



Annual Report and Accounts 2025-26

Listening | Representing | Influencing

NHS Blood and Transplant

Annual Report and Accounts 2025-26

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Peter Wyman,
Chair



Frances O'Callaghan,
Chief Executive and Accounting
Officer

Introduction from the Chair and Chief Executive

We are pleased to present this year's Annual Report for NHS Blood and Transplant (NHSBT), which demonstrates determined progress, shaped by our enduring commitments to patients, donors and the wider NHS. During 2025-26, we have continued to strengthen the foundations of our services while taking important steps to modernise, expand access and build greater resilience for the future. In doing so, we have remained guided by the powerful purpose to save and improve lives through the generosity of donors and the expertise of our people.

At the heart of our work is the vital connection between donors, patients and communities. Over the past year, we have focused on growing and diversifying our donor base – a sustainable, diverse and committed group of donors is essential for meeting the needs of patients today and in the future. We have stepped up efforts to attract new organ, blood, plasma and stem cell donors, while continuing to work with those who give blood, plasma and platelets regularly. We have opened a vibrant new blood donor centre in Brighton, built on our community, commercial and digital partnerships, and launched high-profile campaigns to raise awareness of the life-saving impact of donation.

However, the pressure on UK blood supplies remains high. Demand for Ro blood continues to grow, particularly because of its importance in supporting patients with sickle cell disorder. When supplies of Ro blood are insufficient, the NHS issues more O negative and B negative blood as clinically suitable alternatives, placing additional pressure on these

stocks. In response, we have had to focus some of our available appointment capacity on donors with blood types where stock levels are lowest to meet patient demand and strengthen resilience across the blood supply chain. While this approach has been necessary to meet patient need, it can mean that donors with other blood types have fewer opportunities to donate at certain times.

This is one of the reasons why our overall blood donor base fell during 2025-26, reversing some of the growth achieved in the previous year. Despite this, we have seen encouraging signs, notably the growth in donors with Ro blood types and an associated increase in donors from Black heritage backgrounds. Linked to this, our new Brixton Donor Centre continues to be a major success – from its first months of operation, the centre has attracted a high proportion of new, Black heritage donors, as well as more younger donors, already ranking in the top three centres in terms of the numbers of Black heritage and Ro donors who choose to donate there. But we know that there is more for us to do.

It is also clear that we achieve more when we work together. During 2025-26, we have strengthened our partnerships with community organisations, particularly through our Community Grants programme, helping us to extend our message and reach new audiences across the country. We also built strong relationships with media organisations, including the BBC, Disney and Marvel Studios, alongside corporate employers such as The Co-operative Bank, ITV and the Civil

Service, helping to make donation more visible and accessible. Meanwhile, our revitalised NHSBT Charity, which was relaunched with a new brand identity last year, continues to bring people together and provide invaluable funding.

Listening to our blood donors, we are taking forward a programme of improvements to enhance the donor experience. This includes reviewing the distribution of our collection network with the aim of making it more convenient for donors where possible, expanding our digital booking capabilities, and introducing online eligibility checks to reduce avoidable deferrals.

For plasma, 2025-26 marked a significant milestone as NHS patients began receiving plasma-derived medicines made from UK-donated plasma for the first time in a generation. Although the number of regular plasma donors fell alongside the reductions in our overall blood donor base, we saw increased donation frequency among regular donors. Combined with higher volumes of plasma recovered from whole blood donations, this enabled us to exceed production targets and strengthen national self-sufficiency. This sets us up to be able to expand collection even further in the years ahead: for example, plasma appointments will start being offered in our Newcastle donor centre later this year, giving people in the North East a more convenient way to donate their plasma.

We are also encouraged that over 750,000 people recorded their decision to become an organ donor last year, contributing to more than 28 million people who are now opted in on the NHS Organ Donor Register. This progress is important – when families know their loved one's wishes, they are significantly more likely to support donation, helping to save lives.

Overall transplant activity remained strong despite challenging circumstances, with more transplants carried out in 2025-26 than the previous year. However, the transplant waiting lists reached record levels, underlining the acute pressure on services and the human consequences that come with this. It is clear we need to work even harder to increase consent rates and accelerate the use of new technologies if we want to ensure equitable access for all communities and reduce the number of people dying on the waiting lists.

Every one of us can make a difference by expressing our wish to donate. Partnerships continue to be our most successful way of inspiring people to register a decision on the NHS Organ Donor Register. We are very grateful for our ongoing, successful partnership with the DVLA and in 2025-26 we progressed more initiatives, including improving user journeys within the NHS App and expanding our successful partnership with the Passport Office.

Similarly, our stem cell services continued to evolve. We recruited large numbers of new donors, and the number of successful matches increased

compared to the previous year. At the same time, we acknowledge ongoing challenges in ensuring sufficient representation from minority ethnic groups and strengthening the UK's domestic donor base. Addressing these issues will remain a priority.

Underpinning all of this, we have continued to modernise our infrastructure, recognising that safe, efficient and sustainable services depend on both our physical estate and our digital capabilities. This year saw significant progress, including the relocation and upgrade of key facilities, refurbishment of major sites and continued investment in new donor centres. At the same time, we have advanced digital programmes that improve accuracy, reduce manual processes and support safer patient care – from automated laboratory systems to enhanced organ-matching technology.

Innovation remains central to our work. We are harnessing advances in genomics to improve blood matching, supporting cutting-edge clinical trials, and helping to develop new therapies that have the potential to transform patient outcomes. Our research portfolio continues to deliver high-quality insights and we are focused on translating these into real-world benefits for patients.

All of this progress depends on nurturing our people and building on their commitment and expertise. Last year, we made further progress in delivering our new three-year People Plan, which sets out our ambition to be a more inclusive, supportive and empowering organisation. We have taken steps to improve recruitment, enhance flexible working and strengthen leadership capability, while continuing to advance our commitment to equality, diversity and inclusion. Our staff's dedication, professionalism and compassion remain the foundation of everything we achieve.

We know that there are challenges and also opportunities ahead. Patient safety will always be our highest priority, and we remain committed to learning from, and responding to, the recommendations of the Infected Blood Inquiry. At the same time, we will continue to grow our donor base, improve access and experience, expand our capabilities in plasma and transplantation, and invest in innovation, research and development, and infrastructure. And we know we must go further and faster to tackle health inequalities.

None of this would be possible without our donors – thank you to everyone who has given blood, plasma or platelets, joined the NHS Stem Cell Registry, signed the NHS Organ Donor Register or consented to donate their loved one's organs or tissues. We are grateful to every donor, partner, community representative and member of staff who has contributed to our progress this year. Together, we are building a stronger, more resilient NHSBT – one that is better equipped to meet the needs of patients today and in the future.

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 6,900 people across the UK, with total income and revenue funding of £701 million.

First and foremost we are a healthcare organisation within the NHS, providing frontline care services for donors and patients which form part of the Critical National Infrastructure. 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 platelet 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.

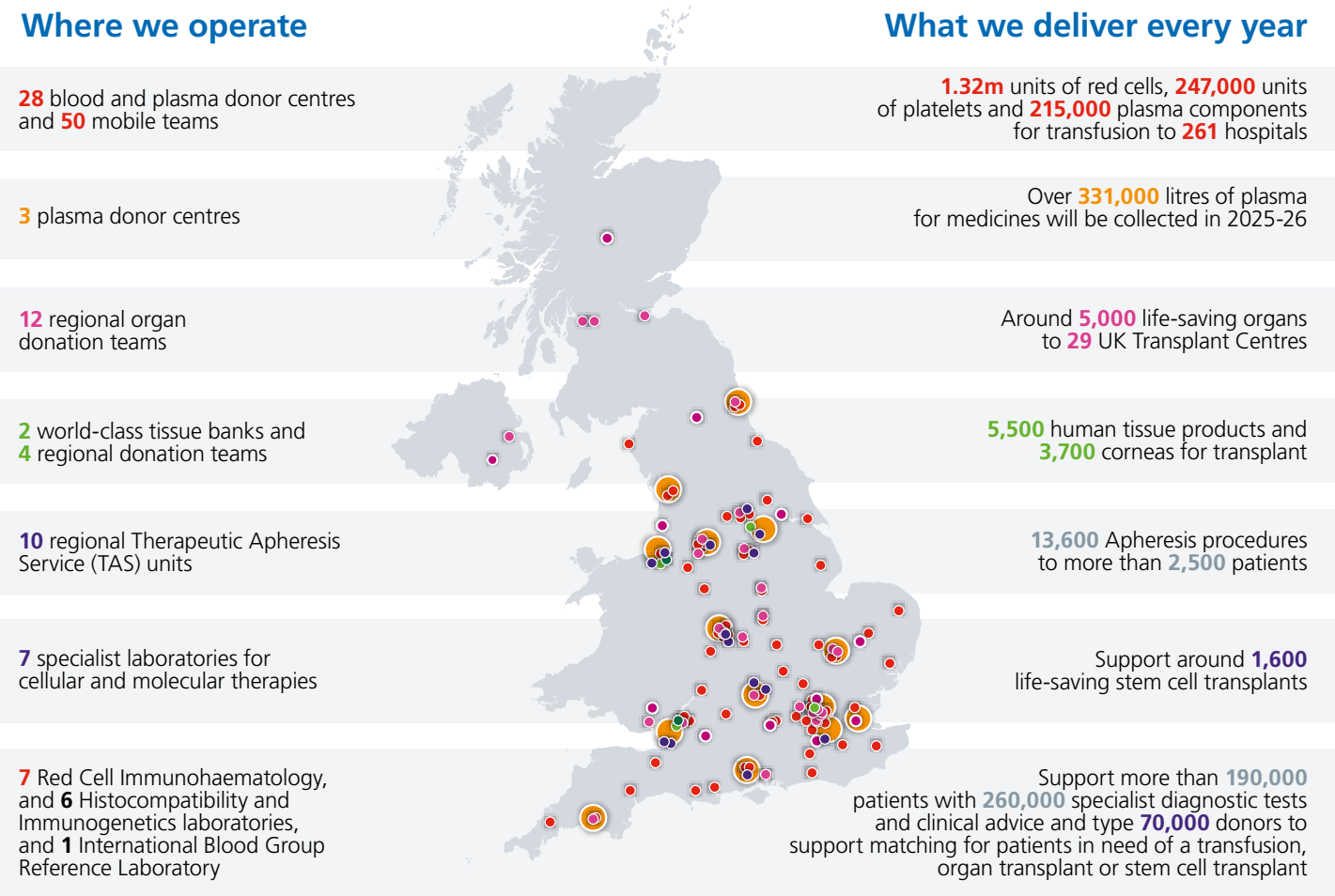
Our mission and ambition

- to save and improve even more lives.

Our values

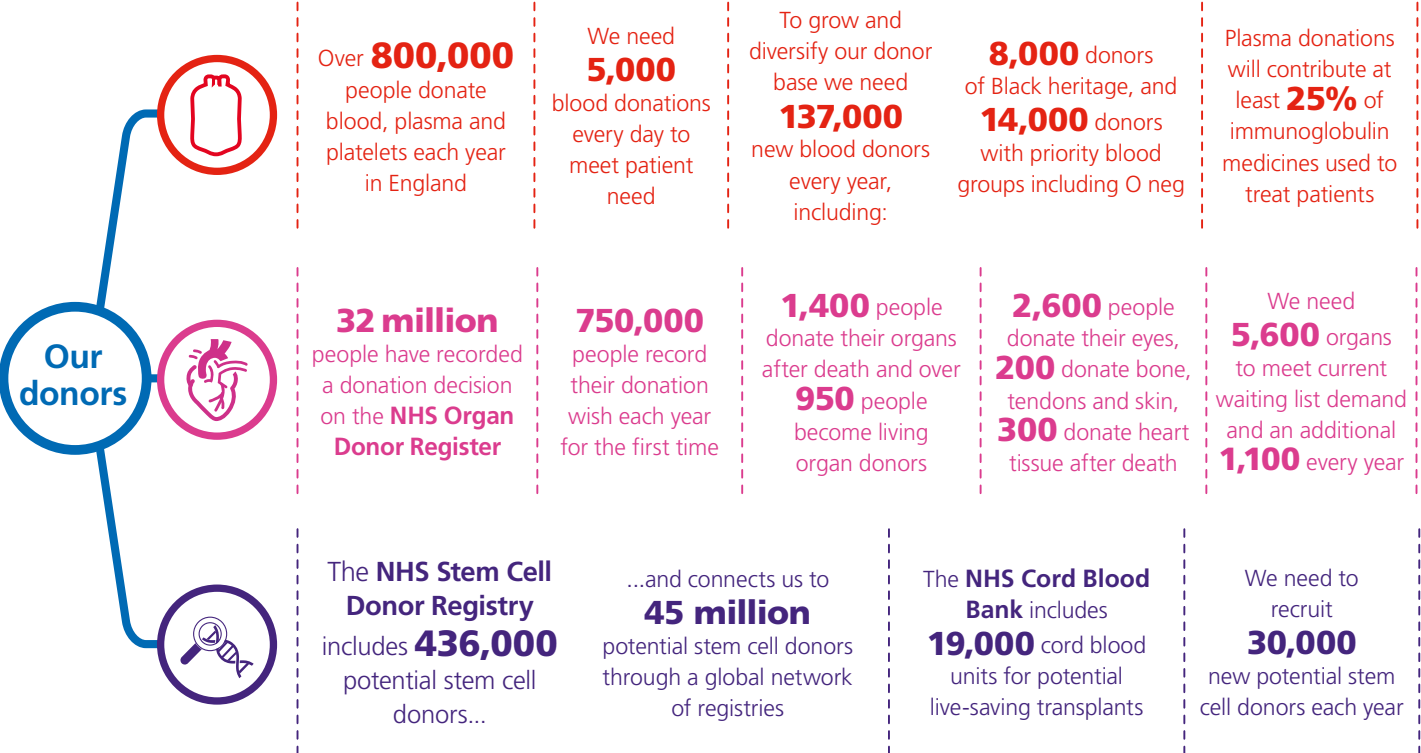
- caring about our donors, their families, our staff and the patients we serve
- being expert in meeting the needs of our customers and partners
- providing quality products, services and experiences for donors, staff and patients.

Our organisation



Our 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 the five strategic priorities shown below. It sets out what we will do to achieve each priority and how we will know when we have succeeded. The strategy also helps us play our part in delivering the Government's **10 Year Health Plan for England: fit for the future**.

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.

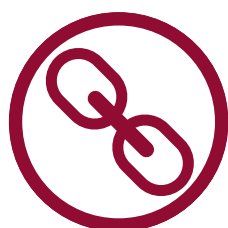
As a Special Health Authority, NHSBT has a unique national role in supporting the NHS with the supply of blood, organs, tissues and stem cells. Our products and services are critical infrastructure for the NHS, so our strategy places strong emphasis on continuity, resilience, safety and security, ensuring patients can rely on us every day, and the NHS can plan with confidence.

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 2025-26 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



Growing and diversifying our donor base



Every day, donors save and transform lives. From emergency transfusions and cancer treatment to organ and stem cell transplants, thousands of patients across the UK depend on these amazing acts of generosity from people they will never meet.

Last summer, during National Blood Week, NHSBT called on the public to become 'one in a million', part of a new long-term drive to build a base of one million regular blood donors to safeguard the nation's blood supply. As demand rises, the NHS will need many more donors to ensure the system is resilient and continues to meet people's needs.

However, the environment for donation remains challenging. It is not always easy for people to find an appointment that fits around their busy lives, and at times our collection teams have had to focus their efforts on the blood types most critically needed. This is making it harder to attract and retain donors.

Despite this, there have been some important areas of progress. The number of donors from Black heritage communities continued to grow, alongside increases in Ro donors – which helps improve care for patients with sickle cell disorder and other conditions who rely on closely matched blood.

More people are also recording their decision on the NHS Organ Donor Register, helping to support life-saving transplants. The NHS's Stem Cell Donor Registry similarly continues to grow, although we need to continue increasing the number of donors so that more patients can find a suitable UK donor match and we can reduce our reliance on donors from international registries.

Across all areas, our focus is on breaking down barriers – making it easier for people to donate for the first time, offering those who already give the best possible experience, and creating a donor base that can fully meet the needs of patients now and in the future.



How we have performed: detailed analysis

Expanding our blood donor base

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
Total size of blood product donor base	795,300	804,910	-1.2%	840,000	Falling – below target
The number of registered donors with Ro blood type who are active donors	27,813	26,678	+4.2%	28,900	Improving – above target
The number of registered donors with O negative blood type who are active donors	107,022	110,946	-3.5%	118,800	Falling – below target

Each year, many thousands of people depend on blood transfusions to treat cancer, blood disorders, trauma, childbirth complications and other conditions. Meeting their needs means not only maintaining a large and committed donor base but also ensuring we collect enough of the blood types that patients need most.

Last year, we saw a dip in the overall number of active blood donors, reversing the growth achieved during 2024-25. The reduction largely reflects difficulties in retaining donors, with many people either not completing their booking journey, or finding it difficult to attend appointments at convenient times – all of which we are working to address.

However, NHSBT has also been adopting a more deliberate and targeted approach to managing its available appointments by prioritising blood types where supply pressures are greatest – particularly O negative, B negative and Ro blood. Through our new Priority Access Service, we have been able to offer more convenient appointments for donors from these critical blood groups, helping to stabilise blood supplies and ensuring we meet patient demand.

These changes have contributed to growth in the number of B negative donors, which increased by three per cent last year. More people from Black heritage backgrounds are also donating, with around 1,100 more active donors over the year: this has, in turn, helped to drive up the number of Ro donors, which rose by 1,139 to 27,813 last year – its highest ever level.

And despite the fall in the overall blood donor base, the volume of blood collected was largely maintained during the year, supported by existing donors giving more frequently as average donation frequency rose from 1.81 to 1.83 donations per donor.

To make it easier for people to give blood, NHSBT has also increased the number of appointments available at community venues, opened new permanent donor centres in Southampton and Brighton, and introduced more accurate iron testing to reduce the number of donors turned away due to low haemoglobin levels. In addition, new mobile sites were launched in Wolverhampton and Hertfordshire, which have performed particularly strongly in attracting O negative, B negative and Ro donors.

Be ‘one in a million’: attracting the next generation of blood donors

As ever, we are hugely grateful to our existing donors for their contribution over the last 12 months. Every donation makes a massive difference in helping to ensure patients receive the care they need when they need it most.

But NHSBT urgently needs more people to come forward. Last year, our marketing initiatives included a national call during National Blood Week – which saw 100,000 people book appointments and 29,000 new donors sign up in just one week in June – as well as a series of targeted campaigns to reach underrepresented groups, including the following:

- Our **'Be There'** advertising campaign showed the life-saving impact donors have in medical emergencies, reaching 90 per cent of our target audience with increased engagement – 70 per cent of people from ethnic minority backgrounds said the adverts felt relevant to them and 66 per cent were inspired to donate blood
- **'Love Is In The Blood'**, our groundbreaking partnership with Channel 4.0, used dating to reframe blood donation as accessible, relatable and culturally relevant for 18 to 34-year-olds, particularly people of Black heritage. The series achieved 17.5 million views, with 85 per cent saying they were inspired to give blood
- Our collaboration with **Marvel Television's Ironheart** marked an exciting step forward in testing a new, community-led collaboration model rooted in culturally resonant storytelling. The campaign brought Ironheart to life through a vibrant programme of activity led by our Community Grant Programme partners and key influencers and designed to connect meaningfully with audiences.



Isaac's story

Isaac was born with Hereditary Spherocytosis, a genetic blood condition which causes fragile red blood cells to break down faster than normal. He receives regular blood transfusions every 12 weeks at the local hospital to stay healthy.

"When Isaac receives his transfusion, you see the colour return to his cheeks, and his energy levels soar before our eyes. It is incredible. Giving blood is a small act that can make a big difference in someone's life."

Scaling up plasma donation for use in medicine

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
Total size of plasma donor base	10,408	11,027	-5.6%	15,030	Falling – below target
The number of plasma for medicine units collected (source and recovered)	331,046	301,197	+9.9% points	240,000	Improving – above target

In March 2026, NHSBT celebrated the first anniversary of UK-sourced plasma-derived medicines being made available to NHS patients – a major milestone in rebuilding the UK’s domestic plasma capabilities after a ban on its use was lifted in 2021. During 2025-26, over 3,200 more NHS patients received life-saving immunoglobulin medicines and around 50,000 patients received albumin medicines, all made from plasma donated by UK donors.

In all, NHSBT collected 331,046 litres of plasma from donors during 2025-26, significantly above our minimum target of 240,000 litres. However, the number of active source plasma donors fell slightly to 10,408 in line with the decline in the overall donor base, although average donation frequency remained strong at around five times in a 12-month period.

Our focus over the next 12 months will be to continue raising awareness about plasma, increasing collections at our existing centres in Birmingham and Twickenham, and restoring full capacity at Reading once a new permanent centre opens in September 2026. During 2026, we will also open an expanded Newcastle Donor Centre, allowing plasma donors to donate alongside blood and platelet donors.



Jessica’s story

Jessica Kent-Hazledine, lost most of her sight just two weeks after giving birth when a rare condition caused antibodies in her blood to attack the nerves in her eyes.

She subsequently underwent multiple plasma exchanges, receiving donor plasma to stop the damaging antibodies. Nearly a year later, she has full sight in her right eye and around 75 per cent vision in her left.

“I had five exchanges, by the third things had started to improve and by the fifth I felt pretty much back to myself. It felt like magic! I still have some blurring but I can look after my son and live an independent life, which I was worried I wouldn’t be able to.”

Growing our organ donor register

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
The number of people opting in to organ donor register (UK)	750,587	735,046	+2.1%	750,000	Improving – above target

Across the UK, thousands of people are waiting for a life-saving transplant – and for many, the best chance of receiving one is through someone who has registered a decision to donate through **the NHS Organ Donor Register (ODR)**.

In 2025-26, NHSBT continued to see strong levels of ODR registrations, with 750,587 more people now **confirming their decision to opt in**. This brings the total number of people on the register who have chosen to donate to 28.8 million (around 42 per cent of the UK population). A further 2.95 million people (four per cent) have recorded a decision to opt out.

However, more than half of the UK population has no recorded decision on the register, which means that too many families are still being left to make difficult decisions at a time of grief and uncertainty while being unaware of their loved ones’ wishes.

Throughout the year, we have worked to increase awareness and prompt conversations about organ donation, with communications focusing on making it easier for people to understand their choices and the importance of discussing them with loved ones.

This has been delivered through a combination of culturally relevant campaigns, workplace initiatives, and partnerships with public services such as the DVLA, helping people make life-saving decisions as part of everyday interactions.



Amrit’s story

Amrit Paul, 25, from London, was diagnosed with chronic kidney disease as a child and has spent five years on the waiting list for a kidney transplant.

During 2025-26, he helped NHSBT appeal for people from the South Asian community and other minority ethnic backgrounds to consider organ donation.

“The main thing is for people to put themselves out there and think about how they will be helping others. I know that because of my ethnicity it can be more difficult to find a match, but I am hopeful that I will get my transplant soon.”

Recruiting new stem cell donors

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
The number of registered stem cell fit panel donors (SCDR Registry)	140,078	125,930	+11.2%	143,000	Improving – below target
The proportion of registered donors from minority ethnic backgrounds	17%	17%	No change	20%	Falling – below target

For patients requiring a stem cell transplant, finding a suitable donor depends on having a large and diverse donor registry to draw upon. Potential donors are primarily recruited when they give blood, plasma or platelets. Human Leukocyte Antigen (HLA) typing is then carried out before they are added to the register and made available for patient searches worldwide.

During 2025-26, over 29,000 blood, plasma and platelet donors agreed to join the NHS Stem Cell Donor Registry (SCDR) – the highest number recorded in the last 30 years – helping the total size of the fit panel to grow by more than 11 per cent to around 140,000 by the end of the year.

Of the new registrations, 4,965 came from donors of Black, Asian and other ethnic heritages, an increase of nearly nine per cent on the previous year. However, overall share of donor recruitment from minority ethnic backgrounds remained slightly below target, accounting for around 17 per cent of total recruitment against a target of 20 per cent.

In all, 223 stem cell matches were successfully sourced from the SCDR over the course of the year. This is an increase of 18.5 per cent compared to 2024-25 (188 matches) and suggests the ongoing efforts to grow and diversify the registry are beginning to improve the chances of patients finding a suitable donor from our register.

This year also marks the 30th anniversary of the NHS Cord Bank, which opened in 1996 and is the world’s third largest cord bank. It celebrated the 1,000th unit transplanted at the end of 2025. A total of 31 cord blood units were issued last year.

Boosting UK self-sufficiency in stem cell provision

Finding the right stem cell donor depends on close cooperation between UK organisations and donor registries around the world to find the best possible match for each patient.

Alongside NHSBT, organisations such as Anthony Nolan recruit donors and help to coordinate donations. Where a suitable UK donor cannot be found, transplant centres can also search international registries, giving patients access to other potential donors across the world, while UK registries similarly provide donors for international patients.

However, relying on overseas donors can increase costs and may introduce delays or uncertainty at critical points in a patient’s treatment. As a result, the Government’s long-term ambition is to increase the proportion of transplants using UK donors.

Last year, despite an increase in stem cell donor matches, NHSBT provided donors for 5.8 per cent of UK patients, below our target of seven per cent. And although the total number of UK-to-UK donations spanning all providers increased to a record 1,300 – up 5.5 per cent on the previous year – this still represented only 24 per cent of the total supply.

In response, the Government has announced a **review of UK stem cell donor provision** to identify how domestic supply can be increased so that more patients can receive transplants from UK donors in future.



NHS Blood and Transplant **Charity**

Relaunch of the NHSBT Charity

The NHSBT Charity supports the work of NHSBT and its partners, enabling staff to do even more for those who rely on these services. It funds new facilities and equipment, groundbreaking research, and new training and education programmes, adding to what the NHS provides.

Examples include a research programme into stem cell transplants and blood transfusion, events bringing paediatric organ recipients and their families together, additional wellbeing support and training for NHS staff, and memory boxes for organ donor families.

During 2025-26, the charity introduced an **ambitious five-year strategy and new brand identity**. It also implemented a **new grant-making framework** that has identified £2.5 million in fundraising priorities, including large-scale innovation, education and infrastructure projects.

Ellaria's story

Ellaria Kirkpatrick received an emergency cord blood transplant four years ago after she developed acute lymphoblastic leukaemia and relapsed after chemotherapy.

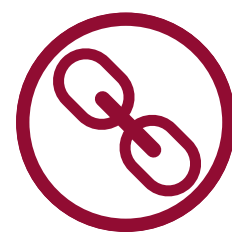
Her mum, Natasha, donated Ellaria's cord blood at birth in 2017 before she received her own life-saving cord blood transplant in 2022. Ellaria is now in year 4 at primary school and remains healthy.

"I cannot thank the mum who donated the cord blood Ellaria received enough. Without the doctors and without that transplant, she would not be here. There are really no words to express how I feel."



Children who have undergone life-saving heart transplants unite at a celebratory event part-funded by the NHSBT Charity. Last year, the charity launched a new fundraising programme and secured a major charitable grant of over £100,000.

Modernising our operations



During 2025-26, NHSBT continued to invest in the systems, facilities and technology that underpin our services, ensuring that we continue to deliver safe, reliable care for donors, patients and NHS partners.

Through our Future Proofing Blood programme, we have been working to strengthen the resilience of UK blood supplies after an Amber Alert for critical shortages of O type blood was lifted last summer. Although demand for some blood groups remained high during the year, stock resilience improved overall, reflecting both the public's generous response to donor appeals and NHSBT's efforts to expand appointment capacity, target collections towards vulnerable blood groups and support hospitals in managing stock levels carefully.

There was also progress in modernising our blood testing facilities, including important upgrades to our microbiology services and the replacement of bacterial screening analysers across our specialist laboratories. These changes are helping improve the reliability and efficiency of blood safety screening and donor testing while also reducing costs.

In addition, NHSBT has been pushing ahead with a series of digital and data transformation projects designed to modernise donor services, laboratories, supply chain operations and clinical systems. This includes a flagship programme to replace donor appointment and session management platforms, as well as broader work to improve laboratory and clinical systems and strengthen the use of data and AI tools.

Digital capability is also central to the new Transfusion Transformation programme being developed with NHS partners. During the year, progress was made in improving digital connectivity with hospitals, expanding electronic requesting and reporting, and supporting better sharing of transfusion and patient data across the NHS.

All of this has been supported by further investment in our estates and facilities during 2025-26, with key upgrades designed to improve the working environment for staff and provide the best possible experiences for donors and patients.



How we have performed: detailed analysis

Future-proofing our blood services

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
Meet customer requirements for delivering product on time and in full including Ro	96.4%	96.6%	-0.2% points	96.9%	Falling – below target
Blood stock stability (days in stock)	7.7	6.2	+1.5	4.5-8.0	Increasing – within target

Ensuring there is enough blood available for the NHS is a delicate balancing act. Blood has a short shelf life, so supplies need to be replenished consistently through donated stock, and overall levels need to be carefully managed on a day-to-day basis to ensure the right blood types are always available.

During 2025-26, our stock levels came under pressure at times, yet by the end of March 2026, **overall stock stood at 7.7 days of supply** – which is over a day more than the equivalent stock levels a year earlier. Although stock levels of key blood groups, such as O negative and B negative, were variable across the year, this did not impact on patient supply – extended periods of low stock were less frequent, and there was a stronger overall buffer across the year compared to 2024-25.

Similarly, while the total number of collections was slightly below target, there was encouraging progress in areas of vulnerability. As we have seen, the **number of donors with B negative and Ro blood** rose during the year, which helped to bolster the amount collected across these crucial blood types. Weekly appointment capacity also rose by approximately 1,300 slots over the year, driven by additional capacity in Wolverhampton, Brighton and Hertfordshire.

However, demand for Ro blood continues to rise steadily, particularly for patients with sickle cell disease, which in turn is leading to more frequent use of O negative and B negative blood as substitutes. In all, 96.4 per cent of hospital requests for blood were successfully **fulfilled on time and in full** – slightly down on the previous year (96.6 per cent).

In cases where we were unable to meet an exact order, hospitals were provided with clinically-safe substitutions, minimising the impact on patients. However, these cases do reflect the increased pressure on certain blood types and the ongoing need for hospitals and NHSBT to manage stocks carefully.



Moving beyond Amber: building long-term resilience

In July 2025, the national Amber Alert for low stocks of O red blood cells, first issued in 2024, was stood down, marking an important step in restoring stability in the supply of this critically important blood type.

NHSBT works with the Department of Health and Social Care (DHSC) and NHS England on efforts to strengthen the resilience of UK blood supply and has taken several important steps under its Future Proofing Blood programme.

These include:

- **focusing donor appointments on blood types most in need**, notably O negative, B negative and Ro where there have been long-standing vulnerabilities
- **increasing appointment capacity** by opening new centres in Brighton and Southampton and expanding mobile provision elsewhere
- **improving efficiencies** by supporting hospitals to use blood more carefully and bringing in more accurate blood testing to reduce the number of donors turned away.

Updating blood testing equipment and facilities

All blood donations are subject to comprehensive safety screening. The **Testing Development Programme** is an integral part of our efforts to modernise and future-proof our blood testing systems, supporting both current service delivery and long-term resilience.

Key milestones in 2025-26 included the implementation of **new equipment within the specialist microbiology laboratory at Colindale**, which is helping to modernise the molecular testing of stem cell and tissue donors.

In addition, **bacterial screening analysers** were replaced across all three testing laboratories with state-of-the-art platforms, enhancing capability, improving reliability, and delivering efficiencies across the service. The programme is also implementing systems and processes required for future integration and automation.



Transforming our digital and data services

During 2025-26, NHSBT continued to develop a series of digital and technology programmes designed to modernise services, improve operational resilience and support better outcomes for donors and patients.

A major focus during the year was the continued development of **the Donor and Session Programme (DASP)**, one of the organisation's most significant long-term digital transformation initiatives. DASP aims to modernise the systems and processes we use to manage donor appointments, collection sessions and frontline donor operations. It is designed to deliver a modern, accessible booking and donor management experience, with smarter scheduling, digitised end-to-end blood collection processes, and improved insight. Work has focused on defining what future service models might look like and how to implement them.

Alongside this, NHSBT continued to develop and align its wider portfolio of **technology-enabled transformation priorities**. These include initiatives involving donor collections, laboratories, transplant services and supply chain operations, as well as organisation-wide investment in interoperability, automation, data and AI capabilities. We are working to develop the future architecture, sequencing approaches, governance arrangements and investment plans for these initiatives, forming a multi-year plan of digital transformation.

We have also expanded our approach to **artificial intelligence (AI), data and automation**.

We have strengthened our AI governance arrangements, introduced approved AI capabilities such as Microsoft Copilot Chat, and delivered several targeted AI and automation pilots. NHSBT has now developed an organisation-wide AI capability framework covering strategy, governance, people, technology and data, helping us to ensure AI is deployed safely, ethically and in line with clinical, regulatory and information governance requirements.

Geopolitical events and technology developments are increasing the cyber threats we face. As seen in well-documented incidents across the economy, the impact of a cyber-attack is felt across the entire organisation, not just its digital function. Consequently, **plans to address cyber security risks** include an organisation-wide response and receive proper scrutiny through organisational governance and through the annual Data Security and Protection Toolkit (DSPT-CAF) return.

And finally, NHSBT completed vital groundwork ahead of the **replacement and modernisation of critical laboratory and clinical systems**, including our laboratory information management system (LIMS) and transplant-related platforms. During 2025-26, this work focused on defining future requirements, improving interoperability and reducing dependency on ageing infrastructure and unsupported technologies.



Digitising transfusion services

NHSBT has worked with partners across the NHS to develop a new five-year strategy to modernise transfusion services, building on the previous Transfusion 2024 programme.

The DHSC's **Transfusion Transformation strategy** sets out a national approach to improving safety, consistency and efficiency across transfusion practice, with a particular focus on data and digital connectivity as well as clinical and scientific standards.

Key digital developments supported by NHSBT during 2025-26 have included:

Fetal Rhesus D (RHD) electronic requesting and reporting: a fully digital service is now in use by 43 hospitals in England with another 42 preparing to go live. The new functionality allows test requests to be referred electronically by hospitals to NHSBT, with results reported automatically into the hospital's laboratory information management system. This should significantly reduce manual transcription processes and quality incidents and improve turnaround times for patients.

Hospital blood data integration: this project is designed to support better planning processes by improving the visibility of data on how blood is used across the NHS. In 2025-26, we successfully developed a proof-of-concept which brought hospitals' blood and component data into NHSBT. Work is now underway to develop automated reports for hospitals.

Electronic requesting and ordering: during 2025-26, we successfully piloted the functionality necessary to refer samples electronically to Red Cell Immunohaematology (RCI) and to Histocompatibility and Immunogenetics (immunogenetics testing only), with plans to begin the rollout of electronic requesting in 2026-27. The aim is to help streamline ordering processes, reducing reliance on paper-based systems and any associated transcription errors.

RCI Assist: 2025-2026 saw the launch of this digital tool, which has been developed to support hospital transfusion laboratories in deciding whether to refer samples for additional tests. Its primary aim is to reduce the risk of delayed transfusions by allowing safe and consistent decision-making, specifically clarifying when investigations can be managed locally and when referral to specialist RCI laboratories is required. Staff have said the tool is helpful in improving their education and confidence in confirming decisions, particularly for those working outside usual hours. RCI Assist has recently been shortlisted for the prestigious Advancing Healthcare Awards 2026.

National Haemoglobinopathy Registry (NHR): the NHR is a secure database that brings together key information on patients with sickle cell disorder, thalassaemia and other rare anaemias to support better planning and care. Over the last 12 months, we completed the process of giving appropriate NHSBT staff read-only access to relevant sections of the NHR. Quality documentation and testing will now be completed.



Modernising our estate

NHSBT has continued to invest significantly in its estate during 2025-26, with work focused on creating better environments for donors and staff, updating key facilities, and strengthening the resilience of critical infrastructure.

At **Colindale**, one of NHSBT's principal blood testing and manufacturing sites, we made further progress in our multi-year improvement programme. This has included opening a new canteen and wellbeing space for staff, and refurbishing its Red Cell Immunohaematology laboratories, which play a vital role in providing blood-matching services for complex transfusions.

Improving our donor centres has been another key focus. In July, **a new donor centre in Southampton** opened, allowing staff and donors to move from the former RAAC-affected site into a modern, fully customised facility. This was followed by the opening of a **new donor centre in Brighton** later in the year (pictured). Both have been designed to reflect local communities and provide a more welcoming environment.

We are also adapting our network to allow more donor centres to collect multiple blood products. Work is underway to **remodel Newcastle into NHSBT's first multi-product centre** during 2026, with expanded capacity for both blood and plasma donation. A new site has been acquired in Sunderland to support plasma donation, and plans are progressing to expand provision at our Shepherd's Bush centre too.



Behind the scenes, we continue to invest in the core infrastructure that keeps our services running safely. This includes upgrades to heating, ventilation and cooling systems, plans for major improvements to electrical infrastructure at Colindale, and preparation for net zero projects such as solar power and electric vehicle charging facilities.

Looking ahead, early work has begun on refurbishing our Tooting site, a key part of NHSBT's blood manufacturing and distribution network. We have also started developing a new long-term **Estates Location Strategy** to guide investment and ensure our facilities continue to meet the needs of donors, staff and patients over the next decade.



Supporting next generation logistics

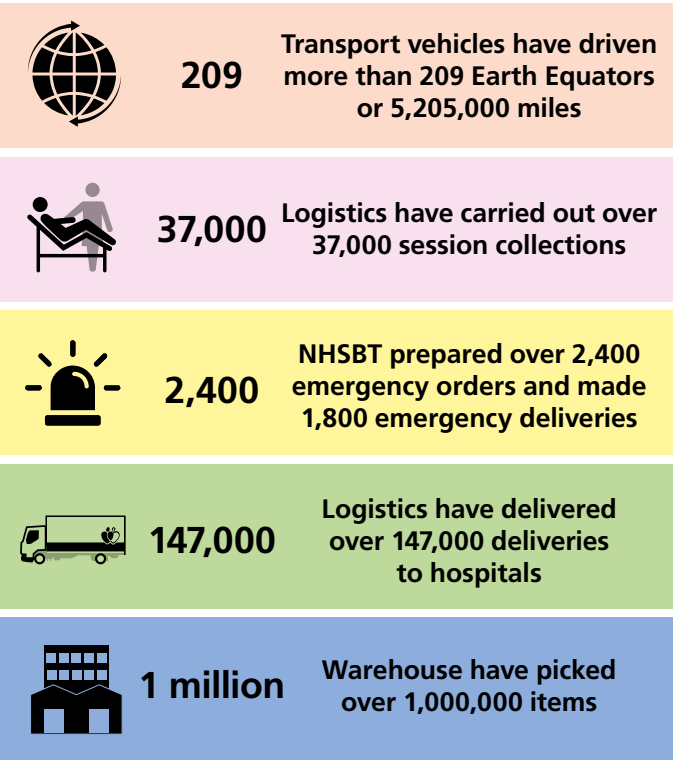
Behind every donation is a large and complex logistics operation working around the clock to move products, equipment and supplies safely across the country to meet demand.

NHSBT's logistics teams operate 24 hours a day, 365 days a year, with around 250 drivers transporting blood products and life-saving equipment between donor centres, manufacturing sites, stock-holding units and hospitals.

Highlights for 2025-26 included:

- **leading the roll-out of new mechanical handling tug equipment**, which has significantly reduced the amount of time lost due to injuries or handling incidents across blood donation sessions teams
- **working alongside NHSBT's Tissues team to consolidate deliveries** to patients of our serum eye drop service which has saved around £250,000 in its first year alone
- **providing transport solutions to Genomics England and the RESTORE project** to support their cutting-edge research programmes
- **attracting the next generation of NHSBT logistics professionals** by supporting a national awareness campaign to encourage young drivers.

Logistics in 2025-2026



Emily's story

Emily Williams is an ambassador for Generation Logistics, a national awareness campaign working with NHSBT to encourage more young people to join its team of drivers, who are responsible for transporting time-critical blood supplies to hospitals across the country.

Each month, NHSBT drivers drive the equivalent of 17 times around the equator, safely collecting and delivering precious units of blood and other vital components, including plasma, platelets and stem cells.

"I feel proud every time I complete a delivery knowing it could mean the difference between life and death. The support and training I've received have made me confident that I've found my career for life."

Investing in our people and culture



As described in our People Plan, NHSBT is committed to building a safe, supportive, empowering and inclusive organisation – giving our staff the best environment in which to deliver for donors, patients and the wider NHS.

During the last 12 months, our recruitment practices have become faster and more effective, helping to fill roles more quickly and contributing towards a reduced reliance on agency staff, which fell by more than 58 per cent during the year. Staff turnover has similarly reduced, helping to stabilise resourcing across teams and reflecting improvements in the overall experience for colleagues.

We have also made progress in our work to build a more open and inclusive organisation. The Anti-Racism Framework continues to be embedded across NHSBT, and further steps have been taken to make recruitment even more inclusive. This is supported by action to improve policies and enhance support for colleagues with different needs, including those who need workplace adjustments.

At the same time, there has been a focus on strengthening leadership and improving our ways of working. Training and development opportunities have been expanded, new approaches to performance and career conversations have been introduced, and better processes are being put in place to support career progression and succession planning.

Finally, supporting the health, safety and wellbeing of our teams continues to be a priority. While there have been improvements in reporting and prevention, we are aware that some significant challenges remain – particularly around long-term sickness absence and work-related stress. Improving workplace safety and mental and physical health will therefore remain a key focus in the year ahead.



How we have performed: detailed analysis

Recruiting and retaining our people

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
Overall vacancy fill rate	91.9%	88.8%	+3.1% points	88%	Improving – above target
Staff turnover/ attrition – NHSBT as a whole	10.1%	11.8%	-1.7% points	12%	Improving – better than target

Having the right people in place is essential to delivering safe and effective services across our organisation. Building on the improvement work started in 2024-25, NHSBT made further progress last year in strengthening our recruitment and retention practices, helping more people join and stay with us.

These include:

- delivering our **Talent Acquisition and Recruitment Transformation programme**, a set of measures designed to speed up recruitment practices and move to a more modern delivery model
- **re-organising our recruitment teams** to align with different parts of the organisation to add more value and provide better support to hiring managers
- **making better use of real-time data** to respond quickly to demand, including during the Amber Alert, so that we can prioritise roles that need to be filled and quickly identify and unblock bottlenecks
- improving **induction processes** so new starters are better supported from the outset
- taking forward **actions to make recruitment even more inclusive** so that we attract applications from a wider range of backgrounds.

As a result, performance improved across key measures. Our **overall vacancy fill rate** reached 91.9 per cent, above both the 88 per cent target and last year’s 88.8 per cent. The **time taken to offer reduced by over 40 per cent**, from 11.8 weeks to 6.8 weeks over the course of the year, helping ensure roles were filled more quickly.

At the same time, **staff turnover fell to 10.1 per cent**, continuing a downward trend seen in recent years and reflecting the improvements in employee experience highlighted in the latest Our Voice survey.



Championing diversity and inclusion

2025-26 marked the culmination of the initial phase of the **Forward Together programme**, which has brought together a range of actions to instil a culture of intentional inclusion across the organisation.

Its cornerstone is the **Anti-Racism Framework**, which continues to be embedded throughout NHSBT, supported by a series of external reviews carried out including one on inclusive recruitment, with recommendations being taken forward in the next phase of this work.

Since the programme began, reports of harassment and discrimination from minority ethnic staff have fallen, and satisfaction with workplace adjustments has increased. These changes will continue to be tracked through a new **Inclusion Dashboard**, which will provide a clearer picture of progress over time.

Last year, we also took practical steps to strengthen support for staff with diverse needs. Our HR policies have been reviewed and updated in line with legislative changes, while work is underway to improve how workplace adjustments are delivered: this will include developing better data and trialling new approaches for supporting neurodiverse colleagues.

As a result, the proportion of employees from ethnic minority backgrounds increased from 25.2 per cent to 26.4 per cent over the year. The number of colleagues declaring a disability also rose by over 12 per cent (from 677 to 760), while staff satisfaction with workplace adjustments improved from 47 per cent to 51 per cent according to the Workforce Disability Equality Standard (WDES). Finally, NHSBT continues to benefit from a diverse age profile, as reflected in the 10 per cent rise in the number of employees aged over 61 (from 700 to 771) over the last 12 months.

Strengthening our staff networks

We aim to reflect the communities we serve by embedding intentional inclusion across all activity. Throughout 2025-26, our staff networks have helped to create an environment where colleagues feel safe, heard and supported.

The DAWN Network has provided disability-focused training, events and resources, including a webinar on allyship. It supported carers through a subgroup and peer networks, and contributed to improving workplace adjustments through user research.

The GRacE Network has strengthened cultural awareness and collaboration through Intersectional Allies training and events. It also supported career progression via skills workshops, coaching, and mentoring through a new member directory.

The LGBT+ Network has delivered events, awareness campaigns, and strengthened communications and insight. The network also supported Pride engagement and contributed to inclusive policy development.

The Men's Network relaunched in November 2025, focusing on membership, sustainability and men's health awareness. It has delivered five webinars, developed an ally network, and raised £1,080 for Prostate Cancer UK.

The Neurodiversity Network has improved access to resources, boosted visibility and supported initiatives such as the Hidden Disabilities Sunflower scheme. The network has also led digital accessibility improvements, developed a Copilot AI prompt, created webinars (now podcasts), and delivered manager workshops.

The Women's Network introduced the Pregnancy and Baby Loss Policy, launched a Menstrual Health Guide, and delivered Connect and Grow development sessions. The network expanded engagement through its Book Club, Safe Spaces and its first hybrid conference. It continues to lead working groups and improve access to support.

Supporting the health and wellbeing of our staff

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
NHSBT sickness absence rate	5.1%	4.9%	+0.2% points	5.0%	Increasing – worse than target
Incident harm rates per 1,000 staff members	6.5	7.5	-1.0	7.1	Improving – better than target

During 2025-26, NHSBT has continued to implement its Health, Safety and Wellbeing (HSW) Strategy, which focuses on acting early to prevent sickness, mental health issues and accidents in the workplace.

Measures included:

- **a new stress reporting tool** to help managers identify and respond to emerging issues within their teams
- **the expansion of wellbeing roadshows** around the country to showcase the advice and support available to our staff
- **trialling new tailored approaches to help neurodiverse colleagues** with their workplace health and wellbeing
- **physical improvements to equipment**, such as the introduction of mechanical tugs, to reduce the risk of manual handling injuries.

Over the course of the year, there was a reduction in the number of reported near-misses across NHSBT, while the proportion of harm incidents per 1,000 members of staff also fell below target. Although in some areas, such as Blood Supply, the number of reported incidents increased – largely due to better reporting – the number of serious manual handling incidents overall has reduced.

However, sickness absence, particularly long-term absence, continued to rise during the year and remained above target from October onwards. It is particularly concerning that reported cases of work-related stress continue to rise, while musculoskeletal injuries increased slightly. Work is underway to address these issues, including through a dedicated programme focused on reducing long-term absence and further improvements to wellbeing support.



Helping our people to thrive

Last year, NHSBT continued to invest in learning, leadership and career development across all levels of the organisation.

We introduced **Connected Conversations**, a new approach to personal development planning that encourages more regular, meaningful discussions between managers and colleagues. This has strengthened development conversations and contributed to a 93 per cent completion rate for annual reviews by the end of the year.

There was also a stronger focus on leadership and talent. A **new performance framework for executive directors was piloted**, alongside a more structured approach to identifying and developing future leaders, including succession planning for 25 critical senior roles. Coaching support was increased, with a new internal coaching offer for managers and 41 managers taking part in virtual coaching programmes.

Leadership and management training opportunities were also expanded. Over the year, **NHSBT delivered 80 learning programmes**, supporting more than 1,000 learning events for leaders at all levels. In addition, 334 managers and leaders accessed the digital learning library, and 224 colleagues completed a Core Strengths development profile to help them assess their skill set and experience.

And we continue to invest heavily in those who are starting and building their career with us. A total of 166 colleagues were supported through more than 40 **apprenticeship routes**, with 48 people completing their apprenticeships during the year. A further 52 trainees took part in **placement schemes**, including science placements, supported internships and student nursing pathways. Finally, NHSBT continued to invest in **scientific and clinical training**, helping develop the specialist skills needed to support high-quality care.



Driving innovation



As medical science opens up new possibilities for the NHS, we are proud of the role our clinical and scientific research teams play in turning these advances into better treatment and outcomes for patients.

During 2025-26, we saw important progress across our research portfolio, as several collaborations testing the potential of new blood products moved forward. This includes the conclusion of a major study on the use of whole blood in emergency care, further work on the development of dried plasma in partnership with the Ministry of Defence, and promising advances in the production of lab-grown red cells.

At the same time, the growing use of genotyping – advanced DNA testing that maps blood types at a molecular level – is helping to match blood more precisely. We have now successfully genotyped more than 77,000 blood donors from our STRIDES study, already uncovering hundreds of ultra-rare blood donors and moving us closer to a more definitive inventory that can help reduce complications in patients requiring frequent transfusions.



We are also supporting other important changes in clinical practice. New approaches in organ donation and transplantation, including the rollout of techniques such as abdominal normothermic regional perfusion, are increasing the number of organs that can be used, while expanded access to treatments like automated red cell exchange is improving the realities of care for patients who require regular transfusions.

How we have performed: detailed analysis

Supporting advances in genotyping matching for blood transfusion

Working with our partners, NHSBT has continued to pursue the goal of more personalised and precision-matched blood transfusion services using advanced genotyping.

Around 77,000 blood donors who participated in **the STRIDES study have now had their blood groups genotyped**. It is the first time people's blood groups have been analysed at this scale in the UK.

There are over 300 known blood types and patients who receive repeated transfusions, such as those with sickle cell disorder or thalassaemia, can develop antibodies to blood that does not closely match their own. Genotyping allows us to identify these differences in detail.

The research programme has already identified 484 ultra-rare blood donors, who our specialist laboratory is now confirming before progressing to freeze units. We are also working to upload the donor blood group genotyping information into our PULSE database and confirming results of around 25,000 other donors to meet regulatory requirements for two valid test results.

In parallel, we are collaborating with **Our Future Health** and expect to receive blood group genotype data from around 80,000 donors who have agreed to participate in this research programme. The aim is to create a more precise and comprehensive inventory of blood types that can be called on when a closely matched unit is needed.

NHSBT will continue to support advances in personalised matching in the year ahead – most notably by introducing a new **Human Leukocyte Antigen (HLA) selected red cell service** for kidney transplant patients across the UK. Many patients requiring a new kidney will need at least one red cell transfusion during their treatment, and HLA-selected transfusions can help reduce the risk of organ rejection and improve clinical outcomes. The programme builds on a successful pilot carried out in 2024 and will be rolled out to all transplant centres over the next two years.



Improving the blood component supply chain

Developing new and improved blood products for emergencies and ongoing treatment is an important part of ensuring patients receive the best possible care. During 2025-26, NHSBT has continued to support several leading research programmes designed to improve how blood components are produced, stored and used in the long term.

A major milestone this year has been **the completion and publication of the SWIFT trial**, which explored whether using whole blood at the scene of an emergency could improve outcomes for patients with severe bleeding. The study involved around 900 patients across 10 air ambulance services and has provided important evidence to guide future trauma care.

Work has also continued on developing **universal blood components** that can be safely given to almost any patient without the need for matching. These products could make it easier to treat patients quickly in emergency situations, while also reducing pressure on A negative platelet stocks. Progress has continued during the year in assessing new technologies.

Alongside this, NHSBT is working with the Ministry of Defence on a new **dried plasma product** that can be transported and used more easily than standard plasma. These qualities would make it invaluable in remote or emergency settings, with the potential to be used by military teams and civilian air ambulance services. Laboratory testing is underway on the new product, with plans for a clinical study being developed.

Finally, important progress has been made in **the RESTORE trial**, which is exploring whether red blood cells grown in the laboratory from stem cells can be used safely and effectively in clinical care – an approach that could help address shortages for people with rare blood types. Recruitment has now been completed for this first-in-human trial, with 22 doses given to participants. The study is moving into its final analysis phase.



Toks' story

Toks Odesanmi, 51, from Colchester has sickle cell disorder and is now being treated closer to her home, following last year's expansion in automated red cell exchange transfer services.

She has previously had to travel to London or Cambridge for her transfusions despite having complications in her treatment which makes travel difficult for her.

"When I had to go to London, it was twice for each transfusion – firstly to give a sample and then two days later for the procedure. Being treated closer to home will mean I don't have to miss work or miss my daughter's school events and parents' evenings – with less exposure to triggers for a sickle cell crisis."

Harnessing technology in organ donation and transplantation

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
Total number of organ transplants carried out (living and deceased)	4,658	4,581	+1.6%	4,680	Increasing – below target
The number of organ transplants per deceased donor	2.56	2.56	No change	2.55	Stable – on target
Overall organ consent/authorisation rate	56.9%	58.9%	-1.9% points	62%	Falling – below target

Throughout 2025-26, new technologies and assessment techniques continued to play an important role in supporting organ donation and transplantation.

During the year, donation activity increased, with more deceased donors (1,428) and more transplants (3,649) than the previous year. However, **the numbers waiting for a transplant on the active list** rose by two per cent to around 8,296. Overall consent or authorisation also fell slightly to 56.9 per cent, which remains below our target.

Patients from minority ethnic backgrounds continue to wait longer for a transplant, reflecting both lower rates of consent in these groups and a lower representation on the donor register. Addressing these gaps remains a priority, with work underway through the **Organ Donation Joint Working Group** to improve awareness, support family conversations, and increase identification of potential donors.

Last year also saw a **continued reduction in neurological death testing**, which fell from 73 per cent to 68 per cent. This represents a significant structural shift in the organ transplant landscape since patients who are confirmed as brain dead can go on to donate more organs with better results. As fewer patients are now being tested in intensive care, fewer of these higher-yield donation opportunities are available, which reduces the number of transplants we can support.

In this environment, making the best use of new technologies is therefore even more crucial as it means we can make the most of every donation that does happen. Greater use of advanced techniques such as **abdominal normothermic regional perfusion** – which was expanded across the country last year (see box out) – is expected to increase the number of organs available for transplant in the future.

Alongside this, new pathways are changing how donated organs are assessed before transplant. During 2025-26, NHSBT launched the **Assessment and Recovery Centres (ARCs) programme**, introducing specialised facilities to improve the way organs are evaluated and prepared. If the pilot is successful, a full UK system will be created with the ability to also recondition organs. We predict a full system would enable up to 750 extra life-saving and life-improving transplants every year – a 19 per cent increase on current activity.

Expanding the use of advanced technologies

Abdominal normothermic regional perfusion (ANRP) is a technique whereby oxygenated blood is circulated through organs, such as the liver and kidneys, before they are retrieved. It helps protect the organs from damage and improves how well they function once transplanted.

Last year, following successful trials, ANRP began to be introduced as standard practice across the UK. ANRP has now been piloted by six of the UK's 10 abdominal transplant centres and will be rolled out to all 10 abdominal retrieval teams by 2027 on an ongoing basis. Once fully implemented, it is expected to enable around 150 additional liver transplants each year.



Alex's story

Alex Cornish, 38, had a transplanted liver that was treated using abdominal normothermic regional perfusion in 2025. She had the operation at the Royal Free Hospital in London.

"When you are on the waiting list it's like you have a dark cloud over you. I am extremely grateful to the hospital and to the family of the donor. Every day feels like a gift."

Collaborating with our partners



Working closely with our partners across the NHS and beyond is essential for delivering advanced therapies and services, many of them at the leading edge of medical science. During 2025-26, NHSBT continued to strengthen these partnerships to expand access to life-saving care.

We have seen growth in areas such as therapeutic apheresis, where our services have extended to reach more patients, and in tissue and eye services where work is underway to increase supply and reduce reliance on overseas providers.

One year on from the first NHS patient benefiting from UK-derived plasma drugs, the Plasma for Medicines programme has also continued to strengthen through our ongoing collaboration with national partners – together helping us build a sustainable UK supply of life-saving, plasma-based medicines.

NHSBT also continued to support hospitals in delivering specialist treatments for blood cancers and other serious diseases through our Cellular and Molecular Therapies teams. During the year, we supported 1,568 stem cell transplants for patients across the NHS, as well as providing specialist collection, testing, processing and storage services for advanced cell and gene therapies, such as CAR-T.

However, demand for specialist services continues to increase and in some areas is outpacing current capacity, reflected in longer waiting times for some advanced treatments, the continued reliance on imported products, and other pressures on services. We are therefore working with partners in national working groups and other reviews to scope future demand and plan how services will need to expand.



How we have performed: detailed analysis

Expanding our Therapeutic Apheresis Service (TAS)

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
The number of therapeutic apheresis procedures carried out	13,609	13,006	+4.6%	14,420	Increasing – below target

The **Therapeutic Apheresis Service (TAS)** provides specialist treatments for patients with a range of serious conditions, including sickle cell disorder, blood cancers and autoimmune diseases. During 2025-26, overall levels of activity continued to rise, although volumes remained below target. In all, TAS units around the country supported a total of 13,609 procedures, 4.6 per cent higher than in the previous year, reflecting a steady growth in demand for these services.

There was a particular rise in the volume of **red cell exchange procedures**, which grew by 25 per cent to 3,572 over the last 12 months. This has been supported by additional investment through the MedTech Funding Mandate, which has allowed us to expand services into new locations, including Basildon, Bradford, Cambridge and Norwich.

By contrast, **cell collection activity** fell below plan, partly due to changes in clinical practice as hospitals increasingly use new therapies for conditions such as myeloma and lymphoma, which do not require stem cell transplantation. However, NHSBT continues to plan for future demand, with a new facility opening in Bristol designed to support a broader range of cell collection activity as these treatments evolve.

Plasma exchange activity was also below our projected target for 2025-26, although demand varied considerably across the year. Plasma exchange is a treatment where a patient’s plasma is removed and replaced with donor plasma or a substitute. It is used to treat a range of serious conditions, including autoimmune diseases, where harmful antibodies in the blood need to be removed.

During 2025-26, a new service in the south west peninsula was introduced to improve care for patients in that region.

Looking ahead, demand for apheresis services is expected to continue to expand in line with the long-term strategy set out in 2022. **A national working group**, led by the DHSC in partnership with NHSBT, has recently reviewed future requirements and will take forward plans for further expansion over the next 12 months.



Improving transfusion skills and training

Alongside the major digital and data initiatives described above (page 22), another important aspect of the new **Transfusion Transformation programme** involves strengthening education and training across the NHS.

During 2025-26, NHSBT continued to work closely with universities, professional bodies and frontline transfusion specialists to improve both medical and scientific transfusion education. Evidence gathered through the programme was presented to the General Medical Council (GMC), helping to enhance transfusion content within **undergraduate medical training**.

Supporting this, NHSBT co-produced **a new professional development framework** with transfusion practitioners working in hospitals. The framework is intended to support more consistent standards of transfusion practice and clearer development pathways for specialist staff.

Progress was also made in scientific and laboratory education. **A national undergraduate working group** was established, bringing together 17 universities, the Institute of Biomedical Science and NHSBT to improve transfusion content within Biomedical Science degrees. During the year, additional funding was secured and three new e-learning modules were developed to support lectures and practical training for students entering the profession.



Tegan's story

Tegan Rendell, 20, attends Bristol's Therapeutic Apheresis Services unit every eight weeks for a plasma exchange to treat Autoimmune Limbic Encephalitis, an autoimmune disease.

The unit, housed in the Bristol Haematology and Oncology Centre, has pioneered the use of ultrasound-guided cannulation to help patients requiring apheresis.

Its success has inspired the roll-out of a new training programme across eight other TAS units across the country, helping more patients to benefit from a less invasive technique.

"My illness means I need to undergo a lot of medical procedures and it can be really traumatic. Ultrasound-guided cannulation – and the incredible nurses who do it – make my experience so much better than it might otherwise be."

Advancing cellular and molecular therapies

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
The number of stem cell transplants supported by Cellular and Molecular Therapies (CMT)	1,568	1,737	-8.1%	1,740	Falling – below target
Total income generated by the Clinical Biotechnology Centre (CBC)	£3.11m	£3.2m	-2.8%	£5.5m	Falling – below target
Total income generated by Advanced Therapies Unit (ATU)	£1.31m	£1.47m	-10.8%	£2.4m	Falling – below target

During 2025-26, NHSBT continued to support hospitals in delivering life-saving treatments for blood cancers by providing specialist services to collect, process, test and store cellular products.

Last year, we supported a total of **1,568 stem cell transplants** for patients, compared to 1,706 in 2024-25. The reduction was due to a decrease in stem donations collected for autologous transplants across NHS trusts, particularly driven by a fall in collections for myeloma treatments as a result of changing clinical practice.

NHSBT also supports the development and delivery of multiple **new cell and gene therapies** for blood cancer and other diseases. It does this in two ways: firstly, by collecting starting materials from patients, then receiving, storing and distributing the therapies for clinical trials and licensed medicines; and secondly, by directly manufacturing the cell and gene therapies in specialist clean room facilities under licence from the Medicines and Healthcare products Regulatory Agency (MHRA) for clinical trials across the UK.

Our work has been supported by a £5m grant from the MRC and LifeArc to successfully develop new viral vector gene therapy manufacturing in-house at the Clinical Biotechnology Centre (CBC) and further funding from the National Institute for Health and Care Research (NIHR) and the Blood and Transplant Research Unit (BTRU), as well as direct payments from companies utilising NHSBT's expertise across our three Advanced Therapy Units (ATUs) and CBC.

In 2025-26, the Barnsley ATU site completed a successful validation of a **gene-modified cell therapy (CAR-T) manufacturing process** in collaboration with a company, although the company withdrew from this area of research for other corporate reasons. The Cellular and Molecular Therapies team also completed manufacture of 10 products for recipients in the RESTORE clinical trial who received red cells derived from adult stem cells.

Income from our ATU and CBC manufacturing services was below target last year, mainly due to delays in securing a customer for viral vector manufacturing and changing customer requirements for our cellular therapy manufacturing projects. During 2025-26, we undertook an external review of commercialisation activities and are now taking forward recommendations to maximise our potential in this area.



Victor's story

Retired engineer, Victor Mattravers, 79, became one of the first patients in the country to get a groundbreaking cell therapy for an aggressive form of leukaemia, using NHSBT's specialist facilities.

He had his white blood cells collected and modified to attack the cancer, a process that involved our Cellular and Molecular Therapies team in Bristol working closely with the NHS and a UK-based drug company.

The resulting drug – called aucatzyl – is a highly personalised treatment for when other treatments for acute lymphoblastic leukaemia (ALL) have failed.

"I've had ALL since 2019. I am very grateful to get such a new treatment. If it keeps proving to work hopefully it will become available to more people."

Scaling up our plasma facilities

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
Total volume of plasma for medicine collected (source and extracted from whole blood)	331,046 ltrs	301,197 ltrs	+9.9%	240,000 ltrs	Increasing – above target

During 2025-26, NHSBT continued to grow its successful **Plasma for Medicines programme**, which has now provided plasma-derived medicines for over 3,200 UK patients, putting us on the road to greater self-sufficiency.

Through a network of blood processing facilities across England – including a new purpose-built testing laboratory in Manchester – our teams prepared and dispatched 459,000 litres of plasma over the course of the year, exceeding our target of 449,000 litres.

This has included completing shipments from the initial launch stockpile in February 2026, as well as the 331,046 litres of plasma collected over the year – exceeding the minimum target of 240,000 litres.

Together, this is ensuring that manufacturers now have a steady flow of UK-sourced plasma to support the ongoing production of these vital medicines and has been achieved despite a reduction in the overall number of source plasma donors.

The Plasma for Medicines programme has been delivered through close collaboration between NHSBT, the DHSC, NHS England and our commercial partner, all working together to build a reliable, end-to-end supply chain. Over the next 12 months, we will focus on strengthening the plasma donor base, restoring full collection capacity across our three specialist centres, and supporting the next phase of UK production.



Samantha’s story

Samantha Bloomfield, 55, has Common Variable Immunodeficiency (CVID) and has relied on intravenous immunoglobulin (IVIG) therapy for over 15 years. In June 2025, she switched to a UK-derived plasma medicine.

Last year, Samantha appeared on BBC Breakfast as part of NHSBT's awareness-raising activity to mark the first anniversary of patients benefitting from UK-donated plasma drugs.

“I am so grateful for the people who donate blood and plasma. My infusions take two little hours every four weeks, they are life changing for me.”

Extending access to tissue and eye services

Key measure	2025-26	2024-25	Year-on-year trend	2025-26 target	Performance
Number of corneas issued for treatment	4,458	3,929	+1.9%	3,816	Increasing – below target
Total income generated by Tissue and Eye Services (TES)	£26.17m	£23.17m	+16.5%	£21.82m	Increasing – below target

Tissue and Eye Services (TES) play an important role in restoring sight and improving quality of life for patients across the UK. During 2025-26, activity increased in some areas, but supply continues to fall short of growing demand for corneas and heart valves.

There was strong growth in **ocular donation and transplantation**. A total of 2,798 cornea donors were recorded during the year, up 12 per cent on 2024-25, and 4,458 corneas were issued, an increase of just over 15 per cent.

Meanwhile, patterns in **tissue donation** continue to fluctuate, which is affecting the availability of key products – in particular, heart valve availability remains critically low, highlighting ongoing challenges in achieving a stable and self-sufficient UK supply.

However, the **Serum Eyedrops programme** continues to be a success story, with strong growth in activity and income. During the year, 6,216 batches were issued to patients, exceeding the target of 5,557. However, demand continues to outstrip supply: the number of patients waiting for treatment increased from 281 in February to 328 at the end of March, with most patients waiting more than six weeks. Work is underway to expand capacity and reduce waiting times.

Overall, **TES income** was broadly in line with plan, with strong revenues generated from serum eyedrop sales offsetting the shortfalls across ocular and tissue services. Looking ahead, the focus remains on increasing donation, improving operational efficiency and expanding capacity to ensure more patients can benefit from these services.



Our sustainability

Our emissions data is set out in the table below. Where detailed activity data is unavailable, spend-based factors sourced from data published by the Department for Environment, Food and Rural Affairs (DEFRA) are used. These spend-based factors underwent significant revision during 2025, resulting in a material increase in some reported emissions, even where spend remained unchanged.

Emissions data April 2025 to March 2026

Emissions source	Carbon (tCO ₂ e) 2025-26	Carbon (tCO ₂ e) 2024-25
Natural gas	2,770	2,978
CO ₂	20	332
Gas oil	1,352	49
Diesel	2,660	2,509
Fugitive refrigerant gases	248	133
Total Scope 1	7,050	6,001
UK national grid electricity	4,202	4,976
Total Scope 1 & 2	11,252	10,977
Transport	642	752
Transmission, distribution and generation loss	1,634	1,656
Flights	92	274
Regular taxi, motor bike and bus	118	32
National rail	177	202
Waste	12	19
Electric vehicles	19	19
Commuting	29	29
Working from home	235	235
Water	7	4
Purchased Goods and Services*	198,368	96,212
Total Scope 3*	201,333	99,434
Total Scope 1, 2 & 3	212,585	110,411
Self-generated renewables during the year	373,573 kWh	256,839 kWh

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. *The 2025 DEFRA spend-based emissions dataset includes significant methodology and data changes compared with previous years. These changes have resulted in major revisions to several emissions factors used in Scope 3 carbon accounting. Substantial increases in reported emissions are therefore likely even where spend levels remain unchanged. The increase reflects a methodological update rather than an actual rise in operational emissions. The spend-based factors are sourced from DEFRA's annual greenhouse gas and carbon dioxide emissions relating to UK and England consumption dataset. These factors support Scope 3 emissions calculations where detailed activity data is unavailable.

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), and strategy parts (a), (b) and (c) are not considered material.

TCFD disclosures

Voluntary compliance

NHSBT is classified as a public corporation and is not consolidated into the DHSC 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 72.

The Board reviews and approves the Net Zero Strategy, and delegates regular monitoring of progress against objectives and targets to the Executive Team.

The aim of the Net Zero Strategy is:

- to be deliverable predominantly through business-as-usual activity
- that decarbonisation is embedded into routine estates and operational decisions
- that where investment is required, it will sit within standard financial governance, and prioritisation will be within the existing investment portfolio

Board oversight of specific investment opportunities and expenditure will therefore be in line with the Standing Financial Instructions and Scheme of Delegation.

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.

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.

Delivery against the strategy is reviewed by the Executive Team. A new Net Zero Oversight Group is being established to monitor progress, challenge directorate leads, and report regularly to the Executive Team.

The responsible officer is the Head of Estates, Facilities and Net Zero, who is responsible for developing and deploying the strategy, as well as the monitoring and reporting process.

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.

Metrics and targets

Our emissions data for 2025-26, together with comparative figures for 2024-25, is set out on page 41. 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 2025-26 was £700.7m (2024-25: £653.5m). Nearly 70 per cent of our income is provided through sales of products and services to the NHS, 26 per cent is provided as programme funding from the 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 increased income in 2025-26 of £47.2m was mainly due to additional funding received from the DHSC in response to i) the Spending Review submission to support inflation and indirect overheads for organ donation and transplantation, and Blood Supply resilience projects; and ii) additional budget to cover unfunded in-year pressures.

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 Statement of Comprehensive Net Expenditure.

The total income received in 2025-26 was £700.7m (2024-25: £653.5m), and NHSBT reported a surplus on an Income and Expenditure basis of £24.9m (2024-25: surplus of £14.8m) as seen on page 118. The planned Income and Expenditure budget for the year was a deficit of £12.8m. In some reporting years, NHSBT will plan for a deficit as it uses cash reserves to fund planned transformation projects.

The improved financial outcome in 2025-26 versus our planning expectations was driven primarily by:

- a favourable in-year position for organ donation and transplantation, however the programme funding is fully required to underpin future years activity
- lower spending than planned on transformation projects across all divisions, primarily driven by reprofiling of key investments including donor centres, cyber and other blood and donor resilience programs
- additional funding from the DHSC to meet discrete cost pressures within the Blood and Group position that have not been recovered through pricing, including reduced Blood and Component income as a result of lower than planned demand and higher pension contribution costs.

Financial performance by segment compared to 2024-25

The overall income for Blood Components was £359.6m in the year. This was broadly in line with 2024-25 (£357.6m) reflecting the low Blood Component income uplift of 1.7 per cent agreed with the National Commissioning Group (NCG) and the lower demand from, and related charges to, our customers for red cell and platelet products.

Organ Donation and Transplantation (ODT) is funded by DHSC and the three devolved UK governments, which covers direct programme costs plus indirect overheads. ODT funding overall has increased by £22.6m, which includes £13m for overheads, and funding for initiatives such as DCD (donation after circulatory death) hearts and donor characterisation, as well as additional baseline funding for activity.

Sales income in Tissue and Eye Services (TES) was £2.2m higher than the previous year at £24.6m (2024-25: £22.4m). TES ended the year with an overall surplus of £2.9m.

Clinical Services income (Pathology, Stem Cells and Therapeutic Apheresis) increased overall by 7.7 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 £103.9m in 2025-26, compared to £96.5m seen in 2024-25.

Plasma services are primarily funded through the Supply Agreement with NHS England £24.2m, plus sales of plasma for diagnostics of £1.9m.

Capital expenditure

Capital funding is required across a range of defined purposes. These include investment in equipment replacement and lifecycle replenishment to ensure NHSBT is able to deliver agreed volumes and activity levels, whilst maintaining compliance with relevant licensing and regulatory requirements. The operational estate, including networked laboratories and production facilities, is maintained to defined standards, reflecting its classification as Critical National Infrastructure (CNI). In addition, the transformation programme, delivered through the Investment Portfolio, represents a significant proportion of capital expenditure. This capital programme is subject to routine oversight and review by the Executive Team, with periodic scrutiny provided by the Board.

At a detailed level, DHSC provided a total of £19.5m funding for capital in 2025-26 (2024-25: £17m), all of which was fully utilised in-year. £6.0m of the funding related to the Blood Technology Modernisation Project, which is upgrading our core blood management system to preserve its long-term future and resilience. £8.5m was invested across the estate on the Colindale Investment Programme, Brighton Donor Centre, Shepherd's Bush Donor Centre and Southampton Donor Centre, with a further £1.6m spent on Matching and Offering software and various IT projects that support the organisation's strategy to modernise core technology. The remaining £3.4m was utilised for the purchase of critical business equipment across Blood Supply, Clinical Services and Tissue and Eye Services laboratories primarily to meet regulatory purposes.

Net assets

Net assets increased to £341.4m at 31 March 2026 from £307.9m at 31 March 2025. The key movements were:

- non-current assets increased from £255.1m to £273.1m, primarily due to right of use asset additions arising from new leases, owned assets additions, and indexation
- trade and other receivables reduced by £3.5m, from £78.8m to £75.3m. A reduction in trade receivables of £23.2m was partly offset by an increase in prepayments and accrued income of £16.9m, and an increase in VAT and other debtors of £2.8m
- there was a small increase in trade and other payables, which increased by £3.5m, from £58.7m in March 2025 to £62.2m in March 2026. This was primarily driven by an increase in trade payables, partly offset by a reduction in deferred income
- other financial liabilities (current and non-current) increased by £8.7m from £28.4m to £37.1m, due to the impact of a number of new property and fleet leases
- cash increased by £30.2m from £37.9m at the end of March 2025 to £68.1m at the end of March 2026, primarily driven by a reduction in trade receivables.

Note 19 of the financial statements describes NHSBT's contingent liabilities. There are no other significant contingent liabilities to report, as at 31 March 2026.

NHSBT is the corporate trustee for the NHSBT Charity. The total net assets of the charity at 31 March 2026 were £101k (compared to £160k at 31 March 2025). The charity accounts are published on the NHSBT and Charity Commission websites. Although the charity assets are controlled by NHSBT, consolidated accounts are not produced as the charity 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 2026-27, 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 could have a material effect on NHSBT’s ability to deliver its core functions and achieve its strategic aims if they were to occur. The overall assessment of each principal risk is shaped by a range of underlying contributory risks, which are managed within the relevant business areas.

Each principal risk has a designated executive director who is accountable for its ownership and oversight. The Risk Management Committee reviews and challenges these risks, and they are examined in greater depth through dedicated ‘deep dive’ sessions at the Audit, Risk and Governance Committee (ARGC).

The Board oversees the position of all principal risks via the Board Assurance Framework and monthly performance reports, and tracks the progress of actions put in place to mitigate, control and reduce risk exposure.

Principal risks are monitored and managed in line with NHSBT’s agreed risk appetite – which is set by NHSBT’s Board on an annual basis. This was last agreed on 1st December 2025. The table below summarises the risks as of 31 March 2026 and illustrates the status in line with the appetite level.

During the year, two principal risks have been removed from the register. P-06 Clinical Outcomes and Health Inequalities was merged into P-01 Donor and Patient Safety, and P-08 Managers and Leaders’ Skills and Capability was merged into P-07 Staff Capacity, Capability, Recruitment and Retention, and the title of risk P-07 was changed to People Staffing.

The title of P-10 was changed to Failure to Deliver Transformational Change.

Risk Code	Risk Title	Risk Appetite	Residual Score	Residual Risk Appetite Level
P-01	Donor and patient safety	Minimal	12	Judgement zone
P-02	Service disruption	Minimal	16	Risk limit
P-03	Service disruption – loss of critical ICT	Minimal	20	Risk limit
P-04	Donor numbers and diversity	Minimal	12	Judgement zone
P-05	Finance	Open	20	Judgement zone
P-07	People staffing	Open	12	Tolerable range
P-09	Regulatory compliance (primary regulators)	Cautious	9	Tolerable range
P-10	Failure to deliver transformational change	Open	15	Tolerable range
P-11	Corporate governance	Minimal	8	Tolerable range

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 range – 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

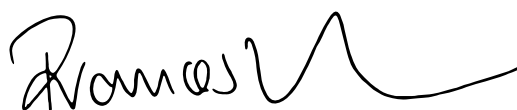
During the year there have been three risks at the 'risk limit', and there are ongoing actions to address these.

P-02 Service disruption. The risk driving the score in 2024-25 was the red blood cell stock, which caused NHSBT to declare an Amber Alert for red cells, and this was lifted in the summer of 2025. The risk currently driving the score is infrastructure failure, with NHSBT's ageing estate being in need of refurbishment. The current geopolitical instability is also a part of the considerations for this risk.

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. A reduction of the risk to judgement zone is anticipated for 2027-28.

P-04 Donor numbers and diversity. This risk was also affected by the blood stock issues that were driving P-02. Similarly, the reduction in score following the stand down of the amber alert status reduced this concern for this risk too, and the risk reduced in score and fell out of the risk limit status in the summer of 2025.

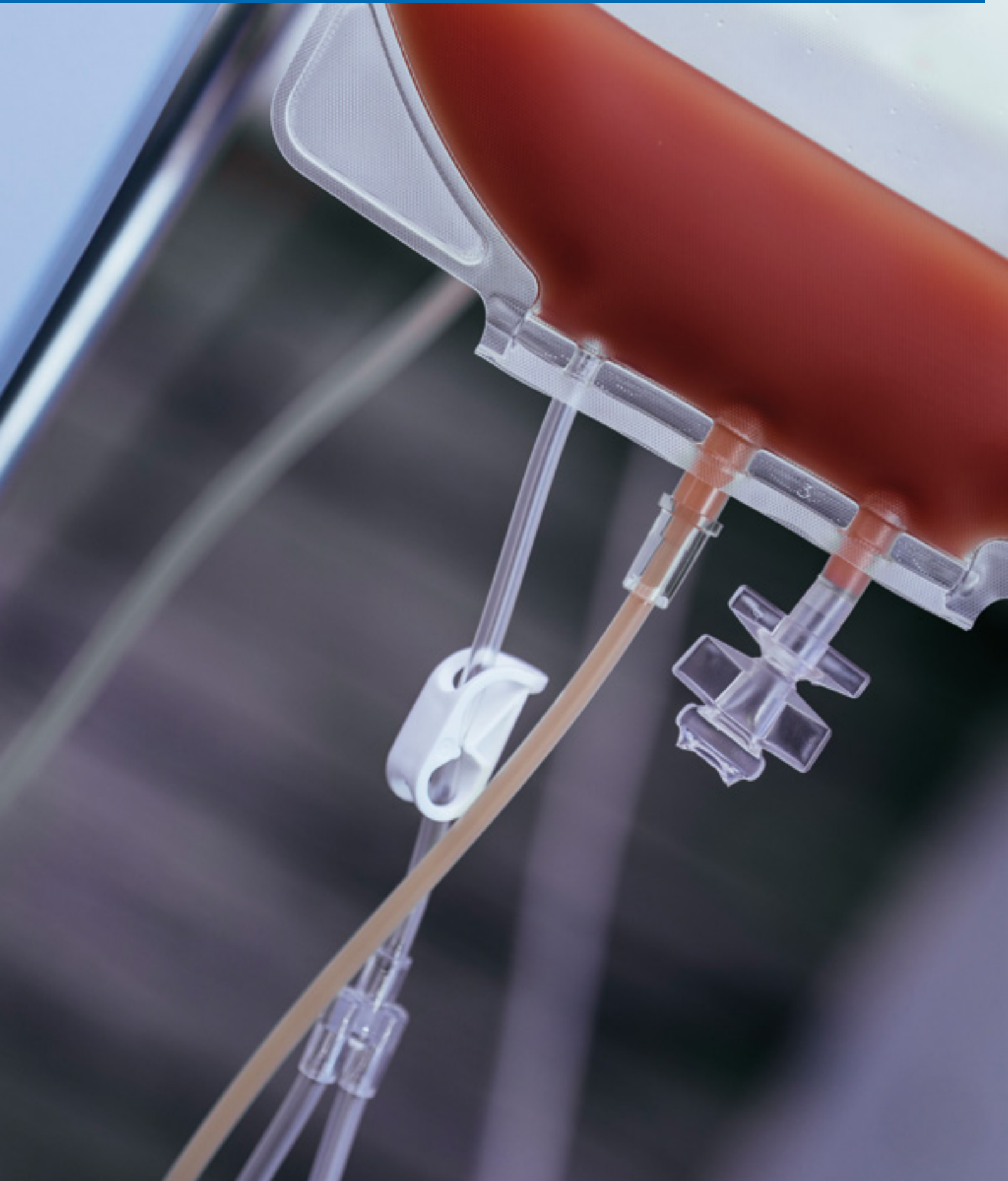
I hereby sign the Performance Report from pages 10 to 47.



Frances O'Callaghan
Chief Executive and Accounting Officer

3 July 2026

Accountability report – remuneration and staff



Our people

At NHSBT, the work we do depends on the expertise, dedication and compassion of our people. Every day, colleagues across the organisation support our donors, manufacture and transport blood products, carry out advanced testing and research, and help to deliver life-saving transplants and transfusions for patients across the UK.

2025-26 marked the second year of our People Plan, which set out to strengthen recruitment and retention practices, improve health and wellbeing support, and build a more inclusive culture where everyone feels valued and able to contribute.

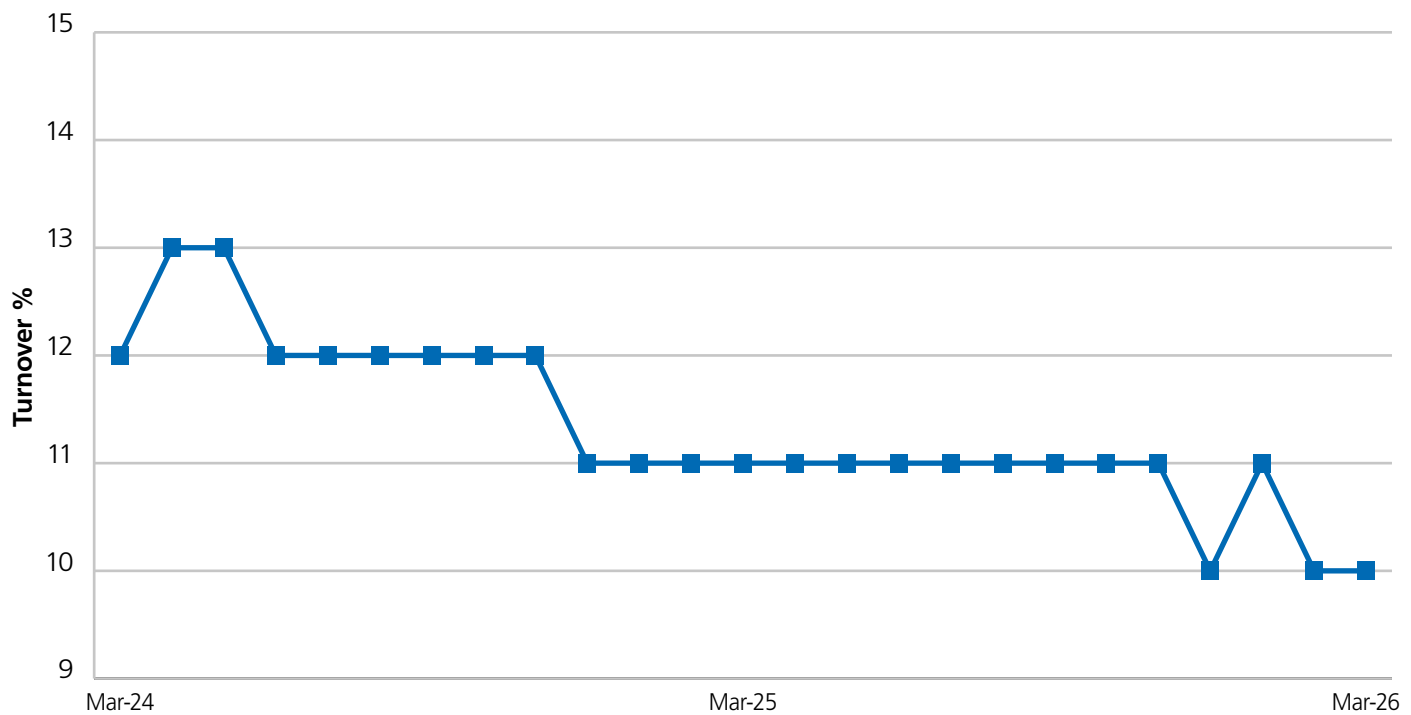
In this section, we provide an overview of our workforce over the last 12 months, including staffing levels, turnover, sickness absence, workforce diversity and leadership representation, as well as information on remuneration and staff costs.

Staff turnover

During 2025-26, we have continued to see our staff turnover steadily decrease, building on the progress made over the previous two years. By the end of March 2026, annual turnover stood at 10.1 per cent, down from 11.8 per cent in 2025. Although this may partly be due to the challenging labour market, it is also likely to reflect improvements in employee experience, as seen in our 2025 staff survey results (see page 60).

Last year also saw some changes in the reasons why people left the organisation, as the proportion leaving because their fixed-term contracts had ended rose from six per cent to 10 per cent. The proportion who left NHSBT because they were dismissed also increased, from four per cent in 2024-25 to over six per cent in 2025-26.

Figure 1. NHSBT's annualised staff turnover (April 2023-March 2026)



Staff numbers and costs

The table on the next page 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 2025-26	Total 2024-25
	£000	£000	£000	£000
Salaries and wages*	266,760	20,119	286,879	270,623
Social security costs**	35,152	1,875	37,027	28,023
Employer pension contributions***	57,140	1,878	59,018	54,062
Total	359,052	23,872	382,924	352,708

* Includes fixed term and bank staff £18.5m (2024-25: £20.2m), agency staff £1.9m (2024-25: £5.7m), and termination benefits £0.6m (2024-25: £0.05m), totalling £21.0m (2024-25: £25.95m), and is net of recoveries in respect of outward secondments £1.7m (2024-25: £1.8m *restated*).

** Includes the apprenticeship levy £1.4m (2024-25: £1.3m).

*** Includes contributions to NHS Pensions £59.0m (2024-25: £54.0m) and to NEST £0.05m (2024-25: £0.06m).

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 £23.3m (2024-25: £21.3m) was paid by NHSBT and matched by funding from the DHSC. The total employer contribution rate is 23.7 per cent.

In addition, staff costs of £1.6m (2024-25: £1.1m) were capitalised as directly attributable to the development of the new Pulse system (an intangible asset) under the 'Blood Technology Modernisation' project (£1.6m NHSBT staff) and the Matching and Offering project (£0.05m agency staff).

	Permanent	Other	Total
Full-time equivalents	Number	Number	Number
Year Ended 31 March 2026	5,720	326	6,046
Year Ended 31 March 2025	5,439	460	5,899
Of which: Number of full-time equivalent (FTE) employees engaged on capital projects:	21	1	22

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

Employee data at 31 March 2026

Year	Female	Male	Total
Directors	15	8	23
Senior manager (Band 8d and above)	157	150	307
Employees (Band 8c and under)	4,976	2,279	7,255
Total	5,148	2,437	7,585

Data in the table above is based on headcount, not FTE, and includes bank staff.

Expenditure on consultancy

Consultancy expenditure during 2025-26 was £227k (2024-25: £177k). 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 2025-26 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 there was no material change in the total pay and benefits pay multiple which was 6.8, compared to 6.7 in the previous year.

	2025-26	2024-25
Highest director banded remuneration	£260k to £265k	£255k to £260k
Lowest banded remuneration	£5k to £10k	£5k to £10k
25th percentile remuneration (total pay and benefits)	£30,162	£29,525
50th percentile (median) remuneration (total pay and benefits)	£38,682	£38,555
75th percentile remuneration (total pay and benefits)	£54,710	£52,809
Remuneration ratio (total pay and benefits)	6.8	6.7

Performance pay and bonuses for the year totalled £13k. When calculating the percentiles in the table above, there was therefore no material difference between total pay and benefits and the salary component of staff remuneration, and accordingly figures have only been presented for total pay and benefits.

Year	25th percentile pay ratio	50th percentile (median) pay ratio	75th percentile pay ratio
2025-26 total pay and benefits	8.7:1	6.8:1	4.8:1
2024-25 total pay and benefits	8.7:1	6.7:1	4.9:1

In accordance with the updated guidance in the HM Treasury Financial Reporting Manual, the figures for 2025-26 in the above two tables exclude non-executive directors. The figures for 2024-25 include non-executive directors and have not been restated.

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 1.96 per cent from the previous year. During 2025-26, no employees (2024-25: 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 £1.90 (2024-25: £5), a fall of 63 per cent.

There was no material change in the 25th, 50th and 75th percentile pay ratios in 2025-26, when compared to 2024-25.

Sickness absence data

Sickness absence data is reported on a calendar year basis in line with national reporting requirements. During the period from January 2025 to December 2025, the total number of full-time equivalent days lost to sickness absence was 70,606 days (2024: 68,658 days). This equates to an average of 11.8 days per full-time equivalent (2024: 11.9 days) and a sickness absence rate of 5.2 per cent (2024: 5.3 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 2026 is based on valuation data at 31 March 2024, updated to 31 March 2026 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 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 £58,966k during 2025-26 (2024-25: £53,998k), and estimates that its employer contributions for 2026-27 will be £61,500k.

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 2026 there were 86 employees enrolled in the NEST scheme (31 March 2025: 122).

Exit packages

This is subject to audit.

During 2025-26, there were seven payments for departures from NHSBT which included four compulsory redundancies, and three other departures including pay in lieu of notice and special severance payments. The sum of £263k has been paid in 2025-26 in respect of these exit packages (2024-25: 5 exit packages and payments of £120k).

There is currently a £480k provision held for exit packages costs (2024-25: £125k).

A total charge (including accruals) of £617k for exit packages was expensed during 2025-26, after adjusting for opening and closing accruals, and is included within salaries and wages in Note 4 of the financial statements (2024-25: £118k). The actual exit packages payment during 2025-26 amounted to £263k.

The table below discloses the number and value by cost band of exit packages paid during 2025-26.

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies (£000s)	Number of other departures agreed	Cost of other departures agreed (£000s)	Total number of exit packages	Total cost of exit packages (£000s)	Number of departures where special payments made	Cost of special payment included in exit package
Less than £10,000	-	-	1	4	1	4	-	-
£10,001 – £25,000	1	11	-	-	1	11	-	-
£25,001 – £50,000	2	79	1	35	3	114	1	35
£50,001 – £100,000	1	80	1	54	2	134	-	-
£100,001 – £150,000	-	-	-	-	-	-	-	-
Totals for 2025-26	4	170	3	93	7	263	1	35
Totals for 2024-25	1	54	4	66	5	120	2	52

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

Five individuals retired early on ill-health grounds in the year generating additional pension liabilities of £312,345 (2024-25: eight individuals, £183,272). 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 76. The Chief Executive and Chief People Officer also attend but excuse themselves when their remuneration is being discussed.

In deciding the remuneration of the Chief Executive and Executive Directors, the committee follows all relevant 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 the DHSC.

Remuneration and pension entitlement of senior managers

This is subject to audit.

Remuneration – Executive Directors

Name and title	Year to 31 March 2026					Year to 31 March 2025				
	Salary	Performance pay and bonuses	Non-cash benefits	All pension related benefits	Total	Salary	Performance pay and bonuses	Non-cash benefits	All pension related benefits	Total
	(in £5k bands)	(in £5k bands)	(to nearest)	(to nearest)	(in £5k bands)	(in £5k bands)	(in £5k bands)	(to nearest)	(to nearest)	(in £5k bands)
	£000	£000	£00	£000	£000	£000	£000	£00	£000	£000
Miss F O'Callaghan (Chief Executive) ¹	30-35	-	-	-	30-35	-	-	-	-	-
Mr C Vincent (Chief Financial Officer)	165-170	-	11	49	215-220	160-165	-	7	46	205-210
Dr G Mifflin (Chief Medical Officer and Director of Clinical Services) ²	260-265	-	-	221	480-485	255-260	-	-	-	255-260
Mr A Clarkson (Director of Organ and Tissue Donation & Transplantation)	160-165	-	18	64	225-230	155-160	5-10	8	18	185-190
Mr G Gogarty (Director of Blood Supply)	155-160	5-10	-	182	345-350	135-140	5-10	-	39	180-185
Mrs H Gillan (Director of Quality & Governance)	130-135	5-10	2	49	185-190	125-130	-	5	17	140-145
Miss R Tinker (Chief Digital and Information Officer)	135-140	-	-	36	170-175	130-135	-	-	34	165-170
Mr M Chambers (Director of Donor Experience)	110-115	-	10	30	145-150	110-115	-	2	28	135-140
Ms J Pinder (Chief People Officer) ³	135-140	-	-	37	170-175	65-70	0-5	-	19	90-95
Mr A Tiernan (Director of Communications and Engagement) ⁴	40-45	-	-	-	40-45	70-75	-	-	-	70-75
Dr J Farrar (Chief Executive Officer) ⁵	45-50	-	-	7	50-55	185-190	5-10	-	27	225-230
Ms W Clark (Deputy Chief Executive Officer) ⁶	70-75	-	-	17	85-90	170-175	5-10	1	46	225-230
Mrs C Walker (Interim Chief Executive) ⁷	105-110	-	-	-	105-110	-	-	-	-	-
Mr P O'Brien (Director of Blood Supply) ⁸	-	-	-	-	-	100-105	-	-	-	100-105
Prof D Thiruchelvam (Chief Nursing Officer) ⁹	135-140	-	-	42	175-180	135-140	-	-	94	225-230

- Miss F O'Callaghan – appointed Chief Executive 1 February 2026, full year equivalent salary (£5k bands) £205-210k.
- Dr G Mifflin – took partial retirement on 12 March 2025.
- Ms J Pinder – appointed Chief People Officer on 23 September 2024, 2024-25 full year equivalent salary (£5k bands) £130-135k.
- Mr A Tiernan – Director of Communications and Engagement to 01 August 2025. 2025-26 full year equivalent salary (£5k bands) £135-140k. Appointed 16 September 2024, 2024-25 full year equivalent salary (£5k bands) £130-135k.
- Dr J Farrar – Chief Executive Officer to 30 June 2025. Seconded from the Ministry of Justice (MoJ) and costs represent the payments made by the MoJ. 2025-26 full year equivalent salary (£5k bands) £185-190k, and employer's pension contributions are (£2.5k bands) £5-7.5k.

- Ms W Clark – Deputy Chief Executive to 5 September 2025. 2025-26 full year equivalent salary (£5k bands) £160-£165k.
- Mrs C Walker – Interim Chief Executive from 1 July 2025 to 31 January 2026, full year equivalent salary (£5k bands) £180-£185k.
- Mr P O'Brien – Director of Blood Supply to 3 November 2024. 2024-25 full year equivalent salary (£5k bands) £160-165k.
- Prof D Thiruchelvam – Chief Nursing Officer to 6 March 2026. 2025-26 full year equivalent salary (£5k bands) £135-£140k.

Remuneration – Non-Executive Board Members

Name and title	Year to 31 March 2026					Year to 31 March 2025				
	Salary	Performance pay and bonuses	Non-cash benefits	All pension related benefits	Total	Salary	Performance pay and bonuses	Non-cash benefits	All pension related benefits	Total
	(in £5k bands)	(in £5k bands)	(to nearest)	(to nearest)	(in £5k bands)	(in £5k bands)	(in £5k bands)	(to nearest)	(to nearest)	(in £5k bands)
	£000	£000	£00	£000	£000	£000	£000	£00	£000	£000
Mr P Wyman (Chair) ¹	60-65	-	-	-	60-65	60-65	-	-	-	60-65
Mr P White ²	-	-	-	-	-	10-15	-	-	-	10-15
Prof C Craddock ³	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms R Jones ⁴	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms C Serfass ⁵	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Prof L Marson ⁶	5-10	-	-	-	5-10	5-10	-	-	-	5-10
Ms P McIntyre ⁷	5-10	-	-	-	5-10	5-10	-	1	-	5-10
Mr I Murphy ⁸	10-15	-	-	-	10-15	5-10	-	1	-	5-10

- 1 Mr P Wyman – appointed Chair 1 April 2022. Full Year equivalent salary (£5k bands) £60-65k.
2 Mr P White – left on 17 February 2025. 2024-25 full Year equivalent salary (£5k bands) £10-15k.
3 Prof C Craddock – appointed on 1 June 2022. Full year equivalent salary (£5k bands) £5-£10k.
4 Ms R Jones – appointed on 1 May 2023. Full year equivalent salary (5k bands) £5-10k.
5 Ms C Serfass – appointed on 1 May 2023. Full year equivalent salary (5k bands) £5-10k.
6 Prof L Marson – appointed on 1 March 2024. Full year equivalent salary (5k bands) £5-10k.
7 Ms P McIntyre – appointed on 1 March 2024. Full year equivalent salary (5k bands) £5-10k.
8 Mr I Murphy – appointed on 1 March 2024. Full year equivalent salary (5k bands) £10-15k.

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 2026 (in £5k bands) £000	Lump sum at pension age related to accrued pension at 31 March 2026 (in £5k bands) £000	Cash Equivalent Transfer Value at 31 March 2026 £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Real increase in Cash Equivalent Transfer Value £000
Miss F O'Callaghan (Chief Executive) ¹	0-2.5	-	0-5	-	10	-	-
Ms W Clark (Deputy Chief Executive) ²	0-2.5	-	25-30	-	400	343	13
Mr A Clarkson (Director of Organ and Tissue Donation and Transplantation)	2.5-5	2.5-5	70-75	185-190	1,678	1,557	74
Mr C Vincent (Chief Financial Officer)	2.5-5	-	35-40	-	595	520	46
Dr G Mifflin (Chief Medical Officer and Director of Clinical Services) ³	10-12.5	-	15-20	-	264	61	177
Ms J Pinder (Chief People Officer)	2.5-5	-	20-25	-	324	273	29
Mr G Gogarty (Director of Plasma for Medicines) ⁴	7.5-10	17.5-20	55-60	135-140	189	131	36
Mrs H Gillan (Director of Quality)	2.5-5	0-2.5	50-55	125-130	1,204	1,112	57
Miss R Tinker (Chief Digital Information Officer)	2.5-5	-	10-15	-	160	124	17
Prof D Thiruchelvam (Chief Nursing Officer) ⁵	2.5-5	0-2.5	40-45	95-100	831	760	37
Mr M Chambers (Director of Donor Experience)	0-2.5	-	5-10	-	109	75	18
Mr A Tiernan (Director of Communication and Engagement) ⁶	-	-	40-45	90-95	861	929	-

Notes

- Appointed Chief Executive 1 February 2026.
- Deputy Chief Executive to 5 September 2025, table above represents the contributions to the scheme until that date.
- The Cash Equivalent Transfer Value reported is for the remaining part of the 2015 scheme only, as Dr Mifflin took partial retirement on 12 March 2025.
- 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.
- Chief Nursing Officer to 6 March 2026, table above represents the contributions to the scheme until that date.
- Director of Communications and Engagement from 16 September 2024 to 1 August 2025. The pension and Cash Equivalent Transfer Values take account of previous NHS service. Mr Tiernan remains employed by NHSBT, but has been on external secondment since 2 August 2025; the Cash Equivalent Transfer Value at 31 March 2026 reflects that he continued to be a member of the pension scheme at that date.
- Dr Jo Farrar, Chief Executive Officer from 1 June 2023 to 30 June 2025, was seconded from the Ministry of Justice, and was a member of the partnership pension scheme, and as such, did not accrue benefits in the Civil Service Pension Scheme. The employer contributions to Dr Farrar's partnership pension account, to the nearest £100, relating to 2025-26 for the period 1 April 2025 to 1 June 2025 were £6,800, full year equivalent £27,200 (2024-25: £27,000).
- Mrs C Walker – Interim Chief Executive from 1 July 2025 to 31 January 2026, opted out of the NHS pension scheme upon appointment.

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 2026.

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 2026, for more than £245 per day	Number
Number of existing engagements earning £245 per day or greater as of 31 March 2026	1
Of which, the number that have existed:	
for less than one year at time of reporting	-
for between one and two years at time of reporting	-
for between two and three years at time of reporting	1
for between three and four years at time of reporting	-
for four or more years at time of reporting	-

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

Table 2: Off-payroll workers engaged at any point during the year ended 31 March 2026, earning £245 per day or greater	Number
Number of engagements earning £245 per day or greater, between 1 April 2024 and 31 March 2025	7
Of which, the number:	
not subject to off-payroll legislation	-
subject to off-payroll legislation and determined as in-scope of IR35	7
subject to off-payroll legislation and determined as out-of-scope of IR35	-
Number of engagements reassessed for compliance or assurance purposes during the year	-
Of which, the number of engagements that saw a change to IR35 status following review	-

Table 3: Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026	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	23

Our approach to diversity and inclusion in our workforce

NHSBT continues to prioritise creating an inclusive, high-performing organisation where everyone feels valued, can be themselves and thrive. This enables us to better reflect the communities we serve, tackle health inequalities and improve outcomes for patients.

This work is delivered through a coordinated approach, combining the Forward Together inclusion programme with strengthened central inclusion expertise and dedicated inclusion leads across each directorate, ensuring both strategic direction and locally tailored delivery.

Forward Together

Three years on from its launch, Forward Together continues to drive our ambition to build an intentionally inclusive and anti-racist organisation. The Anti-Racism Framework remains a cornerstone of this approach, setting clear expectations for fairness, equity and anti-discriminatory practice.

Activity to date has focused on building awareness, embedding inclusive behaviours and strengthening leadership accountability. Local delivery has included allyship and active bystander training, alongside roadshows and engagement events, equipping colleagues and managers with the confidence and skills to challenge inappropriate behaviour.

This has been supported by the introduction of the Inclusion Essentials learning offer, providing accessible, interactive learning to help colleagues understand their role in creating an inclusive workplace. External reviews of inclusive recruitment, diverse recruitment panels and learning needs analysis have also been completed, and NHSBT is now accredited as Inclusive Recruitment Confident by Talent Spaces.

Phase 2 of Forward Together was approved in April 2025, aligning with Years 2 and 3 of the People Plan. This focused on six priority areas:

- improving the digital people service experience through a new HR platform
- building a more inclusive and efficient recruitment approach
- strengthening capability and career pathways
- providing consistent employee support
- enhancing leadership and management development
- creating more inclusive, user-friendly policies.

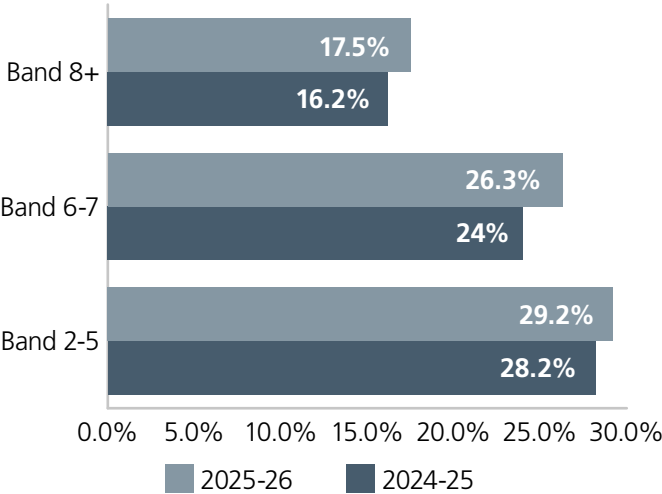
A network of People Change Champions has supported the design, development and testing of programme deliverables and will continue to play an active role as implementation progresses.

Impact from Forward Together to date includes:

- ethnic minority representation increased from 23.9 per cent in 2024 to 26.5 per cent
- representation at Band 8a and above increased to 17.9 per cent (up 1.4 percentage points year-on-year)
- the proportion of disabled colleagues who feel workplace adjustments meet their needs increased from 47 per cent to 51 per cent.

The programme was also shortlisted as a finalist in the Inclusion category at the 2026 Government Project Delivery Awards.

Figure 2. Black and minority ethnic representation across paybands as a percentage of total workforce



Targeted inclusion priorities

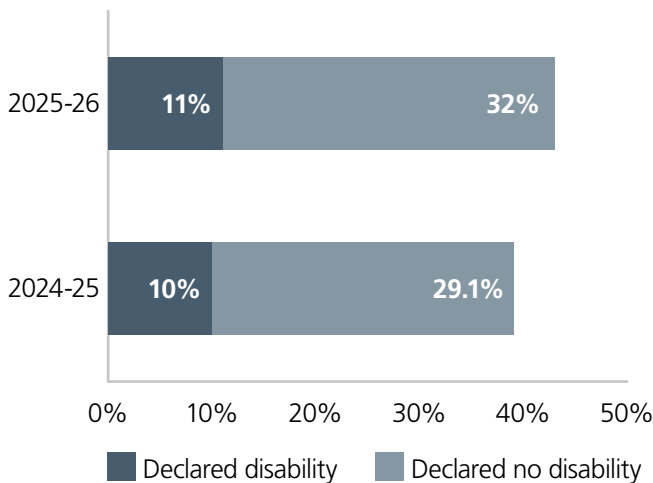
Guided by data and insight, we have focused on improving equity and experience across key protected characteristics and continue to strengthen our understanding of colleague experience.

Disability

NHSBT remains a Disability Confident employer, reflecting our commitment to inclusive recruitment and employment. We operate a guaranteed interview scheme for candidates who meet the minimum criteria and support colleagues through a clear workplace adjustments framework, informed by Access to Work and occupational health provision.

We are strengthening our focus on outcomes by increasing disability declaration rates, improving the timeliness and consistency of adjustments, and monitoring progression and development. Progress is tracked through staff survey insights and the Workforce Disability Equality Standard, enabling targeted action where needed. This increasingly data-led approach is supporting measurable improvements in the experience and inclusion of disabled colleagues.

Figure 3. Proportion of NHSBT staff declaring a disability



Ethnicity

NHSBT continues to prioritise improving the experience, representation and progression of ethnic minority colleagues as part of its commitment to becoming an anti-racist organisation.

Representation has increased across the workforce, supported by a focus on inclusive recruitment practices, including ethnically diverse panels and external review.

At the same time, action to reduce inequalities in experience remains a priority, with targeted interventions through the Anti-Racism Framework and Inclusion Plan, and by working in partnership with our GRaCE staff network.

Improved use of workforce data and insight is enabling more targeted action to address disparities in progression, wellbeing and opportunity, with staff networks continuing to play a key role in shaping priorities and solutions.

Gender

Our latest Gender Pay Gap Report (2025) is available on our website. As of 31 March 2025, NHSBT employed 6,386 relevant staff, with a workforce profile of approximately 68 per cent female and 32 per cent male.

The overall gender balance remains broadly aligned with the wider NHS. Within the upper pay quartile, men continue to be slightly over-represented, reflecting the ongoing challenge of achieving greater gender balance in senior roles.

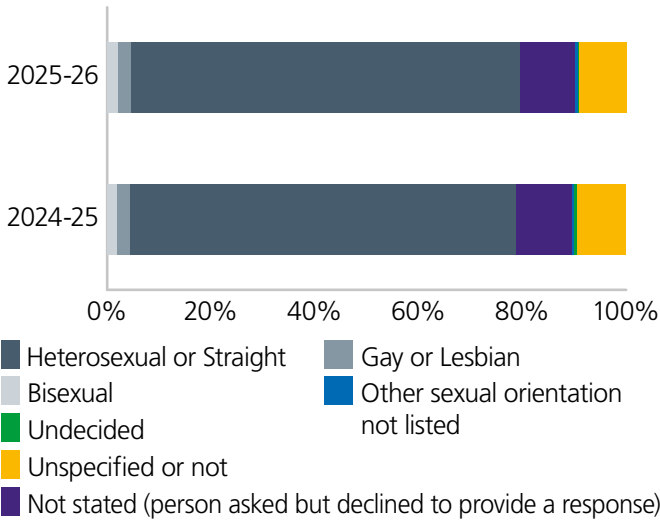
NHSBT’s mean gender pay gap for ordinary pay has reduced further to 3.09 per cent (from 3.81 per cent in 2024), meaning that for every £1 earned by men, women earn £0.97. Our median pay gap has also reduced significantly to 0.6 per cent (from 2.8 per cent in 2024), equating to £0.99 for every £1 earned by men.

These improvements reflect continued progress and compare favourably against national and sector benchmarks. However, we recognise that structural factors, particularly the distribution of men and women across pay bands; continue to influence the overall gap, and targeted action remains focused on improving representation and progression at senior levels.

Sexual orientation

NHSBT continues to strengthen its approach to LGBTQ+ inclusion through engagement with Pride events and partnerships with LGBTQ+ organisations, helping to promote inclusion internally and build trust with the communities we serve. Action to reduce bullying, harassment and discrimination has been prioritised through the Inclusion Plan, supported by targeted interventions, improved reporting routes such as Freedom to Speak Up, and enhanced use of EDI data to better understand staff experience.

Figure 4. Sexual orientation across NHSBT as a percentage of total workforce



Alongside this, we are improving recruitment, retention and progression, supported by increased diversity declaration rates and continued investment in EDI learning. Partnership working with our LGBT+ Network and external organisations has also supported more inclusive policies and practices.

Inclusive Cultures: Governance

Governance has been strengthened through the introduction of the Integrated Inclusion Plan and a dedicated Inclusion Multidisciplinary Team to coordinate delivery. A central inclusion dashboard has also been developed, bringing together key workforce metrics across the employee lifecycle. This provides clearer insight, supports evidence-based decision-making, and enables a more targeted and accountable approach to addressing inequities.

The Inclusion Council brings together central teams, staff networks, staff-side representatives and executive leaders to oversee progress towards becoming an inclusive and anti-racist organisation. The Council monitors delivery of equality objectives and provides oversight of key frameworks and regulatory requirements, including:

- Public Sector Equality Duty
- Workforce Race Equality Standard
- Workforce Disability Equality Standard
- Gender Pay Gap reporting

Further information is available on our website.

Staff engagement

We completed our annual Our Voice survey in October 2025 using a new Voice of the Employee Platform.

Nearly two-thirds (65 per cent) of the workforce responded to the survey (an increase of three percentage points on 2024) including over 50 per cent of every directorate and over 50 per cent of Band 3 and 4 colleagues, which was encouraging and gave confidence in the results.

Our Core Engagement score recorded a 65 per cent positive sentiment from our colleagues, which compared favourably to the previous year.

At an organisational level, our agreed National Actions focus on three key priority areas of Growth, Change and Transformation and Harassment, Bullying and Abuse. A programme of work is in progress to address these over the coming year.

People development

As part of our People Plan, we also remain committed to delivering a comprehensive range of learning and development opportunities for colleagues at all levels of the organisation. These opportunities include apprenticeships and placements, personal skills development, management and leadership training, as well as specialist scientific and clinical education.

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. During the past year, 166 colleagues undertook an apprenticeship, representing two per cent of our total workforce. This includes:

- 153 people active 'in-learning'
- 13 people in a break in learning due to personal circumstances
- 10 people withdrew, due to either leaving the organisation or personal reasons.

Placements

In addition to apprenticeships, our placements and work experience programmes also help us develop future talent and support entry into NHS careers. We offer a range of structured opportunities across clinical, scientific and corporate disciplines, providing individuals with meaningful, hands-on experience.

At the end of the reporting period, there were 52 active trainees participating across five placement schemes. These include programmes such as Biomedical Scientist sandwich placements, the Scientist Training Programme (STP), Higher Specialist Scientist Training (HSST), and supported internships.

Our commitment to inclusive pathways is demonstrated through our participation in the Project SEARCH Supported Internship programme. During 2025-26, we supported 21 interns completing 31 work rotations, helping to create accessible employment opportunities for people with learning disabilities and autism.

In addition, we expanded our support for early careers, including student nursing placements and work experience opportunities, further strengthening our contribution to the wider NHS workforce pipeline.

Scientific and clinical training

We rely on a broad range of specialists with expertise across different scientific and clinical disciplines. The training and support we provide for scientists 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 13 trainees across four disciplines (H&I, transfusion, bioinformatics and virology) and one trainee qualified, becoming a Consultant Clinical Scientist. We support a number of Clinical Fellows and actively support training of HSSTs and other colleagues hosted within the wider NHS.

We actively supported 202 other NHSBT learners through a selection of professional qualifications to achieve progress towards Biomedical Science Registration, and other learners including 24 biomedical scientist apprenticeships.

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.

Middle manager leadership and management development

Throughout 2025-26, we continued to deliver a blended approach to developing all leaders and managers, both current and aspiring. During 2025-26, managers from across NHSBT completed one or more of these programmes. A total of 1,237 individual sessions of formal leadership and management skills and behaviours learning were completed.

To help our managers to deliver increasingly complex operational roles, we have continued to develop the online Leadership and Management Knowledge Resource Toolkits and these have been accessed over 9,900 times throughout the year. In addition, our Viva Engage online community for Leadership and Management continues to grow, with 293 members.

Building on our transformation strategy and recognising that managers and leaders face extraordinary and complex challenges across NHSBT, we have committed to deliver new products and services to support team leaders or supervisors, and senior leaders. These have been designed and tested and will roll out as part of our wider 2026-27 schedule.

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

- 245 middle managers engaged in our Manager 101 and Art of Management programmes
- 771 leadership and management activities were accessed via the NHS Elect platform
- 363 leaders and managers engaged with our digital learning library MindTools
- all new managers attended a manager induction within eight weeks of joining NHSBT.

Talent management and succession planning

2025-26 saw us build on the extensive discovery work undertaken during the previous year to strengthen our approach to talent and performance management, resulting in a series of new initiatives.

These included:

- launching Connected Conversations, a new and more holistic PDPR approach building on year-round dialogue, enhancing the quality of the conversation, driving improved compliance and achieving 93 per cent PDPR completion in Q4
- piloting a new performance framework for executive directors, embedding NHSE standards and 360-degree feedback to strengthen insight and development, with the intention to roll this out to the wider senior leadership team in 2026-27
- developing our approach to talent management and succession planning with a focus executive and business-critical roles, identifying emergency cover and succession risks for the Executive Team, reviewing the talent pipeline and starting to succession plan for the 25 senior leadership roles identified as business-critical
- delivering an extensive programme of Growth roadshow events to promote the career and development opportunities that exist within NHSBT, with a particular focus on frontline Band 3 and 4 colleagues which were identified as a key group within the Our Voice results
- launching a new internal coaching service for people managers, alongside bespoke external coaching for senior leaders and individuals identified as high potential.

Trade union relationships

NHSBT continues to develop and strengthen its Partnership Framework with trade union colleagues, supporting a productive and effective approach to partnership working. Strengthening this partnership is a priority for us as we enter the 2026-27 financial year and beyond, and we are working hard to ensure that our relationship with our union colleagues remains strong, and we have a solid infrastructure to support us to work together moving forward. 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. Furthermore, our Chief Executive meets informally with representatives on a quarterly basis. This reflects our open and transparent approach and supports early discussion and insight in relation to our organisational strategic priorities.

Health, safety and wellbeing

We have not achieved our harm incident reduction target for this year by 0.2 incidents per 1,000 employees but we have lowered our harm rate by 0.7 incidents per employees compared to 2024-25.

Blood Donation has seen more superficial harm incidents as a percentage of overall harm. A superficial harm incident is one that results in no first aid or loss of service. This indicates an improvement in reporting culture linked to an increase in near miss reporting. In addition, Blood Supply have a higher target rate of 10 per cent with all other areas at five per cent, a review of targets is ongoing to ensure their relevance.

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	Grand Total
Apr	52	0	1	3	1	0	57
May	48	1	2	1	0	0	52
Jun	41	2	1	3	2	0	49
Jul	60	2	6	3	1	0	72
Aug	50	1	7	1	1	1	61
Sep	47	1	3	2	1	0	54
Oct	57	0	4	2	3	0	66
Nov	40	1	3	2	2	0	48
Dec	48	0	2	6	1	0	57
Jan	44	0	3	3	1	0	51
Feb	50	0	3	2	1	0	56
Mar	41	0	4	2	1	0	48
2025-26 Incidence Rate	12.8	4.0	2.1	3.3	1.2	0.5	7.3
2025-26 Target	10.1	10.4	3.0	4.8	0.7	0.5	7.1
2024-25 Incidence Rate	13.1	8.2	3.6	4.6	1.2	0.4	8.0

Near miss reporting

Overall, the target has been achieved in nine months out of 12 reflecting management commitment in encouraging near miss reporting. It highlights a positive reporting culture particularly in Blood Supply, which increased to 28.4. The number of near miss reports in the year has increased by 28 per cent showing this is starting to be embedded in our safety culture.

Near Miss Incidence Rate April to March 2026 per 1,000 employees													
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Incident rate 2024-25	12.0	15.2	10.8	14.0	11.2	12.0	14.1	19.0	14.6	19.3	18.9	14.1	14.4
Incident rate 2025-26	12.0	13.6	17.9	26.6	19.3	16.5	21.7	14.1	15.0	17.7	17.3	19.3	17.6
Target	14.7												

Accountability report – corporate governance

Therapeutic Apheresis →

A blurred photograph of a hospital corridor. In the foreground, a dark sign with white text 'Therapeutic Apheresis' and a white arrow pointing right is mounted on the ceiling. The corridor has light-colored walls, a light blue carpet, and metal handrails on both sides. In the background, a person in a blue uniform is walking away from the camera. The image is intentionally out of focus to create a sense of depth and movement.

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.



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.



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. Nicola received an OBE for services to Women in Business and Workplace Equality.



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.

Our Executive Directors

(* denotes voting member of the Board)



Frances O'Callaghan*

Chief Executive Officer (from 1 February 2026)

Frances has more than 20 years' experience of executive roles in acute and community NHS Trusts across London. Prior to joining NHSBT, Frances was Chief Executive of the North Central and North West London Integrated Care Boards. Over 20 years, she has helped shape London's healthcare, running frontline services, setting bold strategy, always pushing for fairer outcomes, and addressing health inequalities as part of her wider commitment to social justice. Frances has also worked in the private sector in corporate finance at Price Waterhouse Cooper where she fused clinical know-how with financial rigour, and had a key role in launching King's Health Partners, one of the UK's flagship academic health-science centres.



Caroline Walker*

Interim Chief Executive Officer (from 1 July 2025 until 31 January 2026)

Caroline is a highly experienced NHS leader. Prior to NHSBT, Caroline was 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.



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.



Wendy Clark*

Deputy Chief Executive Officer (until 5 September 2025)

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 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.



Dr Gail Mifflin*
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* (until 6 March 2026)
Chief Nursing Officer

Denise joined 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 Blood Supply (*from 22 July 2025)

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.



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

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 Tierman
Director of Communications and Engagement (until 1 August 2025)

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. Prior to joining NHSBT, he led communications for the London Fire Brigade and is a Trustee of the national charity, NHS Charities Together.



Mark Chambers
Director of Donor Experience

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

Stephanie Itimi, Associate Non-Executive Director, served on the Board until 5 June 2025.

Dr Jo Farrar, Chief Executive Officer, served on the Board until 30 June 2025.

Antony Tiernan, Director of Communications and Engagement, served on the Board until 1 August 2025.

Wendy Clark, Deputy Chief Executive Officer, served on the Board until 5 September 2025.

Caroline Walker, Interim Chief Executive Officer, served on the Board from 1 July 2025 to 31 January 2026.

Professor Dee Thirulchelvam, Chief Nursing Officer, served on the Board until 6 March 2026.

Details of the remuneration of senior managers of NHSBT can be found in the Remuneration and Staff Report at pages 48 to 63. A full register of interests, updated each year, is available from the NHSBT website here:

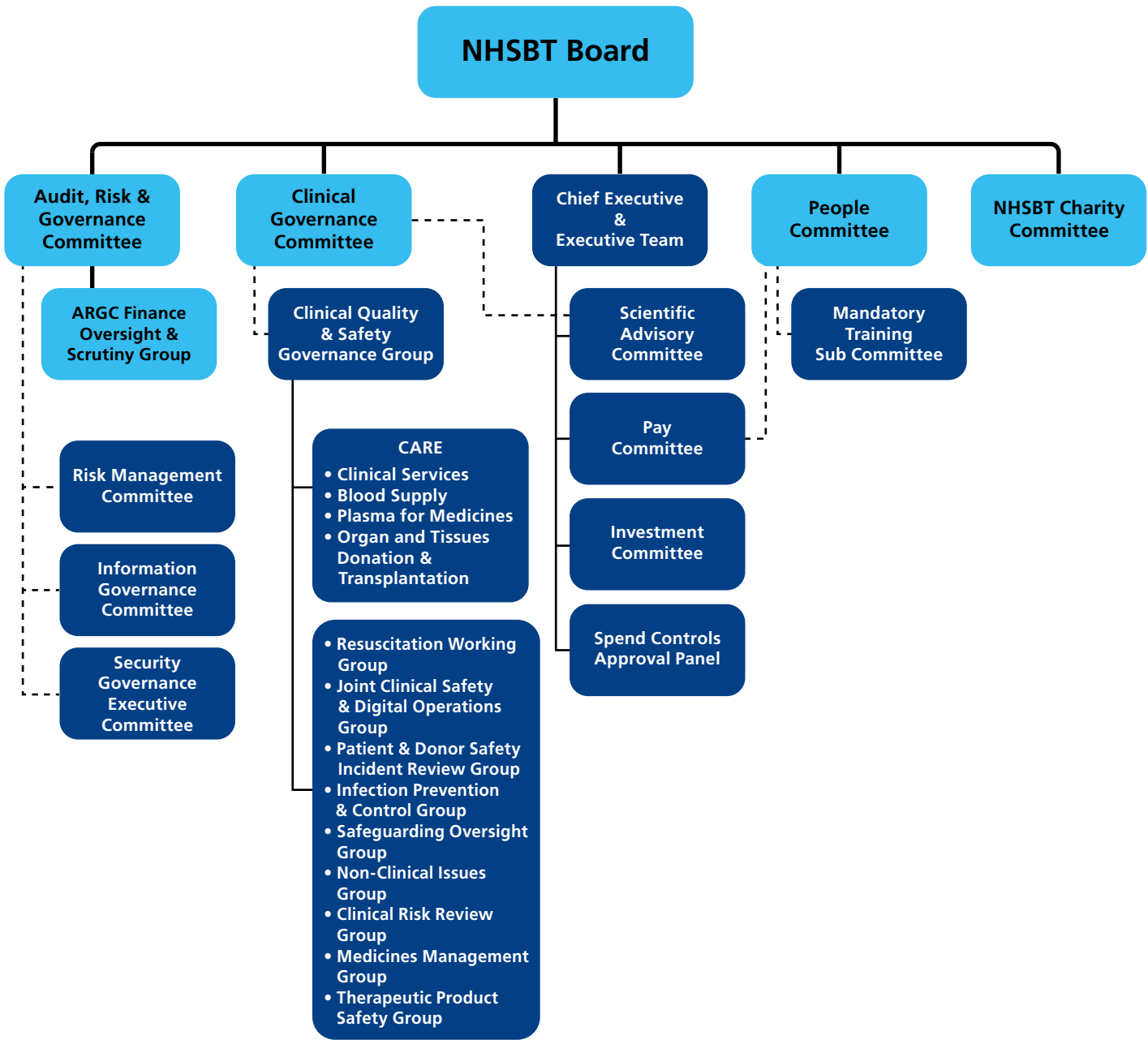
<http://www.nhsbt.nhs.uk/who-we-are/transparency/accounts/board-expenses-and-interests/>

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 currently composed of six other Non-Executive Directors (NEDs), five voting Executive Directors, four non-voting Executive Directors, and one non-voting Associate NED.

The Board developed a skills and capability matrix to determine the composition of the Board and the experience 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 the Department of Health and Social Care, 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 seven times in the past year.

Attendance was as follows:

Name	Title	Total attended /Total possible
Peter Wyman	Chair	7/7
Caroline Serfass	Non-Executive Director	7/7
Professor Charles Craddock	Non-Executive Director	5/7
Rachel Jones	Non-Executive Director	7/7
Ian Murphy	Non-Executive Director	6/7
Professor Lorna Marson	Non-Executive Director	7/7
Penny McIntyre	Non-Executive Director	7/7
Stephanie Itimi (to 5 June 2025)	Associate Non-Executive Director	2/2
Nicola Yates	Associate Non-Executive Director	6/7
Dr. Jo Farrar (to 30 June 2025)	Chief Executive Officer	2/2
Caroline Walker (1 July 2025 to 31 January 2026)	Interim Chief Executive Officer	3/3
Frances O'Callaghan (from 1 February 2026)	Chief Executive Officer	2/2
Wendy Clark (to 5 September 2025)	Deputy Chief Executive Officer	3/3
Anthony Clarkson	Director of Organ and Tissue Donation and Transplantation	7/7
Carl Vincent	Chief Financial Officer	7/7
Dr. Gail Mifflin	Chief Medical Officer and Director of Clinical Services	7/7
Professor Denise Thiruchelvam (to 6 March 2026)	Chief Nursing Officer	6/6
Gerry Gogarty	Director of Blood Supply	7/7
Helen Gillan	Director of Quality and Governance	7/7
Rebecca Tinker	Chief Digital and Information Officer	7/7
Julie Pinder	Chief People Officer	7/7
Antony Tiernan (to 1 August 2025)	Director of Communications and Engagement	3/3
Mark Chambers	Director of Donor Experience	7/7
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: Ian Murphy

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. During the year the Committee’s duties were increased to provide scrutiny of NHSBT’s financial performance and its investment portfolio and transformation programmes. 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 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 five times in the year and the attendance was as follows:

Member	Title	Total Attended /Total Possible
Ian Murphy	Non-Executive Director	5/5
Rachel Jones	Non-Executive Director	5/5
Caroline Serfass	Non-Executive Director	4/5
Nicola Yates	Non-Executive Director	4/5
Niamh McKenna	Independent Non-Executive Member	4/5

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 2024-25, 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
- scrutiny of NHSBT's investment portfolio and transformation programmes
- 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 Lorna Marson

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 are voting members of the Committee. Up to 6 March 2026 the Executive Lead was the Chief Nursing Officer, however this responsibility passed to the Director of Quality and Governance at this time. The Chief Medical Officer/Director of Clinical Services is also a voting member of the Committee.

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

Name	Title	Total Attended /Total Possible
Professor Lorna Marson	Non-Executive Director	4/4
Professor Charles Craddock	Non-Executive Director	4/4
Professor Denise Thiruchelvam (to 6 March 2026)	Chief Nursing Officer	4/4
Dr. Gail Mifflin	Chief Medical Officer and Director of Clinical Services	4/4
Helen Gillan	Director of Quality and Governance	4/4
Gerry Gogarty	Director of Plasma for Medicines	3/4
Anthony Clarkson	Director of Organ and Tissue Donation and Transplant	4/4

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
- 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
- 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: Blood Supply Safety and Experience Assurance, Infection Prevention and Control (IPC) Board Assurance Framework External Assurance and the Scientific Advisory Committee (SAC), Management Quality Review, Safeguarding, Information Governance, Clinical Claims, Non-clinical issues, Clinical Audit, Medical Revalidations, Nursing Revalidations, Complaints, Serious Hazard of Transfusion (SHOT), Joint NHSBT/PHE Epidemiology, Infection Prevention and Control and Donor Derived Transmissions.
- 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: Penny McIntyre

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 the process for 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. The Chief Nursing Officer regularly attended meetings during the year. Other Executive Directors and management staff are invited to attend meetings, to present on specific areas within their area of responsibility, including the Chief Executive.

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 (until 1 May 2025)	Non-Executive Director	1/1
Penny McIntyre	Non-Executive Director	4/4
Lorna Marson	Non-Executive Director	1/4

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 the Anti-Racism Framework
- review and approval of reports, ahead of publication where relevant, 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 including the endorsement of Sexual Safety in Healthcare Organisation Charter
- receipt of mandatory training subcommittee annual report and Terms of Reference
- review of trends in Freedom To Speak Up cases; disciplinary, grievance and resolution cases; and Our Voice Survey findings
- review of the Employer Relations Strategy
- oversight of apprenticeships and placements, noting progress against the September 2023 recommendations, improved outcomes and growth in placements

- monitoring of progress in delivery of the People Plan and review of the Workforce Dashboard
- principal risk deep dive reviews relevant to the remit of the Committee
- 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.

Charity Committee

Chair: Caroline Serfass

The NHSBT Charity 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 Charity, 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 NHSBT Charity'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
Caroline Serfass	Non-Executive Director	4/4
Penny McIntyre	Non-Executive Director	3/4
Rachel Jones	Non-Executive Director	4/4
Carl Vincent	Chief Financial Officer	4/4
Mark Chambers	Donor Experience Director	4/4
Antony Tiernan (to 1 August 2025)	Director of Communications and Engagement	1/1
Kate Thomas (from 8 September 2025)	Interim Director of Communications and Engagement	2/3

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

- approval of the 2024-25 Annual Report and Accounts
- approval of the 2025-26 Annual Budget
- review of quarterly finance reports outlining the financial position and activities
- receipt of reports detailing progress on active Charity supported projects (research and development, wellbeing, and professional nurse advocate grants)
- review of the Charity Trust Deed, Reserves Policy, Procedures and Guidelines
- approval of the Charity Strategy and Operational Plan and Charity risk register
- monitor Charity performance through quarterly review of performance reports
- approval of the change of name of the Committee from Trust Fund Committee to NHSBT Charity Committee
- 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 Responsibilities

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 income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

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

As Accounting Officer, I can confirm that:

- as far as I am aware, there is no relevant audit information of which the auditors are unaware
- I have taken all the steps I ought to have taken to make myself aware of any relevant audit information and to establish that the auditors are aware of that information
- the Annual Report and Accounts as a whole is fair, balanced and understandable
- I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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 operate within the statutory duties of the Secretary of State for Health and Social Care under the Health and Social Care Act 2012, as updated. These include the duty to promote a comprehensive health service, secure continuous improvement in quality, reduce inequalities, and ensure the effective, efficient and sustainable use of NHS resources. These duties are embedded across our governance and assurance frameworks.

As a Special Health Authority delivering national critical infrastructure, we play a central role in maintaining the resilience, continuity and security of supply of blood, organs and tissues to the NHS. This function is fundamental to the Secretary of State's responsibility to ensure a safe, effective and dependable health system.

We also support responsibilities relating to research, innovation, education and training, and the NHS Constitution, contributing to a skilled workforce and high standards of care for patients and service users.

Our business planning aligns with the Department of Health and Social Care's Outcome Delivery Plan, fiscal objectives, and the NHS 10 Year Health Plan (2025). NHSBT is a key enabler of system recovery and reform, supporting reductions in waiting times across emergency, cancer and elective care through the secure and resilient provision of essential clinical products, underpinned by a stronger donor base and modernised operations.

In line with the Secretary of State's focus on financial sustainability and value for money, we are delivering efficiency and productivity improvements, strengthening supply chain performance, reducing waste, and investing in digital and automation to improve outcomes and cost-effectiveness.

We are also supporting the Health Plan's three shifts – hospital to community, analogue to digital, and sickness to prevention – through community-based donation, digital interoperability, genomics and advanced therapies, positioning NHSBT as a critical enabler of a more preventative, data-driven and resilient health system.

We continue to support national strategy development and are positioning NHSBT at the heart of delivery through four priorities:

1. reducing organ and tissue transplant waiting lists
2. transforming public engagement on donation
3. accelerating innovation and national self-sufficiency
4. enabling NHS-wide interoperability to improve safety, resilience and productivity.

These priorities are aligned to our Strategy and Business Plan for 2026–27.

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 72.

The Board Assurance Framework

The Board Assurance Framework (BAF) is the key document used to collate and present information relating to the principal risks that may affect the Board's ability to deliver its strategic priorities.

The BAF supports the Board in the following ways:

- providing continued oversight and understanding of the most significant risks facing the organisation that could impact the achievement of strategic objectives
- enabling insight into the level of residual risk exposure and the actions in place to manage those risks in line with the Board-approved risk appetite
- offering assurance that appropriate and effective controls are established to manage identified risks
- confirming that where control weaknesses are identified, corrective actions have been developed and are being implemented.

Accountability for the preparation, upkeep and coordination of the BAF sits with the Corporate Risk and Assurance Team.

Additional information on the organisation's principal risks, together with the current assessment of their position, is set out in the 'Our principal risks' section on page 46.

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. An externally facilitated review was completed by BDO LLP in 2024 and therefore in 2025 the Company Secretary facilitated an internal review.

Findings from the review were presented to the Board on 3 February 2025 and an action plan agreed by the Board on 24 March.

The review concluded that the Board generally operates well and that improvements over the last year have been achieved particularly in relation to risk management. It found that improvements were also made related to: drive for continuous improvement; maintaining strategic focus, and stakeholder engagement, and that continuing to advance these areas would be beneficial. The review also highlighted opportunities for improvement in relation to: long-term strategic planning, Board culture, knowledge of succession planning; diversity of the Board, and the standard and size of Board papers.

Progress in achieving improvement in these areas is being made through a number of specific and on-going actions.

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

At NHSBT we remain committed to ensuring that every patient, donor and family can have confidence in the safety of NHSBT services. Our approach includes enhancing safety procedures and improved processes in response to the findings and learning from incidents and emerging new evidence. The Chief Medical Officer and Director of Quality and Governance have a shared responsibility for clinical governance and safety.

During 2025-26, the clinical governance structures continued to be strengthened to ensure the organisation can identify, investigate, take action and learn from incidents when they occur.

To further strengthen our processes and bring greater alignment between Clinical Governance and Quality Assurance, during 2026, NHSBT will be undertaking a review of the Clinical Governance processes and structures in alignment with the Good Governance Institute Framework.

The organisational oversight of Clinical Governance is overseen by the Clinical Governance Committee (CGC).

The CGC, as a sub-committee of the NHSBT Board, is chaired by Professor Lorna Marson and oversees all matters relating to clinical governance. The committee meets quarterly, 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 Medicines and Organ and Tissue Donation and Transplantation), and integrated safety report, clinical audit programme updates and Patient Safety Incident Investigation reports, seeking assurances and providing recommendations proportionately as required.

The Clinical Quality and Safety Governance Group (CQSGG) is an executive led safety oversight group and was chaired by the Chief Nursing Officer during 2025-26. The chair has since passed to the Director of Quality and Governance.

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 programmes, 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

NHSBT has transitioned to the Patient Safety Incident Response Framework (PSIRF). PSIRF represents a shift in approach, recognising patient safety incidents as unintended or unexpected events, including omissions, that could or did result in harm. PSIRF supports a more proportionate, flexible, and learning-focused response to incidents, embedding patient safety within a broader system of continuous improvement.

In NHSBT, a Patient Safety Incident Investigation (PSII) is undertaken where an incident or near miss indicates significant risk to patient or donor safety, or where there is potential for meaningful learning and system improvement. The incident types that require a PSII are defined within the NHSBT Patient and Donor Safety Incident Response Plan, published alongside the PSIRF policy on the NHSBT website. PSII's adopt a systems-based approach to investigation, recognising that actions and decisions are outcomes of the wider system rather than sole causes of incidents. This approach is underpinned by the principle that staff act with positive intent and aim to deliver the best possible care within the conditions in which they work.

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'. Should a Never Event occur, this will always require a PSII.

All incidents are assessed and reviewed, with potential PSII's reviewed by the weekly multidisciplinary Patient and Donor Safety Incident Review Group. Escalation and oversight are maintained through Directorate governance, CARE groups, CQSGG, and the Clinical Governance Committee (CGC), with final approval by the CMO and Director of Quality and Governance.

NHSBT is committed to learning from incidents in line with PSIRF principles, ensuring compassionate engagement with staff, patients, and donors and a focus on system improvement. The Freedom to Speak Up service supports an open and transparent culture by providing a confidential route to raise concerns.

Duty of Candour requirements are fully embedded, ensuring openness, timely communication, appropriate support, and apology where required, consistent with a Just Culture approach.

Patient Safety Incident Investigations (PSII) including Never Events

During 2025-26, there were three PSII's completed, one which occurred in 2024 and two which occurred in 2025. None of the incidents met the Never Event criteria or the NHS England national criteria for a PSII (compared to zero Never Events and eight Serious Incidents in 2024-25).

Details of the PSII's are as follows:

1. In November 2024, an incident at NHSBT Liverpool RCI involved the transposition of two foeto maternal haemorrhage (FMH) samples during manual analyser loading, resulting in incorrect results being issued for two antenatal patients. No patient harm was identified; one patient received additional prophylaxis that was not clinically required, while the other remained appropriately treated. The investigation identified key contributory factors, including non-adherence to standard operating procedures, concurrent sample handling, incomplete labelling, and the impact of workload pressures and interruptions within a shared laboratory environment. Internal system controls were not sufficient to detect the error, with identification reliant on external hospital safety netting. Targeted actions have been implemented to reinforce SOP compliance, strengthen human factors awareness, and minimise interruptions during safety-critical tasks. A service-wide audit of high-risk manual processes and a review of system capabilities are in progress. Residual risk is assessed as low and continues to be managed through established governance, audit, and monitoring arrangements.

2. In June 2025, a patient safety incident occurred involving a sample mix-up during crossmatch testing, resulting in a unit of blood being transfused without adverse reaction. The issue was identified during post-examination checks when discrepancies were noted between current and historical serology results. The investigation found failures in sample segregation and reconciliation, alongside incomplete system alerts and misleading clinical information, which reduced the opportunity to detect the error earlier. Immediate communication with the hospital ensured timely awareness, with no missed opportunity to prevent harm. Key improvement actions include reinforcing staff awareness of sample handling risks, implementing human factors training, updating risk registers, and strengthening governance through audits and shared learning. While residual risk remains due to manual processes, it is considered manageable with ongoing monitoring and enhanced assurance measures in place.
3. In September 2025, an IT functionality issue within the Medical and Social History questionnaire in Donor Path resulted in key sexual history questions being incorrectly omitted when a specific response pathway was selected. The issue was identified promptly by the Clinical Support Nursing Team, escalated immediately, and a temporary workaround was implemented, followed by a system fix in October 2025. No patient harm was identified; one tissue transplant proceeded safely, and all affected cases were retrospectively reviewed with no additional risks identified. The investigation found that the incident arose from complexities in IT change management, including evolving requirements, limitations in testing processes, and reduced visibility of the scale of system changes. Additional contributory factors included workload pressures, gaps in end-to-end validation against source documentation, and limited business involvement at key stages. Actions have been implemented to strengthen governance of IT changes, improve requirement clarity and testing alignment, and enhance clinical oversight in system development. Ongoing assurance is being provided through governance frameworks, audit, and monitoring, with residual risk considered low and appropriately managed.

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 2025-26, five 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 2025-26, none were rated as providing substantial assurance. Four audits were rated as providing moderate assurance: an Audit of Patients on Anti-CD38 Therapeutic Monoclonal Antibody (TMAb) Therapies, an Audit of Patients on Anti-CD47 Therapeutic Monoclonal Antibody (TMAb) Therapies, an Audit of RCI Genotyping and an Audit of the Follow-Up of Outstanding Clinical Information Post Organ Donation.

These identified low risk issues which are being addressed through agreed actions. One audit was rated as providing limited assurance: an Audit of Red Cell Exchange Procedures identified a number of both recurring and more significant issues which are being addressed through an extensive action plan. A re-audit is planned to start in late 2026-27.

In addition to these formal audits, small-scale and regular / continuous 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. Expansion of the Tendable system began in earnest in the second half of 2025-26 and continues to be a key part of clinical audit activity within 2026-27.

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 2025-26, 16 of 17 recommendations had been completed, with the final action on track to be completed by August 2026.

A follow-up audit was conducted in January 2026 to assess the implementation and continued compliance with the 2023 Management Action Plan. This confirmed significant improvements in process since the 2023 audit.

Infected Blood Inquiry

NHSBT has continued to work alongside NHS England and the DHSC on our response to the findings of the Infected Blood Inquiry. We have drafted a document that covers the recommendations in R7, relevant to transfusion medicine. We anticipate this document, called Transfusion Transformation, being published in 2026. This will publicly lay out what we collectively need to achieve over the next decade. This will be done once fully agreed.

We continue to work with a local artist to meet our promise to install an NHSBT memorial to remember the events of the past and people affected by them. Board members will also be present at the service of Recognition, Remembrance and Reflection in May 2026, which marks two years since the report was published.

As we continue to reflect on learning from the Inquiry, we are clear that we need to listen to the voices of people impacted by our care in a different way than we do today. We have started a piece of work to understand how we can improve in this. This will report, with recommendations, in the next year.

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. Following the successful appointment of an EU Notified Body and their independent assessment of NHSBT, we received formal recommendation for certification of the quality management system as pertaining to our reagent manufacture.

Compliance with regulatory requirements through our quality management system

During 2025-26, there were 35 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), Care Quality Commission (CQC), the European Federation for Immunogenetics (EFI), and accreditors for medical laboratories, occupational health and safety, business continuity, environment and Underwriters Laboratories. Additionally, NHSBT was routinely inspected by the Environment Agency 15 times in the same period. The overall assessment of these inspections demonstrated that NHSBT is a safe organisation, delivering quality products and services via a robust quality management system.

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. The records ensure continued, demonstrable compliance with our regulatory requirements, licenses, 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 licensed sites, and include:

- **internal quality audits**, we completed 26 improvement audits which were a combination of technical (vertical) and quality management process (horizontal) audits. These are 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. 1 ad-hoc audit was completed in this period.

The Director of Quality and Governance is an executive role that reports into the Chief Executive Officer, 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
- an annual Quality and Governance 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 improving the control of its QMS, building on the successes of its established assurance map and BAF, whilst ensuring the organisation's structures and arrangements ensures it is well-led.

Risk management and assurance

Effective risk management plays a critical role in helping the organisation to save and improve lives, while also supporting the delivery of its strategic objectives.

The organisation's principal risks are set out on page 46, with each risk aligned to the strategic objective it most directly impacts. Ownership and accountability for every principal risk rest with a named member of the Executive Team.

Each risk is subject to ongoing monitoring and review by an allocated oversight committee, which is responsible for scrutinising and overseeing the risk, holding the accountable director to account, and providing appropriate challenge and support where necessary.

Orange Book Comply or Explain

The NHSBT risk management framework is aligned to the HM Treasury Orange Book, as per the requirements of the DHSC/NHSBT Framework Agreement.

Following an assessment conducted in line with the comply or explain requirements, NHSBT's risk management practices are assessed as moderate, demonstrating that NHSBT satisfies the requirements of the five principles of the standard. However, there are elements which will be further strengthened as the agreed continuous improvement objectives are embedded, which include a new risk education package and greater alignment with the assurance mapping process.

Assurance mapping

In 2024-25, NHSBT completed the development and implementation of a simple, workable assurance mapping model and supporting framework. Assurance was mapped across the three lines for key business processes, resulting in the establishment of a formal assurance map and review process, developed with support from our internal auditors, the Government Internal Audit Agency.

The focus in 2025-26 was on embedding the assurance mapping process into business-as-usual activity and expanding its application to cover key areas of mandatory compliance, including the Government Functional Standards. This reflects a move from implementation to maturity, strengthening the organisation's ability to understand, monitor and evidence of assurance across critical requirements.

Assurance outputs are available through an interactive report, enabling users to drill down into detailed supporting data.

NHSBT's overall assurance rating is currently assessed as moderate.

Functional Standards

NHSBT has completed its annual assessment of compliance with the Government Functional Standards. Overall compliance with the mandatory 'shall' requirements has been assessed as partially met.

Of the 14 Government Functional Standards, one standard (GovS-015: Grants) was assessed as not applicable to NHSBT. Of the remaining standards, four have been rated as met, while nine have been assessed as partially met.

For each of the standards rated as partially met, agreed action plans are in place. Delivery of these actions will address the identified gaps and achieve full compliance with the mandatory 'shall' requirements.

Risk management and assurance arrangements are overseen through two principal governance committees:

1. The Risk Management Committee (RMC) is responsible for approving the organisation's risk management framework and the associated governing documentation, and for overseeing how NHSBT identifies, assesses and responds to risk
2. The Audit, Risk and Governance Committee (ARGC) provides assurance to the Board that the overall risk management framework is operating effectively and as intended. While the ARGC reviews the effectiveness of the system, the Board retains ultimate responsibility for approving the Risk Policy and Risk Appetite statements and carries out regular reviews of the Board Assurance Framework.

NHSBT has also implemented a Risk Leads Forum, which operates as a sub-group of the Risk Management Committee. This forum focuses on the review and challenge of risk and assurance arrangements, with its outputs used to inform discussions and decision-making at 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 2025-26 period, the Critical Incident process was stood up on 19 occasions, with the most common incidents involving estates and digital services. Delivery of key products and services was maintained throughout the year.

NHSBT has responded to several disruptive incidents over the year, including disruption to key supplies, IT outages, generator failures, cold room failures, and Storm Goretti.

During 2025-26, NHSBT closed two of the four open minor non-conformities against its certification to ISO22301.

There were three new minor non-conformities raised in the audit undertaken in January 2026, two of which have been closed before the end of the financial year.

Data security, privacy and records management

The Data Security, Privacy, and Records Management (DSPR) function ensures the security, integrity, and lawful processing of NHSBT's information assets. During 2025-26, the team managed increased operational demand, with Data Protection Impact Assessments (DPIAs), Data Subject Access Requests (DSARs), and Freedom of Information (FOI) requests exceeding volumes recorded in previous financial years.

NHSBT maintained high levels of statutory compliance throughout the period, successfully processing 180 FOI requests and 663 DSARs. An on-time response rate of 91.8 per cent was achieved for FOIs, meeting compliance targets. While the response rate for DSARs reduced to 78.9 per cent actions are underway to improve performance, including updating standard operating processes and introducing improved redaction tools. Additionally, the team reviewed 72 DPIAs, evaluating and mitigating data risks inherent in the development of new systems and organisational processes.

The Information and Cyber Security teams continued to strengthen NHSBT's defensive posture and security practices. During the reporting period, 22 cyber alerts were processed via NHS England's 'Respond to a Cyber Alert' service. All 22 alerts were assessed within 48 hours, meeting the 14-day Service Level Agreement (SLA). Following detailed evaluation, five of these alerts were found to be directly applicable to the NHSBT infrastructure and were successfully remediated.

In 2025-26, NHSBT recorded 227 internal data security incidents, representing a decrease from the 247 incidents recorded in 2024-25. The predominant cause of these incidents remains the physical loss of information, specifically Donor Safety Check (DSC) forms. To address this trend, the DSPR team collaborated with the Blood Directorate and individual Donor Centres to review and optimise the DSC workflow, implementing targeted measures to reduce data loss. Regular thematic reviews of incidents enable NHSBT to identify trends, embed lessons learned, and prevent recurrence across nationwide operations.

One incident was reported to the Information Commissioner's Office (ICO) in 2025-26 and remains under review. Appropriate internal action has been taken. NHSBT is currently awaiting the final determination and outcome from the ICO regarding this matter.

Whistleblowing policy and Freedom to Speak Up Guardian

The Freedom to Speak Up (FTSU) service continues to operate with a resource of 1:3.5k Guardian to Worker ratio. There are also approximately 30 'volunteer' FTSU Champions promoting the service.

The Annual Report was presented by the Head of FTSU at the Public Board in February 2026, covering the period from October 2024 to September 2025.

Activity

In 2025-26 149* concerns were raised via FTSU Guardians.

Of these, nine per cent were raised anonymously; down from 16 per cent in 2024-25.

The table below shows the top three types of concerns under each key theme.

Bullying, Harassment, Discrimination and Sexual Misconduct	Total
Bullying by manager/senior leader	22
Discrimination by manager/senior leader	15
Harassment by manager/senior leader	10
Safety, Policy and Process	Total
Risk to patient/donor safety, or quality of a service	14
Application or outcome of formal process	11
Worker Safety	10
People and Culture	Total
Inappropriate attitudes / behaviours of manager or senior leader	36
Management/Leadership Capability/ Performance	17
Team Culture and Behaviours	15

*each concern may include one or more elements, and concerns are recorded as reported to the Guardian, prior to investigation. Concerns remain 'open' until the concern raiser and Guardian are satisfied that all possible steps have been taken by NHSBT to resolve them.

Significant events for the service over the last 12 months include:

FTSU service move from People Directorate to Quality and Governance

To further increase confidence in the independence of the Guardian role, the Head of FTSU now reports into the Executive Lead for FTSU and Whistleblowing, the Director of Quality and Governance, with 'dotted lines' to the non-executive director and Chair remaining.

Independent review of the service by the GIAA

The outcome of the GIAA review was very positive and found that:

"Since its introduction in 2019, the FTSU service has made several positive changes in NHSBT, consistent with the Francis Report recommendations. The dedicated Guardians and the Champion network are supported by governance arrangements and there is a structured approach to cascading information to directorates to support organisational learning."

"NHSBT's FTSU service is operating effectively for the current volume of case work. The introduction of dedicated software will improve resilience and performance management over the case portfolio."

The new case management system has now been purchased and is expected to be implemented in Q1 of 2026-27.

Government national policy changes

Dr Penny Dash's [Review of patient safety across the health and care landscape in England](#), commissioned by the DHSC, and published in July 2025 recommended the National Guardian's Office should close and certain functions should transfer to NHS England, while others will devolve to local organisations.

As part of its wider inspection responsibilities, a core function of the CQC will be to assess the extent to which staff feel safe to raise concerns and have confidence that NHSBT will take effective action, using data such as Our Voice staff surveys and FTSU concerns, and through conversations with staff and FTSU Guardians.

Following Our Voice 2025 data indicating that 35 per cent of workers may not feel safe to speak up and 52 per cent do not have confidence in NHSBT to address concerns, senior leaders have recognised the need to improve psychological safety and belief that they will act on concerns raised.

New sexual harassment legislation

The Worker Protection (Amendment of Equality Act 2010) Act 2023 came into effect on 26 October 2024. The Equality and Human Rights Commission (EHRC) could take action against NHSBT if they do not take reasonable steps to prevent sexual harassment.

From 6 April 2026, sexual harassment is a 'qualifying disclosure' under whistleblowing law. This means whistleblowers making a sexual harassment disclosure have protection from detriment and unfair dismissal.

The FTSU Annual Report 2025 highlighted a risk-averse approach in response to reports of sexual misconduct by NHSBT employees.

In response, a range of new measures have been introduced to ensure concerns indicating serious or gross misconduct are addressed appropriately and in line with NHSBT policy and values.

These include:

- external specialist training for HR and line managers
- commissioning of external investigators where more specialist knowledge and experience are required
- a new case oversight group, chaired by the Chief People Officer, providing 'sense checks' and seeking assurance around thinking and decision making.

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. The policy is reviewed by the Board annually.

We continue to work towards increasing our compliance with the GovS 013: Counter Fraud functional standard. During 2025-26 compliance with the mandatory 'shall' requirements of the standard was achieved, in-line with the NHSBT target for all functional standards (see page 87). We use the Public Sector Fraud Authority's Continuous Improvement Assessment Framework to assess overall compliance with all aspects of the standard, and we continued to make progress against this during the year, with plans in place to make further progress during 2026-27.

We have continued to maintain awareness of fraud, bribery and corruption risks across the organisation, through events such as webinars, our intranet, and presentations to various teams. We report on our plans and ongoing work at each ARGC meeting.

During 2025-26:

- six cases which were under investigation were brought forward from the previous year, five were closed during the year, and one remained ongoing at the end of the year
- five new cases were opened, investigated and concluded during the year
- three 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 CO₂ and reducing waste. Contract reviews are carried out on an ongoing basis across the supplier base to ensure performance of the contract against these indicators.

Health and safety

Health, safety and wellbeing is covered on page 63.

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 2025-26 GIAA Internal Audit programme, agreed by ARGC, included ten audit areas, comprising of nine assurance audits and one follow up review. The outcomes of the nine assurance engagements were:

- two audits received a ‘substantial’ assurance rating
- six audits received a ‘moderate’ assurance rating
- one received a ‘limited’ assurance rating
- no audits conducted resulted in an ‘unsatisfactory’ assurance opinion.

The audit undertaken which was rated as limited assurance was conducted against the Data Security and Protection Toolkit. Some enhancements were recommended following the audit, which could help strengthen the control framework and NHSBT has an established programme of improvement actions in progress to implement these.



Internal Audit – opinion of the Head of Internal Audit

In 2025-26, 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 risk management practices have continued to mature, and that there was a demonstrable 'risk enabled' culture throughout NHSBT, with risk reporting that was proactive and comprehensive. In relation to audit recommendations and management action, NHSBT was found to have maintained its marked improvement in performance throughout the year, with well-understood processes operating at a defined monthly cadence.

In respect of roles and accountabilities, which includes staff skills and training, this year's audits identified positive findings, with some opportunities to further refine the controls in place, particularly for more central oversight for some existing controls.

The Head of Internal Audit concluded that:

I am providing an overall Moderate opinion on the framework of governance, risk management and control within NHS Blood and Transplant (NHSBT) for the year ended 31 March 2026.

In 2024-25, it was identified that ongoing work was needed to ensure the currency of the documentation of key procedures. In 2025-26, processes were embedded to ensure documentation is current and aligned with operational practice. In addition, monitoring of performance, risk management, and overall reporting was found to be robust, with regular clear information being provided that enables decision making where appropriate.

NHSBT's work on assurance mapping was recognised as best practice within cross-government risk forums organised by the HM Treasury Risk Centre of Excellence. By integrating assurance tools internally, the efficiency and effectiveness of processes is enhanced, supporting alignment with wider government standards. This is particularly important in an environment of increasing compliance demands and constrained resources, where practical implementation must be balanced with the need to meet external requirements.

Figure 5. Direction of travel

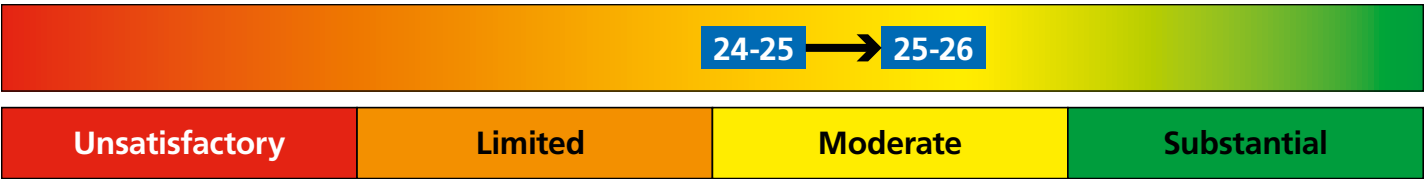
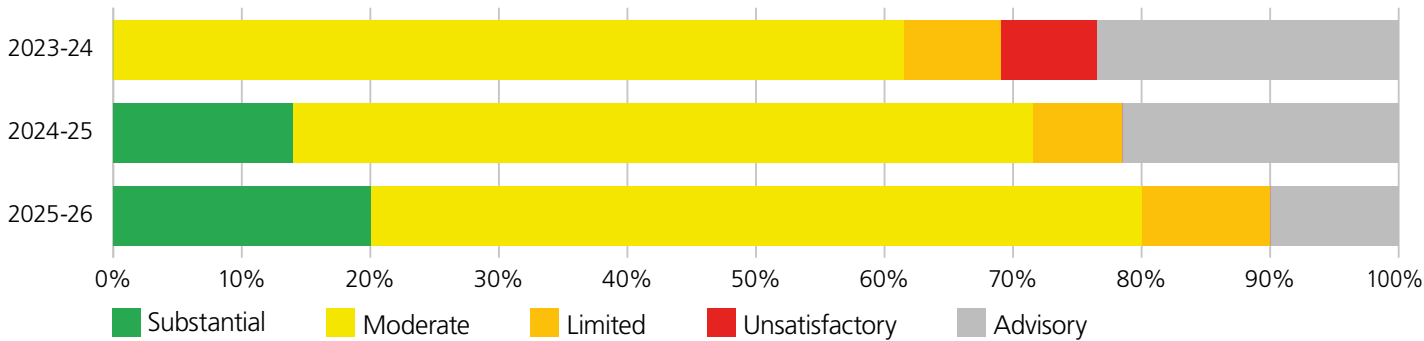


Figure 6. Summary of opinions



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 2024-25, was blood shortage, which is covered below under 'Amber Alert Stand Down'. Since that time, the contributory risk that drives the score of P-02 is the condition of NHSBT estate. There has been a condition survey of the estate to ensure that there is a full picture and the condition of the estate and work on some issues has already started, such as work on the Colindale and Tooting centres.

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 was also affected by the blood stock issue that was driving P-02, but this risk reduced in score as a result of improvement in blood stock and by the end of the year had fallen out of the risk limit zone.

2. Amber alert stand-down

In June 2024, NHSBT called an amber alert for O-group blood types, in response to a cyber-attack on Synnovis, a major pathology provider to NHS Trusts in London.

In July 2025, NHSBT was able to stand down the amber alert, supporting stability in the UK's blood supply. Blood stocks continued to grow over the summer, the first time on record that this has been achieved and, at an overall level, have remained at resilient levels since.

This improvement would not have been possible without the generosity of our volunteer donors, the dedication of our colleagues and the support of hospital customers.

A number of improvements contributed to resilience, including increasing the number appointments for donors to book into, reviewing and improving the on-session deferral process, to support more people to be able to donate, increasing access to appointments for key blood groups and working with hospitals to reduce to demand through even better blood use.

3. Organ and tissue donation and transplantation

The UK is experiencing challenges with the number of proceeding organ donors and consent rates. The pool of potential donors has decreased by 18 per cent compared with pre-pandemic activity. The family consent/authorisation rate, which fell to 59 per cent compared to 68 per cent pre-pandemic. In addition, there is a decline in the number of people registering a decision to donate on the NHS Organ Donor Register. This has contributed to the highest ever recorded number of people waiting for a transplant.

To address this, a joint NHSBT and DHSC working group was established to address three key areas of focus: aligning societal action with public support for organ donation, reversing the decline in consent rates, and expanding the pool of potential donors.

The final report, published in January 2026, provides key actions to be taken to halt the current declines and increase the number of people whose lives can be saved through the gift of organ donation.

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, Caroline Walker.

In 2025-26, my predecessor and I were 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', reporting a continued improvement in the direction of travel, which reflects the embedding of improved processes into business as usual activity, ensuring that audit recommendations are managed and implemented effectively.

My predecessor and I 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. 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 2026 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 £132,500 (2024-25: £130,000). There were no payments to the C&AG for non-audit work during 2025-26 or 2024-25.

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). There were no individual loss or special payment cases in the year that were greater than £300k (2024-25: nil).

Losses Statement	31 March 2026		31 March 2025	
	No. Cases	£000	No. Cases	£000
Losses of pay, allowance and superannuation benefits	7	2	17	4
Losses of accountable stores and vehicle damage	122	471	95	439
Claims waived or abandoned	1	10	18	16
Fruitless payments and constructive losses	3	211	-	-
Total	133	694	130	459

Special Payments	31 March 2026		31 March 2025	
	No. Cases	£000	No. Cases	£000
Compensation payments	22	119	3	5
Ex gratia payments	-	-	11	43
Total	22	119	14	48

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.

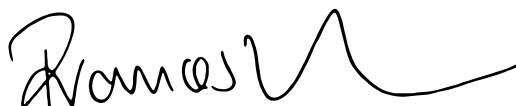
NHSBT made no political or charitable donations or gifts during the current financial year, or previous financial periods.

Fees and charges

This is subject to audit.

We have a statutory duty to set prices to break even 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 2025-26, demand was lower than planned, and therefore no rebate was paid to customers (2024-25 rebate: £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.

I hereby sign the Accountability Report (including the Governance Statement) from pages 48 to 97.



Frances O'Callaghan

3 July 2026

Chief Executive and Accounting Officer

Accountability report – audit certificate and report



	Anti-A	Anti-B	Anti-D	Reagent Control
A-	+	-	-	-
A+	+	-	+	-
B-	-	+	-	-
B+	-	+	+	-
O-	-	-	-	-
O+	-	-	+	-
AB-	+	+	-	-
AB+	+	+	+	-



	Anti-A	Anti-B	Anti-D	Reagent Control
A _{rr}	+	+	+	+
B _{rr}	+	+	+	+
O _{rr}	+	+	+	+
AB _{rr}	+	+	+	+

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 2026 under the National Health Service Act 2006.

The financial statements comprise NHS Blood and Transplant's:

- Statement of Financial Position as at 31 March 2026;
- 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 2026 and its net operating expenditure after interest for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on regularity

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

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements 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 requires 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 the 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 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 head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS Blood and Transplant's policies and procedures 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 Service 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 and the relevant specialists, 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 expenditure recognition. 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 Service Act 2006, Managing Public Money, employment law, pension legislation and tax legislation.

Audit response to identified risk

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

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management, the Audit, Risk and Governance Committee and NHS Blood and Transplant's solicitors concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the Board and internal audit reports;

- 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;
- I addressed the risk of fraud in revenue recognition by increased testing on the cut-off of revenue and reviewing the blood rebate considerations; 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 including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

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

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: 6 July 2026

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 2026

	Note	2025-26 £000	2024-25 £000
Gross Income			
Income from sale of goods and services		496,811	486,281
Other operating income		36,890	44,311
	3	533,701	530,592
Expenditure			
Staff costs	4	(382,927)	(352,708)
Operating expenses	5.1	(257,412)	(247,230)
Depreciation and amortisation	5.2	(22,584)	(25,307)
Other operating expenditure	6	(24,897)	(28,411)
		(687,820)	(653,656)
Net operating expenditure before interest		(154,119)	(123,064)
Finance expense		(1,713)	(1,233)
Net operating expenditure after interest	2	(155,832)	(124,297)
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	1,416	2,700
Net gain/(loss) on revaluation of right of use assets	9	1,422	2,069
Total comprehensive net expenditure		(152,994)	(119,528)

Notes 1 to 22 form part of these accounts.

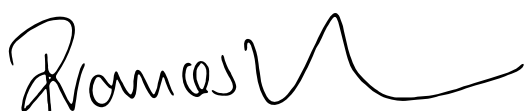
All income and expenditure is derived from continuing operations.

Statement of Financial Position as at 31 March 2026

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Property, plant and equipment	8	175,093	171,084
Right of use assets	9	74,353	66,446
Intangible assets	10	21,532	16,805
Financial assets	12	2,116	766
Total non-current assets		273,094	255,101
Current assets			
Inventories	11	25,645	24,613
Trade and other receivables	12	75,266	78,829
Cash and cash equivalents	13	68,087	37,939
Total current assets		168,998	141,381
Current liabilities			
Trade and other payables	14	(62,217)	(58,740)
Provisions for liabilities and charges	15	(1,090)	(1,177)
Obligations under leases	16	(5,617)	(4,668)
Total current liabilities		(68,924)	(64,585)
Total assets less current liabilities		373,168	331,897
Non-current liabilities			
Provisions for liabilities and charges	15	(249)	(282)
Obligations under leases	16	(31,495)	(23,697)
Total non-current liabilities		(31,744)	(23,979)
Total assets less total liabilities		341,424	307,918
Financed by			
General Fund		265,822	228,664
Revaluation Reserve		75,602	79,254
Total taxpayers' equity		341,424	307,918

Notes 1 to 22 form part of these accounts.

The financial statements on pages 104 to 136 were recommended by the Audit Risk and Governance Committee on 24 June 2026 and approved by the Board in accordance with powers within the NHSBT Standing Orders, and are signed by the Accounting Officer, Frances O'Callaghan.



Frances O'Callaghan
Chief Executive and Accounting Officer

3 July 2026

Statement of cash flows for the year ended 31 March 2026

	Note	2025-26 £000	2024-25 £000
Cash flows from operating activities			
Net operating costs before interest		(154,119)	(123,064)
Adjustments for non-cash transactions	17	23,610	25,856
(Increase)/decrease in trade and other receivables	12	2,213	(8,617)
(Increase)/decrease in inventories	11	(1,032)	(4,486)
Increase/(decrease) in trade and other payables	14	1,727	9,677
Provisions utilised	15	(206)	(117)
Net cash (used in) operating activities		(127,807)	(100,751)
Cash flows from investing activities			
Purchase of plant, property and equipment		(14,863)	(12,569)
Purchase of intangible assets		(7,445)	(5,712)
Increase/(decrease) in capital accruals	14	1,750	479
Purchase of right of use assets		(830)	(663)
Net cash (used in) investing activities		(21,388)	(18,465)
Cash flows from financing activities			
Grant from Department of Health and Social Care		186,500	139,923
Capital element paid in respect of lease obligations		(5,529)	(5,732)
Interest paid in respect of lease obligations		(1,628)	(1,477)
Net cash generated from financing activities		179,343	132,714
(Decrease)/increase in cash and cash equivalents		30,148	13,498
Cash and cash equivalents at 1 April		37,939	24,441
Cash and cash equivalents at 31 March	13	68,087	37,939

Notes 1 to 22 form part of these accounts.

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Note	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2025		228,664	79,254	307,918
Changes in taxpayers' equity for 2025-26				
Net expenditure for the financial period		(155,832)	-	(155,832)
Net gain on revaluation of property, plant and equipment	8	-	1,416	1,416
Net gain on revaluation of right of use assets	9	-	1,422	1,422
Transfer between reserves		6,490	(6,490)	-
Total recognised income and expense for 2025-26		(149,342)	(3,652)	(152,994)
Revenue Grant from DHSC		167,000	-	167,000
Capital Grant from DHSC		19,500	-	19,500
Balance at 31 March 2026		265,822	75,602	341,424

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 loss 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

Notes 1 to 22 form part of these accounts.

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 and indexation, 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.

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 2025-26 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM comply with IFRS to the extent that they are meaningful and appropriate to the public sector context as determined by Change to HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the FReM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of 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 2026-27 are anticipated to be sufficient to meet operational plans, when considered in conjunction with the agreed Cost Improvement Programme, 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 45.

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 the NHSBT Charity, 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.

Valuation of Barnsley and Liverpool Speke properties

During the year, management reassessed the valuation basis for our Barnsley and Liverpool Speke properties. Previously, the right-of-use asset elements of these properties had been subject to professional valuation every five years, and a desktop valuation in the intervening years. However, the leases for both properties include regular rent reviews, which ensure that the leases, and the associated right-of-use assets, reflect market conditions. The valuation basis for the Barnsley and Liverpool Speke right-of-use assets has therefore been moved to the cost model from

2025-26, as a reasonable proxy for fair value. The net book value of these right-of-use assets at 31 March 2026 was £7,278k.

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

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 every five years, with indexation applied in the intervening years, this still involves judgements by the valuer, and by management, around the specific application of the guidance to each asset, the most appropriate indices to use and how these are applied, and in respect of the useful lives of the assets. The carrying value of assets valued on a DRC basis every five years, with indexation applied in the intervening years, is £154,126k (31 March 2025: £167,197k).

The HM Treasury Thematic Review of Non-Investment Properties, and the associated updated guidance in the FReM, require that non-investment properties are professionally valued every five years, with indexation applied in the intervening years, which is a change to the previous requirement for a professional desktop valuation in the intervening years. NHSBT undertook a full valuation of these properties at 31 March 2024, with a desktop valuation at 31 March 2025, and in-line with the updated guidance has applied indexation to these assets for the first time at 31 March 2026. The indices applied to these properties are construction industry, and location, specific to each property. As such, they reflect regional variations, with some indices rising and some falling in 2025-26. The table below illustrates the sensitivity of the valuation to potential average overall movements in the indices:

Net book value at 31 March 2026	Impact on overall valuation	
	+/- 1%	+/- 5%
£154,126k	+/- £1,542k	+/- £7,706k

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 the 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 the 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 the 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 the 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 the 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.

Revaluation and indexation 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.

In accordance with FReM requirements, land and buildings are professionally revalued every five years, with indexation being applied in the intervening years. A full on-site valuation is also carried out 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, and the programme of works has been completed. The change in valuation is reflected in the accounts. A full valuation of NHSBT land and buildings was carried out in March 2024, with a desktop valuation carried out in March 2025. For 2025-26, in accordance with the revised FReM requirements, indexation was applied to those land and buildings that were previously subject to revaluation.

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, that is:
 - 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
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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 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 25 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 2.95 per cent (2024-25: 2.40 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 3.64 per cent (2024-25: 4.03 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 4.22 per cent (2024-25: 4.07 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 5.32 per cent (2024-25: 4.81 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 5.07 per cent (2024-25: 4.55 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 the 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 96.

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

IFRS 17 Insurance Contracts has replaced IFRS 4 Insurance Contracts and is effective for periods beginning on or after 1 April 2025.

An insurance contract is a contract under which the issuer accepts significant insurance risk from the policyholder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder.

NHSBT has assessed its income contracts, and determined that none of these contracts includes insurance as defined by the standard and the FReM interpretation for the public sector:

1.26 Accounting standards that have been issued but have not yet been adopted

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

These standards are still subject to HM Treasury FReM adoption:

IFRS 14 Regulatory Deferral Accounts

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

IFRS 18 Presentation and Disclosure in Financial Statements

Application required for accounting periods beginning on or after 1 January 2027. Standard not yet adopted by the FReM. Early adoption is not permitted.

Interpretation guidance for UK public sector entities has not yet been published, but the standard is expected to change the presentation of the Statement of Comprehensive Net Expenditure and how costs are grouped, aggregated and reported within that statement, as well as introducing a requirement to report management-defined performance measures. A fuller impact assessment will be possible once further public sector guidance has been published.

IFRS 19 Subsidiaries without Public Accountability: Disclosures

Application required for accounting periods beginning on or after 1 January 2027. Standard not yet adopted by the FReM. Early adoption is not permitted.

Interpretation guidance for UK public sector entities has not yet been published. The standard reduces the disclosure requirements for subsidiaries without public accountability. It is not yet clear how public sector bodies will be judged against those criteria. If the standard is applicable to NHSBT, a reduction in disclosures may be possible. If it is not applicable to NHSBT, then there would be no impact. A fuller impact assessment will be possible once further public sector guidance has been published.

Note 2 Operating segments – 2025-26

For the year 1 April 2025 to 31 March 2026	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	470,675	359,642	24,642	-	44,899	17,809	23,633	50
Income from Scottish Parliament	8,931	-	-	8,931	-	-	-	-
Income from National Assembly for Wales	5,125	-	-	5,125	-	-	-	-
Income from Northern Ireland Assembly	3,105	-	-	3,105	-	-	-	-
Other income	45,865	10,283	792	533	2,532	51	5,609	26,065
Programme funding from the DHSC	167,000	38,653	1,592	116,355	3,992	859	4,490	1,059
Total revenue	700,701	408,578	27,026	134,049	51,423	18,719	33,732	27,174
Expenditure								
Variable costs	(73,123)	(41,198)	(3,818)	(3,730)	(8,783)	(5,203)	(4,462)	(5,929)
Direct costs	(307,105)	(144,708)	(14,170)	(81,885)	(25,007)	(9,354)	(19,856)	(12,125)
Direct support costs	(194,201)	(151,617)	(3,381)	(16,064)	(9,615)	(1,561)	(9,910)	(2,053)
Movement in value of stocks	934	2,229	(123)	-	-	-	-	(1,172)
Other support costs	(73,981)	(43,086)	(2,647)	(13,517)	(5,466)	(2,029)	(4,309)	(2,927)
Total expenditure	(647,476)	(378,380)	(24,139)	(115,196)	(48,871)	(18,147)	(38,537)	(24,206)
Operating surplus/(deficit) for the financial period before transformation	53,225	30,198	2,887	18,853	2,552	572	(4,805)	2,968
Transformation costs	(28,334)	(15,454)	-	(8,098)	(988)	(355)	(763)	(2,676)
Operating surplus/(deficit) for the financial period	24,891	14,744	2,887	10,755	1,564	217	(5,568)	292
Add: notional cost of capital included in expenditure above	7,665							
Less: programme funding from the DHSC	(167,000)							
Less: capital charges paid to the DHSC	(21,388)							
Net expenditure	(155,832)							

Note 2.1 Operating segments – 2024-25

For the year 1 April 2024 to 31 March 2025	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	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 the DHSC	(122,923)							
Less: capital charges paid to the DHSC	(23,218)							
Net expenditure	(124,297)							

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 the 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 the DHSC programme funding for Plasma for Medicines, sales of Plasma for Diagnostics, and the Plasma Supply Agreement with NHS England.

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 which are 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 the 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

	2025-26 £000	2024-25 £000
Blood and components	369,925	377,437
Pathology	47,431	45,007
Tissues	25,434	22,724
Stem cells	29,242	27,532
Therapeutic apheresis services	17,860	16,431
Organ donation and transplantation	17,694	16,347
Plasma	26,115	25,114
Total income from activities per SoCNE	533,701	530,592

3.2 Income by source

	2025-26 £000	2024-25 £000
Department of Health and Social Care	39,013	46,828
NHS Trusts	140,598	137,340
NHS Foundation Trusts	294,930	292,554
NHS Clinical Commissioning Groups/Integrated Care Boards	5,792	18
Other Government bodies	24,722	22,222
Non-NHS	28,647	31,630
Total income from activities per SoCNE	533,701	530,592

£22.1m of the Other Government bodies income shown above is contractual income and grant funding from devolved administrations (2024-25: £20.1m).

3.3 Revenue Grant in Aid from DHSC

	2025-26 £000	2024-25 £000
Programme funding – organ donation and transplantation	110,635	91,251
Programme funding – pathology and stem cells	4,227	4,161
Programme funding – corporate	51,628	26,745
Programme funding – tissue and eye services	510	766
Total revenue grant from DHSC per SoCTE	167,000	122,923

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

Note 4 Staff costs

	2025-26 £000	2024-25 £000
Salaries and wages*	286,882	270,623
Social security costs**	37,027	28,023
Employer pension contributions***	59,019	54,062
Total	382,928	352,708

* Includes fixed term and bank staff £18.5m (2024-25: £20.2m), agency staff £1.9m (2024-25: £5.7m), and termination benefits £0.6m (2024-25: £0.05m), totalling £21.0m (2024-25: £25.95m), and is net of recoveries in respect of outward secondments £1.7m (2024-25: £0.1m).

** Includes the apprenticeship levy £1.4m (2024-25: £1.3m).

*** Includes contributions to NHS Pensions £59.00m (2024-25: £54.00m) and to NEST £0.05m (2024-25: £0.06m).

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 £23.3m (2024-25: £21.3m) was paid by NHSBT and matched by funding from the Department of Health and Social Care.

In addition, staff costs of £1.6m (2024-25: £1.1m) were capitalised as directly attributable to the development of the new Pulse system (an intangible asset) under the 'Blood Technology Modernisation' project (£1.6m NHSBT staff), and the Matching and Offering project (£0.05m agency staff).

Note 5.1 Operating expenses

	2025-26 £000	2024-25 £000
Other staff related costs	11,908	14,052
Consumable supplies	83,110	78,278
Maintenance of buildings, plant and equipment	21,549	20,766
Rent and rates	13,862	12,433
Transport costs	30,533	29,986
External contractors	37,203	33,083
Purchase and lease of equipment and furniture	6,586	6,933
Utilities and telecommunications	12,824	12,014
Media advertising	2,924	4,110
Organ Donation Transplant Scheme payments	25,250	24,486
Professional fees *	3,583	2,718
External auditors' remuneration: audit fees **	133	154
Software licence fees	6,697	7,250
Insurance	1,249	967
Total	257,411	247,230

* Professional fees include legal and programme management costs.

** No payment was made to the external auditors for non-audit work. The 2024-25 in year audit fee was £130k, with the difference being due to additional audit fees from the prior year.

Note 5.2 Depreciation and amortisation

	Note	2025-26 £000	2024-25 £000
Depreciation – property, plant and equipment	8	11,709	14,287
Depreciation – right of use assets	9	8,213	8,445
Amortisation	10	2,662	2,575
Total		22,584	25,307

Note 6 Other operating expenditure

	Note	2025-26 £000	2024-25 £000
Capital charges paid over as cash to DHSC		21,388	23,218
Capital non-cash: loss on disposal of fixed assets	7	302	161
Capital non-cash: (reversal of impairments)		905	(49)
Miscellaneous		2,302	5,081
Total		24,897	28,411

Note 7 Other gains/(losses)

	Note	2025-26 £000	2024-25 £000
Loss on disposal: plant and equipment	8	293	161
Loss on disposal: information technology	8	1	-
Loss on disposal: intangible assets	10	8	-
Total		302	161

Note 8 Property, plant and equipment – 2025-26

	Land £000	Buildings £000	Assets Under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Total £000
Valuation/cost at 1 April 2025	13,181	121,916	3,994	68,752	10	21,572	229,425
Additions purchased	-	5,326	5,510	4,027	-	-	14,863
Reclassification*	-	2,678	(3,617)	228	-	762	51
Indexation	(393)	318	-	1,612	-	-	1,537
Other in year revaluations	-	535	-	-	-	-	535
Disposals	-	-	-	(4,475)	-	(1,321)	(5,796)
Valuation/cost at 31 March 2026	12,788	130,773	5,887	70,144	10	21,013	240,615
Accumulated depreciation at 1 April 2025	-	3,319	-	41,317	10	13,695	58,341
Provided during the year	-	5,605	-	3,529	-	2,575	11,709
Reclassification**	-	-	-	-	-	3	3
Indexation	-	-	-	970	-	-	970
Other in year revaluations	-	-	-	-	-	-	-
Disposals	-	-	-	(4,181)	-	(1,320)	(5,501)
Accumulated depreciation at 31 March 2026	-	8,924	-	41,635	10	14,953	65,522
Net book value at 1 April 2025	13,181	118,597	3,994	27,435	-	7,877	171,084
Net book value at 31 March 2026	12,788	121,849	5,887	28,509	-	6,060	175,093
Net book value at 31 March 2026 comprises:							
Owned assets	12,788	121,849	5,887	28,509	-	6,060	175,093
Revaluation reserve	2,687	42,789	-	2,767	-	-	48,243

* £51k was reclassified to Property, plant and equipment from Intangible assets during the year.

** £3k was reclassified to Property, plant and equipment from Intangible assets during the year.

The gross cost of Plant and Machinery that had been fully depreciated, but which was still in use at 31 March 2026, was £2,752k (31 March 2025: £15,359k).

The gross cost of Information Technology that had been fully depreciated, but which was still in use at 31 March 2026, was £18k (31 March 2025: £4,087k).

Note 8.1 Property, plant and equipment – 2024-25

	Land £000	Buildings £000	Assets Under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Total £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
Indexation	-	-	-	2,827	-	-	2,827
Other in year revaluations	-	(2,828)	-	-	-	-	(2,828)
Impairments	-	687	(1,691)	-	-	962	(42)
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
Revaluation reserve	3,080	43,457	-	2,908	-	-	49,445

Note 8.2 Revaluation of property, plant and equipment

NHSBT last 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). In 2024-25, a desktop revaluation was performed by the same valuer.

For 2025-26, in accordance with the new requirements set out by the HM Treasury Financial Reporting Manual (FReM), indexation was applied to those land and buildings that were previously subject to revaluation. Advice on the appropriate indices to use for each property was provided by Newmark Gerald Eve LLP, and the indices selected were aligned with the nature of the property (specialised/non-specialised), their geographic location, and construction and property industry valuation practice.

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

In line with the new requirements set out by the FReM, revaluations of land and buildings are performed every five years, with indexation being applied in the intervening years. NHSBT will therefore next undertake a full revaluation exercise in the 2028-29 financial year.

Property 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.

NHSBT's non-specialised properties, Gloucester Oakes House and London West End Donor Centre, are valued at their Existing Use Value (EUV), as market-based evidence can be used for the valuations.

Note 9 Right of use assets – 2025-26

	Land £000	Buildings £000	Transport Equipment £000	Total £000
Valuation/cost at 1 April 2025	12,661	61,269	9,668	83,598
Additions	266	11,462	3,572	15,300
Indexation	(143)	976	-	833
Impairments	41	-	-	41
Disposals	-	(3,847)	(1,863)	(5,710)
Valuation/cost at 31 March 2026	12,825	69,860	11,377	94,062
Accumulated depreciation at 1 April 2025	16	11,685	5,451	17,152
Provided during the year	293	6,051	1,869	8,213
Disposals	-	(3,847)	(1,809)	(5,656)
Accumulated depreciation at 31 March 2026	309	13,889	5,511	19,709
Net book value at 1 April 2025	12,645	49,584	4,217	66,446
Net book value at 31 March 2026	12,516	55,971	5,866	74,353
Net book value at 31 March 2026 comprises:				
Leased assets	12,516	55,971	5,866	74,353
Revaluation reserve	9,452	17,907	-	27,359

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.

During the year, we reassessed the valuation basis for our Barnsley and Liverpool Speke properties. Previously, the right-of-use asset elements of these properties had been subject to professional valuation every five years, and a desktop valuation in the intervening years. However, the leases for both properties include regular rent reviews, which ensure that the leases, and the associated right-of-use assets, reflect market conditions. The valuation basis for the Barnsley and Liverpool Speke right-of-use assets has therefore been moved to the cost model from 2025-26, as a reasonable proxy for fair value. The net book value of these right-of-use assets at 31 March 2026 was £7,278k.

Note 9.1 Right of use assets – 2024-25

	Land £000	Buildings £000	Transport Equipment £000	Total £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

9.2 Amounts recognised in Statement of Comprehensive Net Expenditure

	2025-26 £000	2024-25 £000
Depreciation expense on right-of-use assets	8,213	8,445
Interest expense on lease liabilities	1,714	1,233
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	811	1,056
Non-recoverable VAT	780	851
	11,518	11,585

9.3 Amounts recognised in Statement of Cash Flows

	2025-26 £000	2024-25 £000
Total cash outflow on interest expense on leases	1,628	1,477
Total cash outflow on repayment on lease liabilities	5,529	5,732
Total cash outflow on purchase of right of use assets	830	663
	7,987	7,872

Note 10 Intangible assets – 2025-26

	Software £000	Assets Under Construction £000	Total £000
Valuation/cost at 1 April 2025	23,802	2,351	26,153
Additions	4,427	3,018	7,445
Reclassification*	2,300	(2,351)	(51)
Disposals	(1,171)	-	(1,171)
Valuation/cost at 31 March 2026	29,358	3,018	32,376
Amortisation at 1 April 2025	9,348	-	9,348
Provided during the year	2,662	-	2,662
Reclassification**	(3)	-	(3)
Disposals	(1,163)	-	(1,163)
Amortisation at 31 March 2026	10,844	-	10,844
Net book value at 1 April 2025	14,454	2,351	16,805
Net book value at 31 March 2026	18,514	3,018	21,532
Net book value at 31 March 2026 comprises:			
Owned	18,514	3,018	21,532
Revaluation reserve	-	-	-

* £51k was reclassified from Intangible assets to Property, plant and equipment during the year.

** £3k was reclassified from Intangible assets to Property, plant and equipment during the year.

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 2026 BTM had a gross book value of £22.2m (2024-25: £14.4m), a net book value of £17.0m (2024-25: £11.8m) and an expected remaining useful life of 6 years (2024-25: 7 years).

Note 10.1 Intangible assets – 2024-25

	Software Purchased	Assets Under Construction	Total
	£000	£000	£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
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
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:			
Purchased	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.

Note 11 Inventories

	31 March 2026 £000	31 March 2025 £000
Raw materials and consumables	7,865	7,765
Work in progress	2,022	2,036
Finished processed goods	15,758	14,812
Total	25,645	24,613

At 31 March 2026, we held 6,024 litres of plasma for diagnostics (31 March 2025: 23,743 litres), which were valued at £444k (31 March 2025: £1.84m). We also held 55,610 litres of plasma for medicine (31 March 2025: 200,816 litres), which were valued at £4.1m (31 March 2025: £3.88m).

At 31 March 2026, we held finished processed blood and component stocks valued £8.65m (31 March 2025: £6.33m).

Note 12 Trade and other receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade receivables	39,985	63,204
Allowance for impaired contract receivables	(27)	(22)
Other debtors	832	558
VAT	5,941	3,440
Prepayments and accrued income	28,535	11,649
Subtotal	75,266	78,829
Non-Current		
Other prepayments and accrued income	2,116	766
Subtotal	2,116	766
Total trade and other receivables	77,382	79,595
Allowances for credit losses		
	2025-26 £000	2024-25 £000
At 1 April	(22)	(30)
New allowances arising	(13)	(8)
Utilisation of allowances (written off)	2	9
Reversed unused (recovered)	6	7
At 31 March	(27)	(22)

Note 13 Cash and cash equivalents

	31 March 2026 £000	31 March 2025 £000
At 1 April	37,939	24,441
Net change in year	30,148	13,498
At 31 March	68,087	37,939
Comprising:		
Cash in hand	1	1
Cash with the Government Banking Service	68,086	37,938
Total cash and cash equivalents	68,087	37,939

Note 14 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables – revenue	14,548	12,084
Trade payables – capital	2,534	784
Tax and social security costs	9	12
Accruals	34,943	34,365
Deferred income	10,183	11,496
Total current trade and other payables	62,217	58,741

Note 15 Provisions for liabilities and charges

	PAYE £000	Employee benefits £000	Redundancy £000	Product liability & other £000	Total £000
At 1 April 2025	58	315	35	1,050	1,458
Provisions arising in the year	29	5	510	251	796
Change in discount rate	-	(10)	-	-	(10)
Utilised during the year	(11)	(34)	(35)	(126)	(206)
Reversed unused	(18)	(3)	-	(687)	(708)
Unwinding of discount	-	9	-	-	9
Balance at 31 March 2026	58	282	510	489	1,339
Expected timing of cash flows:					
– not later than 1 year	58	33	510	489	1,090
– later than one year and not later than five years	-	124	-	-	124
– later than five years	-	125	-	-	125
Total	58	282	510	489	1,339

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

The provision for employee benefits is in respect of permanent injury benefit awards which are payable over the lifetime of the individuals receiving the payments. The discount rate applied is plus 2.95 per cent as published by HM Treasury in December 2025.

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 £510k in relation to 10 redundancies at 31 March 2026 (31 March 2025: £35k).

At 31 March 2026 £9,065k is included in the provisions of NHS Resolution in respect of the clinical negligence liabilities of NHSBT (31 March 2025: £9,857k).

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 2026 £000	31 March 2025 £000
Not later than one year	7,369	6,235
Later than one year and not later than five years	21,633	16,692
Later than five years	24,917	21,024
	53,919	43,951
Less future finance charges	(16,807)	(15,586)
Present value of future lease obligations	37,112	28,365
Present value of minimum lease payments		
Not later than one year	5,617	4,667
Later than one year and not later than five years	16,563	12,114
Later than five years	14,932	11,584
Present value of future lease obligations	37,112	28,365
Analysed as:		
Current borrowings	5,617	4,667
Non-current borrowings	31,495	23,698
	37,112	28,365

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 2026 there were no commitments to property leases which had yet to commence (31 March 2025: £4,817k). 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	2025-26 £000	2024-25 £000
Depreciation	8 & 9	19,922	22,733
Amortisation	10	2,662	2,575
Impairments/(reversal of impairments)	6 & 9	864	7
Loss on disposal	7	302	141
Provisions arising in year	15	796	594
Provisions reversed in year	15	(708)	(398)
Other miscellaneous non-cash adjustment		(228)	204
Total		23,610	25,856

Note 18 Contingent assets and liabilities

At 31 March 2026 contingent liabilities relating to potential costs associated with donor claims, personal injury claims, employment tribunals, and other employer and public liability claims were £35,470 (31 March 2025: £135,088).

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 2026 the value of contracted capital commitments was £250.2k (31 March 2025: £1,584.7k).

Note 20 Related parties

The DHSC is regarded as a controlling, related party of NHSBT.

Therefore, the individuals and entities that the 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 2025-26, and had the following balances as at 31 March 2026:

NHS Confederation: expenditure £18k (2024-25: £9k), amount owed to related party £nil.

In addition, during the year NHSBT has had a significant number of material transactions with the DHSC, and with other entities for which the 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 £667m in income (2024-25: £617m) and £35m of expenditure (2024-25: £35m). Of the income,

NHSBT received £167.0m (2024-25: £122.9m) from the DHSC in relation to operational grant-in-aid and £19.5m (2024-25: £17.0m) 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 £25m of income (2024-25: £22m) and £129m of expenditure (2024-25: £112m)*.

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

2025-26 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	1,119	176	345	-
Rachel Jones	Non-Executive Director	Northern Care Alliance NHS Foundation Trust	Non-Executive Director	4,991	227	86	9
Lorna Marson	Non-Executive Director	NHS Lothian	Non-Executive Director	318	3,065	66	86

In accordance with IAS 24 the NHSBT Charity is regarded as a related party. NHSBT made recharges to the Charity during the year for costs incurred on its behalf of £136k (2024-25: £31k) and the Charity had £25k outstanding debtors at 31 March 2026 (31 March 2025: £7k).

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
Lorna Marson	Non-Executive Director	NHS Lothian	Non-Executive Director	355	2,457	34	80
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

Other related parties – income and expenditure

	2025-26		2024-25	
	Income £000	Expenditure £000	Income £000	Expenditure £000
NHS and DHSC bodies	647,322	34,906	476,742	34,567
Other Whole of Government Accounts bodies	24,722	37,774	22,222	111,615

Other related parties – receivables and payables balances

	31 March 2025		31 March 2025	
	Receivables £000	Payables £000	Receivables £000	Payables £000
NHS and DHSC bodies	29,127	1,427	50,359	515
Other Whole of Government Accounts bodies	4,111	380	7,154	589

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.

At the end of the financial year, work to clarify the interpretation of a clause in a key contract was ongoing. The work was concluded prior to the financial statements being authorised for issue, and operating expenses were therefore adjusted to include an additional £455k of costs.

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 the DHSC. NHSBT is not, therefore, exposed to significant liquidity risks.

