NHS
Blood and Transplant

NHSBT Board

28th May 2020

Chief Executive's Report

Status: Official

Since our last Board meeting in March, we have continued to focus on our four key COVID-19 priorities:

- The safety and wellbeing of our workforce;
- Continuity of supply;
- Support to the wider national effort; and
- Building our donor base for the future.

I am incredibly proud of how the organisation has risen to the challenge and is delivering against these priorities in hugely challenging circumstances, both professionally and personally.

Priority 1: Safety and Wellbeing

In line with evolving Government and PHE guidance, and in close collaboration with our trade unions, we have worked to update our policies, train staff, and introduce new safety measures across our operations. These include triage, social distancing, appropriate PPE and increased cleaning of our facilities, as well as a shift to home working for c30% of our staff.

We continue to risk assess vulnerable at-risk individuals to allow them to continue working safely. With the support of our BAME staff network, we are undertaking risk assessments with our BAME colleagues, recognising the disproportionate impact that COVID-19 is having on this section of the population.

Recognising the increased level of stress and anxiety created by this unprecedented situation, we have also increased the level of mental health and wellbeing support to leaders, managers and staff. Whilst additional mental health cases remain low, we are actively monitoring the situation and encouraging colleagues to take time to talk, take their annual leave, and ask for help when they need it.

Priority 2: Continuity of Supply

<u>Blood</u>

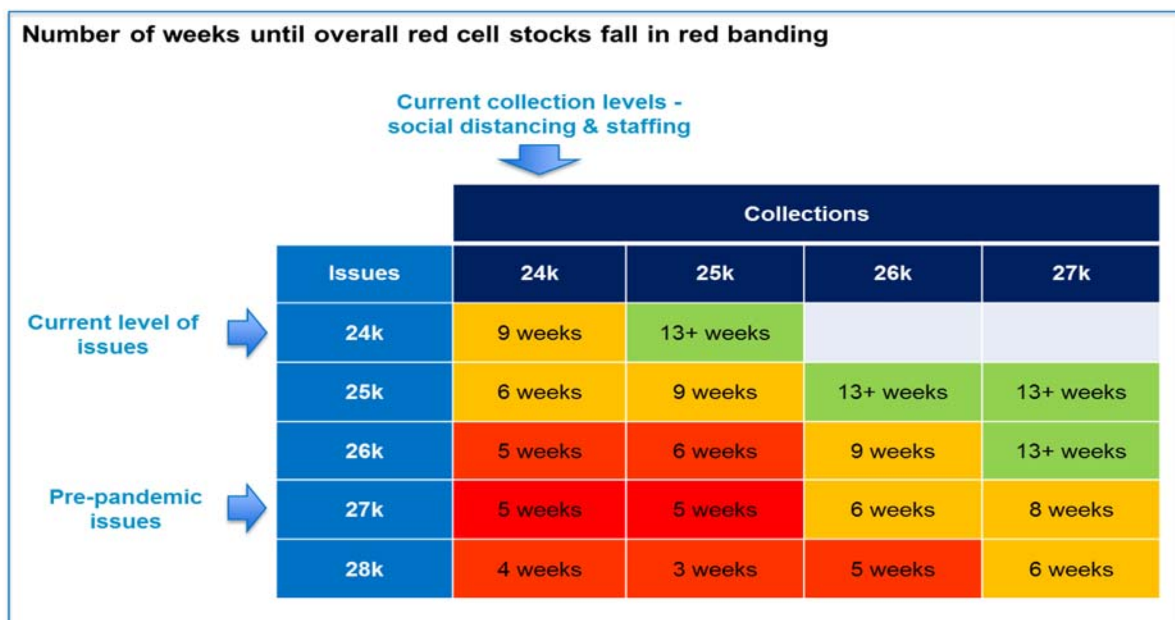
Blood stocks have been at or above target over the last 8 weeks, and service levels have remained strong with 96.8% On Time In Full (OTIF) performance. Since Easter,

we have started to see an increase in demand as hospitals have looked to rebuild stock in advance of resuming normal services. We are in contact with NHS England and regional Emergency Preparedness Resilience and Recovery (EPRR) teams to understand and plan the pace of recovery. We are also working closely with Trusts to gain local intelligence. This is being fed into our established demand planning processes.

We have increased donor mobilisation and collection capacity and, as of mid-May, stock has stabilised at c8 days of supply. However, we are facing a number of constraints to our ability to restore pre-pandemic collection volumes, e.g. ongoing staff absences and social distancing measures on session. We are working to secure larger venues and improve staffing levels, but there is still a risk that stock could fall if demand recovers more quickly than we are able to increase collections.

As part of our scenario planning, we have modelled how quickly stocks could fall below 4.5 days of stock (red band) based on different levels of demand and collections per week (table below). Should stocks fall towards 4-4.5 DOS, we will look to activate mitigating actions, such as a donor appeal and bringing forward Work In Progress.

Social distancing & staffing challenges – risk if demand reverts to 100% of pre-Pandemic levels



Number of weeks until overall red cell stocks fall in red banding

Current collection levels - social distancing & staffing (24k collections)

		Collections			
	Issues	24k	25k	26k	27k
Current level of issues	24k	9 weeks	13+ weeks		
	25k	6 weeks	9 weeks	13+ weeks	13+ weeks
	26k	5 weeks	6 weeks	9 weeks	13+ weeks
Pre-pandemic issues	27k	5 weeks	5 weeks	6 weeks	8 weeks
	28k	4 weeks	3 weeks	5 weeks	6 weeks

Since April, O neg demand has fallen in absolute volume by about 10%, but as a percentage has continued to increase and year to date represents 14.8% of total demand and 16.5% of total issues (or 1 in 6 units). We will be bringing a paper to the July Board to discuss the drivers behind this demand and our planned organisational response.

With COVID-19 suppressing the demand for platelets, we have redirected platelets collection capacity to support the collection of convalescent plasma. This is being reviewed on a weekly basis as part of our Integrated Supply Planning process.

Our project to end the importation of plasma, in line with SABTO recommendations and DHSC instructions, is on track. Production of imported plasma has now ceased and stocks of non UK plasma will be run down over the next few months. NHSBT, as agreed, will continue to support the Northern Ireland Blood Service with non UK FFP and Cryo until November 2020.

The work to set up and validate the new neonatal UK plasma components as per the Red Blood guidelines is on track. Increased donations from Group A and AB male donors are now at the level required to meet demand, although demand has fallen by c30% due to COVID-19.

Organ and Tissue Donation and Transplant

We saw a significant reduction in organ donation and transplant activity over the past two months due to the pressure on ITUs. In response, over 250 of our specialist nurses volunteered to return to the clinical frontline in their embedded Trusts and Boards. Between 30 March and 1 May, our nurses provided hospitals with 17,850 hours of clinical support. This support ranged from direct care to patients in ITUs, PICUs and Nightingale Hospitals to family bereavement care.

At the request of the Northern Care Alliance, we worked with NHS stakeholders and charities to set up a bereavement helpline, which is manned with specialist nurses who, for various reasons, are unable to nurse within the critical care environment. As donation and transplant activity is now starting to pick up, we are working with DHSC to hand this over to a national programme being run by the Ministry of Justice.

The Board will remember that we paused marketing and comms on Opt Out legislation during the peak of COVID-19 in order to focus on security of blood supply. At the time, we expected a delay to the go live date for legislation. Ministers, however, have decided to go ahead on 20 May and we have re-started radio advertising, supported by proactive media activity, paid-for search and partner comms. Unfortunately, our latest survey has shown that overall awareness has dipped from 62% to 58% (below our 2019/20 target). BAME awareness has also dropped from 48% to 41% (though I'm told this is not statistically significant because of the sample size). A fuller update will be provided as part of a standalone agenda item.

Clinical Services

Our PBM team have been providing transfusion advice and support to the set-up of the Nightingale hospitals. They have also been developing closer links with both the NHSE Specialised Commissioning team for Blood and the EPRR regional restoration groups. We have been working closely with the NBTC to develop plans for major haemorrhage in the event of any blood shortages and have run webinars to support the fast roll-out of clinical trials in Convalescent Plasma.

Work in our stem cell area has reduced due to COVID-19 but we expect activity to start picking up as the NHS looks to restore services. In parallel, we are developing a programme of work with the UK Stem Cell Strategic Forum, BSBMTCT (British Society for Blood and Marrow Transplantation and Cellular Therapies) and the NHSE Clinical Reference Group. More details on this work will be brought to the Board in July as part of a wider discussion on our emerging thoughts on the strategic direction for this clinical area.

In TAS, our activity is currently around 80% of expected although is beginning to rise. Over the past two months we have delivered additional unplanned support to several acute NHS Trusts unable to provide in-house services due to staff absence, relocated our Bristol service within the Trust at their request, established a new on-site extracorporeal photopheresis service in Cardiff (to reduce space pressure in Bristol) and agreed to provide extra collection capacity in Oxford for Anthony Nolan. We hope this will provide us with a greater footprint as we come out of the pandemic.

Quality

There have been no external regulatory inspections in April or May, however the MHRA have now informed us that they will commence desk top inspections of Basildon, Oxford and Sheffield over the coming weeks.

Internal quality assurance over the last two months has been focused on critical processes for maintaining regulatory compliance in order to create capacity to support Convalescent Plasma and the Bereavement Helpline. Whilst overdue items rose in Q4, as reported at the last Board, we have seen some encouraging improvements in April, though we are not yet back to Q3 levels.

Priority 3: Support to the Wider National Emergency Response Effort

Convalescent Plasma

The Board will know that we are leading a major programme to collect convalescent plasma from people who have recovered from COVID-19. Early units are being provided to the REMAP-CAP and RECOVERY clinical trials. In parallel, we are working to scale our collection capacity so that we will be in a position to deliver large scale volumes to hospitals should the trials prove successful. We are collaborating with PHE, NHS Digital and the other UK blood services, as well as our international counterparts who are leading similar efforts in their home countries. A fuller update will be provided as part of a separate, stand alone item on the agenda.

In other countries, convalescent plasma is being pooled and ‘fractionated’ by pharmaceutical companies to make plasma-derived medicines to fight COVID-19. Whilst we are not currently allowed to use UK plasma for fractionation, the MHRA has started to review the use of UK plasma for fractionation. We are in discussions with DHSC on the associated policy issues. Again, more details will be provided as part of a separate agenda item.

In conducting their review, the MHRA will have in mind the ongoing Infected Blood Inquiry (IBI). Delivery of NHSBT boxes to the IBI had been paused due to COVID-19

but is due to recommence in early June. The Inquiry hearings in June and July, when evidence was due to be heard from clinicians and others who could shed light on the policies and practices of haemophilia centres across the UK, have been postponed. It is hoped that the hearings will resume in mid-September but dates are still to be confirmed.

Testing

We have also been providing support to various pillars of the the Government's testing programme.

NHS swab testing (Pillar 1): We have released one of our two high-throughput Nucleic Acid Technology (NAT) testing machines to PHE Porton Down. We also took on NAT testing for the Welsh Blood Service so that they could free up and lend their machine, as well.

Antibody Testing (Pillar 3): Working with The National COVID-19 Scientific Advisory panel on the assessment of lateral flow tests, we provided plasma from over 100 blood donors that was collected prior to November 2019. This has provided an invaluable panel of negative controls for determining the specificity of SARS-CoV-2 tests.

Surveillance Testing (Pillar 4): Since the end of March, we have provided over 6,700 samples from blood donors to PHE which are being used in seroprevalence studies to help understand exposure to SARS-CoV-2 by detecting antibodies against the coronavirus. We plan to continue providing around 2,000 samples per week over the next few months.

National Effort (Pillar 5): We are collaborating with a number of initiatives to enable the national testing programme, e.g.

- We have provided convalescent plasma with varying levels of neutralising antibodies to the National Institute for Biological Standards and Controls (NIBSC). These units are being used to create standards for test assessment and;
- We are in discussions with Sir Mike Ferguson (UK Serology Task Force) and Lord Ara Darzi (Home Testing Programme) about how we can supply them with both confirmed negative and positive samples so that they can validate their assays and scale up the testing.

Priority 4: Building our Donor Base for the Future

As previously reported, we have seen a significant increase in new donor registrations: up 24% in April. This upswell in pride and support for the NHS offers a unique opportunity to strengthen and diversify our donor base for the future. Unfortunately, we originally found ourselves having to stop all comms and recruitment activity due to an inability to process the increase in registrations. With the help of some pro bono support from Bain (consulting) and Cohaesus (digital boutique), we will shortly be launching a new digital service, designed specifically to capture and manage new donor interest.

In parallel, we have recently completed our work with McKinsey to re-imagine our E2E donor engagement process, with a particular focus on closing our black Ro supply/demand gap. It's clear that there are no silver bullets but we now have a blueprint which will form the basis of the Donor Experience teams's plans over the coming months and years. Delivering will require a significant investment of time and resource, and carries with it high execution risk. We face a similar challenge to improve the diversity of our organ and stem cell donor registries. But doing so is mission critical if we are to meet clinical demand and reduce heath inequalities.

Diversity and Inclusion

One of the key insights from our work with McKinsey is that making NHSBT a more diverse and inclusive organisation will be a key enabler to improving the diversity of our donor base. In other words, we will not be successful in saving and improving more lives if we do not take concerted action about our culture and workforce.

We know from the quantitative evidence (e.g. the Workforce Race Equality Standard (WRES) data, Stonewall report, and gender pay gap) as well as from the recent organisational diagnostic at Colindale and McKinsey personal experience, that we have a lot of work to do in this respect. To lead our efforts, I have decided to recruit a Chief Diversity and Inclusion Officer, who will report to Katie Robinson, our new Strategy and Transformation Director. This new senior appointment will also join the Executive Team ('ET'), to improve diversity in our decision making.

It will take several months to recruit our new ET member. In the meantime, I have invited the chairs of our staff networks to join our meetings on a rotational basis - to improve the diversity of our decision making and to contribute to the development of our strategy and action plans on Equality, Diversity and Inclusion ('EDI').

At the request of our network chairs, we will shortly be announcing ET 'champions' for each of our staff networks. Millie Banerjee has already agreed to be our Board-level Champion for Equality, Diversity and Inclusion.

In parallel, I will be creating an EDI Council to oversee and drive our EDI efforts and to hold the organisation to account for delivery. I intend to chair this new governance forum, which will comprise several other members from the ET, as well as the chairs of our BAME, LGBT, Women's and Disability staff networks, and a staffside representative.

We will shortly be publishing the findings from the organisational diagnostic we commissioned at Colindale. We have already shared the high level themes with the Colindale Taskforce with whom we are working to implement the recommendations.

Looking Forward

Recovery and Transformation

As summarised above, COVID-19 has led to significant changes to what and how we deliver. As the Government looks to relax certain restrictions, we will need consider if

and when to roll back some of these changes. At the same time, we want to consider the lessons learnt from this experience and use them to re-imagine how we might operate in the post COVID-19 world.

For example, we know that some colleagues are keen to return to the office as soon as possible, whilst others have found a new equilibrium working from home, which they are loathe to lose. In parallel, we have built additional collection capacity to support our convalescent plasma programme. Depending on the outcome of the MHRA review, we may be able to convert this capacity into an ongoing plasma collection operation, which could fundamentally alter our future estate, technology and workforce plans - and create surpluses to subsidise the price of blood to the NHS.

We also know the NHS is looking to accelerate planned changes to how they operate at the national and regional level. This could fundamentally change the landscape for transplant, but also for diagnostics and therapeutic services. It is incumbent upon us not just to respond to these changes but, where possible, shape them as well.

With hospital activity already starting to recover, our challenge will be to create the time and capacity to focus on these big strategic questions whilst ensuring continuity of supply.

EU Exit

We will also have to create time and space to prepare for EU Exit. Subject to any request for an extension, we are still due to leave the EU at the end of the year - with or without a deal. At this point, we expect to re-establish the EU Exit Project in July, in order to implement any required stock build and/or other preparations ahead of the final phase of transition.

In the meantime, we continue to engage regularly with the DHSC Policy team, the Continuity of Inbound Supply team and the ALB oversight group. We have provided responses to a number of commissions in recent weeks, including contributions to a Multi Layered Approach to managing the supply chain, tariff consultations and on a Minimum Viable Product for Substances of Human Origin at time of transition.

Implementing the Northern Ireland Protocol (NIP) remains a key concern for the DHSC across EU/trade policy areas. We are focussing on any potential impacts to blood and organ movements as a result of the new arrangements.