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The Minutes of the Ninety-Eighth Public Board Meeting of NHS Blood and Transplant held at 10:00 on Thursday 23rd July 2020 via video conference

Present:	Ms M Banerjee	Mr G Methven
	Ms B Bassis	Dr G Miflin
	Mr R Bradburn	Mr J Monroe
	Mr A Clarkson	Mr C St John
	Ms H Fridell	Prof P Vyas
	Prof D Kelly	Mr P White
In Attendance:	Mr I Bateman	Dr S Allard (item 10)
	Ms W Clark	Mr Z Asghar (item 14)
	Ms A Rashid	Ms N Ashley (item 6)
	Ms K Robinson	Ms S Baker
	Ms Ka Robinson	Mr S Durgacharan (item 14)
	Mr D Rose	Ms K Ellis
	Ms K Smith	Mr G Gogarty (item 11)
	Mrs K Zalewska	Ms J Hardy (item 12 onwards)
		Ms C Howell (Observer)
		Ms C Lewis
		Mr M Overy (item 6)
		Ms M Thermidor (item 14)

1 **APOLOGIES AND ANNOUNCEMENTS**

Ms Banerjee welcomed Ms Sam Baker from the Scottish Government, Ms K Ellis from DHSC, and Ms Caroline Lewis from the Welsh Government. Ms Joan Hardy from the Department of Health in Northern Ireland was also due to join the meeting. Also welcomed to her first NHSBT Board meeting as a Non-Executive Director was Professor Deirdre Kelly.

No apologies were tendered.

On behalf of the Board Ms Banerjee congratulated Mr Clarkson who had been awarded a Fellowship of the Royal College of Nursing, the highest award given by the College.

Ms Banerjee outlined the protocol for the public meeting and asked those observing to reserve any questions for the end of the meeting.

2 **DECLARATION OF CONFLICT OF INTEREST**

There were no declarations of interest.

3 (20/47) **BOARD 'WAYS OF WORKING'**

The 'Ways of Working' were noted.

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4 (20/48) **MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 28th May 2020 were agreed as a correct record.

5 **MATTERS ARISING**

There were no matters arising.

6 (20/49) **PATIENT STORY**

Ms Natalie Ashley and Mr Matthew Overy joined the meeting to introduce the patient story which documented the story of one particular organ donor during the pandemic and the adaptations made to facilitate the donation.

The donor was admitted via the Yellow (Covid-19 suspected or incubated patients) Emergency Department before being transferred to Yellow ITU whilst awaiting Covid-19 test results. From this location he was referred to the organ donation team as a potential organ donor. The process of assessing and supporting both a potential organ donor and their family was extremely challenging due to Covid-19. Whilst waiting for the Covid-19 test results the embedded Specialist Requester (SR) could not assess the donor in person whilst in the Yellow area as this would mean they could not then accompany the patient to the Green area if the test results were clear. Remote support was offered to his bedside nurse who was not ITU trained due to the need for increased resource in ITU, and electronic patient records were utilised in the absence of contact nursing.

Throughout this process the family had been unable to visit and Covid-19 restrictions meant they could only keep in touch by 'phone. However, following confirmation of a negative Covid-19 test and recognising how difficult informing the family of the patient's death would be over the 'phone it was agreed by the Specialist Requester, Consultant and Nursing Team that the patient could be moved to the Green area. As well as allowing the family to visit the donor to say their farewells this allowed a face to face approach for organ donation to take place. Family members were allowed to visit in staggered groups and whilst wearing PPE. One family member who was shielding was included in all conversations via a mobile 'phone. The donation discussion was particularly challenging in this environment due to the fact that key guides for a Specialist Requester are often unspoken, facial and physical reactions to the donation discussion, made difficult to read due to PPE.

As the Green ITU was at capacity, and largely staffed by non-ITU Nurses with a very high workload, the SR stayed overnight with the Specialist Nurse in order to try to reduce the length of the process. Due to the urgency of organ donation, further samples for Covid-19 testing were expedited. Without these further samples the offering and acceptance of the organs could not take place. The National Organ Retrieval Service (NORS) teams brought their own PPE supplies to prevent using already limited hospital supplies and the donation went

ahead. The heat in theatre in full PPE was challenging for the entire team as was communicating due to the general noise level in theatre and the PPE. Despite the challenges and issues with lengthening of the timelines due to samples having to be re-tested, the family remained fully supportive throughout the process and the donor went on to successfully donate both kidneys, heart and liver to four different recipients.

In response to a query on the effect of Covid-19 on organ donation during the pandemic, Mr Clarkson undertook to look into whether it was possible to identify how many donations were not progressed due to the challenges and risks posed by Covid-19.

The Board thanked all those involved in overcoming the many obstacles to enable organ donation to continue during these challenging times and asked what support the teams were receiving whilst facing these challenges. Despite the heightened pressure and stressful situations there was a great deal of support for the teams involved with opportunities to debrief, have two-way conversations, check-ins with managers, WhatsApp groups etc.

7 (20/50) **CHIEF EXECUTIVE'S BOARD REPORT**

Members noted the report and Ms Bassis drew members' attention to the key priority areas.

- This was a busy time for the organisation. The pace and scale of the emerging convalescent plasma (CP) programme meant that NHSBT was continuing to be very busy with huge demands being placed on the organisation alongside managing business as usual operations which themselves have had to cope with unprecedented pressure. Given the circumstances, the business was coping well as evidenced on the Situation Reports and the Board Performance report. However, this super-human effort across the organisation was unsustainable over a longer period of time. The Executive were taking steps to build the management bandwidth and wider resources to deliver services in a more sustainable fashion as the organisation was coming out of the pandemic and beginning to scale up on plasma. The Executive was aware that the Board and other stakeholders would need assurances that the organisation could maintain security of supply, look after its people, and deliver against this ambitious programme on convalescent plasma which is multiple times the size of the normal annual change programme.
- The Secretary of State had thanked NHSBT for its ambition in delivering fabulous results on CP. However, this ambition came with high execution risk and NHSBT now needed to build the resources, management bandwidth, governance and assurance processes to mitigate that execution risk.
- CP and business as usual operations were not the only challenge. Addressing the serious issues of institutional racism and bias highlighted by the Colindale report and feedback from McKinsey were very high on the agenda for NHSBT with many colleagues feeling

rightly aggrieved and frustrated at the situation; some were feeling threatened and on the defensive; whilst others were still trying to process the information that had come to light. A Chief Diversity & Inclusion Officer had been appointed and would be joining the organisation on Monday 27th July to lead on a large programme of work on diversity and inclusion.

- EU Exit planning had restarted for the end of the transition period on 31st December 2020 with the potential for a no-deal situation. Although the organisation had prepared for this previously, this time it would be taking place at the same time as preparing for a potential second wave of Covid-19, a difficult flu season and bad winter weather. However, the CEO was confident in the business continuity and incident management arrangements which had so far worked well and assured the Board that the Executive and the entire organisation would continue to rise to the occasion.

Plans were being made to target over 70% of front-line colleagues with the flu vaccine this winter. It was suggested that this target should cover all colleagues, not just front-line colleagues.

Mr White queried how the organisation was monitoring employee engagement through these challenging times. The Peakon survey had launched recently and engagement figures were encouraging with just under a week to go. This was a short survey focusing on colleagues' wellbeing and how they felt supported by managers over this difficult period. Extensive risk assessments were also taking place to support the health and wellbeing of BAME colleagues.

The Executive was very aware of the need to make considered and timely decisions during the pandemic and that these would likely be reviewed at a later date for lessons learned. The Board noted that all decisions had been recorded and logged to ensure transparency and clarity. Additionally, the internal auditors were undertaking a review of performance during this period in parallel with an independent audit review. The internal audit was due to report prior to the September Board meeting.

8 (20/51) **CLINICAL GOVERNANCE REPORT**

Dr Miflin presented the report as detailed in paper 20/51 and highlighted the following item:

- INC 4791 - In December 2019 a patient proceeded to multi-organ donation for lungs, kidneys and liver. The heart was not suitable for transplantation and there was no consent for heart valve donation. Subsequently it was reported by the coroner that the heart was not present in the body at post-mortem. An investigation was undertaken which did not identify anything unusual about the organ donation operation. The heart would have been removed to access the lungs and then replaced; however, it was reported that the heart was not present at post-mortem. The family were understandably upset, and a meeting with them was being scheduled. In the meantime, new processes and documenting procedures were being put in place. The NORS (National Organ Retrieval Service) team was also informed and involved in the investigation. Board

members noted the action taken and emphasised the importance of putting in place actions to mitigate the risk of this recurring.

9 (20/52) **BOARD PERFORMANCE REPORT**

The Board accepted the report for June 2020. Mr Bradburn reported that the external audit of the 2019/20 accounts had been completed with no adjustments or issues raised. The National Audit Office (NAO), however, had proposed a qualified audit opinion based on their inability to physically verify stock due to lockdown. Although this was a national issue with many NHS Trusts and government bodies subject to the same qualification, it was decided to work with the NAO to identify the work needed to remove the qualification. The additional work was underway, and it was expected that the NAO would be able to remove the qualified opinion. The additional work implied that NHSBT would now lay its accounts in early September, rather than the original plan for early July. This was consistent, however with most government bodies, especially within DHSC, and hence taking the time to remove the qualification had been well worth it. It was now expected that the Chief Executive would sign the accounts at the end of August, with certification by the C & AG in early September. Two minor adjustments to the draft accounts seen by the Board would be made prior to this:

- Narrative to be added to reflect the post balance sheet activity with regard to the larger/extended Convalescent Plasma project
- An amendment to the remuneration report re 2018/19 pension figures for one Director.

Mr Bradburn reported that the primary performance challenge facing NHSBT was the management of blood stocks over August. The planning assumed that red cell demand would return to normal on September at c.a. 27.5 units/week. Collection capacity is constrained to c.a. 25k units/week as a result of staff resource and availability and the need for larger venues due to social distancing requirements. If issues were as forecast and collections continued at 25k/week then total stocks would fall into the red band in August. This was being closely managed with major emphasis on getting existing staff back to work and additional recruitment. In the short term, however, it was likely that some of the capacity directed to convalescent plasma (CP) would need to return to whole blood during August, particularly in those centres with lower utilisation.

The Board recognised that this was a challenging scenario and acknowledged the need to give reassurance of healthy blood stocks whilst increasing stocks of high and medium-titre plasma for CP. New funding was available to allow the creation of stand-alone CP capacity which would ease the pressure.

Mr St John reported that the Finance Committee had asked that additional performance data should be added to the performance report in order to segregate out the impact of Covid-19, e.g. quarterly data.

Mr Bradburn noted that block contracting for blood would continue to apply until the end of August, and most likely for the rest of the year. As a result, the income for blood would continue to be protected and the shortfall in specialist services contribution would be offset against the rebate contingency. As a result, the forecast for the year for NHSBT was a deficit of £15m compared to a planned deficit of £19.5m.

Ms Banerjee gave a brief summary of how the wider NHS was beginning to deal with recovery and return to business as usual, with issues of extending estates and staff returning to work following sickness or shielding. Innovative testing regimes were becoming available for those people at risk, particularly in a front-line capacity, to allow a safe return to work.

10 (20/53) **O D NEGATIVE DEMAND**

Dr Miflin introduced a presentation from Ms Catherine Howell and Dr Shubha Allard to provide assurance on actions being taken to manage the demand for O D negative blood. Demand for O D negative blood started to increase in August 2018 and was now reporting at approximately 13.3%. However, issues were higher than demand, currently at around 15.3%, due to substitution as NHSBT was unable to provide appropriate ABO matched Ro units of blood.

Initiatives had been taking place between NHSBT and the wider NHS to reduce inappropriate use of O D negative blood relating to stock and waste management, as well as focusing on education to deal with variability in transfusion practice within and between hospitals. Whilst data was available from hospitals on stock holding and wastage, no real time data was available on the clinical use of blood by specialty.

The challenges presented by this were debated at Transfusion 2024, a symposium facilitated by the National Blood Transfusion Committee and NHSBT. The Transfusion 2024 strategy would be a platform for a system wide, renewed focus and approach to address demand for OD negative blood.

The reason for the change in demand profile for O D negative from declining to increasing from the summer of 2018 was queried. It was explained that there was no single cause, but that this was due to a combination of factors and had been the subject of much discussion in the transfusion community which agreed with this explanation.

There were currently 16 hospitals on a vendor managed inventory (VMI) platform but no immediate plans to roll this out to more hospitals until the system was moved to a more secure platform. Once achieved, the decision to increase the number of hospitals would need to be discussed and agreed. In order to gain a better understanding of the current clinical use of blood there was a need to source real-time data. This would be considered as part of the work to deliver the recommendations of Transfusion 2024.

The Board thanked the teams for the work carried out on the appropriate use of blood. Transparency and better knowledge of the use of blood remained a strategic issue for NHSBT. It was acknowledged that Transplantation 2024 would present options for a renewed approach to managing blood use across the system and welcomed further information on this at the September Board meeting.

11 (20/54) **CONVALESCENT PLASMA**

Dr Miflin introduced a presentation to update the Board on progress with Phase 1 of the Convalescent Plasma (CP) Programme and the next steps. In the first 16 weeks over 20,000 donors had been booked in, 15,000 units collected and over 300 units issued across the clinical trials.

There were key learnings from the first phase of activity both on scaling up and donor learning based on attrition in the donor pathway. As a result of these key learnings the collection strategy was being refined to a new segmented strategy with a 'sample-first segment' and a 'straight to donation segment'. The pilot for this strategy was underway with a national rollout expected in early August 2020.

DHSC had suggested that the CP Programme be expanded beyond Phase 1 as part of the planning for a second wave of the pandemic and emerging international evidence of the positive outcomes from the use of CP in reducing mortality. This would involve scaling up capacity to collect up to around 7,500 units per week. Key requirements for the increased capacity would be securing around 100 apheresis machines, opening ten new plasma donor centres, and recruiting additional colleagues at collection sites and across the supply chain.

Mr Gogarty presented the three options for CP collection for the six months following Phase 1 (November 2020 to April 2021).

- Option 1 – Shut down CP Programmes
- Option 2 – Optimise and put in place a sustainable operating model
- Option 3 Scale up above Option 2 collection capacity

The Board noted that the CP Programme had been recognised by NHSBT's partner organisations as a key success story in the fight against Covid-19, both now and in the future. The governance approach used for Phase 1 was presented with a view to continuing to be used for Phase 2 with the addition of formal inclusion of the NHSBT Board in the governance of this programme as it expands. This had been accepted by the DHSC Steering Group of the project. Any time critical decisions may require ad hoc Board meetings to be called. It was noted that NHSBT was required to report progress to the Secretary of State every fortnight.

Dr Miflin responded to questions from Board members both on the requirements for scaling up for options 2 and 3 and on the risks and mitigation needed for both options.

The key to taking this forward to a second phase was in building the infrastructure and creating the capacity in the right place at the right time. The infrastructure would also be crucial if the outcome of the MHRA review was to approve plasma for fractionation (PFF) and NHSBT was asked to collect plasma for PFF as well. NHSBT would need to ensure the capacity was available to collect convalescent plasma and would need to work across multiple channels, including with partners such as the NHS and GPs, to ensure that potential donors are flagged, as well as marketing directly to the public. However, there are constraints to donation that might disappoint many prospective donors; NHSBT would need to acknowledge and mitigate through greater efforts at recruitment.

12 (20/55) **TRANSFORMATION PORTFOLIO**

Ms Katie Robinson gave a brief introduction to the paper updating the Board on the impact of Covid-19 on the transformation priorities and portfolio of investments in 2020/21. Convalescent Plasma had emerged as a significant new priority and this, together with additional demands arising from Covid-19, had resulted in some of the original transformation plans for 2020/21 being paused or reprofiled.

Work on refreshing the portfolio had started, with the aim of continuing work across the transformation priorities identified in January. These included investing in digital and IT infrastructure and capabilities; improving the diversity and experience of donors; improving the diversity and inclusion of the workforce; and restructuring leadership structures to deliver. Ms Clark updated members on progress with the larger IT investments.

The Board reviewed the emerging priorities and plans for allocating funding and managing resources and Mr Rodgers joined the meeting to respond to questions. Following on from the discussion on understanding the demand for blood, the Board asked for reassurance that the portfolio included transformation projects to help to address this issue. One theme running through the portfolio was the opportunity to partner with other organisations to acquire knowledge and build infrastructure to support the wider NHS. It was recognised that the organisation needs to strengthen how it captures and starts conversations on this, even if it is not yet ready to implement this year.

It was noted that, in parallel with restarting the portfolio, a longer-term strategy across the whole of the NHSBT portfolio would be developed to capture a multi-year roadmap. This would look at how to align expertise and opportunities and to understand the interdependencies and consider capacity requirements.

13 (20/56) **ORGAN DONATION & TRANSPLANTATION STRATEGY**

Following extensive stakeholder engagement, the first draft of the new Organ Donation and Transplantation (ODT) Strategy was presented to the Board in January 2020. Development of the strategy was then

suspended in March 2020 to enable full operational focus on the Covid-19 pandemic. A recovery programme had been established for organ and tissue donation and transplantation to manage recovery from the pandemic and future transformation. Covid-19 has had a significant negative impact on the transplant waiting list which is expected to return to levels last seen in 2015/16. It was therefore essential to finish the work to develop and publish the strategy to inform the future activities required to increase the levels of organ donation and transplantation.

Re-examination of high-impact initiatives were proposed to restore the UK system and deliver more transplants. In donation the opportunities arising from the change in legislation need to be maximised together with opportunities to increase organ utilisation. However, this would require significant investment in each of the five years from April 2021.

The aim is to present the changes to the strategy to the Board in September, making clear the impacts of the pandemic on the strategy and the proposals to address these.

In response to a question on understanding the reasons why transplant centres reject organs, Mr Clarkson advised that previous studies revealed the main reason was the quality of the organ, however a number of resource constraints within transplant centres had also been highlighted. Although there were agreed standard donor criteria in place there is variation across transplant centres, in addition to which many of the potential donors were considered to be marginal donors. The strategy would consider initiatives to increase the quality of the data received from transplant centres when rejecting an organ. The adoption of novel technologies and the potential to assess and improve the quality of donated organs were also key to increasing organ utilisation.

It was highlighted that, in terms of international comparisons, the UK had one of the lowest rates of cardiothoracic transplantation and it was important to find a way to expose the difficulties driving this situation. An international peer review of the strategy would be sought but further work would need to take place regarding cardiothoracic transplantation to understand and address the challenges.

14 (20/57) **DIVERSITY & INCLUSION UPDATE**

The Board were joined by Ms M Thermidor and Mr Z Asghar, joint chairs of the BAME network, and Mr S Durgacharan, Chair of the BAME taskforce at Colindale.

Ms Bassis explained the background to the decision to undertake a diagnostic report in Colindale following allegations of discrimination raised at a site visit. The report findings came at the same time as feedback from the McKinsey work on donor experience. It was acknowledged that the issues highlighted in the report were by no means limited to Colindale or one particular department, this is evident from WRES data and from the experience of people working on the McKinsey project. A number of immediate actions had been put in place

and colleagues were being encouraged to speak up if subjected to bias or unacceptable behaviour. Work was ongoing with the BAME taskforce at Colindale as well as the wider staff networks on a wider plan of activity to tackle these issues.

NHSBT had shown recently, through large initiatives such as Convalescent Plasma, that investing time, effort, leadership and budget could achieve great things. In tackling diversity and inclusion with a systematic and programmatic approach it was clear that NHSBT needed to invest time, effort, leadership and funding to improve diversity and inclusion within the organisation. With this in mind a new Chief Diversity & Inclusion Officer had been appointed and would be commencing in role on 27th July and a D&I Council had been established as a subcommittee of the Executive Team. In addition, an organisational development practitioner had been brought in to act as advisor to the CEO, Executive Directors and wider leadership team.

The Executive Team had spent a lot of time listening to colleagues and hearing their lived experience of working in NHSBT. The CEO and Chair thought it was important that the entire Board had an opportunity to hear some of these stories as well.

Mr Azghar and Ms Thermidor emphasised that the network chairs had a responsibility to share the experiences of their colleagues whose 'hidden voices' were often not captured or reflected upwards.

The Board were presented with a video where NHSBT colleagues talked openly about racism and their experiences within the organisation, many of whom had worked in the organisation for a significant amount of time. Although uncomfortable to hear, the Board and the Executive needed to be aware of and recognise these experiences in order to work to achieve the change in culture required. The Board members reflected on the video and expressed their gratitude at the bravery of those who had raised issues and spoken up. Although the content was humbling and distressing to hear, it brought into focus the impact of these issues on NHSBT colleagues. When reflecting on the video the Board acknowledged the need to be fully inclusive not only in relation to racism but in all areas of diversity.

On behalf of the Board, Ms Banerjee thanked those who took part in the video and those instrumental in its production. She added that the video had a very powerful set of messages and that the Board was very fortunate that the colleagues felt they trusted the Board enough to share their experiences; she added that the Board were obliged to listen to as many voices as possible and that the input today was the first of many. Commenting on a statement in the video that mentioned "their cause" she emphasised that this issue was "our cause" and that it was a shared responsibility across the NHSBT Board to take appropriate action, and this would be reflected on over the next few months. Board members respected the courage of those prepared to speak out on this issue and reiterated how humbling it was to hear of these experiences. It was

important that these messages continued to be sought out, listened to and reflected upon.

One speaker on the video commented on the 'radio silence' from the Chair. Ms Banerjee apologised for that she had not spoken publicly on this issue for a while and explained that this was not intentional or because the issue was not considered to be significant but was a result of considering when was the right time and how best to communicate with colleagues on this issue.

The Board fully supported the programme of work already commenced and the additional actions being planned. Diversity and inclusion was a strategic objective of NHSBT and the Board, working with the Executive, would hold itself accountable for its delivery. The aim was to return to the Board in September with a more detailed report on progress and the strategic objectives. It was important, in the meantime, to continue to hear from colleagues on their experiences of discrimination. Work would take place on delivering the appropriate metrics for D & I, and the involvement of network chairs in developing these was key. These would then be added to the performance report and to enable NHSBT to be benchmarked against other organisations.

The network chairs acknowledged members' comments and thanked them for their support and commitment to change. The challenge would be in managing people's expectations for change to happen more quickly. Mr Durgacharan thanked members for their response to the issues raised in the video and for the recognition of the issues and the enormity of the work to be done to change to a more diverse and inclusive organisation.

15 **REPORTS FROM THE UK HEALTH DEPARTMENTS**

15.1 **England**

Ms Ellis reported that DHSC had been working closely with NHSBT on a number of items of work since the beginning of lockdown, including convalescent plasma, organ donation opt-out and organ utilisation.

15.2 **Northern Ireland**

- The Minister of Health in N Ireland had announced a move to progress to consultation on a soft opt-out for organ donation.
- The NI Organ Donation Promotions Manager had now been appointed.
- Rebuilding of organ donation and transplantation services in Northern Ireland was taking place following Covid-19. Deceased donor transplants were going well although the number of living donations was low. Work was continuing with colleagues in the other UK countries on opt-out.

15.3 (20/58) **Scotland**

The report was noted. Ms Baker added that the focus was currently on the implementation of opt-out, taking forward the post 2020 action plan, and progressing recovery for transplant centres.

15.4 (20/59) **Wales**

The report was noted. Work was taking place on Covid-19 recovery and it was noted that the pancreas transplant programme had restarted.

16 **ANY OTHER BUSINESS**

There were no further items of business.

17 **FOR INFORMATION**

17.1 (20/60 & 20/61) **Ratification of Terms of Reference for GAC and RemCo**

Both Terms of Reference were noted.

17.2 (20/62 – 20/66) **Annual Report of Board Sub-Committees**

The annual reports for the following Board Sub-committees were accepted.

- Governance & Audit Committee
- Research & Development Committee
- Remuneration Committee
- Transplant Policy Review Committee
- Trust Fund Committee

17.3 (20/67) **Board forward plan**

The plan was noted.

18 **DATE OF NEXT MEETING**

The next meeting would be held on Tuesday, 22nd September 2020.

19 **RESOLUTION ON CONFIDENTIAL BUSINESS**

The resolution was noted.

Meeting Close