NHS
Blood and Transplant

NHSBT Board

26 November 2020

Chief Executive's Report

Status: Official

It's hard to believe it's been 10 months since the pandemic began. As we go into the second wave, as well as the end of the transition period with the EU, we have re-escalated our operational planning and response activity, and remain focused on delivering against the four priorities that we set out in March:

- The health and safety of our donors and staff;
- Continuity of supply of our critical products and services;
- Support to the wider national response; and
- Strengthening our donor base for the future.

We have also set out two longer term priorities for the organisation:

- Recovery and transformation, picking up on the work that we started with the Board ahead of the pandemic; and
- Making NHSBT a great place to work for everyone, incorporating our work on diversity and inclusion.

A copy of our latest SitRep is attached but, as in previous months, I have structured this report along these key priorities.

Health and Safety

We continue to review and update our safety measures in line with evolving Government and public health advice, as well as our own internal Test and Trace measures. We have had to report four instances of COVID-19 transmission in the workplace to the Health and Safety Executive. Specifically, in the following sites:

- Eastern Organ Donation Team;
- CMT laboratory in Birmingham;
- Hospital Services department in Colindale; and
- Liverpool Moorfields donor centre.

A total of 10 of our colleagues tested positive across these four sites. Having investigated these incidents, we have made improvements to our COVID-secure mitigations (e.g. more screens), made it mandatory for colleagues to wear face coverings where social distancing cannot be maintained, and reminded colleagues that our workplaces are only COVID-secure to the extent that they follow the guidance religiously.

COVID-related absence has risen from c1% to 3% and is being closely monitored. Shielding for extremely clinically vulnerable has returned in England as part of the

national lockdown; colleagues in this category will be supported to work from home. We have so far identified 55 individuals but expect this number to increase. Of this group, five wish to continue working so we are holding case reviews with them to carry out detailed risk assessments.

Flu vaccinations are running ahead of last year, at 51%. We have not yet received any planning guidance as to when the COVID vaccine will be made available for NHSBT staff, nor have we been given access to regular asymptomatic testing over and above that being offered to the general public in certain regions. We understand that other parts of the NHS have been asked to prepare detailed plans to roll out the COVID vaccine. We continue to escalate via DHSC and NHSE/I the front-line nature of our work and the need to remember NHSBT in their plans. We have also offered to explore whether our national cold chain and logistics infrastructure could be used to support the Government's rollout efforts.

Quality

We had one regulatory inspection during September and October: the MHRA performed a remote inspection of our new Barnsley site. They granted our Blood Establishment Authorisation (BEA) with only one 'Other' finding raised. The HTA also granted the necessary processing, storage and distribution license. This is a great achievement, allowing the planned move to go ahead. Further licenses will be required to cover other activities such as stem cell processing, but these are not required until later this year.

The MHRA have been extremely helpful and flexible in assessing the license variations associated with the new Convalescent Plasma donor centres, without as much notice and in much shorter timescales than would be normal. We have been very grateful for this support as it has allowed us to deliver to plan against very ambitious timelines.

The MHRA carried out an onsite inspection of our Oxford centre and our new Convalescent Plasma donor centre in Reading on 10 November. The inspection went extremely well with only one 'Other' item raised. We are also preparing for inspections from the MHRA at Liverpool and Filton later this quarter. The HTA have confirmed that they will be carrying out their first Virtual Regulatory Assessment of the Liverpool licensed activities in early December.

On 1 September, the MHRA issued guidance that the Medical Device Regulation ('MDR') and In Vitro Diagnostic Regulation ('IVRD') will not be transposed into UK law as they now both come into effect after the End of Transition Period (EoTP). Therefore, devices intended to be placed on the market only in Great Britain (GB) will not be required to follow the new regulations and will instead, continue to follow the existing UK Medical Devices Regulations 2002. However, devices such as NHSBT Reagents products intended for EU and/or NI customers will need to comply with the new MDR and IVDR. The MHRA will now commence work on drafting new Regulations for GB, though we don't expect these to come into force until 2023.

Continuity of Supply

Blood Supply

At the September Board, we discussed the risk that stock levels could fall below target levels (<4.5 days stock), even if we delivered against our 'back to green' plans. With thanks to our donors and the hard work of colleagues across the organisation, overall red cell stocks as at mid-November are holding at >5 days of stock. This is despite hospital demand remaining strong at c95% of pre-pandemic levels.

BOLT continues to oversee performance on a weekly base and has taken further action to build stocks ahead of the Christmas period. Having increased collection capacity through staff recruitment and larger venues, our focus now is on appointment fill rate. Fill rates for mobile sessions remain around 95% whereas fixed centres vary considerably based on the local environment, the strength of local donor panels, and the time any newly created collection capacity has been available for booking. In the short term, we have increased local marketing and outbound donor contact and, where possible, extended working weeks from four to five days. In the longer term, we have agreed to set up two new 'pop up' donor centres in Lewisham and Shepherds Bush. These will be in place from March onwards.

Recent reports on donor cancelations and attendance show a slight worsening of our KPIs, coinciding with the start of lockdown. We are implementing additional interventions (e.g. email and text) to encourage donors to remain committed. Despite the challenges of COVID-19, customer service metrics remain strong. In October, our customer satisfaction was 82% (vs target of 75%) and our net promoter score was 86.4. Complaint volumes came in a 0.5 per million (vs our target of 0.56). The key complaints were around slot availability, cancelled appointments, and staff attitude.

The first survey of Transfusion Laboratory Managers since September 2019 has now reported. Overall satisfaction with NHSBT has increased, with 83% of respondents (from 77%) giving us 'top box' scores. Satisfaction with NHSBT as a supplier of blood components has also increased, with a score of 85% (up from 63%). This is a great result and reflects tremendous work right across the organisation.

Organ and Tissue Donation and Transplantation

As we move into the second wave of COVID-19, organ transplant numbers have dropped again. However, unlike in the first wave, all transplanting centres have remained open. Work continues with colleagues across the pathway to ensure that opportunities for donation and transplantation are optimised. In October, this resulted in 107 deceased donors and 249 transplants.

Activity monitoring has shown a fall in the number of DBD donors suitable for donation. There has also been an increase in the number of offers declined for kidneys and livers as transplant centres are restricted in the number of transplants they can perform. This is despite efforts to move patients between centres to facilitate transplant.

Year to date, we have had a total of 694 deceased organ donors, representing a 25% decrease over the same period last year. This has led to a 21% decrease in the

number of organ transplants from 2222 to 1749. All organ types have seen a drop in the number of transplants, except for heart. Ocular donation rates have improved but are still a concern and area of focus with a plan to secure a long-term sustainable supply of Ocular tissue being developed.

We are approaching the 6-month mark since deemed consent legislation was introduced in England; the change continues to be well received and supported. Between 20 May (when the new law came into effect) and 31 October, 135 donations in England proceeded under deemed consent as the donor had not expressed a decision. These donations have resulted in a total of 341 transplants and account for 26% of all proceeding donations during this time period.

September research showed that awareness of the law change has fallen to 59% from a high of 68% in May. Our delayed awareness campaign launched on 2nd November, with significant TV and out-of-home advertising to ensure we meet our 75% target for this year. This includes specific media targeting to address the lower awareness figures seen amongst Londoners, 16-34s, and Black and South Asian respondents.

In Scotland, work is underway to train the nursing and clinical teams ahead of their legislation coming into force on 26 March. We continue to provide support to Northern Ireland with the development of a public consultation on how the law should be implemented.

Clinical Services

Despite the outbreak of COVID-19 in the Birmingham CMT lab (reported above) and the consequent need for some staff to self-isolate, the remaining team worked tirelessly to ensure clinical service was maintained by reprovisioning work to CMT labs in Sheffield, Oxford and Filton. Isolating staff are now back at work and the workload has been rebalanced back to Birmingham where the new safety measures are now in force.

We continue to experience ongoing issues with the supply of critical kit and consumables which have been affected globally by the impact of suppliers switching manufacturing capacity to support COVID-19 testing. With help from DHSC, we have managed to secure additional stocks from other parts of the NHS which, in the short term, has allowed us to maintain services to date. We continue to manage this and other stock and supplier issues closely.

The RCI and H&I laboratories in Leeds and Sheffield are on track to start moving into the new Barnsley centre this month. This will be the culmination of extensive planning and preparation work which has been particularly intense throughout the period of the pandemic. The construction of our new CBC in Filton also remains on track. As soon as COVID-19 restrictions allow, I hope we can invite the Board and other key stakeholders to visit these amazing new sites.

Activity within our Therapeutic Apheresis Service was significantly impacted by the first wave of COVID-19. Whilst demand for some treatments reduced, we received numerous requests for help from Trusts and have stepped in to support several services, most notably the red cell exchange service at Barts. We hope this will result

in a longer-term collaboration with Barts to bring benefits to patients. We are, however, experiencing some issues with staffing levels in London. We have paused non-patient facing activity in order to prioritise patient treatment and have recently held a successful round of recruitment which we hope will provide some resolution in the medium term.

On the agenda is a first reading of our emerging Stem Cell and Therapeutics strategy. This is intended to build on the discussions we had with the Board when visiting SNBTS this time last year, as well as the background paper that came to the Board last January.

Support to the Wider National Response

Convalescent Plasma remains our most significant contribution to the wider national response to the pandemic. The Board will get a full update as part of a separate, substantive agenda item. The key headline is that our Phase 2 capacity is coming in 'online and on time' - a huge achievement for the team. Our focus is now on identifying and recruiting enough high titre donors from the second wave so that we can fully utilise the new collection capacity.

We will shortly know the outcome of the RECOVERY trial. If successful, we expect hospital demand will exceed supply. We are therefore working with the relevant clinical bodies to agree rationing protocols, such as those that exist for other therapeutics (e.g. Remdesivir). We are also exploring whether we can further expand our collection capacity to increase supply.

Of course, we must also develop a plan should the clinical trials not be successful. We have sought guidance from DHSC as to whether we should plan on shutting down the programme or re-purpose this new national infrastructure to collect plasma for fractionation. Doing so would, of course, be subject to the outcome of the MHRA's review into the safety of UK plasma for fractionation. But a pivot to plasma for fractionation could ensure that the Government's £100m investment in plasmapheresis capacity could still contribute to the fight against COVID - whether for the production of hyper-immunoglobulins and/or by reducing the UK's dependence on overseas plasma (supplies of which have fallen due to the pandemic) for the production of immunoglobulins.

Building our Donor Base for the Future

As previously reported, the upswell in support for the NHS led to a significant increase in registrations early on in the pandemic. In response, we developed a new online journey which has enabled us to identify and prioritise high priority target donors. We are now in regular communication with c450k 'warm donors' and have encouraged c135k of these to book their first appointment.

In October, we launched our 'Blood Squad' campaign with ITV2, promoting both blood and plasma donation. Throughout the winter, we will be delivering another campaign highlighting the importance of being there for the NHS when needed. This will include a celebrity outreach programme, strategic partners and extensive press.

We continue to follow through on the recommendations from our work with McKinsey earlier in the year. Good progress has been made to mobilise, discover and deliver the prioritised initiatives. Some key highlights include:

- A Pulse change to allow donor prioritisation by ethnicity. This will support the dedicated allocation of appointments to priority ethnicities (as well as priority blood types) and to override any cap on new donors where it restricts the delivery of our donor mix objectives;
- An 8-week discovery into the digitisation of the donor health check. This will entail mapping out the current donor journey and exploring both digital and non-digital solutions to improve the donor experience. This project will need to be aligned with broader organisational dependencies, e.g. Session Solution and FAIR/individualised risk assessments; and
- Research on new barriers and motivations for black donors in the post pandemic world. This research will be critical to ensuring the relevance and effectiveness of our black donor recruitment and retention activity which, as we know, is critical to meeting clinical demand for appropriately matched blood.

We are planning to bring the first cut of our multi-year Donor Experience improvement programme to the Board in January.

Recovery and Transformation

Organisational Changes

Consultation has closed and final arrangements have been made to establish the new target operating model for both Blood Supply and Clinical Services. Recruitment to key posts in Clinical Services and Donor Experience is underway. The People Directorate has commenced a review of their op model, with engagement sessions planned throughout November with stakeholders both within the function and across the wider organisation. The aim is to have a 'to be' proposal in December so that we can move quickly to consultation and implementation in Q4.

Digital, Data and Technology

We are making steady progress on the implementation of our Blood Technology Strategy following the mobilisation of the portfolio in April. Key highlights include:

- starting to re-write the Pulse application in a modern code base;
- implementing tooling to increase release management agility and quality;
- reducing the backlog of changes; and
- the creation of a single product centre under a single Assistant Director to lead the transformation.

Convalescent Plasma has required us to make a number high priority changes to Pulse that were not in our plans at the start of the year. This has delayed the implementation of the first strategic release which includes the new digital Session Solution capability. This release is now forecast for June 2020. An OBC for the next year of investment in the Blood Technology Programme will be presented for approval at the January board.

Transformation of the Digital (blood) Donor Experience is also progressing alongside critical Convalescent Plasma work. The on-line Donor Health Check initiative is in the Discovery phase and capability to reduce on-session deferrals has moved into the Alpha phase.

The next key milestone in the Data Centre Programme is the replacement of the Core Shared Server and Storage Infrastructure running the majority of our business applications and back office services. The project started late as a result of COVID-19 activity but was still on target to transition into service this calendar year with migration taking place across the first 3-months of 2021. However, in the last week we have uncovered a fault on our core network which needs to be resolved before we connect the new network to it. The remediation will take 4-8 weeks and will mean migration cannot start until late February. The new infrastructure will still be available by the end of the calendar year and if we were to suffer a failure on the existing infrastructure, we still have the option to switch to the new solution earlier.

Leadership and Organisational Development

One of the key objectives I agreed with the Board both this and last year was to invest in leadership and organisational development. This was identified as a key enabler to delivering on our strategic ambitions for the future. At the Executive level, I have engaged YSC to provide executive coaching for each member of the Executive Team. This investment is designed to support their individual development as well as our development as a team.

We are also reviewing our wider leadership and talent development efforts. The Executive Team recently spent some time developing our thoughts on the leadership traits that we want to develop throughout the organisation - recognising the pace of change in our external environment. A rich picture of this discussion is attached to this report. It will start to inform further discussions within the organisation, as well as the development of a new suite of leadership and development interventions to identify and nurture our future leaders. It also provided a useful standard when conducting a nine-box grid assessment of our AD community, which gave us an up-to-date picture of our talent and where we may need to address capability gaps and improve succession planning.

Governance and Risk Management

It was a pleasure to spend time with the Board in ‘development mode’ during September and October, stepping back from our normal formal agenda items to have an open discussion on Board dynamics and ways of working. It was recognised that NHSBT is going through a period of immense change brought about by the pandemic, which requires robust but agile governance and risk management.

Going into the sessions, I was concerned that the NEDs might be feeling the need for increased reporting and oversight given the pace at which things are moving and the inherent risk (execution and reputational) associated with programmes like Convalescent Plasma. What I heard, however, was that the Board felt they were getting the right assurances and, indeed, were keen to see the same pace and innovation applied to other parts of the organisation.

Another takeaway was that the Executive Team should remember to engage the Board outside of formal Board and committee meetings. This offered an opportunity to leverage members' diverse views and experience when there was still an opportunity to develop and shape strategy. This is the same shift that we are trying to achieve at the Executive Team level, as well.

Finally, I met with the CQC in October, who informed me that they had no imminent plans to conduct an inspection or Well Led Review. We will nevertheless continue to work on strengthening our governance and risk management across the organisation, as part of our wider transformation efforts. This will include responding to the recommendations from the desktop review that Deloitte conducted earlier in the year against the CQC's Key Lines of Enquiry.

Making NHSBT a Great place to Work

Further to the last Board update in September, we continue to progress our ambitious Diversity and Inclusion agenda as part of our wider efforts to make NHSBT a great place to work for everyone. National Inclusion Week and Black History Month provided the opportunity to create a programme of events to engage colleagues, raise the profile of different issues (e.g. inter-sectionality), and hear from different voices in and outside the organisation. This month, Rosna Mortuza has launched a series of virtual 'Let's Talk D&I' discussions, with members of the Executive Team discussing how they are working to make NHSBT a more diverse and inclusive organisation.

Activity continues in Colindale to address the issues highlighted in the Organisational Diagnostic Report, with positive feedback from the Colindale Taskforce. Rosna Mortuza will shortly be chairing a stocktake to assess progress against the report's recommendations and to agree next steps.

The Equality, Diversity and Inclusion Council met again on 22 October, with an in-depth discussion on recruitment and promotion. It was recognised that we need to improve outcomes for all protected groups, but a specific target was agreed for our BAME workforce. Specifically, that 15% of our 8A and above cohort should come from a BAME background within five years time (up from 9% currently). This target will ensure that our leadership reflects the ethnic diversity of our organisation and the population at large. It also aligns with the target set by NHS England for other NHS organisations. Rosna Mortuza and Patricia Grealish will be co-sponsoring the work to deliver against this target, including a review of our E2E recruitment and promotion policies, processes and systems.

We also discussed the Stonewall Workforce Equality Index and our ambition to achieve Bronze status, ideally within the next year (feasibility of this tbc).

On engagement more broadly, work continues within each of the Directorates to respond to the Our Voice Survey which took place back in July. We achieved a 71% response rate and an engagement score of 7.5 (out of 10). This showed little movement from the 7.6 score from the last survey in 2018. Going into the survey, we expected to see a more significant drop given the pandemic, Colindale report and recent organisational changes.

Highest scoring areas included ‘my manager treats me with respect’ and ‘my manager cares about my mental health and wellbeing’. Lower scoring areas included ‘I have confidence in how senior leadership are managing the impact of COVID-19 on NHSBT’ and ‘I can voice a contrary option on to others without fear of negative consequences’. Senior leaders and their teams are now delving into their individual reports and working up plans to respond to the feedback and verbatim comments. This will be incorporated into our corporate strategy and transformation plans, with improvements in engagement tracked through further surveys.