a true and fair view of the state of NHS Blood and Transplant's affairs as at 31 March 2025 and its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on regularity

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

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom (2024)*. 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 2024*. I am independent of NHS Blood and Transplant in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

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

Conclusions relating to going concern

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

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

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

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

Other Information

The other information comprises information included in the Annual Report, but does not include the financial statements and my auditor's certificate and report 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.

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

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the National Health Service Act 2006.

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

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

Matters on which I report by exception

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

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

- adequate accounting records have not been kept by NHS Blood and Transplant or returns adequate for my audit have not been received from branches not visited by my staff; or
- I have not received all of the information and explanations I require for my audit; or
- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or

- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Accounting Officer for the financial statements

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

- maintaining proper accounting records;
- providing the Comptroller and Auditor General with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the Comptroller and Auditor General with additional information and explanations needed for his audit;
- providing the Comptroller and Auditor General with unrestricted access to persons within NHS Blood and Transplant from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error;
- preparing financial statements which give a true and fair view in accordance with Secretary of State directions issued under the National Health Service Act 2006;
- preparing the annual report, which includes the Remuneration and Staff Report, in accordance with Secretary of State directions directions issued under the National Health Service Act 2006; and
- assessing NHS Blood and Transplant's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS Blood and Transplant will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006.

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

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

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

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

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

- considered the nature of the sector, control environment and operational performance including the design of NHS Blood and Transplant's accounting policies;
- inquired of management, NHS Blood and Transplant's and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS Blood and Transplant's policies and procedures on:
  - identifying, evaluating and complying with laws and regulations;
  - detecting and responding to the risks of fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS

Blood and Transplant's controls relating to NHS Blood and Transplant's compliance with the National Health Services Act 2006 and Managing Public Money;

- inquired of management, NHS Blood and Transplant's Head of Internal Audit and those charged with governance whether:
  - they were aware of any instances of non-compliance with laws and regulations;
  - they had knowledge of any actual, suspected, or alleged fraud;
- discussed with the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

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

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

Audit response to identified risk

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

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management and the Audit, Risk and Governance Committee concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the Board and internal audit reports; and
- I addressed the risk of fraud through management override of controls by testing the appropriateness of journal entries and other adjustments; assessing whether the judgements on 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; and
- I addressed the risk of fraud in revenue recognition by increased testing on the cut-off of revenue and the variable element of blood income; and
- I addressed the risk of fraud in expenditure by increased testing of cut-off of expenditure and accrued expenses.

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

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

Other auditor's responsibilities

I am required to obtain sufficient appropriate audit evidence to give reasonable assurance that the expenditure and income 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.

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

Report

I have no observations to make on these financial statements.

Gareth Davies **Date: 10 July 2025**
Comptroller and Auditor General

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

Our finances

Financial statements

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024-25 £000	*Re-presented** 2023-24 £000
Gross Income			
Income from sale of goods and services		486,281	434,507
Other operating income		44,311	30,705
	3	**530,592**	**465,212**
Expenditure			
Staff costs	4	(352,708)	(313,656)
Operating expenses	5.1	(247,230)	(233,848)
Depreciation and amortisation	5.2	(25,307)	(18,165)
Other operating expenditure	6	(28,411)	(25,793)
		(653,656)	**(591,462)**
Net operating expenditure before interest		**(123,064)**	**(126,250)**
Finance expense		(1,233)	(1,369)
Net operating expenditure after interest	2	**(124,297)**	**(127,619)**
Other comprehensive net expenditure Items which will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment	8	2,700	(4,021)
Net gain/(loss) on revaluation of right of use assets	9	2,069	1,347
Total comprehensive net expenditure		**(119,528)**	**(130,293)**

* Software licence fees and Insurance were previously included in Other operating expenditure, but from 2024-25 are included in Operating expenses. 2023-24 comparative figures have been re-presented to reflect this change. Additionally, £18,518k relating to plasma income has been reclassified from Other operating income to Income from sale of goods and services, to reflect how the equivalent income was reported in 2024-25.

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 2025

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Property, plant and equipment	8	171,084	170,284
Right of use assets	9	66,446	69,242
Intangible assets	10	16,805	13,626
Financial assets	12	766	504
Total non-current assets		**255,101**	**253,656**
Current assets			
Inventories	11	24,613	20,127
Trade and other receivables	12	78,829	70,474
Cash and cash equivalents	13	37,939	24,441
Total current assets		**141,381**	**115,042**
Current liabilities			
Trade and other payables	14	(58,740)	(48,585)
Provisions for liabilities and charges	15	(1,177)	(1,058)
Obligations under leases	16	(4,668)	(5,442)
Total current liabilities		**(64,585)**	**(55,085)**
Total assets less current liabilities		**331,897**	**313,613**
Non-current liabilities			
Provisions for liabilities and charges	15	(282)	(313)
Obligations under leases	16	(23,697)	(25,777)
Total non-current liabilities		**(23,979)**	**(26,090)**
Total assets less total liabilities		**307,918**	**287,523**
Financed by			
General Fund		228,664	209,529
Revaluation Reserve		79,254	77,994
Total taxpayers' equity		**307,918**	**287,523**

Notes 1 to 22 form part of these accounts.

The financial statements on pages 107 to 140 were recommended by the Audit Risk and Governance Committee on 26 June 2025 and approved by the Board in accordance with powers within the NHSBT Standing Orders, and are signed by the Accounting Officer, Caroline Walker as Interim Chief Executive Officer.

Caroline Walker
Interim Chief Executive and Accounting Officer

8 July 2025

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Note	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2024		209,529	77,994	**287,523**
Changes in taxpayers' equity for 2024-25				
Net expenditure for the financial period		(124,297)	-	**(124,297)**
Net gain on revaluation of property, plant and equipment	8	-	2,700	**2,700**
Net gain on revaluation of right of use assets	9	-	2,069	**2,069**
Transfer between reserves		3,509	(3,509)	**-**
Total recognised income and expense for 2024-25		**(120,788)**	**1,260**	**(119,528)**
Revenue Grant from DHSC		122,923	-	**122,923**
Capital Grant from DHSC		17,000	-	**17,000**
Balance at 31 March 2025		**228,664**	**79,254**	**307,918**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2024

	Note	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2023		204,316	84,575	**288,891**
Changes in taxpayers' equity for 2023-24				
Net expenditure for the financial period		(127,619)	-	**(127,619)**
Net loss on revaluation of property, plant and equipment	8	-	(4,021)	**(4,021)**
Net gain on revaluation of right of use assets	9	-	1,347	**1,347**
Transfer between reserves		3,907	(3,907)	**-**
Total recognised income and expense for 2023-24		**(123,712)**	**(6,581)**	**(130,293)**
Revenue Grant from DHSC		113,425	-	**113,425**
Capital Grant from DHSC		15,500	-	**15,500**
Balance at 31 March 2024		**209,529**	**77,994**	**287,523**

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 2025

	Note	2024-25 £000	2023-24 £000
Cash flows from operating activities			
Net operating costs before interest		(123,064)	(126,250)
Adjustments for non-cash transactions	17	25,856	18,429
(Increase)/decrease in trade and other receivables	12	(8,617)	4,846
(Increase)/decrease in inventories	11	(4,486)	(1,796)
Increase/(decrease) in trade and other payables	14	9,677	(26,637)
Provisions utilised	15	(117)	(520)
Net cash (used in) operating activities		**(100,751)**	**(131,928)**
Cash flows from investing activities			
Purchase of plant, property and equipment		(12,569)	(10,695)
Purchase of intangible assets		(5,712)	(4,456)
Increase/(decrease) in capital accruals	14	479	(263)
Purchase of right of use assets		(663)	-
Net cash (used in) investing activities		**(18,465)**	**(15,414)**
Cash flows from financing activities			
Grant from Department of Health and Social Care		139,923	128,925
Capital element paid in respect of lease obligations		(5,732)	(6,675)
Interest paid in respect of lease obligations		(1,477)	(1,152)
Net cash generated from financing activities		**132,714**	**121,098**
(Decrease)/increase in cash and cash equivalents		13,498	(26,244)
Cash and cash equivalents at 1 April		24,441	50,685
Cash and cash equivalents at 31 March	13	**37,939**	**24,441**

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 2024-25 Government Financial Reporting Manual (FReM) issued by HM Treasury (HMT). 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 HMT, 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 NHSBT for the purpose of giving a true and fair view has been selected. The particular policies adopted follow. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 Accounting convention

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

1.1.2 Going concern

The organisation's annual report and accounts have been prepared on a going concern basis. NHSBT is financed by fees and charges for blood and specialist services, and grant-in-aid for organ donation, transplantation, and stem cells, and draws this funding from the Department of Health and Social Care (DHSC), with a proportionate amount of funding also received from the other Devolved Governments. Prices and funding for 2025-26 have been agreed, and NHSBT is not aware of any pending changes to its functions. In addition, the FReM adopts the assumption that services will continue to be provided, unless there is specific information to the contrary. Fuller details of the going concern assessment and context can be found in Our finances on page 44.

1.2 Critical judgements and key sources of estimation uncertainty

In the application of NHSBT's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed.

Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period; or in the period of the revision and future periods if the revision affects both current and future periods.

1.2.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see 1.2.2), that management has made in the process of applying NHSBT's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Charities consolidation

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

1.2.2 Sources of estimation uncertainty

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

- use of depreciated replacement cost (DRC) to value land and buildings (see accounting policy note 1.10). NHSBT provides specialist products and services, the majority of which are unique in the geographic areas in which it operates, and this makes its specialised properties particularly challenging to value, as they are not easily comparable to other

more common properties. Although, as set out in accounting policy 1.10, these properties are professionally valued, this still involves professional judgements and assumptions by the valuer, and judgements by management around the useful lives of these assets. The carrying value of assets valued on a DRC basis at 31 March 2025 was £167,197k.

1.3 Operating segments

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

1.4 Revenue from contracts with customers

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

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

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

1.4.1 Revenue from NHS contracts

The main source of income for NHSBT is contracts with NHS trusts primarily for the supply of blood and components, and diagnostic and therapeutic services.

Products and services are normally accrued in month and billed in the month following delivery, with the exception of blood and components, where customers are normally billed a monthly fixed contract value, and a variable price based on activity monthly in arrears.

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

1.4.2 Revenue from project contracts

NHSBT receives income from contracts for projects, such as research and development, and clinical trials. The customers are mainly universities and commercial entities. Where project contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that NHSBT's interim performance does not create an asset with alternative use for NHSBT, and NHSBT has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and NHSBT recognises revenue each year over the course of the contract.

1.4.3 Expected credit losses

In line with FReM requirements, stage 1 and stage 2 impairments of receivables are not recognised where the counterparty is a government department or its executive agency.

1.5 Other income, funding and grants

1.5.1 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 grant-in-aid from DHSC for the provision of organ donation and transplantation services. Such grants are taken directly to the General Fund and not counted as income.

They are shown in Note 2 to these accounts.

1.5.2 Other income

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

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

1.6 Other expenses

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

1.7 Grants payable

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

1.8 Value added tax

Most of the activities of NHSBT are outside the scope of value added tax (VAT) and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets, except right of use assets acquired under a lease, where the irrecoverable VAT is not included in the value of the non-current asset, but is expensed at the point at which it falls due in line with IFRIC 21. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.9 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 per cent) 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, grant-funded, and peppercorn leased, assets
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund deposits (excluding cash balances held in GBS accounts that relate to a short-term working capital facility).

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by DHSC, the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the financial statements. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the financial statements.

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

1.10 Property, plant and equipment

Note 1.10.1 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 more than £250 each, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control, or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost. Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

1.10.2 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 land and buildings 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. Their values are determined as follows:

- non-specialised land and buildings – existing use value
- specialised land and buildings – depreciated replacement cost. This is the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

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

Plant and machinery assets are indexed annually in accordance with appropriate ONS indices. The carrying value of existing assets at that date will be written off over their remaining useful lives. Plant and machinery purchased during the year is carried at depreciated historic cost, as this is not considered to be materially different from fair value. Information technology and transport equipment are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

Land and buildings are professionally revalued in accordance with IAS 16 every five years. Professional valuers undertake a desktop valuation for each of the interim years, except for where cumulative additions since the last full valuation are greater than £2m and represent a greater than 20 per cent increase in the net book value, in which case a full on-site valuation is carried out. The change in valuations is reflected in the accounts. A full valuation of NHSBT land and buildings was carried out in March 2024, and a desktop valuation was carried out in March 2025 and the values of land and buildings in this report are based on this valuation.

1.10.3 Subsequent expenditure

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

1.10.4 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned, or significant changes made to it.

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

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

1.11 Intangible Assets

1.11.1 Recognition

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

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

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

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

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is charged to the Statement of Comprehensive Net Expenditure in the period in which it is incurred.

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

1.11.2 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 at historic cost, intangible assets are carried at amortised cost as a proxy for fair value. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12 Depreciation, amortisation and impairments

1.12.1 Depreciation

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

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

Assets held under 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	1 – 90 years
Plant and machinery	1 – 30 years
Information technology	1 – 15 years
Transport	1 – 15 years

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

1.12.2 Impairments

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

In accordance with FReM, impairments that arise from a clear consumption of economic benefits or of the service potential of the asset are charged to operating expenses.

A compensating transfer is made from the revaluation reserve to the general reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

1.12.3 Amortisation

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

Software	1 – 20 years

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

1.13 Donated assets

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

1.14 Government grant funded assets

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

1.15 Leases

1.15.1 Elections and expedients

NHSBT has used the following elections and expedients in applying IFRS 16:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraphs 6-8 of the standard
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value, which for NHSBT is considered to be those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5(b) of the standard
- in alignment with other DHSC bodies, NHSBT does not apply IFRS 16 to intangible assets, but will apply the treatment described in accounting policy 1.11.

HM Treasury has adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16. NHSBT is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. NHSBT is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value.

These arrangements are described as peppercorn leases. Such arrangements are required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16.

The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

1.15.2 NHSBT as lessee

At the commencement date of a leasing arrangement the lessee recognises a right-of-use asset and corresponding lease liability. Subsequently, property, plant and equipment held under finance leases are revalued as described in accounting policy 1.10.2, except where the frequency of rent reviews serve as a suitable proxy for ensuring that the cost of the lease reflects market value.

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

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

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

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

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

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

Disclosures regarding right-of-use assets and lease liabilities, and other required disclosures, can be found in Note 9 and Note 16.

1.16 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 cost recovery 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.

1.17 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 three 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.

1.18 Foreign exchange

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

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

1.19 Expenditure on employee benefits

1.19.1 Short-term employee benefits

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

1.19.2 NHS Pension Schemes

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

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

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

1.19.3 National Employment Savings Trust (NEST) Pension Scheme

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

1.20 Provisions

Provisions are recognised when NHSBT has a present legal or constructive obligation as a result of a past event, it is probable that NHSBT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 2.40 per cent (2023-24: 2.45 per cent) in real terms.

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date.

A nominal short-term rate of 4.03 per cent (2023-24: 4.26 per cent) for inflation adjusted expected cash flows up to and including five years from the Statement of Financial Position date.

A nominal medium-term rate of 4.07 per cent (2023-24: 4.03 per cent) for inflation adjusted expected cash flows over five years up to and including ten years from the Statement of Financial Position date.

A nominal long-term rate of 4.81 per cent (2023-24: 4.72 per cent) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term rate of 4.55 per cent (2023-24: 4.40 per cent) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

1.20.1 Clinical risk pooling

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

1.20.2 Non-clinical risk pooling

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

Both are risk pooling schemes under which NHSBT pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Financial instruments

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

In accordance with IFRS 9 and FReM, NHSBT is required to recognise a loss allowance representing expected credit losses on trade receivables. NHSBT has applied the simplified approach, as required, and measured the loss allowance at an amount equal to lifetime expected credit losses. NHSBT only has financial assets at amortised cost, there are no other financial assets at fair value through profit and loss or through other comprehensive net expenditure.

1.22 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain events not wholly within the entity's control, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation, or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the entity's control. A contingent asset is disclosed where an inflow of economic benefits is probable.

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

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHSBT not been bearing its own risk (with insurance premiums then being included as normal revenue expenditure), see page 124.

1.24 Gifts

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

NHSBT made no political or charitable donations or gifts during the current financial year, or previous financial periods.

1.25 Accounting standards that have been issued but have not yet been adopted

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

These standards are still subject to HM Treasury FReM adoption:

IFRS 14 Regulatory Deferral Accounts

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

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2023. Adopted by the FReM from 1 April 2025. NHSBT has made an initial assessment of the potential impact, using the Government Finance Function Technical Accounting Centre of Excellence checklist, and application guidance issued by the Department of Health and Social Care, and has concluded that the standard will have no impact on the organisation.

IFRS 18 Presentation and Disclosure in Financial Statements

Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM.

IFRS 19 Subsidiaries without Public Accountability: Disclosures

Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM.

2025-26 FReM changes to non-investment asset valuations

In December 2023 HM Treasury released an exposure draft on potential changes to valuing and accounting for non-investment assets (e.g. property, plant and equipment, and intangible assets). The following changes to the valuation and accounting of non-investment assets will be included in the 2025-26 FReM for mandatory implementation:

References to assets being held for their 'service potential' and the terms 'specialised' and 'non-specialised' assets are being removed from the FReM. Non-investment assets are instead described as assets held for their 'operational capacity'. This change has no impact on the valuation basis of non-investment assets, which remains Existing Use Value (EUV).

An adaptation to IAS 16 will be introduced to withdraw the requirement to revalue an asset where its fair value materially differs from its carrying value. Assets will be valued using the one of the following processes:

- a quinquennial revaluation supplemented by annual indexation
- a rolling programme of valuations over a five-year cycle, with annual indexation applied to assets during the four intervening years
- for non-property assets only, appropriate indices
- in rare circumstances where an index is not available, a quinquennial revaluation supplemented by a desktop revaluation in year three.

The option to measure intangible assets using the revaluation model will be withdrawn. The carrying values of intangible assets at 31 March 2025 will be considered the historical cost at 1 April 2025.

Note 2 Operating segments – 2024-25

For the year 1 April 2024 to 31 March 2025	Total £000	Blood Components (inc. R&D) £000	Tissue and Eye Services £000	Organ Donation & Transplant £000	Pathology £000	Therapeutic Apheresis Services (TAS) £000	Cell, Apheresis and Gene Therapies (excl. TAS) £000	Plasma £000
Revenue								
Provision of products and services	**461,215**	357,643	22,363	-	42,668	16,075	22,419	47
Income from Scottish Parliament	**7,462**	-	-	7,462	-	-	-	-
Income from National Assembly for Wales	**5,011**	-	-	5,011	-	-	-	-
Income from Northern Ireland Assembly	**2,962**	-	-	2,962	-	-	-	-
Other income	**53,942**	19,794	361	912	2,339	356	5,113	25,067
Programme funding from the DHSC	**122,923**	18,045	1,496	95,122	3,062	568	3,888	742
Total revenue	**653,515**	**395,482**	**24,220**	**111,469**	**48,069**	**16,999**	**31,420**	**25,856**
Expenditure								
Variable costs	**(73,862)**	(42,065)	(3,746)	(3,551)	(8,025)	(4,986)	(4,299)	(7,190)
Direct costs	**(299,937)**	(142,566)	(12,952)	(81,938)	(23,915)	(8,394)	(18,044)	(12,128)
Direct support costs	**(175,206)**	(137,404)	(3,549)	(12,704)	(8,924)	(1,473)	(9,497)	(1,655)
Movement in value of stocks	**4,660**	(80)	608	-	-	-	-	4,132
Other support costs	**(72,880)**	(42,982)	(2,562)	(13,552)	(5,497)	(1,996)	(4,279)	(2,012)
Total expenditure	**(617,225)**	**(365,097)**	**(22,201)**	**(111,745)**	**(46,361)**	**(16,849)**	**(36,119)**	**(18,853)**
Operating surplus/(deficit) for the financial period before transformation	**36,290**	30,385	2,019	(276)	1,708	150	(4,699)	7,003
Transformation costs	(21,515)	(10,150)	-	(5,720)	(1,276)	(440)	(957)	(2,972)
Operating surplus/ (deficit) for the financial period	**14,775**	**20,235**	**2,019**	**(5,996)**	**432**	**(290)**	**(5,656)**	**4,031**
Add: notional cost of capital included in expenditure above	7,069							
Less: programme funding from DHSC	(122,923)							
Less: capital charges paid to the DHSC	(23,218)							
Net expenditure	**(124,297)**							

Note 2.1 Operating segments – 2023-24

For the year 1 April 2023 to 31 March 2024	Total	Blood Components (inc. R&D)	Tissue and Eye Services	Organ Donation & Transplant	Pathology	Therapeutic Apheresis Services (TAS)	Cell, Apheresis and Gene Therapies (excl. TAS)	Plasma
	£000	£000	£000	£000	£000	£000	£000	£000
Revenue								
Provision of products and services	**415,989**	322,299	19,382	-	39,191	14,965	19,650	502
Income from Scottish Parliament	**7,232**	-	-	7,232	-	-	-	-
Income from National Assembly for Wales	**4,753**	-	-	4,753	-	-	-	-
Income from Northern Ireland Assembly	**2,703**	-	-	2,703	-	-	-	-
Other income	**34,535**	7,946	-	1,298	3,134	376	3,263	18,518
Programme funding from the DHSC	**113,425**	11,118	963	78,512	2,945	333	3,410	16,144
Total revenue	**578,637**	**341,363**	**20,345**	**94,498**	**45,270**	**15,674**	**26,323**	**35,164**
Expenditure								
Variable costs	**(67,033)**	(40,961)	(3,331)	(3,814)	(8,076)	(4,694)	(4,194)	(1,963)
Direct costs	**(286,142)**	(145,826)	(11,713)	(74,780)	(22,456)	(6,739)	(16,438)	(8,190)
Direct support costs	**(149,104)**	(114,347)	(3,442)	(10,362)	(8,254)	(1,435)	(8,270)	(2,994)
Movement in value of stocks	**(72)**	383	2	-	-	-	-	(457)
Other support costs	**(55,859)**	(33,664)	(1,978)	(10,228)	(3,866)	(1,221)	(2,938)	(1,964)
Total expenditure	**(558,210)**	**(334,415)**	**(20,462)**	**(99,184)**	**(42,652)**	**(14,089)**	**(31,840)**	**(15,568)**
Operating surplus/(deficit) for the financial period before transformation[1]	**20,427**	6,948	(117)	(4,686)	2,618	1,585	(5,517)	19,596
Transformation costs	(19,756)	(6,395)	-	(6,600)	(941)	(394)	(686)	(4,740)
Operating surplus/(deficit) for the financial period	**671**	**553**	**(117)**	**(11,286)**	**1,677**	**1,191**	**(6,203)**	**14,856**
Add: notional cost of capital included in expenditure above	7,028							
Less: programme funding from DHSC	(113,425)							
Less: capital charges paid to the DHSC	(21,893)							
Net expenditure	**(127,619)**							

We report our financial performance in operating units as follows:

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

Organ and Tissue Donation and Transplantation includes:

Tissues and Eye Services retrieves and provides human tissue and eye products.

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

Clinical Services includes:

Pathology which provides specialist diagnostic laboratory services (Red Cell Immunohaematology, and Histocompatibility and Immunogenetics), molecular diagnostics and reagents.

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

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

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

Plasma was funded through the remaining non-recurring DHSC programme funding for Plasma for Medicines, sales of Plasma for Diagnostics, and funding from NHS England as per the Plasma Supply Agreement.

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

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

Note 3 Income

Income largely consists of revenue from contracts and service level agreements with customers, the majority of customers being NHS bodies. Contracts typically run for a period of one, two or three years. In all cases, income is accounted for in the year in which performance obligations within the contract are met, as outlined in note 1.4. NHSBT also 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 or services are provided.

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

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

3.1 Income by nature

	2024-25 £000	2023-24 £000
Blood and components	377,437	330,245
Pathology	45,007	42,325
Tissues	22,724	19,382
Stem cells	27,532	22,913
Therapeutic apheresis services	16,431	15,341
Organ donation and transplantation	16,347	15,986
Plasma	25,114	19,020
Total income from activities per SoCNE	**530,592**	**465,212**

3.2 Income by source

	2024-25 £000	2023-24 £000
Department of Health and Social Care	46,828	17,273
NHS Trusts	137,340	128,663
NHS Foundation Trusts	292,554	263,050
NHS Clinical Commissioning Groups/Integrated Care Boards	18	50
Other Government bodies	22,222	20,791
Non-NHS	31,630	35,385
Total income from activities per SoCNE	**530,592**	**465,212**

£20.1m of the Other Government bodies income shown above is contractual income and grant funding from devolved administrations (2023-24: £19.2m).

3.3 Revenue Grant in Aid from DHSC

	2024-25 £000	2023-24 £000
Programme funding – organ donation and transplantation	91,251	76,114
Programme funding – pathology and stem cells	4,161	4,162
Programme funding – blood supply	-	3,640
Programme funding – plasma for medicine	-	16,138
Programme funding – corporate	26,745	12,871
Programme funding – tissue and eye services	766	500
Total revenue grant from DHSC per SoCTE	**122,923**	**113,425**

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

Note 4 Staff costs

	2024-25 £000	2023-24 £000
Salaries and wages*	270,623	244,921
Social security costs**	28,023	26,214
Employer pension contributions***	54,062	42,521
Total	**352,708**	**313,656**

* Includes temporary staff (fixed term contracts, bank and agency staff) £25.9m (2023-24: £19.8m) and termination benefits £0.05m (2023-24: £0.20m), and is net of recoveries in respect of outward secondments £0.1m (2023-24: £0.1m).
** Includes the apprenticeship levy £1.3m (2023-24: £1.2m).
*** Includes contributions to NHS Pensions £54.00m (2023-24: £42.37m) and to NEST £0.06m (2023-24: £0.09m).

On 1 April 2019, the employer contribution rate for the NHS Pension Scheme increased by 6.3 per cent, and was increased by a further 3.1 per cent from April 2024. The additional cost of £21.3m (2023-24: £12.9m) was paid by NHSBT and matched by funding from the Department of Health and Social Care.

In addition, staff costs of £1.1m (2023-24: £1.1m) were capitalised as directly attributable to the development of the new Pulse system (an intangible asset) under the

'Blood Technology Modernisation' project (£0.9m NHSBT staff and £0.2m agency staff).

Note 5.1 Operating expenses

	2024-25 £000	*Re-presented**** 2023-24 £000
Other staff related costs	14,052	12,975
Consumable supplies	78,278	76,730
Maintenance of buildings, plant and equipment	20,766	20,359
Rent and rates	12,433	10,444
Transport costs	29,986	24,038
External contractors	33,083	31,437
Purchase and lease of equipment and furniture	6,933	6,839
Utilities and telecommunications	12,014	16,587
Media advertising	4,110	2,466
Organ Donation Transplant Scheme payments	24,486	21,731
Professional fees *	2,718	2,858
External auditors' remuneration: audit fees **	154	129
Software licence fees***	7,250	5,906
Insurance***	967	1,349
Total	**247,230**	**233,848**

* Professional fees include legal and programme management costs
** No payment was made to the external auditors for non-audit work. The in year audit fee was £130k, with the difference being due to additional audit fees from the prior year.
*** Software licence fees and Insurance were previously included in Note 6 under Miscellaneous. 2023-24 comparative figures have been re-presented to reflect this change.

Note 5.2 Depreciation and amortisation

	Note	2024-25 £000	2023-24 £000
Depreciation – property, plant and equipment	9	14,287	8,656
Depreciation – right of use assets	10	8,445	7,723
Amortisation	11	2,575	1,786
Total		**25,307**	**18,165**

Note 6 Other operating expenditure

	Note	2024-25 £000	*Re-presented** 2023-24 £000
Capital charges paid over as cash to DHSC		23,218	21,893
Capital non-cash: loss on disposal of fixed assets *	8	161	74
Capital non-cash: (reversal of impairments)		(49)	(346)
Miscellaneous **		5,081	4,172
Total		**28,411**	**25,793**

* Loss on disposal of fixed assets (£161k) relates to the book losses of plant and machinery (2023-24: £74k) due to the annual asset verification exercise.

** Software licence fees and Insurance were previously included within Miscellaneous, but are now reported as individual line items in Note 5.1. 2023-24 comparative figures have been re-presented to reflect this change.

Note 7 Other gains/(losses)

	2024-25 £000	2023-24 £000
Loss on disposal of non-current assets	(161)	(74)
Loss on disposal of plant and equipment	**(161)**	**(74)**

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

Note 8 Property, plant and equipment – 2024-25

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/cost at 1 April 2024	**13,181**	**120,422**	**1,802**	**69,490**	**10**	**22,085**	**226,990**
Additions purchased	-	3,635	3,883	4,990	-	61	12,569
Reclassification	-	687	(1,691)	-	-	962	(42)
Indexation	-	-	-	2,827	-	-	2,827
Other in year revaluations	-	(2,828)	-	-	-	-	(2,828)
Disposals	-	-	-	(8,555)	-	(1,536)	(10,091)
Valuation/cost at 31 March 2025	**13,181**	**121,916**	**3,994**	**68,752**	**10**	**21,572**	**229,425**
Accumulated depreciation at 1 April 2024	**-**	**2,831**	**-**	**42,617**	**10**	**11,248**	**56,706**
Provided during the year	-	4,927	-	5,378	-	3,983	14,288
Indexation	-	-	-	1,738	-	-	1,738
Other in year revaluations	-	(4,439)	-	-	-	-	(4,439)
Disposals	-	-	-	(8,416)	-	(1,536)	(9,952)
Accumulated depreciation at 31 March 2025	**-**	**3,319**	**-**	**41,317**	**10**	**13,695**	**58,341**
Net book value at 1 April 2024	13,181	117,591	1,802	26,873	-	10,837	170,284
Net book value at 31 March 2025	**13,181**	**118,597**	**3,994**	**27,435**	**-**	**7,877**	**171,084**
Net book value at 31 March 2025 comprises:							
Owned assets	13,181	118,597	3,994	27,435	-	7,877	171,084
	13,181	**118,597**	**3,994**	**27,435**	**-**	**7,877**	**171,084**
Revaluation reserve	**3,080**	**43,457**	**-**	**2,908**	**-**	**-**	**49,445**

The gross cost of Plant and Machinery that had been fully depreciated, but which was still in use at 31 March 2025, was £15,359k (31 March 2024: £6,801k).

The gross cost of Information Technology that had been fully depreciated, but which was still in use at 31 March 2025, was £4,087k (31 March 2024: £nil).

Note 8.1 Property, plant and equipment – 2023-24

	Land	Buildings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/cost at 1 April 2023	**16,046**	**127,944**	**-**	**63,630**	**10**	**20,215**	**227,845**
Additions purchased	-	954	1,802	5,425	-	2,514	10,695
Indexation	-	-	-	9,526	-		9,526
Other in year revaluations	(2,865)	(8,822)	-	-	-		(11,687)
Impairments	-	346	-	-	-		346
Disposals	-	-	-	(9,091)	-	(644)	(9,735)
Valuation/cost at 31 March 2024	**13,181**	**120,422**	**1,802**	**69,490**	**10**	**22,085**	**226,990**
Accumulated depreciation at 1 April 2023	-	**2,509**	**-**	**44,375**	**10**	**8,957**	**55,851**
Provided during the year	-	5,121	-	600	-	2,935	8,656
Indexation	-	-	-	6,659	-	-	6,659
Other in year revaluations	-	(4,799)	-	-	-	-	(4,799)
Disposals	-	-	-	(9,017)	-	(644)	(9,661)
Accumulated depreciation at 31 March 2024	**-**	**2,831**	**-**	**42,617**	**10**	**11,248**	**56,706**
Net book value at 1 April 2023	16,046	125,435	-	19,255	-	11,258	171,994
Net book value at 31 March 2024	**13,181**	**117,591**	**1,802**	**26,873**	**-**	**10,837**	**170,284**
Net book value at 31 March 2024 comprises:							
Owned assets	13,181	100,199	1,802	26,873	-	10,837	**152,892**
Subsequent expenditure on or relating to assets acquired under a Finance Lease	-	17,392	-	-	-	-	17,392
	13,181	**117,591**	**1,802**	**26,873**	**-**	**10,837**	**170,284**
Revaluation reserve	**3,080**	**43,331**	**-**	**2,622**	**-**	**-**	**49,033**

Note 8.2 Revaluation of property, plant and equipment

NHSBT undertook a quinquennial full revaluation of land and buildings as at 31 March 2024. The valuation was performed by independent RICS registered valuer Gerald Eve LLP (now known as Newmark Gerald Eve LLP).

For 2024-25, the revaluation was performed by the same valuer, and was a desktop revaluation, which occurs in the years between the full quinquennial revaluation.

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

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

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

Specialised properties are revalued at their 'Depreciated Replacement Cost'. This technique involves assessing all the costs of providing a modern equivalent asset using pricing at the valuation date. There are two exceptions, Gloucester Oakes House and London West End Donor Centre which are valued at their Existing Use Value (EUV), as these are non-specialised assets where market-based evidence can be used for valuations.

Note 9 Right of use assets – 2024-25

	Land	Buildings	Transport Equipment	Total
	£000	£000	£000	£000
Valuation/cost at 1 April 2024	11,087	62,560	6,597	**80,244**
Additions	12	489	3,083	**3,584**
Other in year revaluations	1,562	(1,773)	-	**(211)**
Impairments	-	(7)	-	**(7)**
Disposals	-	-	(12)	**(12)**
Valuation/cost at 31 March 2025	**12,661**	**61,269**	**9,668**	**83,598**
Accumulated depreciation at 1 April 2024	10	7,406	3,586	**11,002**
Provided during the year	288	6,284	1,873	**8,445**
Other in year revaluations	(282)	(2,005)	-	**(2,287)**
Disposals	-	-	(8)	**(8)**
Accumulated depreciation at 31 March 2025	**16**	**11,685**	**5,451**	**17,152**
Net book value at 1 April 2024	11, 077	55,154	3,011	**69,242**
Net book value at 31 March 2025	**12,645**	**49,584**	**4,217**	**66,446**
Net book value at 31 March 2025 comprises:				
Leased assets	12,645	49,584	4,217	**66,446**
Revaluation reserve	**11,375**	**18,434**	**-**	**29,809**

Land and buildings held under leases are revalued as described in accounting policy 1.10.2, except where the frequency of rent reviews serve as a suitable proxy for ensuring that the cost of the lease reflects market value.

Note 9.1 Right of use assets – 2023-24

	Land £000	Buildings £000	Transport Equipment £000	Total £000
Valuation/cost at 1 April 2023	10,325	57,368	5,245	**72,938**
Additions	-	7,422	1,371	**8,793**
Rent reviews	-	203	-	**203**
Other in year revaluations	762	(1,447)	-	**(685)**
Disposals	**-**	(986)	(19)	**(1,005)**
Valuation/cost at 31 March 2024	**11,087**	**62,560**	**6,597**	**80,244**
Accumulated depreciation at 1 April 2023	6	3,476	1,830	**5,312**
Provided during the year	90	5,877	1,756	**7,723**
Other in year revaluations	(86)	(1,947)	-	**(2,033)**
Disposals	**-**	**-**	**-**	**-**
Accumulated depreciation at 31 March 2024	**10**	**7,406**	**3,586**	**11,002**
Net book value at 1 April 2023	10,319	53,892	3,415	**67,626**
Net book value at 31 March 2024	**11,077**	**55,154**	**3,011**	**69,242**
Net book value at 31 March 2024 comprises:				
Leased assets	11,077	55,154	3,011	**69,242**
Revaluation reserve	**9,802**	**19,159**	**-**	**28,961**

9.2 Amounts recognised in Statement of Comprehensive Net Expenditure

	2024-25 £000	2023-24 £000
Depreciation expense on right-of-use assets	8,445	7,723
Interest expense on lease liabilities	1,233	1,369
Expense relating to low value, short-term leases and leases where substantially all the economic benefits of the assets will not be obtained over the period of the lease	1,056	4,926
Non-recoverable VAT	851	815
	11,585	**14,833**

9.3 Amounts recognised in Statement of Cash Flows

	2024-25 £000	2023-24 £000
Total cash outflow on interest expense on leases	1,477	1,152
Total cash outflow on repayment on lease liabilities	5,732	6,675
Total cash outflow on purchase of right of use assets	663	-
	7,872	**7,827**

Note 10 Intangible assets – 2024-25

	Software £000	Assets Under Construction £000	Total £000
Valuation/cost at 1 April 2024	19,226	1,173	**20,399**
Additions	3,361	2,351	**5,712**
Reclassification	1,215	(1,173)	**42**
Disposals	-	-	**-**
Valuation/cost at 31 March 2025	**23,802**	**2,351**	**26,153**
Amortisation at 1 April 2024	6,773	-	**6,773**
Provided during the year	2,575	-	**2,575**
Disposals	-	-	**-**
Amortisation at 31 March 2025	**9,348**	-	**9,348**
Net book value at 1 April 2024	12,453	1,173	**13,626**
Net book value at 31 March 2025	**14,454**	**2,351**	**16,805**
Net book value at 31 March 2025 comprises:			
Owned	14,454	2,351	**16,805**
Asset financing	**14,454**	**2,351**	**16,805**
Revaluation reserve	**-**	**-**	**-**

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

NHSBT's most material intangible asset is BTM (Blood Technology Modernisation), which is upgrading our core blood management system, to preserve its long-term future and resilience. At 31 March 2025 BTM had a gross book value of £14.4m (2023-24: £10.2m), a net book value of £11.8m (2023-24: £9.0m) and a expected remaining useful life of 7 years (2023-24: 8 years).

Note 10.1 Intangible assets – 2023-24

	Software Purchased	Assets Under Construction	Total
	£000	£000	£000
Valuation/cost at 1 April 2023	7,725	8,280	**16,005**
Additions	3,283	1,173	**4,456**
Reclassification	8,280	(8,280)	**-**
Disposals	(62)	-	**(62)**
Valuation/cost at 31 March 2024	**19,226**	**1,173**	**20,399**
Amortisation at 1 April 2023	5,051	-	**5,051**
Provided during the year	1,786	-	**1,786**
Disposals	(64)		**(64)**
Amortisation at 31 March 2024	**6,773**	**-**	**6,773**
Net book value at 1 April 2023	2,674	8,280	**10,954**
Net book value at 31 March 2024	**12,453**	**1,173**	**13,626**
Net book value at 31 March 2024 comprises:			
Purchased	12,453	1,173	**13,626**
Asset financing	**12,453**	**1,173**	**13,626**
Revaluation reserve	**-**	**-**	**-**

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

Note 11 Inventories

	31 March 2025 £000	31 March 2024 £000
Raw materials and consumables	7,765	7,940
Work in progress	2,036	2,240
Finished processed goods	14,812	9,947
Total	**24,613**	**20,127**

At 31 March 2025, we held 23,743 litres of plasma for diagnostics (31 March 2024: 22,143 litres), which were valued at £1.84m (31 March 2024: £1.58m). We also held 200,816 litres of plasma for medicine (31 March 2024: 237,596 litres), which were valued at £3.88m (31 March 2024: £nil).

At 31 March 2025, we held finished processed blood and component stocks valued £6.33m (31 March 2024: £6.47m).

Note 12 Trade and other receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade receivables	63,204	50,969
Allowance for impaired contract receivables	(22)	(30)
Other debtors	558	264
VAT	3,440	3,497
Prepayments and accrued income	11,649	15,774
Subtotal	**78,829**	**70,474**
Non-Current		
Other prepayments and accrued income	766	504
Subtotal	**766**	**504**
Total trade and other receivables	**79,595**	**70,978**

Allowances for credit losses

	2023-24 £000	2023-24 £000
At 1 April	(30)	(36)
New allowances arising	(8)	(29)
Utilisation of allowances (written off)	9	5
Reversed unused (recovered)	7	30
At 31 March	**(22)**	**(30)**

Note 13 Cash and cash equivalents

	31 March 2025 £000	31 March 2024 £000
At 1 April	24,441	50,685
Net change in year	13,498	(26,244)
At 31 March	**37,939**	**24,441**
Comprising:		
Cash in hand	1	1
Cash with the Government Banking Service	37,938	24,440
Total cash and cash equivalents	**37,939**	**24,441**

Note 14 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables – revenue	12,084	4,608
Trade payables – capital	784	305
Tax and social security costs	12	16
Accruals	34,365	32,541
Deferred income	11,496	11,115
Total current trade and other payables	**58,741**	**48,585**

Note 15 Provisions for liabilities and charges

	PAYE £000	Employee benefits £000	Redundancy £000	Product liability & other £000	Total £000
At 1 April 2024	58	347	79	887	1,371
Provisions arising in the year	29	4	-	560	593
Change in discount rate	-	1	-	-	1
Utilised during the year	(29)	(34)	(29)	(25)	(117)
Reversed unused	-	(11)	(15)	(372)	(398)
Unwinding of discount	-	8	-	-	8
Balance at 31 March 2025	**58**	**315**	**35**	**1,050**	**1,458**
Expected timing of cash flows:					
– not later than 1 year	58	33	35	1,050	1,176
– later than one year and not later than five years	-	126	-	-	126
– later than five years	-	156	-	-	156
Total	**58**	**315**	**35**	**1,050**	**1,458**

The PAYE provision is in respect of the probable values that will be due to HMRC under the annual PAYE Settlement Agreement process, and in respect of dual office travel expenses.

The provision for employee benefits is in respect of permanent injury benefit awards which are payable over the lifetime of the individuals receiving the payments. The discount rate applied is plus 2.40 per cent as published by HM Treasury in December 2024.

The product liability and other category relates to legal actions brought by individuals arising from the use of NHSBT products; legal claims from donors and employees; and other employee liability and public liability claims.

NHSBT has recognised a provision of £35k in relation to two redundancies at 31 March 2025 (31 March 2024: £79k).

At 31 March 2025 £9,857k is included in the provisions of NHS Resolution in respect of the clinical negligence liabilities of NHSBT (31 March 2024: £10,024k).

Our accounts do not include any provisions related to infected blood, these are included in the accounts of the DHSC.

Note 16 Obligations under leases

Obligations under leases where NHSBT is the lessee.

Minimum lease payments	31 March 2025 £000	31 March 2024 £000
Not later than one year	6,235	6,780
Later than one year and not later than five years	16,692	17,085
Later than five years	21,024	23,438
	43,951	**47,303**
Less future finance charges	(15,586)	(16,084)
Present value of future lease obligations	**28,365**	**31,219**
Present value of minimum lease payments		
Not later than one year	4,667	5,442
Later than one year and not later than five years	12,114	12,807
Later than five years	11,584	12,970
Present value of future lease obligations	**28,365**	**31,219**
Analysed as:		
Current borrowings	4,667	5,442
Non-current borrowings	23,698	25,777
	28,365	**31,219**

Leased properties are held for four main purposes: regional operations (specialist manufacturing, scientific and stock holding), warehousing, donor team bases, and donor centres where the public can donate. Properties are selected specifically to fulfil one of these purposes, and their nature and location, as well as potentially covenants in the leases themselves, may preclude their use for an alternative purpose. The majority of leases include provision for periodic rent reviews, the outcomes of which are not known until the time of the review. Leases liabilities shown in the table above do not assume that break clauses will be exercised, except where a firm decision has been taken to do so. At 31 March 2025 NHSBT was committed to property leases with a value of £4,817k which had yet to commence. When considering the liquidity risk inherent in the maturity analysis of lease liabilities, NHSBT takes into account its going concern status and the ongoing essential need to deliver the products and services it provides, and the potential break clauses available in its leases.

Note 17 Other cash flow adjustments (non-cash)

Other cash flow adjustments	Note	2024-25 £000	2023-24 £000
Depreciation	9 & 10	22,733	16,380
Amortisation	11	2,575	1,785
Impairments/(reversal of impairments)	9 & 10	7	(346)
Loss on disposal	8	141	74
Provisions arising in year	16	594	817
Provisions reversed in year	16	(398)	(216)
Other miscellaneous non-cash adjustment		204	(65)
Total		**25,856**	**18,429**

Note 18 Contingent assets and liabilities

At 31 March 2025 contingent liabilities relating to potential costs associated with donor claims, personal injury claims, employment tribunals, and other employer and public liability claims were £135,088 (31 March 2024: £95,000).

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 2025 the value of contracted capital commitments was £1,584.7k (31 March 2024: £68.0k).

Note 20 Related parties

The DHSC is regarded as a controlling, related party of NHSBT.

Therefore, the individuals and entities that DHSC identifies as meeting the definition of related parties are also deemed to be related parties of NHSBT. In respect of organisations identified as related parties of DHSC Ministers, senior officials or Non-Executive Directors, NHSBT undertook the following transactions during 2024-25, and had the following balances as at 31 March 2025:

NHS Confederation: expenditure £9.1k, amount owed to related party £nil.

In addition, during the year NHSBT has had a significant number of material transactions with DHSC, and with other entities for which DHSC is regarded as the parent Department, including:

- NHS England
- NHS Foundation Trusts
- NHS Trusts
- Integrated Care Boards (ICB)

During the year these transactions were valued at £617m in income (2023-24: £538m) and £35m of expenditure (2023-24: £33m). Of the income, NHSBT received £122.9m (2023-24: £113.4m) from the DHSC in relation to operational grant-in-aid and £17.0m (2023-24: £15.5m) funding for its capital programme.

In addition, NHSBT has had several material transactions with other government departments, central and local government bodies, and NHS bodies of Scotland, Wales and Northern Ireland. These transactions amounted to £22m of income (2023-24: £21m) and £112m of expenditure (2023-24: £92m)*.

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

2024-25 NHSBT Board member	NHSBT appointment	Related party	Related party position held	Income from Related party £000	Expenditure with related party £000	Amounts due from related Party £000	Amounts owed to related Party £000
Charles Craddock	Non-Executive Director	Anthony Nolan	Advisor	1,190	18	343	17
Deborah McKenzie	Chief People Officer	Portsmouth Hospitals University NHS Trust	Associate Non-Executive Director	4,262	77	117	-
Rachel Jones	Non-Executive Director	Northern Care Alliance NHS Foundation Trust	Non-Executive Director	4,536	173	213	28
Lorna Marson	Non-Executive Director	NHS Lothian	Non-Executive Director	355	2,457	34	80

In accordance with IAS 24 the NHS Blood and Transplant Trust Fund is regarded as a related party. NHSBT made recharges to the Trust Fund during the year for costs incurred on its behalf of £31k (2023-24: £14k) and the Trust Fund had £7k outstanding debtors at 31 March 2025 (31 March 2024: £1k).

2023-24 (restated) NHSBT Board member	NHSBT appointment	Related party	Related party position held	Income from Related party £000	Expenditure with related party £000	Amounts due from related Party £000	Amounts owed to related Party £000
Charles Craddock	Non-Executive Director	Anthony Nolan	Advisor	744	13	212	-
Charles Craddock	Non-Executive Director	Accelerating Clinical Trials Ltd	Trustee and Founding Member	-	63	-	-
Deirdre Kelly	Non-Executive Director	Birmingham Women's and Children's NHS Foundation Trust	Consultant Paediatric Hepatologist	614	13	100	3
Gail Miflin	Chief Medical Officer and Director of Clinical Services	Accelerating Clinical Trials Ltd	Non-Executive Director	-	63	-	-
Rachel Jones	Non-Executive Director	Northern Care Alliance NHS Foundation Trust	Non-Executive Director	801	35	118	6

Other related parties – income and expenditure

	2024-25		2023-24	
	Income £000	Expenditure £000	Income £000	Expenditure £000
Accelerating Clinical Trials Ltd grant funding	-	-	-	63
NHS and DHSC bodies	476,742	34,567	409,036	33,443
Other Whole of Government Accounts bodies	22,222	111,615	20,791	92,268

Other related parties – receivables and payables balances

	31 March 2025		31 March 2024	
	Receivables £000	Payables £000	Receivables £000	Payables £000
NHS and DHSC bodies	50,359	515	24,783	12,135
Other Whole of Government Accounts bodies	7,154	589	15,992	7,088

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.

There are no events after the reporting period.

Note 22 Financial instruments

Financial risk management

Due to the continuing service provider relationship that NHSBT has with its customers, and the way they are financed, NHSBT is not exposed to the degree of financial risk faced by business entities. Financial instruments therefore play a much more limited role in creating or changing risk than would be typical of non-public sector bodies. NHSBT has limited powers to borrow or invest surplus funds and financial assets, and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing NHSBT in undertaking its activities.

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

Currency risk

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

Interest rate risk

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

Credit risk

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

Liquidity risk

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

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