

# NHSBT Board Meeting in Public - 27th May 2021

<b>Schedule</b>	Thursday 27 May 2021, 9:30 — 12:30 BST
<b>Venue</b>	Via video-conference
<b>Description</b>	NHSBT Board Meeting in Public
<b>Notes for Participants</b>	Apologies received from Phil Huggon & Patricia Grealish
<b>Organiser</b>	Rebecca Vickers

## Agenda

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9:40	3. Board ways of working (21-28) For Reference - Presented by Millie Banerjee		4
9:40	4. Minutes of the previous meeting (21-29) For Approval - Presented by Millie Banerjee		6
9:40	5. Matters arising from previous meeting (21-30) For Report - Presented by Millie Banerjee		14
9:40	6. Patient story (21-31) For Discussion - Presented by Gail Miflin	(15 mins)	17
9:55	7. Chief Executive's Board report (21-32) For Report - Presented by Betsy Bassis	(20 mins)	20

10:15	8. Clinical Governance report (21-33) For Report - Presented by Gail Miflin	(20 mins)	33
10:35	9. Board Performance Report (21-34) For Report - Presented by Katie Robinson and Rob Bradburn	(20 mins)	38
10:55	10. Finance Report (21-35) For Report - Presented by Rob Bradburn	(10 mins)	75
11:05	Tea/Coffee Break	(10 mins)	83
11:15	11. Corporate Strategy Development: Emerging Strategic Themes (21-36) - Tracey Barr to join For Discussion - Presented by Katie Robinson	(25 mins)	84
11:40	12. D&I Metrics update (21-37) - Shane White & Richard Crossen to join For Discussion - Presented by Rosna Mortuza	(25 mins)	109
12:05	13. Blood Technology Modernisation Programme - Status Update (21-40) - Christie Ash to join For Report - Presented by Wendy Clark	(10 mins)	169
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	15.1. Annual Management Quality Report (21-39) For Reference - Presented by Ian Bateman		189
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12:25	16. Any Other Business Presented by Millie Banerjee	(5 mins)	211
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12:30	17. Date of Next Meeting: Thursday, 22nd July 2021 ( via video-conference)		212
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12:30	18. Resolution on Confidential Business Presented by Millie Banerjee		213
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# Agenda

# 1. Apologies and announcements

For Reference

Presented by Millie Banerjee

## 2. Declarations of conflict of interest

For Reference

Presented by Millie Banerjee

### 3. Board ways of working (21-28)

For Reference

Presented by Millie Banerjee



## **NHSBT BOARD – AGREED WAYS OF WORKING**

The Board should at all times exemplify the values of the organisation and these behavioural guidelines are constructed in line with the three pillars of NHSBT values.

This document sets out what we expect from the NHSBT Board, both in Board meetings and in routine contacts with the NHSBT organisation. The Board will monitor its own performance against these standards and reflect on its ability to live these values at the end of each Board meeting, highlighting successes and areas for improvement.

### **1. *Caring***

- The needs and care of patients, donors and our colleagues are paramount.
- Care and compassion are at the forefront in decision making.
- Members are open and transparent.
- Members should be constructively challenging.

### **2. *Expert***

- A clear focus on the safety of our products, services and employees.
- Stakeholders' views are routinely sought and considered
- Members keep up-to-date and informed and come well prepared for meetings.
- Members adopt a positive and dynamic mindset.

### **3. *Quality***

- We ensure that public funds are used wisely at all times.
- A proportionate approach is taken to risk and service quality, ensuring appropriate systems of assurance are in place.
- Adhere to the principles of good corporate governance at all times.
- Drive for innovation in the provision of our products and services
- NHSBT offers our customers good value for money through a focus on efficiency and business improvement and the application of Continuous Improvement methodology.

This document will be reviewed periodically by the Board and updated as necessary.

Issue 3 – Jan 2019



## 4. Minutes of the previous meeting (21-29)

For Approval

Presented by Millie Banerjee

Draft for approval  
Status - Official



## Blood and Transplant

### Minutes of the One Hundredth and Second Public Board Meeting of NHS Blood & Transplant

#### Zoom Videoconference Thursday 25<sup>th</sup> March 2021, 9:30-12:15

<b>Present</b>	Millie Banerjee (MB) (Chair) Betsy Bassis (BB) Rob Bradburn (RB) Anthony Clarkson (AC) Helen Fridell (HF) Prof Deirdre Kelly (DK)	Greg Methven (GMe) Dr Gail Miflin (GMi) Charles St John (CSJ) Piers White (PW) Jo Lewis (JL) Phil Huggon (PH)
<b>In attendance</b>	Ian Bateman (IB) Wendy Clark (WC) Patricia Grealish (PG) Rosna Mortuza (RM) Katie Robinson (KaR) David Rose (DR) Kay Ellis (KE) Andrea Ranson (AR) (For item 6) Matt Kay (MK) (For item 11)	Christie Ash (CA) (For item 12) Ella Poppitt (EP) (For item 13) Marina Pappa (MP) Joan Hardy (JH) Patricia Vernon (PVe) Linda White (LW) Alia Rashid (AR) Katrina Smith (KS) Alice Williams (Minutes)

		Action
1	Welcome, Apologies and Introductions	
	M Banerjee confirmed that for the first time the meeting was available as a live stream on the NHSBT website and thanked observers for joining the meeting.  Phil Huggon & Jo Lewis were welcomed to their first NHSBT Board meeting, and apologies were received from Professor Paresh Vyas.	
2	Declaration of Conflict of Interests	
	No further declarations of interest were raised.	
3	Board Ways of Working	
(21-15)	The Board Ways of Working were noted.	
4	Minutes of the previous meeting	
(21-16)	The minutes of the last meeting were agreed as a true record.	
5	Matters arising	
(21-17)	Action B11 was agreed as closed, and B12 would be discharged and closed at the next Board meeting.	
6	Patient Story	

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(21-18)	<p>A Clarkson was joined by A Ranson to share the patient story on the UK's First Conjunctival Transplant through International Collaboration.</p> <p>Commending the innovation highlighted in the patient story, Board members queried whether this type of transplant would be repeated. It was confirmed that the team had anticipated surveying transplant surgeons and working through the ocular tissue advisory group to understand patient need.</p> <p>AC also commented that there is a broader opportunity for NHSBT to develop its position as a leader in the supply of tissues, utilising its unique position and drawing on its wide-ranging strategic partnerships in this area. It was noted this could give the organisation a greater understanding of tissue imports to the UK.</p> <p>Members noted that NHSBT has had a large number of successes in new areas across 2020 and that further recognition and celebration of these should be considered.</p>	
7	CEO Report	
(21-19)	<p>B Bassis provided an update on the organisational priorities and challenges since the last Board meeting and outlined the context for the proposed discussions on the budget and business plan for 2021/22 in the context of the wider strategic ambition for the organisation, the first Blood Technology Modernisation programme report, and early conversations on the organisation's Genomics aspirations.</p> <p>BB shared reflections on the one-year anniversary of the first national lockdown and highlighted the recent NHSBT Together Awards which provided an opportune occasion to recognise the amazing achievements of NHSBT's people over the last year.</p> <p>The Board expressed their disappointment at the delay of the publication of the NHSBT Organ Donation and Transplantation strategy. AC highlighted that whilst the donor specific elements of the strategy are progressing, the delay has had significant implications for the progress on the transplantation side and may hinder discussions with partners and stakeholders. It was also commented that this may affect NHSBT's ability to engage in decisions regarding specialised commissioning. MP highlighted that whilst the delay is disappointing and was due in part to competition with other major announcements ahead of purdah, the proposed taskforce as outlined in the strategy will soon be established. Colleagues were encouraged to continue developing business cases and clear rationale for ambitions outlined in the strategy beyond the first year of funding.</p> <p>BB also remarked on the significant transformation and change of the People agenda and the planned investment in leadership and organisational development.</p> <p>In anticipation of further D&amp;I discussion at the Board development day in May, it was highlighted that additional funding has been set aside in the budget to accelerate D&amp;I improvement initiatives, and an Executive D&amp;I Programme Board has been established to provide structure and focus and efforts. Board members remarked on the expectation for change on D&amp;I and how these are supported/managed. It was noted that whilst the data might not necessarily demonstrate change immediately, the Board is aware and acknowledges the legitimate challenge that more needs to be achieved. The</p>	

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	<p>Board will be updated on the work done to date and the communications planned.</p> <p>Board members reflected on what NHSBT had achieved in a challenging year and commended the Executive Team for their leadership.</p>	
8	Clinical Governance Report	
(21-20)	<p>GMI presented the Clinical Governance report to the Board, summarising the discussions from the most recent CARE meeting. Within the reporting period of December 2020 and January 2021 it was confirmed that no new serious incidents were reported, one SI was closed. GMI also introduced Samaher Sweity as Interim Corporate Clinical Governance lead.</p> <p>It was also confirmed that the safety framework was reviewed, CARE recommended the continued use of the ABO Risk-Based Decision-Making Framework for any significant safety decisions, to which ARGC had agreed.</p>	
9	Board Performance Report	
(21-21)	<p>R Bradburn presented the February performance report, highlighting the ongoing efforts of the operational team to maintain collection performance, and the headlines from the Q3 forecast position that NHSBT is forecasting a full year I&amp;E deficit of £12.1m, £7.4m ahead of plan in part driven by a surplus in ODT and supplier rebate.</p> <p>There was discussion on the treatment of Covid costs in 2020/21 and 2021/22. It was noted that Covid costs have been tracked throughout the year and in agreement with DHSC, the blood rebate had been retained and used as contingency to offset against Covid costs. For 2021/22, it was confirmed that Covid costs had been absorbed into BAU, and 3.5% of the proposed 9% price increase for blood components had been outlined for Covid related costs, of which Trusts will be reimbursed by a separate funding stream from NHSE. It was confirmed that Covid costs will continue to be tracked closely in all financial reporting.</p> <p>Board members were also asked to consider and provide feedback by email return on the proposed revised board performance report to K Robinson and RB ahead of the report's first publication/use at the May Board.</p> <p><b>Action:</b> The Board noted the report and encouraged the Executive to ensure that future reports clearly illustrate and track costs related to Covid-19. Feedback on the proposed new format was requested by correspondence.</p>	RB
10	For approval: Budget 2021/22	
(21-22)	<p>RB presented the draft 2021/22 budget for Board approval subject to noting that whilst programme funding for ODT and the income envelopes proposed for blood components and specialist services are yet to be formally approved by DHSC, confirmation is expected. It was noted whilst individual Trusts will not be aware of the specific price increase, NHSBT has set expectations to date for a significant price increase in 2021/22.</p> <p>RB highlighted two further considerations for the Board's attention which had not included in the paper due to timing considerations. Firstly it was raised that there is still uncertainty surrounding the NHS pay deal and corresponding NHSBT salary costs which had been assumed as 2.5% in the budget proposal. MB stated that in relation to the current assumption on the</p>	

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	<p>pay deal discussions NHSBT would not be expected to fund the difference if the deal were to increase.</p> <p>Additionally it was noted that since the publication of the budget paper the forecast cash position for end 2021/ had improved from £3m to £9m in part due to additional funding supplied for stem cells and skin products, and also due to changes in transformation spending. Clarification was provided on the NHSBT cash reserves policy, and it was highlighted to the Board that approval had been granted by NHSE/DHSC for the previously referenced ODT surplus to be carried forward to 2021/22 for critical project expenditure.</p> <p>Board members sought further understanding behind the increase in group service costs for blood supply relative to a minimal change in expected volumes.</p> <p>Executive members recognised the increase in prices linking these to required investment in our people and IT agendas in particular, but also acknowledged the increasing pressure on the 'public purse' and reiterated the areas where we would be seeking efficiencies.</p> <p>The Board recognised the proposed transformation portfolio for 2021/22 and queried the adequacy of the governance in place to manage it effectively. The Executive reminded the Board that the Convalescent Plasma Programme alone was several times larger and was delivered successfully alongside a wider transformation portfolio of a similar size to the one being proposed. The Executive assured Board members that appropriate and proportionate programme and portfolio governance was in place and offered to share greater detail offline.</p> <p>The Board discussed the impact of the revised assumptions on the cash position and salary costs, and whether the budget could be approved as submitted to the Board, or whether an additional approval process would be required once the cash position had been updated. Whilst acknowledging the current uncertainties affecting the budget proposal, it was confirmed that no further discussion was required on income &amp; expenditure for 2021/22 but that the cash budget schedule should be added to the pack with final approval then sought by correspondence. Members also requested that the budget pack should also include the key assumptions (which would have more than a 1% effect on costs or revenues) and requested clarity on how these assumptions would be monitored in the newly revised Board Performance Report.</p> <p><b>Outcome:</b> The Board requested that the key assumptions and the cash budget (and revised forecast) be added to the budget pack, and to assume no further changes to salary costs.</p> <p><b>Action:</b> RB to update budget proposal with key assumptions and the cash budget/forecast and circulate to Board members for final approval by correspondence.</p>	RB
11	Business Plan	
(21-23)	K Robinson and M Kay introduced the draft 2021/22 business plan and highlighted the process for developing the plan and welcomed feedback from the Board on the present iteration.	

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	<p>The Board welcomed the draft plan and in recognising that the approach, process and plan itself was new, members reaffirmed their interest and expectation to be kept informed of the plan’s development.</p> <p>Some concern was expressed regarding the ambition of the plan, and whether it will be achievable in 2021/22 – a year in which most NHS bodies are focusing on recovery. Similarly, there was a suggestion for a further prioritisation exercise to detail the difference between priorities and actions, and to further clarify the proposed outcomes of the plan in order for the Board to understand and measure success.</p> <p>Board members queried whether the sequencing of producing the budget before the business plan had affected their alignment. Executive members were confident that as the strategy team and finance team had collaborated, any pressures or misalignment had been removed. Members also discussed how the delivery of the plan would be tracked, and it was confirmed that the revised Board Assurance Framework, Board Performance Report and refreshed Transformation portfolio reporting would give a holistic view of delivery for the Board.</p> <p>On the recommendation of closer working with the NHS, it was recommended that the reference is revised, and a map of NHSBT’s stakeholders in the wider NHS is provided for Board members to better understand this dynamic. Board members also encouraged the Executive to consider whether the reference to gene therapy and genomics should be more prominent.</p> <p>MB challenged the reference to BAME in the plan and commented that the current interpretation suggest that responsibility is being passed to others to lead and tackle current challenges, and it was agreed that whilst this was not intentional the wording would be revised to reflect the commitment of NHSBT and NHSBT’s leadership to enact positive change.</p> <p>Lastly there was discussion on the importance of the publication and internal cascade of the business plan, and whether publication of the strategy in June would be too late. Election and purdah restrictions had affected publication, but it was confirmed that the Strategy and Transformation leads within Directorates had been engaged in the development of the draft plan, and that internal stakeholder conversations underway.</p> <p>Next steps, it was confirmed that the Finance &amp; Performance Committee are due to review the business plan in April, and that this feedback will be incorporated into the final version.</p> <p><b>Outcome:</b> Board feedback would be incorporated and BB &amp; MB to confirm when the business plan will be next presented to the Board and what format this engagement will take.</p>	<p>KaR</p>
<p>12</p>	<p>For information: Blood Tech Modernisation Update</p>	
<p>(21-24)</p>	<p>Following the approval of the Blood Technology Modernisation (BTM) Programme at the last Board meeting and the funding for the first year, W Clark and C Ash presented the first progress report and sought feedback and agreement from the Board on the proposed format.</p>	

Draft for approval  
Status - Official

	<p>CA also provided a brief verbal update on the status of the programme, noting that an amber status will be reported until the delivery estimation matures.</p> <p>Board members considered and discussed the format of the first report, suggesting that whilst it was clear to read, some were still unclear on what success looks like/what will be achieved at the end of the programme. WC and CA offered to provide a short briefing session offline for DK, PH, and JL. There was also further discussion on how the report could better illustrate if the programme was still on track to deliver its intended aims at the end of the 5 years. WC and CA agreed to discuss this offline with CSJ to improve this presentation.</p> <p>It was also highlighted that following an initial impact assessment, the organisational pivot to collecting recovered plasma would have minimal impact on the BTM programme.</p> <p><b>Outcome:</b> Members noted the report, acknowledging that further revisions would be made in light of feedback from the Board.</p>	<p>WC</p> <p>WC/CSJ</p>
13	For information: Nursing Strategy	
(21-25)	<p>AC and E Poppitt presented the draft NHSBT Nursing Strategy 2021-2026, designed to support the Nursing profession across the organisation and outline the the ambitions and priorities for supporting and energising a profession that sits at the heart of NHSBT's work to save and improve lives. Feedback and endorsement was sought from Board members ahead of its publication on 12th May.</p> <p>Board members discussed the theme of progression opportunities for nurses as highlighted in the strategy and reiterated how important is it to maximise career opportunities and retain top talent which may include promoting nurses into non-specific nursing roles or provide secondments or fixed term roles in the wider NHS which will not only benefit the individuals involved, but would also see other departments benefit from the experience and professionalism of the nursing cohort. The Board noted the role of the People team and strategic workforce planning to enable this.</p> <p>It was highlighted that there have been significant efforts recently to promote and develop the roles of senior nurse practitioners in leadership roles, citing the recent appointment of a nurse to the Cellular Therapies leadership team and plans to replicate this in TAS.</p> <p>Members suggested that the strategy should also capture the current feedback from the nursing cohorts in order to better measure progress as the strategy is implemented. It was confirmed that employee engagement had been undertaken as part of the development of the strategy and that the themes from this could be added into the strategy to illustrate the organisation's starting position.</p> <p>Lastly it was highlighted that other professional strategies were under consideration, such as the role of scientists in NHSBT, and would be shared with the Executive and Board in future as they are developed. DK offered to share thoughts offline regarding how doctors might develop/be considered in such a strategy.</p>	

Draft for approval  
Status - Official

	<b>Outcome:</b> The strategy was noted, and it was agreed that Board feedback was to be considered and incorporated into the final version and circulated to members ahead of the publication date.	
14	Reports from UK Health Departments	
	England	
	It was confirmed that DHSC would continue to work with NHSBT prior to the confirmation of the future model for blood pricing.	
	Northern Ireland	
(21-26a)	J Hardy provided an update on the soft opt-out system for organ donation in Northern Ireland, noting that it was progressing well. It was also reported that due to the pandemic, the kidney transplant service in Belfast has been temporarily paused other than for highly sensitised patients for whom it is extremely difficult to find a suitable match.	
	Scotland	
(21-26b)	L White confirmed that the implementation of the Human Tissue (Authorisation)(Scotland) Act 2019 was on track for 26th March 2021 and thanked NHSBT for their support throughout its development. It was also reported that the Donation and Transplantation Plan for Scotland: 2021 – 2026 had been published.	
	Wales	
(21-26c)	P Vernon highlighted that the Minister for Health and Social Services in Wales has agreed to the transfer of responsibility for future organ donation campaigns in Wales to NHSBT, and an additional funding allocation of £285,000 had been agreed to support this activity.	
15	For information: Revised Board Performance Report	
(21-27)	No further feedback was provided.	
16	AOB	
	No other business was reported	
17	Q&A	
	A question was received via email: <i>Will we have a strategy to develop scientists and understand the important contribution they can and do make?</i>	
	GMI commented that whilst there are no immediate plans to develop a scientific strategy, it will be a consideration for the new Chief Scientist when they are appointed in post.	



## 5. Matters arising from previous meeting (21-30)

For Report

Presented by Millie Banerjee



## NHSBT Public Board Action Log

## Blood and Transplant

Action Reference	Date Action Arose	Agenda Item	Item	Owner	Expected Close Date	Progress/Comments	Status
B12	28.01.21	<b>D&amp;I update</b>	Action: It was agreed that the metrics would be shared at the May Board meeting and the Board requested a further update on the D&I programmes at the next appropriate point.	RM	Mar-21	Included on the May Board agenda	Closed
B13	25.03.21	<b>Board Performance Report</b>	Action: Covid costs to be clearly marked in all future financial reporting	RB			Ongoing
B14	25.03.21	<b>Budget 2021/22</b>	Action: To update budget proposal with key assumptions and the cash budget/forecast and circulate to Board members for final approval by correspondence.	RB		Updated pack circulated to Board on 8th April	Closed

B15	25.03.21	<b>Business Plan 2021/22</b>	Action: Incorporate Board feedback into Business Plan before presentation to Finance & Performance Committee	KaR			Closed
B16	25.03.21	<b>Blood Tech Modernisation Update</b>	Action: Short briefing session offered for DK, PH, and JL on Blood Tech Modernisation programme	WC		Confirmed as a standing agenda item	Closed
B17	25.03.21	<b>Blood Tech Modernisation Update</b>	Action: Report feedback session to be set up for CSJ,CA and WC	WC		Charles shared feedback by e-mail that we will incorporate into the update narrative going forwards.	Closed

## 6. Patient story (21-31)

For Discussion

Presented by Gail Miflin

## NHSBT BOARD

### May 2021 Patient/Donor Story

#### Status: Official

Darren Buttrick is Head of Business Sales at O2 and lives in Staffordshire. At 48 years old, he was healthy and had no underlying health conditions but on 17<sup>th</sup> March 2020, Darren tested positive for COVID-19.

Darren was rushed into hospital 3 days later with an extremely high temperature and not able to breathe, which he describes as like being strangled. He didn't realise how ill he was until he was told the only option to save his life was ventilation and being put into an induced coma. Even then with only a 50/50 chance of survival. It was very scary and confusing when Darren was told he had 15 minutes to phone his family to let them know. Darren does not remember much about this time until waking from a coma to see his wife on FaceTime, after a nurse used her personal phone to call her. He was finally discharged after spending 10 days in the ICU.



NHSBT contacted Darren to ask him if he would consider donating his plasma and in April last year, he made his first donation. Cut to 26<sup>th</sup> April 2021 when Darren gave his first Plasma For Medicines donation and his 25<sup>th</sup> plasma donation overall, a year and one day from the date of his first donation. Darren also received his 50-donor certificate to thank him.

Following the end of the trials to donate convalescent plasma for COVID, he is

now donating Plasma For Medicines, to help provide life-saving and life-enhancing medicines for people who depend on these treatments.

Darren says the whole experience has made him more determined to help and give back. He wants to continue donating and supporting the Plasma For Medicines initiative. Darren has shared his story to promote donation for NHSBT on outlets including ITV Good Morning Britain, Sky News, and the BBC. In addition to donating plasma, Darren also volunteers at vaccination centres on weekends and wants to take up further voluntary work at The Royal Wolverhampton Trust.

#### Commentary

Darren's story is compelling as it reminds us of the dedication and commitment, we see every day from our donors, who volunteer and help save lives time and time again.

Darren was one of thousands of selfless donors who donated their plasma containing high COVID antibodies despite having been ill themselves, it could then be transfused into people struggling to fight the virus as part of the REMAP-CAP and RECOVERY trials. In March 2021, the success of the convalescent plasma programme supported a Government decision to allow the use of UK plasma for the production plasma-derived medicinal products

(PDMPs) or Plasma For Medicines (PFM) following a recommendation on its safety from the MHRA. These PFMs will be supplied exclusively to the NHS for UK patients, and will be used to treat conditions such as trauma, congenital deficiencies, immunologic disorders and infections.

The UK's PFM supply is currently completely dependent on plasma collected internationally and there is a global shortage. Plasma from NHSBT's donors can now be used to meet part of the UK market demand, benefitting thousands of UK patients. Each dose of medicine is made from many different plasma donations, so we need a large number of donors to sign up to donate their plasma.

To grow and sustain the domestic supply and make us less reliant on imported plasma the Donor Experience Directorate are now looking at how we build and develop a donor base of people willing to donate plasma. We are doing this by encouraging as many people as possible to start donating, who have previously registered but not yet donated. Additionally, alongside our usual work with the press and stakeholders, we are also using our Community Engagement team to reach out to workplaces, sports clubs, community organisations and more to sign up donors.

It is because of the dedication and commitment from donors like Darren and all the people who work across the plasma journey from donor centre to the patient receiving the treatment; that we can rise to this new and exciting challenge and continue to save and improve lives.

**Jayne Williams**, Plasma Lead, Donor Experience

**Lorraine Tresnak**, Executive Assistant to CMO, Clinical Services

**Gail Miflin**, CMO and Director of Clinical Services

**David Rose**, Director Donor Experience

## 7. Chief Executive's Board report (21-32)

For Report

Presented by Betsy Bassis



## Blood and Transplant

NHSBT Board

**27 May 2021**

Chief Executive's Report

### **Status: Official**

As the latest wave of the pandemic recedes and the country slowly comes out of lockdown, so too can NHSBT lift its head and start to focus on Recovery and Transformation. Having paused our work on strategy development to focus on the demands of COVID, we are now in a position to pick up where we left off and look forward to re-engaging the Board on our ambitions and plans for the future.

Pre pandemic, the Board identified several shifts that we wanted to make as an organisation. These are included in Appendix A, as a reminder, and are referred to again in the strategy paper later on the agenda. It would be good to hear from the Board whether these still resonate or if the events of the last year require us to go back and modify this list. As part of this discussion, I am keen to expose and resolve any outstanding concerns about our strategic direction as it will be critical for the Board to be aligned if we are to develop – let alone deliver – a new corporate strategy and multi-year transformation programme.

In many ways, I think the pandemic reinforced the importance of the strategic shifts we previously identified, e.g. system leadership, agility, and clinical responsiveness. Indeed, it accelerated our ability to make some of these shifts – something the Board recognised at our last meeting. The challenge now will be building on this momentum whilst avoiding the human cost that we experienced this year in terms of long hours, sustained pressure, and cancelled holidays. These challenges were, of course, compounded by the stress and trauma happening in people's private lives – something that we have recognised and sought to address.

### **Health, Safety and Wellbeing**

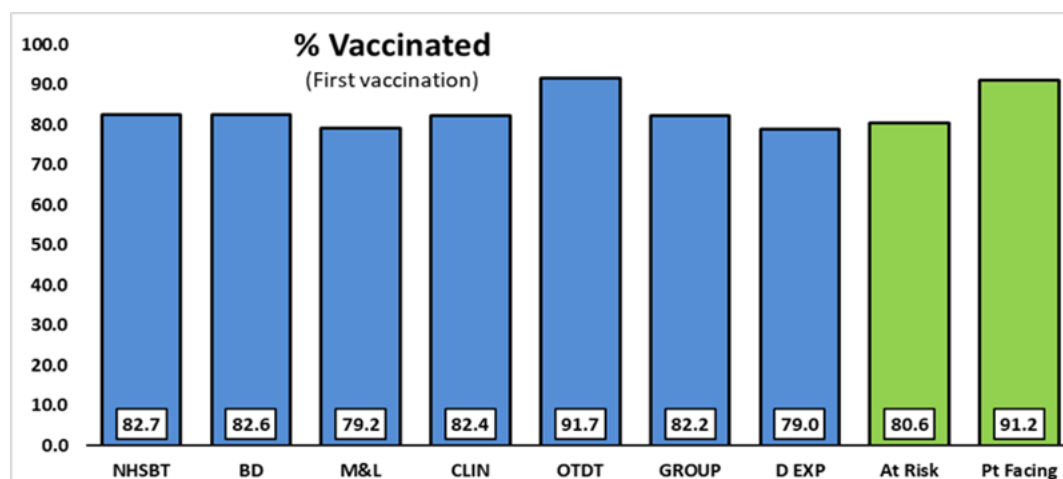
We have been working to ensure that individuals and teams have access to the right help and support to process the events of the last year. We recently launched a wellbeing survey to better understand awareness and outcomes. The results will be used to refine further efforts and plans.

At the leadership level, we are trying to take deliberate steps to slow the pace of the organisation and catch our collective breath so that we can move forward at a more sustainable pace, attending to the long term strategic, as well as the short term tactical.



I am pleased to say that NHSBT has been certified to the ISO 45001 Health, Safety and Wellbeing (HSW) quality standard, reflecting a 2-year migration plan. This international standard integrates wellbeing into our HSW system for the first time. NHSBT is the first ABO member to gain this certification by independent audit and one of the first in the NHS.

Since my last report, there have been no further coronavirus outbreaks and almost 83% of colleagues have received their first vaccination. A further break down is provided here.



Given this success and the improving external situation, we have transitioned the vaccine and asymptomatic testing programme to BAU. We will maintain a watching brief and re-escalate, if required. Our focus now is working out – in collaboration with our union colleagues – how we bring more colleagues back into the workplace whilst keeping everyone COVID-secure. We are also thinking about the 'Future of Work', including the culture, policies and systems that will be required to meet many colleagues' desire for more flexible, hybrid working.

## Organisational Changes

Despite the challenges of the pandemic, we have made good progress implementing the senior level organisational changes that followed the review of our operating model in 2019. This has led to more change at the Executive and Assistant Director level than this cohort had experienced in many years, and has understandably unsettled certain teams and individuals. We have lost valued colleagues and institutional memory due to a combination of restructuring, retirement and people taking up new opportunities outside of NHSBT. At the same time, we have been able to recruit in some fantastic new talent to complement our internal ranks. This includes four appointments (44% of total) from a minority ethnic background at 8D and above (and clinical equivalents) in the last 12 months. A summary of some of the most recent senior level arrivals and departures is attached in Appendix 2 for info.

## Diversity and Inclusion

On the agenda is a separate update on our D&I programme, including a detailed data pack on our workforce, which we are using to inform our initiatives and track progress.

As we come up on the one-year anniversary of the Organisational Diagnostic, we have commissioned an independent review on our progress implementing the 9 recommendations set out in the report. This is just one way that we are looking to hold ourselves to account for delivery.

Ahead of this independent report, I sent a more general D&I update to all staff at the end of March which, for those of you who may be interested, can be found on our external website:

<https://nhsbt.dbe.blob.core.windows.net/umbraco-assets-corp/22817/diversity-and-inclusion-april2021.pdf>

Finally, just this week, we learned that three women in our Digital, Data and Technology Services (DDTS) team have been shortlisted for the prestigious Women in IT Awards: Marian Zelman in the Tech for Good category for the work she did on convalescent plasma; Cat Ongers in the Team Leader category for her work on the Datacentre programme; and Wendy Clark as CIO of the Year. The winners will be announced at a virtual awards ceremony on 24 June. Whatever the outcome, this is great recognition for the talented women we have working in DDTS. We hope public recognition will attract more women to want to join DDTS where we currently have 32% women.

## Regulatory and Legal

There were no regulatory inspections in March and April, but the MHRA have notified us that they will be undertaking an "in person" audit of our Blood Establishment Authorisation licence at Barnsley and associated sites in early June. This will include the decommissioning of the Convalescent Plasma programme and the implementation of the collection and storage of plasma for fractionation (PFF). We have been meeting with the MHRA on a monthly basis to discuss the regulatory requirements for PFF. We have also engaged blood services across the world (including the Netherlands, Australia and Canada) to obtain as much regulatory insight as possible and ensure that we are learning the lessons from more mature plasma programmes.

Following an update to the Board at our last meeting, we continue to formulate a response to the large organisational Rule 9 request from the IBI; a further extension is being sought. An Executive-level steering group has been constituted to provide additional oversight and will meet shortly. Last week, the IBI started witness hearings concerning the support schemes available to those infected. We understand that the Health Secretary will be giving evidence on 21 May regarding the England Infected Blood Support Scheme.

## **Digital, Data and Technology**

The Datacentre programme continues to progress to plan. Following the approval of the OBC for the Co-location Project, the supplier has confirmed that we do not need to move out of our secondary datacentre by March 2022. This is welcome news as it relieves the pressure on the team who are working on multiple projects at the same time. We are reviewing plans and will likely submit a change request to move the migration date to end June 2022. In the meantime, we continue to work on detailed planning and production of the FBC.

The Session Solution pilot is currently in-flight at four centres. Due to some early technical problems with the session controller, we have decided to extend the pilot to a further four centres before moving into full implementation.

This summer we will be launching a brand-new version of the 'Give Blood' digital app, transforming the user experience with a cleaner and more intuitive design based on NHS Digital standards. Donors will see improvements in how to book appointments with new calendar views, ease of venue selection and targeted filtering. We are working with donors to identify and prioritise future updates and enhancements.

## **Plasma**

We have decommissioned all but 14 convalescent plasma centres which we have successfully repurposed to start collecting plasma for fractionation (PFF) for an initial period of three months (to 30 June). As at the time of writing, we have collected c3k litres of PFF which we are stockpiling while NHS England undertakes a procurement to appoint a fractionator(s). We are also working up plans to begin stockpiling plasma recovered from whole blood donations.

As reported at the last Board, we have supported DHSC on the development of a business case to collect PFF on a longer-term basis. We will bring an update to the Board with the latest position.

## **Blood Supply**

Close collaboration is underway between teams in Blood Supply, Donor Experience and Clinical Services to implement the outcome of the FAIR (For the Assessment of Individualised Risk) review announced in December. From 14 June (the start of World Blood Donor Week), all blood, plasma and platelet donors will be asked new questions to check if they can donate, marking an historic move to make blood donation more inclusive while keeping blood just as safe. From this date, men will no longer be asked if they have had sex with other men. Instead, all donors – regardless of gender – will be asked the same questions about recent sexual behaviours; new deferrals will be introduced relating to possible exposure to a sexual infection. Regardless of sexuality, donors who have had the same sexual partner for the last three months may be eligible to donate blood.

This is a significant operational change and dedicating enough time for collection teams to receive comprehensive training will result in lower levels of collection during May. In anticipation of this, we built red cell stocks (>7 DOS) going into May, but expect these to return to target levels during the month.

Hospital demand levels over March and most of April returned to pre-COVID levels. In recent weeks, however, we have seen even higher levels of demand as Trusts look to restore services and catch up on postponed activity. Working closely with our clinical colleagues, we have updated our demand forecast and are now planning for a 5% uplift on pre-COVID levels over the summer period. We are seeking further intelligence and will keep the demand forecast under close review.

Higher levels of summer demand could coincide with a less responsive donor base as social contact restrictions are eased and as large events like the European Football Championships and Olympics restart. While there are no certainties, we are planning now for this scenario, but will need to work flexibly and responsively to changes in hospital demand and donor behaviour as the nation hopefully emerges from the pandemic.

As part of our longer-term strategy development, a cross-directorate team have started to review our collection footprint. Based on initial donor and demographic analysis, more capacity is required in London to help solve the Ro supply challenge and the resulting health inequalities. This reflects the fact that more than 60% of England's Black population live in London and c40% of Black people have Ro Kell negative blood (vs <2% in non-Black population). To pinpoint exactly where we need more collection capacity, the team have reviewed demographic data down to the postcode level – a level of detail that has not been looked at before.

Our analysis has also identified opportunities to increase productivity by removing excess capacity in certain high-cost areas. More work is needed before we develop specific recommendations. A fuller update will come to the Board in September.

At the same time, we will also look to bring an update on our wider efforts to increase the diversity of our donor base and close the Ro Kell Neg supply gap. These include:

- New marketing campaigns and partnerships to increase Black African and Black Caribbean donor registrations;
- Increased number and wider choice of appointment slots for donors who declare Black ethnicity and priority blood types (thanks to more sophisticated appointment management and new London-based centres); and
- Portfolio of improvements to the E2E donor journey, e.g. new app and website products, dedicated Ro team at our contact centre, and 'Ro champions' pilot.

## **Organ and Tissue Donation and Transplantation**

We had hoped that the Organ Donation & Transplantation 2030 Strategy would be launched formally by the end March. DHSC are now co-ordinating a revised launch date with their counterparts in the devolved administrations; we hope to have a date confirmed shortly. We are ready to support this with a series of webinars, briefings and press releases.

Looking back at the year 2020/21, We are hugely grateful to our donors, colleagues and NHS partners for their magnificent support during the pandemic. Despite the pressure, we were able to maintain 71% of proceeding deceased donor activity and 79% of deceased donor transplants compared to the previous year. This is a huge achievement given the circumstances.

Based on our latest assessment, however, we expect transplant waiting lists to increase to levels not seen since 2013/14. We will be working closely with our partners across the healthcare system as they rebuild services and seek to address the backlog. We are encouraged by the strong levels of donation and transplantation activity during March and April this year. The challenge will be sustaining this recovery over the coming months and years.

On 20 May, we will be marking the 1<sup>st</sup> year anniversary of the Opt Out law change in England. Our 'Leave Them Certain' PR campaign will be supported by additional paid media and partnerships which have already created good cut through, particularly with target Black and South Asian audiences.

We have successfully transferred the Opt Out programme into business as usual. Scotland continues to embed deemed authorisation after the Go-Live on 26<sup>th</sup> March 2021. We continue to work closely with the Government and Health Departments of the Isle of Man and Northern Ireland to progress their deemed legislation.

Opt Out legislation is anticipated to lead to over 700 additional organs available for transplant every year. Unfortunately, we know that transplant rates have not kept pace with the increase in consent rates over recent years. There are a range of reasons for this, including the increasing age and co-morbidity of both donors and patients. We have focused our efforts to date on supporting Clinical Leads for Utilisation and improving the data provided to transplant teams. Going forward, we will be taking an even more proactive approach as part of a new Organ Utilisation Programme. This will see us working closely with NHSE commissioners, as well as transplant units and patient groups, to identify and deliver further opportunities to maximise organ utilisation. We will look to bring a more detailed update on the scope and structure of this programme later this year.

## **Clinical Services**

We have continued to receive strong feedback from our hospital colleagues despite the challenges of the pandemic. TAS received a top box (9 or 10 out of 10) from 89% of respondents for overall satisfaction. This is up from 83% and 75% in 2019/20 and 2018/19, respectively. Our hospitals survey, which reflects the views of transfusion laboratory managers at 126 hospitals across England, was also very positive with 83% giving us a top box score. We were particularly pleased to receive positive feedback from Barnsley-supplied hospitals given their previous concern about the closure of our sites in Leeds and Sheffield.

On R&D, we hit a major milestone this month with over 1m donors recruited into the STRIDES (STRategies to Improve Donor ExperienceS) study just 18 months after its launch. This collaboration with the University of Cambridge and the NIHR seeks to understand how best to reduce the risk of fainting in blood donors, as well as recruiting donors into the National Institute of Health BioResource for involvement in future studies. STRIDES is taking place across all of our whole blood donation centres and mobile sessions and is due to conclude in November 2022.

As part of our ongoing support to the wider national response to the pandemic, we have been involved in helping to understand more about vaccine-induced thrombosis and thrombocytopenia (VITT). As members of the Expert Haematology Panel of the

British Society for Haematology, colleagues have been involved in compiling current guidance on the diagnosis and care of patients with VITT

(<https://b-s-h.org.uk/media/19590/guidance-version-17-on-mngmt-of-vitt-20210420.pdf>).

This involves urgent treatment with IVIg, as well as sending samples to H&I in Filton, which is one of only two labs in England providing testing for PF4 antibodies. Working collaboratively with colleagues at UCLH, we published the results of an initial study in the New England Journal of Medicine.

(<https://www.nejm.org/doi/full/10.1056/NEJMoa2105385>).

The paper highlights the importance of rapidly spotting this new syndrome and then following a particular treatment approach which is very different from the standard approach to thrombosis.

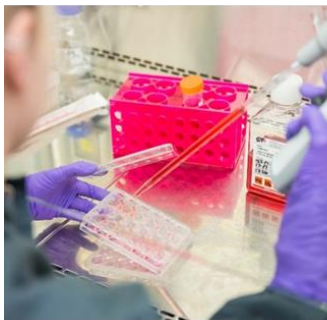
Separately, we have worked closely with the MHRA to share our data and experience seeing people referred to us for organ donation after suffering a major clot. We also published guidance for the ODT community on our website

(<https://nhsbt.dbe.blob.core.windows.net/umbraco-assets-corp/22975/inf1569.pdf>)

and have submitted a paper for publication on our experience.

Finally, we have reviewed and revised our donation deferrals for blood, tissues and stem cells in light of increasing knowledge of VITT. For stem cells, for example, this will be increased to 28 days in allogeneic donors to avoid any potential interactions with G-CSF therapy.

## Strategic Shifts



### A System Leader

Historically, NHSBT has positioned itself as a stand alone ALB, providing products and services to the NHS. It has done so effectively, but as a national provider operating in a federated system of local hospitals, we have a responsibility to step up and take a more proactive role in identifying and driving improvements across the system, as well as identifying opportunities where we can benefit from closer working relationships. Whilst we do not always have the hard levers to drive change, we have untapped convening power (to bring players together) and valuable data about variation in practice and outcomes which we can and should use to optimise the system and improve patient care.

### Proactive & Clinically Responsive

As patient needs and clinical practice evolve, so too does the demand for our products and services. At times, we have found ourselves on the back foot, reacting to changes rather than anticipating and planning for them effectively. Looking forward, we aim to become more proactive and clinically responsive by reacting quickly to signals and working across our supply chain to manage short fluctuations and longer term structural changes in demand. The need to be proactive extends to other aspects of our work, where we must all aim to take responsibility to be the change we want to see rather than waiting for or expecting someone else to take the lead.



### Modern & Agile

There is a perception, if not a reality, that it takes a long time to get things done in (some parts of) NHSBT, and that there is an opportunity to adopt more modern tools and practices, without sacrificing our commitment to quality and safety. We aspire to be – and be seen to be – a modern organisation that embraces innovation and new technology, and is able to act quickly in response to new requirements and opportunities

### Top Choice for Talent

Despite the important, life saving work we do, NHSBT suffers at times from being relatively unknown as an employer. By assuming a more visible role across the NHS and promoting our commitment to diversity and inclusion, we want to be recognised as a great place to work and, thus, a destination of choice for top talent. We will create career paths for each of our professions and work to identify and nurture talent at every stage of people's careers.





## Blood and Transplant

Dear Colleagues

23 April 2021

Despite the pandemic, we have continued to press forward with organisational changes that followed the review of our operating model in 2019. This has led to a number of new senior level appointments – both internal and external – as well as a number of departures.

This note serves to summarise the key changes following our last update in November 2020. When looking at it all together, you will see that there have been a lot of changes over the last six months. I would like to thank you for your resilience, focus and support during this period of transition.

It is worth reminding ourselves that these changes have been driven by the need to line up our senior leadership team behind our new operating model which was designed to strengthen our relationship with donors; modernise and extend our E2E operations; take a more proactive approach to driving improvements across the system; and ultimately save and improve more lives.

We've recruited some amazing new talent and made a number of internal promotions. We've also had to say goodbye to a number of colleagues who will be greatly missed, but who leave behind a wonderful legacy from their time working with us.

Please join me in welcoming our new joiners, congratulating our internal appointments, and wishing well to the colleagues who will sadly be leaving us.

Thank you

Betsy

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### **Executive Team**

**Katie Robinson** has recently accepted a new role within the Civil Service. A departure date will be announced once we have decided how to backfill her role as Director of Strategy and Transformation. I want to thank Katie for establishing this new directorate within NHSBT and for leading changes to governance and risk, project and programme management, business planning and Board reporting – all areas that had been highlighted by the Board as needing improvement. We have made good progress this year, leaving solid foundations on which to build for the future.

**Rosna Mortuza** – in her role as Chief Diversity and Inclusion Officer – will be picking up oversight of our Heads of Centre. This change reflects the important role that we want and need our Heads of Centre to play in fostering inclusive communities and making NHSBT a great place to work *for everyone*.



**Katherine Robinson** has been on secondment to the Vaccine Programme since January but has decided to leave NHSBT when this comes to an end given the reorganisation of the People Directorate which is currently underway. Katherine has made a tremendous contribution to NHSBT over the past 14 years and we wish her all the best in her new endeavours.

### **Strategy and Transformation**

On 1 April, the Corporate Communications and Internal Communications teams transferred into the Strategy and Transformation Directorate to form a unified Communications function, led by **Steve Park**, Assistant Director, Corporate Communications.

**Richard Rackham** is currently seconded to work at NHS England and Improvement on the vaccines programme. Tom Cowdrey has stepped up to provide broader leadership cover on business continuity and coordinating our COVID response while Richard is on secondment. Katrina Smith is providing oversight and support to the risk team.

### **Blood Supply**

**Dean Neill** has been appointed to the new role of Assistant Director of Performance, Planning and Stock Management as of 19 April. This was one of the roles announced in the new Blood Supply Operating model structure.

### **Clinical Services**

**Dan Hollyman** has been appointed Director of Cellular Therapies, reporting to Gail Mifflin, following an external recruitment process. His responsibilities include:

- Cellular and Molecular Therapies (CMT) including our national network of laboratories undertaking routine stem cell processing and the manufacture of advanced cell and gene therapies;
- Stem Cell Donation and Transplantation (SCDT) including the British Bone Marrow Registry and the NHS Cord Blood Bank; and
- Therapeutic Apheresis Services (TAS).

**Laura Hontoria Del Hoyo** has been appointed Director of Pathology, also reporting to Gail Mifflin, after an external recruitment process. Laura is currently on secondment to DHSC where she has been leading plasma policy development but is expected to take up her new post in May. **Andrea Harmer** has done an outstanding job leading the function on an interim basis and will continue to develop our genotyping strategy, in addition to continuing her H&I responsibilities.

**Dr Farrukh (Farrah) Shah** has been appointed Medical Director of Transfusion post following a competitive recruitment process and will be joining NHSBT from 1 July 2021. She will be an integral part of both the Clinical Services and Blood Supply senior teams and will develop and lead the newly created Transfusion team to take forward the Transfusion 2024 strategy. Farrah is currently a Consultant Haematologist and Chair of the Blood Transfusion Committee at the Whittington Health NHS Trust. She is an international expert in treating people with Thalassaemia and Sickle Cell Disease. Nationally, Farrah is Chair of the UK Forum on Haemoglobin Disorders and of the National Haemoglobinopathy Register working with NHSE/I, she also has an active research portfolio.

**Edwin Massey** is now on a career break to join the Welsh Blood Service as Deputy Medical Director from 6 April 2021. This is an exciting opportunity for Edwin, and we wish him all the best in the new role.

**Nick Watkins** left NHSBT at the end of December following changes to the operating model in Clinical Services. As Assistant Director for Research and Development, Nick oversaw the creation of four National Institute for Health Research (NIHR) funded Blood and Transplant Research Units (BTRUs) which have become centres of research excellence in Transfusion and Transplantation.

**Catherine Howell** will also be leaving NHSBT at the end of June as her role as Assistant Director for Commercial & Customer Services was disestablished as part of the organisational changes in Clinical Services. In her 27 years with NHSBT, Catherine has made a demonstrable contribution to our organisation, which was recognised when she received an OBE for her services to nursing and healthcare in 2017.

With Catherine leaving, we are now in the process of recruiting to the Chief Nurse and Lead for Corporate Clinical Governance. The Patient Blood Management and Hospital Customer Services teams will report to the Medical Director, Transfusion going forward.

### **Donor Experience**

The Donor Experience team has been restructured under four new Assistant Directors:

**Mark Croucher** has been appointed Assistant Director, Donor Experience Services, responsible for all online and offline experiences for our donors. His team will work closely with DDTS, Blood Supply and OTDT for delivery of these services. Mark joins us from Virgin Atlantic Airways where he worked for over 20 years, most recently as Head of Customer Experience at Virgin Holidays.

**Terry Omiyi** has been appointed Assistant Director, Direct Marketing and Contact Centre. Terry is responsible for all direct communication to the donor, as well as being responsible for donor service, compliments and complaints across all channels. Terry's previous roles include time with the Post Office as an internal consultant and at Sky UK as Head of Direct Marketing.

**Lynne Willdigg** has been appointed Assistant Director, Donor Planning, Insights and Transformation, Lynne joins us from Scotland's National Blood Transfusion Service where she was Assistant Director, Donor & Transport Services.

**Helen Duggan** has been appointed Assistant Director, Donor Campaigns, Advertising and Creative Services. Many of you will remember Helen from last year when she was seconded to NHSBT from Public Health England to lead our Organ Donation campaign. Helen will be joining us from 14 June. **Kevin Anderson**, who has been leading the Community Engagement team on the Convalescent Plasma programme, will be filling in for Helen on an interim basis until she arrives.

Finally, **Altaf Kazi** is our new Head of Partnerships. Altaf joined NHSBT last summer and many of you will have worked with him in his current role as our Head of Faith & Belief Engagement. Previously he worked at Muslim Aid as head of their UK programmes, at the National Zakat Foundation as Head of Marketing and Fundraising, and originally with Birmingham City Council in their housing division.

**John Latham** has left NHSBT following changes to the operating model in Donor Experience. We would like to thank Jon for his invaluable contribution to NHSBT over the last 11 years.

## Quality

**Helen Gillan** has been appointed Assistant Director, Quality and Regulatory Compliance following an external recruitment process. Helen took up the role on 1 March. Helen has a strong background in quality assurance within NHSBT and the British Standards Institute and has successfully led Tissue and Eye Services for the past nine years.

**Fidelma Murphy** has recently left NHSBT to take up an exciting new role as the Director of Quality for the New Zealand Blood Service and we would like to thank her for her contribution to NHSBT and wish her all the best in her new role.

## Organ and Tissue Donation and Transplantation

**John Richardson** has been appointed Assistant Director – Organ Donation. This portfolio will focus on the operational delivery of the organ donation pathway and to that end we have brought the ODT Hub and Information Services Team to sit within Organ Donation, alongside their operational colleagues.

Following Helen Gillan's transfer to the Quality Directorate, **Kyle Bennett** will be acting up into the role of Assistant Director, Tissue and Eye Service on an interim basis. We shall look to advertise and appoint substantively into this role within the next few months.

To align our structure with those of colleagues in the Blood Donation and Clinical Directorates we have created a Chief Nurse – OTDT role. **Olive McGowan** has become OTDT's Chief Nurse, undertaking the Chief Nurse duties in addition to Education and Governance. Olive has also taken over leadership of the Donor Records Department.

**Karen Quinn** continues to lead our UK Commissioning function and in addition will develop the Service Development function within her portfolio. **Ben Hume** will now focus on strategy and transformation taking the ODT and TES strategies forward and developing ambitious road maps and delivery plans to realise our strategic vision. Ben will also lead the now merged OTDT Performance Team.

## Finance

**Eugene Cook** retired from his role as Assistant Director Procurement on 31 March 2021. Recruitment has been underway for the role of Commercial Director, replacing the AD role but adding to it a need for greater stakeholder engagement and to incorporate leadership for managing supply chain risk. We hope to announce the new Commercial Director very soon.

## 8. Clinical Governance report (21-33)

For Report

Presented by Gail Miflin



## Blood and Transplant

### NHSBT Board Meeting 27<sup>th</sup> May 2021 Clinical Governance Report

#### Status: Official

#### Summary and Purpose of Paper

This paper summarises the clinical governance issues discussed at NHSBT CARE meeting held 4<sup>th</sup> May 2021. There are two new SIs which have been reported to the Board. These both involve different aspects of consent in OTDT and are detailed below.

An anonymous whistle blower to the CQC alleged a poor clinical practice at one of the donor centres. The incident was investigated by the Chief Nurse in Blood Supply and no grounds for concern were found. A response was sent to CQC who were satisfied, with no further actions required.

The 'For the Assessment of Individualised Risk' (FAIR) group changes to eligibility criteria for MSM will be implemented on 14th June.

Significant business critical supplier issues affecting primarily Diagnostic Functions (pipette tips) were reported which have potential for direct clinical impact. Affected departments are liaising directly with procurement and DHSC. Currently there is sufficient supply to maintain our operations, but multiple actions are in progress to address this and minimise clinical risk.

A cluster of donors whose cause of death was a rare cerebral venous sinus thrombosis (CVST) combined with low platelets occurring a few days after vaccination for COVID was identified. Clinical leads for organ donation have been informed of the British Society of Haematology (BSH) guidelines as well as guidance on assessing potential donors. Work on the implications of this syndrome for organ donation and transplantation are being considered and, as always, we will monitor outcomes on those who have received a transplant to determine whether special follow up is required.

#### Action Requested

The Board is requested to note the contents of the paper and discuss where relevant.

#### 1. Serious Incidents (SI)

1.1 During February and March 2021, no new Serious Incidents (SIs) were reported. Subsequent to this reporting period, two new SIs have been reported to the Board:

➤ OTDT: INC5466 – A heart was retrieved without the donor family's agreement

A family were approached for deemed consent for donation after brain stem death. Due to the geographical location of the donor hospital and transportation logistics, the family approach and consent conversation with the Specialist Requestor (SR) took place via Zoom. The family were told that the heart may not be suitable for donation and following further discussion the family decided they did not wish for the heart to be donated for heart valves either.

There were three Nurses involved in the donation process; the SR carried out the consent conversation and SNODs 2 and 3 were mobilised to the hospital to facilitate donation. The



## Blood and Transplant

SR emailed the consent form to SNOD 2 but there was no verbal handover. SNODs 2 and 3 did not review the consent form. On initial investigation it appeared that the retrieval team only looked at the front sheet of the consent form and did not go through which organs had been consented.

As requested by the SNODs on-site, another member of the Organ Donation Services Team (ODST) contacted the external heart valve bank to assess the suitability of the heart for valves who advised that the pulmonary valve could potentially be used. The abdominal NORS team were mobilised and the heart was retrieved for heart valve donation.

The SR that established consent reviewed DonorPath and noted that the heart had been retrieved. SNOD 2 contacted the donor family to discuss. The family initially gave retrospective consent for the heart to be retrieved for heart valves, however, later the family informed the SNOD that a family member was very distressed and requested that the heart be returned to the body. The heart was repatriated to the donor hospital and returned to the body. The RCA is planned for the end of May 2021.

➤ OTDT: INC5477 – Eye tissue was retrieved despite Coroner’s restriction to the retrieval of corneas

Consent was obtained from a potential donor family for solid organ, tissue and eye donation. The patient was subsequently discussed with the Coroner who gave ‘restricted’ permission to donation stating ‘no’ to corneas due to the cause of death. The family were informed that eye tissue would not proceed due to the Coroner restriction.

A referral was made to the National Referral Centre (NRC) and the SNOD verbally informed the NRC that the Coroner had stated ‘no’ to eye donation. It was later noted by the SNOD on DonorPath that an entry had been made stating ‘Tissue retrieved – eyes’. It was subsequently confirmed that eye donation had taken place.

Initial investigation has confirmed that a verbal discussion between the SNOD and Tissue and Eye Services (TES) regarding ‘restricted’ permission was not noted on the documentation. A paper form is used to aid the NRC in acquiring all relevant information from DonorPath succinctly. The conversation had by the SNOD informing that there was no permission from the Coroner for eye tissue should have been noted on this form, but this did not occur.

The Coroner has been contacted and eye retrieval did not impact on the post-mortem findings. The family have been contacted and have requested that the eye tissue is returned to the body which was facilitated. A full RCA is to be arranged.

## 2. Care Quality Commission (CQC) update

- 2.1 The CQC are currently reviewing what is within or out of registration based on the review of 2014 regulations. The outcome of this review may have some implication on NHSBT in terms of what is inspected. This is also being discussed with the DHSC.
- 2.2 An anonymous whistle blower to the CQC alleged a poor clinical practice at one of the donor centres. The incident was investigated by the Chief Nurse in Blood Supply and no grounds for concern or poor practice were found. A response was sent to CQC who were satisfied, and no further actions were required.

## 3. Risk Management



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- 3.1 The strategic level (parent) risk: NHSBT-01, Safety and Quality of Clinical Care, currently has 48 recorded functional (child) level risks, with no high scoring, priority 1 risks (risks with a residual score  $\geq 15$ ). The current 'worst child' score is moderate, with a score of 10. Since the previous risk report, no new risks have been recorded and one risk has been closed.

### 4. Clinical Governance

- 4.1 The new Donation Safety Check and Consent Information Leaflets are being finalised ready for the implementation of the 'For the Assessment of Individualised Risk' (FAIR) group changes on 14th June.
- 4.2 Following a recent independent review, a project is underway, led by Donor Experience to improve the management of the donor complaint process. It will focus on developing staff to effectively manage dissatisfied donors, and it will be supported by a new complaints management system.
- 4.3 Significant business critical supplier and procurement issues affecting primarily Diagnostic Functions (pipette tips) were reported which have potential for direct clinical impact. All affected departments (IBGRL and CMT) are liaising directly with procurement and DHSC. Currently there is sufficient supply to maintain our operations, but multiple actions are in progress to help address this and to minimise future clinical risk.
- 4.4 A draft policy 'NHSBT Divergent Outcomes Policy' prepared in consultation with, and supported by, the Royal College of Ophthalmologists was submitted and discussed. The aim of this paper is to outline the response when underperformance is suspected or divergent outcomes for corneal transplantation have been indicated by NHSBT. The paper describes the methods used to identify potential surgeon outliers, as well as detailing the subsequent actions following a signal of divergence including, where necessary, suggesting further clinical or analytical support.
- 4.5 A cluster of donors whose cause of death was a rare cerebral venous sinus thrombosis (CVST) combined with low platelets occurring a few days after vaccination for COVID. An urgent group has been set up by the British Society of Haematology (BSH) to develop guidelines for this group of patients/donors. The recommendation is not to give heparin or platelet therapy to this group of patients. Clinical leads for organ donation in all major ICU departments in the UK have been informed of these guidelines. There is now a need to examine detailed information from donors, testing for potential recipients or those who have received a transplant to monitor outcomes and to decide whether special follow up is required. Work is ongoing in this area and the Vaccine induced thrombocytopenia and thrombosis (VITTs) guidance has been updated and will continue to be updated based on emerging information.

### 5. Clinical Audit

- 5.1 An audit of the effectiveness of convalescent plasma donors has been removed from the programme as no longer applicable, leaving a total of twelve audits due for completion within 2020/21.

### 6. Information Governance (IG)

- 6.1 The IG team have begun a dedicated project to streamline a variety of processes and procedures including the Freedom of Information, Subject Access Request, and Data Privacy Impact Assessment processes. This involves working closely with Customer Service and Corporate Communications Teams as well as relevant lines of business



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to ensure that each process is customer-centric while maintaining adherence to compliance obligations.

- 6.2 The Information Commissioner's Office (ICO) closed, in April 2021, the ongoing complaint regarding a FOI request for 'all internal NHS guidelines currently in force, relating to the Organ Donation (Deemed Consent) Act 2019'.

### 7. Safety and Policy

- 7.1 A collaboration between SaBTO and NHSBT has led to the development of a rapid reference guide for transplant clinicians to help decision-making when considering the use of organs for transplantation from donors with infection, malignancy and other potentially transmissible diseases. This is a web app hosted on the ODT website: <https://www.odt.nhs.uk/transplantation/tools-policies-and-guidance/donor-transmissible-disease-reference-guide/>



## 9. Board Performance Report (21-34)

For Report

Presented by Katie Robinson and Rob Bradburn



## Blood and Transplant

### NHSBT Board NHSBT Monthly Performance Report 27<sup>th</sup> May 2021

**Status: Official**

#### 1. Summary and Purpose of Paper

This cover paper introduces the new, streamlined board performance report for April 2021 and outlines the rationale and approach to the new format. Directors will briefly provide a short overview of the metrics they have chosen to include, and key highlights for the month in the meeting.

Following discussions at previous Board meetings, Finance and Strategy & Transformation have worked closely with the wider Executive Team (ET) over recent months to develop a revised performance report. The new report is shorter, focussed on headline KPIs with supporting narrative, and moves from a typical 32-page report to an 8-10-page report.

The performance report will be provided in future as part of a suite of reports that will include a refreshed Board Assurance Framework and a transformation portfolio report that are in development and will be shared in due course.

#### 2. Action Requested

Our ask of the Board is to discuss the new, streamlined performance report, and provide feedback as part of the performance updates from Directors.

#### 3. Background and context

This iteration is the result of several rounds of engagement with directorates, discussions at the Finance and Performance Committee, and updates to the draft version considered at the March 2021 Board following further feedback. On multiple points there have been conflicting views and preferences for what should be included in the report and how it should be presented. We have attempted to address these on balance by applying a number of overarching design principles, based on ET and Board-level feedback and discussion:

- The report should be shorter, simpler, and clearer
- The report shall present data and narrative in a manner that is broadly consistent across each area and directorate, and draws attention to the key issues
- Only the most important leading metrics and narrative content should be included
- Additional supporting metrics and data will be provided separately as required
- Content will be decided upon at ET level by respective directors, who have accountability for what is reported
- The report should include specific corporate sections on Quality, People Services and DDTS



## Blood and Transplant

### **Governance and Assurance**

It is important to note that in moving to this shorter report format, a large amount of performance data and information is no longer explicitly reported.

Whilst this information will continue to be available when required, Directors are responsible for providing the governance and assurance around the monitoring of these performance elements.

A significant amount of governance and assurance already underpins the information within ET and Board Performance Reports as part of NHSBT's integrated performance framework. Each month, each relevant group (e.g. BOLT, directorate SMTs, and programme boards) review performance data in depth and sign off the analysis presented in the performance reports.

Quarterly Performance Reviews also take place with each directorate allowing a more detailed assessment of performance against directorate objectives and business plans.

Where performance is off-track more detailed analysis and commentary will be provided e.g. explanations of drivers of current performance if not green, narrative on projections, risks to future green status and mitigating actions.

### **4. Next steps**

- This new format will form the basis of quarterly performance reporting to DHSC from 2021/22 onwards.
- Over the coming months, the Head of Performance Management will work with DDTS to develop a more dynamic, online version of the report, which we aim to start testing by Q4 2022.

Authors:

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May 2021

# NHSBT Board Performance Report

## April 2021

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# QUALITY: Director Report – April 2021

## Key risks, issues and actions for attention:

- EU In-Vitro Device Regulations (IVDR) implementation - project status currently rated as 'amber' due to late completion of some tasks.
- Plasma for Medicines (PFM) - risk remains that without the appointment of a fractionator, we are collecting PFM at risk. We are mitigating this by engaging with fractionators (in line with direction from NHSEI/DHSC) and engaging the services of a contract Qualified Person (QP).
- Overdue QMS events remain at high levels. Events are managed to ensure no increased safety risk, but there is an increased risk of a regulatory finding being raised at inspection.

### External Inspection Performance:

No external MHRA or HTA inspections performed in April

### Upcoming Inspections:

MHRA will visit Barnsley week commencing 7/6/2021 for the first full on-site inspection since going live. Compliance will be assessed against the Blood Safety & Quality Regulations (BSQR)

External Majors  
(Target = 0)

**Nil** ↔

Y-T-D raised = 0

### Externally Reported Events:

(Serious Adverse Blood Reaction & Event / Serious Adverse Event & Reaction)

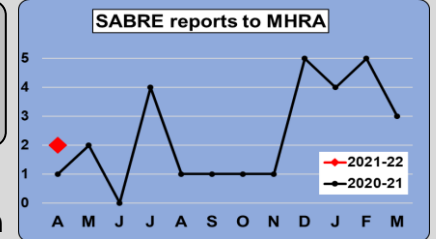
**SABRE: Y-T-D = 2**

2 events in April

- 1 delayed recall
- 1 wrong product sent

SABRE events  
(Target <= 5)

**2** ↓



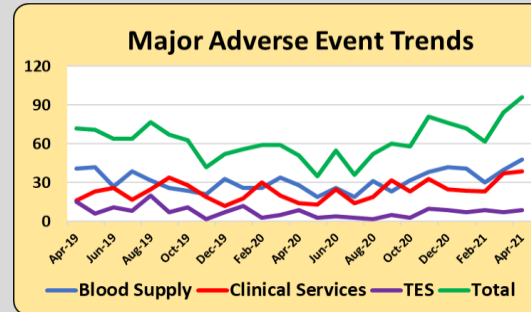
Events being managed, no area of concern

**Serious Incidents (SIs): Y-T-D = 1**

- 1 SI event raised in April in OTDT re Corneal retrieval and Coroner consent.

### Major Adverse Events:

- There was an increase in Major adverse events (Quality Incidents and/or Complaints) raised this month in both Blood Supply and Clinical Services. Events were higher in BD-M&L (5 Majors linked to labelling errors) and CS – patient facing medical (no trend observed).



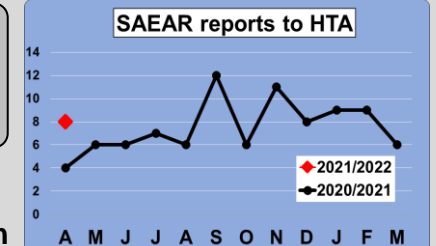
**SAEAR: Y-T-D = 8**

8 events in April

- 4 bacteriology positive
- 2 primary graft failure
- 1 patient adverse event
- 1 death before engraftment

SAEARs events  
(Target TBA)

**8** ↑



Events being managed, no area of concern

### Regulatory Radar:

- **EU In-Vitro Device Regulations (IVDR)** - The project to ensure IVDs manufactured for the EU/NI market by NHSBT are compliant with the EU IVDR by the May 2022 deadline has had some delay to timelines due to the impact of Covid-19 and the complexity of the regulatory changes across different markets with overlapping implementation timelines. The project team are working to get the project back on track. **Currently rated** Amber

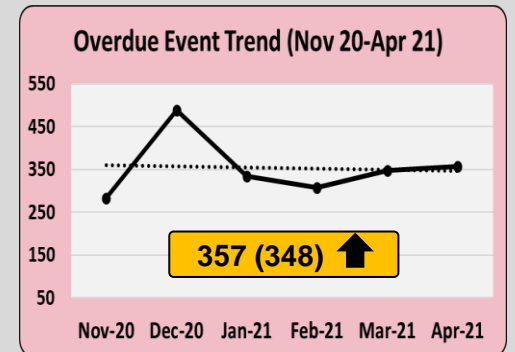
### Licence Update:

**Wholesale Distribution Authorisation (WDA)** - Leeds and Sheffield sites removed.

### Overdue Quality Management System (QMS) Event Performance:

- Overdue QMS events **rose** very slightly in April for the 2nd consecutive month.
- There was an increase in audit findings, change controls and QIs overdue in several functions.

No individual department of concern but total numbers continue to remain at elevated levels.

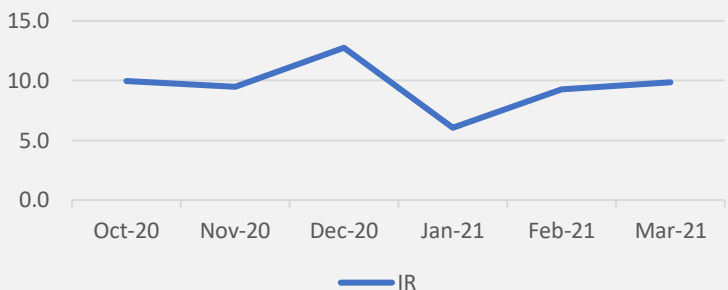


# PEOPLE SERVICES: Health Safety & Wellbeing Director Report – April 2021

## Key risks, issues and actions for attention:

- Following feedback received the metrics in the report are being reviewed – updates/changes will be incorporated into future reports
- Consultation on the first phase of the new People Operating Model launched on 5 May 2021. Consultation is expected to last in to June 2021.
- The health and wellbeing survey was launched and the results are awaited.

### Harm



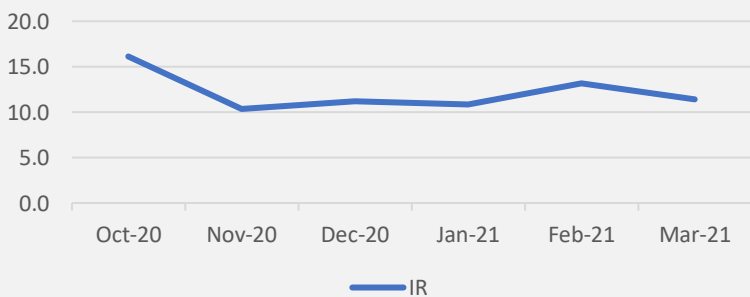
Harm IR - March 21  
(Target = 10.5 G= better than target, R = worse then target )

**9.9** ↑

There was an increase in Harm Incidents from the February 2021 figure but still better than target for 2020/21. Target for 2021/22 financial year reduced to 9.6.

Harm is an unplanned event which resulted in injury or ill health to a person and/or property damage. Incidence rate for accidents and near misses is monthly number divided by total number of staff x by 1000

### Near Misses



Near Miss IR –March 21  
(Target = 8.4 G= on or better than target, R= under target )

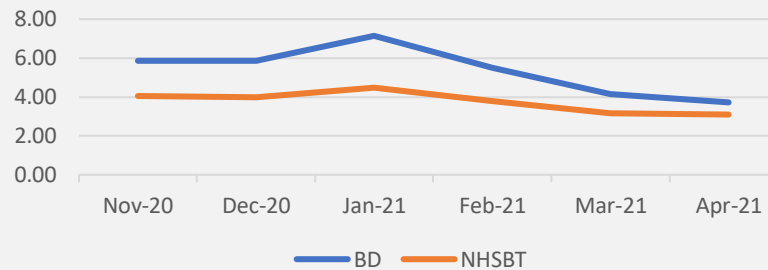
**11.4** ↓

Near Misses – good numbers across NHSBT maintained. Target for 2021/22 financial year increased to 10.4.

Near miss is an unplanned event which could have resulted in injury or ill health to a person and/or property damage, but was avoided by good luck.

**Reminder: H&S Reported in arrears**

### Sickness Absence



NHSBT sickness absence % - 30/04/21

NHSBT Absence Target 4%  
G= <4, A = 4 – 4.5, R= >4.5%

**NHSBT 3.08%**

BD Sickness Absence % 31/03/2021

(Target = 5% G=5, A= 5-5.5, R = > 5.5%)

**BD 3.72%**

- Sickness Absence continues to be monitored at a directorate level. No significant impact on operational delivery from sickness absence.
- Sickness Absence targets were set at 5% for Blood Donation (Pre pandemic)
- Definition sickness absence is % of absence related to sickness of total of number of employees

### COVID Vaccination

- COVID First vaccination rate is still increasing however the rate is slowing.
- % of vulnerable staff receiving first vaccination is lower than overall, HSW are reviewing individual risk assessments for each person to ensure support is available for them and encourage vaccination.

% of staff 1<sup>st</sup> COVAX Vaccination – 13/05/21

**83.0%** ↑

% of patient facing staff 1<sup>st</sup> COVAX Vaccination – 13/05/21

**91.2%** ↑

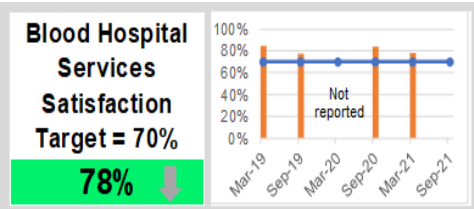
% of vulnerable staff 1<sup>st</sup> COVAX Vaccination – 21/04/21

**80.6%** ↑

# CLINICAL SERVICES: Voice of the Customer: Director Report – April 2021

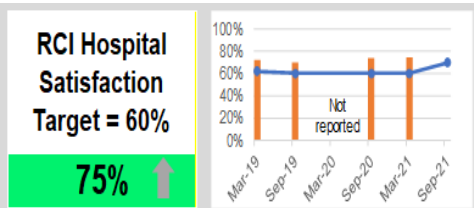
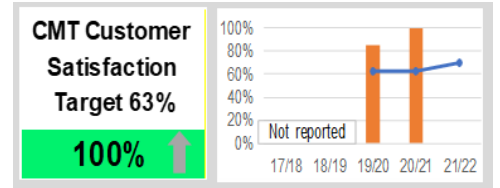
## Voice of the Customer: Hospital Customer Satisfaction Survey

- The survey reflects the views of hospital transfusion laboratory managers at 126 (50%) directly supplied hospitals in England for the period October 2020 to March 2021
- Results are reported as percentage of customers scoring a “Top Box” score of 9 or 10 out of 10 and the average scores from all responses
- Satisfaction with NHSBT Overall is high at 83%; the average score of 9.2 continues the upward trend
- Barnsley hospitals very engaged with 78% responding to the survey and overall satisfied / very satisfied; reassuring given initial customer concerns over the relocation



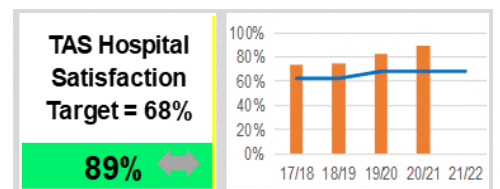
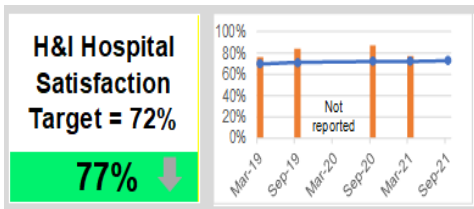
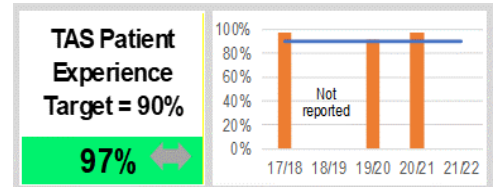
### Blood Supply

- The relationship between Hospital Services and our hospital customers is working well with positive comments relating to courtesy and helpfulness; **Hospital Services** scored 78% above target of 70%
- Three from four fulfilment Top Box scores reduced, however, strong average scores (9.2 to 9.4) have been maintained, indicating continued high levels of satisfaction
- The online blood ordering system continues to be well regarded with suggestions to enhance it further
- Our overall score for **routine delivery** improved to 74% from 58% since 2019, attributed to the successful routine delivery utilisation project
- Customers continue to show preference for NHSBT drivers (88%) over couriers (48%); this may be due to familiarity with our drivers



### Clinical Services

- **RCI** customers scored 75% for overall satisfaction; above target 60%; target increased to 70% in 21/22
- There is a notable appetite for electronic requesting / reporting direct to LIMS
- **H&I** customers scored 77% for overall satisfaction; above target 72%
- **Hospital Customer Services Team** scored 89%; a continued upward trend; team recognised for being helpful, knowledgeable, supportive
- **Clinical Support Team** hit a new high of 87%; also a continued positive trend
- In addition, **TAS** conduct their own satisfaction surveys for customers and patients
- The latest survey outcomes reported for 2020/21 include patient experience at 97% (up from 92% last year) and customer satisfaction at 89% (up from 83% in 19/20)
- In **CMT** the 20/21 survey scored 100% for customers scoring  $\geq 9/10$  for satisfaction, albeit from a low number of customer returns (8)

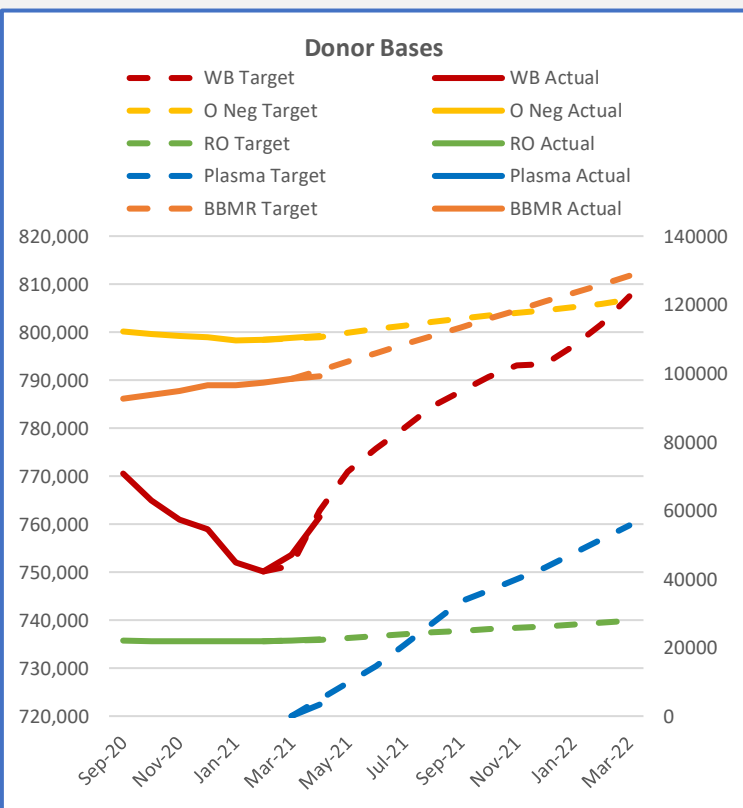


# DONOR EXPERIENCE: Director Report – April 2021

Key:  Current performance  FY22 target

## Key Headlines, risks and mitigations

- All WB Blood donorbases have started to grow following the falls of 2020 caused by the pandemic, the increase in April was driven by an increase in retention. The recruitment of new donors dropped in April due to a drop in paid media spend. There was also a drop in donors returning after lapsing. Once marketing budgets are agreed with Cabinet Office and media spend increases it is likely that higher levels of new donors will help maintain the current trend of growth on the donorbase.
- The levels of people Opting In on the ODR has increased in April, as a large part of this is driven by partners like DVLA it is less impacted by any delays in marketing budgets being agreed. Opt outs have remained flat in April
- There was an increase in Donor Satisfaction and a decrease in Complaints from Blood Donors in April



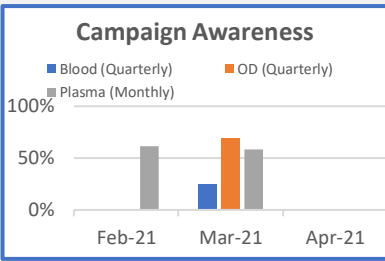
**WB 12M Donor Base**  
(FY22 Target = 807k  
April 21 Target = 763K)  
**761k**

**O neg Donor Base**  
(FY22 Target = 121k  
April 21 Target = 110k)  
**110k**

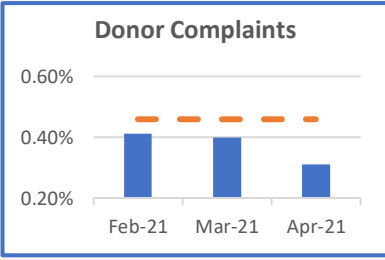
**Ro Donor Base**  
(FY22 Target = 28k  
April Target = 22k)  
**22k**

**Plasma Donor Base**  
(FY 22 Target = 55k TBC  
Jun 21 Target = 15k)  
**3.4k**

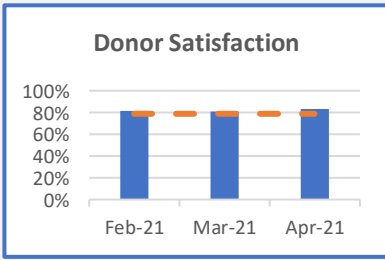
**BBMR Donors**  
(FY22 Target: = 130,000 tbc  
April 21 Target = 101k)  
**99k**



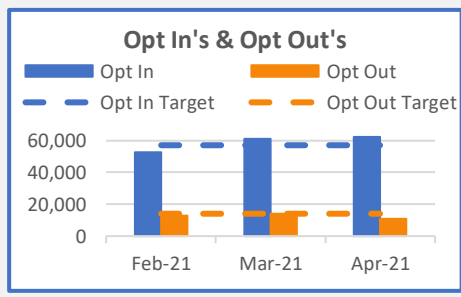
**% Plasma Awareness (FY22 Target TBC)**  
**58%**



**% Donor Complaints (FY22 Target 0.46%)**  
**0.31%**



**Donor Satisfaction (FY22 Target 79%)**  
**84%**



**Organ Donation Opt In's (Target 57k)**  
**62k**

**Organ Donation Opt Out's (Target 17k)**  
**10k**

### Delivering the Volume of Donor

- The donorbase has stabilised and started to rise following the falls of 2020. Currently the donorbase is just below the monthly target mainly due to lower levels of New donors following planned reductions in collection and removal of over 9,000 bookable slots to reduce stock levels. Additionally, Marketing budgets have not yet been finalised with cabinet office

### Delivering the Mix of Donors

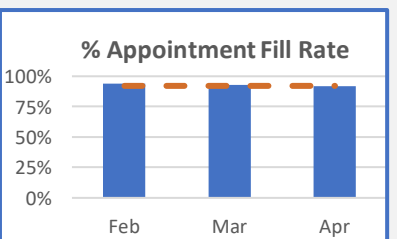
- The O negative and RO donorbases have continued to grow steadily and are currently on track for the YTD targets

### Improving our donors' experience

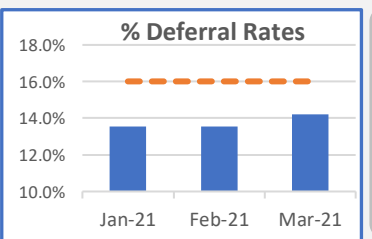
- Donor Satisfaction is above target for April and has increased from March to 84%. Complaints also fell in April
- WB online booking rate remains consistent at 76%
- Deferral Rates have increased slightly in April but still below the 16% target

### Building a plasma base for the future

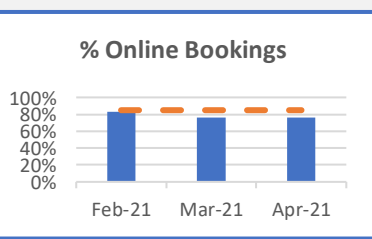
- The plasma for medicine donorbase is currently very small but is expected to grow as the programme develops
- Plasma awareness tracking is due to go live in May subject to budget agreement for Cabinet Office



**% Fill Rates (FY22 Target= 95% Apr 21= Target 92%)**  
**92%**



**% On-Session Deferral (FY22 Target 16%)**  
**14%**



**% Online WB Bookings (FY22 Target 85%)**  
**76%**



# BLOOD SUPPLY: Director Report – April 2021

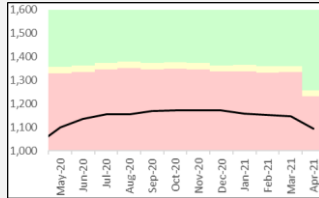
## Key risks, issues and actions for attention:

- Demand for blood components has recently increased and may continue to be more variable than usual as hospitals restore services and catch-up on postponed activity. Stocks are currently healthy and the collection forecast is strong, which will mitigate against any significant changes in hospital ordering.

### Productivity

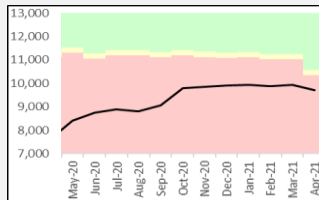
Collection Productivity  
YTD Target = 1,256

1,094 ↓



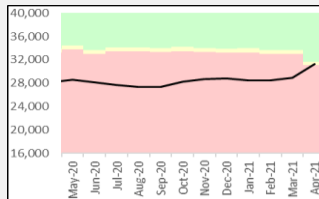
Processing Productivity  
YTD Target = 10,564

9,707 ↓



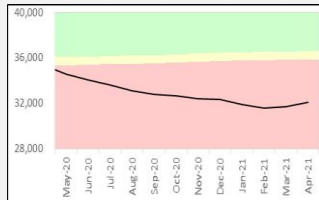
Testing Productivity  
YTD Target = 31,692

31,212 ↑



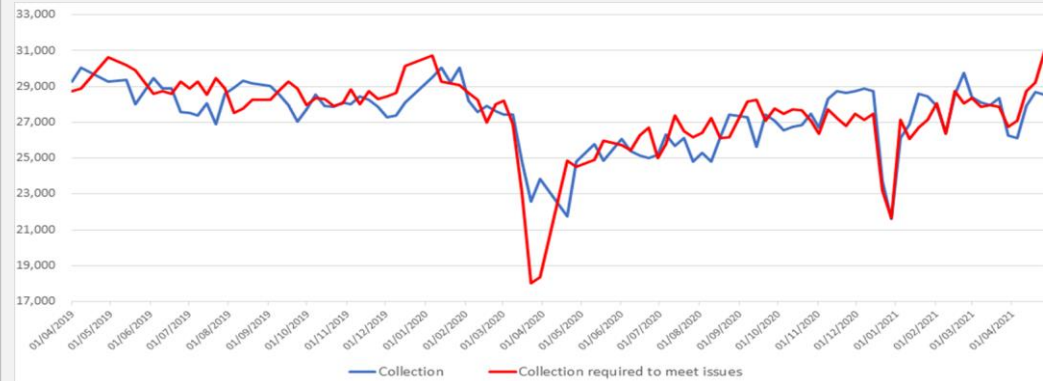
Hospital Services Productivity  
YTD Target = 36,703

32,952 ↑

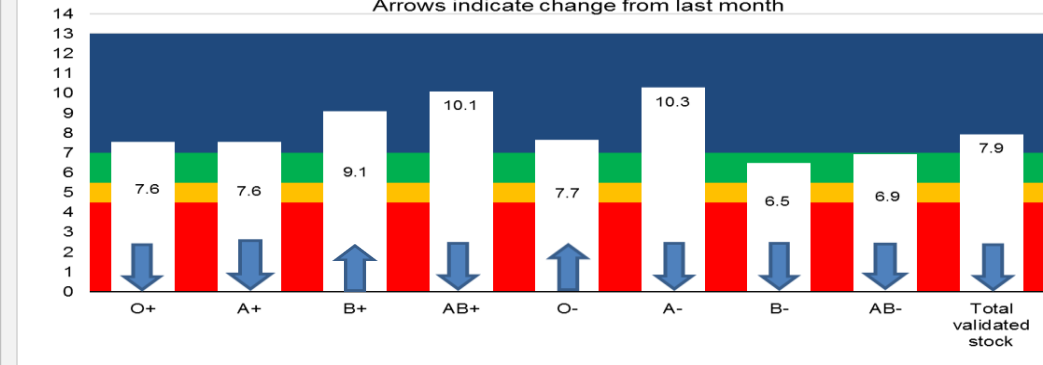


Productivity remains below target, primarily due to the impact of COVID-19 (less activity and more staff to cover absence and impact of social distancing). Activity is forecast to increase as hospitals further restore services and catch-up on postponed activity. Fixed term contracts can also be reviewed in year, as required.

### Collection Performance and Stock



Average Days of Red Cell Stock - April 2021  
Arrows indicate change from last month



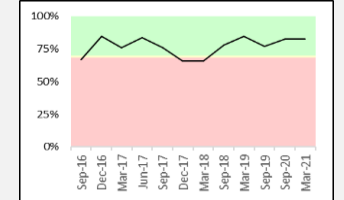
Red cell demand increased during April 2021, as hospitals have restored services and re-planned postponed activity. Collections have broadly kept pace with these higher levels of demand.

We planned to enter May with stocks above target levels, anticipating that stocks will return to target levels during May due to a combination of higher demand and temporarily lower levels of collections to enable training for blood collection teams ahead of changes to the donor selection criteria following 'For the Assessment of Individualised Risk' (FAIR) recommendations.

### Service

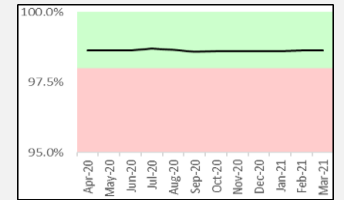
Overall Hospital Satisfaction  
YTD Target = 70%

83% ↑



OTIF Excl. Ro Fails  
YTD Target = 98%

98.8% ↑



Record levels of OTIF performance sustained throughout the pandemic.

# CLINICAL SERVICES: Director Report – April 2021

## Key risks, issues and actions for attention:

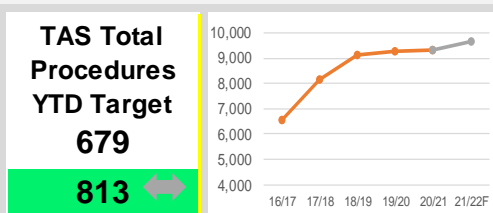
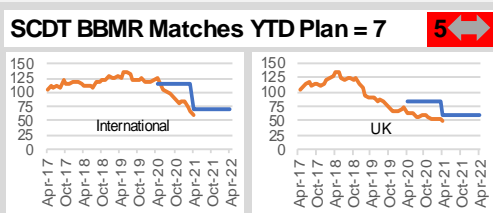
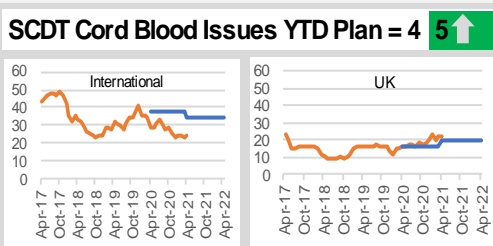
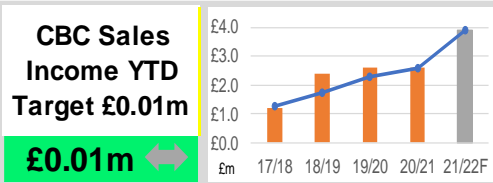
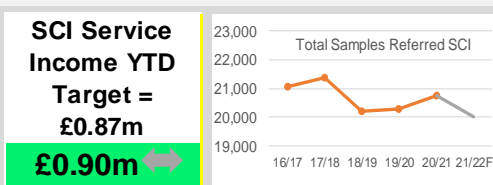
- Demand for Clinical Services products/services has improved during April across most operational areas as we continue to emerge from the second wave of the pandemic
- Ongoing issues relating to consumables supply, driven by suppliers supporting the pandemic vaccine roll out, continue to be managed on a week-by-week basis

### Stem Cells and Therapeutics

- **Cellular and Molecular Therapies (CMT)** routine service income 3% above plan due to cryopreserving allografts activity
- The number of stem cell transplants supported was just above target in April (145 v 142)
- Clinical Biotechnology Centre income forecast to plan
- CBC consumable supply issues ongoing with key items used for Covid vaccine production
- **Stem Cell Donation and Transplantation (SCDT)** cord blood issues were one unit above plan this month
- British Bone Marrow Registry (BBMR) donor to patient matches below target by two units
- Driven by lower transplant activity due to the pandemic
- BBMR exports impacted by US policy
- US considering domestic matches first to avoid logistical challenges and reduce risk to patients

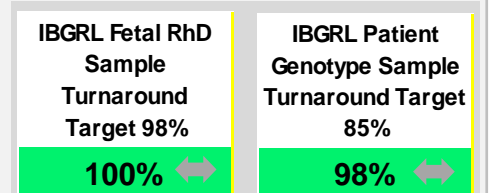
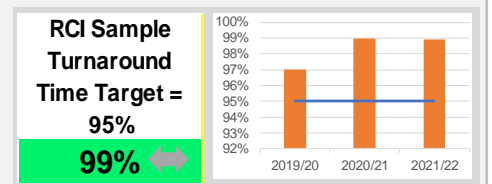
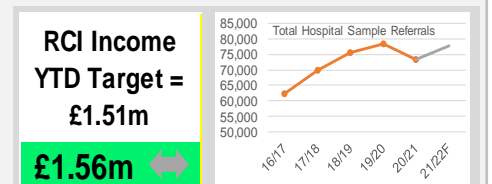
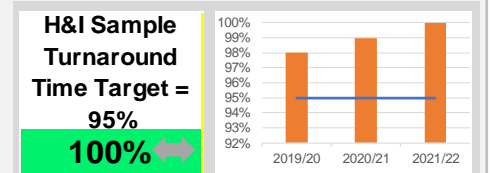
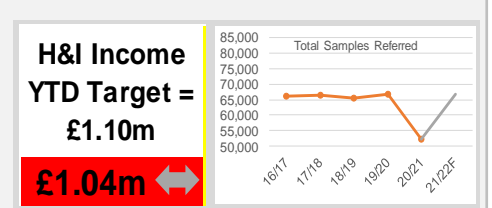
### Therapeutic Apheresis Services (TAS)

- TAS overall activity above plan by ca 20% in April driven by increased Plasma Exchange activity across multiple units
- Nursing workforce issues in London are now resolving with a number of new starters coming into post



### Pathology Services

- **Histocompatibility and Immunogenetics (H&I)** income 5% down on plan in April
- Income 140% above April 2020, with activity closer to pre-pandemic levels
- Sample turnaround times remain better than plan
- Supplier issues continue to be managed affecting test kits and plasticware
- **Red Cell Immunohaematology (RCI)** activity above plan in-month
- Pre-transfusion patient sample referrals up 63% on last years pandemic hit April
- Sample turnaround times remain better than plan
- **International Blood Group Reference Laboratory (IBGRL)** sample turnaround times above target for all services
- Ongoing consumable supplier issues being managed



Note: blue lines on the charts = target; orange bars / lines = Annual Total / MAT; grey bars / lines = forecast

# OTDT: Director Report – April 2021

## Key risks, issues and actions for attention:

- In support of the NHS system's recovery, we have set the challenge of exceeding our best-ever performance during 2021/22. Organ donation and transplantation targets are phased this year to better track our progress out of the pandemic. Based on April data, we remain cautiously optimistic about the recovery at this early stage.
- We are seeing increased demand for key tissue and eye products, but also a growing organ transplant list. Consent / authorisation rates, deceased donors and deceased donor transplants were short of our ambitious targets for April – but are trending upwards on a "Moving Annual Total" basis. Living donation is being gradually re-established by NHS partners.
- We are continuing to focus operational teams on the core drivers of more transplants, including deceased donation consent /authorisation rates and identifying more eye donors.

**Serious Incidents (Target 0)**

1

↑

**Serious Incidents (SIs) related to OTDT**

- **1 SI:** Corneal Retrieval and Coronial Consent
- We continue to closely monitor and learn from reported incidents.

**Consent/Authorisation (Target 74%)**

67%

↓

**Organs Donation**

Key measures trended down in-month (Amber & Red) while trending up on a *Moving Annual Total* basis:

- Referral and SN-OD presence strong, with family refusals in complex cases being the driver of a lower consent rate in-month.
- MAT consent / authorisation rate of 69% remains on-target.
- Ongoing and new COVID-19 protocols still impeding some possible donations / transplants.
- 1,252 deceased donors MAT (Green).

**Deceased Donors (Target 127)**

113

↓

**Deceased Transplants (Target 321)**

279

↓

**Living Transplants month in arrears**

45

↑

**Active Transplant List**

5,031

↑

**TES - Income (Target = 1,063k)**

£1,292k

↑

**Tissues and Eyes Donation**

- Ocular donations in April 2021 were down slightly from March.
- Because issues for transplant increased above target, we are monitoring stock closely.
- We are also continuing to focus on increasing ocular donations further through Level 1 Organ-Donating Hospitals.
- Data capture for audit of ocular consent from organ donors has been completed by operational leads. Quality assurance will be complete by the end of May.

**TES - Contribution (Target = 4,017k)**

TBC

**Customer Satisfaction (Target = 80%)**

85%

↑

**Cornea Donors (Target = 300)**

210

↓

**Sales**

- TES income for April 2021 is £165k ahead of target (subject to confirmation).
- Elective surgery restarted in March, with a large backlog to address.
- Hospitals reported that their elective capacity was c.70% in April; increase to 100% anticipated towards mid Q2.

**Cornea Issues for Transplant (Target = 231)**

312

↓

**Key notes**

**Metric boxes:** YTD targets. RAG for YTD position. Arrow indicates month-on-month trend.

**Charts:** ODT- Activity against MAT targets. TES- YTD Actuals against target. (ODT&TES G≥98%, A<98%, R<90%)

**Transplant List:** Does not accurately reflect the need for an organ transplant due to the pandemic. Different practices established across the UK and organ groups with regards to list management.

# PEOPLE SERVICES: Director Report – April 2021

## Recruitment

- Time taken to recruit has improved this month from 12.36 weeks to 9.99 weeks.
- Successful vacancies filled remained stable at 93% over this month.
- Turnover remains at 11.5%. This is now the 10<sup>th</sup> month that this figure has remained stable at close to 11.5%.
- In April there were 62 new starters with 19 colleagues being from an ethnic minority background. With 56 leavers, of which 10 were from an ethnic minority, this represents a Net Increase of 9 new ethnic minority colleagues. In Band 8 there were 7 leavers with 1 colleague from an ethnic minority leaving. 2 new Band 8 starters commenced with no new starters from an ethnic minority – a Net decrease of 1.

Ethnic Minority staff +/- net for all staff (Band 8a plus in brackets)

**+9 (-1)**

Ethnic Minority as % of new starters (8A & Above in bracket)

**30% (0%)**

Time to Recruit –Req to Start (G= <14, A= >14, <15, R= >15)

**9.99**

No of vacancies filled (G= >90, A = <90, >75, R= <75%)

**93.43**

Turnover G= <12, A = 13-20, R = >20%

**11.57%**

## Leadership and Learning

- PDPR target performance has increased from 83% to 85%.
- Mandatory Training target has remained stationary at 91%
- 59 attended leadership programmes, 23 in Inclusive Leadership, 22 in ELM and 14 in the ALM

No. accessing leadership programmes

**50**

PDPR Compliance (G= >95, A= >80, <95, R= <80)

**85%**

MT Compliance (G = >95, A=>80, <90 R= <80%)

**91%**

NHSBT Engagement Score (n out of 10)

**7.8**

Course	Ethnic Minority	%	White	%	Not Stated	%	Total
Advanced Line Manager	3	21%	11	79%	0	0%	14
Effective Line Manager:	3	14%	18	82%	1	5%	22
The Inclusive Leader	5	22%	15	65%	3	13%	23
Total Delegates (March)	1	19%	44	75%	4	7%	59

## Case Resolution

- Live cases at month end is 25 cases.
- 20 out of 25 cases are on track within the 90-day SLA
- 5 cases are over-running against the SLA. 1 in Donor Exp, 1 in Group and 3 in Blood Supply - Blood Donation.
- 3 of the over-running cases are Dignity at Work cases registered with 2 external consultants, all of which are associated with the same BD team and 1 DAW in Donor Experience which is registered with external consultant complex case unit support.
- 9 new cases in April 2021 = 5 Disciplinary, 3 Grievance, 0 Dignity at Work, 0 Capability, 1 Probation.
- 3 Ethnic Minority, 0 Disability and 0 LGBT+ protected characteristic considerations are registered for new April cases.
- 7 cases closed in April with an average case time-line of 69 calendar days.

No. of new cases last period (last month in bracket)

**9 (13)**

No. of closed cases last period (G = 80%+, A = 70-80%, R= less than 70%)

**7 (86%)**

No. of live cases month end

**20**

Current live cases within SLA (G= 80% plus, A = 70-80%, R= less than 70%)

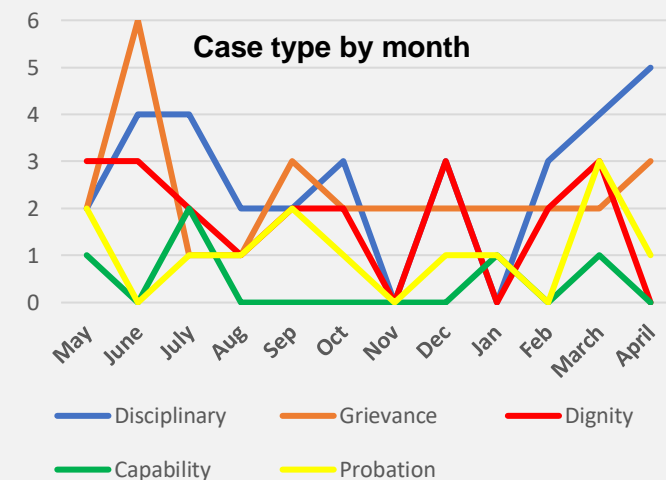
**25 (80%)**

Protected Characteristics Live Cases month end

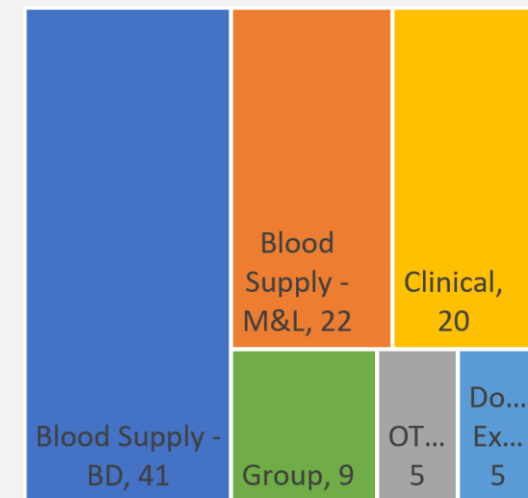
**Ethnic Minority**  
7 (28%)

**Disability**  
1 (11%)

**LGBT+**  
0 (0%)



Case distribution April 20- April 21



# DIGITAL, DATA AND TECHNOLOGY SERVICES: Director Report – April 2021

## Key DDTs Updates and Risks

- System availability for April was on target across Critical National Infrastructure and Key Hospital Systems but we did experience an issue on our corporate websites
- The Session Solution pilot has been extended across more sites as we work to fix a small technical issue, feedback from staff has been very positive and we are confident the issue will be resolved enabling full deployment.
- Releases this month include improvements to the Organ Donation Registration journey to improve data integrity and the capture of protected characteristics, extending access to Sp-ICE to the Welsh Blood Service to enable them to access patient reports at the point of care and improvements to the Session Solution application following pilot feedback and testing.
- The ABO CIO Working Group have produced an overview of the digital landscape across our services and agreed to collaborate further on cyber and decision support automation and personalisation through better use of data.

## Key Systems Availability

Critical National Infrastructure (CNI)				Key Public Systems (KPS)		Key Hospital Systems (KHS)		
<b>Overall CNI Availability</b> <span style="font-size: 24pt; font-weight: bold;">100%</span> ↔				<b>Overall KPS Availability</b> <span style="font-size: 24pt; font-weight: bold;">99.84%</span> ↑		<b>Overall KHS Availability</b> <span style="font-size: 24pt; font-weight: bold;">100%</span> ↑		
<b>Pulse</b> (Target = 99.95%) <span style="font-size: 24pt; font-weight: bold;">100%</span> ↔	<b>Hematos</b> (Target = 99.95%) <span style="font-size: 24pt; font-weight: bold;">100%</span> ↔	<b>National Transplant Database (NTxD)</b> (Target = 99.95%) <span style="font-size: 24pt; font-weight: bold;">100%</span> ↔	<b>Organ Donor Register (ODR)</b> (Target = 99.95%) <span style="font-size: 24pt; font-weight: bold;">100%</span> ↔	<b>Donor Portal</b> (Target = 99.90%) <span style="font-size: 24pt; font-weight: bold;">100%</span> ↔	<b>Corporate Websites</b> (Target = 99.00%) <span style="font-size: 24pt; font-weight: bold;">99.67%</span> ↑	<b>Transport Mgt</b> (Target = 99.70%) <span style="font-size: 24pt; font-weight: bold;">100%</span> ↑	<b>Online Blood Ordering System (OBOS)</b> (Target = 99.90%) <span style="font-size: 24pt; font-weight: bold;">100%</span> ↔	<b>SO99</b> (Target = 99.90%) <span style="font-size: 24pt; font-weight: bold;">100%</span> ↔

- **Critical National Infrastructure** and **Key Hospital Systems** all met service targets in reporting period
- **Key Public Systems** - Donor Portal met service targets but we did experience a loss of access to Blood.co.uk for a period of 142 minutes. The root cause of the problem has been identified and resolved with further work ongoing to avoid a recurrence of the problem.

## Cyber and Information Governance

<b>ICO Incidents (Target =&lt;5)</b> <span style="font-size: 24pt; font-weight: bold;">3</span> ↔		<ul style="list-style-type: none"> <li>• <b>ICO Incidents:</b> Reportable Information Commissioner’s Office (ICO) incidents from May 2020 until April 2021: there have been three reportable incidents; one had been closed with the ICO but the requestor has subsequently asked for it to be re-opened. This is being actively managed by the Information Governance team in conjunction with the relevant affected Directorate. The other two are on-going but being managed within expected SLAs. This metric is amber due to the long-running nature of one of the ICO incidents.</li> <li>• <b>DPIA’s subject to COPI:</b> The Data Protection Impact Assessments (DPIA) subject to Control of Patient Information (COPI): 29 data flows that are reliant upon the COPI notice. A master DPIA for the NHS Digital set (that underpins a majority of the COPI notices data flows) has been drafted and is going through sign-off. This will expedite the completion of the remaining COPI orientated DPIAs</li> <li>• <b>DSPT Mandatory Requirements:</b> Data Security and Protection Toolkit Performance 2020 is 92.45%. Work on collating the 2021 DSPT submission is currently underway. Preliminary analysis indicates an improved position from the 2020 submission.</li> </ul>
<b>DPIAs subject to COPI</b> <span style="font-size: 24pt; font-weight: bold;">29</span> ↔		
<b>DSPT Mandatory Requirements</b> (G = 100%; A = >90%; R = <90%) <span style="font-size: 24pt; font-weight: bold;">92.45%</span>		

# Appendix to NHSBT Board Performance Report

## Performance Charts & Graphs

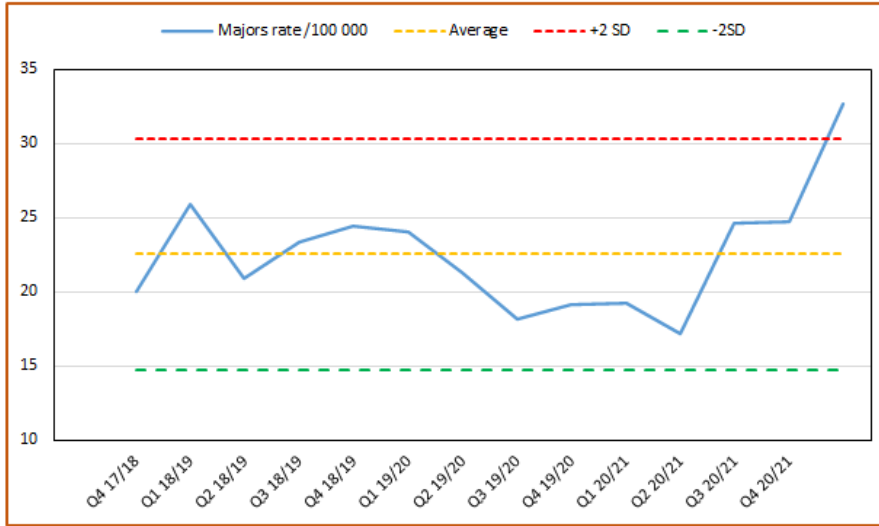
### April 2021

Contents	Page
1. Safety & Compliance	2
2. Donor Experience	3-4
3. Blood	5-12
4. Clinical Services	13-16
5. OTDT	17-21
6. Corporate Services	22
7. Index	23

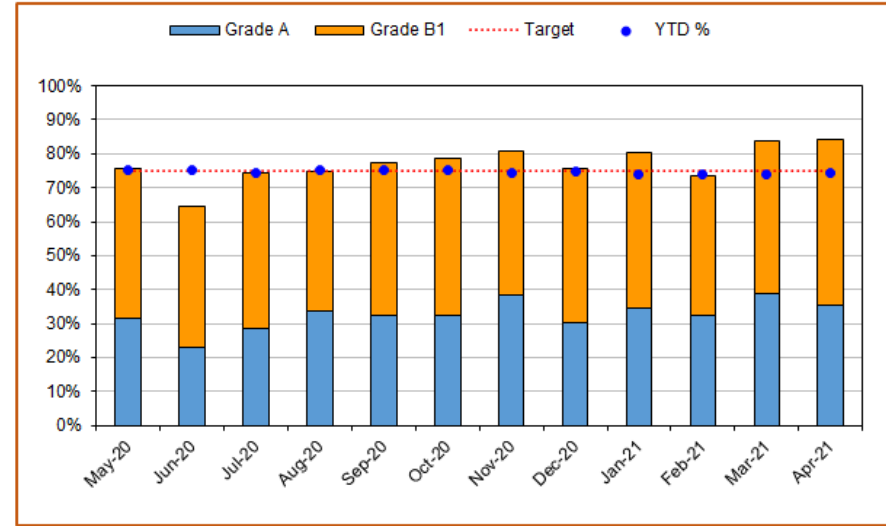
## Monthly Performance Report - As at the end of April 2021

### NHSBT - Safety and Compliance

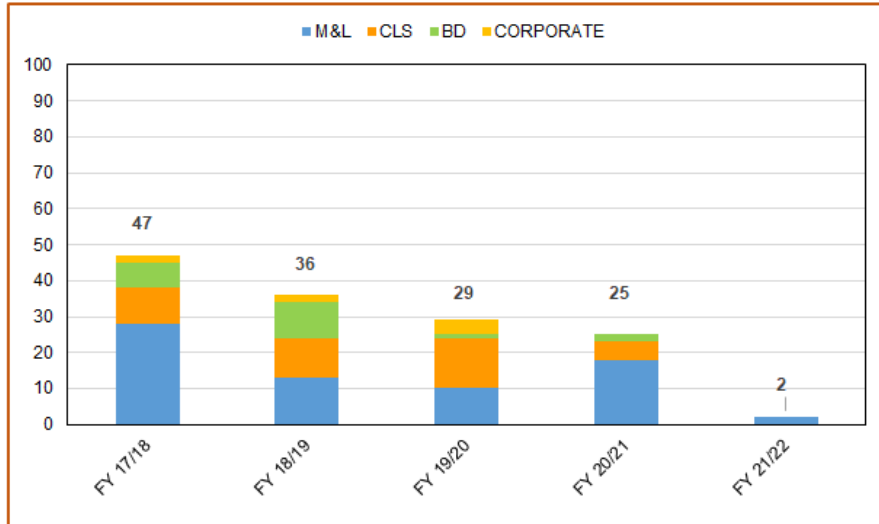
#### 1. Major QIs raised per month - Blood Supply Directorate



#### 2. % of Patients Receiving Grade A or B1 HLA Matched Platelets



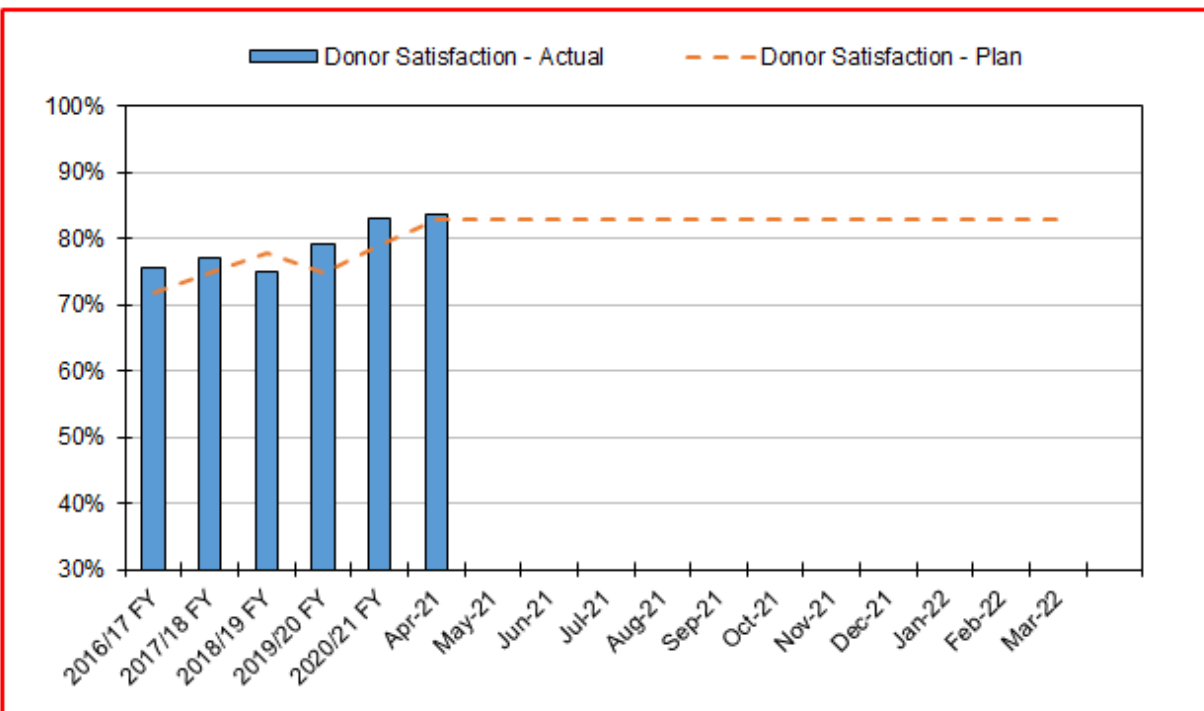
#### 3. Reports to SABRE



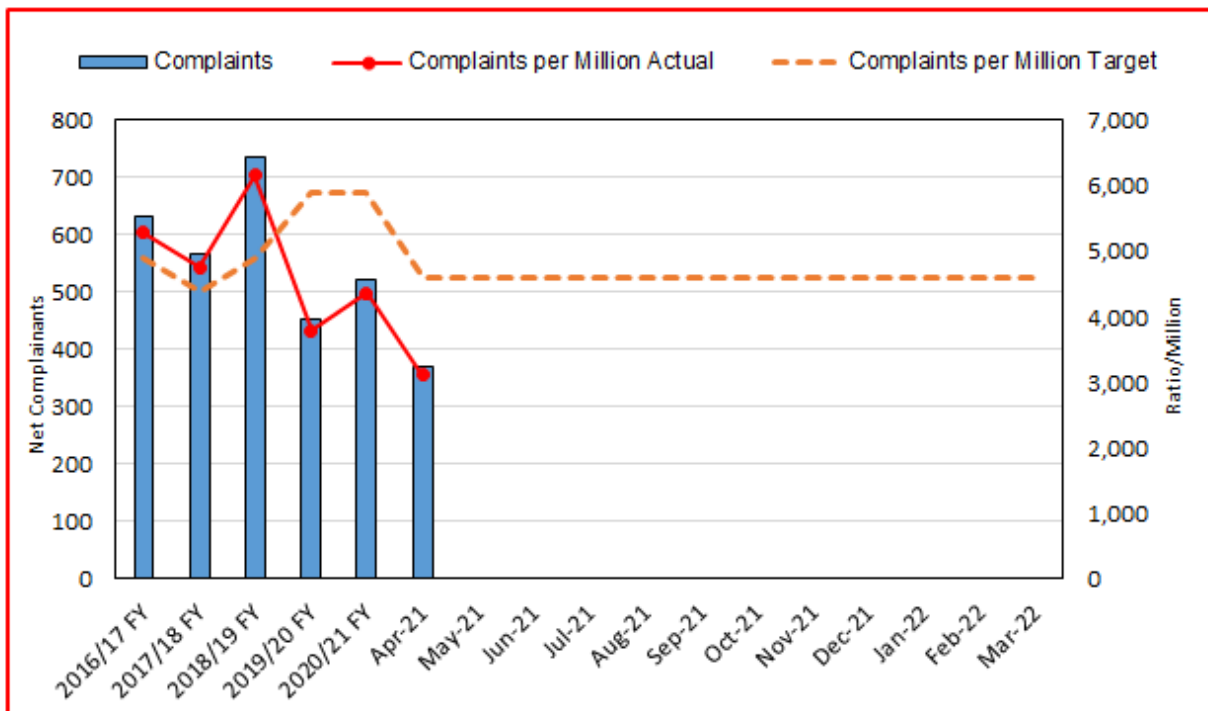
## Monthly Performance Report - As at the end of April 2021

### Donor Experience - Donor Satisfaction

#### 14. Donor Satisfaction



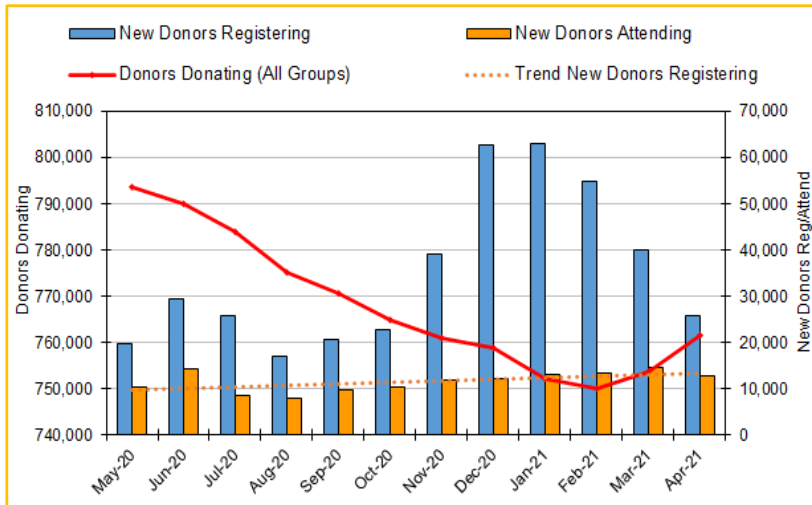
#### 15. Donor Complaints



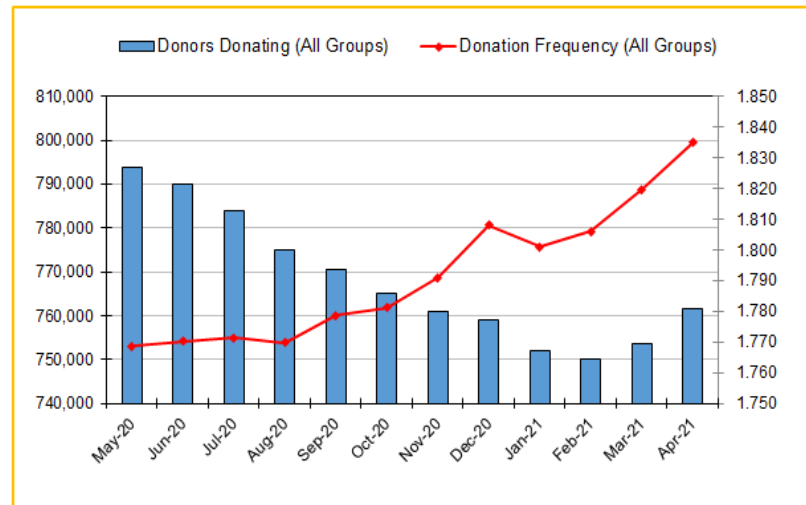


Monthly Performance Report - As at the end of April 2021  
 Donor Experience & Blood Supply - Donor Base & Donation Frequency

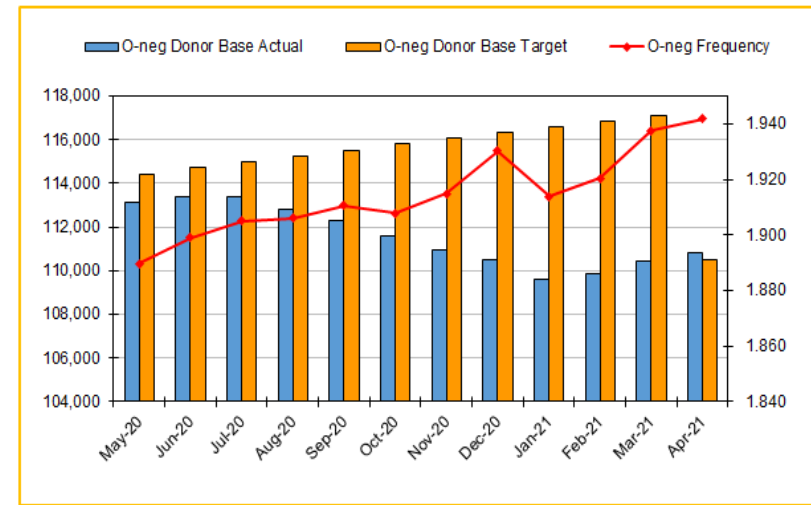
20. Donor Base All Groups



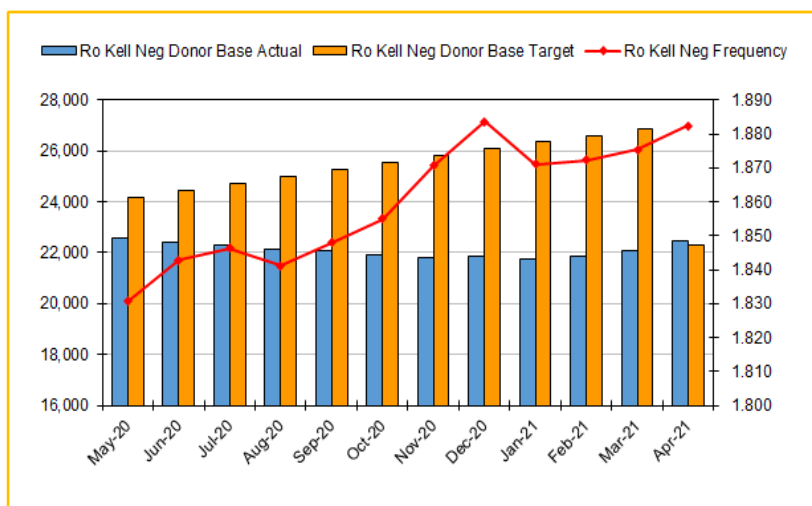
21. All Groups: Donor Base and Frequency of Donation



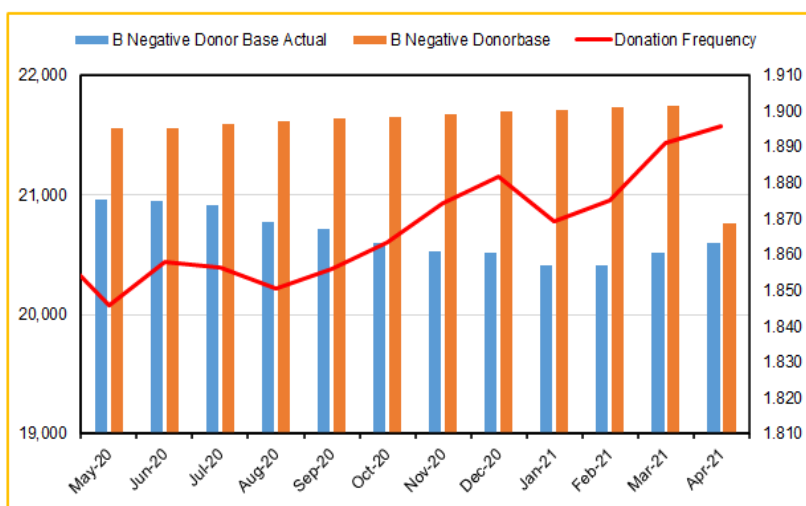
22. O Neg: Donor Base and Frequency of Donation



23. Ro Kell Negative Donor Base and Frequency of Donation



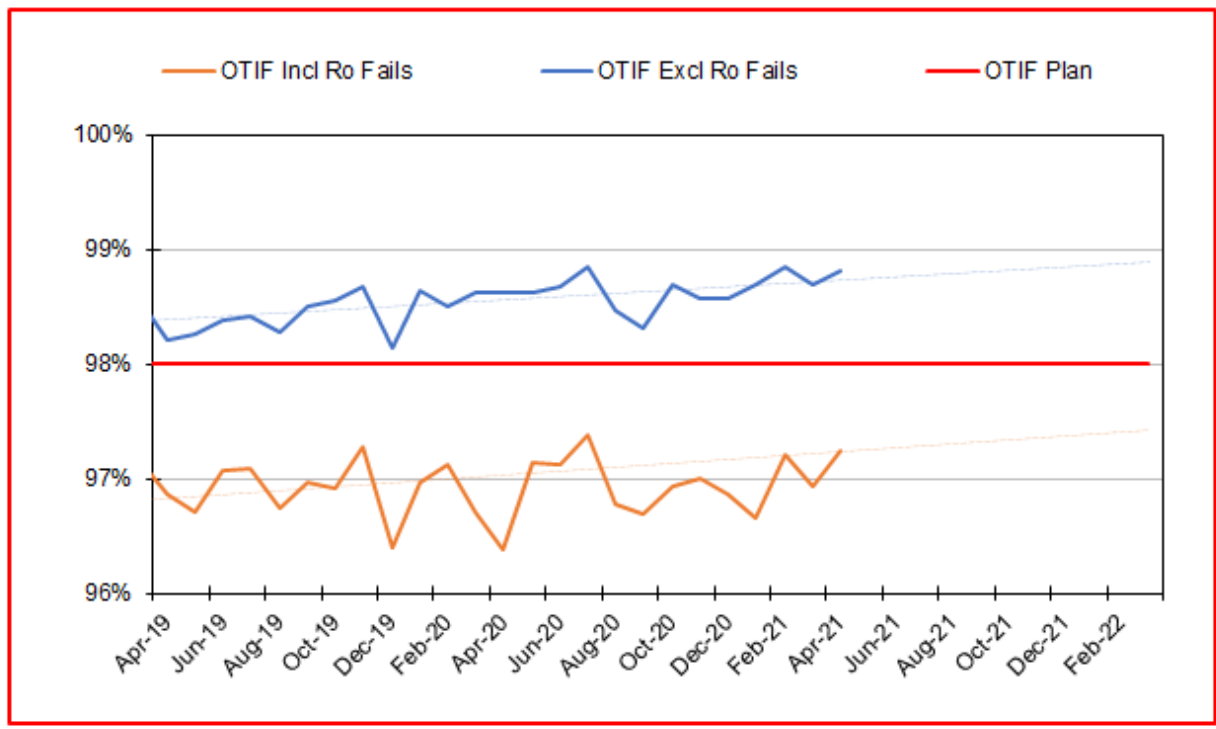
24. B Negative Donor Base and Frequency of Donation



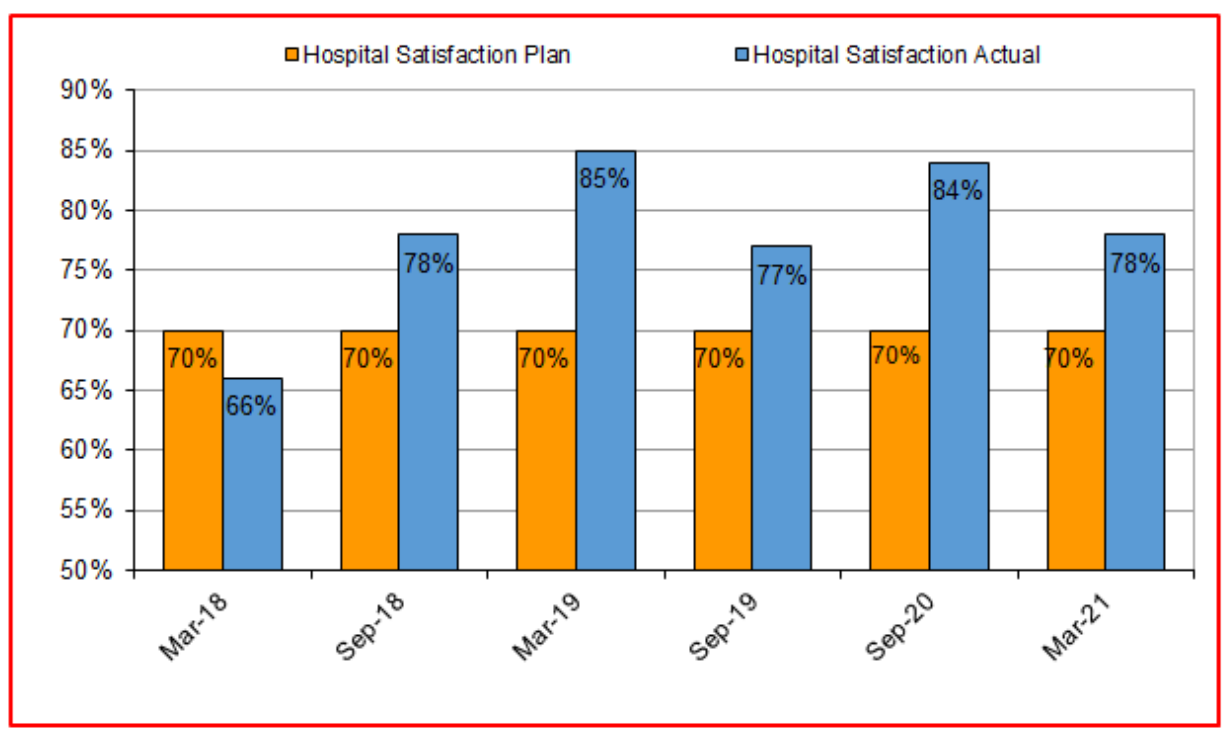
## Monthly Performance Report - As at the end of April 2021

### Blood Supply - Customer Service

#### 4. Percentage of Products Issued OTIF (excluding Ro 'in full' fails)



#### 5. Hospital Satisfaction - Hospital Services

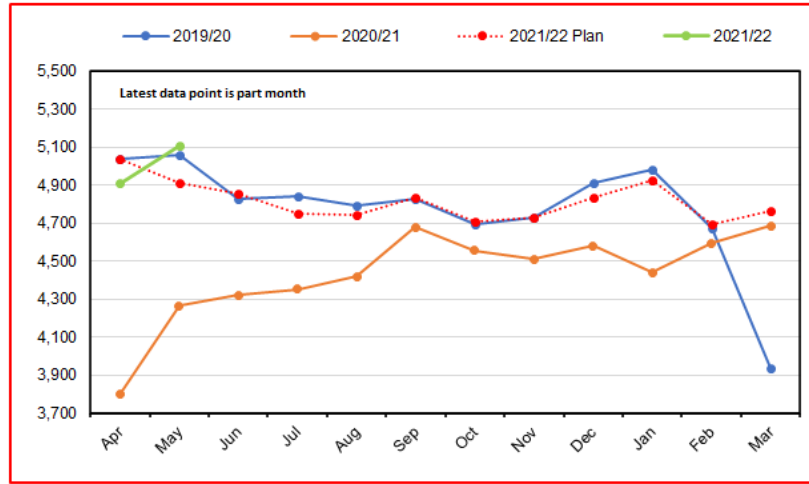


## Monthly Performance Report - As at the end of April 2021 Blood Supply - Red Cell Issues & Demand

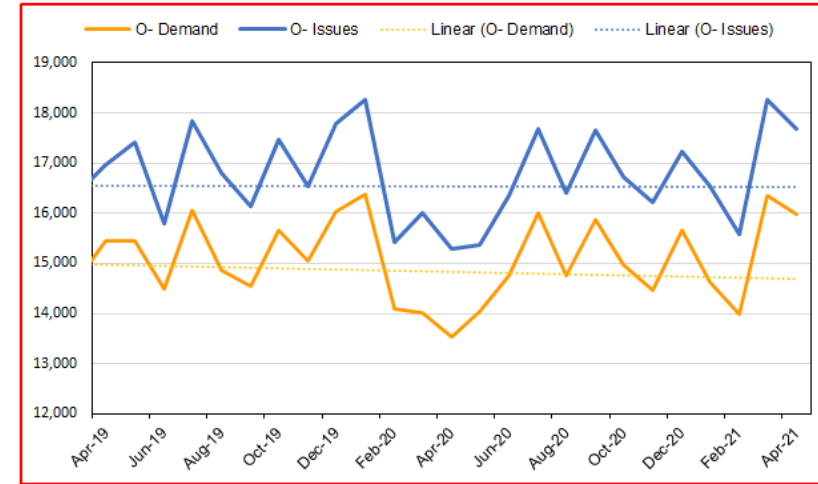
**6. Red Cell Supply - Year to Date by Blood Group**

Blood Group	2021/22 - YTD April 2021	2020/21 - YTD April 2021	Change
A Neg	8,940	7,805	14.5%
A Pos	32,721	24,783	32.0%
AB Neg	750	554	35.4%
AB Pos	2,079	1,677	24.0%
B Neg	3,232	2,680	20.6%
B Pos	9,208	7,331	25.6%
O Neg	17,670	15,277	15.7%
O Pos	40,741	30,409	34.0%
<b>Total</b>	<b>115,341</b>	<b>90,517</b>	<b>27.4%</b>

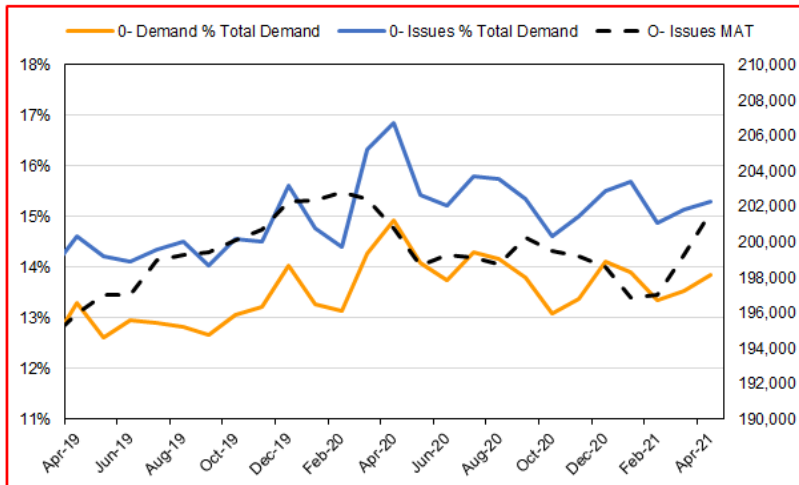
**7. Average Weekday Red Cell Issues By Month - from April 2017**



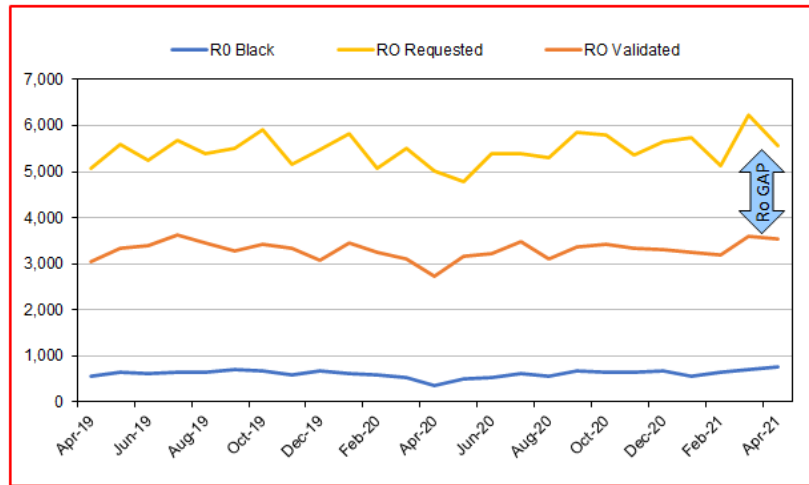
**8. O neg Red Cell Demand and Issues**



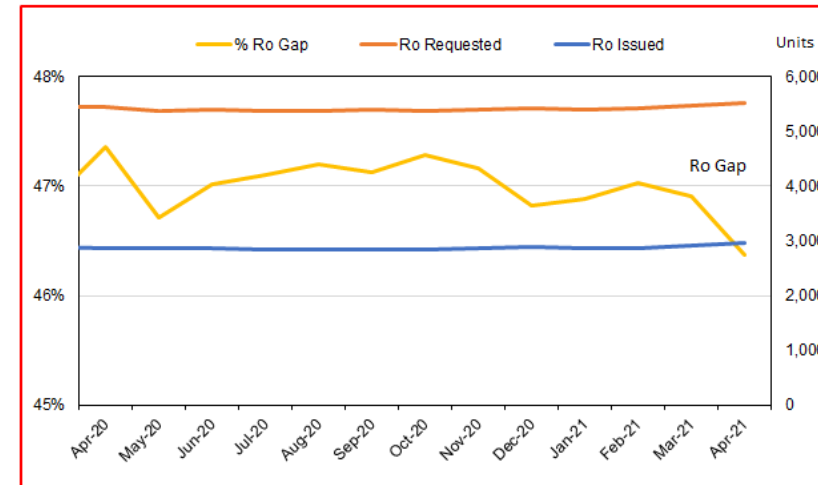
**9. O neg Red Cell Issues and Demand as % of Total Demand**



**10. Ro Gap - Red Cells Demand & Issues**

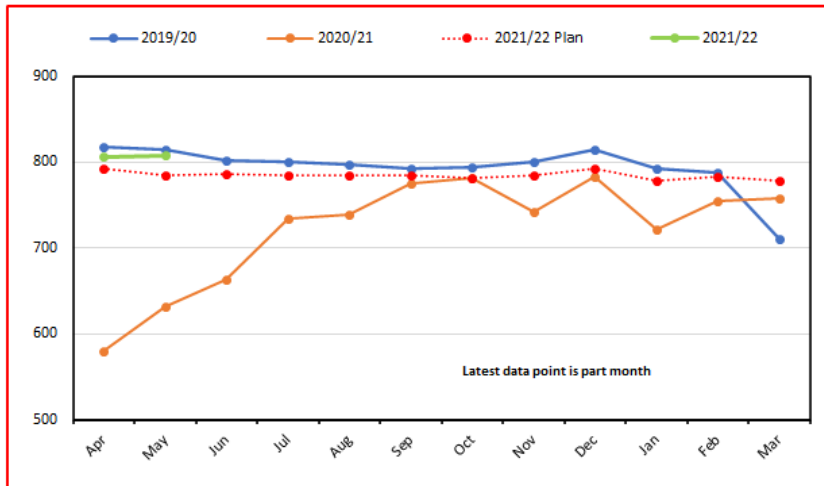


**10a. % Ro Gap**

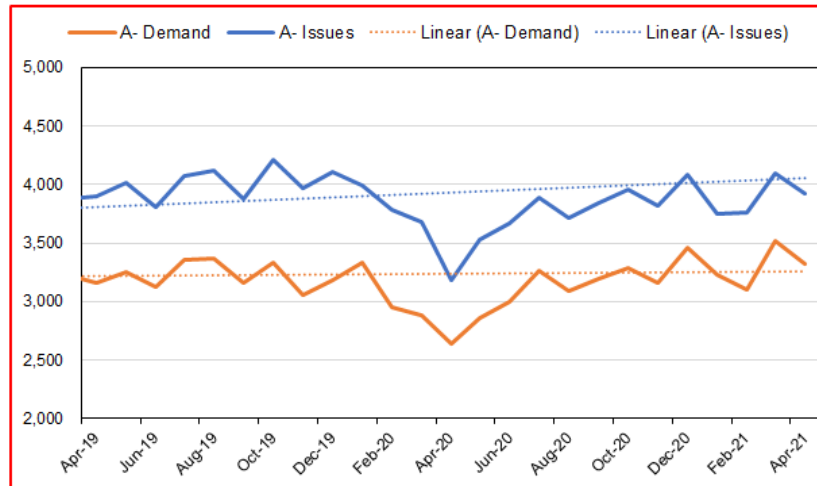


**Monthly Performance Report - As at the end of April 2021**  
**Blood Supply - Platelet Demand, Issues & Donor Base**

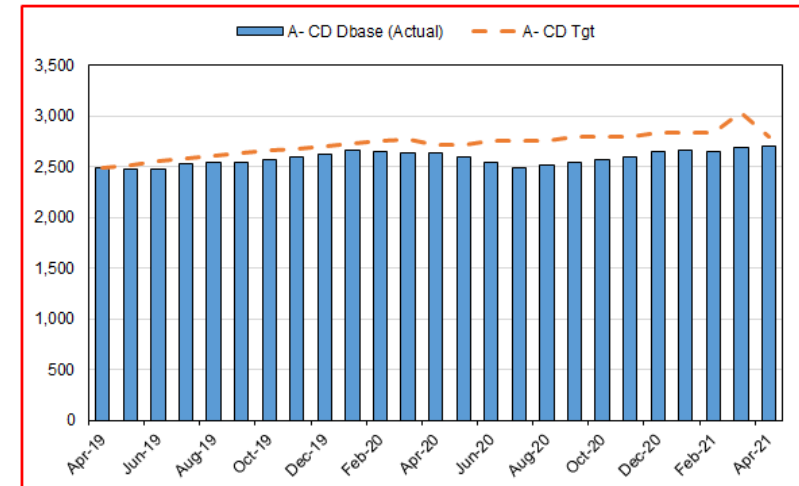
**11. Average Weekday Platelet Issues By Month - from April 2017**



**12. A neg Platelet Demand and Issues**



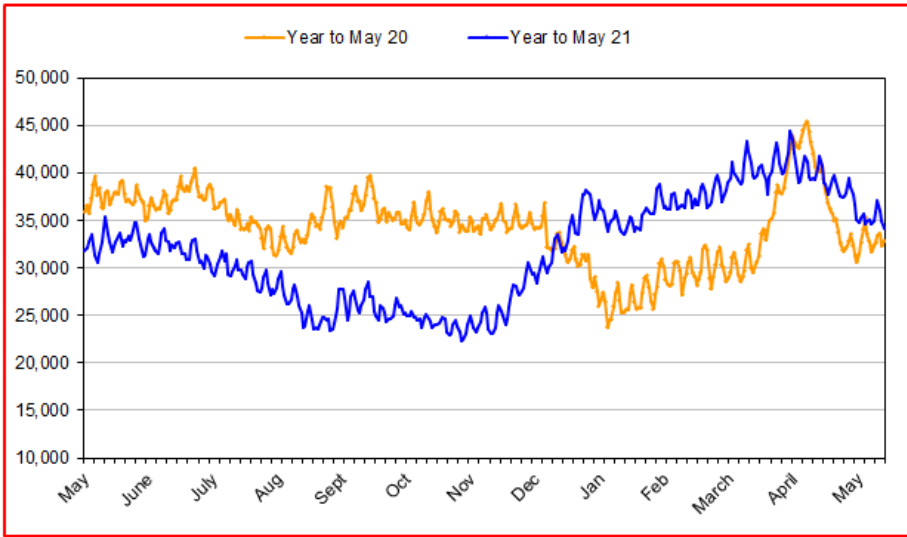
**13. A- CD Platelet Donorbase**



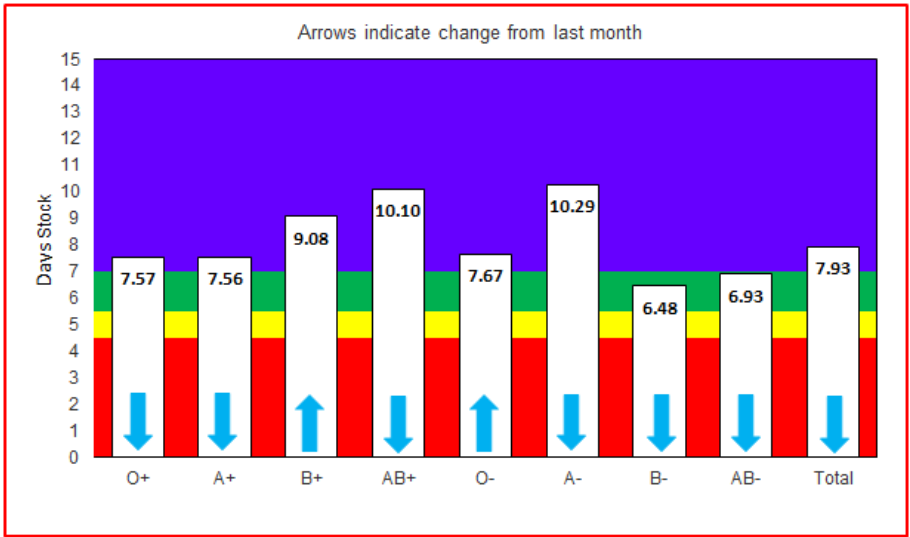
# Monthly Performance Report - As at the end of April 2021

## Blood Supply - Stock

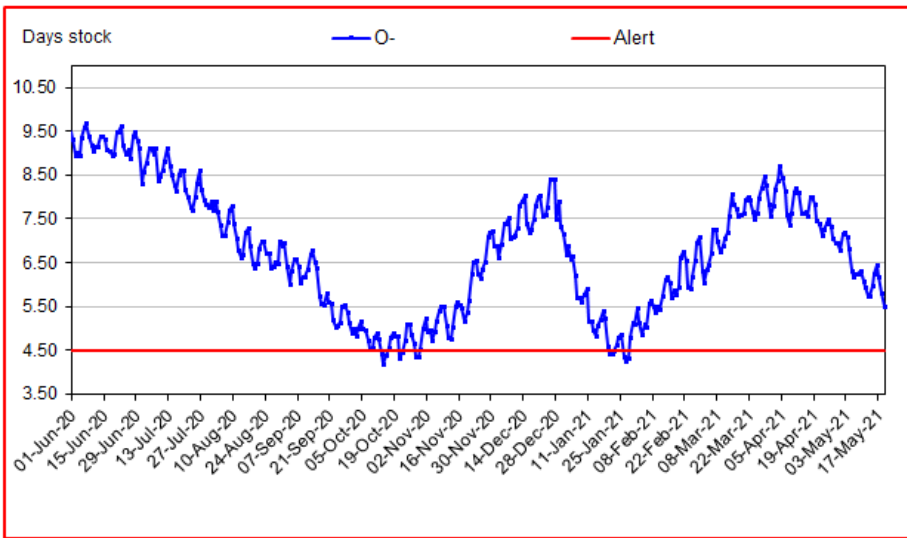
**16. Red Cell - Blood Stocks (Units)**



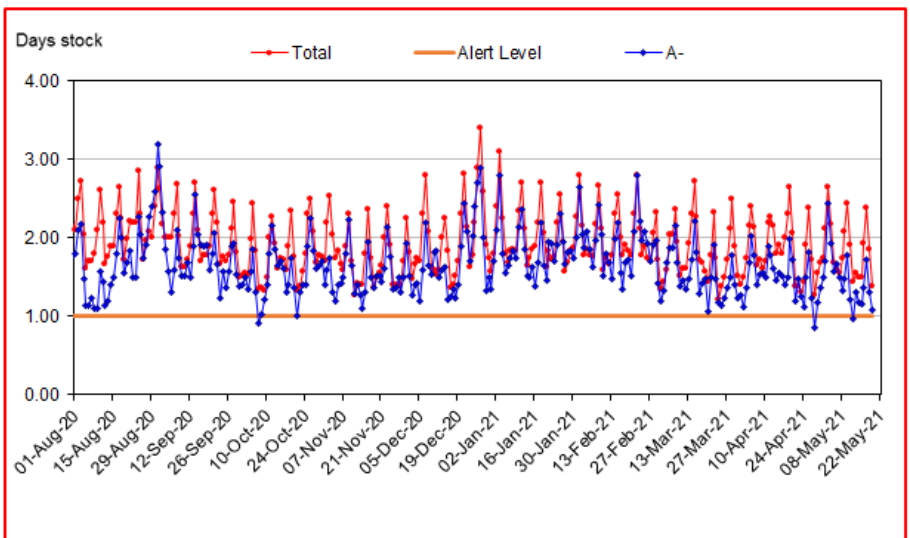
**17. Average Red Cell Stock Levels for the month by blood group**



**18. Red Cell - O neg : weekday stock levels**



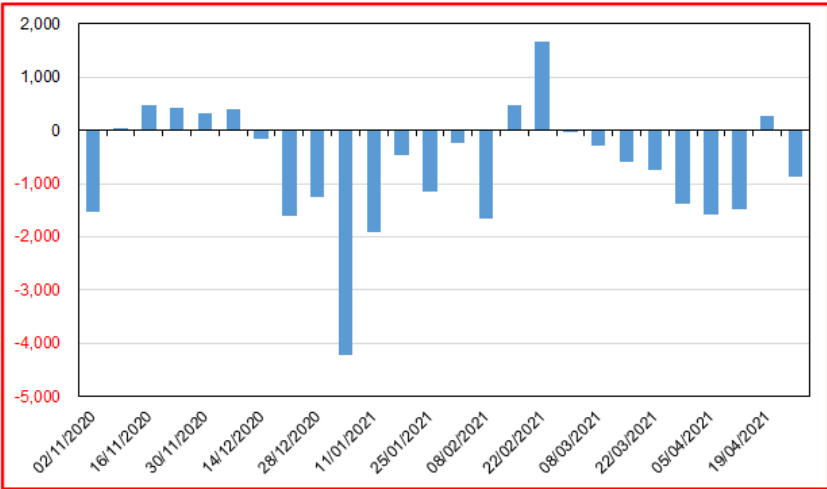
**19. Platelet - Total and A neg : weekday stock levels**



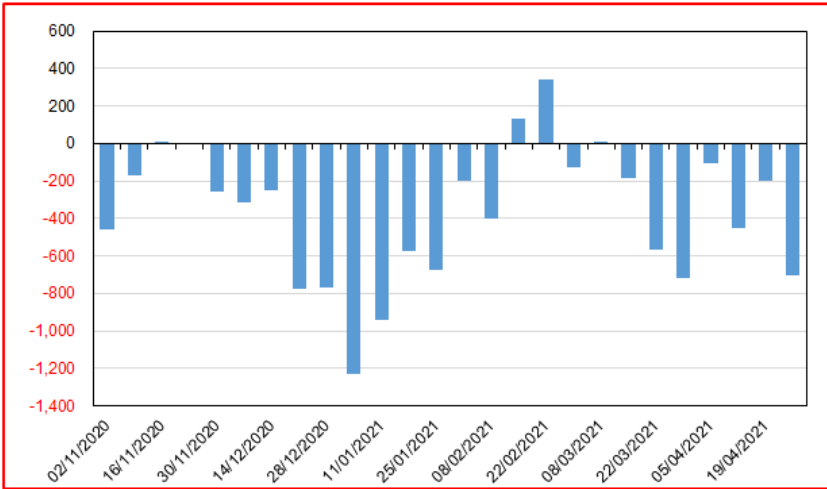
## Monthly Performance Report - As at the end of April 2021

### Blood Supply - Blood Collection Adherence to Plan

**25. Overall Weekly Collection Variance to Plan**



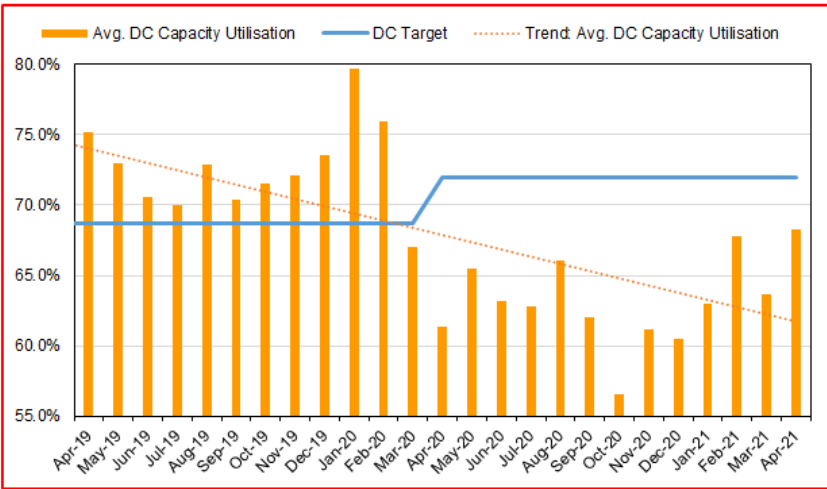
**26. Weekly Collection Variance to plan - O Neg**



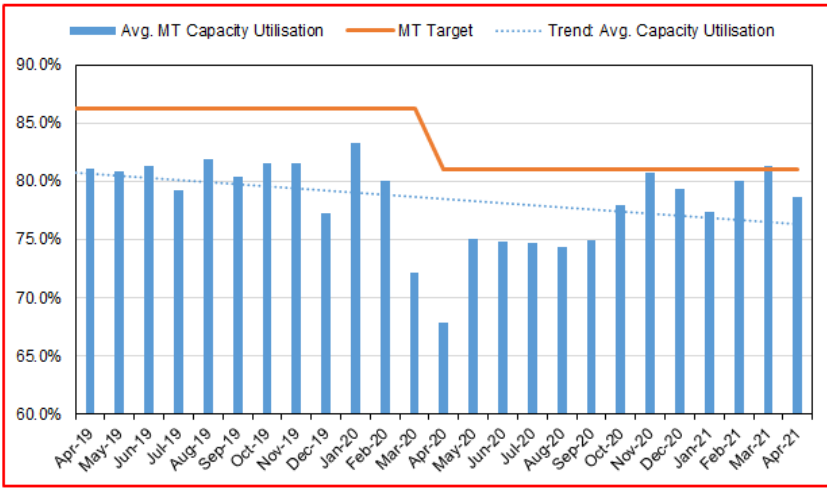
Note: Collection below plan in April 2021 following ISP request to reduce collection by 4,000 units to bring stock levels down. If the BP was amended to reflect this change, collection would have been 100.1% to target.

## Blood Supply - Collection Capacity Utilisation

**27. Capacity Utilisation - Donor Centres (DC)**

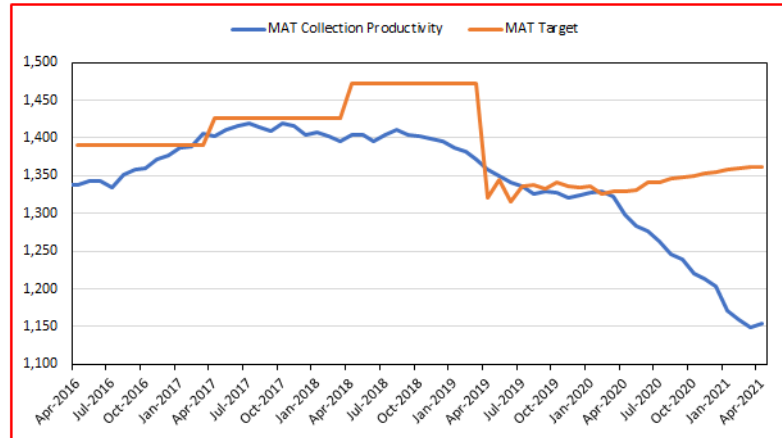


**28. Capacity Utilisation - Mobile Teams (MT)**

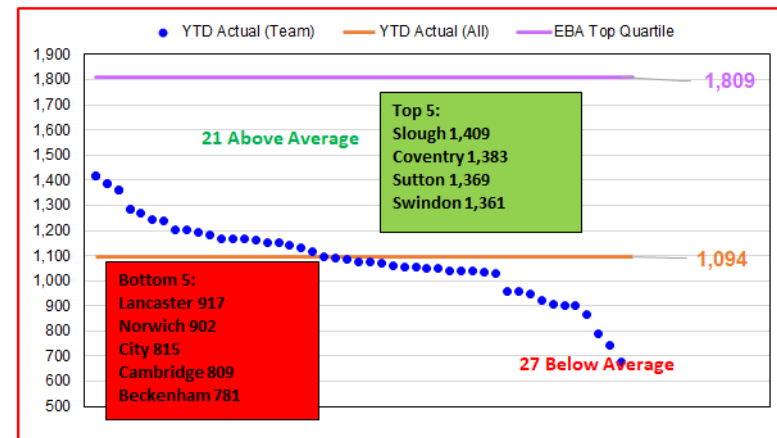


**Monthly Performance Report - As at the end of April 2021**  
**Blood Supply - Productivity**

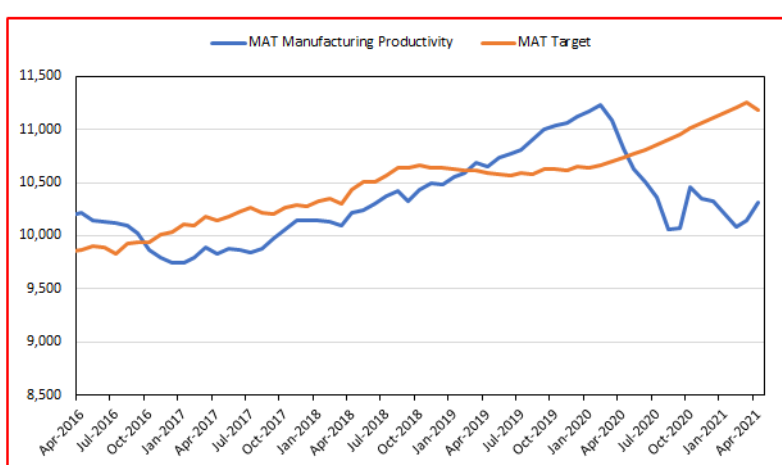
**29. Collection Productivity MAT**



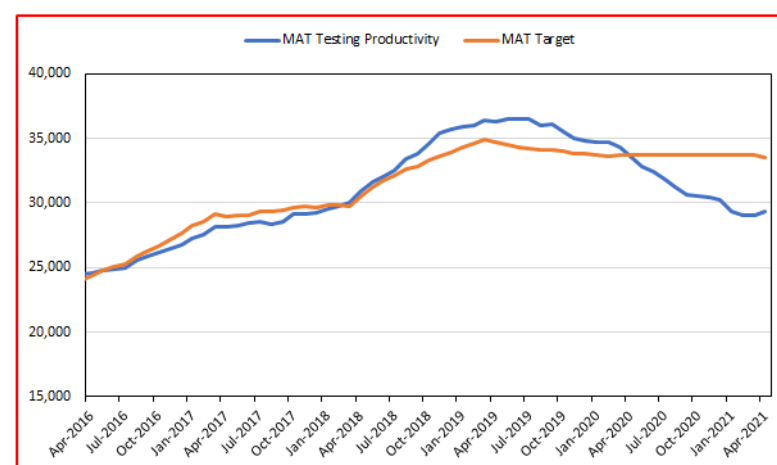
**30. Collection Productivity Distribution Mobile Teams**



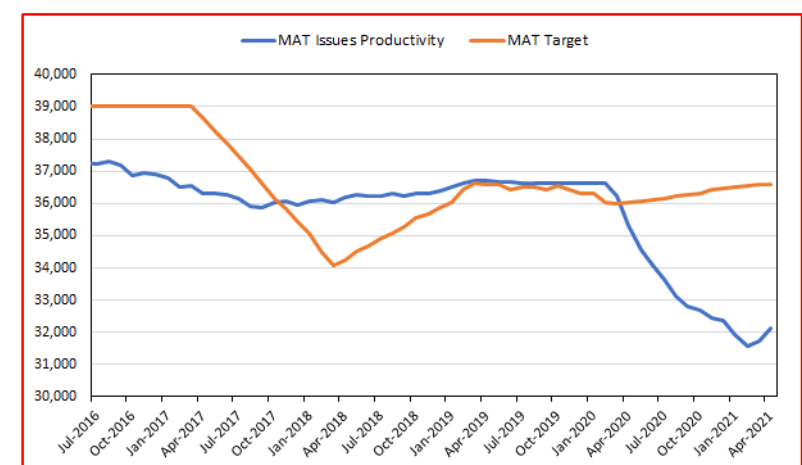
**31. Manufacturing Productivity MAT**



**32. Testing Productivity MAT**



**33. Hospital Services (Issues) Productivity MAT**



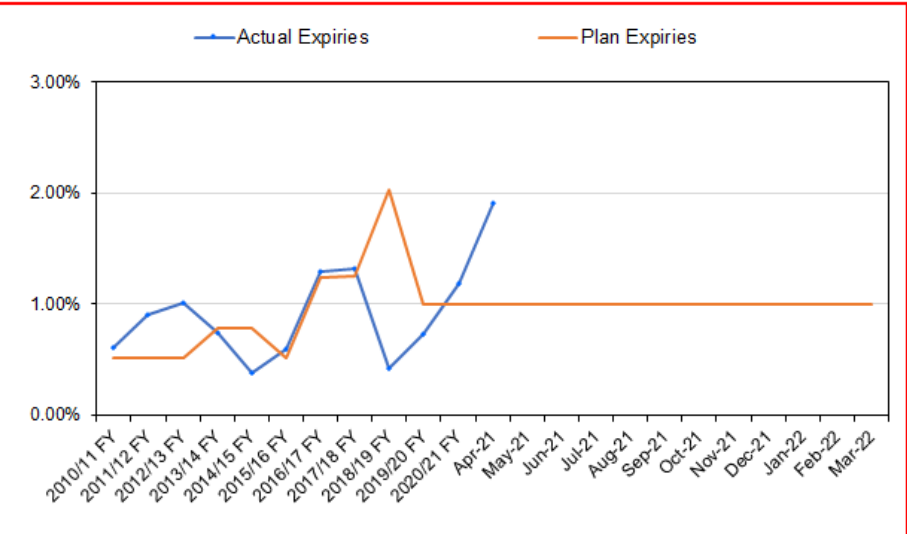
## Monthly Performance Report - As at the end of April 2021

### Blood Supply - Supply Chain Losses

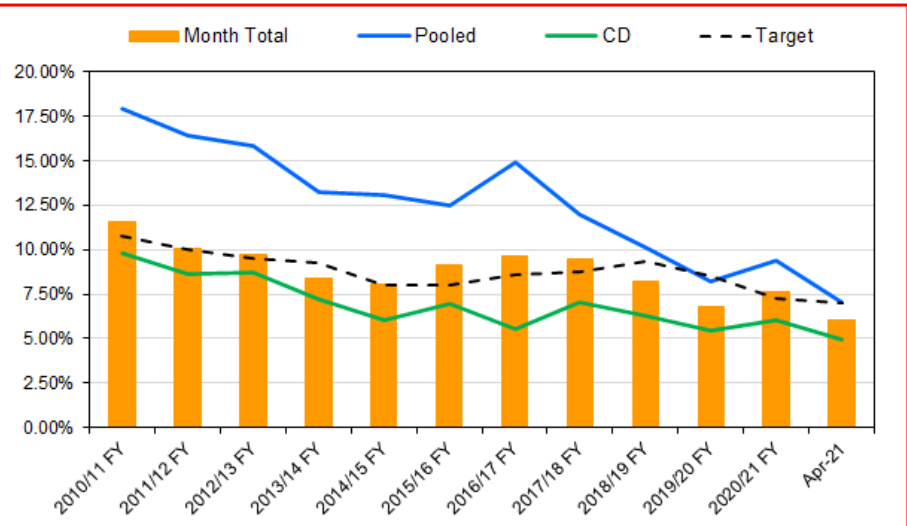
**34. % of Donations NOT Converted to Validated Red Cells**



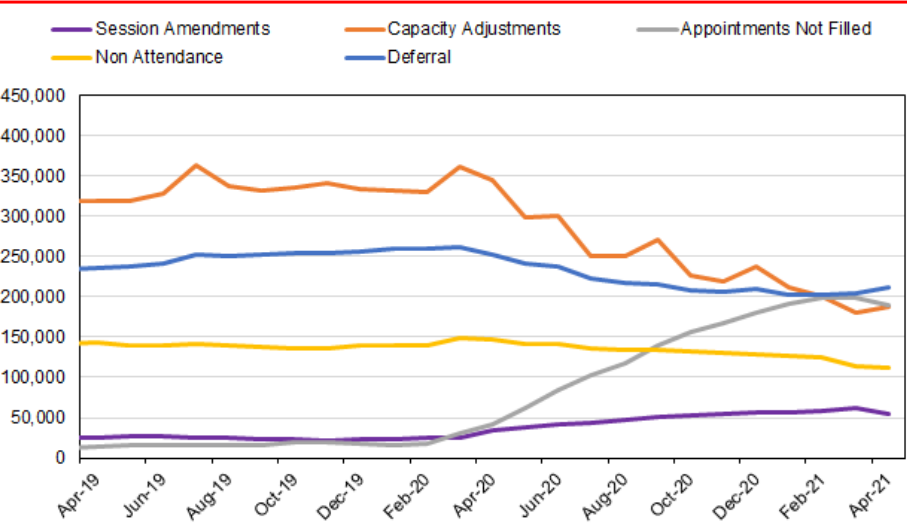
**35. Red Cell Expiries**



**36. Percentage of Platelets Produced NOT Issued**



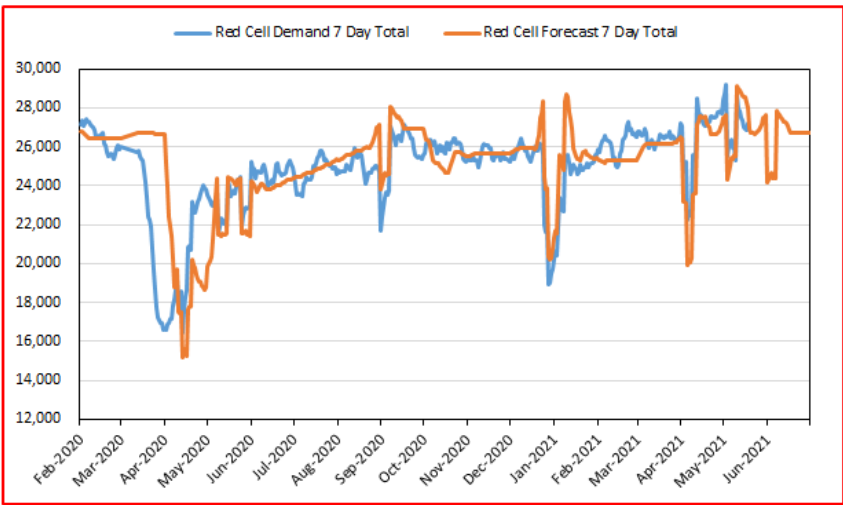
**37. Appointment Slots Not Resulting in a Validated RC (MAT)**



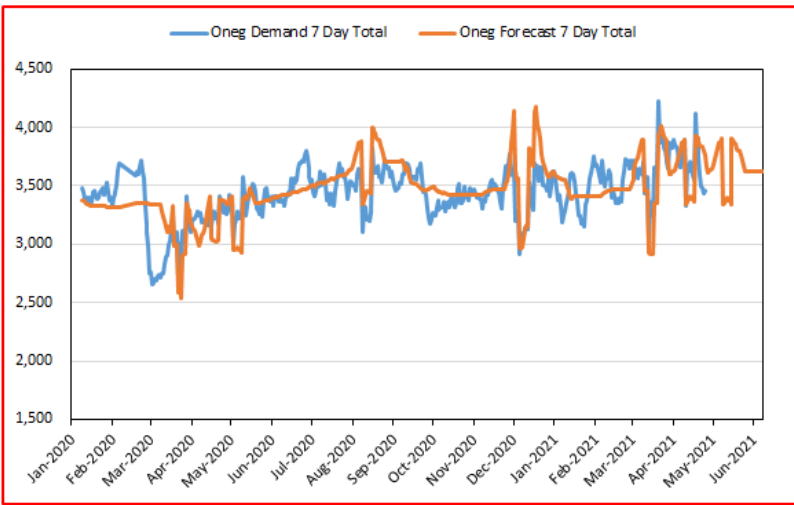


**Monthly Performance Report - As at the end of April 2021**  
**Blood Supply - Red Cell Demand 7 Day Monitoring**

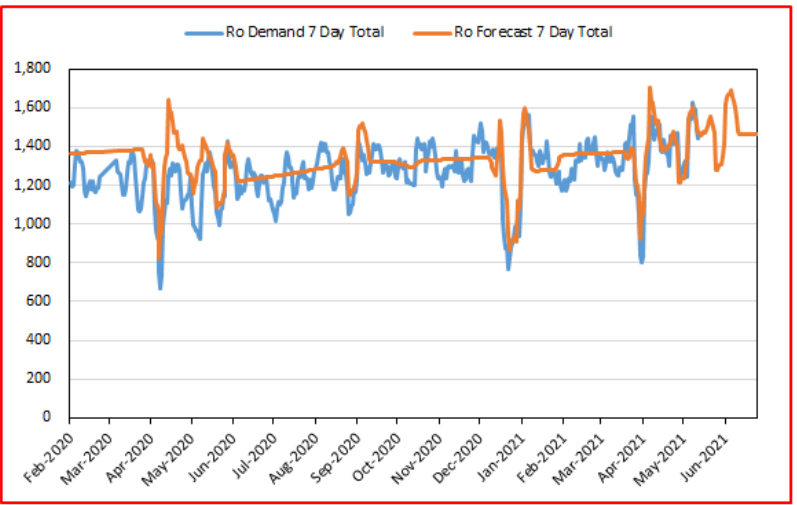
**78 Red Cell 7 Day Moving Demand**



**79 Red Cell O Negative 7 Day Moving Demand**

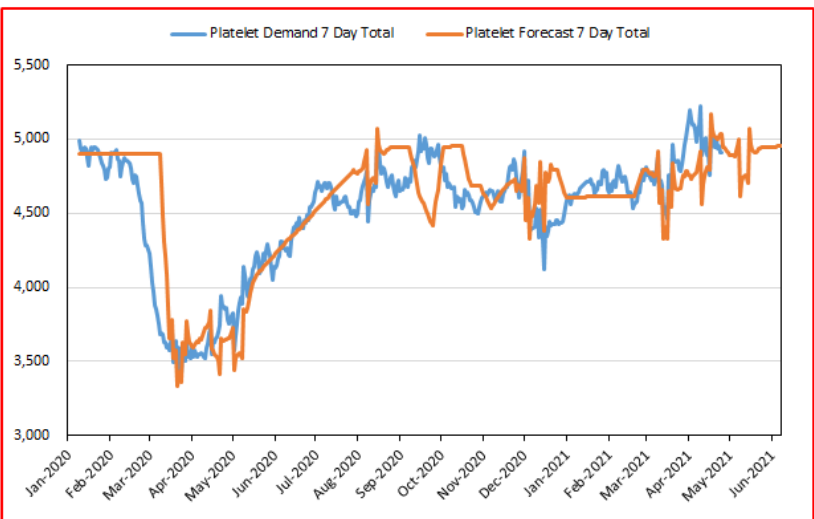


**80 Red Cell Ro 7 Day Moving Demand**

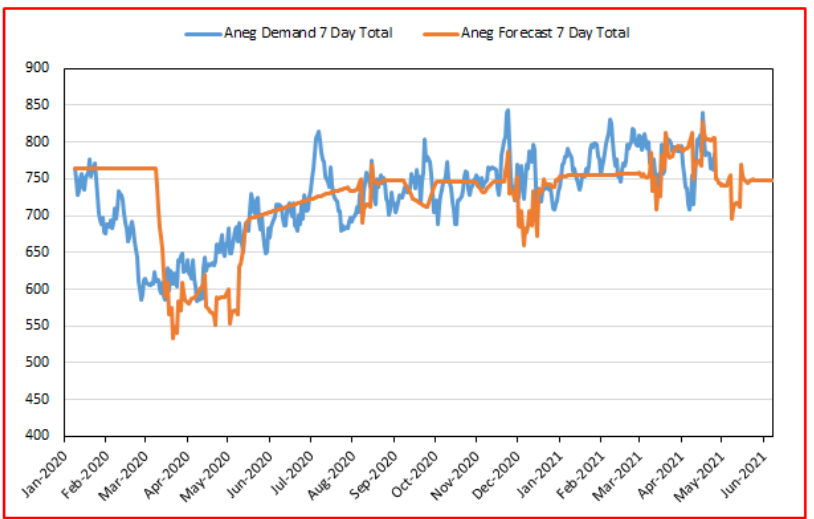


**Monthly Performance Report - As at the end of April 2021**  
**Blood Supply - Platelet Demand 7 Day Monitoring**

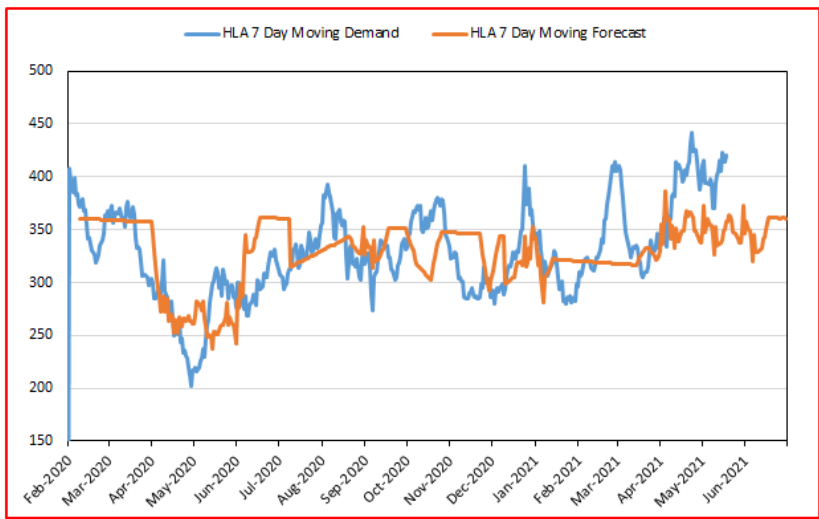
**78 Red Cell 7 Day Moving Demand**



**79 Red Cell O Negative 7 Day Moving Demand**



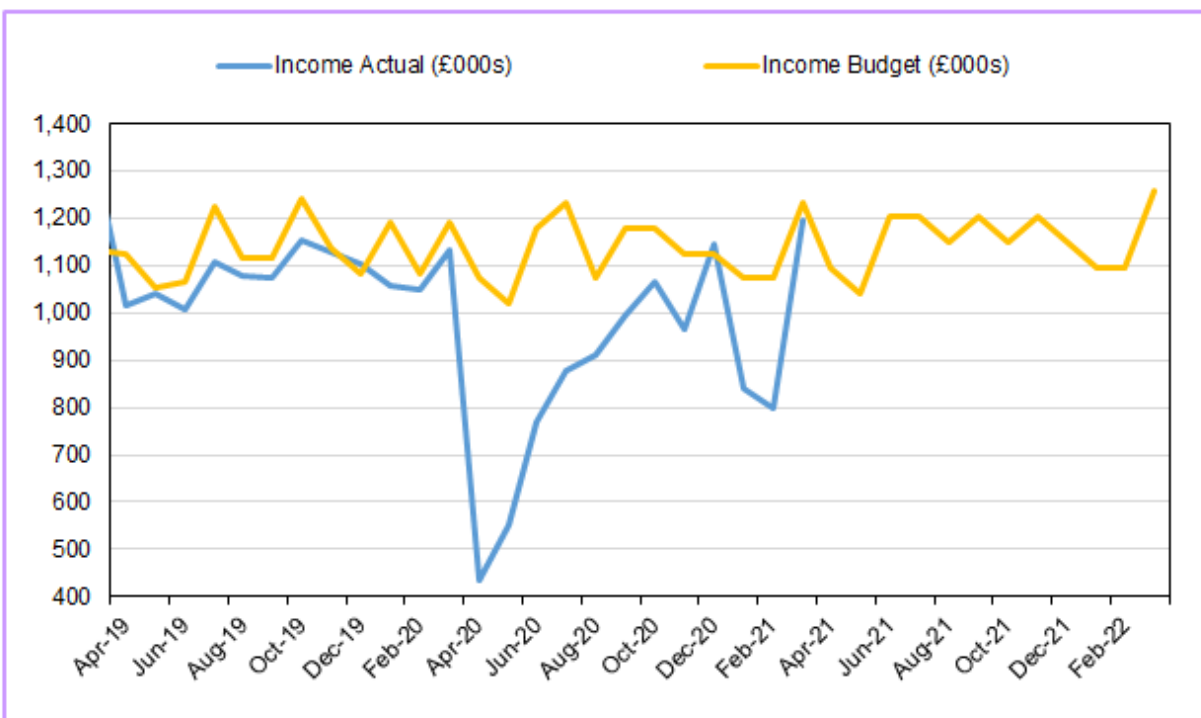
**80 Red Cell Ro 7 Day Moving Demand**



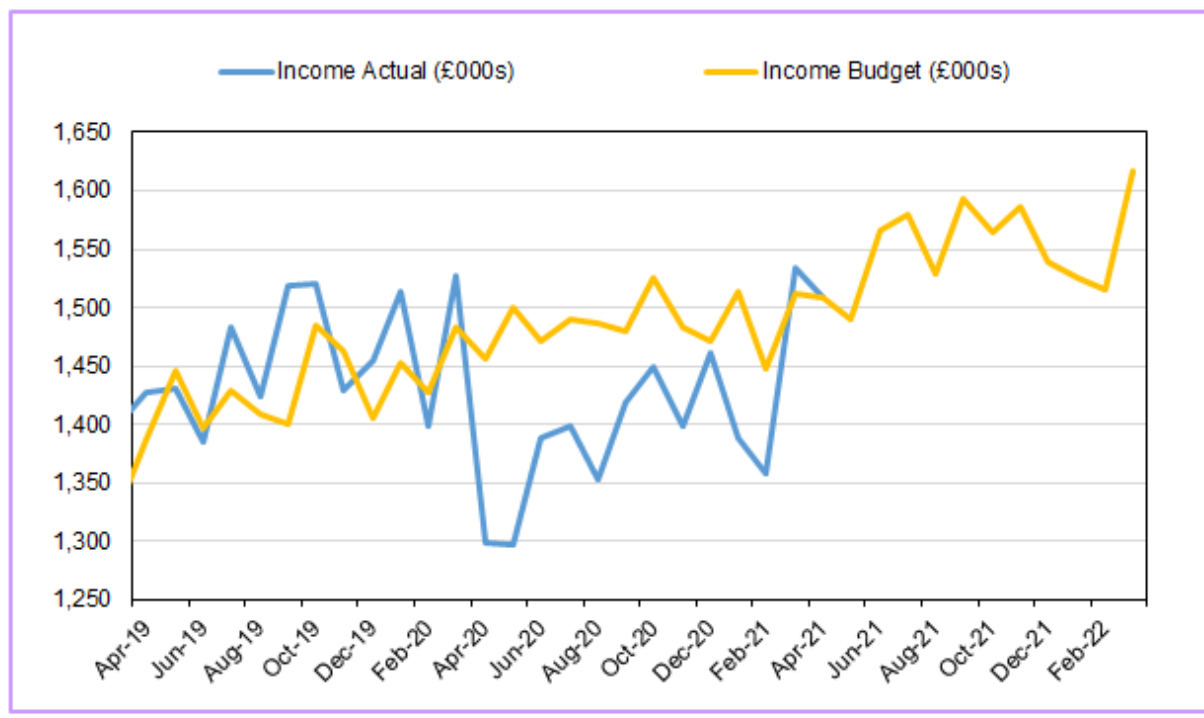
## Monthly Performance Report - As at the end of April 2021

### Clinical Services - Pathology Services Income

#### 38. H&I Income

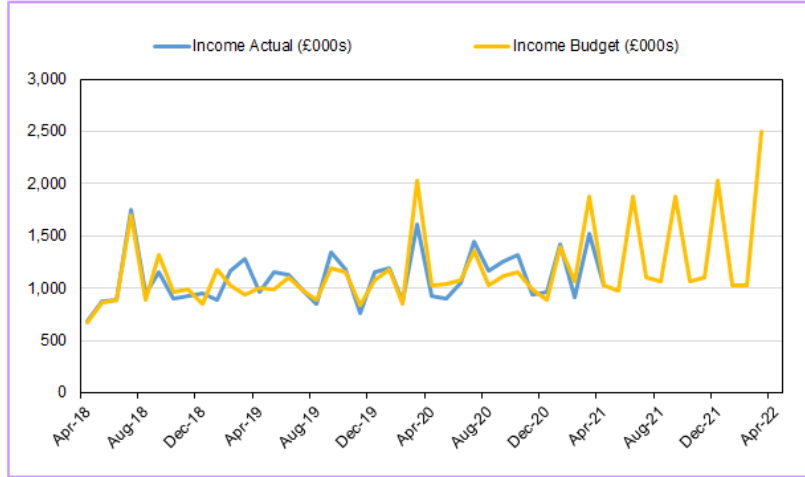


#### 39. RCI Income

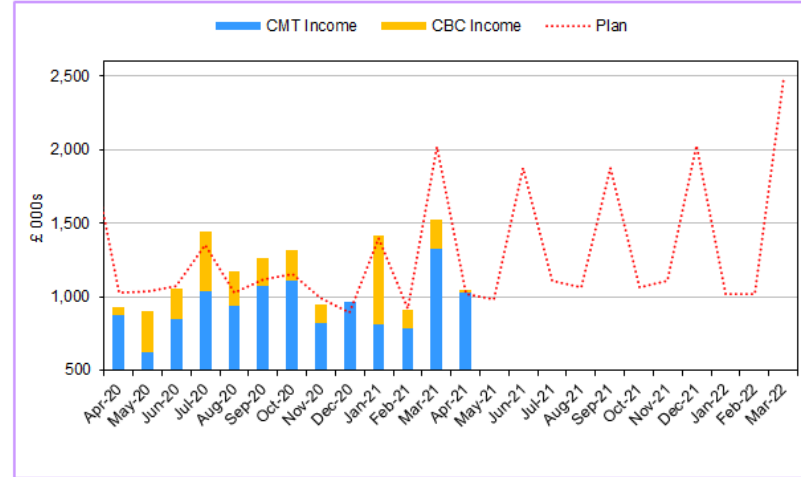


Monthly Performance Report - As at the end of April 2021  
Clinical Services - S Tem Cell and Therapeutics Income

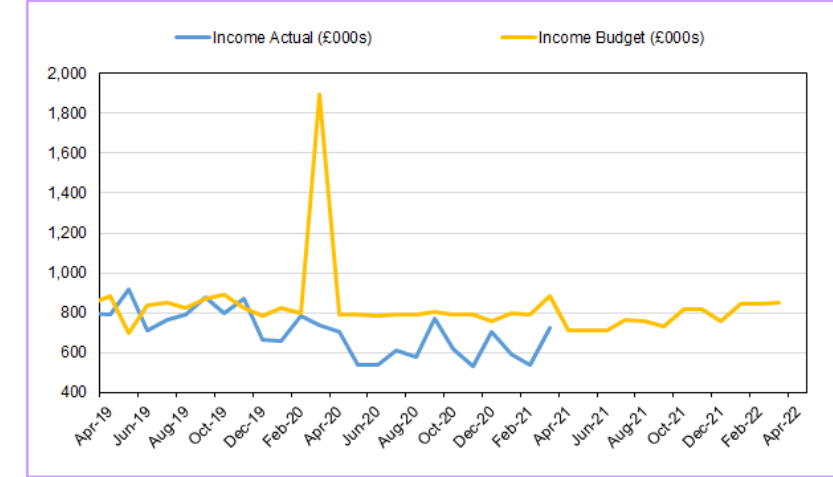
40. CMT Total Income



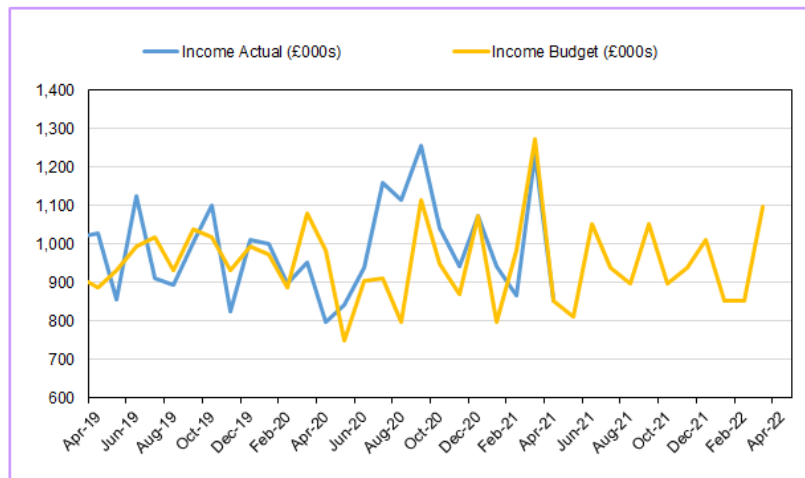
41. CMT Income - BMT, ACT & CBC Income



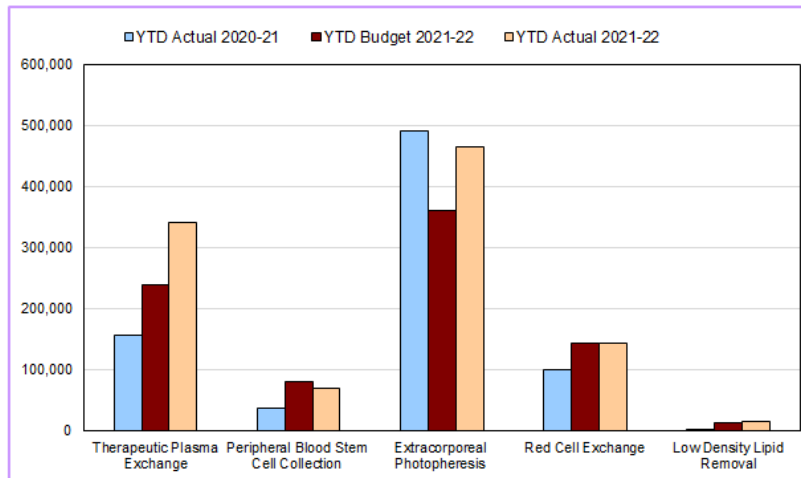
42. SCDT Income



43. Therapeutic Apheresis Services Income

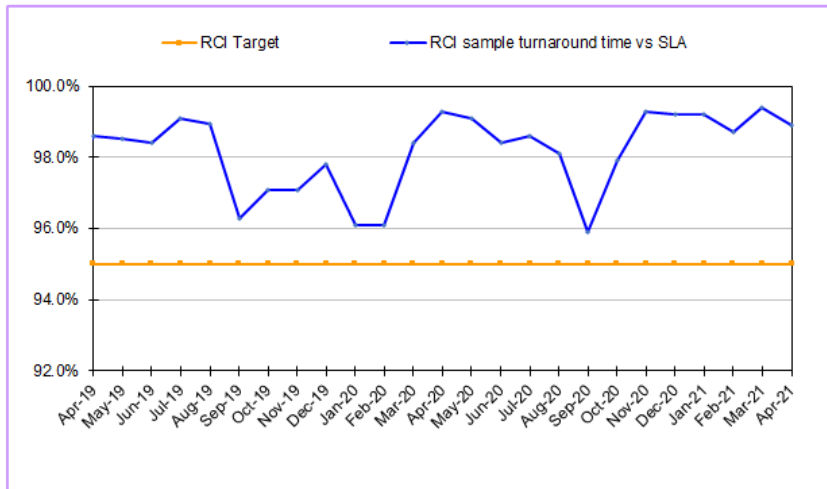


44. TAS - YTD Income Activity v Target

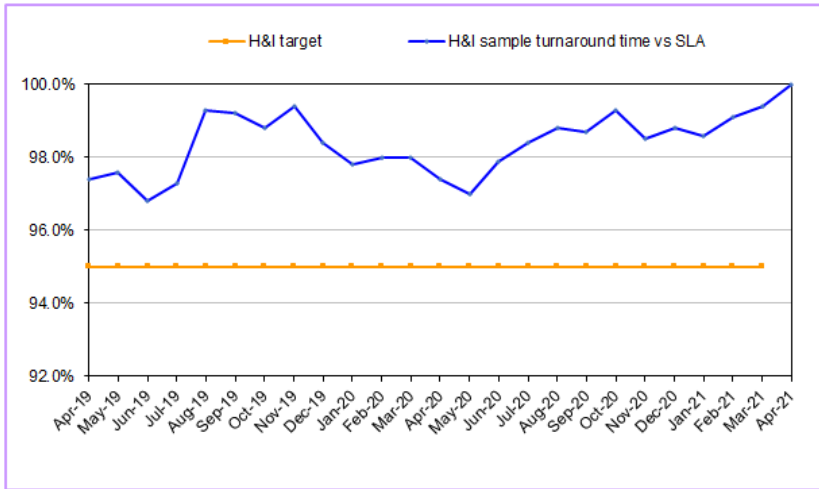


Monthly Performance Report - As at the end of April 2021  
 Clinical Services - Pathology, Stem Cells & Therapeutics Service Performance

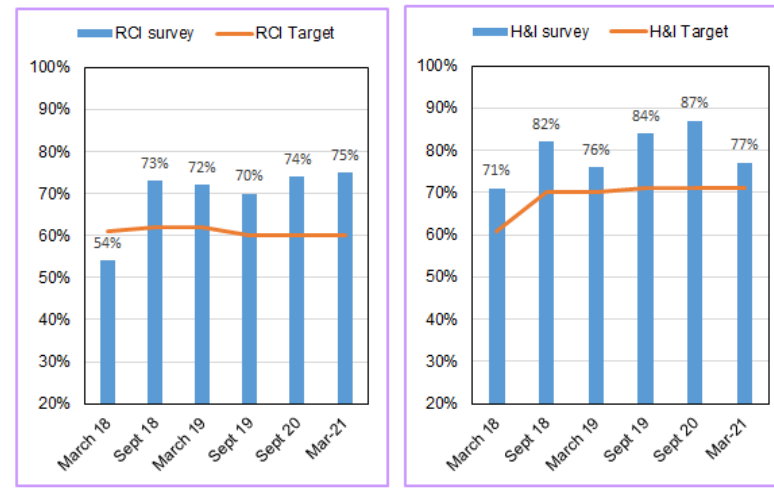
45. Turnaround Time vs SLA (RCI)



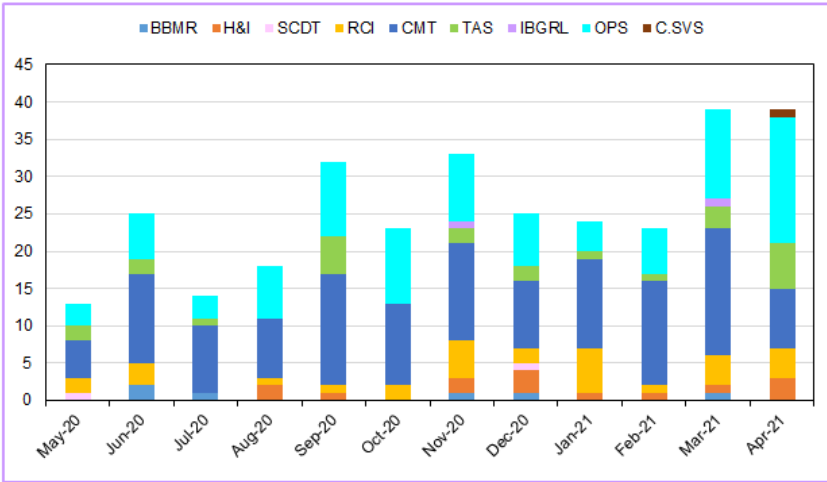
46. Turnaround Time vs SLA (H&I)



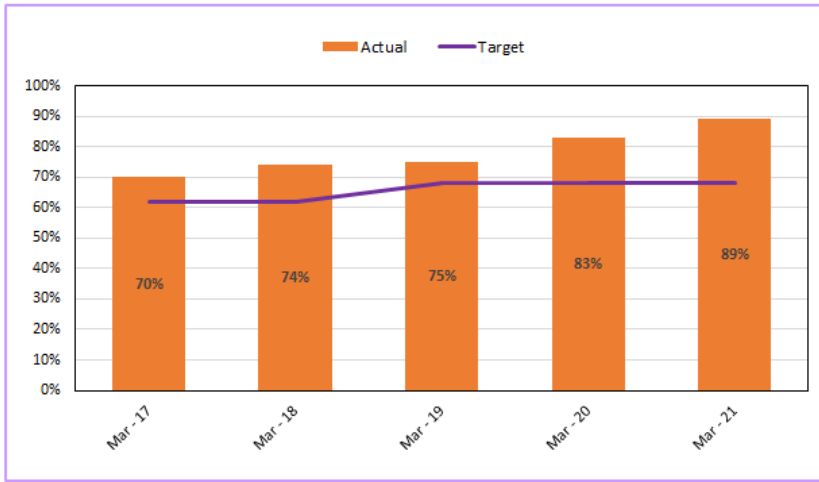
47. Pathology Services - Hospital Satisfaction



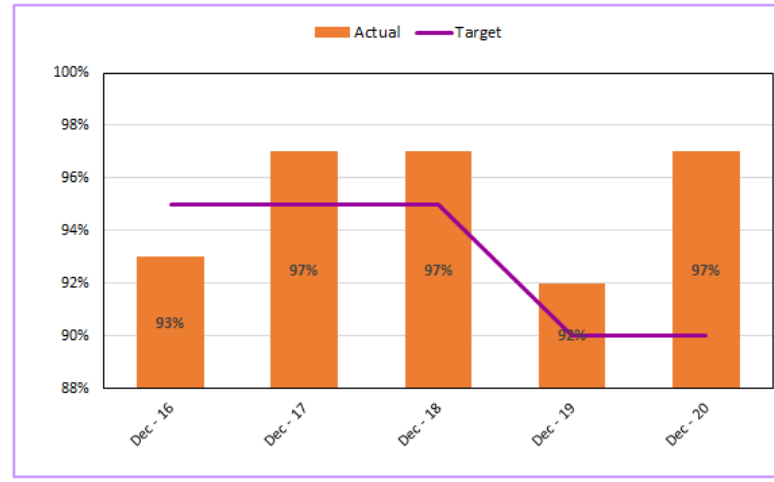
48. Major QI's raised per month - Clinical Services



76 TAS Hospital Satisfaction (Clinicians % Top Box Scores)

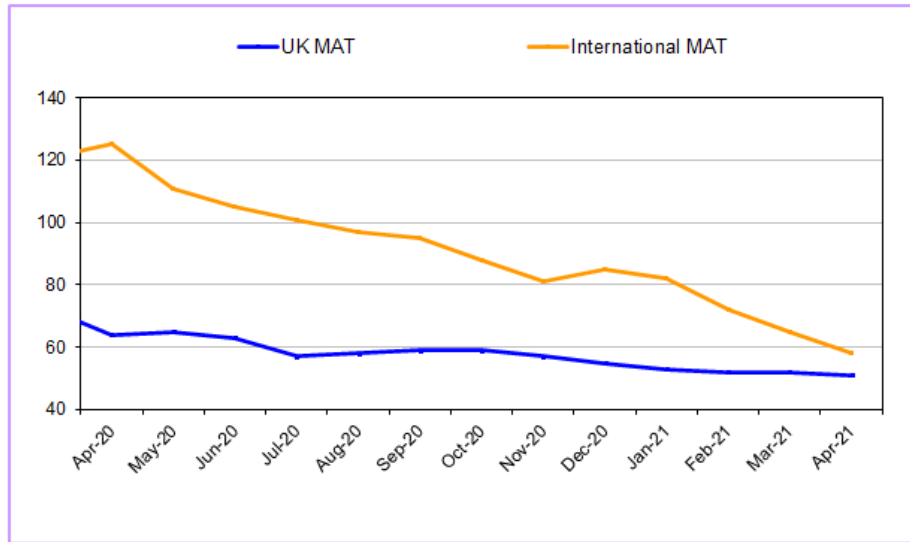


77 TAS Customer Satisfaction (Patients % Top Box Scores)

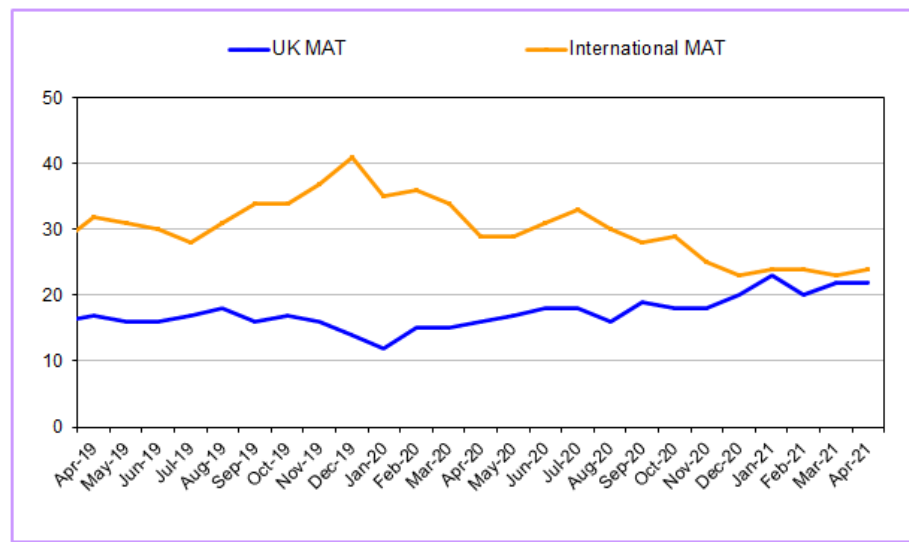


Monthly Performance Report - As at the end of April 2021  
 Clinical Services - Stem Cells & Therapeutics Service Performance

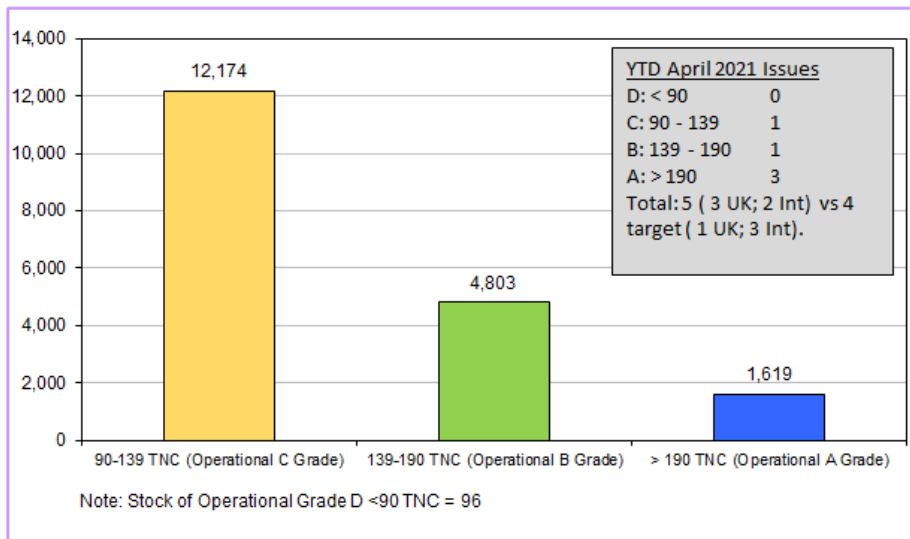
49. Adult donor provisions : UK and International - MATs



50. Issue of cord blood units : UK and International - MATs



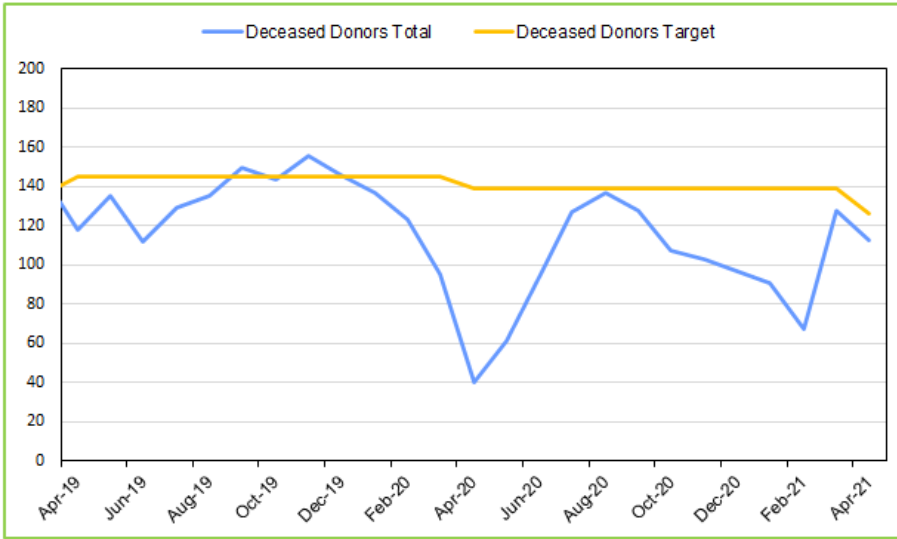
51. NHSBT CBB stock (active units - cell dose post process TNC)



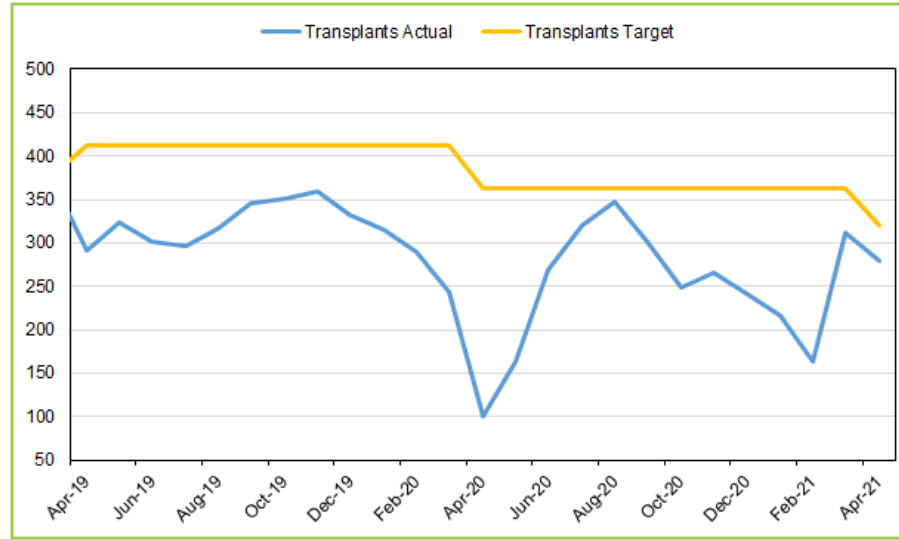
# Monthly Performance Report - As at the end of April 2021

## OTDT - Outcomes

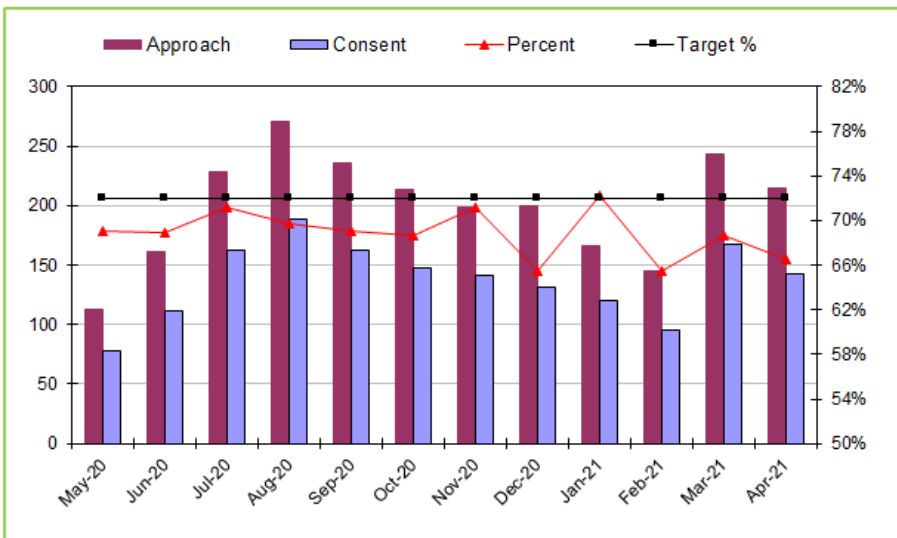
### 52. Deceased Organ Donors



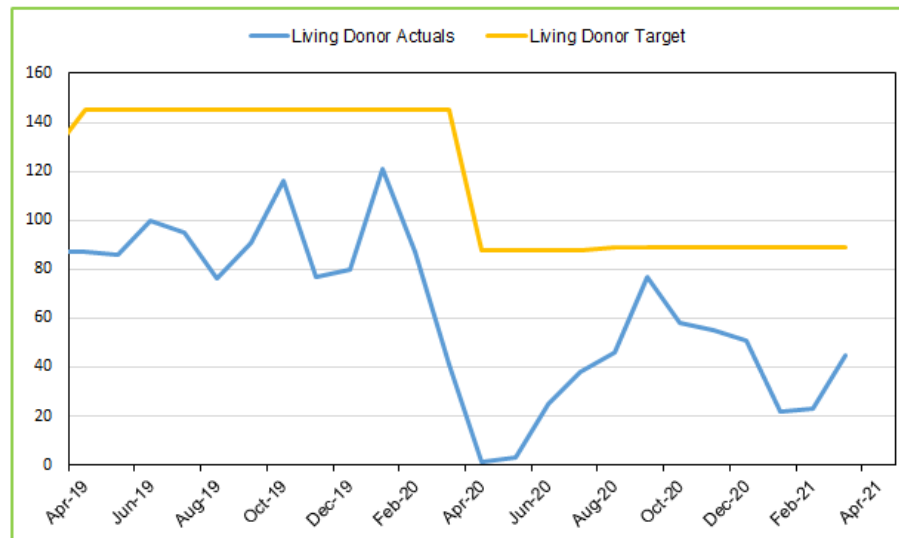
### 53. Deceased Donor Organ Transplants



### 54. Consent / Authorisation rate (DBD & DCD)



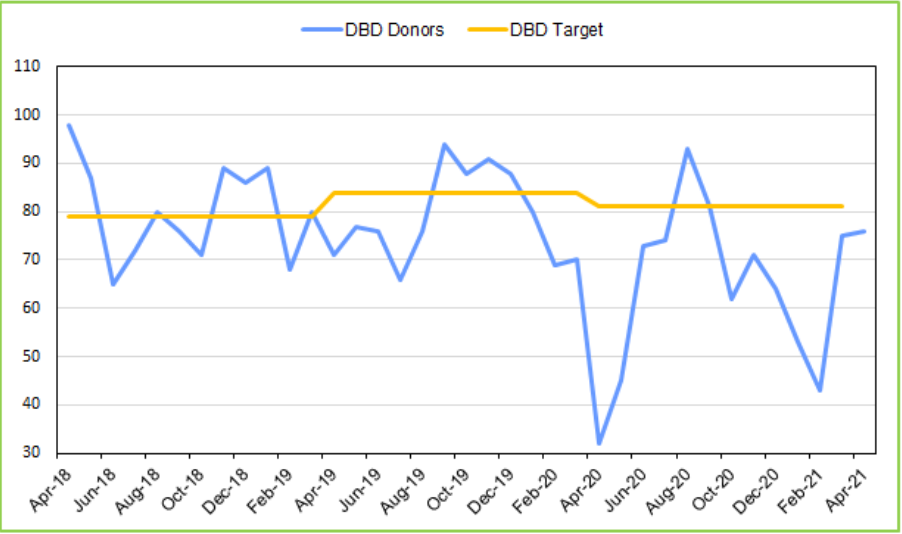
### 55. Live Organ Donors (reported one month in arrears)



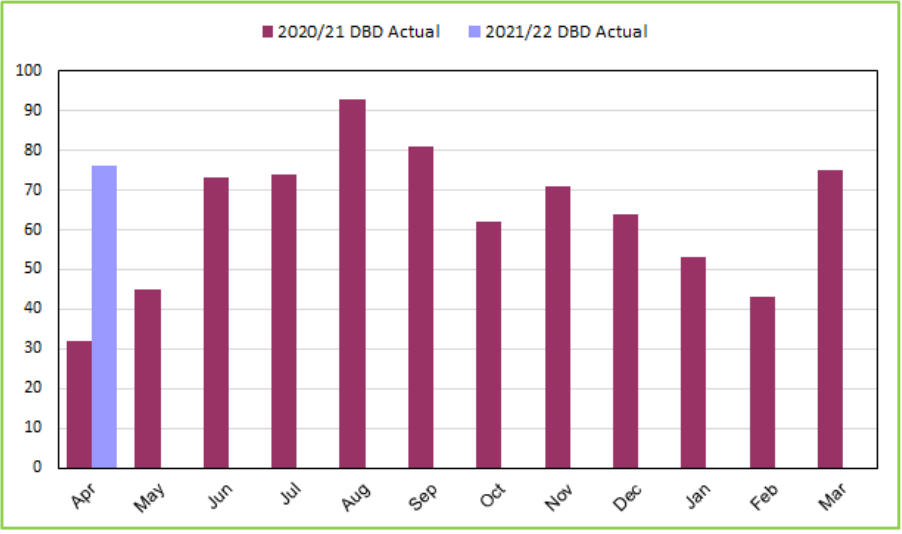
## Monthly Performance Report - As at the end of April 2021

### OTDT - DBD Activity

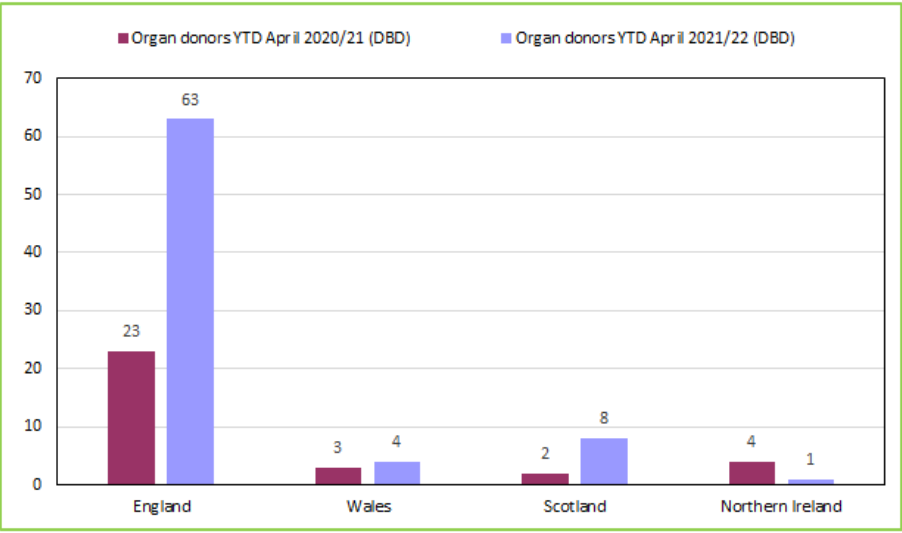
**56. Deceased Organ Donors (DBD)**



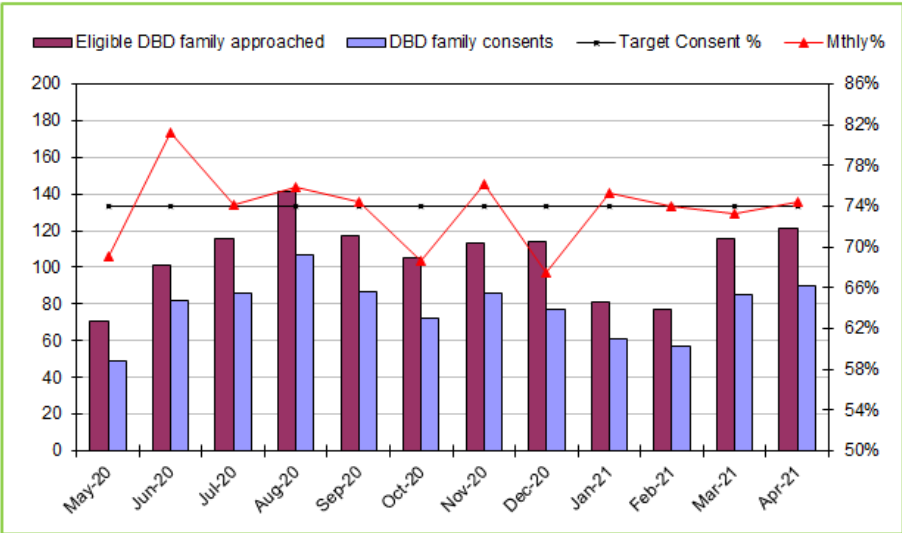
**57. Deceased Organ Donors - Monthly (DBD)**



**58. Deceased Organ Donors - By Nation (DBD) - 19/20 v 20/21**



**59. Consent/Authorisation rate (DBD) per month**

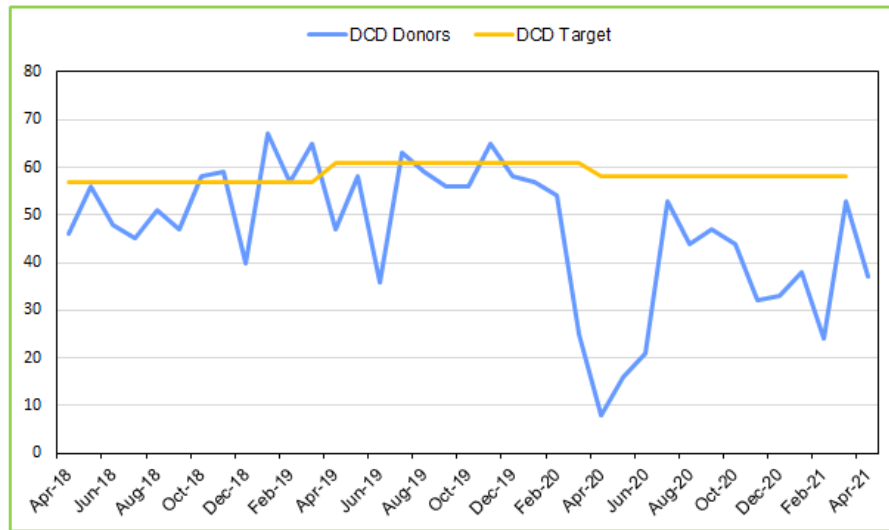




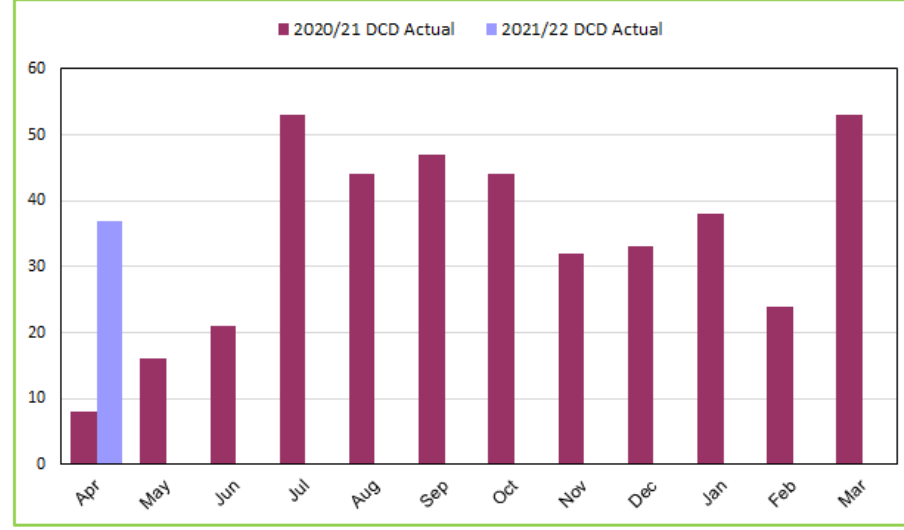
## Monthly Performance Report - As at the end of April 2021

### OTDT - DCD Activity

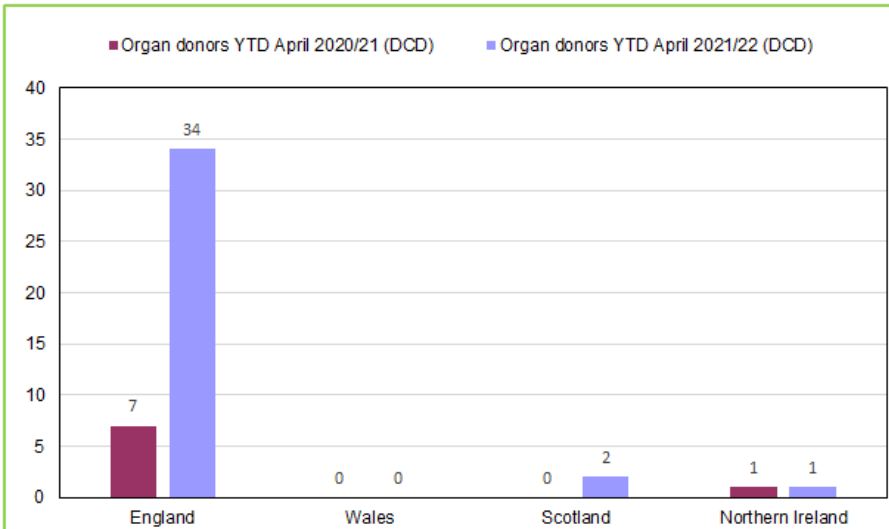
#### 60. Deceased Organ Donors (DCD)



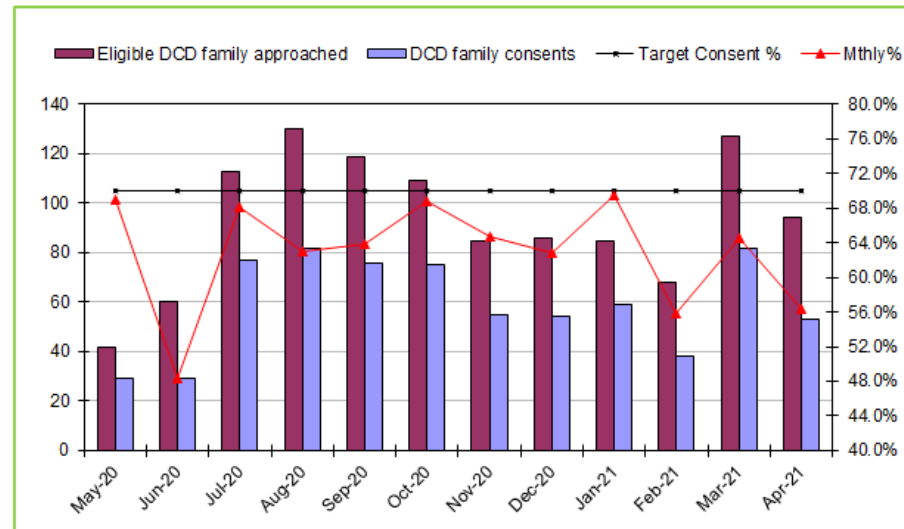
#### 61. Deceased Organ Donors - Monthly (DCD)



#### 62. Deceased Organ Donors - By Nation (DCD) - 19/20 v 20/21



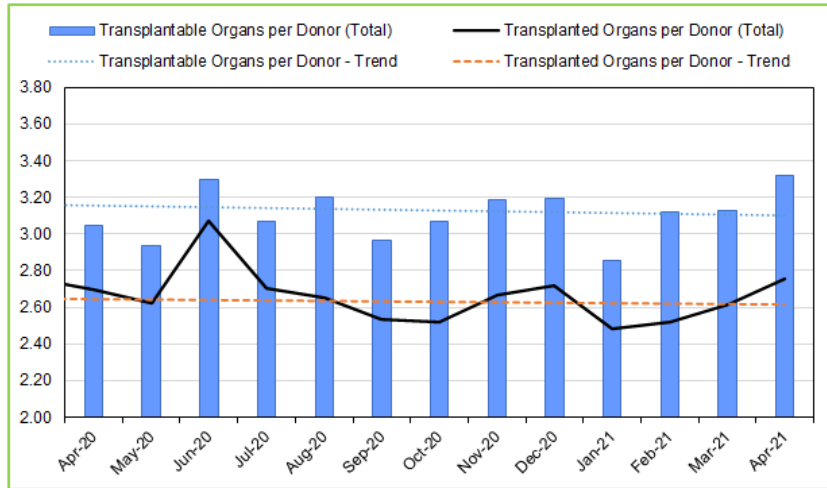
#### 63. Consent/Authorisation rate (DCD) per month



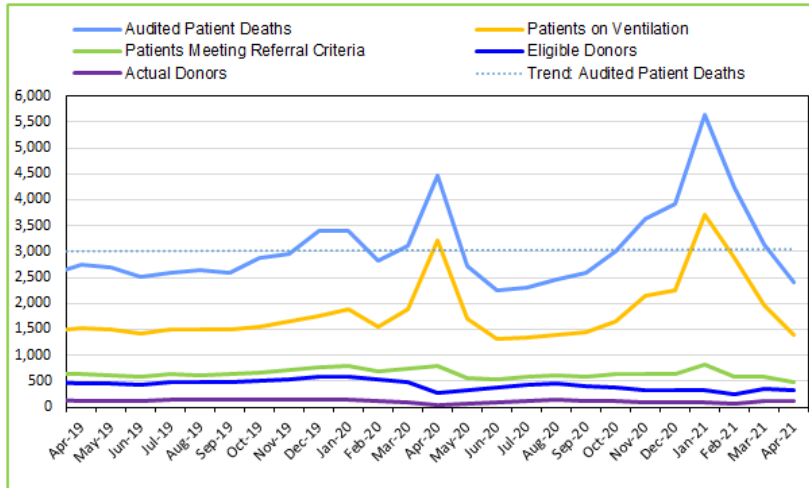
Monthly Performance Report - As at the end of April 2021

OTDT - Organ Availability & Utilisation

64. Transplantable v Transplanted Organs per Donor

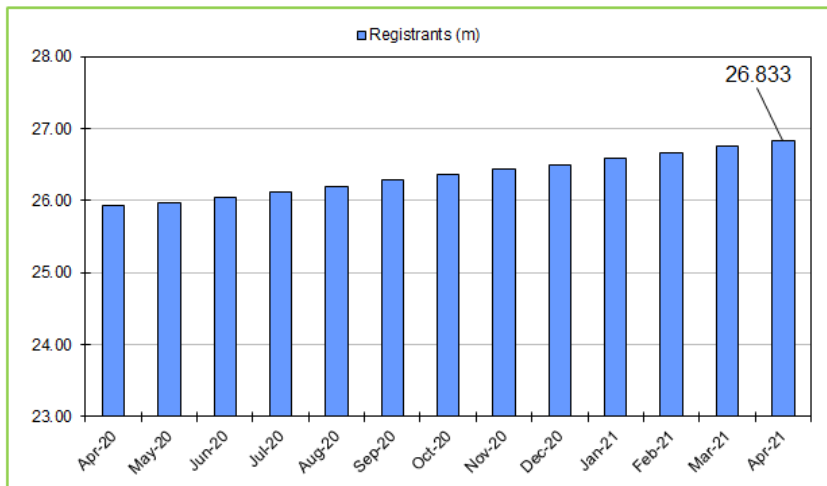


65. OTDT Donor Pool - DBD/DCD Donors - All UK Trusts/Health Boards

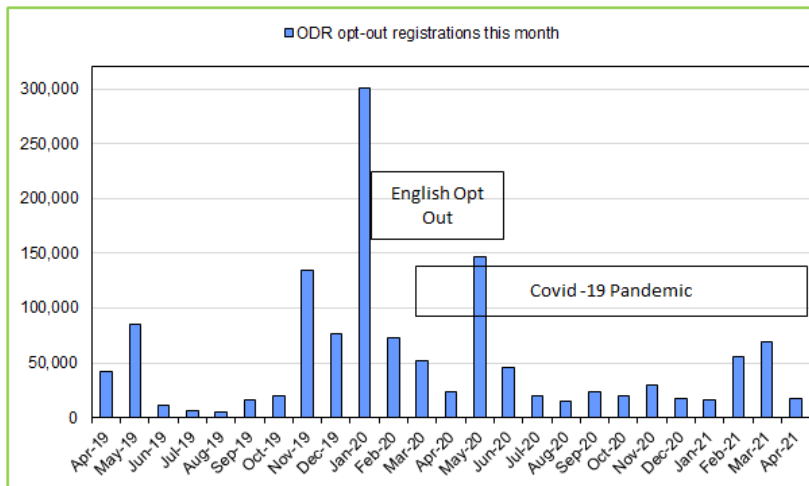


Organ Donation and Transplant - Employee Absence & Turnover

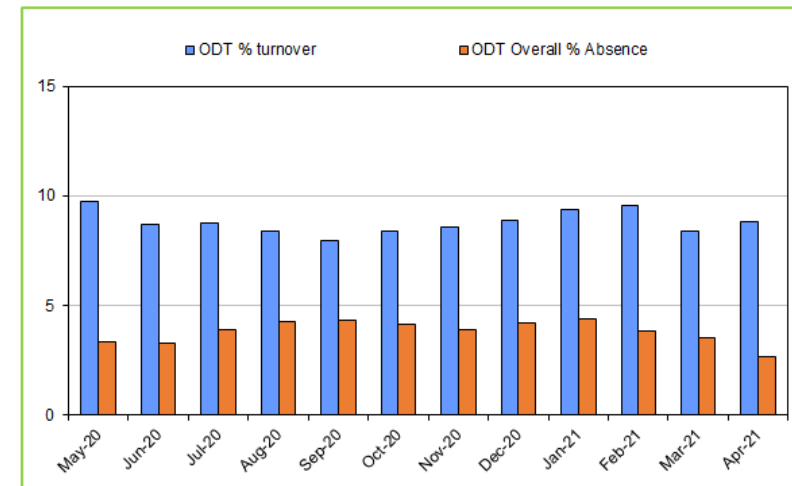
66. Number of People Registered on the ODR (Opt-Ins)



67. Number of People De-registering from ODR (Opt-Outs)



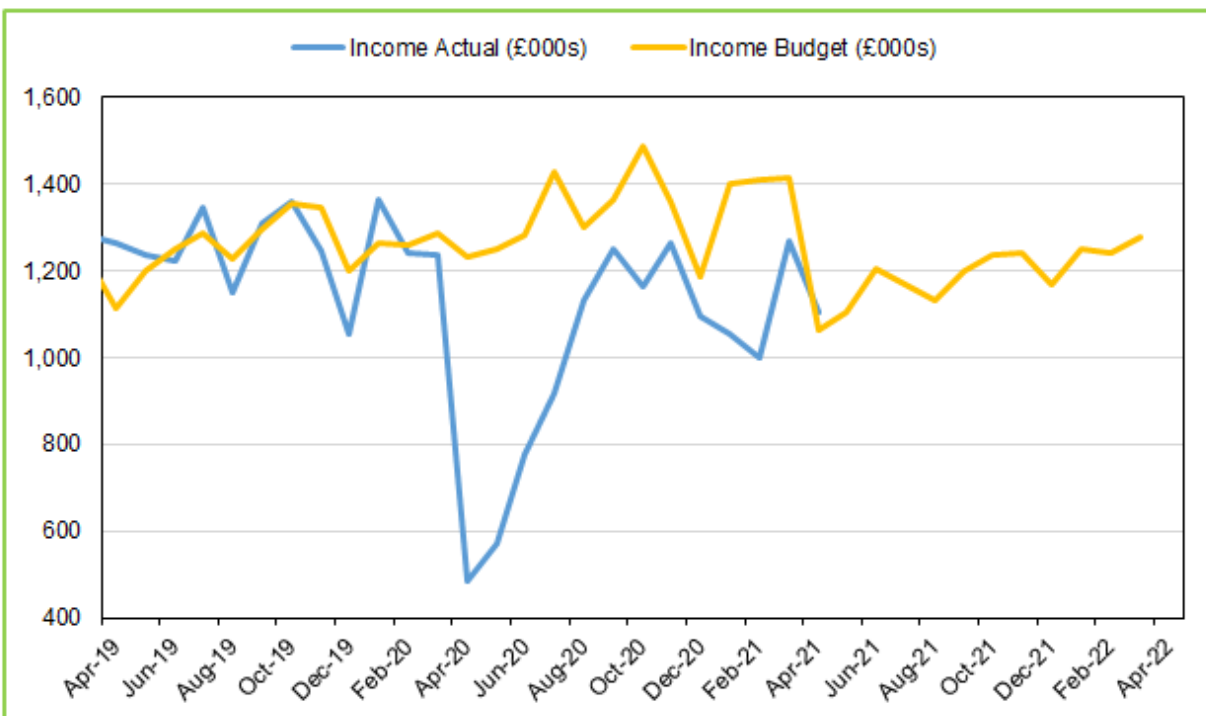
68. ODT Employee Turnover & Absence Rates (%)



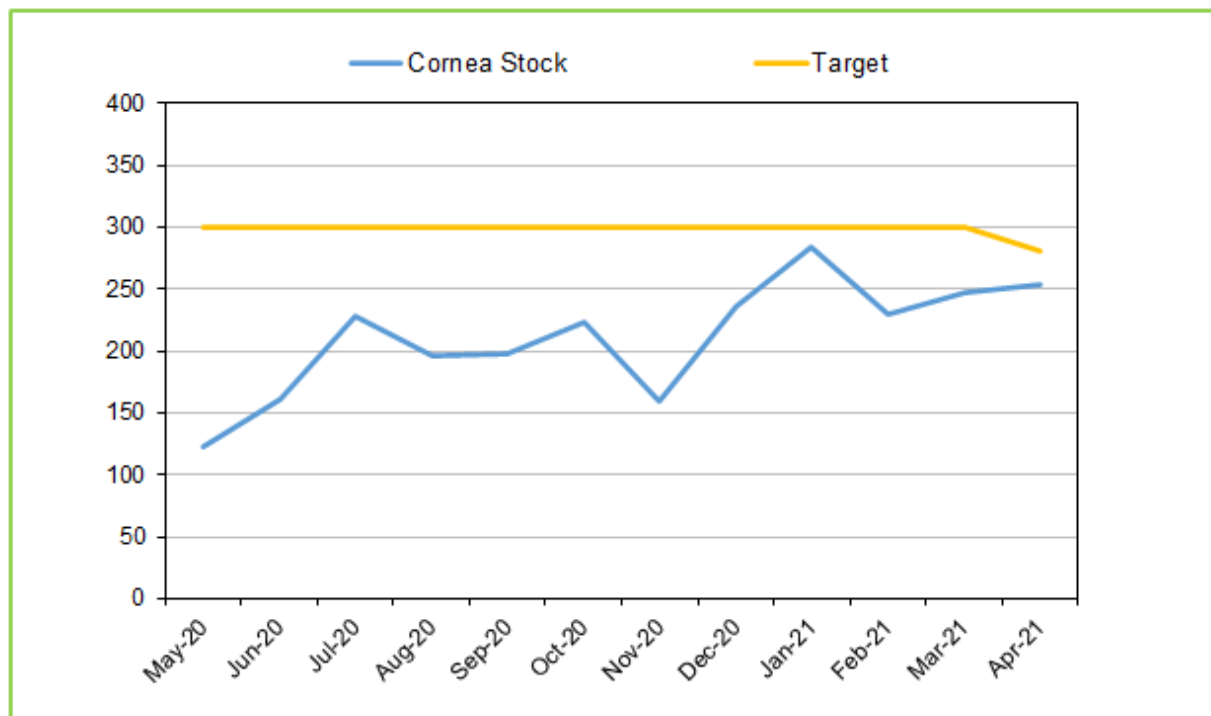
## Monthly Performance Report - As at the end of April 2021

### OTDT - Tissue & Eye Services

#### 69. Tissue and Eye Services Income



#### 70. Suitable Cornea Donations - Cornea stocks



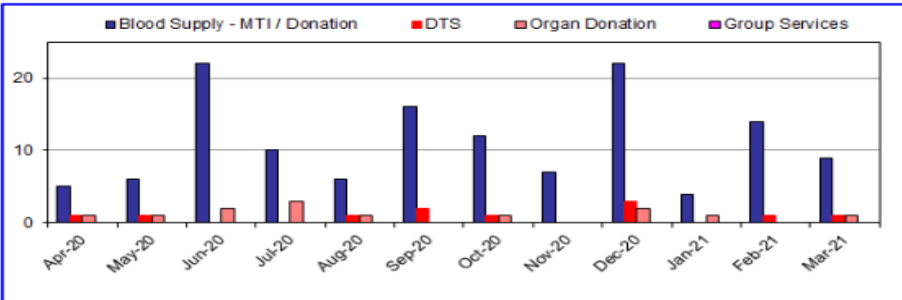
## Monthly Performance Report - As at the end of April 2021 NHSBT Corporate - DTS, Quality & People

### 71. IT System Performance (Availability)

Service	Period Target	Mar-21	Apr-21	RAG Trend
Donor Portal	99.95%	100.00%	100.00%	↔
Donor Path	99.95%	100.00%	100.00%	↔
Pulse	99.95%	100.00%	100.00%	↔
OBOS	99.95%	100.00%	100.00%	↔
TMS	99.95%	99.74%	100.00%	↑
Hermatos	99.95%	100.00%	100.00%	↔
Sp-ICE	99.95%	100.00%	100.00%	↔
ODR	99.95%	100.00%	100.00%	↔

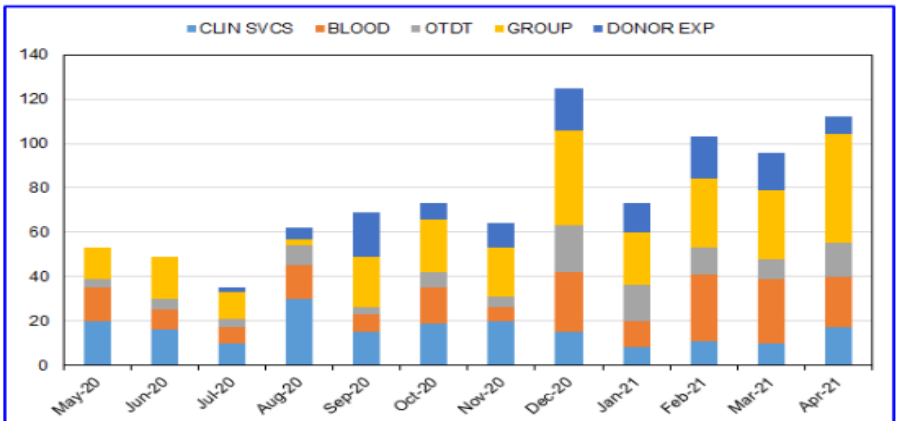
### 72. Health and Safety - Accident Reporting (one month in arrears).

H&S Incident Levels (x 1 mth in arrears)	Level 1&2 MAT Target	Level 1&2 MAT Total	Level 1-3 Mthly Target	Level 1-3 Pd Actual
Blood Supply	<=24	40	<=11	9
Clinical	<=3	2	<=1	1
OTDT	<=3	0	<=1	1
Donor Experience	<=0	0	<=0	0
Group Services	<=0	0	<=0	0
<b>NHSBT</b>	<b>&lt;=30</b>	<b>42</b>	<b>&lt;=13</b>	<b>11</b>

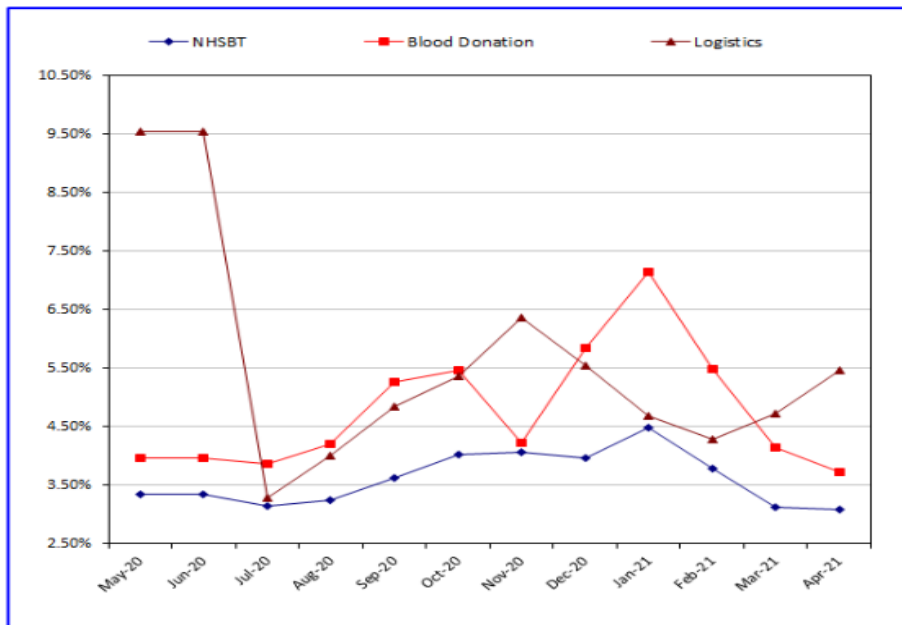


### 73. Quality System Items >30 days Overdue

Directorate	Docs	Quality Incidents	Adverse Events	Change Control	Audit Findings	TOTAL
BLOOD SUPPLY	2	11	0	8	2	23
CLINICAL	4	1	0	10	2	17
DONOR EXP	2	6	0	0	0	8
GROUP	15	3	0	8	0	26
OTDT	1	9	0	5	0	15
<b>Total</b>	<b>24</b>	<b>30</b>	<b>0</b>	<b>31</b>	<b>4</b>	<b>89</b>



### 74. Sickness Absence - Excluding Covid-19 Special Leave.



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28	Capacity Utilisation Mobile Teams	58	DBD Organ Donors by Nation		Clinical
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## 10. Finance Report (21-35)

For Report

Presented by Rob Bradburn

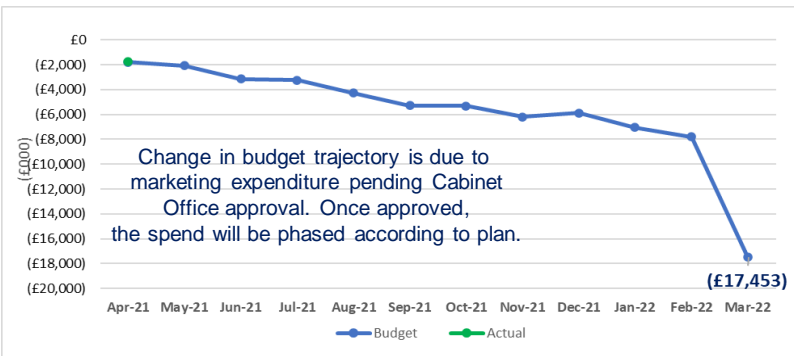
# NHSBT Finance Report

April 2021

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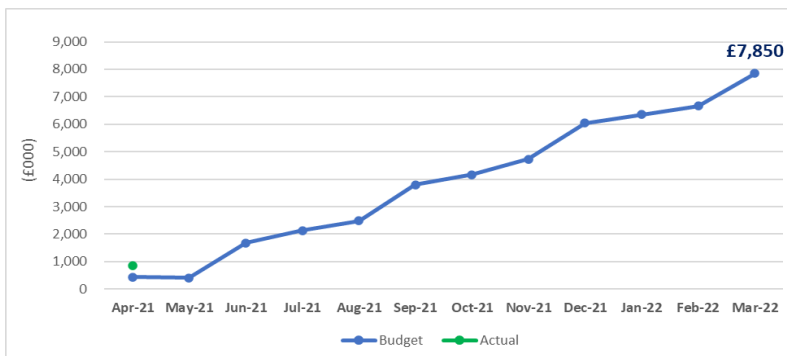
Surplus of £0.8m (£0.9m ahead of plan)

## Blood and Group Net Income & Expenditure (excl. Change Programme)



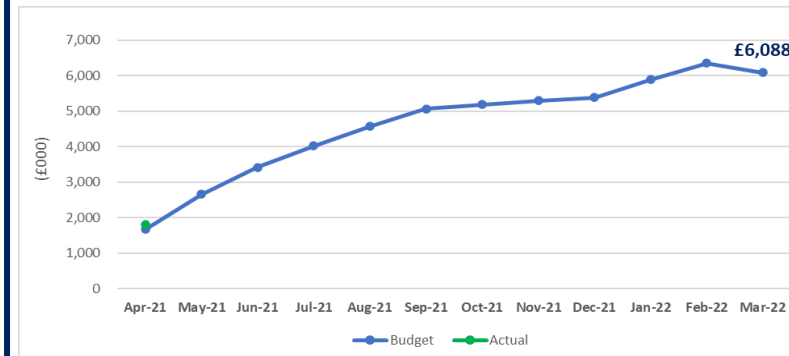
In line with budget.

## Clinical Services Net Income & Expenditure



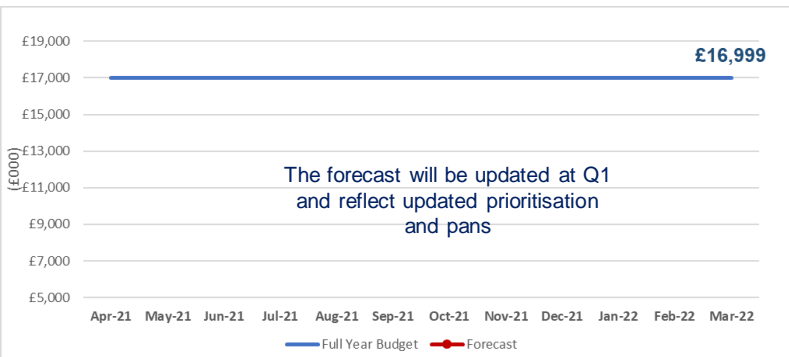
Favourable +£0.5m variance – activity higher than plan (predominately TAS and RCI)

## Organ Donation & Transplantation: Net Funding & Expenditure



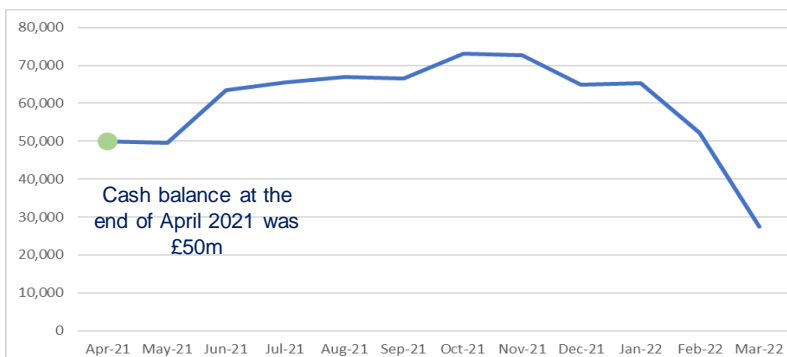
In line with plan

## Blood and Group Change Programme: Full Year Forecast



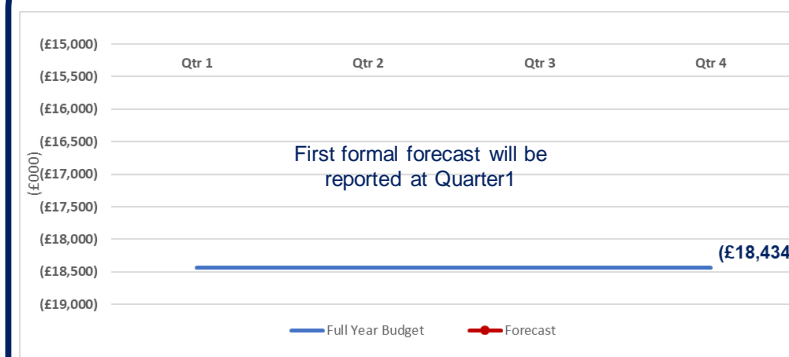
Full Year budget is £17m.

## NHSBT Cash Flow 2021/22



Forecast closing cash balance at the end of March 2022 is £27.4m.

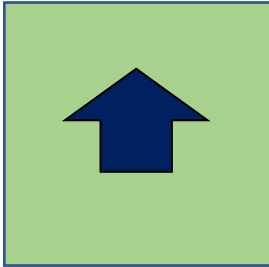

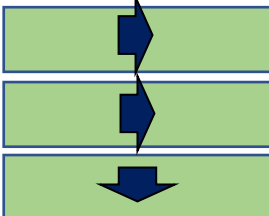
## NHSBT Income & Expenditure Full Year Forecast



NHSBT Full Year Budget is an £18.4m deficit (driven by transformation spend)



# 2021/22 NHSBT Financial Performance Headlines – April 2021

<p>Year to date I&amp;E Position</p>	<p>+£0.8m surplus</p>	<p><b>NHSBT I&amp;E position surplus +£0.8m, £0.9m better than plan.</b></p> <ul style="list-style-type: none"> <li>• Blood and Group – in line with plan</li> <li>• Clinical Services +£0.4m – increased activity (predominately TAS &amp; RCI)</li> <li>• ODT – in line with plan</li> <li>• TES +£0.3m – increased sales activity (predominately Ocular)</li> </ul>	
<p>Full year forecast</p>	<p>-£18.4m deficit</p>	<p><b>Budget deficit of £18.4m, driven by planned transformation expenditure</b></p> <ul style="list-style-type: none"> <li>• First formal forecast will be provided at Quarter 1</li> </ul>	
<p>Cash and Debtors</p>	<p>Cash balance £50m</p>	<p><b>Debtor days finished at 11 days - 11 days ahead of target</b></p> <p><b>90+ overdue remains at £0.4m (£0.1m ahead of target)</b></p> <p><b>Closing cash balance at the end of April 2021 is £50m. Cash forecast of £27m at the end of March 2022.</b></p>	

The existing pages of the old Board performance report will continue to be reported through Q1 pending a refresh of the structure and content (for the June / Q1 report).

Work on strategy and plans continues. Subject to this, the current trajectory (effectively a “do nothing” scenario) is suggesting a 5.6% price increase would be needed for Blood in 2022/23.

DHSC have requested a short turn around submission in cost saving opportunities (by 2024/25) in advance of the formal SR21 process. In respect of NHSBT, this applies to the programme funding received for ODT and Stem Cells. An update will be provided to the May Board meeting.

# Financial Performance by Division – Year to Date April 2021 (full I&E statement follows)

## Surplus of £0.8m (+£0.9m ahead of plan)

Blood Supply	April (APM01)		
	Bud.	Act.	Var.
<b>(£)m</b>			
Income	24.5	24.8	0.2
CVP Funding	0.0	4.4	4.4
Expenditure	(14.0)	(14.7)	(0.7)
CVP Expenditure	0.0	(4.4)	(4.4)
<b>Surplus/(Deficit)</b>	<b>10.6</b>	<b>10.1</b>	<b>(0.4)</b>

Demand is higher than plan for blood components (£0.1m) and non-clinical issues (£0.1m).

This is offset by increased operating expenditure across all directorates (Blood Donation, Manufacturing and Logistics) driven by increased headcount, agency and venue hire. This will be monitored and any adverse persistent trends reported in the Q1 re-forecast.

Group Services	April (APM01)		
	Bud.	Act.	Var.
<b>(£)m</b>			
Income	1.3	1.4	0.1
Expenditure	(13.6)	(13.2)	0.4
Blood and Group Transformation	(0.5)	(0.5)	0.0
<b>Surplus/(Deficit)</b>	<b>(12.9)</b>	<b>(12.4)</b>	<b>0.5</b>

Group Services are reporting small favourable variances across the majority of directorates.

<b>Blood and Group Surplus/(Deficit)</b>	<b>(2.3)</b>	<b>(2.2)</b>	<b>0.1</b>
--	--------------	--------------	------------

Clinical Services	April (APM01)		
	Bud.	Act.	Var.
<b>(£)m</b>			
Income	5.4	5.6	0.2
Expenditure	(4.9)	(4.7)	0.2
Change Programme	(0.1)	(0.1)	0.0
<b>Surplus/(Deficit)</b>	<b>0.4</b>	<b>0.9</b>	<b>0.4</b>

Activity is higher than plan – especially in TAS and RCI.

Organ Donation & Transplantation	April (APM01)		
	Bud.	Act.	Var.
<b>(£)m</b>			
Income	7.0	6.7	(0.3)
Expenditure	(5.5)	(5.1)	0.4
Change Programme	0.2	0.2	0.0
<b>Surplus/(Deficit)</b>	<b>1.7</b>	<b>1.8</b>	<b>0.1</b>

DHSC funding is lower than budget. We are checking that costs transferred into group services, as part of the Operating Model changes (primarily IT costs) have not been excluded from the funding requirement.

The transformation plan (£5m) agreed with DHSC is funded through cash reserves brought forward from 2020/21.

Tissues and Eye Services	April (APM01)		
	Bud.	Act.	Var.
<b>(£)m</b>			
Income	1.1	1.3	0.2
Expenditure	(1.0)	(0.9)	0.1
<b>Surplus/(Deficit)</b>	<b>0.1</b>	<b>0.4</b>	<b>0.3</b>

Activity is higher than (a conservative) plan – with hospitals increasing elective surgery.

<b>NHSBT Total</b>	<b>(0.1)</b>	<b>0.8</b>	<b>0.9</b>
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Period				Year to date			Full year	
Budget	Actual	Variance		Budget	Actual	Variance	2020-21 Actual	Budget
£k	£k	£k		£k	£k	£k	£k	£k
0	4,350	4,350	<b>Blood and Group</b>	0	4,350	4,350	57,623	0
883	883	0	Programme Funding - Convalescent Plasma	883	883	0	11,061	10,600
24,282	24,505	223	Programme Funding - Corporate	24,282	24,505	223	280,280	291,747
263	279	16	Blood & Components Income	263	279	16	3,165	3,313
186	215	29	Blood Supply Other Income	186	215	29	2,000	2,377
87	92	5	Clinical Services - Research & Development	87	92	5	1,221	1,042
134	177	42	Clinical Services Income - Medical	134	177	42	3,385	1,652
<b>25,836</b>	<b>30,501</b>	<b>4,666</b>	Group Services Other Income	<b>25,836</b>	<b>30,501</b>	<b>4,666</b>	<b>358,735</b>	<b>310,731</b>
(1,104)	(804)	301	<b>Blood and Group Income</b>	(1,104)	(804)	301	(515)	0
(22)	(4,372)	(4,350)	Cost of Sales - Blood Component Stock Movement	(22)	(4,372)	(4,350)	(57,623)	(22)
(5,883)	(6,319)	(436)	Convalescent Plasma	(5,883)	(6,319)	(436)	(66,820)	(70,814)
(5,364)	(5,571)	(208)	Blood Supply: Blood Donation	(5,364)	(5,571)	(208)	(63,248)	(66,131)
(1,625)	(1,970)	(346)	Blood Supply: Manufacturing, Testing & Issue	(1,625)	(1,970)	(346)	(20,293)	(19,693)
(65)	(52)	13	Blood Supply: Logistics	(65)	(52)	13	(644)	(780)
(1,415)	(1,348)	67	Chief Executive and Board	(1,415)	(1,348)	67	(18,252)	(20,369)
(505)	(459)	47	Donor Experience	(505)	(459)	47	(5,378)	(6,166)
(3,574)	(3,500)	75	Quality	(3,574)	(3,500)	75	(45,278)	(44,767)
(522)	(536)	(14)	Estates & Facilities	(522)	(536)	(14)	(6,012)	(6,271)
(307)	(311)	(4)	Finance	(307)	(311)	(4)	(3,088)	(3,696)
(176)	(120)	57	Strategy and Transformation	(176)	(120)	57	(1,675)	(2,123)
(825)	(862)	(37)	Business Transformation Services	(825)	(862)	(37)	(9,510)	(10,112)
(3,066)	(2,879)	187	People	(3,066)	(2,879)	187	(34,923)	(39,879)
(541)	(541)	0	Digital, Data and Technology Services	(541)	(541)	0	(12,701)	(16,999)
(391)	(402)	(10)	Change Programme	(391)	(402)	(10)	(4,835)	(5,346)
(1,399)	(1,363)	36	Clinical Services: Research & Development	(1,399)	(1,363)	36	(15,417)	(16,692)
(1,387)	(1,358)	30	Clinical Services: Medical	(1,387)	(1,358)	30	(32,073)	(15,325)
<b>(28,171)</b>	<b>(32,765)</b>	<b>(4,593)</b>	Miscellaneous and Capital Charges	<b>(28,171)</b>	<b>(32,765)</b>	<b>(4,593)</b>	<b>(398,287)</b>	<b>(345,183)</b>
<b>(2,335)</b>	<b>(2,263)</b>	<b>72</b>	<b>Blood and Group Expenditure</b>	<b>(2,335)</b>	<b>(2,263)</b>	<b>72</b>	<b>(39,552)</b>	<b>(34,452)</b>
			<b>Blood and Group Total</b>					
			<b>Clinical Services (DTAS)</b>					
455	455	0	Programme Funding - Diagnostics, Therapeutic Apheresis & Stem Cells	455	455	0	4,173	5,462
4,934	5,117	183	Diagnostic and Therapeutic Services Income	4,934	5,117	183	58,608	66,747
<b>5,389</b>	<b>5,572</b>	<b>183</b>	<b>Clinical Services Income</b>	<b>5,389</b>	<b>5,572</b>	<b>183</b>	<b>62,781</b>	<b>72,209</b>
(4,893)	(4,653)	240	Clinical Services: Diagnostics, Therapeutic Apheresis and Stem Cells	(4,893)	(4,653)	240	(53,645)	(60,618)
(60)	(58)	1	Clinical Services: Diagnostics, Therapeutic Apheresis and Stem Cells Change Programme	(60)	(58)	1	(903)	(3,740)
<b>(4,953)</b>	<b>(4,712)</b>	<b>241</b>	<b>Clinical Services Expenditure</b>	<b>(4,953)</b>	<b>(4,712)</b>	<b>241</b>	<b>(54,548)</b>	<b>(64,358)</b>
<b>436</b>	<b>860</b>	<b>424</b>	<b>Clinical Services Total</b>	<b>436</b>	<b>860</b>	<b>424</b>	<b>8,233</b>	<b>7,850</b>
			<b>Organ Donation &amp; Transplantation</b>					
5,970	5,717	(254)	Programme Funding - Organ Donation & Transplantation	5,970	5,717	(254)	62,327	71,643
54	34	(20)	Programme Funding - Organ Donation and Transplantation - Opt Out	54	34	(20)	12,091	650
278	329	52	Organ Donation & Transplantation - NHSE Income	278	329	52	1,617	3,333
994	994	0	Organ Donation & Transplantation - UKHDs & Other Income	994	994	0	11,971	11,930
<b>7,296</b>	<b>7,074</b>	<b>(222)</b>	<b>ODT Income</b>	<b>7,296</b>	<b>7,074</b>	<b>(222)</b>	<b>88,006</b>	<b>87,557</b>
(5,462)	(5,110)	353	OTDT - Organ Donation and Transplantation	(5,462)	(5,110)	353	(55,260)	(66,167)
(165)	(150)	16	OTDT - Organ Donation and Transplantation Change Programme	(165)	(150)	16	(14,860)	(15,302)
<b>(5,628)</b>	<b>(5,259)</b>	<b>368</b>	<b>ODT Expenditure</b>	<b>(5,628)</b>	<b>(5,259)</b>	<b>368</b>	<b>(70,120)</b>	<b>(81,469)</b>
<b>1,669</b>	<b>1,815</b>	<b>146</b>	<b>ODT Total</b>	<b>1,669</b>	<b>1,815</b>	<b>146</b>	<b>17,886</b>	<b>6,088</b>
			<b>Tissues and Eye Services</b>					
1,064	1,250	187	Tissue & Eye Services Income	1,064	1,250	187	11,994	14,298
42	42	0	Programme Funding - Tissues & Eye Services	42	42	0	0	500
<b>1,105</b>	<b>1,292</b>	<b>187</b>	<b>TES Income</b>	<b>1,105</b>	<b>1,292</b>	<b>187</b>	<b>11,994</b>	<b>14,798</b>
(63)	(53)	9	Cost of Sales - Tissues Stock Movement	(63)	(53)	9	(727)	(750)
(976)	(869)	107	OTDT - Tissue and Eye Services	(976)	(869)	107	(10,850)	(11,967)
<b>(1,039)</b>	<b>(923)</b>	<b>116</b>	<b>TES Expenditure</b>	<b>(1,039)</b>	<b>(923)</b>	<b>116</b>	<b>(11,577)</b>	<b>(12,717)</b>
<b>67</b>	<b>370</b>	<b>303</b>	<b>TES Total</b>	<b>67</b>	<b>370</b>	<b>303</b>	<b>417</b>	<b>2,080</b>
			<b>NHSBT Summary</b>					
<b>39,627</b>	<b>44,440</b>	<b>4,813</b>	<b>Income</b>	<b>39,627</b>	<b>44,440</b>	<b>4,813</b>	<b>521,516</b>	<b>485,294</b>
<b>(39,791)</b>	<b>(43,658)</b>	<b>(3,868)</b>	<b>Expenditure</b>	<b>(39,791)</b>	<b>(43,658)</b>	<b>(3,868)</b>	<b>(534,532)</b>	<b>(503,728)</b>
<b>(164)</b>	<b>782</b>	<b>946</b>	<b>NHSBT Surplus/(Deficit)</b>	<b>(164)</b>	<b>782</b>	<b>946</b>	<b>(13,016)</b>	<b>(18,434)</b>

# Contribution Statement – Year to Date April 2021

Year to date Actual £m	Blood & Components inc. R&D	Diagnostics		Stem Cells			TAS	TES	ODT	TOTAL
		RCI	H&I	CMT	CBC	SCDT				
<b>Income</b>										
Prices	24.8	1.7	1.0	0.9	-	0.2	1.0	1.3	-	30.9
Central Funding from DHAs	-	-	-	-	-	-	-	-	1.0	1.0
Grant in Aid	5.2	-	-	-	-	0.5	-	0.0	5.8	11.5
Other	0.5	0.1	0.0	0.1	0.0	-	(0.0)	-	0.3	1.1
<b>Total Income</b>	<b>30.5</b>	<b>1.7</b>	<b>1.0</b>	<b>1.0</b>	<b>0.0</b>	<b>0.7</b>	<b>1.0</b>	<b>1.3</b>	<b>7.1</b>	<b>44.4</b>
<b>Expenditure</b>										
Variable Costs										
Consumables	(2.5)	(0.2)	(0.3)	(0.1)	(0.1)	(0.1)	(0.3)	(0.2)	(0.3)	(3.9)
Other	-	-	-	-	-	-	-	-	-	-
<b>Total Variable Costs</b>	<b>(2.5)</b>	<b>(0.2)</b>	<b>(0.3)</b>	<b>(0.1)</b>	<b>(0.1)</b>	<b>(0.1)</b>	<b>(0.3)</b>	<b>(0.2)</b>	<b>(0.3)</b>	<b>(3.9)</b>
<b>Variable Contribution</b>	<b>28.0</b>	<b>1.6</b>	<b>0.8</b>	<b>0.9</b>	<b>(0.0)</b>	<b>0.6</b>	<b>0.8</b>	<b>1.1</b>	<b>6.8</b>	<b>40.5</b>
Direct Costs										
Cost of Sales	(0.8)	-	-	-	-	-	-	(0.1)	-	(0.9)
Pay	(10.2)	(0.8)	(0.6)	(0.4)	(0.1)	(0.2)	(0.4)	(0.6)	(2.6)	(15.9)
Non Pay	(5.1)	(0.0)	(0.0)	(0.1)	(0.0)	(0.1)	(0.1)	(0.2)	(2.5)	(8.1)
<b>Total Direct Costs</b>	<b>(16.1)</b>	<b>(0.8)</b>	<b>(0.6)</b>	<b>(0.5)</b>	<b>(0.2)</b>	<b>(0.3)</b>	<b>(0.5)</b>	<b>(0.8)</b>	<b>(5.1)</b>	<b>(24.9)</b>
<b>Direct Contribution</b>	<b>11.9</b>	<b>0.8</b>	<b>0.2</b>	<b>0.4</b>	<b>(0.2)</b>	<b>0.3</b>	<b>0.3</b>	<b>0.3</b>	<b>1.7</b>	<b>15.6</b>
Direct Support										
Operational Directorate costs	(1.4)	(0.2)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.1)	(0.2)	(2.1)
Logistics	(1.6)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(1.6)
Clinical	(0.8)	(0.0)	-	(0.0)	-	(0.0)	(0.0)	(0.0)	(0.1)	(1.0)
Attributable Estates costs	(1.9)	(0.1)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(2.4)
Attributable IT costs	(1.7)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.4)	(2.3)
Depreciation / Cost of Capital	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.4)
<b>Total Direct Support</b>	<b>(7.5)</b>	<b>(0.6)</b>	<b>(0.2)</b>	<b>(0.3)</b>	<b>(0.0)</b>	<b>(0.1)</b>	<b>(0.1)</b>	<b>(0.3)</b>	<b>(0.8)</b>	<b>(9.8)</b>
Notional Internal Income Uplift	(0.2)	0.0	0.2	0.0	(0.0)	(0.0)	-	0.0	(0.0)	0.0
<b>Contribution to Unallocated Costs</b>	<b>4.3</b>	<b>0.3</b>	<b>0.1</b>	<b>0.1</b>	<b>(0.2)</b>	<b>0.1</b>	<b>0.2</b>	<b>0.0</b>	<b>0.9</b>	<b>5.8</b>
<b>Total Allocated Costs</b>	<b>(26.3)</b>	<b>(1.5)</b>	<b>(0.9)</b>	<b>(0.9)</b>	<b>(0.3)</b>	<b>(0.6)</b>	<b>(0.8)</b>	<b>(1.3)</b>	<b>(6.2)</b>	<b>(38.6)</b>
Unallocated Costs Apportioned										
Directorate costs	(1.9)	(0.2)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.1)	(0.7)	(3.4)
Estates costs	(0.4)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.8)
Depreciation / Cost of Capital	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)
<b>Total Unallocated Costs</b>	<b>(2.5)</b>	<b>(0.2)</b>	<b>(0.1)</b>	<b>(0.1)</b>	<b>(0.0)</b>	<b>(0.1)</b>	<b>(0.1)</b>	<b>(0.2)</b>	<b>(0.9)</b>	<b>(4.3)</b>
<b>Operating Net Surplus / (Deficit)</b>	<b>1.8</b>	<b>0.1</b>	<b>(0.0)</b>	<b>(0.0)</b>	<b>(0.3)</b>	<b>0.1</b>	<b>0.1</b>	<b>(0.1)</b>	<b>0.0</b>	<b>1.5</b>
Transformation Costs	(0.5)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	-	(0.1)	(0.7)
<b>Total Allocated Costs Inc Transformation</b>	<b>(26.8)</b>	<b>(1.5)</b>	<b>(0.9)</b>	<b>(0.9)</b>	<b>(0.3)</b>	<b>(0.6)</b>	<b>(0.8)</b>	<b>(1.3)</b>	<b>(6.3)</b>	<b>(39.4)</b>
<b>Net Surplus / (Deficit) Inc Transformation</b>	<b>1.2</b>	<b>0.0</b>	<b>(0.0)</b>	<b>(0.0)</b>	<b>(0.3)</b>	<b>0.0</b>	<b>0.1</b>	<b>(0.1)</b>	<b>(0.1)</b>	<b>0.8</b>
<b>Budget (YTD)</b>	<b>1.0</b>	<b>(0.1)</b>	<b>0.0</b>	<b>(0.1)</b>	<b>(0.3)</b>	<b>0.0</b>	<b>(0.1)</b>	<b>(0.4)</b>	<b>(0.2)</b>	<b>(0.1)</b>
<b>Variance</b>	<b>0.3</b>	<b>0.1</b>	<b>(0.1)</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.2</b>	<b>0.3</b>	<b>0.0</b>	<b>0.9</b>
<b>RAG STATUS (Actuals V Plan)</b>	<b>G</b>	<b>G</b>	<b>A</b>	<b>G</b>	<b>G</b>	<b>G</b>	<b>G</b>	<b>G</b>	<b>G</b>	<b>G</b>

## Notes:

1. DTS Management costs (incl Transformation) allocated prorata across Clinical Services Operating unit using allocated costs as a basis.
2. IBGRL & Reagents now included in RCI
3. SCDT includes BBMR & CBB

	Actual Apr-21 £k	Forecast May-21 £k	Forecast Jun-21 £k	Forecast Jul-21 £k	Forecast Aug-21 £k	Forecast Sep-21 £k	Forecast Oct-21 £k	Forecast Nov-21 £k	Forecast Dec-21 £k	Forecast Jan-22 £k	Forecast Feb-22 £k	Forecast Mar-22 £k	Total £k
<b>Opening bank balance</b>	<b>53,211</b>	<b>49,942</b>	<b>49,550</b>	<b>63,435</b>	<b>65,537</b>	<b>67,029</b>	<b>66,575</b>	<b>73,071</b>	<b>72,733</b>	<b>64,990</b>	<b>65,316</b>	<b>52,166</b>	<b>53,211</b>
<b>Receipts</b>													
Debtors & Other Receipts	33,878	33,557	36,247	34,102	29,804	35,530	38,401	33,893	33,359	35,192	33,545	39,582	417,089
Revenue Cash Limit	0	0	17,651	5,884	5,884	5,884	5,884	5,884	5,884	5,884	5,884	5,884	70,605
Revenue Cash Limit - Pensions Uplift	824	0	0	3,296	824	824	824	824	824	824	824	1,536	11,424
Capital Cash Limit	0	0	0	0	0	6,000	0	0	5,000	0	2,000	9,500	22,500
<b>Total Receipts</b>	<b>34,702</b>	<b>33,557</b>	<b>53,898</b>	<b>43,282</b>	<b>36,512</b>	<b>48,237</b>	<b>45,109</b>	<b>40,600</b>	<b>45,067</b>	<b>41,899</b>	<b>42,253</b>	<b>56,502</b>	<b>521,618</b>
<b>Payments</b>													
Staff Expenses	15,253	19,483	19,711	20,669	19,918	20,217	20,362	21,381	22,810	20,375	20,862	27,742	248,782
Other Revenue Payments	22,286	14,065	19,802	20,011	14,501	17,591	17,350	18,557	28,500	19,199	20,357	43,567	255,788
Capital Charges Less DH Credit Due	0	0	0	0	0	10,184	0	0	0	0	10,184	0	20,368
Capital Payments	432	400	500	500	600	700	900	1,000	1,500	2,000	4,000	9,968	22,500
<b>Total Payments</b>	<b>37,971</b>	<b>33,949</b>	<b>40,013</b>	<b>41,180</b>	<b>35,019</b>	<b>48,692</b>	<b>38,612</b>	<b>40,939</b>	<b>52,810</b>	<b>41,574</b>	<b>55,402</b>	<b>81,277</b>	<b>547,438</b>
<b>Closing bank balance</b>	<b>49,942</b>	<b>49,550</b>	<b>63,435</b>	<b>65,537</b>	<b>67,029</b>	<b>66,575</b>	<b>73,071</b>	<b>72,733</b>	<b>64,990</b>	<b>65,316</b>	<b>52,166</b>	<b>27,390</b>	<b>27,390</b>

<b>Debtor Days (Target is 22 days)</b>	11
<b>YTD BPPC By Value % (Target is 95%)</b>	92.2%
<b>YTD BPPC By Number % (Target is 95%)</b>	94.3%

Overdue Debtors NBS/ODT £000's	1-30 Days overdue £000's	31-60 Days overdue £000's	61-90 Days overdue £000's	>90 Days overdue £000's	Total Overdue £000's
<b>Total Overdue Debtors</b>	<b>3,003</b>	<b>813</b>	<b>270</b>	<b>369</b>	<b>4,454</b>

Top 5 > 90 days Overdue Debtors £000's	Mar-21		Apr-21	
	>90 Days overdue £000's	Total Overdue £000's	>90 Days overdue £000's	Total Overdue £000's
LEEDS TEACHING HOSPITALS NHS TRUST	97	165	83	395
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUN	63	137	65	219
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	14	32	31	588
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	15	106	23	253
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST			16	173
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	29	57		
<b>Total 5 Overdue Debtors</b>	<b>217</b>	<b>497</b>	<b>218</b>	<b>1,628</b>
Other Debtors	138	3,944	151	2,826
<b>Total Overdue Debtors</b>	<b>335</b>	<b>3,943</b>	<b>369</b>	<b>4,454</b>

<b>Notional Cash Split</b>	
Blood	£13.7m
Clinical Services	£4.7m
ODT	£9.0m

>90 DAYS OVERDUE	Profile by Month											
	Actual Apr-21 £000s	Actual May-21 £000s	Actual Jun-21 £000s	Actual Jul-21 £000s	Actual Aug-21 £000s	Actual Sep-21 £000s	Actual Oct-21 £000s	Actual Nov-21 £000s	Actual Dec-21 £000s	Actual Jan-22 £000s	Actual Feb-22 £000s	Actual Mar-22 £000s
Target £0.5m for over 90 days by 30 Apr 2021												
Ledger Balance at month end	369											
Target	500											

Tea/Coffee Break

# 11. Corporate Strategy Development: Emerging Strategic Themes (21-36) - Tracey Barr to join

For Discussion

Presented by Katie Robinson



## Blood and Transplant

### Corporate Strategy Development

#### Emerging Strategic Themes

27 May 2021

#### 1. Summary and Purpose of Paper

We have kicked-off our corporate strategy development process with a two-day workshop with the Executive Team. This paper summarises the emerging strategic themes and will inform our plans for how we progress the development of the NHSBT corporate strategy.

#### 2. Action Requested

We would welcome discussion on these emerging strategic themes and whether you feel there is anything missing that should be included.

#### 3. Developing the corporate strategy

There has been some debate among the Executive Team about the purpose of our corporate strategy. The corporate strategy will set out our core purpose, the level of our ambition, what we need to do and how we need to change as an organisation to deliver that ambition. It will provide us with a framework for prioritising where we focus our efforts and invest our resources and will drive synergies across the services to ensure we are more than the sum of our parts and reduce duplication between directorates. As part of the development of our corporate strategy we will be looking at the external environment we are operating in and seeking input from external stakeholders.

Over the next three to six months the strategy team will be working with Executive Team to lead the development of a new corporate strategy for the next 3 to 5 years, building on the work done pre-Covid whilst recognising that the pandemic has brought many changes that have created new opportunities and challenges that this strategy will need to respond to.

#### 4. Background

Development of our corporate strategy builds on the work started in 2019, which included engagement across the organisation to build on the strengths of the organisation and plan for our future. This was set out in the January 2020 Board Paper *NHSBT Strategic Review – Defining Our Future*<sup>1</sup> which identified **four strategic shifts** for the organisation that support our ambition to save and improve even more lives:

- **System leader:** Historically NHSBT has positioned itself as a stand-alone ALB providing products and services to the NHS. However, as a national provider operating in a federated system of local hospitals we are well placed to step up and be more proactive in bringing players together to drive improvements and reduce variation in patient care and optimise the use of resources across the system.
- **Pro-active and clinically responsive:** Being on the front foot and being more proactive in anticipating and planning for changing patient needs and clinical practice and aiming

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<sup>1</sup> The January 2020 Board Paper *NHSBT Strategic Review – Defining Our Future* is included for reference as Appendix 1.





## Blood and Transplant

to take responsibility for being the change we want to see rather than waiting for or expecting someone else to take the lead.

- **Modern and agile:** Building on the opportunity to adopt more modern tools and practices, without sacrificing our commitment to quality and safety. We aspire to be a modern organisation that embraces innovation and new technology and able to react quickly in response to new requirements and opportunities.
- **Top choice for talent:** Be recognised as a great place to work and destination of choice for top talent by assuming a more visible, promoting our commitment to diversity and inclusion and creating career paths that identify and nurture talent at every stage of people's careers.

A key objective of the workshop was to revisit these shifts, confirm whether they remain relevant and still resonate given the changing environment, and discuss what they mean from the perspective each of the service areas and the implications for the enabling strategies. We will continue to refine these in line with the strategic pillars set out in our 2021/22 business plan which align more with our operating model.

### 5. Day One: Strategic Themes

Our Day One discussions focused on the external trends, the four strategic shifts and the opportunities and challenges these represent for each of the individual services in better meeting the needs of patients.

#### **Theme 1: Our role in the system**

A recurrent theme throughout the day was the need to clearly define NHSBT's role in the health and care system and create a clearer vision as to how it contributes to improving patient outcomes, reducing health inequalities and optimising the use of resources across the system.

#### **Theme 2: System Leader**

Opportunity: All the service areas recognised this as an opportunity but highlighted that it would look different across the organisation. Some are already very well placed to be system leaders because of their established and strong market positions (ODT, Blood). In others where the market is more competitive and fragmented it may mean leveraging our expertise to develop our leadership as part of wider system collaboration (cellular therapies, TES). And in others we are leveraging unique expertise alongside other parts of the health system (pathology, plasma).

What's changed: The pandemic has brought a change of narrative and the system is more open to collaboration. The space has always been there but, with this change, NHSBT has been able to step into that space more easily and has made an impact (e.g. ODT) and built new relationships at the national level (e.g. plasma). We have an opportunity to build on this not only for ODT but for other parts of the business.

Ambition: We want to increase our visibility and be the 'go-to' organisation sitting at the right top table to drive improvement, set standards, reduce variation in clinical outcomes and inequalities for patients, optimise use of resources and ensuring that the UK is at the forefront of innovation.



## Blood and Transplant

**Enablers:** We will need to be more visible, create more space to develop networks and partnerships building on our existing relationships and strengthen our influencing skills at all levels, using our data, insights and international links to leverage our position. We will also need to identify where we are uniquely placed, due to our national footprint and/or specialist expertise, to add value and improve outcomes through strengthening our role in the system.

### **Theme 3: Proactive and Clinically Responsive**

**Opportunity:** To move from being reactive to changes that impact our ability to provide services that meet patient needs, better anticipate and more proactively identify and address future 'gaps', and better understand our impact on clinical outcomes. Changes can arise from a number of sources, such as longer term changes in supply (e.g. donor attitudes, behaviours, donations), demand (e.g. patient demographics, diversity, needs, emerging new diseases) and clinical practice (e.g. treatments). Responding to these changes may require a different volume and/or mix of products and services or create opportunities for new products and services.

**What's changed:** Changing donor behaviours and attitudes, changes in clinical practice (ODT), demand shift for more personalised components (blood) along with innovative technologies that enable us to better understand and match our donors to patient needs (clinical services) and optimise the usability and extend the 'life' of our donor products.

**Ambition:** NHSBT is able to provide everyone who needs our products/services (blood, organ, tissue, stem cells) with something that matches their specific needs and has the knowledge and insight to know how and where to target our efforts. This has a strong link to the role we play in reducing health inequalities.

**Enablers:** We will need to build a bigger donor base and reimagine our model from donor to patient, including changing how we type and match donors. This will need to be supported by improved intelligence and predictive analytics for demand and supply management and patient outcomes. We will need to attract and retain donors to meet evolving clinical need and, in parallel engage more proactively with the clinical community to better understand and meet demand. We will look to strengthen our partnerships with academic and research bodies and support them to get innovations to market and adopted in practice.

### **Theme 4.1: Modern and Agile**

**Opportunity:** Modernise our ways of working, optimising the use of data, technology and automation and develop our culture, governance, processes, and competencies to enable us to be more agile. This will enable us to move faster in the future whilst maintaining quality and safety. We also need to develop our cultural competencies to ensure we understand and communicate and engage effectively with different cultures and communities across the UK.

**What's changed:** Rapid pace of change of real-time data, analytics, digital technologies, and AI is impacting all our businesses. There has been a step-change in the digital infrastructure and greater information sharing across the system to coordinate the response to Covid-19 with increased use of digital communication channels and sharing of data with patients.



## Blood and Transplant

**Ambition:** To react and respond quickly to new opportunities and be able to see integrated data across the end to end pathways from donor to patient.

**Enablers:** Build from solid foundations to implement planned modernisation programmes which may require new facilities and to progress the organisation development work that is already underway. Data, technology, and inter-operability with NHS systems will be key to underpin the modernisation of services and liberate data from closed systems.

### **Theme 4.2: Modern and Agile / Efficient and Productive**

**Opportunity:** Continue to seek opportunities to improve our efficiency and productivity and to better use our estate and resources, ensuring we secure the benefits of scale, integration, co-location and maximise use of our capacity. Ensure we have the best geographic strategy for service delivery that aligns our services and operations to meet our customers' needs.

**What's changed:** Closer working and greater integration between NHSBT services with an increasing shift to 7-day working across the NHS.

**Ambition:** NHSBT optimises use of its resources, including in the context as part of the wider health and care system, and the benefits and synergies from the different services that sit within it. This could result in growth in some areas, and changes in the scope of services in others.

**Enablers:** Develop a better understanding of our customer's changing needs and ensure our footprint is aligned to meet these changing needs. Draw on benchmarking and leverage insights from across the system to identify opportunities to increase productivity and optimise use of resources within NHSBT and for the system.

### **Theme 5: Top Choice for Talent / A Great Place to Work for Everyone**

**Opportunity:** Greater visibility and promotion of NHSBT, attracting the current and next generation of pioneers and influencers and better forward planning to ensure we have the rights skill sets and capabilities to deliver our plans, including multiple priorities in parallel. To shift the culture to one with greater autonomy, delegation and more empowered teams and a commitment to diversity and inclusion and a shift in our engagement both internally and externally.

**What's changed:** We will need to expand our pool of existing skills as well as develop new skills sets (e.g. influencing, data analysis, new discipline of medical science) to deliver our plans. The impending retirement of clinical pioneers creates succession planning challenges.

**Ambition:** To be a destination of choice for top talent and recognised as a great place to work for everyone.

**Enablers:** Strategic workforce planning recognising the new skills sets that will be needed to deliver our plans (including succession planning).

## 6. Day Two: Key Enablers



## Blood and Transplant

Our Day Two discussions focused on what the implications of the strategic themes discussed on Day One have for the enabling strategies. The top three priorities emerging from these discussions are summarised by area.

### Stakeholders and Partnerships

1. **Stakeholder Management:** We need to develop a better understanding of who our key stakeholders and customers are, their priorities and a deeper understanding of what they want / need.
2. **NHSBT Brand:** We need to be more visible and better explain, communicate, and actively promote who we are, what we do, and how we can help.
3. **External Focus:** Use thought leadership and data and evidence to increase our visibility, build networks and engage more with partners across the system.

### Funding and Pricing

1. **New Funding Sources:** We need to think differently about how we fund investment and explore other funding options, such as commercial, R&D, sponsorship, fundraising.
2. **Investment Strategy:** We need a longer-term approach to financial planning looking beyond the 1 to 2-year horizon linked to what we need to deliver our strategic priorities.
3. **Communicate our Value:** We need to review our pricing strategy and develop clear value propositions that support multi-year investment and enable service development, alongside ensuring best use of resources and consideration of our cost base and efficiency.

### Commissioning

1. **Influencing:** Better understand the needs and priorities of commissioners and position ourselves to respond to those needs and to influence them working closer in partnership.
2. **New commissioning models:** A new strategic commissioning relationship with NHSE where we establish our role in setting standards, agree what we are commissioned to do on behalf of the NHS and an approach to co-commissioning at national and sub-national level.
3. **Skills and capabilities:** We need to develop / strengthen our skills and capabilities in influencing/persuading, commercial awareness/understanding, business development.

### Infrastructure

1. **Better use our estate:** We need to review the footprint and adapt our estate accordingly from both an efficiency and geography perspective, to ensure we make best use of resources and are aligned to meet the changing needs of our customers.
2. **Smarter working:** Optimise our infrastructure by exploiting smarter ways of working such as hybrid/collaborative or co-working space, alongside developing a culture that embraces innovation and new ways of working.
3. **Procurement:** Build on the work done in preparing for Brexit to understand and plan for any potential impacts on the business from global shortages and future cost inflation.

### Workforce



## Blood and Transplant

1. **Skills and Capabilities:** Develop technical, information, clinical and business skills and explore opportunities to 'grow our own' and better support internal movement of staff.
2. **Fair, inclusive and values driven:** Promote diversity and inclusion within NHSBT by developing cultural competency at all levels, recognising and rewarding 'good' behaviour and ensuring our policies are fair.
3. **Modern Management:** Improve our management capabilities, including developing a flexible workforce and succession planning and promoting for people leadership and management abilities not just technical skills.

### Technology

1. **Skills:** Develop the skills and capabilities to understand, use and identify and develop opportunities to exploit technologies.
2. **Investment:** Sustained investment with multi-year plans and priorities combined with the ability to exploit emerging opportunities. We need to treat technology as a strategic enabler rather than purely as a cost or invest-to-save option.
3. **Principles:** To support decisions around how and when to use technology, for example automate repeatable tasks, outsource non-specialised work, and human centred design.
4. **Partnerships:** Identify partnerships with tech giants where their interests align with ours and aim for integration / interoperability with the wider NHS.

### Data

1. **Capabilities and skills:** Develop the skills and platforms to enable the potential to exploit data, including embedding data analysis into our ways of working.
2. **New data:** Improve data in specific areas, such as clinical outcomes and clinical usage, health inequalities, diversity, and inclusion, and explore where we can access more data in the future, such as NHS patient records and genomics.
3. **Data strategy:** Develop a comprehensive data strategy which includes an understanding of the data we have and need, ability to extract insight and use it to drive improvements, liberate data from closed systems and integrate data architecture with the wider NHS. Invest in building new data platforms to enable a data driven strategy.

## 7. Next steps

Over the next three to six months we will be continuing to develop the strategic priorities, building on the themes from our workshops earlier this month. To inform this we will be continuing to build on diagnostic work, including horizon scanning and undertaking some more detailed stakeholder engagement work. We will bring updates to the Board and would welcome discussions with the Non-Executive Members to talk through and test as the work develops.

**Tracey Barr, Interim Strategy Lead**

**Katie Robinson, Director of Strategy and Transformation**

**May 2021**

**DRAFT FOR REVIEW**



# NHSBT Strategic Review

**Defining our future**

January 2020

**DRAFT FOR REVIEW**

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## 1. Executive Summary

NHSBT has a long and proud history. We are trusted nationally for quality and safety; admired internationally for our expertise and efficiency; and our people are known for having a strong sense of pride and commitment to our mission of saving and improving lives.

As we look to the future, our ambition is to save and improve even more lives by driving improvements in transfusion, transplantation and advanced stem cell therapies.

To achieve this ambition, we must hold tight to the things that have made this organisation great, not least our values of caring, expert and quality. At the same time, must recognise that that the world is changing around us and be prepared to challenge the status quo and innovate for the benefit of patients.

We have agreed a number of design principles to inform our strategic plans:

- Improve clinical outcomes, by gearing processes and systems around patient needs;
- Improve the experience of donors, colleagues and customers through user-centred design and a focus on diversity and inclusion;
- Enhance agility by clarifying accountabilities and delegating decision making
- Embrace innovation through horizon scanning, investment in R&D, digital and new technology and a culture of curiosity and learning;
- Optimise the transfusion and transplantation systems through data insight and working proactively with our NHS colleagues; and
- Reduce duplication to reduce the cost of complexity and to maximise synergies and valuable resources.

We have reviewed our operating model in line with these principles. To date, we have focused on governance and risk, technology, organisational structures and culture. The outcome of our review will inform an integrated, multi-year roadmap of strategic change and investment. In delivering, we will be cognisant of the need to perform today whilst we transform for tomorrow.



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## 2. Document Overview

The purpose of this document is to summarise NHSBT's strategic ambition, intended Operating Model and current plans for investment and major change. We envision this being a living document that we will update as our thinking develops and our strategic context evolves. We intend it to serve as a helpful narrative for internal and external stakeholders, providing the golden thread between our mission and day-to-day activities.

This document is divided into four main chapters:

### **1. Strategic Context (the 'Why')**

This chapter sets the context or reasons behind our decision to review our operating model. It identifies the internal and external drivers for change and outlines our strategic vision.

### **2. Strategic Ambition (the 'Where')**

This chapter outlines the strategic shifts we want to make as an organisation, in order to save and improve even more lives in the years ahead. This strategic ambition sets the direction of travel for our work today and an overarching narrative into which we will look to incorporate operational-unit and functional strategies.

### **3. Our Operating Model (the 'How')**

This chapter outlines our design principles, which were developed to inform our decisions and how we want to operate. We then translate these into a desired 'future state' for each layer of our operating model e.g. technology, governance, culture, etc.

### **4. Transformation Roadmap (the "What" and 'When')**

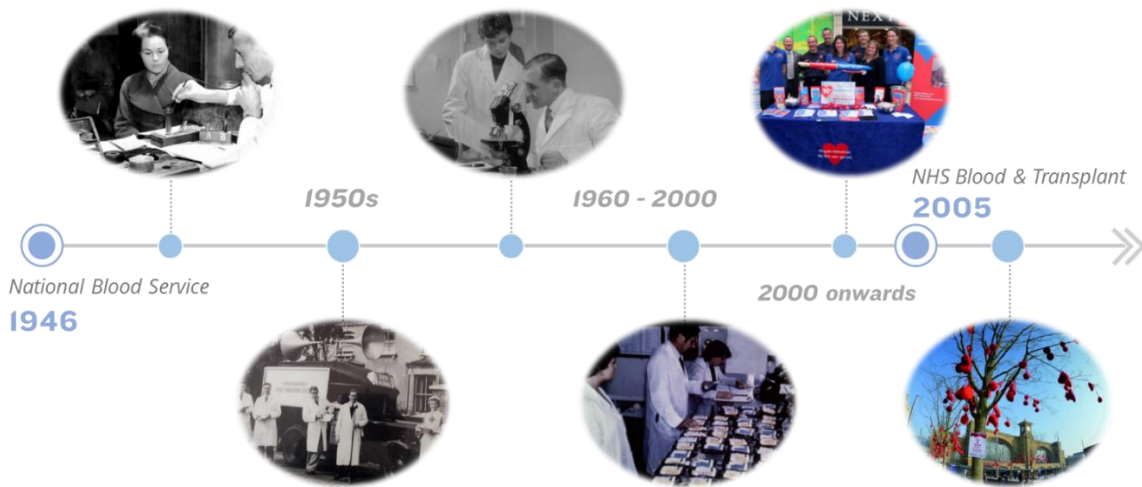
Finally, this chapter sets out the sequence of specific investments and changes that we will look to make over the coming years, to realise our strategic ambitions.

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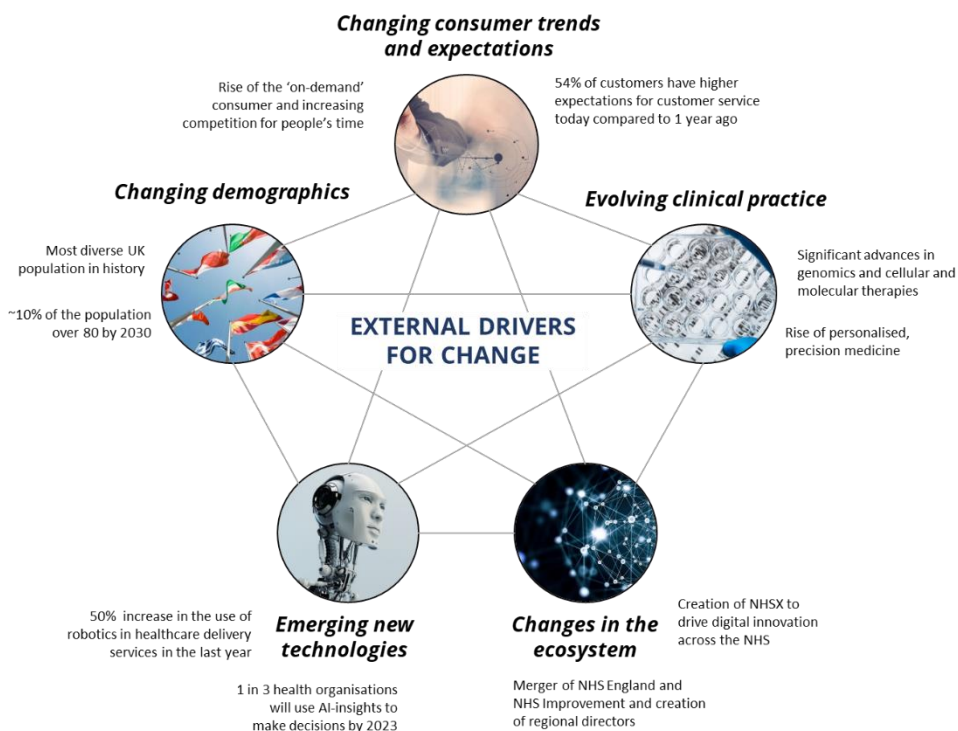
### 3. Our Strategic Context

NHSBT has a long and proud history – from the creation of the National Blood Service in 1946 to the more recent merger with UK Transplant in 2005. We play a unique role in the NHS, linking generous donors with patients who need blood, tissues, stem cells and organs to save or improve their lives. We collect, manufacture and transport to hospital these products of human origin. Our world leading scientists conduct advanced diagnostics, research and development. And our therapeutic service teams provide life-saving treatments direct to patients.

Over the years, NHSBT has witnessed huge changes in its external environment, and risen to the challenge by continuing to innovate and transform. As a result, we are trusted nationally for quality and safety, and admired internationally for our expertise and efficiency.


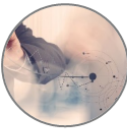
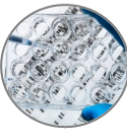




Today, the strategic context in which we operate continues to change around us – from changing demographics and consumer trends to emerging new technology, evolving clinical practice, and changes across the NHS.



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Many expect the next decade will see a revolution in healthcare as we transition away from the standardised, hospital-based systems of the Industrial Age to the 21st century of personalised, precision medicine. The potential benefits are profound but will require us to challenge traditional ways of working; invest in new skills and capabilities; and work imaginatively across boundaries to develop new business models and solutions.

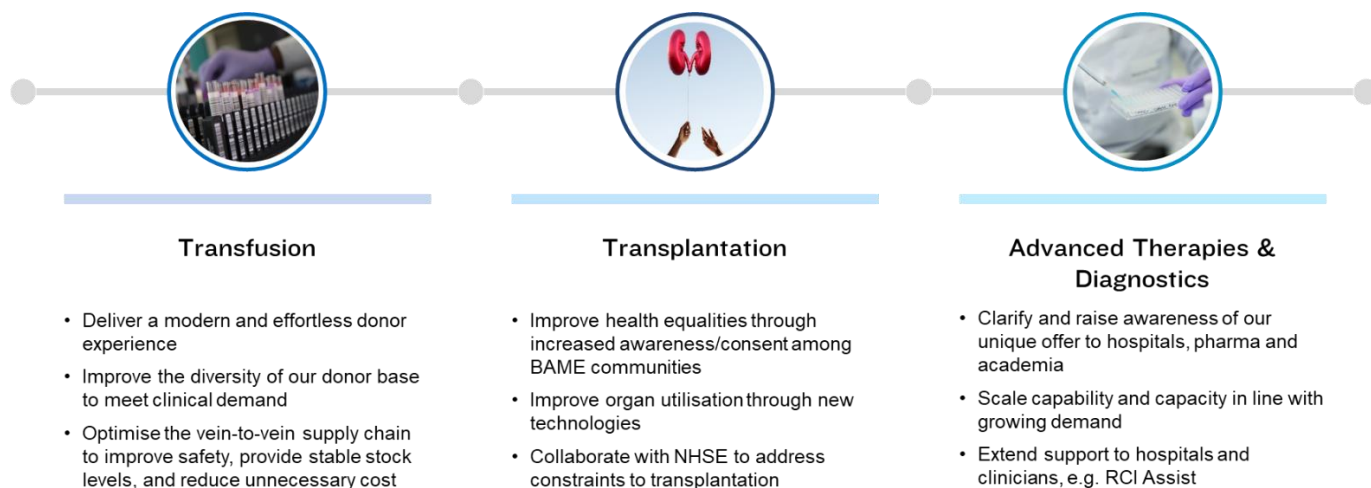
EXTERNAL DRIVERS	IMPLICATIONS
 <p><b>Changing demographics</b></p>	<ul style="list-style-type: none"> <li>• Engage with BAME communities on all forms of donation to tackle health inequalities</li> <li>• Refresh our donor base through attracting a new generation of donors</li> </ul>
 <p><b>Changing consumer trends &amp; expectations</b></p>	<ul style="list-style-type: none"> <li>• Enhance our donor experience, for example more self-service through digital channels</li> <li>• Offer a more personalised, effortless service in recognition of competing demands on donor time</li> </ul>
 <p><b>Evolving clinical practices</b></p>	<ul style="list-style-type: none"> <li>• Increase our agility and strengthen our clinical relationships to enable foresight and rapid response</li> <li>• Develop more specialised products and services, for example more specific matching</li> </ul>
 <p><b>Emerging new technologies</b></p>	<ul style="list-style-type: none"> <li>• Improve safety, drive efficiency and enhance user experience through introduction of automation and AI</li> <li>• Opportunities for interoperability with the NHS, for example dynamic matching of donor supply to demand</li> <li>• Invest in new capabilities to leverage new opportunities</li> </ul>
 <p><b>Changes in the ecosystem</b></p>	<ul style="list-style-type: none"> <li>• Leverage the health ecosystem to maximise patient benefits</li> <li>• Continue to drive efficiencies and find new ways of working in response to pressures on the health sector</li> </ul>

Like all organisations, we have also experienced our share of challenges over recent years – from failures in governance and risk management (e.g. of major projects and programmes) to areas of poor behaviour and engagement. Together with our external context, these internal issues represent the strategic drivers for change and transformation.

## 4. Strategic Ambition

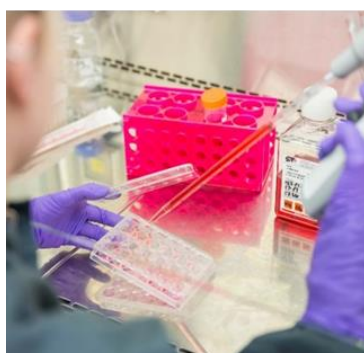
At NHSBT, our mission is to save and improve lives.

As we look to the future, our ambition is to save and improve *even more* lives by driving improvements in transfusion, transplantation, and advanced stem cell therapies. These improvements (summarised below) will be set out in more detail in our Blood Supply, ODT and other operational strategies.



To deliver against these strategic ambitions, we must hold tight to the things that have made NHSBT great, not least our values of caring, expert and quality. But we must also consider the changes in our external environment and respond to feedback from internal and external stakeholders about how we must continue to evolve as an organisation.

Having done so, we have identified the need to make a number of Strategic Shifts:



### A System Leader

Historically, NHSBT has positioned itself as a stand alone ALB, providing products and services to the NHS. It has done so effectively, but as a national provider operating in a federated system of local hospitals, we have a responsibility to step up and take a more proactive role in identifying and driving improvements across the system, as well as identifying opportunities where we can benefit from closer working relationships. Whilst we do not always have the hard levers to drive change, we have untapped convening power (to bring players together) and valuable data about variation in practice and outcomes which we can and should use to optimise the system and improve patient care.

### Proactive & Clinically Responsive

As patient needs and clinical practice evolve, so too does the demand for our products and services. At times, we have found ourselves on the back foot, reacting to changes rather than anticipating and planning for them effectively. Looking forward, we aim to become more proactive and clinically responsive by reacting quickly to signals and working across our supply chain to manage short fluctuations and longer term structural changes in demand. The need to be proactive extends to other aspects of our work, where we must all aim to take responsibility to be the change we want to see rather than waiting for or expecting someone else to take the lead.



**DRAFT FOR REVIEW****NHS**  
**Blood and Transplant**

## Modern & Agile

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There is a perception, if not a reality, that it takes a long time to get things done in (some parts of) NHSBT, and that there is an opportunity to adopt more modern tools and practices, without sacrificing our commitment to quality and safety. We aspire to be – and be seen to be – a modern organisation that embraces innovation and new technology, and is able to act quickly in response to new requirements and opportunities

## Top Choice for Talent

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Despite the important, life saving work we do, NHSBT suffers at times from being relatively unknown as an employer. By assuming a more visible role across the NHS and promoting our commitment to diversity and inclusion, we want to be recognised as a great place to work and, thus, a destination of choice for top talent. We will create career paths for each of our professions and work to identify and nurture talent at every stage of people's careers.

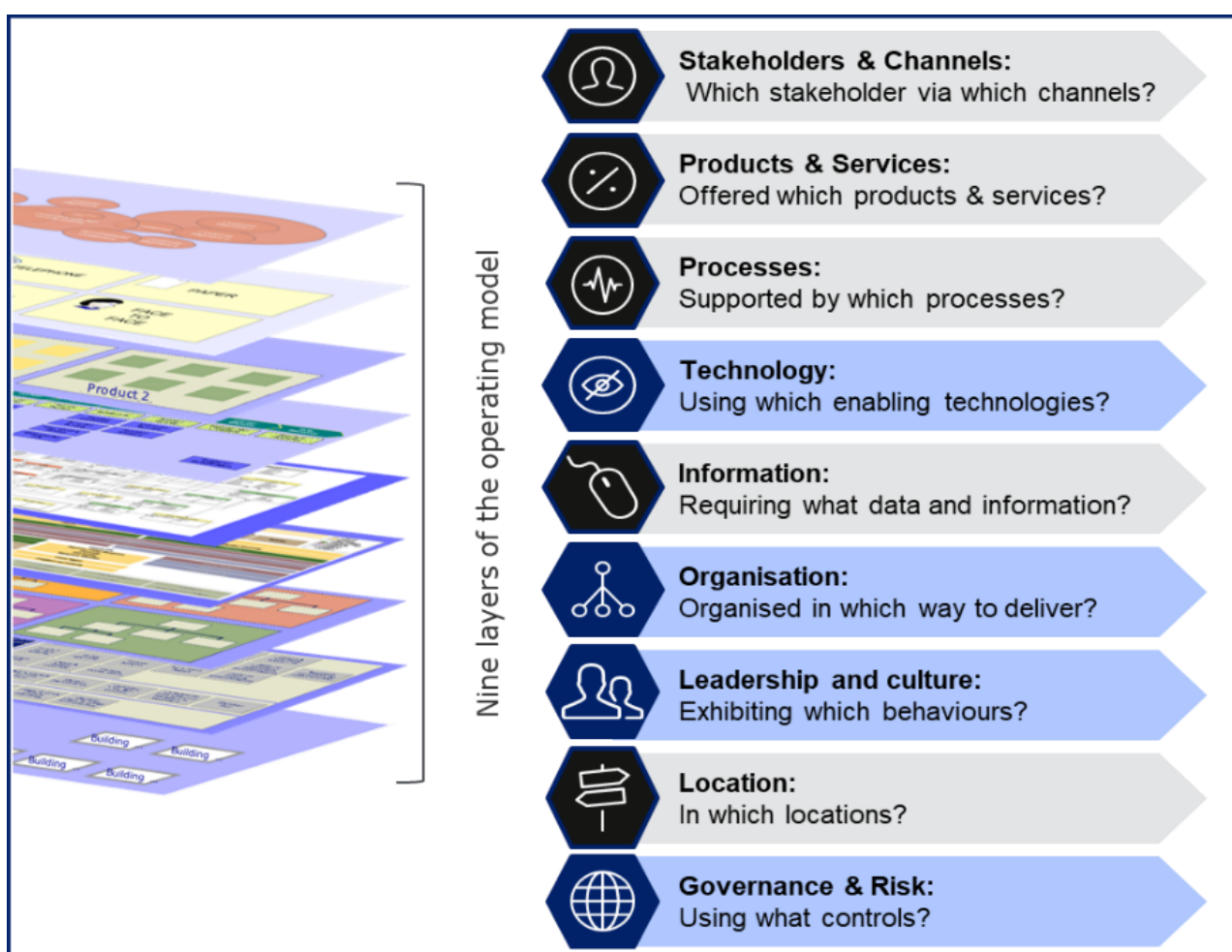


## 5. Our Operating Model

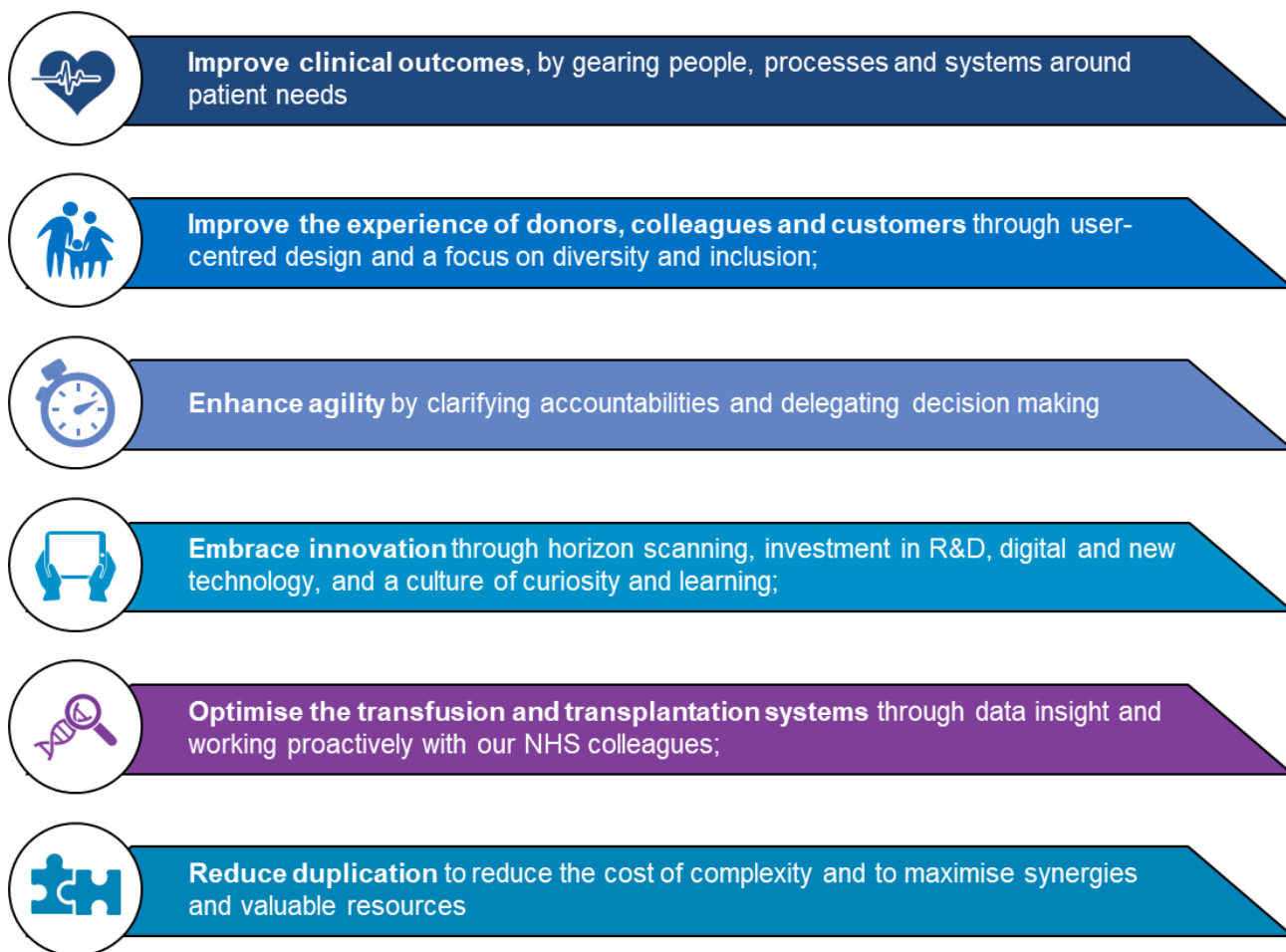
We have reviewed our Operating Model with two things in mind:

- The need to address some of the contributing factors to the issues experienced in the last few years (e.g. CSM, low blood stock levels, limited Internal Audit opinion); and
- The desire to make the strategic shifts set out in Section Four

Operating Models look at an organisation through several lenses or ‘layers’. We have initially focused on the Organisational, Governance and Risk, Leadership and Culture, and Technology layers of NHSBT, though we intend to review other layers over the coming year – particularly Location and, through our work with McKinsey, our Channels and Processes for engaging donors



Before developing our new Operating Model, we first translated our strategic ambitions into a set of Design Principles, which set out the requirements that our Operating Model must support if we are to be successful in executing against our strategy.

**DRAFT FOR REVIEW****Design Principles:**

We have assessed our 'as is' operating model against these design principles and identified the need to make a number of changes, as summarised below. We will continue to use these design principles to inform business planning and to objectively assess our decision making.

**Organisational Layer: how we organise to deliver**

We have re-aligned our directorate structure and senior leadership to support our strategic ambitions. Specifically:

We have brought together the teams responsible for the recruitment and retention of our donors (Marketing, Communications and Donor Relationship Services) into a new **Donor Experience** directorate. In bringing these teams together, our aim was to create a single point of accountability for ensuring that the right mix and volume of donors are available to meet patient needs – today and in the future. We aim to build a clearer view of existing and potential donors, including their motivations and behaviours. We will use this to modernise and improve the donor experience.<sup>[SEP]</sup>

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We have brought together Blood Collections, Manufacturing, Hospital Services and Logistics into an end-to-end **Blood Supply** directorate. This team is responsible for ensuring the safe, reliable and efficient supply of blood components and products to meet hospital demand. This team will have clear accountability for the end to end blood supply chain, giving integrated management from collections through to hospital deliveries. [L1L1] [SEP1SEP1]

We have brought together responsibility for Tissues and Eye Services (TES) and Organ Donation and Transplantation (ODT) under a single **Organs, Tissues and Eyes** directorate. Our goal in bringing these two teams together is to better coordinate our efforts in respect of deceased donors, their families and the transplant and surgical community, and to increase the number and quality of tissues and organs available for transplant. [L1L1] [SEP1SEP1]

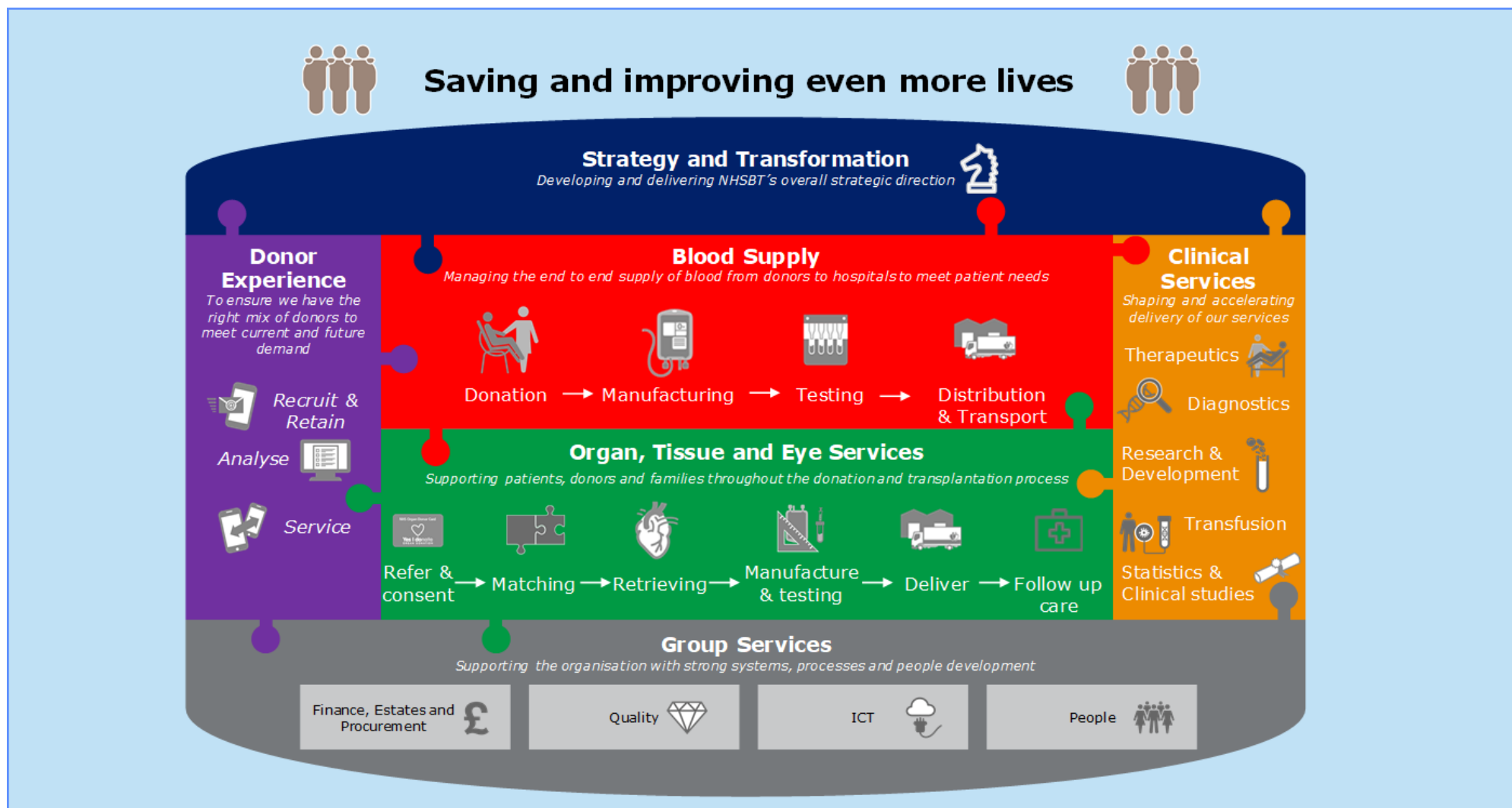
We have expanded the scope of the **Clinical Services** directorate to include our diagnostic and therapeutic services teams. In bringing these clinical and scientific teams together, we seek to strengthen our ties with clinical decision makers in hospitals and to accelerate innovation in what and how we deliver. This team will provide clinical and scientific leadership to internal operational teams and, externally, to the transfusion and transplantation community. As a national provider, we have a responsibility to take the lead in optimising the end-to-end system and improving patient outcomes.

Finally, we have created a new **Strategy and Transformation** team to oversee and coordinate the development and delivery of our corporate strategy.

This new organisational model is illustrated in Figure 1. We will shortly be reviewing how our Group Services functions (Finance, Estates and Procurement, Quality, ICT and People) best support this new model.



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**Figure 1: Our new organisational model**

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**Leadership and Culture layer: enabling the organisation to deliver**

NHSBT benefits from a committed workforce that is passionate about our mission to save and improve lives. The organisation actively invests in leadership and talent development.

In Let’s Talk and other staff engagement exercises, we have heard the need to improve communication and collaboration across directorates and levels. We have also heard the need for leaders to do a better job of listening and creating an open culture. It is critical that people feel encouraged and safe to speak up when they have questions or concerns, whether about operational and project performance; donor and patient care; and/or how they are managed and treated by other colleagues.

In response to this feedback, we have implemented a number of leadership and organisational development interventions to begin addressing these issues:

Executive Team	Wider Leadership Team	All Colleagues
<ul style="list-style-type: none"> <li>• Shorter and more frequent meeting cadence</li> <li>• Regular ‘check ins’</li> <li>• Facilitated development days offsite</li> <li>• Annual 360 feedback</li> <li>• Individual development plans</li> </ul>	<ul style="list-style-type: none"> <li>• Weekly ‘stand ups’ – to report progress and flag issues</li> <li>• Regular conferences and master classes</li> <li>• Talent discussions and development plans/ programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Let’s Talk events across the country</li> <li>• Regular ET engagement via Yammer</li> <li>• Appointment of a Freedom to Speak Up Guardian</li> <li>• 3<sup>rd</sup> party organisational diagnosis at Colindale</li> <li>• Increased D&amp;I activity and comms</li> <li>• ‘Proud of our Past, Excited about our Future’ comms campaign</li> </ul>

Recognising that ‘strategy eats culture for breakfast’, we will continue to invest in this important area, building a stronger and more collaborative team, as well as a more open, safe and inclusive culture where everyone - regardless of their gender, ethnicity, age, disability, age or sexual orientation - is able to do their best work.

We will work with our diversity networks to better understand the lived experience of different groups, and with our Heads of Centre to understand the subcultures and challenges in different locations. We will use this, together the feedback and insight from regular People Surveys, to inform our plans in this area.

Culture is essentially the product of our everyday words and actions. It can be summarised as ‘what it feels like to work round here’. Our aim is to make NHSBT a great place to work - for everyone.

**Governance layer: providing assurance and controls**

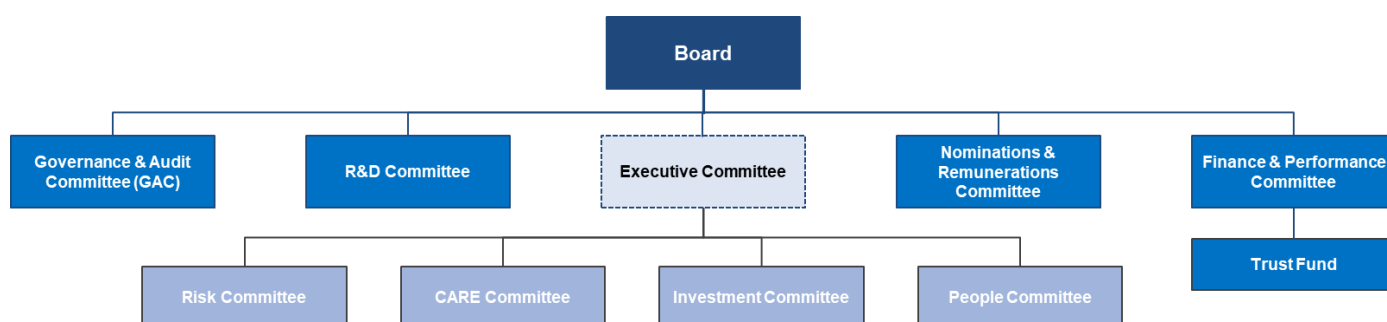
We have reviewed our governance structures, processes and capabilities with an eye to ensuring clear accountability, increasing delegation (where appropriate) and, importantly, improving decision making, risk management and Board assurance.

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As a result, we have expanded the scope of the Remuneration Committee to include Nominations and, similarly, clarified the scope of the Finance Committee to include performance. The Finance and Performance Committee will also take responsibility for the NHSBT Trust Fund.

We have agreed to disband the Transplant Policy Review Committee (TPRC) and subsume their responsibilities in the Care Committee for Organ Donation and Transplantation. We have also agreed to disband the National Administrations Committee. The Non-Executive Directors with special responsibility for each country will continue to represent the interests of the devolved administrations ('DA') at the Board, which is also attended by DA representatives.

We have formalised the concept of an Executive Committee and created a number of new sub-committees to provide increased scrutiny and assurance of strategic risk management, investment decisions and our people strategy. The proposed configuration is set out below, followed by a summary of the Terms of Reference for the Board and each committee.



**The Board** - The Board's role is to provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed. The Board should set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance. The Board set the organisation's values and standards and ensures that its obligations to patients, the wider NHS, the Department of Health and Social Care and the Secretary of State are understood and met.

**The Governance and Audit Committee (GAC)** – The GAC is responsible for the oversight of scrutiny and review of financial systems, financial information and matters of compliance with law and the Code of Conduct. The GAC reviews audit of risk management and clinical governance systems and the systems that provide organisational control. The GAC ensures that these responsibilities are properly addressed through the organisation's committee structure. Through its scrutiny and reports, the GAC enables the Board to have confidence in its control systems and it provides an important voice when the Board considers the Statement on Internal Controls (SIC) and its implications.

**The R&D Committee** – This committee approves, on an annual rolling basis, the R&D programme for presentation to the Board, having assurance of the quality, relevance and translation of the research, the facilities for its delivery, and the quality of the research staff. The R&D Committee makes decisions on allocation of research and development funds, within the delegated financial limits of NHSBT. The R&D Committee receives annual reports and

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monitors progress on funded projects. The R&D Committee reviews, on an annual basis, the portfolio of external grants held by NHSBT's Principal Investigators.

**Finance and Performance Committee** – This committee is responsible for scrutinising NHSBT financial and planning reports, making recommendations to the NHSBT Board on financial performance, planning and pricing issues and supporting the Board with its financial and investment decisions.

**The Remunerations and Nominations Committee** – This committee advises the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive members. The Board may also decide to extend the Committee's remit to include other senior managers' terms. Advice should include all aspects of salary, provisions for other benefits, including pensions and cars, as well as arrangements for termination of employment and other contractual terms. To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the board and make recommendations to the board with regard to any required changes. The committee will give consideration to and make plans for succession planning for the Chief Executive and other Executive directors. In addition, it will oversee the Fit and Proper Persons test for the submission of statements to the CQC.

**The Executive Committee** - The Executive Committee manages the day-to-day activities of the organisation by developing and implementing strategy, operational plans, policies, procedures and budgets; driving and monitoring operating and financial performance; assessing and controlling risk; and prioritising and allocating resources. In fulfilling its purpose, the Executive Committee will give due consideration to the interests of various stakeholders (donors, patients, employees, partners, regulators and the public at large); upholding the integrity, brand and reputation of NHSBT; and planning the organisation's future development. Committees reporting to the Executive Committee will be:

**The Risk Management Committee** – This committee will be responsible for the oversight of risk management and assurance. These will cover all risks that might prevent the organisation from meeting the goals set out in its Business Plans. The Committee is expected to ensure that the organisation has a strategy which allows for the continuing identification and prioritisation of risks, a description of action taken to manage each key risk and the identification of how risk is measured. The Committee should report significant risks to the Executive Committee and the Board for their consideration.

**The Clinical Audit, Risk and Effectiveness Committee (CARE)** – The committee's purpose is to provide the Executive Committee with information on all elements of clinical effectiveness, and thus provide assurance of maximum patient/donor benefit and safety, as well as management of clinical risk.

**The Investment Committee (IC)** – This committee's purpose will be to scrutinise business cases over £Xm (to be defined) in order to: assure the strategic fit; options analysis and Value for Money; affordability; procurement strategy; and organisation's plans to deliver. The IC will provide recommendations to the Executive Committee for business cases over £Xm and have delegated authority from ExCo to approve business cases up to £Xm. The IC will review delivery across the approved portfolio of projects and programmes and may request assurance if/where delivery is at risk.

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**The People Committee** – The purpose of this new committee is to be responsible for the colleague experience of working at NHSBT. In this capacity it will assure and inform the Executive Team on all matters that relate to the management and leadership of People across NHSBT. The committee will set and monitor people-based metrics, determine the approaches to leadership, talent management, recruitment & retention, reward & benefits, change management and scrutinise papers and business cases in detail that impact the Employee Experience. The People Committee will make recommendations to the Executive Committee where investment is required or where there is a significant impact to colleagues across NHSBT.

Feeding into this structure, there are many additional 'boards' and committees operating across the organisation. Further work is underway to review and streamline these fora, to reduce duplication and clarify accountabilities.

**The Technology Layer – improving our systems and user experience**

Technology will be a key enabler in delivering against our strategic ambitions. Here, we set out our desired future state that we will look to build towards as part of a multi-year roadmap of investment and change.

**Future State**

We embrace and leverage new technology and innovation driving improved performance within the organisation; providing donors with the high-quality digital experience they expect; improving clinical outcomes through digital interoperability with the rest of the NHS; and exploiting data to create insight and improve services.

Our technology products and services are designed around user-needs and are accessible to all. They are built on platforms that enable us to deliver new capability at pace whilst maintaining stability and are compliant with regulatory requirements like IVD and GDPR. Our technology is value for money because we maximise opportunities to share services from across the NHS and government, use open source solutions where possible and continuously maintain and upgrade our systems. In return we work in the open, make our systems appropriately accessible to others through APIs and share our knowledge and experiences with the Digital, Data and Technology communities.

Our technology team are continuously developing their skills, are actively curious about developments across NHSBT. Roles and grades are aligned with the cross NHS Digital Data & Technology profession allowing us access to a broader pool of talent with health tech skills.

**Improved Performance**

Everyone who works for NHSBT has access to the foundational tools they need to be effective, they can work collaboratively with internal and external colleagues and virtual meetings are as effective as face-to-face meetings. Colleagues are able to get maximum benefit from our investment in Office 365.

We use data to improve the way operate. We use real-time data to support our decision making across every layer of the organisation providing robust rationale and evidence for our decisions.

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We take opportunities to simplify and digitise our processes and supply chains, for example we have automated our key manual manufacturing processes (sample handling, donor and product testing, blood labelling, stock management and dispatch).

**Digital donor experience**

Our digital donor experience enables us to effectively recruit and retain targeted donors. We have improved the donor experience by digitalising the donor journey including donor health checks, early donor seeing, self-check in, platelet donor records and improvements to appointment booking. We have a 'single donor view' across the organisation, with integrated donor information from all touchpoints and interactions from each directorate. We provide consistent, effective and personalised communication across the donor's preferred channel. The digital and the off-line experience for donors are seamlessly aligned into an overall service.

**Digital interoperability with the NHS**

We use technology to collaborate with the NHS and have interoperability between key systems, for example we are able to have dynamic matching of donor supply to hospital demand. We can easily communicate with colleagues from around the NHS supported by easy access to NHS Mail addresses and collaboration tools.

We have a strong partnership with NHSX and NHS Digital enabling us to influence national priorities and take advantage of national funding.

**Creating insight from data**

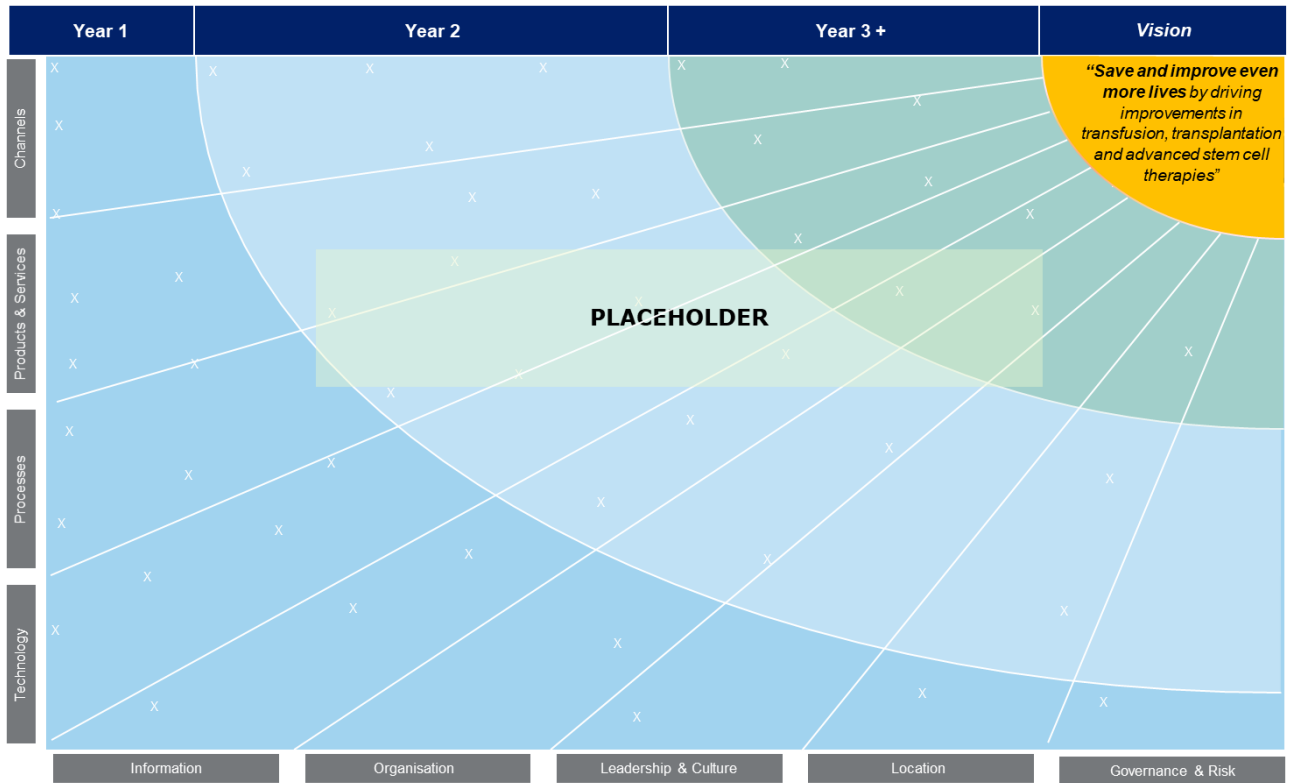
We have a clear understanding of the data we hold, where it is and how well it is protected. We proactively use our data and combine it with other data sources to create insights and drive improvements to clinical outcomes and services.

For example, we use our data on variation in practice and outcomes, internally within NHSBT and externally with the NHS, to optimise the system and improve patient care.

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## 6 Transformation Roadmap

**Currently updating**



## 12. D&I Metrics update (21-37) - Shane White & Richard Crossen to join

For Discussion

Presented by Rosna Mortuza





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### NHSBT Board

### Diversity and Inclusion Update

27<sup>th</sup> May 2021

**Status: Official**

#### 1. Summary and Purpose of Paper

To provide an update on where we are with developing a framework for delivering Diversity and Inclusion at NHSBT with a focus on a discussion of D&I Metrics and data to drive improvement.

#### 2. Action Requested

The Board is asked to:

- Provide continued endorsement and support of the D&I Programme.
- Consider and comment on the D&I Dashboard attached as part of the report.

#### 3. Background

The purpose of this paper is to share progress update on our Diversity and Inclusion (D&I) programme of work following the last Board update in March and discussion in January. We've delivered actions agreed in January's paper as outlined in summary below with a view to focus the discussion here on how we're optimising organisational data, to finalise metrics that matter and drive improvement.

#### 4. Executive Summary

##### 4.1 D&I Framework for Delivery – Appendix A

This sets out how we consolidate at Executive level all the work being done to achieve greater transparency, grip and discipline on planning and delivery. The framework applies to the whole organisation for delivering D&I, setting out accountability at:

- Corporate level – reviewing our policies and processes with tools to support positive change
- Directorate and Team level – ensuring there is real engagement, collaborative action plans and delivery with metrics that matter to their own teams
- Individual level – focussing on our own learning and individual accountability

The framework directly holds Executive Directors to account through for example, their directorate level D&I plans. The plans are expected to reflect real and localised issues in respective areas, actions being taken by the directorate's senior responsible officers with a clear line of sight to the impact being achieved. This will include how directorates plan to achieve a minimum 15% national target of BAME colleagues in senior positions, setting targets to ensure we are an LGBT+ inclusive organisation and supportive of colleagues with disabilities and/or long term health conditions to improve disclosure and declaration rates. The



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shaping of actions and outputs around this must include and be experienced at every level. I've also added guidance and key lines of enquiry our directorate teams should be asking themselves and looking for answers in an inclusive way, as part of providing a clear framework for delivering on D&I. Appendix A attached illustrates this as well as our overall framework which continues to be shaped as we move forward. We will have key monthly reporting on plans at Directorate and Corporate level with key stakeholder scrutiny sessions in plan to keep pace and momentum on progress as well as impact that is meaningful to our people.

### 4.2 D&I Communications and Engagement – Appendix B

For better transparency and to better inform and engage the organisation on D&I activities, progress and feedback loops, we've initiated a number of specific actions including my D&I Update consolidating all D&I activity in an accessible place on and offline (Appendix B) attached, with a link on our governance structures to share key actions and takeaways from meetings including the D&I Programme Board and EDI Council.

## 5. D&I Metrics

Over the past months we've worked across the organisation in a joint effort to review and develop our metrics that matter to our people and meet the needs of the organisation. We will use Diversity and Inclusion metrics to prioritise initiatives, set targets and programme goals with clear lines of accountability.

Our metrics will serve 3 purposes:

- Diagnose and unpack key priorities and risk areas (including workforce data, employee engagement and Staff Network hot topics)
- Set targets and track progress against initiatives
- Measure the impact of initiative

Metrics evidencing the impact of our D&I work will be used to engage with our people, strengthen leadership commitment and scale up further change. This will promote workforce trust, satisfaction and commitment to an agenda that will require multi-year investment and staying power for transformational change. In developing our metrics, we need to start with where we are. Consideration must be given to the maturity of our D&I programme and the specific initiatives we are trying to implement. The use of metrics will also help work towards de-escalating some of the personalised, historical and high emotional charge associated to diversity and inclusion issues in the current organisational climate.

### 5.1 Workforce data

A key priority has been to produce a workforce data pack to inform accurate insights and prioritisation. Our workforce data has been a consistent theme and ask across the organisation from our staff networks to directorate teams. We have therefore developed a workforce data pack with common data principles to serve as a 'single source of truth' for the organisation, and to help build our understanding of workforce inequality gaps and drive change particularly in recruitment and progression workstreams, whilst addressing our expertise and capability requirements in these areas.

We are currently at beta stage with the data pack providing a high-level D&I dashboard of our workforce against protected characteristics. It will also capture trends including progression of



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applicants across the end to end recruitment process; monthly net positions of Black and Asian Minority Ethnic (BAME) workforce; Grievance, Dignity at Work and Disciplinary cases; levels of employee engagement heatmap and geographical/centre based variations. There will also be further breakdowns by protected characteristics (where available and appropriate) as well as Directorate level D&I Dashboards.

To drive greater transparency, we are working towards building the data workforce pack into our data platform, Power BI. This will allow access to the information and to be extrapolated by users as required. In the first instance, the data tool will be available to Staff Networks and Management Teams with a view to publish more widely once data security has been established.

### 5.2 Workforce data insights – Appendix C

In the meantime, our insights from Workforce data is driving change in several areas including the following examples:

- The data shows an issue relating to non-disclosure particularly in relation to Sexual Orientation and Disability. Work is taking place with the People Team and Internal Communications to promote and increase declarations. This has been helped by recent Yammer posts made by Wendy Clark encouraging declarations on behalf of the staff Disability and Wellbeing Network. The People Team is also re-launching a workstream campaign to encourage and enable declarations around disability and long-term health conditions.
- The data confirms the challenge with low BAME representation at Band 8 and above levels. Over the last 3 months there has been a Net increase in the number of BAME colleagues of 22 however the numbers within Band 8 posts shows no Net change. Work continues on identifying and addressing the barriers to career progression. In addition, work is coming to fruition to redesign our Employee Value Proposition to ensure we are attractive as an employer. We are also looking at how we appoint senior posts to develop processes that 'blind test' up front candidates' abilities.
- Our heatmap of geographical (centre) bases will drive targeted interventions in poorly represented areas of service in relation to patient-facing roles.
- The production of the data pack has allowed a greater focus on casework both in terms of type but also in understanding how different protected characteristics are represented in the cases that progress following triage. We now have transparency on cases that are progressing with the agreed SLAs and which need intervention. This is key as we know cases that take longer to resolve become increasingly challenging to resolve.
- Whilst the overall picture is informative the pack allows a focus to be applied to the discrepancies across Directorates. For example, only DDTS, Donor Experience and Strategy & Transformation have BAME representation at a senior level. Interestingly these directorates have undergone significant recruitment over the last 2 years. It is encouraging therefore that this demonstrates change is achievable. However, many challenges remain in the other directorates to ensure that the senior teams reflect the organisation we lead.



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### 6. Next Steps

- Finalising data pack with feedback from Exec Team
- Meeting with Jo Lewis and Piers White to sense check arranged for 25<sup>th</sup> May 2021
- Board learning session on D&I to be re-scheduled.

**Author: Rosna Mortuza, Chief Diversity and Inclusion Officer**

**Responsible Director: Katie Robinson, Director of Strategy and Transformation**

**Patricia Grealish, Interim Chief People Officer**

**May 2021**



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# **Diversity and Inclusion – Strategic Framework development**

**To be reviewed June 2021**

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# Objectives

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To build a strategic framework for delivery of Equality, Diversity and Inclusion (EDI) priorities across the organisation by establishing a **D&I Programme Board**.

The core purpose of the D&I Programme Board will be:

- To consolidate all D&I programmes and activity to optimise transparency, support and scrutiny
- To define metrics and provide oversight of delivery of agreed programme initiatives
- To provide corporate guidance and steer for Directorates to develop and deliver their own plans
- To create pace, reporting and greater accountability in directorate and team level activity
- To unlock barriers and accelerate activity and progress into visible and measurable impact
- To have collective and visible leadership in driving D&I implementation

# D&I Programme Board

The **scope** of the Programme Board will address three key areas:

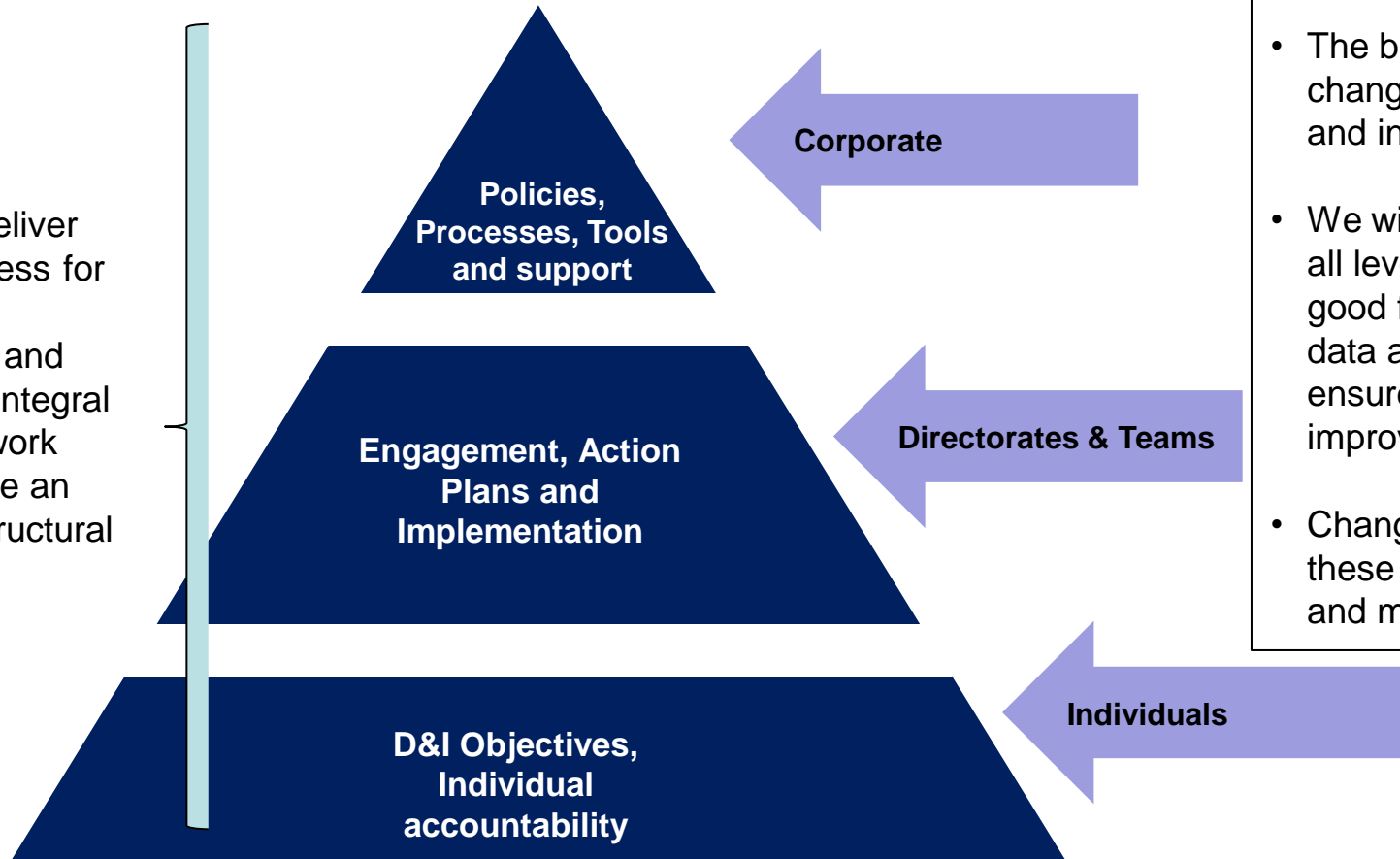
1. Corporate level – how our policies, processes and tools support all levels of the organisation
2. Directorate level – how our Directorates and Teams engage and implement action plans at localised levels
3. Individual accountability – supporting our people in their own D&I journeys, so that change is also felt in the day to day experience and behaviours

## Programme Board **form**:

- The Programme Board will be Chaired by the CDIO
- Membership will consist of all Executive Team members as SROs
- Workstream leads will be invited to present / provide exception reporting
- Meetings have been set monthly for 2021 and will be supported by the Company Secretariat
- The first meeting has been set for **March 18<sup>th</sup> 2021**
- Standing Agenda items will include 1) Progress updates 2) Key areas for attention 3) Proposals for sign off

# Framework for delivery

- We will develop and deliver education and awareness for impact at scale
- We will ensure culture and *lived experiences* are integral throughout this framework
- The D&I Team will have an oversight role for all structural interventions



- Action needs to be taken at all levels within the organisation
- The biggest impacts will be felt by changes in the day to day experience and in behaviours of people
- We will need to work on changes at all levels in parallel, ensure we have good feedback loops through our data and measurement cycles to ensure continuous learning and improving
- Change programmes in each of these areas will work towards parallel and multiple timeframes



# D&I Priorities

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1. Inclusive Recruitment
2. Promotions and succession planning
3. Managing conflict and grievances
4. Leadership and Management
5. Communications, Education and Engagement
6. Data quality and metrics will be a cross-cutting workstream running as a golden thread in all the above

An information pack will be available consolidating our workforce and people survey data (by organisation and directorate) indicating how we've arrived at these priorities.

Data reports and visualisation tool in development.

# Data and Measurement

## Analysis and Insights to drive decision-making

This workstream will provide oversight of our data (qualitative and quantitative) and drawing in wider analysis and evidence on diversity and inclusion. Key aspects of this will include:

- Developing corporate and directorate KPIs and reporting, which will include [draft KPIs on next slide]
  - Baselineing
  - Trends
  - Variation by centre (geography) and directorate
- Joining up with the data strategy to improve data, analysis and reporting [link with DDTS – Dan Jeffrey]
- Establish workforce data pack with visuals (Patricia outsourcing) as single source of truth and for communications
- Supporting engagement across the organisation to improve data quality and reporting by characteristic
- Quantitative data will be analysed alongside other sources of evidence internally and externally to shape our programme, including:
  - D&I Team intelligence gathering (and sense check)
  - EDI Consultative Committee
  - EDI Council and staff networks
  - FTSU

# Key Organisational Metrics available right now

Description - Workforce	Baseline measure currently	Comparator	Target metric to reach
BAME, Gender and LGBT <b>representation at senior levels</b>	Establish baseline % BAME – 10% currently	NHS NHS ALBs	Min. 15%BAME representation in senior leadership (8a+) over next 5 years. Stretch to 20% where feasible. <b>(Quarterly)</b>
<b>Diversity representation</b> at all levels of workforce	Segmentation by pay bands, directorates, professional group 15% BAME overall 3% Disability 2% LGBT+  WRES/WDES/WEI measures	NHS NHS ALB ranking ONS by geog. region Stonewall WEI ranking	Min. 20% BAME representation at all levels over 5 years 10% increase in disclosure rate of LGBT and Disability/LTHC year on year <b>(Quarterly)</b>
<b>Retention</b> (average tenure) for employees and by protected characteristics	Net differences between p/c groups		Set target to close gap <b>(6 monthly)</b>
<b>Recruitment</b> – tracking # diverse applicants across pipeline (attraction, selection, induction ) against potential/total pool of applicants	Totals by organisation Totals by directorate Plus feedback from applicants, review of job adverts and recruitment practice		Tba following baseline analysis. Agree % target representation for interview stages (i.e. Rooney Rule at 8a+). <b>(Monthly)</b>

## Key Organisational Metrics available right now

Description - Workforce	Baseline measure	Comparator	Target metric
<b>Pay and benefits</b> – analyse pay and reward opportunities across functions (esp. by Gender and Ethnicity)	Equal Pay Audit report	National	<b>(Annual)</b>
<b>Staff Engagement</b> – (Peakon engagement scores across people, directorates, protected characteristics)	Peakon Pilot results 2020 Retrospective staff survey results last 5 years	NHS	10% improvement in 2021 from last year – sections tba <b>(6 monthly)</b>
<b>Exit interviews</b> – employee reasons for leaving and overall lived experience (by protected characteristics)	Completion rate (and by protected characteristics) Analysis of retrospective reviews and key themes		<b>(6 monthly)</b>
<b>Conflict and Grievances</b> – track HR case management, grievances and legal action (by protected characteristics)			<b>(Monthly)</b>

# Key Organisational Metrics to be developed

Description – External engagement	Baseline measure	Comparator	Target metric
<b>Professional Development</b> – tracking lateral moves, stretch/‘acting-up’ opportunities, training and development opportunities	Take up rates and feedback by workforce (directorates, functions and protected characteristics)	NHS	<b>(Quarterly)</b>
<b>Promotion</b> - tracking promotions (by protected characteristics and timeframe)	By directorate, pay bands, professional group		<b>(Quarterly)</b>
<b>Talent Management:</b> <b>Programme offer</b> <b>Identified talent pools</b> <b>Employee Networks and focus groups</b> - complementing workforce analytics	Take up rates analysis (by p/c) Identifying and tracking Talent by directorate Key baseline themes and SMART responsive actions		<b>(Quarterly)</b>
<b>Organisational brand/reputation</b> – capturing the quality and strength of our brand among different identity groups	The development of these are at early stages with dependencies on external data sources - may take longer.		
<b>Service user engagement, experience and diversity</b> – understand/redress sub-optimal experiences, access and health inequality issues			
<b>Supplier diversity</b> – track policies, practices and contracting is aligned with D&I standards including the Stonewall WEI framework			

# Translating priorities into plans *example* – Corporate

Priorities	Initiatives	Senior Responsible Officer	Timeframe	KPI / Metric(s)
<b>Inclusive Recruitment</b>	'Re-imagining Inclusive Recruitment'	<i>People Directorate to complete</i>	<i>People Directorate to complete</i>	<i>People Directorate to complete</i>
	Corporate review and refresh of recruitment pipeline			
	Workforce data and quality reporting			
<b>Promotions and succession planning</b>	Talent Management review and succession plans			
	Identifying our leaders ready now and those emerging			
<b>Managing conflict and grievances</b>	Establishing a special case review unit			
	Refresh towards conflict resolution approach			
	Engaging with staff networks and wider organisation			
<b>Leadership and Management</b>	Inclusive Leadership programme to transform behaviours, culture and D&I impact			
	D&I objective in every PDPR			
	Reciprocal Mentoring			
	Equality Academy leadership workshops			
<b>Comms, Education and Engagement</b>	D&I Comms and engagement plan			
	Update education offer and mandatory training			
	Ongoing updates and feedback loop so that we are a 'listening and doing' organisation (e.g. Webinars; Peakon survey; FTSU)			
<b>Data quality and metrics</b>	Systemising the way we collate and report on D&I metrics. Building D&I into all relevant KPIs over time with clear targets and trajectories.			

# D&I Team – Strengthening Corporate Impact

	Oversight of safe space(s)	EQIA tools to support decision making	Review of corporate policies	Action Plans for protected characteristics	Education/Training
<b>Structural, Mid-Term, Fast Track, Discover, Maintain</b>	Fast-track	Structural (refresh)	Structural	Structural	Mid-Term Discover
<b>Programme</b>	Peakon FTSU 'Drop-ins' HR Direct Team Talks Equality Academy sessions	Programmatic approach to building org. capability to assess strategies and plans addressing inequalities (internal and external)	(To be defined) Review levels of inclusive decision-making in for example: Service design Procurement Governance models	National standards / compliance: WRES WDES Stonewall WEI Pay Equality	Review core offer and organisational level compliance Training Needs Analysis Explore bespoke packages
<b>Timeframe</b>	Immediate	Medium term	Medium term	Annual/Ongoing	Medium term
<b>Resource</b>	Directorates re: relevant programme implementation above i.e. FTSU Guardian – People Dir.  D&I Team to oversee stocktakes, responsiveness and rate of satisfaction	D&I Team	Led by D&I Team – implementation leads will be at directorate level depending on findings	D&I Team	D&I Team lead on requirements and review OD team lead on implementation
<b>Investment</b>	Tba	Tba	Tba	Data analytics	Tba
<b>Expected outcome / success measures</b>	Take-up rates + analysis Issues closed/resolved Qualitative feedback	No. of EQIAs conducted. Metrics to capture gap reduction in workforce and donor access	Greater transparency and trust in practices (associate with outcome measures for relevant policy)	High quality data analytics and metrics, real time tracking, driving measurement and improvement	Take up/participation rates Qualitative feedback 1/3/6 month follow ups

# Translating priorities into plans *example* – Directorate

Priorities	Initiatives	Senior Responsible Officer	Timeframe	KPI / Metric(s)
<b>Inclusive Recruitment</b>	Plan to achieve min. 15% BAME target 8a and above	<i>Directorates to complete</i>	<i>Directorates to complete</i>	<i>Directorates to complete</i>
	Future-proof recruitment planning with focus on inclusive attraction and selection (including LGBT+ and disability targets)			
	Updated training for panel members (and include observers)			
<b>Promotions and succession planning</b>	Understand and unpack your glass ceilings (quantitative and qualitative data – <i>where are your blocks?</i> )			
	Talent Management review +Succession plans; Offering stretch assignments/ shadowing opportunities/ mentoring, Transparent support in place for emerging talent and leaders			
<b>Managing conflict and grievances</b>	Create safe/r spaces to have the right conversations			
	Early interventions - <i>How are potentially difficult conversations aired/facilitated/resolved?</i>			
<b>Leadership and Management</b>	Embed and quality assure D&I objective in every PDPR			
	Extend Reciprocal Mentoring			
	Transformative leadership – how are you growing inclusive leadership?			
<b>Comms and Engagement</b>	D&I Charter (linked to Vision and Aims)			
	How does engagement, action and information flow (you said, we did) at local level?			
	Education/training needs analysis (localised as required)			
	Engage in outward facing thinking and best practice			



# Inclusive Recruitment – Directorates Key Lines of Enquiry (KLOE)

## Diagnostics

What does your data say about your recruitment pipeline over the last 12 months? (i.e. BAME candidate rate of attraction and selection)

What does your workforce data show re: where your biggest gaps in diversity are? And in which bands/professions do you need to target your efforts?

What are your trajectories to reach min. 15% BAME representation in 8a and above? And for other diversities?

## Reflections

What are you noticing from the data as an SMT?

What are you not seeing?

Where is your biggest opportunity for impact?

## Action

How are you going to market to bring in more diverse pools? i.e. outreach, apprenticeships, national positive action programmes, creating networks/relationship management externally

What filters are you using for longlists and shortlists?

How are you ensuring your interview panels and their competencies are fit for purpose?

## Engagement

How are you bringing in diverse thinking into the design, delivery and monitoring of your inclusive recruitment plans?

How are you engaging with the rest of your directorate to get buy-in at every level?

What best practice examples can you explore beyond NHSBT?

What other support/resources can you draw on i.e. inclusion champions on recruitment panels?

# Promotions and Succession Planning – Directorates KLOE

## Diagnostics

Where are your diversity gaps in current workforce makeup? And in which bands/professions do you need to target your efforts?

What is your understanding of the barriers to progression for colleagues?

What feedback/qualitative data do you have from BAME, LGBT and other colleagues in your directorate?

## Reflections

What are you noticing from the data as an SMT?

What are you not seeing?

Where is your biggest opportunity for impact?

## Action

How are you managing talent in your directorate? Who is ready now? Where is your emerging talent? What support is in place for them over the next 6-12 months?

How many mentoring, shadowing, coaching, feedback and assignment opportunities are you offering as an SMT over the next 6-12 months?

How diverse is your succession planning? What do you need to prioritise so that change is felt with colleagues in your directorate?

## Engagement

How are you challenging your 'group think' as an SMT?

How are you engaging with the rest of your directorate to further understand and overcome barriers? What do people need?

What will success look like for you in 12-18 months?

# Managing Conflict and Grievances – Directorates KLOE

## Diagnostics

What is data showing about HR cases, dignity, grievances and disciplinary action in your directorate? What is the diversity background of complainants?

What management areas and functions is conflict concentrated in?

What is the rate of resolving/concluding these cases?

## Reflections

What are you noticing from the data as an SMT?

What are you not seeing?

Where is your biggest opportunity for intervention?

## Action

How are you managing conflict in your directorate? Where are the opportunities for early intervention and that's resolution focussed?

Where are your safe space conversations?

What are the behavioural changes and skillsets you need to work on in your team culture?

## Engagement

What are the type of conversations you need to have?

How are you ensuring there is a feedback loop (virtuous learning cycle) when issues are raised?

# Leadership and Management – Directorates KLOE

## Diagnostics

What does your leadership and management look like?

How do you think your leadership and management culture is perceived by others?

How approachable and accessible are you to aspiring leaders from a different background to you?

## Reflections

What are you noticing about your leadership and management culture?

What 3 things are working? What 3 things do you need to focus on?

Where is your biggest opportunity for impact?

What do you need as leaders to build more inclusive teams?

## Action

How will you embed and quality assure meaningful D&I objectives in every PDPR?

What is your practice around calling out bad behaviours?

## Engagement

Do you have a shared understanding of inclusive leadership? What conversations are taking place?

How are you listening to those you do not line manage?

# Comms and Engagement – Directorates KLOE

## Diagnostics

What is the Staff Peakon data telling you about your directorate and teams? (levels of engagement, trust, dynamics with leadership)

What areas do you urgently need to focus on?

What is your workforce turnover? (and diversity background)  
What data do you have from exit interviews?

## Reflections

What are you noticing from the data?

What 3 things are working? What 3 things do you need to focus on?

Where is your biggest opportunity for impact?

## Action

What are the priorities in your Peakon/engagement action plan?  
How has this been shaped by colleagues most effected?

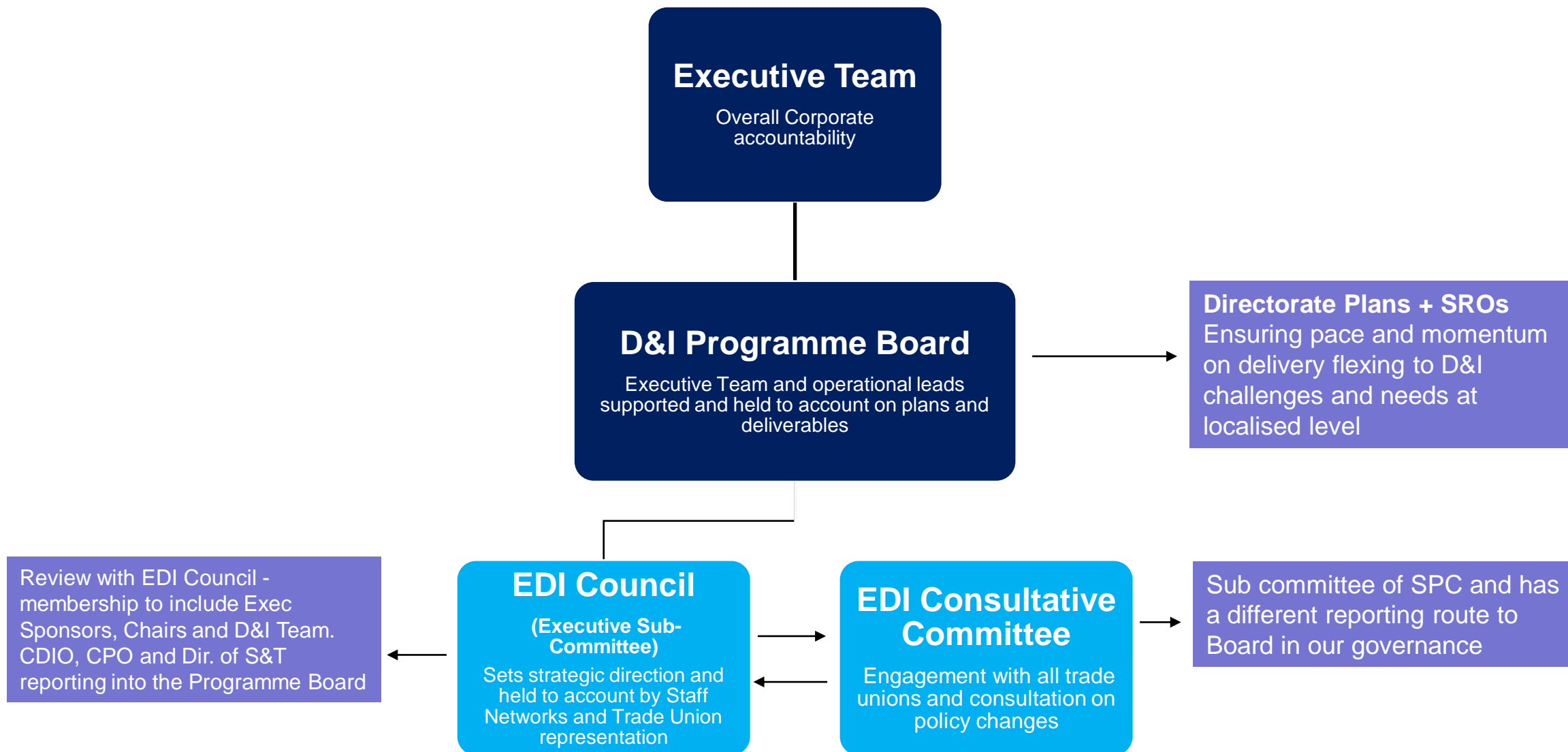
## Engagement

How have you engaged with wider teams on their ideas and solutions to improve dynamics?

How often are you having informal/unstructured conversations with those showing highest dissatisfaction from the Peakon data?

What other support/resources can you draw on?

# D&I Governance



# D&I Programme Board - accountabilities by role

## Executive responsibilities

<p><b>Executive Directors</b></p>	<ul style="list-style-type: none"> <li>• Ultimately accountable for the <b>delivery of on-time EDI plans</b> that achieve measurable impact</li> <li>• Identify SROs for each workstream area within Directorate Plan (and links to Corporate plan where required)</li> <li>• Ensure their SMTs are realistically resourced, supported and held to account on operational delivery, drive inclusive practices and leadership behaviours</li> </ul>
<p>Recruitment and Talent Management <b>Patricia Grealish</b></p>	<ul style="list-style-type: none"> <li>• Ultimately accountable for establishing <b>inclusive recruitment and talent management practices</b> required to achieve a diverse workforce and a place where <i>everyone</i> can thrive</li> </ul>

## Corporate Roles

<p><b>SRO</b> Betsy Bassis</p>	<ul style="list-style-type: none"> <li>• Ultimately accountable for <b>the success of the Programme and delivery of expected benefits</b>, providing clear leadership and direction throughout its life</li> </ul>
<p><b>D&amp;I Programme</b> Rosna Mortuza</p>	<ul style="list-style-type: none"> <li>• Responsible for <b>providing steer, leadership and identifying success criteria and performance</b></li> <li>• <b>Supporting and holding Executive Team to account</b></li> </ul>
<p><b>PMO</b> Tba</p>	<ul style="list-style-type: none"> <li>• Daily problem solving to ensure <b>programme remains on plan, escalating critical path activities and driving drumbeat</b></li> <li>• Ensuring the <b>programme team has the resources</b> it needs to deliver on its overall goal</li> </ul>

# Resources

Team	Resource investment need	Rationale
Diversity and Inclusion team	Senior D&I programme lead (8c budget request made) Analytics Lead (8b budget request made) Secretariat Team for D&I Programme Board (support confirmed)	Increase capacity to drive as a programme Develop and improve an evidence based and data driven approach corporately and in directorates
People Directorate	Additional resource needed or within new structure proposed (Patricia to confirm)	Data/Insights analyst to support workforce data and quality
All Directorates	Implementation support (Transformation Fund)	6-month interim support of D&I expertise is recommended to enable directorates with independent expertise, start up mode, facilitate sensitive conversations and build directorate capability where needed. Led by CDIO  Sustainable planning for delivery and build in to business as usual



# Next Steps

Action required	Responsibility
<ul style="list-style-type: none"> <li>Set up inaugural D&amp;I Programme Board meeting 18<sup>th</sup> March 2021.</li> <li>Establish monthly meeting cycles.</li> </ul>	Rosna (+ Secretariat Team)
<ul style="list-style-type: none"> <li>ET to establish directorate SMT/Steering Group to develop its plan.</li> <li>ET to achieve first draft plans by end April 2021.</li> </ul>	Executive Team
<ul style="list-style-type: none"> <li>Resourcing agreed prior to first meeting.</li> </ul>	All
<ul style="list-style-type: none"> <li>PMO support to be allocated/appointed.</li> </ul>	Rosna



## Blood and Transplant



Rosna Mortuza  
Chief Diversity and Inclusion Officer

We are rising. Diversity and Inclusion (D&I) is now on the forefront of agendas and part of conversations across NHSBT from Board level right through to front line staff who care for our donors. It's reaching out from our staff networks to policy and decision makers at NHSBT who know that they must listen and change. I've witnessed D&I discussions take place at every Executive Team meeting I've attended. I believe there is serious potential for the organisation to learn, grow and transform its culture and ways of working to reflect both diversity and inclusion. I can see this having worked with a number of senior colleagues who are ready to be genuine advocates and champions for change.

But words are not enough. It's time for action – we all need to see it and feel it. It will take time, some results may take longer than others, and not everything will capture the painful reality of lived experiences within tidy metrics and formatted tables. It's about the journey and the lived experience as much as getting us to a place where unconscious inclusion is the norm. So, we have to start from where we're at. It's not going to be perfect. We may miss things, there may be missteps along the way, but we have to be willing to learn deliver and get the basics right. We are building the foundations to an agenda that has no golden template or silver bullet. We have to put the work in to keep listening, keep learning and keep the agenda rising.

In our first D&I newsletter update, some of the important work that has begun is highlighted below. Over the past months, we've been focusing on getting the structures right to deliver equality, diversity and inclusion. We've also been listening and translating the key hard messages we've heard to re-wire the way we work. What I've shared below is just the start. There will need to be further iterations and conversations to shape and keep re-shaping this work. If you have any feedback in the meantime you'd like to share – please do reach out to me or any member of the D&I team. We'd love to hear from you. - **Rosna, May 2021**

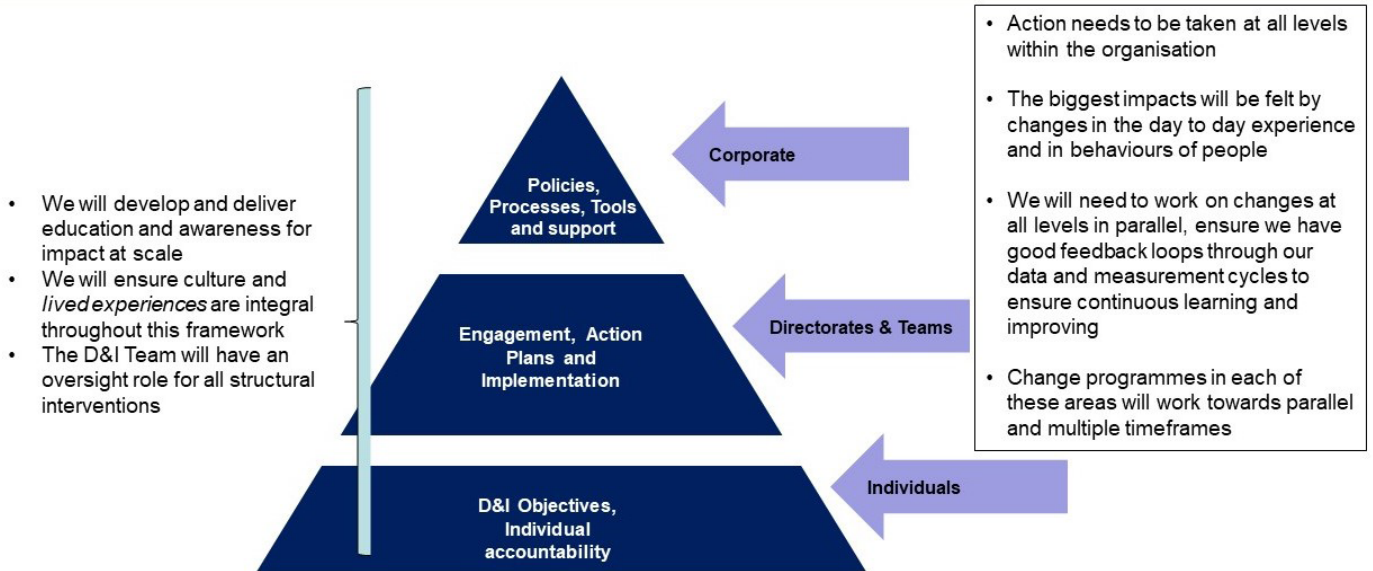
### D&I Framework for Delivery

This sets out how we consolidate at Executive level all the work being done to achieve greater transparency, grip and discipline on what is being delivered. The framework applies to the whole organisation for delivering D&I, setting out accountability at:

- Corporate level – reviewing our policies and processes with tools to support positive change
- Directorate and Team level – ensuring there is real engagement, collaborative action plans and delivery with metrics that matter to their own teams
- Individual level – focussing on our own learning and individual accountability

The framework directly holds Executive Directors to account through their directorate level D&I plans. The plans need to reflect the real issues in their respective areas, what actions are being taken by the directorate and the impact being achieved. This will include how directorates plan to achieve a 15% national target of BAME colleagues in senior positions, setting targets to ensure we are an LGBT+ inclusive organisation and supportive of colleagues with disabilities and/or long term health conditions to improve disclosure and declaration rates. The shaping of actions and outputs around this must include and be experienced by their teams at every level. I've also added some guidance on [key lines of enquiry](#) our directorate teams should be asking themselves and looking for answers in an inclusive way, as part of providing a clear framework for delivering on D&I.

If you wish to help shape your directorate plans, please do reach out to your manager, Senior Management Team or Director. We welcome your views and support.

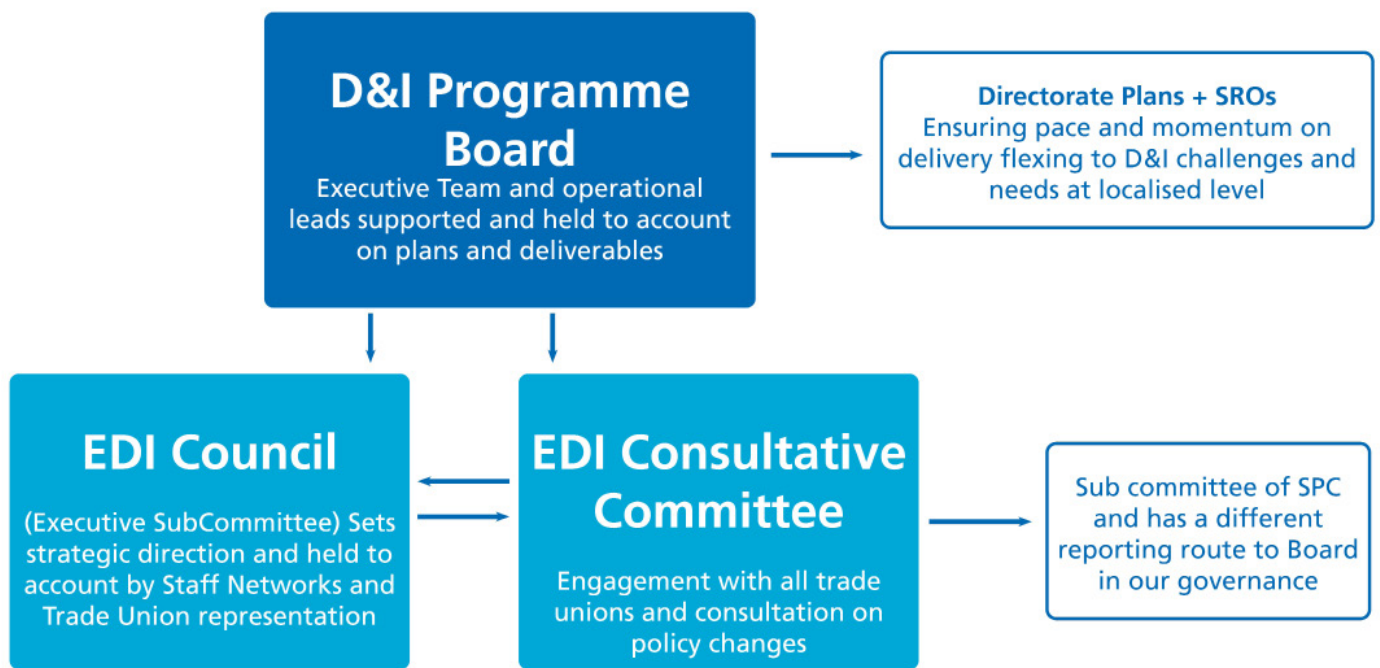


## D&I Metrics for Measuring Change

If we don't measure, we can't improve. This is where we can use key performance indicators to define what good looks like and measure how we are moving towards positive change. We currently have an overview of our metrics – what is available right now and what still needs to be developed going forward. We are in the final stages of development and we will be sharing this shortly. Watch this space.

## D&I Governance and Accountability

We have set up a number of structures to ensure we hold leaders to account. We want to be transparent about the conversations we are having in these forums. We have established a [Governance](#) page where you will be able to access a summary of discussions from each meeting, including the D&I Programme Board [key messages](#) from the meeting held on Friday 30 April.



## Organisational Diagnostic Report

A lot of work has taken place in response to the recommendations in the Organisational Diagnostic Report published in June 2020.

Key areas include:

- strengthening the supervisory and leadership team in our Colindale centre
- reviewing and improving development opportunities
- better support and mentoring for managers
- ensuring colleagues have a meaningful development plan as part of their Personal Development and Performance Review (PDPR) with discussions to support progression and development

We can't be complacent however and know there is still much more to do. We are keen to take learnings and progress to apply to wider parts of the organisation. The most recent update was shared in February 2021 and is available on Link.

An independent review will be undertaken over the next few weeks to sense check how action is being delivered and how it is felt across Colindale. We will be sharing this report in June.

You can find the report, updates and further support on the [Organisational Diagnostic Report](#) page on Link.

## Re-imagining Inclusive Recruitment

We have been listening to feedback across the organisation and launched a '[Re-imagining Inclusive Recruitment](#)' workstream to drive rapid improvement in our process and practices from attraction and selection to inductions and training, both in the short term and longer-term. The People Directorate are looking at the following priority areas:

- We are looking at how we can get more diverse applicants applying for jobs at NHSBT – for example by developing targeted marketing, diversity networks and offering drop-in sessions to support candidates in making an application
- Improving the inclusiveness of selection processes – this could be by having inclusion champions on interview panels, involving teams as part of the selection process and challenging our own practices
- We are reviewing retention and career progressions so that we support colleagues in clear and transparent ways throughout their careers with NHSBT
- We held an Amplify event in April to hear best practice around inclusive recruitment from other organisations and are implementing key recommendations

We must keep asking ourselves, what are the steps we need to take to give all colleagues trust that we have fair and inclusive recruitment practices? You can watch the highlights from this event [here](#).

The [BAME Recruitment Support Panel](#) initiative has been refreshed and we are looking for more BAME colleagues to join and support our ongoing work towards creating a more representative workforce across NHSBT. Online open day sessions were held in April and training workshops led by Jazz Sehmi, Diversity and Inclusion Manager, are running throughout May. Webinars are also planned to ensure that recruiting managers understand the role of BAME panel members; that they are equal partners of the end-to-end recruitment process. You can find more information, eligibility and how to register your interest on [Link](#).

## Managing Conflict and Grievances

We have commissioned an independent review of our grievance, dignity and work policy and other related policies. This work is planned to be completed over the Summer, with a view to managers being trained in new processes throughout the Autumn. Our whistleblowing process has been promoted alongside reviewing the role of the Freedom To Speak Up Guardian. We have also established a complex case unit to investigate complaints promptly and build the skills of our internal team.

As part of refreshing our conflict resolution approach, policies and guidance for HR colleagues has been improved, specific resource allocated to ensure casework is scheduled to be resolved within 90 calendar days, and to better track case milestones. Case reporting for SMT and Board performance reports has also been established and this will evolve to capture other themes and issues raised through different routes.

Insight sessions with staff networks, trade union representatives and HR have taken place to understand concerns and support them in raising issues to ensure all voices are heard. We will also be looking at how we can capture 'informal' complaints.

## Learning and Development

The first cohort for our Inclusive Leadership programme is underway, following a successful pilot across Colindale and Barnsley Centres. This aims to transform leadership behaviours and culture. We have two more cohorts planned for the year and the programme forms an integral part of a culture programme in Blood Supply.

The Reciprocal Mentoring Programme, managed by the NHS Leadership Academy, will launch in the coming months and will provide opportunities for individuals from under-represented groups to work as equal 'partners in progress', with senior leaders in a relationship where knowledge and understanding of lived experiences creates awareness, insights and action that directly contributes towards the creation of a more equitable and inclusive organisation. We will be able to share more information on this programme, as well as Fostering Anti-Racist Practice with the Equality Academy, soon.

## Promotions and succession planning

We are reviewing our talent management and succession plans and identifying glass ceilings to offer better support and opportunities for our current employees, including shadowing opportunities and mentoring. We have increased the number of places available on our Inclusive Leadership Management level 5 coaching programme. The first cohort launched in March and a second cohort is planned for later this year. A Coaching Apprenticeship is also likely to launch in September.

We are re-establishing the Stepping Up programme for aspiring BAME colleagues who work in healthcare at band 5-7 to learn new skills and be ready for management positions. Discussions are taking place in the next few weeks to agree a timeline for the re-launch.

## Executive Sponsors of Staff Networks

Each Staff Network is supported by an Executive Sponsor to help raise awareness, champion causes and escalate problem-solving issues where there may be institutional barriers. Our Executive Sponsors have promoted and supported key events such as Black History Month, International Women's Day, LGBT History Month and Disability Awareness days. If you would like a discussion or to raise any issues, please reach out to the relevant sponsor:

- David Rose, Director of Donor Experience: BAME Network
- Ian Bateman, Director of Quality: LGBT+ Network
- Wendy Clark, Chief Digital and Information Officer: Disability and Wellbeing Network
- Anthony Clarkson, Director of Organ and Tissue Donation and Transplantation, Women's Network

## D&I Best Practice

Finally, we want to share examples of D&I best practice initiatives across NHSBT. Shared learning is an important tool that can help others imagine and initiate change in their own areas. If you have any examples of an intervention that's gone on to have impact, and made a difference for you or your team, please reach out so that we can share and celebrate the small things that make a big difference.

There is so much more to share and help build the conversation. In the next issue we will cover Staff Networks, D&I Top Picks and other hot topics. If you have ideas and suggestions of what you'd like to see, please do get in touch with [laura.fenn@nhsbt.nhs.uk](mailto:laura.fenn@nhsbt.nhs.uk).

# Diversity and Inclusion Dashboards

May 2021 (April data)

v1.1

# NHSBT D&I Dashboard

**5988**  
Total Headcount End Apr 21

**Workforce**  
**5988**

**Bands 2-7**  
**5228**

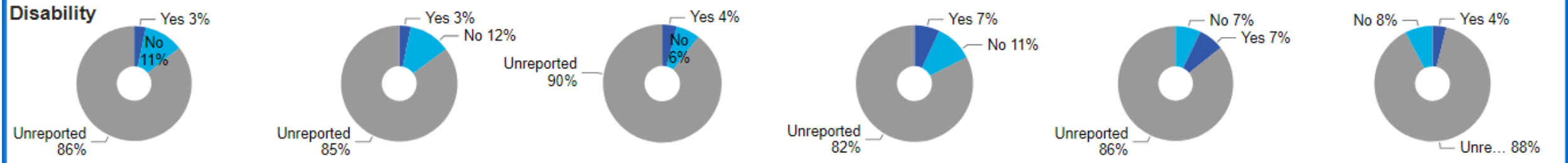
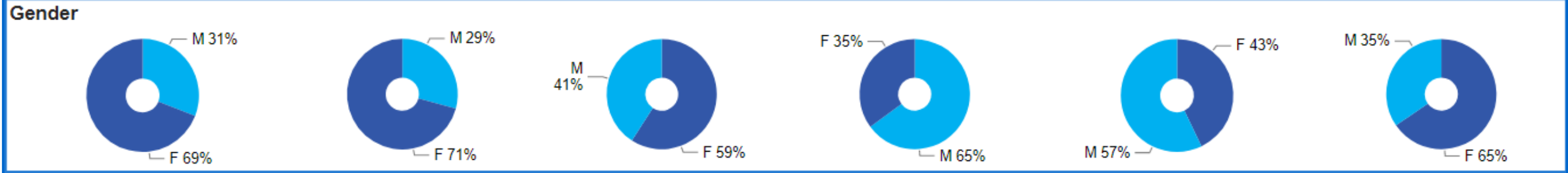
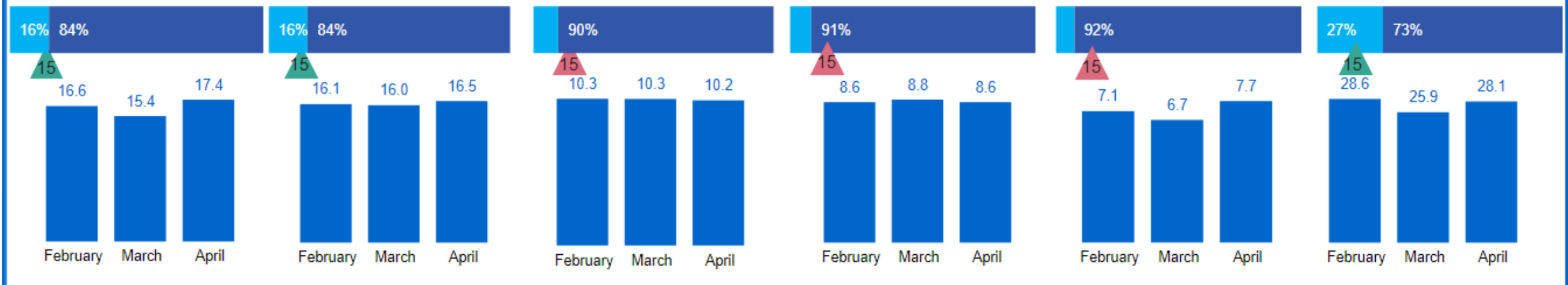
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**631**

**Bands 8D-9**  
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**Exec & Board**  
**14**

**Medical**  
**52**

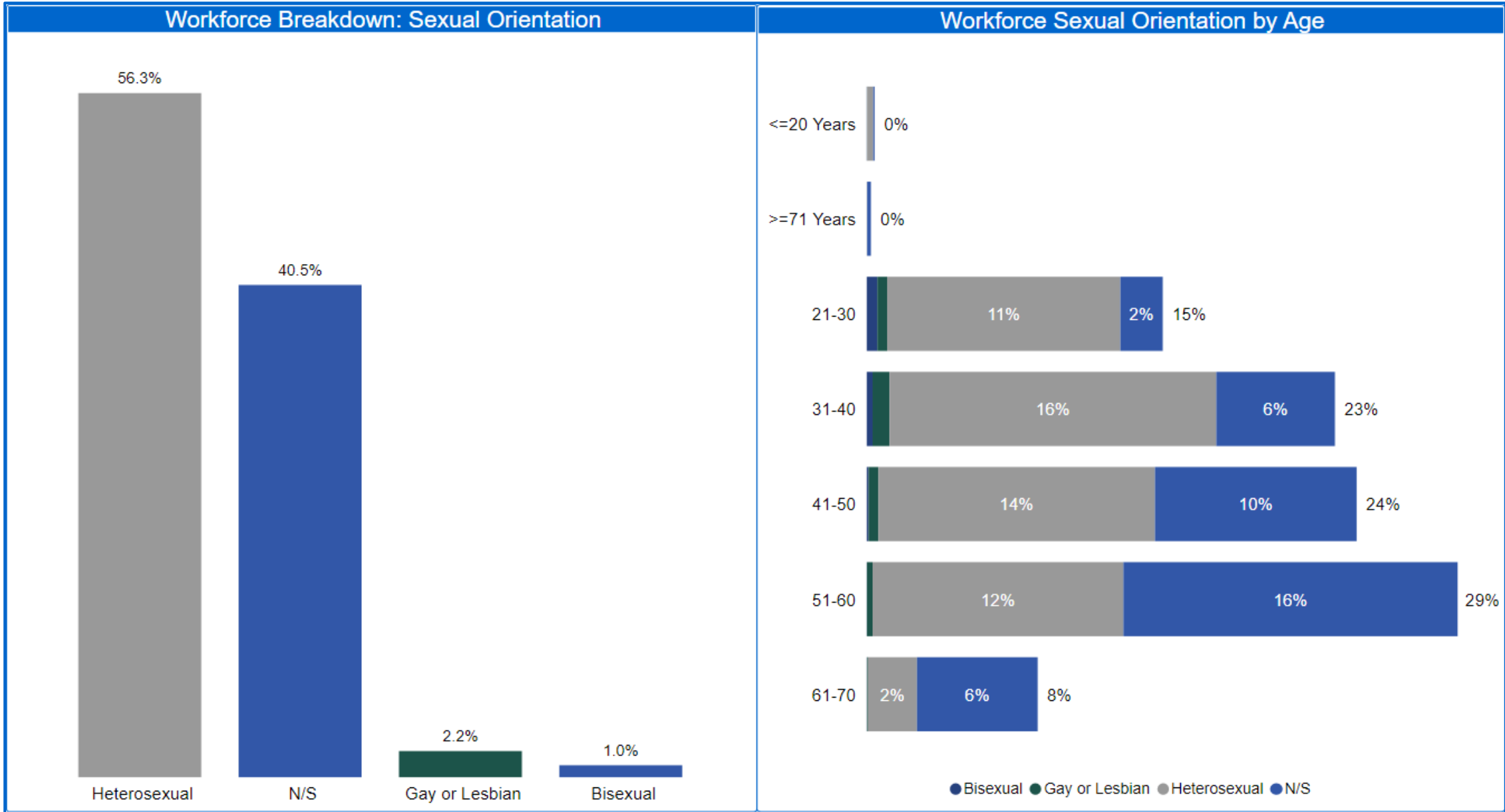
**Ethnicity** Key: %BAME %White + N/S



Source: NHS Diversity Detail

# D&I – Supplementary Metrics

Blood and Transplant



Source: NHS Diversity Detail



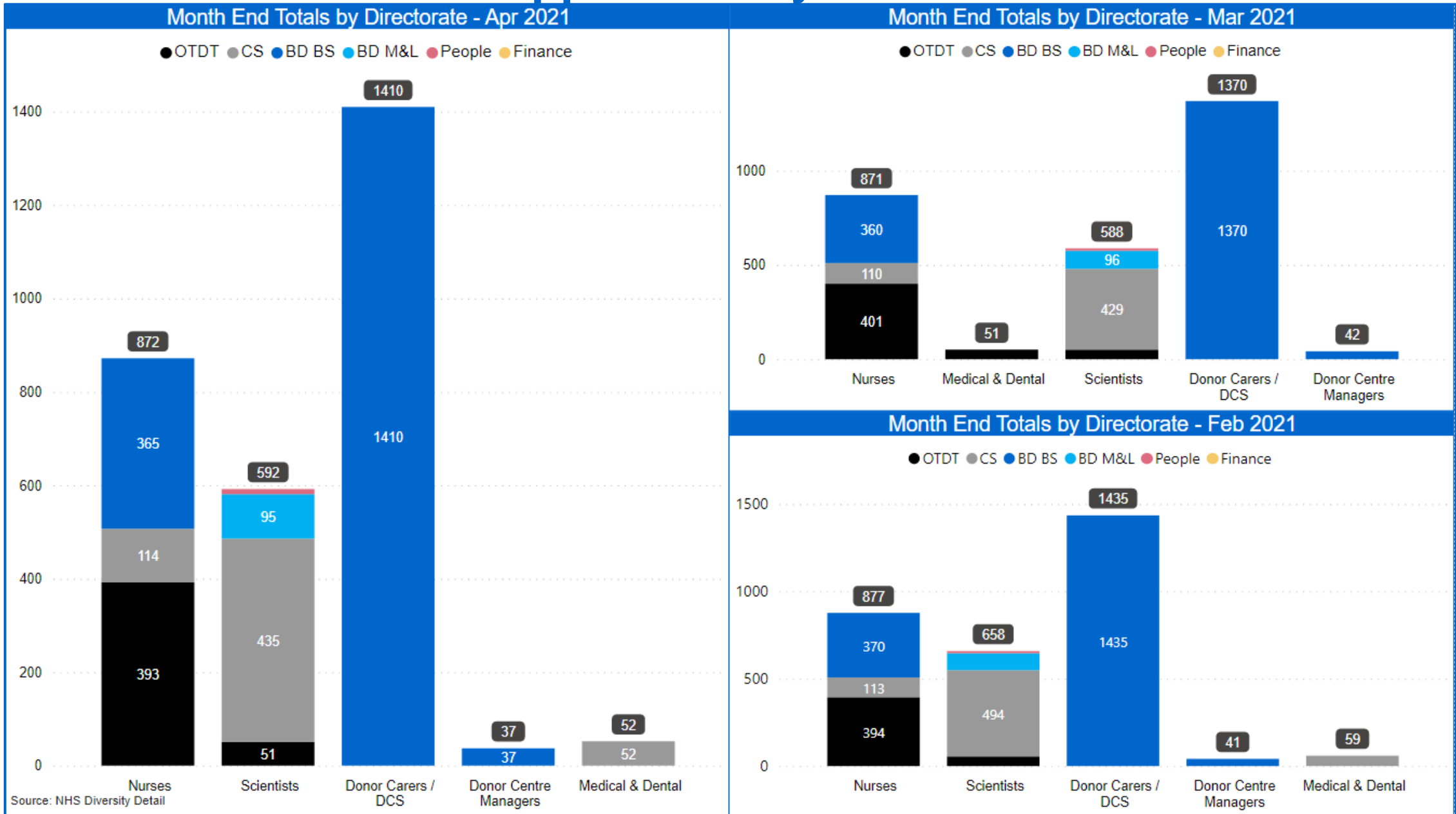
# D&I – Supplementary Metrics

Blood and Transplant

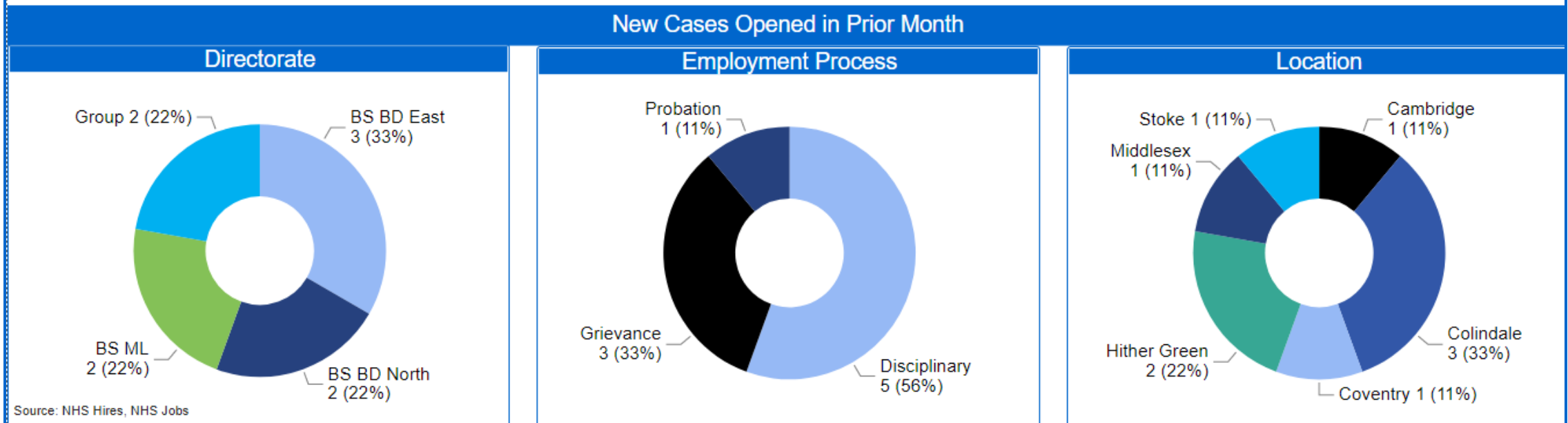
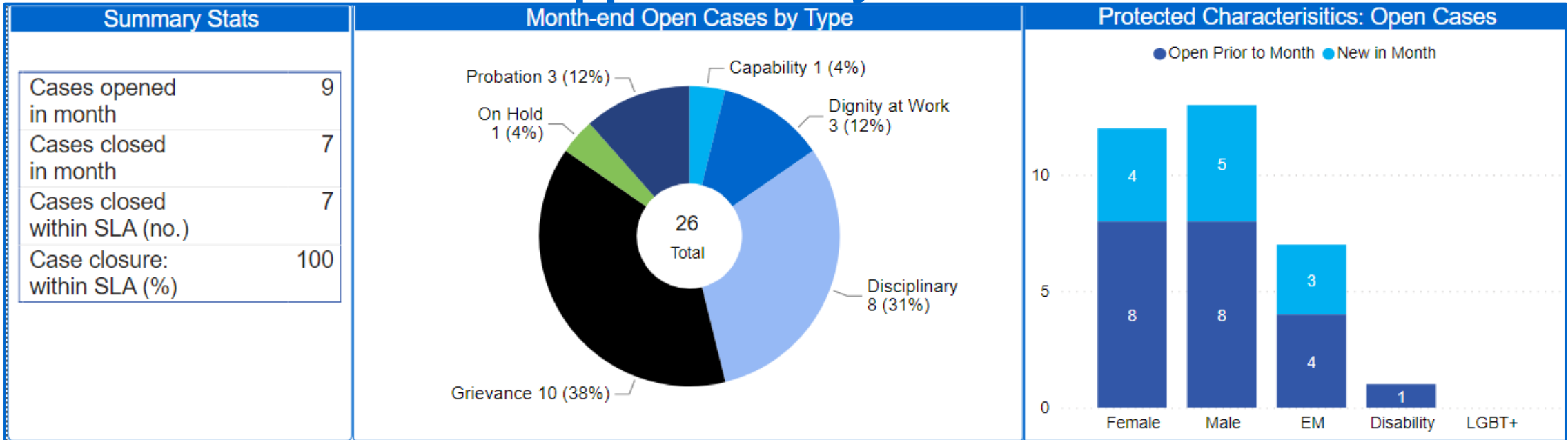


Source: NHS Diversity Detail

# D&I – Supplementary Metrics



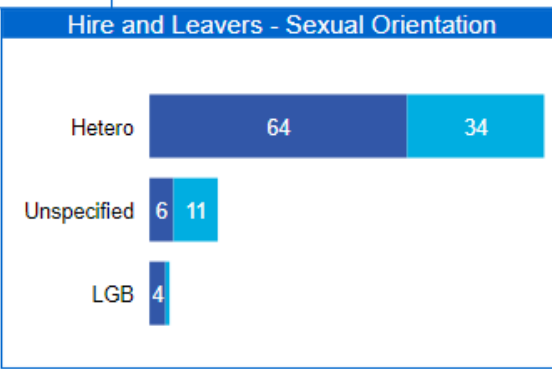
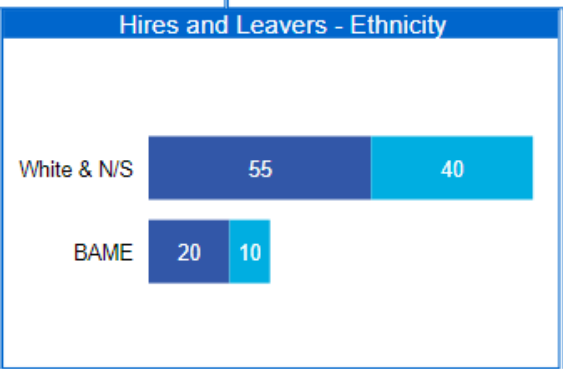
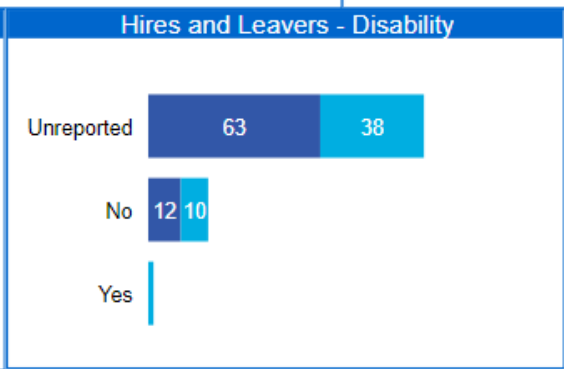
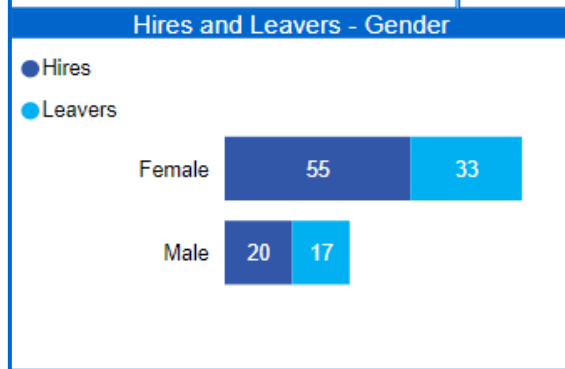
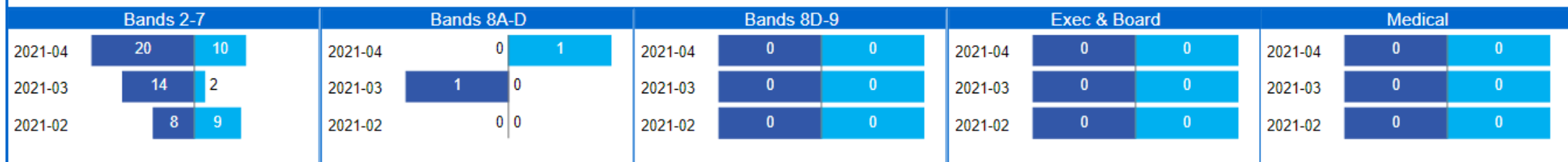
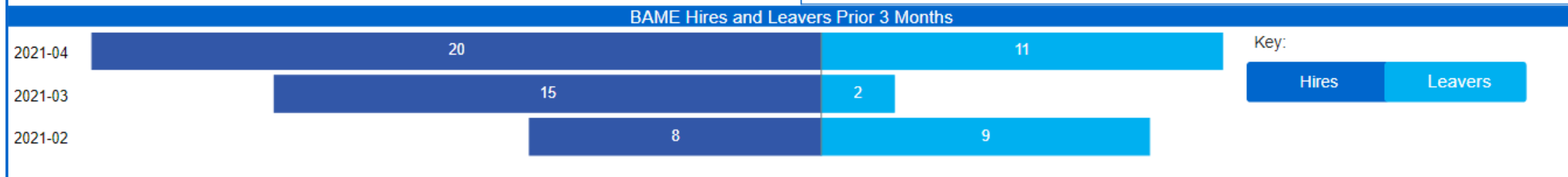
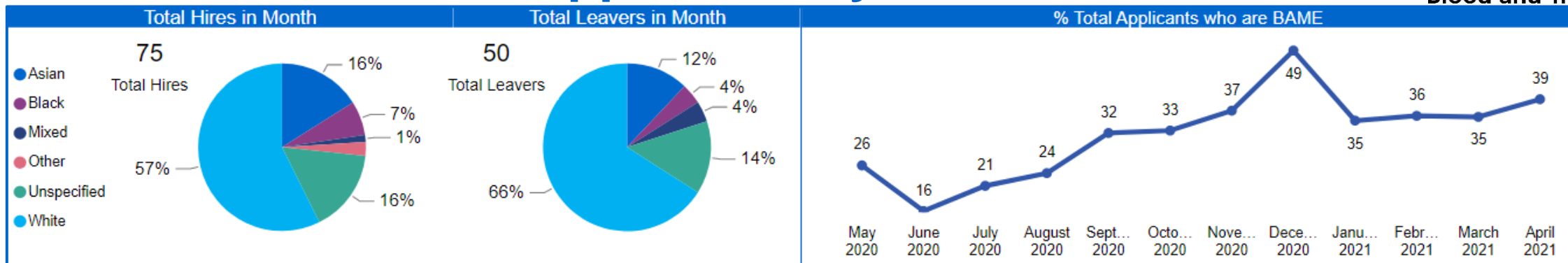
# D&I – Supplementary Metrics



Source: NHS Hires, NHS Jobs

# D&I - Supplementary Metrics

Blood and Transplant



Source: NHS Hires, NHS Jobs

# D&I – Supplementary Metrics

Blood and Transplant

## Employee Engagement Heat Map

Source: Employee Engagement Survey June 2020

	Female	Male	Disability	Disability 'No'	BAME	Non-BAME	LGBT+	Hetero
<b>Engagement</b>	7.6	7.3	7	7.6	7.3	7.6	7.7	7.7
<b>Accomplishment</b>	7.1	6.8	6.5	7	6.9	7.1	7.4	7.2
<b>Freedom Of Opinions</b>	7.4	7.2	6.9	7.3	6.9	7.4	7.5	7.4
<b>Growth</b>	7.4	7.3	7	7.4	7.2	7.4	7.7	7.4
<b>Equality</b>	7.8	7.5	7	7.8	6.8	7.9	7.4	7.7
<b>COVID-19</b>	7.2	7	6.7	7.1	7.2	7.1	7.1	7.2

Key: = highest value = mid values = lowest value

**Narrative**

- Context** Data source is > 8 months old and is therefore becoming out-of-date. Aspiration is to conduct this survey potentially quarterly (tbc) in order to derive trends.
- Population Analysis** Given the previous point, this data indicates that management attention should potentially be directed to the results provided by the **Disability** and **BAME** populations, particularly in respect of Accomplishment, Freedom of Opinions and Equality.
- Engagement Categories** At the time of survey, across all populations, the categories of **Accomplishment** and **COVID-19** stand in marked negative contrast to the remainder, although a watch should be kept on **Freedom of Opinions** - as per point 2. **Engagement** and **Equality** are the 2 most positively rated themes.

# D&I – Supplementary Metrics

## Blood and Transplant

### NHSBT comparison to Census 2011 data (%)

Source: Feb 21 NHSBT data

#### Key

	NHSBT < 30% Census
	NHSBT < 50% Census

Lancaster	White	Mixed	Asian	Black	Other	N/S
NHSBT	96.8	0.0	1.6	1.6	0.0	0.0
Census	95.6	1.0	2.7	0.5	0.2	0.0

Newcastle	White	Mixed	Asian	Black	Other	N/S
NHSBT	94.0	1.5	0.9	0.3	0.9	2.4
Census	85.5	1.5	9.7	1.8	1.5	0.0

Manchester	White	Mixed	Asian	Black	Other	N/S
NHSBT	75.2	4.2	7.7	6.5	1.2	5.2
Census	66.6	4.6	17.1	8.6	3.1	0.0

Barnsley	White	Mixed	Asian	Black	Other	N/S
NHSBT	88.3	0.9	3.7	1.7	0.8	4.6
Census	97.9	0.7	0.5	0.5	0.4	0.0

Liverpool	White	Mixed	Asian	Black	Other	N/S
NHSBT	93.0	1.2	1.4	0.5	0.2	3.8
Census	88.9	2.5	4.2	2.6	1.8	0.0

Cambridge	White	Mixed	Asian	Black	Other	N/S
NHSBT	87.9	1.5	3.8	0.4	0.8	5.7
Census	82.5	3.2	11.0	1.7	1.6	0.0

Birmingham	White	Mixed	Asian	Black	Other	N/S
NHSBT	71.4	2.9	13.9	4.6	0.5	6.6
Census	57.9	4.4	26.6	9.0	2.0	0.0

Basildon	White	Mixed	Asian	Black	Other	N/S
NHSBT	92.1	0.0	0.9	1.8	0.0	5.3
Census	92.7	1.7	2.4	2.7	0.6	0.0

Oxford	White	Mixed	Asian	Black	Other	N/S
NHSBT	76.8	3.1	4.9	6.3	1.8	7.1
Census	77.7	4.0	12.4	4.6	1.4	0.0

Colindale	White	Mixed	Asian	Black	Other	N/S
NHSBT	55.1	3.4	20.9	12.7	2.2	5.7
Census	64.1	4.8	18.5	7.7	4.9	0.0

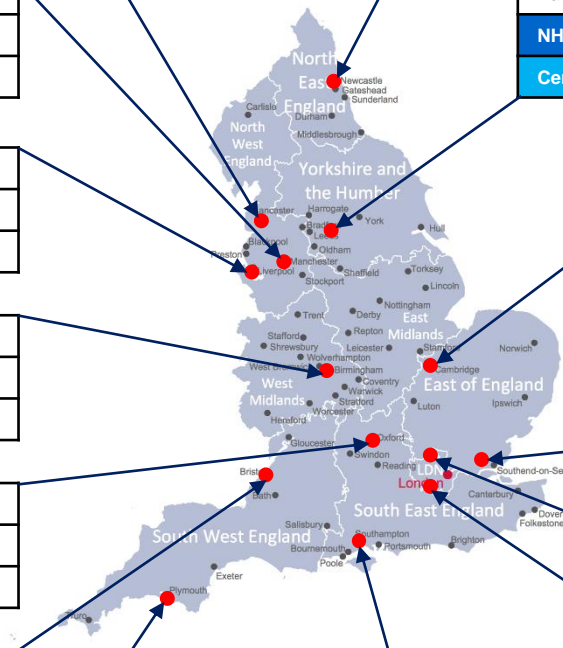
Bristol	White	Mixed	Asian	Black	Other	N/S
NHSBT	80.8	1.6	5.6	3.4	1.9	6.7
Census	84.0	3.6	5.5	6.0	0.9	0.0

Tooting	White	Mixed	Asian	Black	Other	N/S
NHSBT	66.2	2.7	7.4	13.5	1.4	8.8
Census	71.4	5.0	10.9	10.7	2.1	0.0

Plymouth	White	Mixed	Asian	Black	Other	N/S
NHSBT	90.2	3.3	0.0	0.0	0.0	6.6
Census	96.2	1.3	1.5	0.7	0.4	0.0

Southampton	White	Mixed	Asian	Black	Other	N/S
NHSBT	88.8	1.3	2.6	0.9	0.0	6.4
Census	85.9	2.4	8.4	2.1	1.2	0.0

Home-based	White	Mixed	Asian	Black	Other	N/S
NHSBT	86.3	2.5	6.3	1.3	0.0	3.8
Census	86.0	2.2	7.5	3.3	1.0	0.0



# Appendix 2: Breakdown of Protected Characteristics

# Appendix 1: Directorate D&I Dashboards



**2102**  
Total Headcount End Apr 21

# BS-BD D&I DASHBOARD

**Blood and Transplant**

Workforce  
**2102**

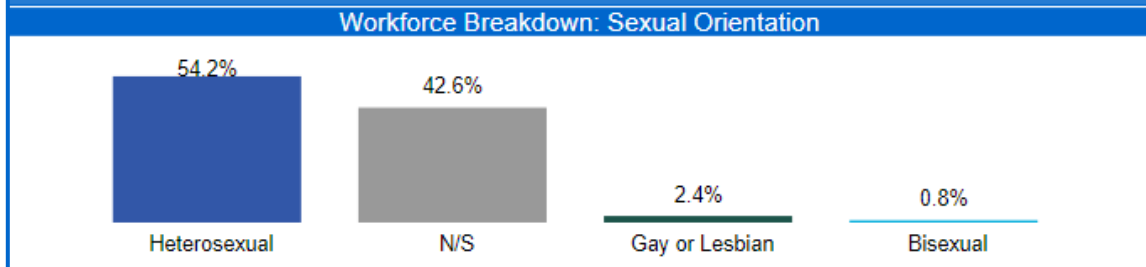
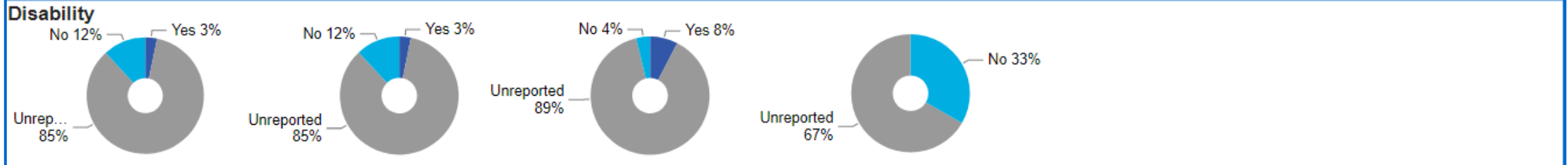
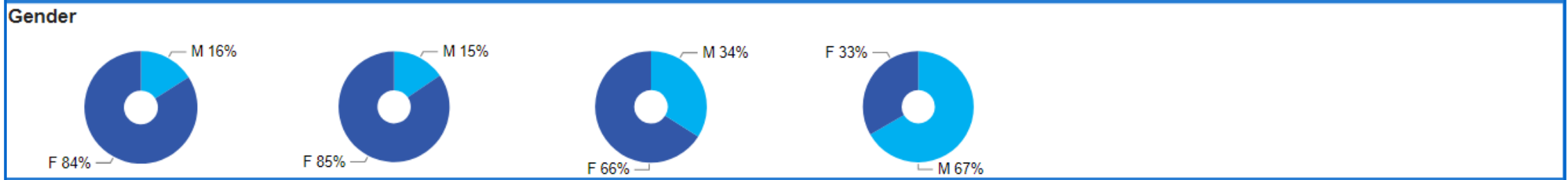
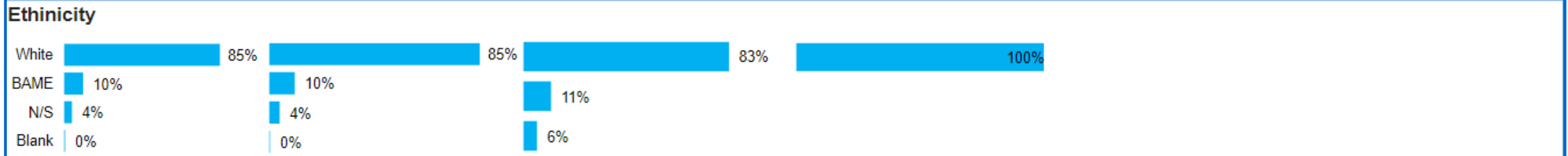
Bands 2-7  
**2046**

Bands 8A-C  
**53**

Bands 8D-9  
**3**

Exec & Board  
**(Blank)**

Medical  
**(Blank)**



**1232**  
Total Headcount End Apr 21

# BS-M&L D&I DASHBOARD

**Blood and Transplant**

Workforce  
**1232**

Bands 2-7  
**1152**

Bands 8A-C  
**72**

Bands 8D-9  
**7**

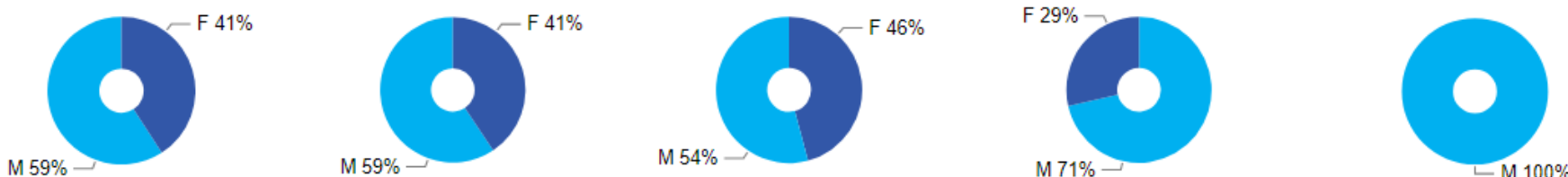
Exec & Board  
**1**

Medical  
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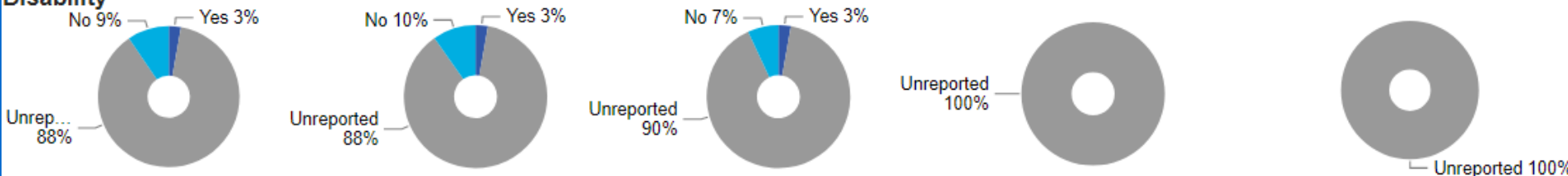
**Ethnicity**



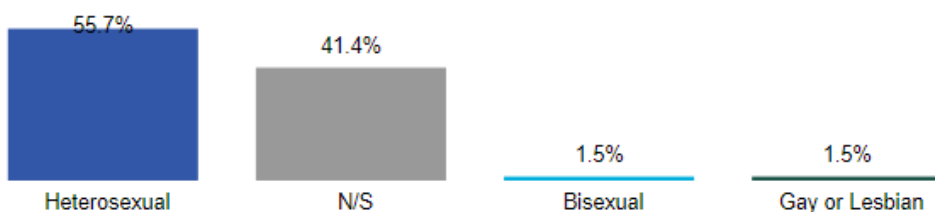
**Gender**



**Disability**



**Workforce Breakdown: Sexual Orientation**



# BS D&I - Management Commentary

<Please insert Management Commentary text here>

**661**

Total Headcount End Apr 21

# OTDT D&I DASHBOARD

**Blood and Transplant**

Workforce

**661**

Bands 2-7

**560**

Bands 8A-C

**91**

Bands 8D-9

**6**

Exec & Board

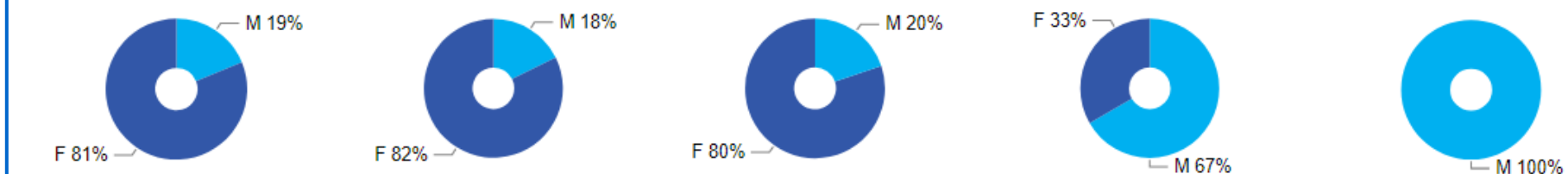
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Medical  
(Blank)

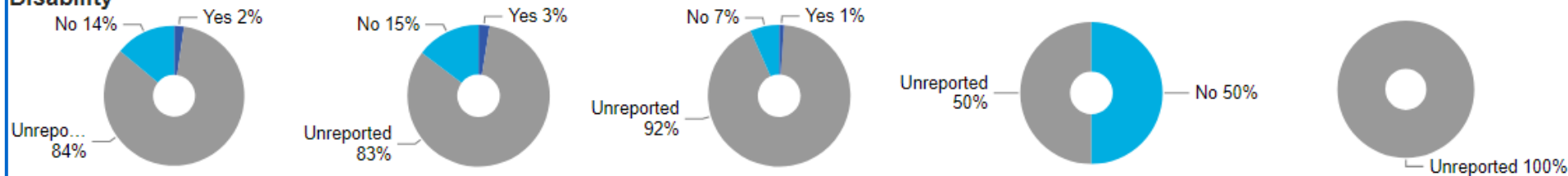
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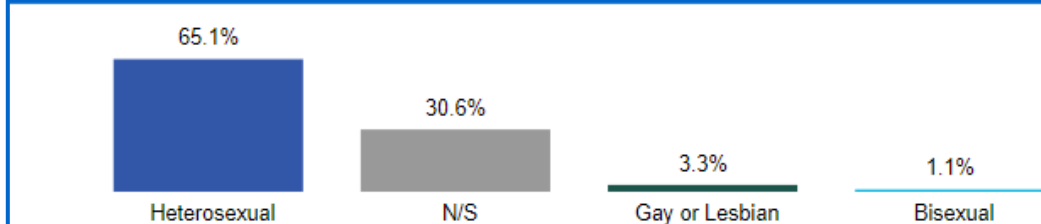
**Gender**



**Disability**



**Workforce Breakdown: Sexual Orientation**

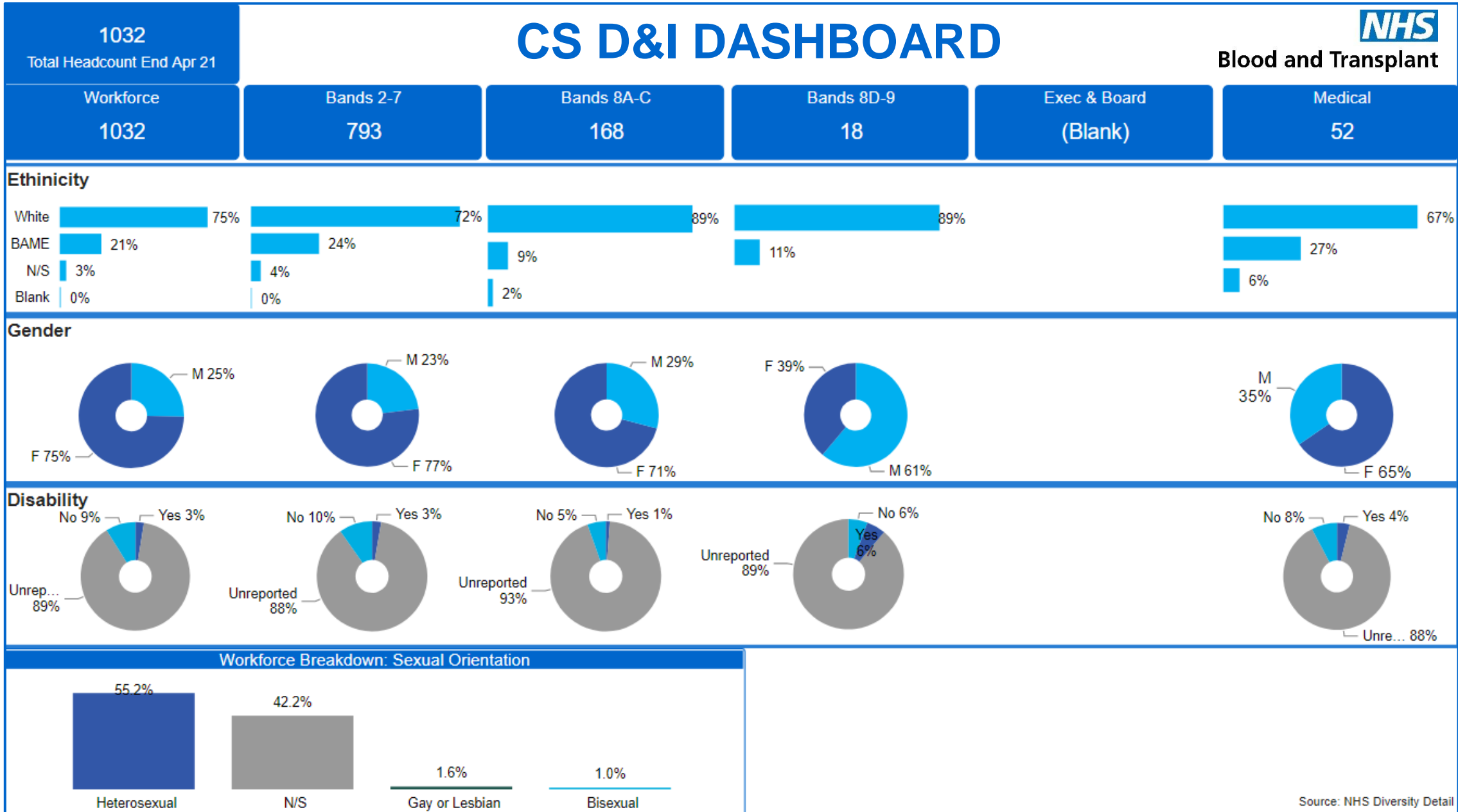




# OTDT D&I - Management Commentary

Blood and Transplant

<Please insert Management Commentary text here>



# CS D&I - Management Commentary

<Please insert Management Commentary text here>

249

Total Headcount End Apr 21

# DDTS D&I DASHBOARD

Blood and Transplant

Workforce

249

Bands 2-7

172

Bands 8A-C

67

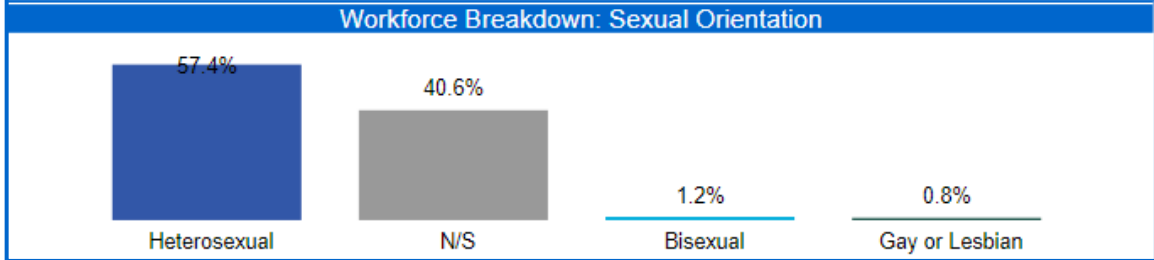
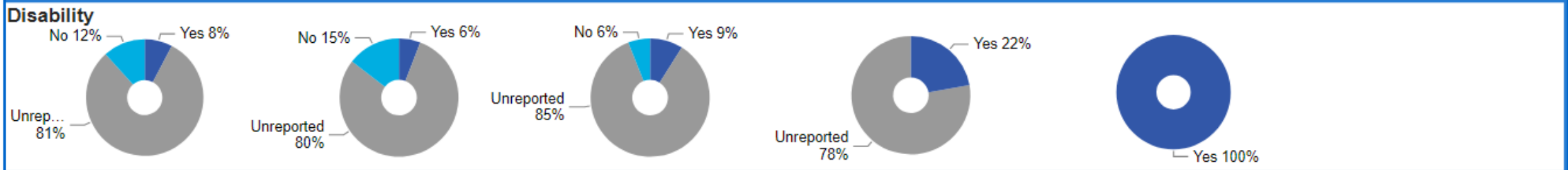
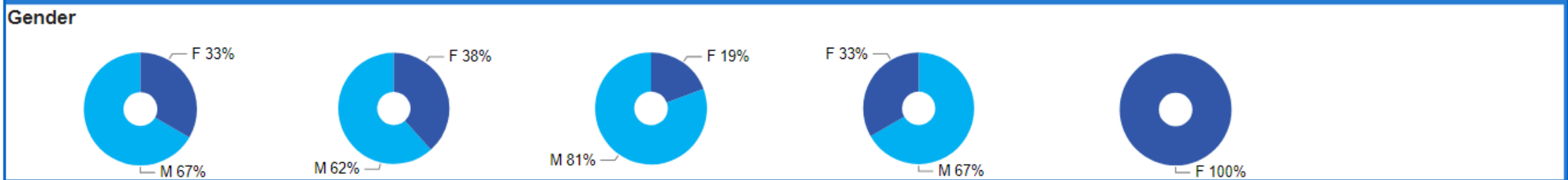
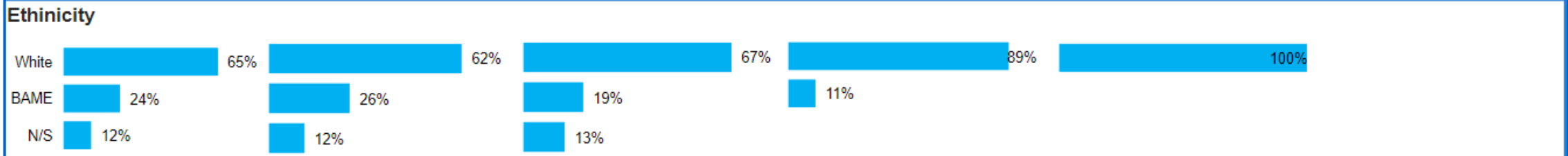
Bands 8D-9

9

Exec & Board

1

Medical  
(Blank)





# DDTS D&I - Management Commentary

<Please insert Management Commentary text here>

174

Total Headcount End Apr 21

# DX D&I DASHBOARD

Blood and Transplant

Workforce

174

Bands 2-7

152

Bands 8A-C

18

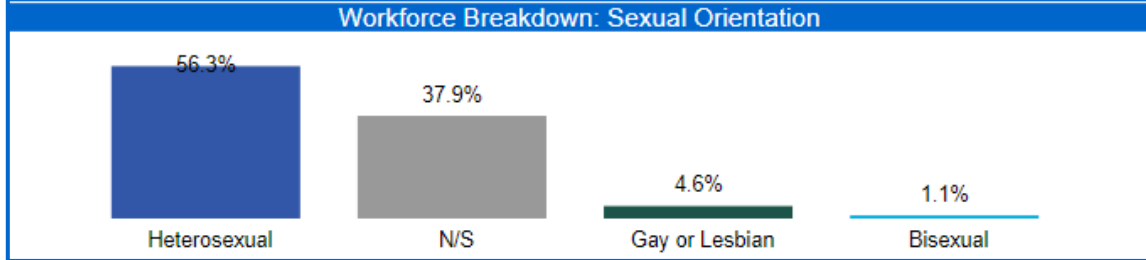
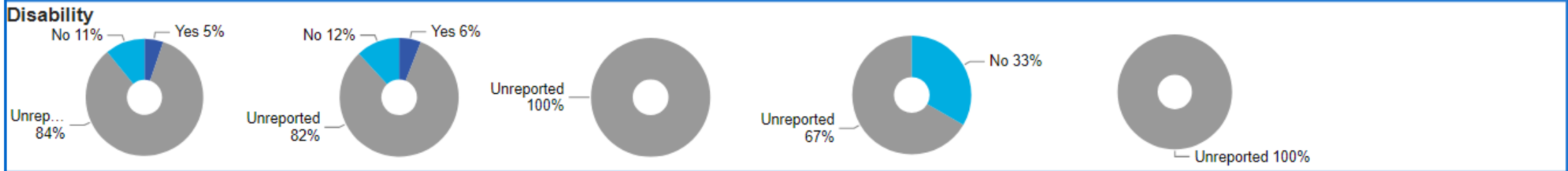
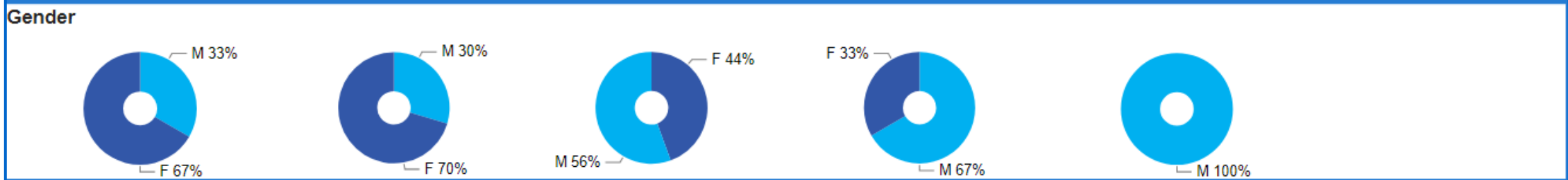
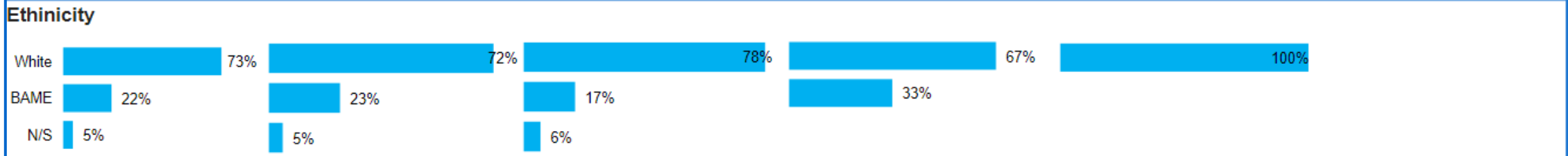
Bands 8D-9

3

Exec & Board

1

Medical  
(Blank)



# DX D&I - Management Commentary

<Please insert Management Commentary text here>

**190**

Total Headcount End Apr 21

# Finance D&I DASHBOARD

**Blood and Transplant**

Workforce

**190**

Bands 2-7

**142**

Bands 8A-C

**43**

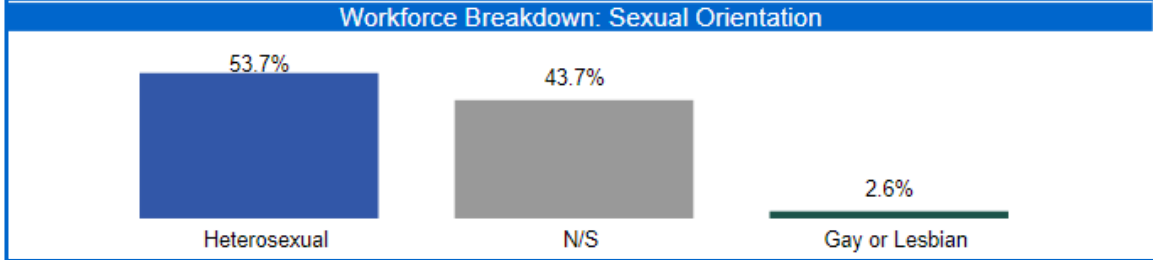
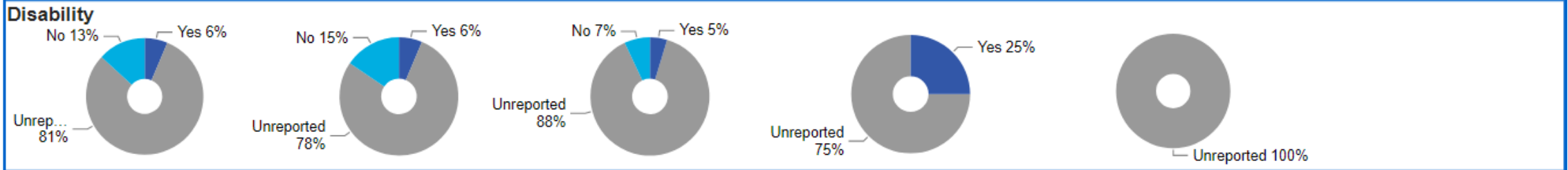
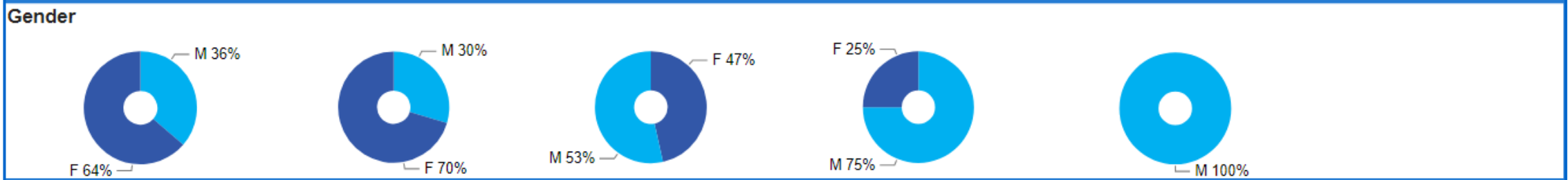
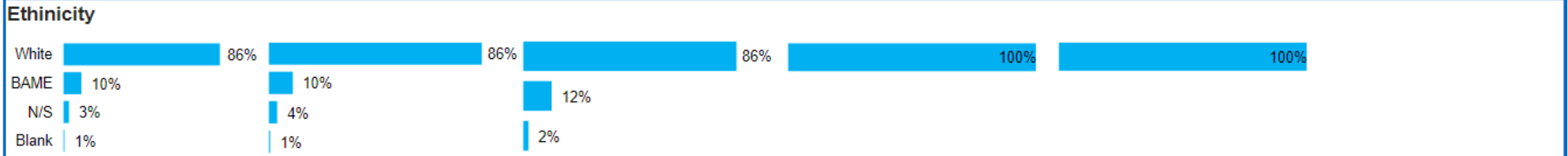
Bands 8D-9

**4**

Exec & Board

**1**

Medical  
(Blank)





# Finance D&I - Management Commentary

Blood and Transplant

<Please insert Management Commentary text here>

**149**

Total Headcount End Apr 21

# People D&I DASHBOARD

**Blood and Transplant**

Workforce

149

Bands 2-7

101

Bands 8A-C

46

Bands 8D-9

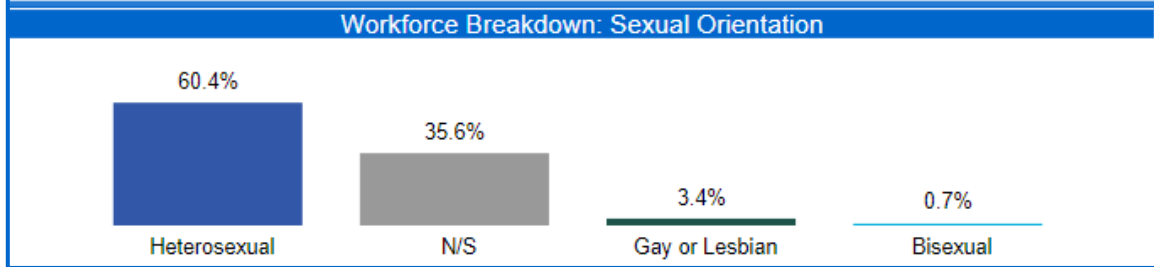
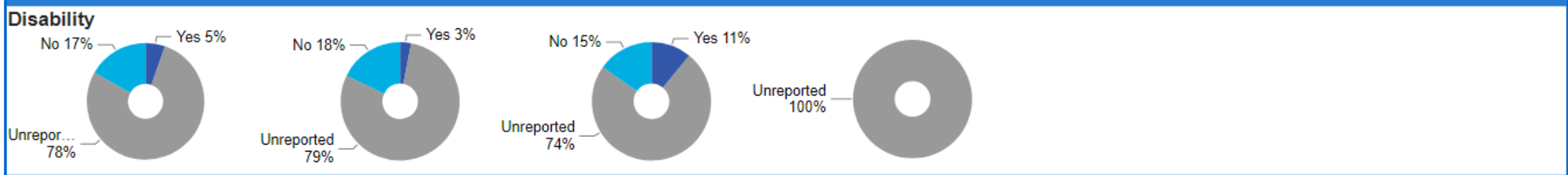
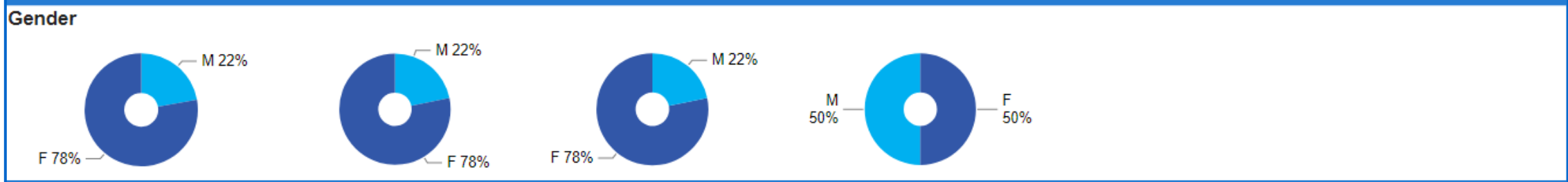
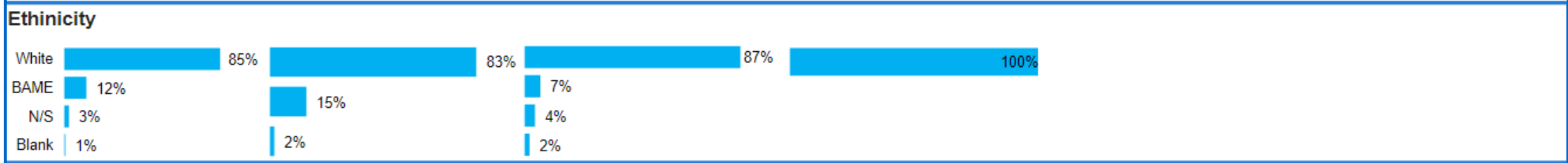
2

Exec & Board

(Blank)

Medical

(Blank)





# People D&I - Management Commentary

Blood and Transplant

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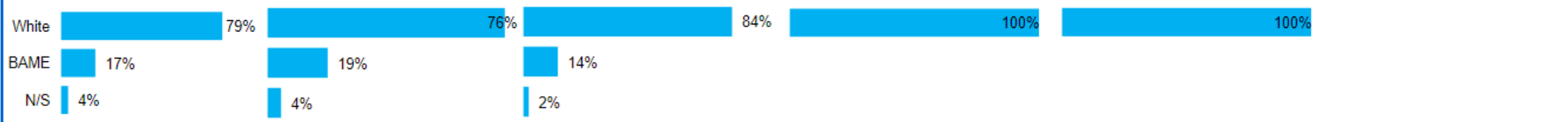


Blood and Transplant

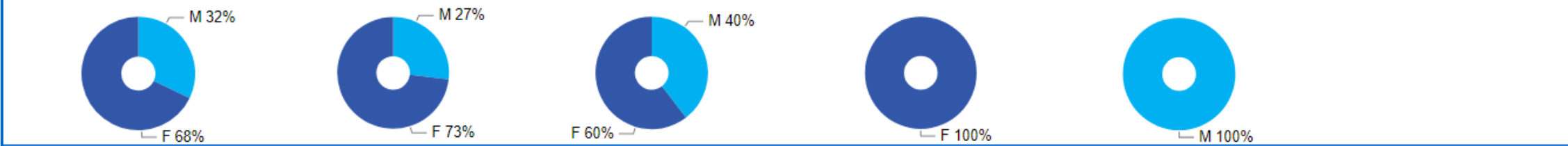
# Quality D&I DASHBOARD

<b>112</b> Total Headcount End Apr 21					
<b>Workforce</b> 112	<b>Bands 2-7</b> 67	<b>Bands 8A-C</b> 43	<b>Bands 8D-9</b> 1	<b>Exec &amp; Board</b> 1	<b>Medical (Blank)</b>

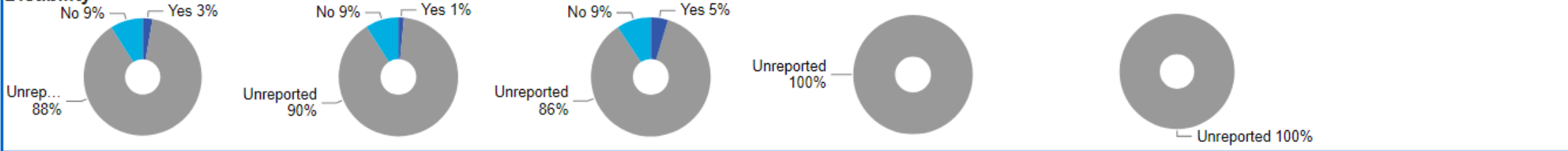
**Ethnicity**



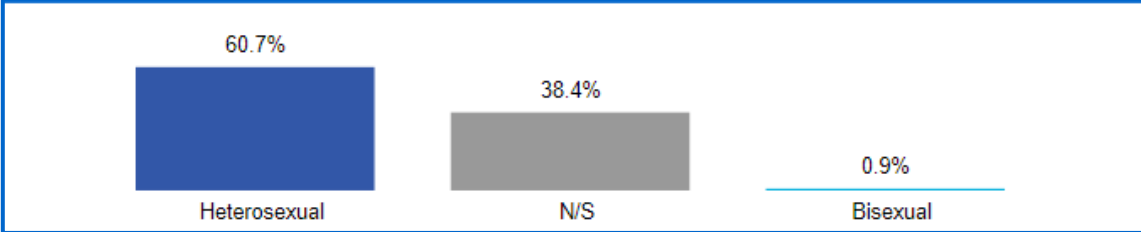
**Gender**



**Disability**



**Workforce Breakdown: Sexual Orientation**



Source: NHS Diversity Detail

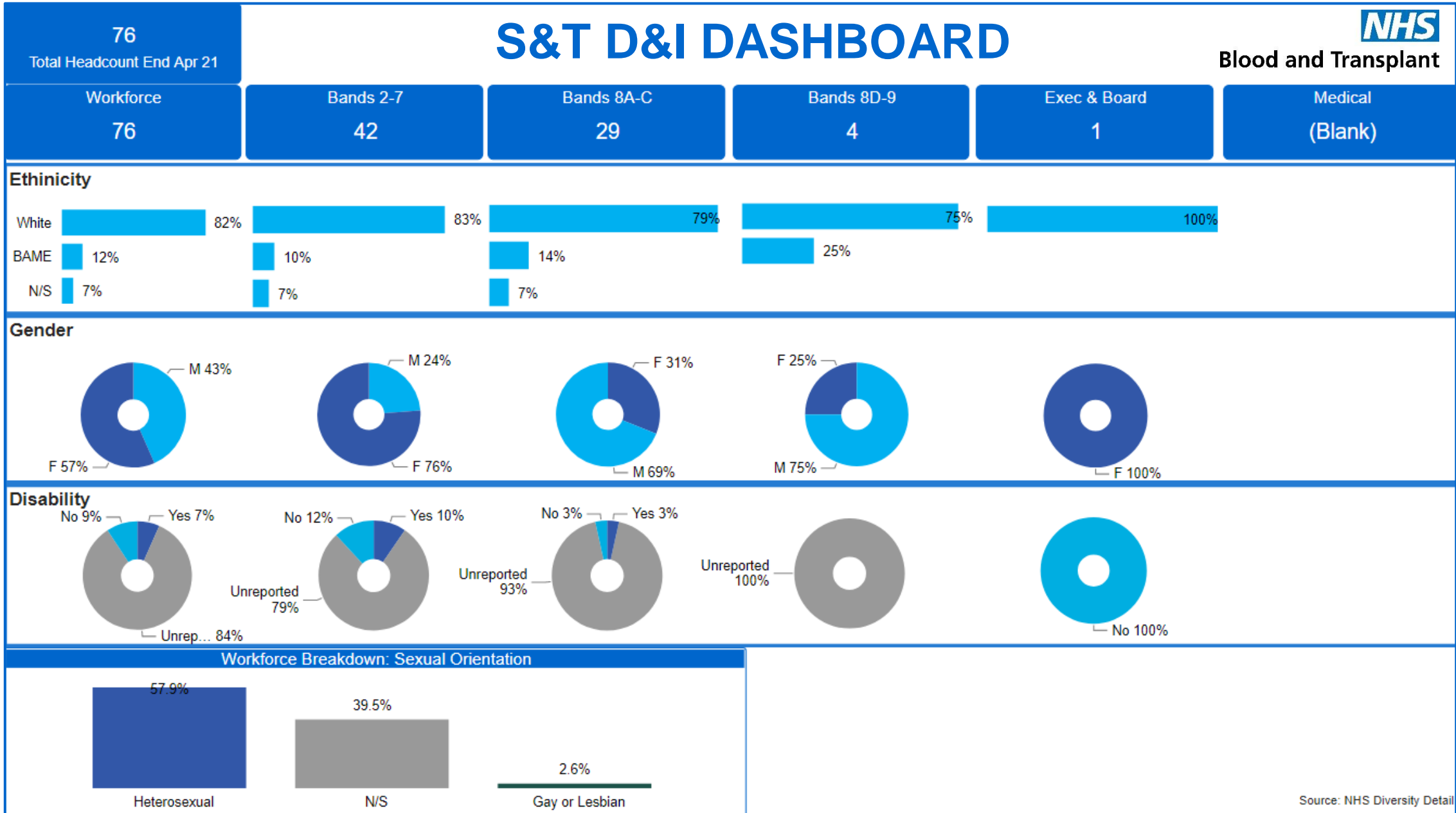




# Quality D&I - Management Commentary

Blood and Transplant

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# S&T D&I - Management Commentary

Blood and Transplant

<Please insert Management Commentary text here>

# 13. Blood Technology Modernisation Programme - Status Update (21-40) - Christie Ash to join

For Report

Presented by Wendy Clark



## Blood and Transplant

### NHSBT Board

#### Blood Tech Modernisation Programme – Status Update

27<sup>th</sup> May 2021

**Status: Official**

#### 1. Summary and Purpose of Paper

The Blood Technology Modernisation (BTM) programme has been established to deliver the stabilisation and security of blood IT, the Programme Strategic Outline Case and first year Full Business Case was approved at the Jan 21 Board. This paper provides the board with an update on progress, highlighting issues for escalation.

#### 2. Action Requested

The Board is asked to note

that the BTM Programme is currently delivering the approved scope on plan and within budget.

#### 3. Background

The BTM programme has been approved as a 5 year programme to deliver the stabilisation and security of blood IT set out in the Blood Technology Strategy. The programme will establish a new blood technology product centre to:

1. Grow existing and establish new capabilities to deliver releases in months not years
2. Convert the application to a supported language (C#)
3. Re-platform the database from Mimer to a mainstream database
4. Enable access to real-time data for improved decision making (PowerBI)
5. Improve the integrations between Pulse and other applications (Donor Portal, OBOS, SO99, etc.)

#### 4. Detail of report

Delivery against plan

The programme is on track to deliver agreed scope by the dates and targets set for 21/22.

Requirements from the Plasma for Medicine programme have been absorbed with a manageable level of disruption. We continue to work closely with the programme whilst we wait to see what requirements they have for the coming months. A small amount of capacity in upcoming releases has been allocated to meet Plasma for Medicine requirements. Any requests for capacity above the allocation will be Impact Assessed so that prioritisation decisions can be made by the relevant boards.



## Blood and Transplant

Progress against the people plan is also going well. All Wave 1 roles have been advertised and interviews are in progress. A number of offers have been accepted and our Engagement and Enablement scores continue to be high at 5.1/6.

We continue to manage 4 significant risks, the highest being the impact of new demand from new initiatives such as Plasma for Medicine and we continue to work with Blood Supply to define the future Ways of Working.

The Programme will continue to report an Amber status until Q3 when delivery estimate assumptions will have been tested and validated through development of the first release.

### Financial position

The underspend of £401k in financial year 2020/21 has been reviewed and causes include delays in resourcing. The delays on-boarding resource did not impact programme delivery during the period.

2021/22 spend for this reporting period is on plan and within budget. The finance team are reviewing the classification of programme spend to confirm capital and revenue split.

### Sign off

Next Board report July 21. Next significant milestone, September legacy release which clears the backlog for modernisation delivery.

**Author: Christie Ash, Programme Director**

**Responsible Director: Wendy Clark Chief Digital and Information Officer**

**Date: May 21**



***Blood and Transplant***

**Blood Technology Modernisation  
NHSBT Board Report**



Reporting date: 14/05/2021  
 SRO: Wendy Clark  
 Accountable Exec: Christie Ash

# Programme Summary

Note from Programme Director

## The programme objectives are to Stabilise and Secure Blood Technology.

RAG Status	
Previous	A
Current	A
Trend	➡

- Programme is progressing well but continues to report Amber due to unproven C# development estimates. This will continue for 6 months as estimate assumptions are tested and validated.
- FY21/22 baseline programme plan accepted by Programme Board 04/05. Plan achieves targets set for FY, subject to risks including effort estimate validation.
- Legacy releases are on track. Session Solution continues with extended pilot whilst an issue is being managed. The scheduled bug fix deployed into Go-Live successfully on 09/05 with 0 Pulse related defects reported.
- All Wave 1 roles advertised with interviews in progress and several offers accepted.
- We are working closely with the Plasma Programme Team to understand and Impact Assess any new demand. Expecting a decision on scope by the end of May.
- Engagement and Enablement scores continue to be high 4.9/6
- Underspend of £401k FY20/21 was due to various causes, primarily delays in resourcing, but have not impacted programme delivery.

Key Performance Indicators

Progress against plan			Budget/spend			Scope			Quality			Benefits			Leadership Continuity			Vendor Relationship			Engagement Scores														
Previous	Current	Trend	Previous	Current	Trend	Previous	Current	Trend	Previous	Current	Trend	Previous	Current	Trend	Previous	Current	Trend	Previous	Current	Trend	Previous	Current	Trend	Previous	Current	Trend	Previous	Current	Trend						
A	G	➡	G	G	➡	G	G	➡	A	G	➡	G	G	➡	G	G	➡	G	G	➡	G	G	➡	G	G	➡	G	G	➡	G	G	➡	G	G	➡
Integrated plan baselined			Unforeseen BAU environment costs are being calibrated across Programme spend			Expected downward trend due to possible CRs from PfM / CVP			Quality Incident from 14/03 mitigated through planning and Quality checkpoints			Benefits defined and baseline measurements taken			Several leadership vacancies			No concerns			February – 5.0 April – 5.1 May – 4.7 (out of 6)			February – 5.1 April – 5.1 May – 5.0 (out of 6)											

Risks and Issues

Type	ID	Description	Inherent Risk		Mitigation Actions / Resolutions	Residual Risk	Owner
			Impact	Likelihood			
R	Prg-R070	New demand such as Plasma for the manufacturing of medicines (PfM), Convalescent plasma (CVP) or other unforeseen demand may impact timelines and capacity and place heavy workloads upon key individuals.	4	5	<ul style="list-style-type: none"> <li>Established demand mgmt. process to provide a single channel for work to enter the product centre.</li> <li>Accountable Executive has regular check-ins with PfM representative to enable alignment and foresight of demand.</li> </ul>	Very High	CA
R	Prg-R071	The plan is based on development estimates. As we haven't proven these estimates and how long it takes to convert a module of Pulse, there is a risk the programme doesn't deliver to plan and requires increased investment.	5	4	<ul style="list-style-type: none"> <li>First C# release will test assumptions built into estimates. Following this, we will be able to assess the validity of remaining C# upgrade plan.</li> </ul>	Very High	CA
R	Prg-R079	There is a risk to filling vacancies in a timely manner and with strong candidates at the banding assigned and for FTC contracts depending on candidates that are available and choose to apply	3	4	<ul style="list-style-type: none"> <li>Monitor applications</li> <li>Prepare Recruitment Premiums if required</li> <li>Consider targeted recruitment options (e.g. headhunting)</li> </ul>	Very High	CA
R	Prg-R072	Decisions on the future organisational model may not be taken quickly, which would invalidate the current resourcing and recruitment plan and increase costs.	4	3	<ul style="list-style-type: none"> <li>Blood Supply Service Model completed, with support from the Programme and progressing with un-impacted role recruitment.</li> </ul>	High	GM/CA

Summary (Apr)	
Approved budget (£k)	£ 4,168
April Spend (£k)	£ 309
Cumulative Spend (£k)	£ 309
Forecast for this FY (£k)	£ 4,169
Status	On Track

Green	On track with no major risks or issues
Amber	On track but major risks
Red	Issues impacting delivery
Grey	Not commenced
Blue	Complete

Budget Update





**Blood and Transplant**

Reporting Date: 14/05/2021  
 SRO: Wendy Clark  
 Accountable Exec: Christie Ash

# Progress against scope

Green	On track with no major risks or issues
Amber	On track but major risks
Red	Issues impacting delivery
Grey	Not commenced
Blue	Complete

The table below shows the % complete of total programme scope over time in each area. The last row of the table shows the % of total budget (excluding contingency) spent. Taken together, the table shows the % of budget spent to achieve a % of scope. The % complete takes account of the estimated effort involved, and the complexity of the work is a contributing factor in the estimating process. Please refer to the appendix for further detail on the method of calculation.

Tracking the Cumulative Delivery and Budget Over Time														
	FY20/21 Target	FY20/21 Actual	May '21 Plan	May '21 Actual	Jul '21	Sep '21	Nov '21	Jan '22	Mar '22	FY21/22 Target	FY22/23 Target	FY23/24 Target	FY24/25 Target	FY25/26 Target
Product Centre Enablement	75%	75%	81%	81%*	86%	92%	96%	100%	100%	100%				
Legacy Delphi Delivery	n/a	51%	51%	51%	51%	51%	100%	100%	100%	100%				
C# Upgrade	- Requirements Definition	15%	13%	13%	25%*	30%	46%	46%	53%	57%	50%	80%	95%	100%
	- Design and build	5%	6%	6%	7%*	8%	10%	tbc	tbc	tbc	25%	50%	75%	100%
	- Test	0%	0%	0%	2%*	0%	0%	tbc	tbc	tbc	20%	45%	70%	100%
	- Accept and Deploy	0%	0%	0%	0%	0%	0%	tbc	tbc	tbc	15%	40%	65%	100%
	- Decommission	5%	0%	0%	0%	0%	3%	3%	5%	9%	10%	30%	55%	80%
Data Ecosystem & Power BI	0%	0%							20%	20%	75%	100%		
Database Modernisation	0%	0%							0%	0%	5%	25%	50%	100%
Integration Modernisation	0%	0%							5%	5%	10%	25%	75%	100%
Budget % of overall (excl. VAT)	n/a	12%	15%	15%	19%	22%	26%	29%	31%	31%	47%	64%	80%	98%

Delivery estimates have yet to be proven, and therefore ability to forecast accurately is limited. Increased confidence in estimates is expected over coming months as team's experience increases; further forecasts will be released over the Summer.

Budget % restated to exclude VAT from FY21/22 onwards following conversations with Finance. Final FY20/21 actuals were also updated, to reflect FY20/21 underspend.

(\*) = delivery progress includes work-in-progress, subject to milestone approval

**Key Delivery Milestones**

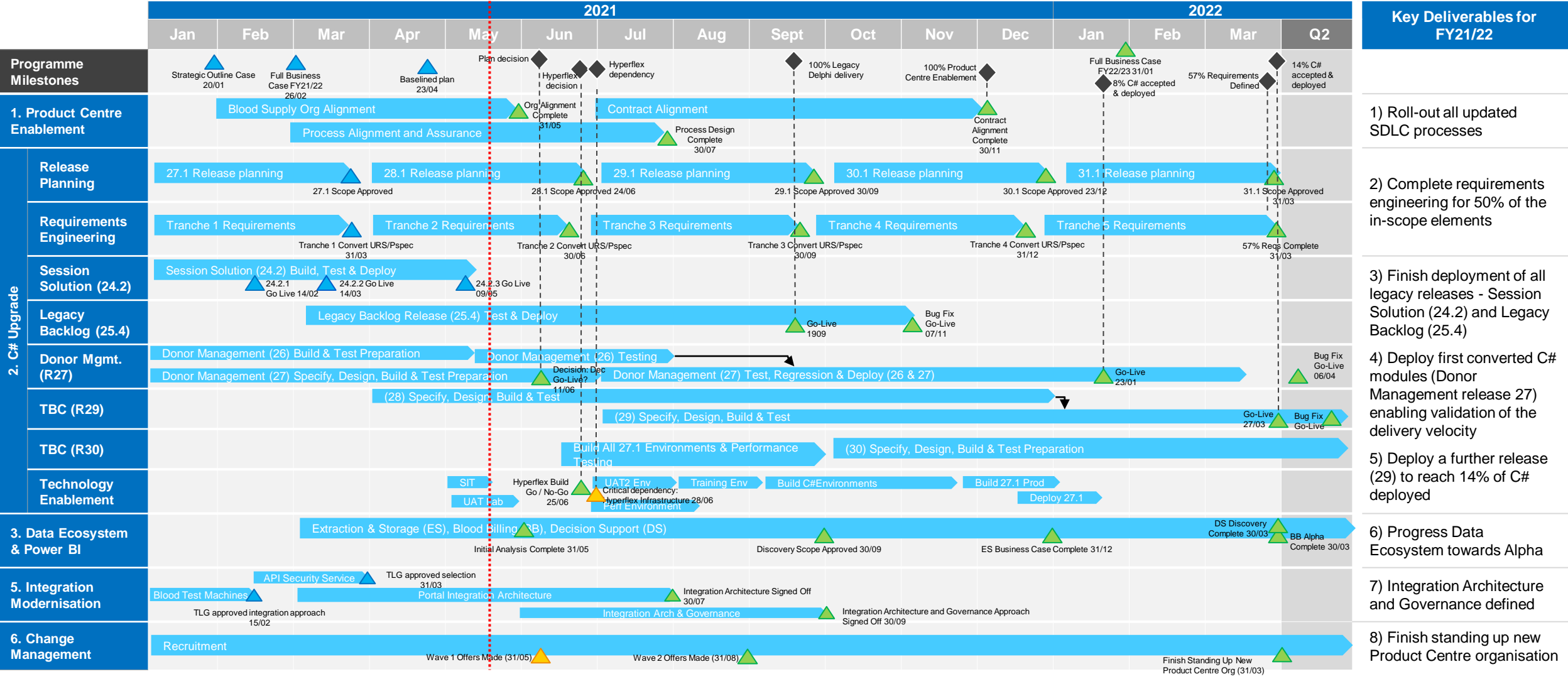
Workstream	Milestone Description	Baseline Date	Forecast Date	RAG	Commentary
All	Baselined programme plan	-	22/04	C	
Legacy delivery	Session Solution Big Fix Go Live (24.2.3)	09/05	09/05	C	
C# Upgrade	Donor Management (R27) Build Complete	30/06	30/06	G	
Change Management	Wave 1 Offers Made	31/05	31/05	A	Challenges with several roles, see R079



# Integrated Programme Plan

The plan shows work streams on the left, with their activities, key milestones and dependencies across the centre of the page. The activities drive achievement of key deliverables on the right. Milestones will show as on track (green), at risk (amber/red) or completed (blue).

Key	
Green	On track with no major risks or issues
Amber	On track but major risks
Red	Issues impacting delivery
Grey	Not commenced
Blue	Complete
▲	Milestone
→	Activity



# Supporting slides

# A1: Key performance indicators explained

KPI	Measure	Green	Amber	Red
<b>Progress against plan</b>	Milestone progress against plan	No significant issues or delays with delivery and acceptance of milestones/deliverables. Confidence of Level 1 milestones/deliverables delivery and acceptance on time >80%.	Minor delays, significant issues require short term attention, milestones/deliverables may miss target. Confidence of Level 1 milestones/deliverables delivery and acceptance on time 60-80%.	Major issues / delays, require immediate attention, will not meet target for milestones/deliverables. Confidence of Level 1 milestones/deliverables delivery and acceptance on time <60%.
<b>Budget/spend</b>	Budget remaining vs. forecast to end of FY	Finances are under control and within tolerances set. <b>Under-spend:</b> If no tolerances set, then any favourable variance is within 90 -100% of Budget.	<b>Over-spend (forecast or actual):</b> Finances require attention, and may exceed tolerances set. There are issues but these can be resolved with short term action. Formal application for draw-down of any contingency fund will be required. <b>Under-spend:</b> If no tolerances set, then any favourable variance forecast is between 85% & 90% of Budget.	<b>Over-spend (forecast or actual):</b> Financial viability of the programme is under question and requires significant attention. Forecast to exceed contingency fund identified in the Business Case. If forecast spend is in excess of the lower of 10% or 100k of budget then the business case must be revisited: additional funding is required subject to relevant approval. <b>Under-spend:</b> If no tolerances set, then any favourable variance forecast is below 85% of Budget or £100K under-spend whichever is smaller.
<b>Scope</b>	No. of major and minor CRs in last year	Scope is under control with only minor changes to a limited number of deliverables, which do not affect time, cost and required outcomes of the programme.	Changes or additional deliverables have been requested which will negatively impact time and cost or delivery of other deliverables. There is a risk that "scope creep" may threaten the programme. Formal Change Control is underway.	Changes or additional deliverables have been requested which will impact time and cost or delivery of other deliverables. These will significantly impact time and cost and other indicators beyond agreed tolerances.
<b>Quality</b>	Delivery to Customer's Quality expectations (including GMP & MHRA requirements)	Customer Quality requirements are clear and milestones/deliverables delivered to customer are meeting or will meet customer quality requirements	Some Customer Quality requirements are unclear or there is pushback on the quality of some milestones/deliverables, but these can be rectified without impacting overall programme delivery.	Potentially serious regulatory / quality issues which would prevent programme outcomes becoming accepted into service. Customer is pushing back on the quality of milestones/deliverables being delivered or Customer Quality requirements are unclear. This will severely impact the overall programme delivery and customer acceptance.
<b>Benefits</b>	Benefits progress against plan	No significant issues or delays in realising benefits - will hit or exceed the target.	Minor delays or minor reduction is expected against the benefits defined in the business case. If no tolerance set, then will be within 5% of Business Case.	Viability of the programme is under question from a benefits delivery perspective. Major delays in delivery or significant reduction in expected benefit - reduction in benefit is greater than 5%.
<b>Leadership continuity</b>	% change in leadership in last quarter – includes SRO and product centre LT	No or minor leadership changes	Several leadership changes over short period of time, which can be mitigated through thorough handovers. New leaders continue programme delivery as per Business Case and plans.	Leadership changes without thorough handovers, leading to loss of expertise. New leaders alter programme course, impacting on programme delivery.
<b>Vendor relationship</b>	Vendor relationship as scored by SRO and AD	No concerns or minor concerns.	Diversion of opinion on some topics and/or strained communications, which can be addressed without impacting overall programme delivery.	Significant diversion of opinion and strained communications, which will severely impact the overall programme delivery.
<b>Engagement scores</b>	Monthly programme engagement score metrics on knowledge and engagement	Good engagement scores (4.5 to 6 out of 6).	Mediocre engagement scores (3 to 4.5 out of 6) or sudden drop in scores.	Poor engagement scores (0 to 3 out of 6) or sudden large drop in scores.

# A2: How delivery % is measured for tracking and reporting

Tracking the Cumulative Delivery and Budget Over Time														
	FY20/21 Target	FY20/21 Actual	May '21 Plan	May '21 Actual	Jul '21	Sep '21	Nov '21	Jan '22	Mar '22	FY21/22 Target	FY22/23 Target	FY23/24 Target	FY24/25 Target	FY25/26 Target
Product Centre Enablement	75%	75%	81%	81%*	86%	92%	96%	100%	100%	100%				
Legacy Delphi Delivery	n/a	51%	51%	51%	51%	51%	100%	100%	100%	100%				
C# Upgrade	- Requirements Definition	15%	13%	13%	25%*	30%	46%	46%	53%	57%	50%	80%	95%	100%
	- Design and build	5%	6%	6%	7%*	8%	tbc	tbc	tbc	tbc	25%	50%	75%	100%
	- Test	0%	0%	0%	2%*	0%	0%	tbc	tbc	tbc	20%	45%	70%	100%
	- Accept and Deploy	0%	0%	0%	0%	0%	0%	tbc	tbc	tbc	15%	40%	65%	100%
	- Decommission	5%	0%	0%	0%	0%	3%	3%	5%	9%	10%	30%	55%	80%
Data Ecosystem & Power BI	0%	0%							20%	20%	75%	100%		
Database Modernisation	0%	0%							0%	0%	5%	25%	50%	100%
Integration Modernisation	0%	0%							5%	5%	10%	25%	75%	100%
Budget % of overall (excl. VAT)	n/a	12%	15%	15%	19%	22%	26%	29%	31%	31%	47%	64%	80%	98%

(\*) = delivery progress includes work-in-progress, subject to milestone approval

### How C# and Delphi delivery % is measured

### How Blood Power BI and Integration Modernisation delivery % are measured

- A list of in-scope C# and Delphi elements has been baselined.
- C# and Delphi elements have an estimate for the percentage of overall work that they represent.
  - Estimates are reached through a calculation of lines of code, forms (GUI) and an experience factor.
- Delivery of in-scope elements over time has been planned and baselined.
- Percentage delivery of the total is shown in a table over time, with baseline vs. actual progress.

- Blood Power BI and Integration Modernisation have yet to commence and detailed deliverables planning will happen in due course.
- The delivery percentage plan was based on a high level estimate and will be firmed up as planning gets under way.

### How Product Centre Enablement delivery % is measured

### How Budget % is measured

- Product Centre Enablement progress is assessed based on resource allocation over time until the final milestone.

- Cumulative actual (when available) or forecast (for future dates) spend is divided by the total budget excluding contingency.

## 14. Reports from the UK Health Departments

## 14.1. England (no written report provided)

For Reference

## 14.2. Northern Ireland (21- 38a)

For Reference



## **NHSBT Board Meeting – 28 May 2021**

### **Written update from Northern Ireland**

#### Introduction of an Opt-out System for Organ Donation

Following the public consultation, work is progressing on a draft Bill for consideration by the Executive and NI Assembly to enshrine the policy proposals into law.

As part of this process, an Organ Donation Clinical Advisory Group (ODCAG) has been established. The aim of the ODCAG is to provide a mechanism for clinicians and other stakeholders with relevant expertise to advise the Department on the development and implementation of the new legislation.

Members of the group include representatives from –

- NHSBT – Clinical Leads for Organ Donation, Clinical Lead for Organ Utilisation, Specialist Nurses for Organ Donation and National Clinical Lead for Organ Donation;
- Public Health Agency;
- Human Tissue Authority;
- British Medical Association; and
- Belfast Health and Social Trust.

The first meeting of the group was held on 27 April 2021 and provided a useful forum for discussion with members regarding the draft Bill.

#### Kidney Transplant Service

Following a pause in the kidney transplant service due to the pandemic for all but the most highly sensitised patients for whom it was extremely difficult to find a suitable match, living donor kidney transplants resumed at the end of March 2021 on a phased approach. Deceased donor transplants for all suitable patients resumed on 6 April 2021.

Officials continued to work closely with Commissioners, Trusts and NHSBT to consider options for the full restoration of the service, including the consideration of alternative locations.

The Belfast Health and Social Care Trust recently submitted a Renal Surgery Recovery Plan, which includes details of how the service will increase incrementally between April and June 2021. This includes a commitment to carrying out transplants over the next four months for those identified in the recent UK Living Kidney Sharing Scheme matching run.

The Department of Health would like to formally thank NHSBT staff for the invaluable support they have provided to both the opt-out process to date and in re-establishing the renal transplant service.

#### Organ Donation Promotion

The NI Organ Donation Promotion Manager continues to develop and roll out a series of promotional events. Recent progress has included the creation of dedicated Organ Donation Twitter and Facebook pages ([organdonationNI](#)).

The next meeting on the NI Organ Donation Steering Group is scheduled to take place on 10 June 2021 and discussions will include the forthcoming Organ Donor Week in September.

## 14.3. Wales (21-38b)

For Reference

## **NHSBT BOARD – 27 May 2021**

### **UPDATE FROM THE WELSH GOVERNMENT**

#### **1. Communications and awareness**

- The last piece of content overseen by the Welsh Government communications team was delivered on all our social media channels on 30 April 2021, as part of a 'Best Of' month featuring images from the last couple of years.
- We are currently in the process of transferring our communications assets to NHSBT.

#### **2. Welsh Transplantation Advisory Group – WTAG**

- The WTAG meeting held on 5 May 2021 considered the latest organ donation and transplantation numbers. Presentations on organ donation and transplantation performance were given as well as other updates regarding Commonwealth Tribute to Life, the Human Tissue Authority, WHSSC and Health Board updates.
- A Commonwealth 'Tribute to Life' Organ Donation and Transplantation Memorandum of Understanding (MOU) is being developed to allow Commonwealth nations to share knowledge and expertise for the purpose of increasing organ and tissue transplantation to benefit of all Commonwealth citizens. The MOU has seen good progress with the establishment of a Commonwealth Tribute to Life Board (chaired by Dr Satya Sharma, MBE, Deputy Lieutenant West Midlands) and a Tribute to Life UK Advisory Panel (chaired by Professor Baroness Finlay of Llandaff). There has also been progress made towards establishing a planned Tribute to Life International Advisory Panel.
- Next meeting is scheduled for 5 July 2021.

#### **3. Update from Welsh Blood Services (WBS)**

- World Blood Donor Day will be held on 14 June.
- We are working with WBS on announcements around the FAIR study questionnaire changes in relation to MSM and possible sub-Saharan sexual partner question.
- A working group with the WBS, to include the Welsh Government Chief Pharmacist, is to be set up to look at fractionation and its medicinal products.

## 14.4. Scotland (21- 38c)

For Reference



## **NHSBT BOARD SCOTTISH GOVERNMENT UPDATE**

### **The Human Tissue (Authorisation)(Scotland) Act 2019**

- The Human Tissue (Authorisation) (Scotland) Act 2019 came into effect on Friday 26 March 2021.
- The Opt out system is now in place, with thanks to the collaborative working and expertise from NHSBT and SNBTS.
- The final Opt out Programme Board meeting will take place on 2 June.
- An evaluation of the law change public awareness campaign is underway and key highlights will be reported at the Programme Board meeting.

### **Donation and Transplantation Plan for Scotland: 2021 – 2026**

- The new Donation and Transplantation Plan for Scotland was published on 24 March.
- Work has commenced on the development of an implementation plan, which is being discussed with the Scottish Donation and Transplant Group (SDTG).
- Preliminary work has begun to further scope the recommendations from the Scottish Plan.

### **Donation and Transplantation in Scotland**

- Transplant units in Scotland are open and functioning as normal.
- The Living Donation Scotland Board meeting took place on 5 May 2021 and work is underway to develop a PR campaign to raise awareness of living kidney donation in Scotland during June.

**Scottish Government  
May 2021**

## 15. For information

## 15.1. Annual Management Quality Report (21-39)

For Reference

Presented by Ian Bateman





## Blood and Transplant

### NHSBT Board

#### Annual Management Quality Review 2020-2021

27<sup>th</sup> May 2021

#### Status: Official

#### Summary and Purpose of Paper

In a year dominated by the response to the COVID-19 pandemic NHSBT:

- maintained compliance with all regulatory requirements
- underwent 13 remote and on-site external regulatory inspections none of which resulted in critical or major findings
- retained all laboratory accreditations
- completed all regulatory preparations for EU Exit as required.

Key transformation/BAU activities completed or progressed included:

- the opening of NHSBT Barnsley, now fully licensed and operational for blood supply and tissue and cell activities
- the convalescent plasma project where 23 new sites were opened and licensed and,
- successful continuity of the self-inspection programme despite lockdown restrictions, following adaptation to remote auditing.

Key objectives for 2021/22 will be to:

- work with regulators in preparation for the expected move to full-scale collection of plasma for manufacture into medicinal products (PFM)
- increase focus on Quality Management System Continuous Improvement (CI) activities, after a pause to initiatives during 2020/21
- manage the additional regulatory burden arising from the new medical devices regulations, which require the up classification of devices needing use of Notified/Approved Bodies in conformity assessment.

#### Action Requested

The Board is asked to note that the report is provided to the Board for information and has been discussed in detail at the ARGC.

#### Link to Risk Strategic Priority or Regulatory Requirement

Continued regulatory compliance is critical for NHSBT to maintain its licences and accreditations, including its Blood Establishment Authorisation (BEA), Human Tissue Authority (HTA) Licences for Tissues, Cells and Organs, Medicinal Products licences and the Care Quality Commission registrations, all of which are essential to allow us to continue to save and improve lives. This report provides an annual overview of regulatory activity, key trends, information, and assurances in line with NHSBT's strategic targets for safety and compliance.



## Blood and Transplant

### 1. External Inspection Performance and External Reports

#### 1.1 Inspection visits

There was a reduced number of external inspections in 2020/2021, as several were postponed until later in 2021, with regulators taking a risk-based approach to regulatory oversight while COVID-19 lockdown restrictions were in place. Despite this, 13 successful regulatory audits were carried out by inspectors using both remote and on-site methods. NHSBT underwent a further 10 external inspections pertaining to Health and Safety and Business Continuity standards and four of our suppliers inspected us.

##### 1.1.1 Highlights:

- **No Critical or Major findings** were raised.
- Three remote Medicines and Healthcare products Regulatory Agency (MHRA) Blood Establishment Authorisation (BEA) inspections were carried out at Basildon, Oxford, and Sheffield – 3 Other deficiencies were raised, one at each site. Follow-up on-site inspections later in the year at Basildon and Oxford included visits to new convalescent plasma sites at Reading and Stratford and only 1 Other finding at Oxford was noted.
- A Human Tissue Authority (HTA) virtual inspection was performed at Liverpool with 1 minor shortfall and two pieces of advice and guidance raised. The HTA further performed a pre-licensing assessment of the Barnsley site prior to receiving tissue and cell licences for human application activity and storage of material.
- NHSBT Barnsley also achieved MHRA BEA and Wholesale Distribution Authorisation (Human) approvals via successful remote audits. One Other and one Comment was raised during the MHRA assessment.
- NHSBT Barnsley RCI and H&I laboratories were added to the United Kingdom Accreditation Service (UKAS) certification for ISO15189.
- The Liverpool Reagents laboratory retained ISO13485 certification following remote assessment by the Underwriter's Laboratory.
- NHSBT laboratories: RCI sites, NTMRL and NBL (the latter two now known as Microbiology Services Laboratory) underwent further UKAS remote assessment and in each case accreditation to ISO15189 was successfully maintained.

##### 1.1.2 Inspection Outcome Summary:

The table below summarises the outcome from inspections. Refer to Appendix 1 for further details of key findings.

Licence/ Accreditation:	Number of Audits performed:	Outcome:
MHRA BEA	4 Remote 2 On-site	5 Others 2 Comments
HTA TQSR	2 Remote	1 Minor shortfall 2 Advice & Guidance
Accreditations (UKAS and UL)	5 Remote	15 Findings 5 Recommend'ns

##### 1.1.2 Identified trends, risks and actions taken from Inspections



## Blood and Transplant

All findings have been, or are in the process of being, addressed to the satisfaction of the relevant regulator.

Finding/risks highlighted	Risk to donor / patient safety or NHSBT	Actions taken or in progress	Measure of success
Poor incident investigation and management / complaint handling  (raised in two inspections and a recurring finding noted in inspections last year)	Potential for ineffective corrective and preventive actions to result in repeat incidents and hence not reduce the risk to donor/patient.	Holistic review of all aspects of incident management has been completed with a phased improvement project underway. June 2021 will see the launch of process improvements to give clarity to staff and regulators, supported by enhanced training and launch of a web reporting tool for incidents	A decrease in external findings for poor investigation and management of incidents.
Lack of documented procedures (examples noted at three inspections)	Potential for critical steps to be performed incorrectly or inconsistently if not fully documented in SOPs, which may impact on donor/patient safety.	Re-emphasised to all teams that ALL critical steps of procedures must be documented	No further examples identified.
Team MQR meetings were cancelled and not rescheduled within a suitable time. (previously noted in 2019/20 also)	Failure to meet regulatory responsibilities for regular management review of performance. Potential that identification, or management of, adverse trends is delayed or omitted.	Teams reminded of the requirement to maintain regular and documented MQR meetings.	No further examples identified

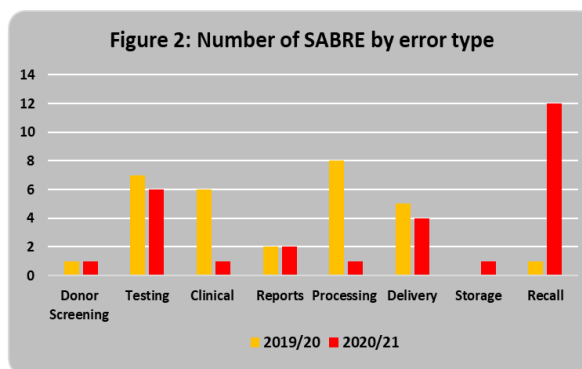
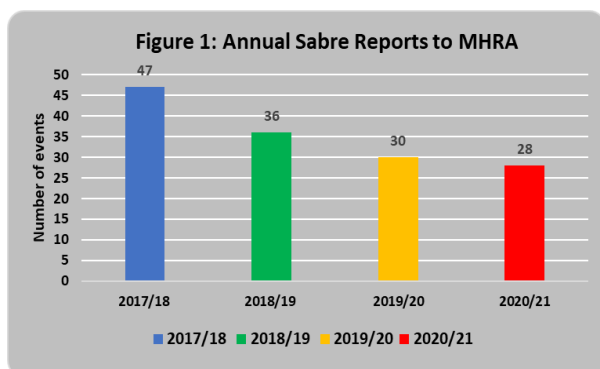
### 1.2 Serious Adverse Blood Reactions and Events (SABRE)

There were 28 SABREs reported to MHRA this year, **a decrease of 2 on the previous year and the lowest number for 4 years.** See *Figures 1 and 2.*

Q4 had 12 events giving a final quarter rate of 3.3 events per 100,000 donors which is higher than Q3 (1.5), however the annual rate was 1.9 events/100 000 donors; this is a slight improvement compared to 2019/20 (2.1). This figure remains equal to or better than recent SABRE data from the three other UK Blood Transfusion Services.



## Blood and Transplant

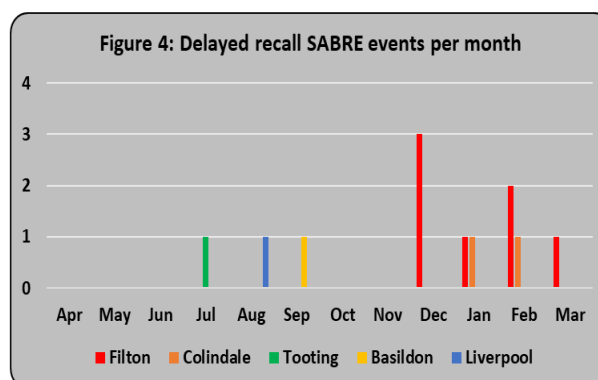
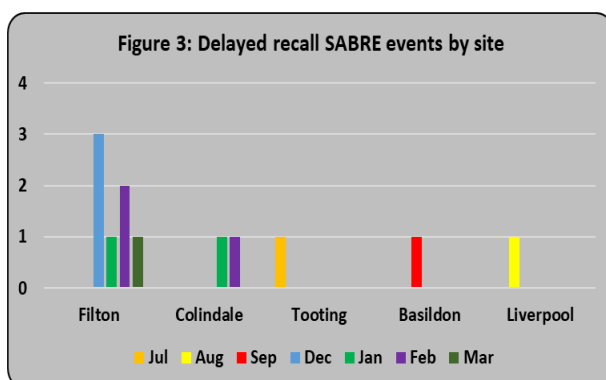


### 1.2.1 Highlights:

- **Processing errors have decreased**, largely due to a fall to zero for events of failure to irradiate blood products (4 reports last year)
- **Clinical events have decreased**
- **Donor screening events remain low** for the second consecutive year.

### 1.2.2 Improvements needed:

- The **most common reason for SABRE** reporting this year was delayed notification to hospitals of **product recalls** (12). This compares with only one recall issue reported to MHRA for each of the two preceding years. Delays in recalling product increases the risk that an unsuitable unit is transfused to a patient – in each of these events **the delay did not result in any adverse patient impact**. Seven events occurred at Filton and in the last 4 months of the year. Root cause analysis identified failure to prioritise recall incidents and staffing issues over the Christmas/New Year period. Preventive measures have been introduced and by March improvement had been noted with only one late recall reported in that month. A continuous improvement workshop scheduled for April 2021, will identify if further actions are needed. *See Figures 3 and 4.*



## 1.3 Human Tissue Authority (HTA) Tissue and Cells Serious Adverse Events and Adverse Reactions (SAEARs)

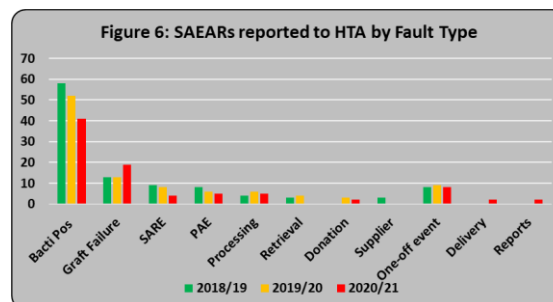
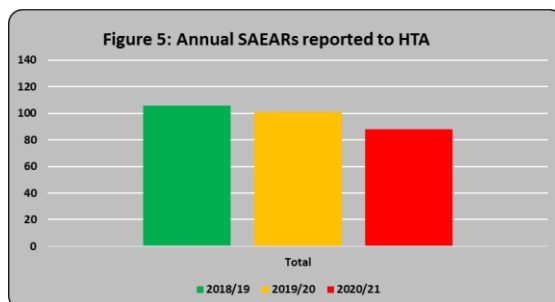
There were 88 SAEARs reported to the HTA this year compared with 101 last year.

### 1.3.1 Highlight:



## Blood and Transplant

- The **number of SAEARs reported this year has decreased for the second consecutive year**. The most common causes are consistent with previous years and **there are no trends of concern**. Excluding clinical events (Patient Adverse Event / Serious Adverse Reaction/Event / failed engraftment), there were 19 events raised that were attributable to NHSBT. These are being managed via appropriate CAPA and with no significant trends. See *Figures 5 and 6*.
- **The number of bacterial contamination reports decreased this year by 19%**. The majority of reports are raised from within Cellular Molecular Therapies (CMT) laboratories (78%). Due to the open nature of the cell and tissue collection process, bacterial contamination particularly from skin flora and the environment, is a known risk. CMT laboratories test products received and report the bacteriology results and the sensitivities to the clinicians involved, although this does not indicate contamination occurred within the CMT facility. **The values of bacterial contaminated products in CMT are in keeping with published results** and all bacteriology positive results are investigated and followed up with a clinical review. NHSBT employs stringent aseptic protocols and routine environmental monitoring of both operator technique and clean room facilities to ensure there is minimal additional risk to donations during laboratory processing.



### 1.4 Organ Donation and Transplantation (ODT) SAEARs reported to HTA

As part of its Assisted Function role, NHSBT reports all incidents submitted by transplant centres to the HTA.

- **There was only one SAEAR event** directly attributable to NHSBT activity – this was due to an error by our third-party transport provider where they delivered a donated liver to the incorrect location. A full investigation has been performed, CAPA has been implemented, and the HTA have closed this incident.

## 2. Quality Management System Performance Update

### 2.1 Critical and Major Internal Quality Events: there were no internal events classified as Critical during 2020/21.

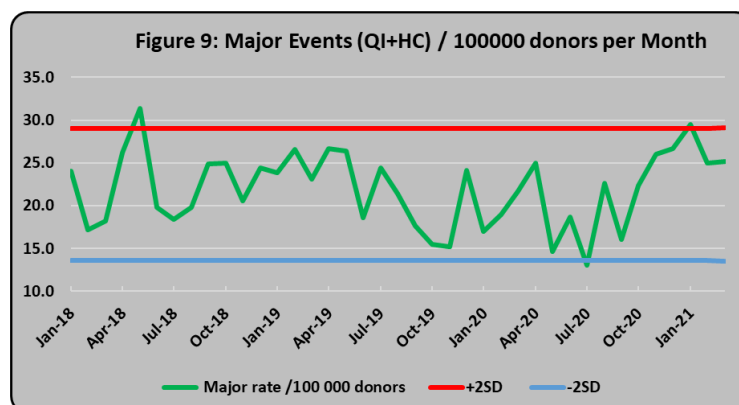
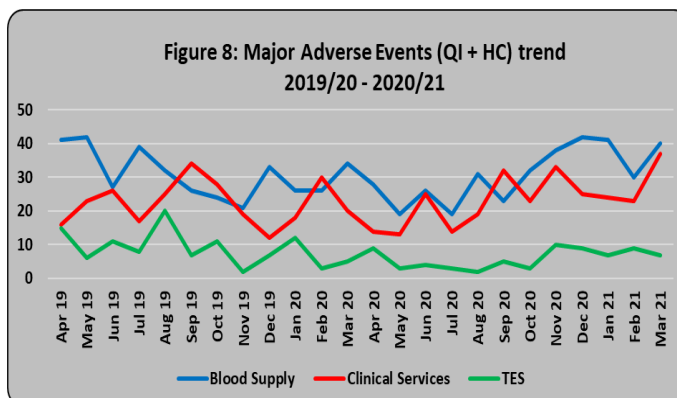
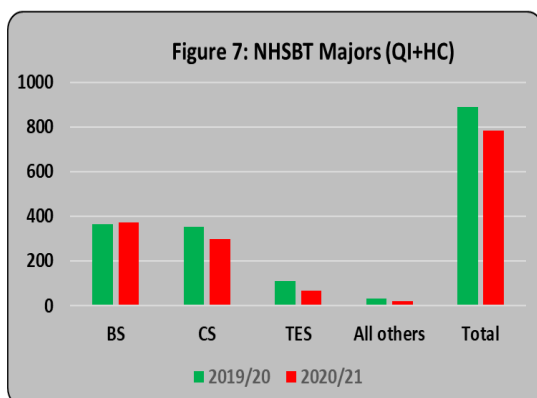
There was a reduction in total events (quality incidents and hospital complaints) raised compared to last year. Clinical Services (CS), previously Diagnostic Therapeutic Services, and Blood Supply (BS), as the two largest Directorates, continue to raise most adverse event reports, with Tissue and Eye Services (TES) responsible for a further 9% of events. See *Figure 7*.



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The decrease was due to a fall in both CS and TES events, possibly corresponding to less activity in Q1/Q2, as some cell collections and tissue procurement were reduced or paused due to Covid-19 restrictions. As activity levels picked up in the latter part of the year, the number of adverse events also started to increase again. See Figure 8.

Blood Supply (BS) saw a rising trend over 2020/21, which peaked in January 2021 when all new convalescent plasma sites were fully operational. Analysis of the number of majors per number of donors found that, apart from the January peak, event occurrence was within the normal range and thus indicated that the increased reports noted was **reflecting an increase in activity rather than an increase in error rate** – See Figure 9. This is further reinforced by the comparison with last year’s figures that showed BS majors in 2020/21 finished on 371 events, only marginally ahead of 2019/20 (363). Figure 8 shows the monthly trend for the past two years.



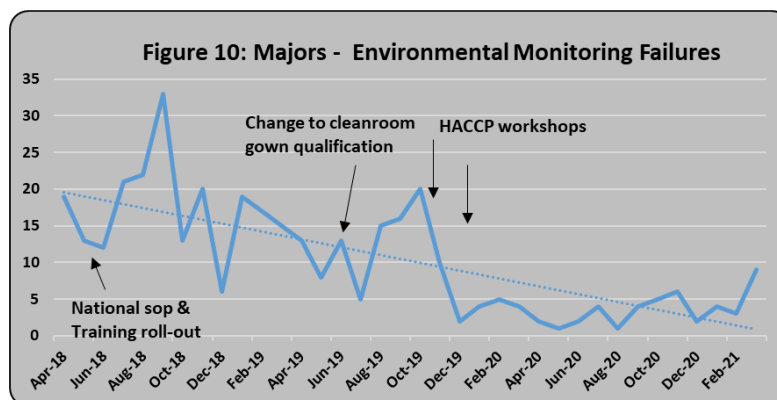
### 2.1.1 Highlight:

- Sustained improvement in numbers of environmental monitoring (EM) failures in clean rooms.** Building on improving figures in 2019/20 after the rollout of a standardised national procedure and training package, in addition to other contamination control strategies introduced over the past two years, 2020/21 saw all laboratories report consistently lower monthly rates of EM failures, indicating the interventions made have been successful. This provides assurance in the quality of



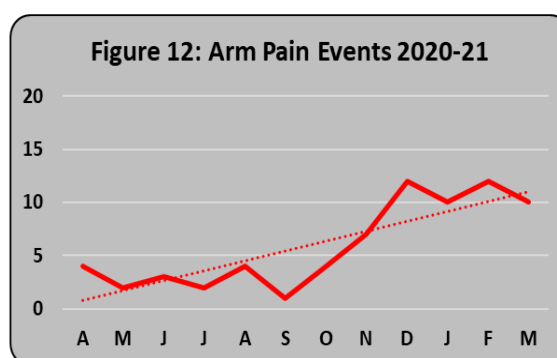
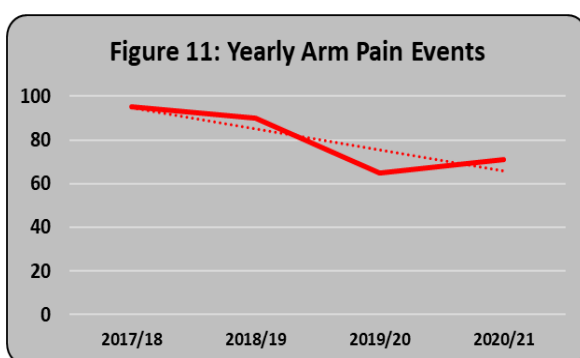
## Blood and Transplant

the aseptic training and technique of our staff, the performance of our cleanroom facilities and the safety of our products. See *Figure 10*.



### 2.1.2 Improvement Needed:

**Arm Pain Events increasing:** CI activity during the past three years including introduction of an e-learning module and procedural changes had produced a sustained reduction in arm pain events which continued well into 2020/21. This resulted in a 2-year trend of reduced numbers of serious adverse events of donation (SAED) where donors experienced arm pain lasting more than 12 months (see 2.3). However, from Q3, there has been a threefold increase in events raised each month. A review has been initiated by Blood Donation of all Donor Adverse Events including Arm Pain Events. This will aim to review risk, establish the root cause(s) and enable further improvement initiatives to be taken. See *Figures 11 and 12*.

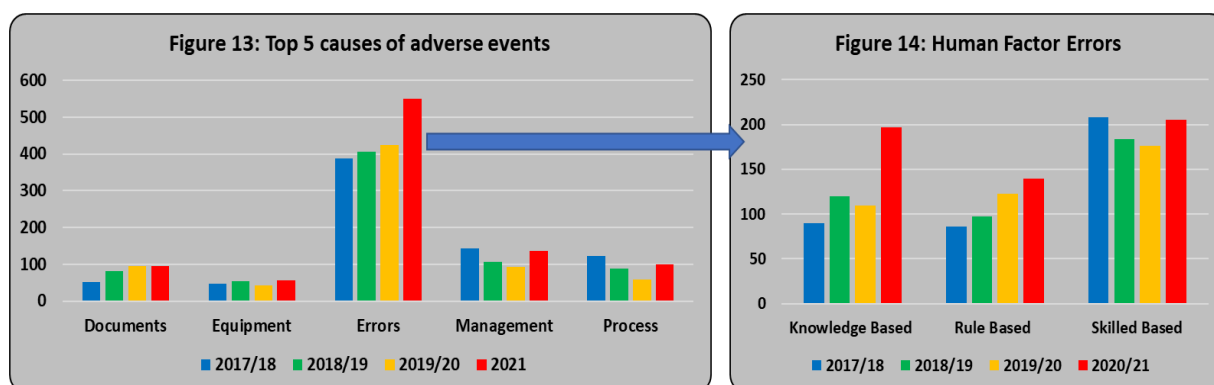


### 2.1.3 Common Root Cause Trends of Major Adverse Events:

The top five root causes of adverse events have remained the same this year.

- **Errors with a human factor cause made up 52% of identified causes - this is an increase of 3% on 2019/20.**
- Increases were seen in all three human factor error types, however of most note was a **79% increase in knowledge-based errors**. The Human Factors working group is continuing its work on human factors to reduce errors, this will be a key focus in 2021/22. See *Figures 13 and 14*.

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**2.2 Patient Adverse Events (PAEs):** numbers increased slightly this year to 157 (148 last year). Events potentially attributable to NHSBT fell to just 9 events (6%), however a notable increase was seen in clinical events, rising to 148 from 106 last year. This is a reversal of previous years where the clinical events have trended down. Events have been reviewed at BSCARE and there have been no untoward trends identified.

**2.3 Serious Adverse Events of Donation (SAED):** the numbers of SAED reported fell slightly to 31. See Figures 15 and 16.

As in previous years, **the top three causes of SAEDs** continue to be:

- needle insertion issues lasting more than 12 months,
- hospital admission within 24 hours of donation events and
- fractures, also within 24hrs of donation.

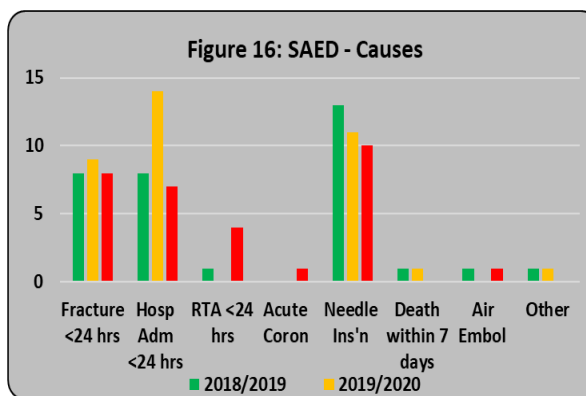
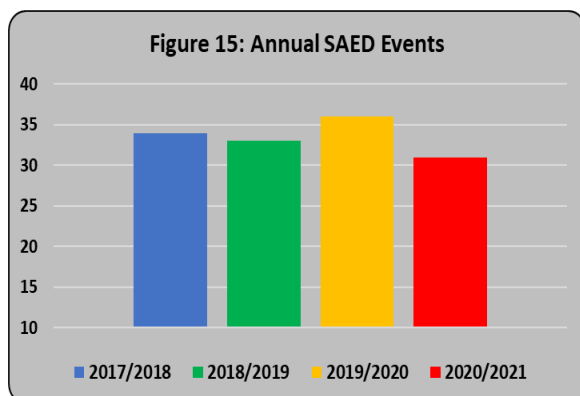
Within two of the top three causes, improvements were noted:

- **A fall in hospital admissions post-donation**, following the introduction of the STRIDES study (STRategies for Improving Donor Experience) during 2019/20. This involved trialling several interventions to reduce the severity of vasovagal events (fainting), which is one of the main causes for hospital admission after blood donation. The pilot was successfully concluded with good outcomes, and the procedure is currently being rolled out to all sites as BAU.
- **Needle insertion events lasting longer than 12 months decreased for the second consecutive year.** Substantial refinements in recent years focussed on the collection process, and associated training. This, until recently has resulted in a reduction of overall numbers of events, including those lasting greater than 12 months. The recent increase in arm pain incidents noted in 2.1.2 has not yet impacted on the numbers of longer-term arm pain events classed as SAEDs, as these are only reported 12 months after donation.



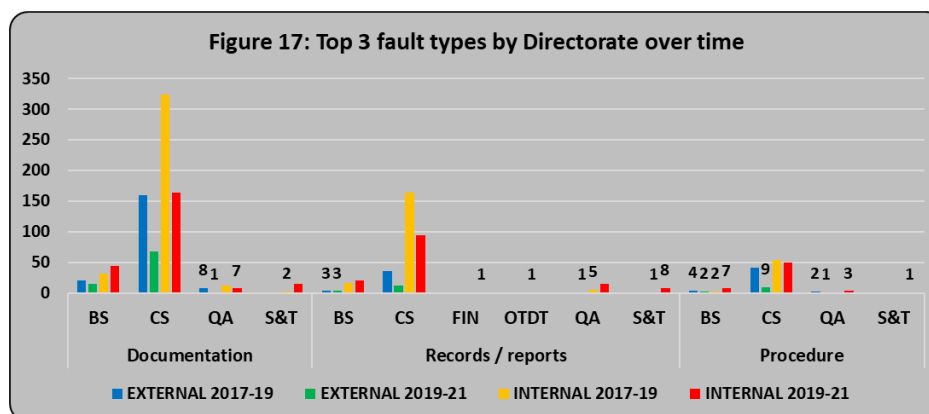


## Blood and Transplant



### 2.4 Self-inspection:

- Analysis of audit outcomes continue to show **strong and positive correlation between internal and external inspection findings**. This provides good assurance that our self inspection process remains effective. The report in Appendix 2 provides longer term assurance on self inspection performance.
- Trend analysis has identified the most common fault types. The top three have remained the same as previous years with the reduction in those related to training (previously 3<sup>rd</sup>) continuing. See Figure 17 below and Appendix 2 for further details on audit trending.
- **36/40 internal audits were completed in year and the remaining four are in progress** using the 3-step process developed this year to include a desktop assessment of licenses and quality system data. Only where necessary, were on-site follow-ups performed. This was in line with guidance from and approaches taken by MHRA, HTA and UKAS.
- Although not without its challenges for auditors unfamiliar with remote audit techniques, this broad approach has proved successful and will be continued into the 2021/22 schedule to reduce time spent on site and increase efficiency of self inspections.



### 2.5 Supplier Audits:

- Four supplier audits were completed in 2020/21; three were remote audits and one on site - all were in relation to new suppliers.
- The project to improve the Supplier Management Process for Quality Critical Items and Services has continued throughout the year. Implementation of the new documents was



## Blood and Transplant

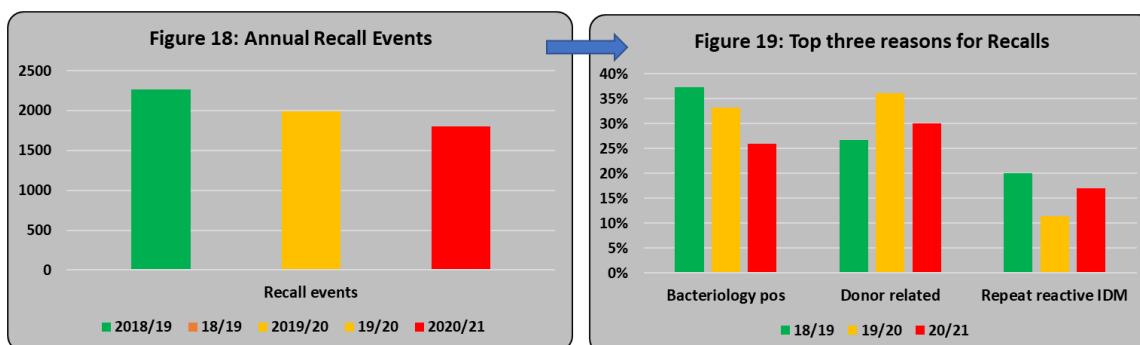
achieved on target in July 2020 despite the original planned face to face workshops not being possible. The alternative blended learning approach consisting of a training manual, videos and interactive virtual workshop was well received. This work will provide data to enhance forward planning of the supplier audit schedule ensuring audits are prioritised based on risk and informing a 3-5-year supplier audit plan.

- The Supplier Management Process for Quality Critical Items and Services was reviewed by UKAS who told us it **“is the most robust supplier review process I have ever seen, it’s very impressive”**

### 2.6 Product Recalls:

The number of **product recall events decreased by 10%** to 1797, further improving on a 12% decrease noted last year.

- The top three reasons to recall products remained the same as last year, with donor-related recalls the most prevalent cause.
- **The percentage of recalls due to bacteriology positive tests fell to 26%** from a third of all events last year, consolidating year on year improvements since a new air-conditioning system was installed in the Manchester Bac-T laboratory in 2018.
- A cold room issue in Filton saw a one-off increase in manufacturing defect events (this constituted 13% of all recalls, last year 4%) – data not shown. *See Figures 18 and 19.*



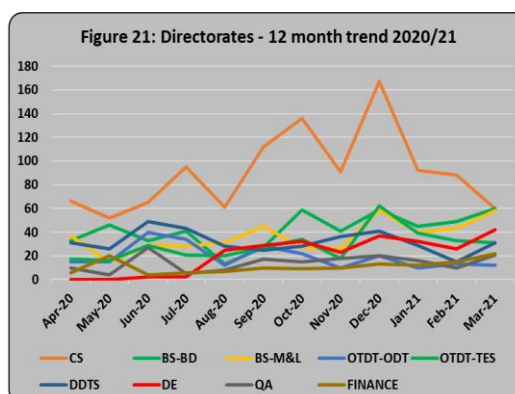
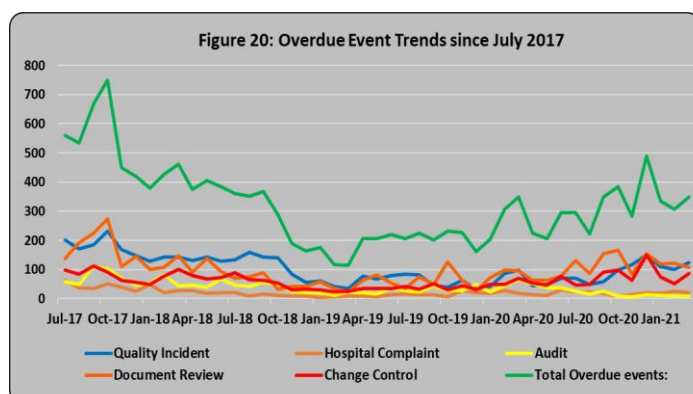
### 2.7 Overdue Quality Management System (QMS) Event Management:

- **Numbers of overdue events remained at high levels this year** with 348 events overdue at year end, the same as 2019/20. This was in part due to the risk-based decision taken to prioritise more serious incidents, in light of the increased resources directed to COVID-19-related projects throughout 2020/21 - **thus ensuring no increased risk to donor or patient safety.**
- **Periodic improvements were seen**, with a good recovery in Q4 after a high of 489 events over the December-January period, and **the six month trend is down.** However further sustained reductions are needed in order to demonstrate the QMS continues to operate effectively. Some planned strategies to address this were paused this year; a key regulatory focus for the coming year will be to resume CI activities with a view to improve and then sustain performance to acceptable levels in 2021/22. Some work has already recommenced in Q4 and successful pilots such as Quality Management Cells, which proved effective in reducing events in Clinical Services, will be rolled out to other departments.



## Blood and Transplant

- Within Directorates, the performance of **Clinical Services was of note, finishing the year with a 64% reduction in events** from a high in January 2021 of 167.



### 3. Quality and Compliance Support

#### 3.1 Regulatory Updates/Licence Changes:

2020/21 was a very busy year from a regulatory perspective, much of which was due to the participation in two COVID-19 Convalescent Plasma (CP) trials (REMAP-CAP and RECOVERY), the End of the Transition Period for EU Exit and the merger of two existing blood donor centres into the new Barnsley Centre.

- The past 12 months has had a significant pull on QA resource given the required focus on the support of plasma collection; initially Convalescent Plasma to support Clinical Trials and then in the last quarter the pivot to Plasma for Medicines. The period covered regulatory engagement and the subsequent QMS risk assessment support falling out of an extensive Change Control programme including: the set up and BEA licencing of 23 new temporary Donor Centres, the validation and implementation of new collection machines and bespoke harnesses, the assurance requirements surrounding new staff training systems, the initial importing of results and then in-house set-up and validation of required COVID-19 antibody testing, the provision of timely document control and deviation advice and guidance, the set-up of a technical agreement to store plasma off site at Blood Products Laboratory, the support for off-site sampling activity, (and then) the pivot to PFM (following the initial project with QA led intelligence gathering for the stockpile of recovered plasma as a proof of concept in December), CP site de-commissioning (ongoing), off site storage specification/audit and temperature mapping at Pullyen (3<sup>rd</sup> party of site storage facility), the support in writing/approving a PFM specification, support surrounding required changes to Donor consent, support of required British Pharmacopeia Protein testing methodology changes (for required product testing), support for the specification development for HAV/B19 testing and ongoing QA-led intelligence gathering to ensure the process and systems set up minimise the risk of collected plasma and samples not being able to be released and accepted by a NHSEI appointed fractionator.
- NHSBT Barnsley became operational during Q2. Successful remote pre-approval inspections by MHRA and HTA resulted in Barnsley being granted HTA licences in the tissues and cells human application and research sectors and the site was also added to the BEA and Wholesale Distribution Authorisation. An application to the manufacturing licence for investigational medicinal products will be made next financial year to licence the new Advanced Therapies Unit.



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- Further variations were made to the BEA with the addition of a new London whole blood donor centre at Shepherd's Bush and the relocation of the Liverpool donor centre to an interim location pending a final move to a new, final location later in 2021. The interim move was required at short notice after building maintenance issues at Moorfields rendered the existing site unsuitable.
- The end of the EU Exit transition period in Q3 passed with minimal disruption to NHSBT activities. Throughout 2020/21, we performed ongoing reviews of licenced activities and changing requirements to ensure we remained compliant with post-transition UK regulations. The UK's exit from EU regulatory oversight and the implementation of the Northern Ireland Protocol meant that the majority of products sent to Northern Ireland and/or the EU are now considered exports and we will continue to need to maintain compliance with EU regulations for those products. Products received from the EU are classified as UK imports and where required, licences have been updated to accommodate this.

### 3.2 Support and Improvement Activities:

- **Blood Supply** - Despite the challenging circumstances, all events have been logged promptly through QA Direct. Pro-active management and trending of the events has ensured that risk-based support has been provided and where required, improvement opportunities have been identified and taken. CI initiatives include:
  - a CI facilitated workshop held in Q3 with key operational and QA stakeholders in the North, to look at improving the event management process and ways of working, to prevent overdue events. The outputs are to be taken forward nationally following review and agreement
  - trend review as part of the monthly MQR process which quickly identified a rising number of recall events raised in Hospital Services. There is now a CI facilitated workshop planned for April 2021 involving key stakeholders (including clinical), to review the end to end recall process and put forward recommendations
  - monthly meetings between CI and QA to review high frequency events reported through the MQR process. In January 2021, 'Reconciliation' events were noted to have risen sharply in December 2020. This has initiated a review of both event classification and the effectiveness of national actions implemented in 2018/19 to reduce the number of 'missing unit' events
  - national review of an increasing incidence of potential high risk 'air in line' events (with potential air embolism for a donor) using Scinomed machines in the CP collection programme. Joint working with the supplier enabled review of the machine set up, alarm flags and key consumables. A further QI raised in Q4 resulted in the machines being removed from use and a medical device report being made to the MHRA in collaboration with the supplier.
  - pilot of a new group to review clinically significant events before they are discussed at the BSCARE meeting. The group, formed following Head of Nursing/Lead Quality Specialist discussions, has been termed the 'MRI - Scan' (Major event Review Initiative). The first meeting was held in Q4 and covered Discretionary Testing. Several actions were identified and will now be followed up at the April 2021 meeting.
  - Change Programme and Project Support: a number of transformational projects in Blood Supply were paused during Q1-Q3 to allow focus on critical activity needed during the Covid 19 pandemic. In Q4, some projects re-commenced, these include Session Solution, e-Rostering, the Logistics Review Programme, replacement Arm



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Cleaning device, International Blood Pack 1, and the suite of Testing Programme projects. These projects are fully supported by QA resource.

- QA support has continued for the work linked to replacement of the current bulk Copper Sulphate supplier (for risk issues). A desk-top audit was completed in quarter 4 by QA as part of this activity.
- **Plasma for Medicines (PFM)** - QA representatives have supported the delivery of Minimum Viable Product (MVP) for PFM in several areas including testing, manufacturing, off-site storage, quality monitoring, collections, pulse modifications and document control. QA have been actively managing the change controls associated with the project, ensuring that all relevant actions were closed in advance of the first sourced plasma collection. This support enabled the Responsible Person to approve go-live of PFM collections in Q3 (April). We have continued to liaise with the MHRA to ensure that they are aware of the progress of the PFM project and that all NHSBT sites are appropriately licensed.
- **CAR-T Cell Expansion** - With three sites already operational for Chimeric Antigen Receptor Treatment (CAR-T) for NHS patients, Q4 saw the first commissioned CAR-T treatment at St. James' Hospital Birmingham. This was supported by QA, TAS Leeds and SCI Birmingham. Work is continuing on commissioned CAR-T products and clinical trials to commence in CMT Barnsley.
- **Organ Donation and Transplantation (ODT)** - QA has continued to provide regulatory advice to support delivery of the OTDT-ODT business plan - notable projects this year included:
  - Increasing the Number of Organs Available for Research (INOAR) – this project went live in Q4 2021
  - Assessment and Recovery Centres – determine the regulatory pathway for virtual and/or physical perfusion hubs (under the organ utilisation programme)
  - Rollout of the Opt-out Organ Donation phase II, after the Deemed Consent Act became law in Q1
  - Digitisation of the UK Living Kidney Sharing Scheme (UKLKSS) in order to reduce manual errors and,
  - Rectus fascia – service development - introduce a process for retrieval from organ donors to store/release as a tissue.

#### 4. Continuous Improvement Plans for 2021-2022

- 4.1 The Quality strategy will be refreshed this year. This “enabling” strategy for NHSBT will be developed in consultation with stakeholders and also take into consideration “what good looks like” in other similar and relevant industries e.g. other blood services, pharmaceutical, logistics. The Quality Management System needs to be easy to comply with and we aim to work in partnership across NHSBT to add value to our services. The discovery work required will begin in Q2 2021/22.
- 4.2 As discussed in section 2, we will be addressing issues noted with delayed recall incidents, increased arm pain events in donors, overdue event rates and also look to reduce the number of errors in the workplace caused by human factors. Additionally, other quality management system/regulatory compliance themes have been identified across directorates as continuing priorities for improvement.
- **Data Integrity** – we will continue to improve compliance and build on the good progress made this year. Following the release of a new Data Integrity MPD during Q3, training



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was delivered to >160 staff who undertake the development of new processes, update existing processes, and are involved in the procurement of new systems. A Data Integrity SharePoint site was launched in January, which provides links to DI training (Module 1), which must be completed by all NHSBT staff. This includes a scenario-based assessment. Module 2 is currently in development which is aimed at those involved in tenders, change control leads, authors of validation protocols, and process owners. Additionally, a solution for a Data Integrity Assessment tool has been procured (CoreStream), and its design for this use approved by DDTs. There is a project plan in place for the testing and the implementation of the tool in Clinical Services (CS), with pilots planned for May and June 2021. CS departments have identified all systems and processes that will be assessed using this tool.

- **Incident management** - The management and/or recording of incidents, associated risk assessments and resulting actions were found to be lacking on several occasions during external inspections and through PwC audit in 2019/2020. A full review of our management of incidents has now been completed this year. A phased improvement plan has commenced to ensure we improve this critical area of regulatory compliance. Process refinements will launch in June 2021, alongside a new web reporting tool for Q-Pulse to give electronic access for reporting adverse events to all staff.
- **PFM** - QA will continue to support PFM for the initial 3-month duration of the project, pending consideration of the business case. Key activities include support to the selection and appointment of a third-party test house for HAV/B19 testing and quality monitoring of component total protein; automation of manual processes and tendering for new plasmapheresis machines. A key QA focus will be on the design of a batch release process to ensure that plasma can be released to fractionators with the appropriate level of evidence.
- **OTDT-TES** – Islet transplantation involves removing a pancreas (as a solid organ) from an organ donor in an operating theatre prior to being processed to harvest the islets, which are then transplanted as cells. Previously pancreas donated for this purpose had been treated as an organ donation, however the HTA are clear that islets are tissues and therefore the process must meet requirements as set out in the Tissue Quality and Safety Regulations (TQSR). QA will continue to be work with the islet steering committee and the National Scottish Blood Transfusion Service to ensure the process is compliant with TQSR – this will include donor selection, testing and tissue release.
- **QA-Technology Assurance (QA-TA)**, will continue to support the following:
  - business driven programmes/projects with IT system impact including Blood Technology Modernisation (BTM), Session Solution, PFM, eHematos, ODT Recovery, Living Donation, and emerging Genomics work.
  - The DDTs programmes/projects including Data Centre and Critical Infrastructure (DCCIP), Local Infrastructure and Cyber Security.
  - The establishment of Product Centres, the associated new ways of working, resulting process changes and safety and regulatory implications and the business-as-usual IT system work undertaken.
  - The Test Assurance Board activities, continually improving the software development lifecycle for safety critical systems.
- **Training** - Refine and improve parts of the Quality Management System to support training modernisation in NHSBT.



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- **Electronic QMS** - following discovery work in 2020/21, we will be considering options available for procurement of NHSBT's electronic quality management system. The specification aims to provide a common incident management system for quality and health and safety. The current Q-Pulse contract has 2 additional, optional years which will end in October 2022, aligning with the Datix contract which also ends in 2022.
- **QA Direct** - An audit of QA Direct was performed by the Government Internal Audit Agency in Q4 2020-21. This concluded that overall, the QA Direct service is well designed and working effectively. The new processes appear to be bedded in and customers are accessing the new service as intended. Having successfully integrated QA Direct into the QMS, one focus next year will be to reduce manual transcription of QMS forms by transferring to a web-based reporting system, which will allow a wider group of users access to electronic reporting tools.
- **New sites** – QA will work with operational staff to ensure appropriate licensing requirements are in place for the upcoming opening of Barnsley ATU and the opening of CBC on the Filton site.

### 5. Key upcoming regulatory changes

Regulatory Affairs maintain a Regulatory Radar which scans for and tracks any new and changing regulations. This ensures that NHSBT can contribute to development of new/changing regulations and that we are ready for implementation with compliant quality management systems. There have been a number identified this year, but two of interest are;

- 5.1 **Medical Devices and In-Vitro Devices Regulations (MDR/IVDR):** New EU regulations concerning medical devices (MDR) and in vitro diagnostic medical devices (IVDR) will fully apply in the EU on 26th May 2021 for medical devices and on 26th May 2022 for in vitro diagnostic medical devices. On 1st September 2020, the MHRA published guidance on regulating medical devices from January 2021 (i.e. after the end of the EU Exit transition period). As these regulations will not take effect until after the transition period with the EU has ended, they will not be EU law automatically retained by the EU Withdrawal Agreement Act and will therefore not automatically apply in Great Britain. Nonetheless because NHSBT supply in vitro diagnostic medical devices to customers in the EU and Northern Ireland the requirements of the IVDR will have to be implemented in order to continue supplying devices to these markets. The EU regulations are complex and implement significant new requirements compared to the current directives, particularly in areas such as clinical performance evaluation, post-market surveillance and vigilance. Despite having a detailed project plan, the interpretation and implementation of the regulations is proving a significant challenge set against a backdrop of delays to the project due to COVID-19. Additionally, the MHRA have implemented new requirements for UKCA marking of medical devices placed on the GB market; this route to market was available from 1st January 2021 and is mandatory from 1st July 2023 when CE marking will cease to be recognised in Great Britain. On top of this the MHRA have announced proposals for a new regulatory regime for medical devices in the UK the detail and implementation timeline for which are not yet known. Having to interpret and implement complex regulatory changes across different markets with overlapping timeframes is creating significant challenges for QA and operational colleagues in RCI Reagents. Some aspects of the project are behind plan particularly delivery of the underpinning Quality Management System processes and procedures and we are working to get these back on track. The new medical devices regulation will also create additional



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regulatory burden and cost-pressures moving forwards due to up-classification of devices requiring greater involvement of Notified/Approved Bodies in conformity assessment.

- 5.2 **EU Blood and EU Tissues and Cells Directives:** An EU-led consultation on revisions to the Directives closed in April 2021. NHSBT contributed to a UK-wide response. Updated legislation is expected to be released by the end of 2021 and although no longer directly applicable to NHSBT for products made within Great Britain, this will remain of significance to us as we will have to demonstrate equivalence with any change in standards for products we send to Northern Ireland or the EU.

### 6. Benchmarking

During 2020/2021 QA continued with membership of the Alliance of Blood Operators (ABO) Benchmarking Group and in Q2 contributed data on recall rates, product quantities and on time in full rates for the annual member survey. The results of the survey are yet to be circulated.

### 7. Conclusions

The Covid-19 pandemic ensured this was a year like no other. Nonetheless, NHSBT has had a very successful year as we continued to maintain regulatory compliance across all of our operations and kept external non-conformances to extremely low levels, despite increased workloads, lockdown restrictions and at times, reduced resources due to illness or staff needing to isolate.

A number of key milestones and projects were achieved that had substantial compliance and licensing impacts to manage; this included the successful launch of a major new centre at NHSBT Barnsley, the completion of the convalescent plasma trials, which helped inform the international community of the benefits (or lack of) of CP treatment for COVID-19 patients, a swift, safe and compliant pivot to PFM and the end of the EU exit transition period with minimal interruption.

The upcoming year is predicted to be equally challenging from a regulatory perspective as we emerge from the pandemic and aim to progress both planned and delayed continuous improvement initiatives across the organisation, prepare for the coming into force of significant new regulations both in the EU and here in the UK, adjust to new requirements brought in by the PFM work, as well as the opening of an ATU facility at Barnsley and the relocation of the CBC into new facilities at Filton. Additionally, it may be expected that regulatory inspections will resume at pace during 2021/22 and may even exceed the usual timetable as regulators and accreditors look to compensate for having to delay some audits during lockdown restrictions.

As always, QA will continue to support the Operational Directorates in maintaining compliance in the most effective way possible in order to improve our regulatory performance even further.

**Author: Leigh Mison (Regulatory Affairs Manager)**

**Edited by Joanne McMahon (Quality Systems Manager) and Helen Gillan (Assistant Director of Quality and Regulatory Compliance)**

**Responsible Director: Ian Bateman, Director of Quality**





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### Appendix 1: Key findings raised at external inspection

Licence/ Accreditation:	Audits:	Outcome:	Key findings
MHRA BEA	4 Remote 2 On-site	5 Others 2 Comments	<ul style="list-style-type: none"> <li>• <b>Management of incidents/ investigations was insufficient</b> - effectiveness of CAPAs were not monitored, RCA not formally justified and QIs were extended with no formal assessment</li> <li>• <b>Quality system found to be deficient:</b> e.g. Team MQR meetings were cancelled and not rescheduled within a suitable time, QIs took too long to be closed and contributing factors to human errors in QIs were not considered.</li> <li>• <b>Process not documented</b> - lack of written instructions detailing what actions to take should a blood donation venue (mobile) have an ambient temperature of &gt;25C</li> <li>• <b>Change control inconsistencies</b> e.g. actions in risk assessments not clearly referenced in change plan and Q-Pulse, change controls did not capture all actions and  inconsistent risk ratings in risk assessment</li> <li>• <b>Control of equipment and facilities deficient</b> e.g. a quality risk management approach had not been used for the validation of the Team Stores (temperature mapping had been performed only during winter/spring months without appropriate justification) and there was no clear procedure to detail action to take if -40C freezers malfunctioned.</li> </ul>
HTA TQSR	2 Remote	1 Minor shortfall 2 Advice & Guidance	<ul style="list-style-type: none"> <li>• <b>Process not documented</b> - there is a national procedure on conditioning dry shippers before use. Staff complete a form which is placed around the dry shipper to record the time of filling. This procedure is not documented, and the form is not a controlled document.</li> <li>• A&amp;G1: determine if there are other local procedures which supplement national protocols and to ensure that these are documented</li> <li>• A&amp;G2: reinforce the role and responsibilities of trainers, especially when experienced staff are being trained.</li> </ul>
Accreditations	5 Remote	15 Findings 5 Recommend'n s	<ul style="list-style-type: none"> <li>• <b>Complaint handling</b> - not always possible to verify that complaints had been assessed correctly to determine the need to report to the appropriate regulatory authorities</li> <li>• <b>Process not documented</b> - process put in place to manage EQA exercises during the pandemic not added to SOP.</li> <li>• <b>Process not documented</b> - the lab has not effectively documented its approach to the periodic review of requests, and suitability of procedures and sample requirements.</li> <li>• <b>Training deficient</b> - lack of evidence all staff have been made aware of the quality manual and policy. The TBTR records do not include all clinical and management staff and the training matrix for clinical staff has not been updated.</li> <li>• <b>There was slippage of the internal audit programme.</b> There is no evidence of a risk assessment that the</li> </ul>



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			<p>department has considered the impact of the lack of audit on the assurance of quality and technical processes.</p> <ul style="list-style-type: none"> <li>• <b>Records inaccurate</b> - records reviewed are inaccurate with regards to PT (EQA) providers</li> <li>• There is no named deputy for the Clinical Lead nor description how the laboratory would manage long term absence from the clinical on call and the clinical management aspects of the role.</li> </ul> <p>A number of other technical findings were raised pertaining to test / assay specifics – not detailed.</p>
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### Appendix 2: Internal Audit Process Review Report

(Author: Betty Wickens, Quality Systems Audit Manager)

#### Background

The purpose of the Self Inspection system is to provide assurance that regulation and accreditation standards are being met.

The report includes 4 years of data from April 2017-March 2021, over which we have had 2 regulatory inspection cycles. The COVID pandemic and associated travel restrictions meant a risk-based approach was taken by regulators and NHSBT to delay some external inspections, whilst others and all self-inspections, were undertaken remotely using desktop and remote audit techniques. This has impacted on the number of audit findings during 2020-21.

The report comprises two sections.

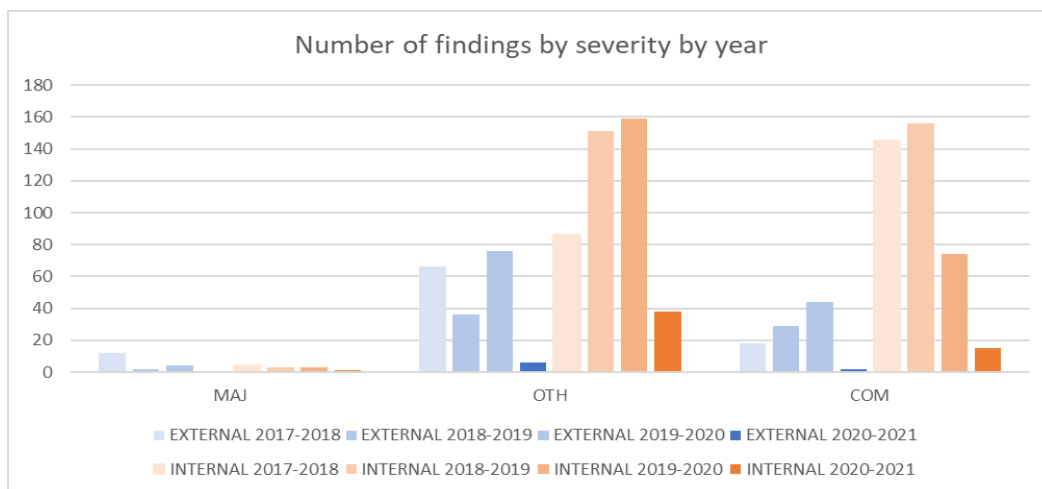
1. Regulatory inspections by Medicines and Healthcare Regulatory Agency (MHRA) and the Human Tissue Authority (HTA).
2. Accreditation audits
  - United Kingdom Accreditation Service (UKAS) for ISO15189
  - Underwriters laboratory for ISO13485
  - European Federation of Immunogenetics (EFI)
  - Joint Accreditation Committee ISCT-Europe & EBM (JACIE)
  - Foundation for Accreditation of Cellular Therapy (FACT)
  - World Marrow Donor Association (WMDA)

**Headline:** Internal and external findings show good correlation which demonstrates that our self-inspections are effective.

#### Section 1: Regulatory inspections

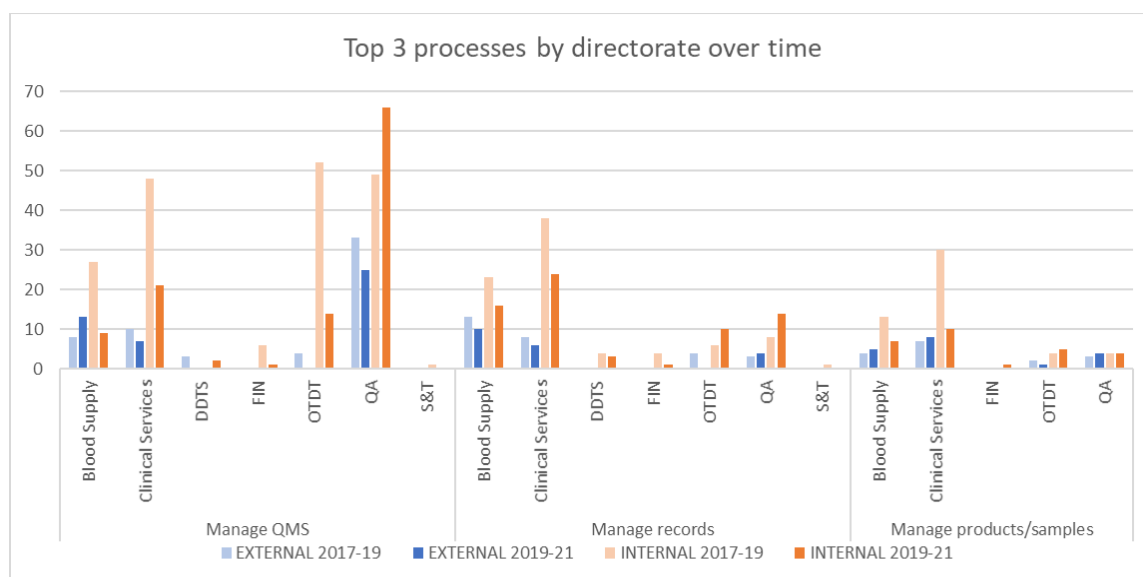
**We have identified more findings internally over 4 years (2 audit cycles) than were found by external inspections.**

This is to be expected and is consistent with self-inspection being more focused and identifying improvement opportunities which are raised as either deficiencies or comments. Importantly, there is good correlation in the Major category where regulatory risk is higher. This is again good assurance that our internal inspection system is effective.



**Internal and external findings show a similar profile across both processes and fault type (all audit findings are recorded against the process they impact and the kind of error that has led to the finding), again with more findings in internal inspections**

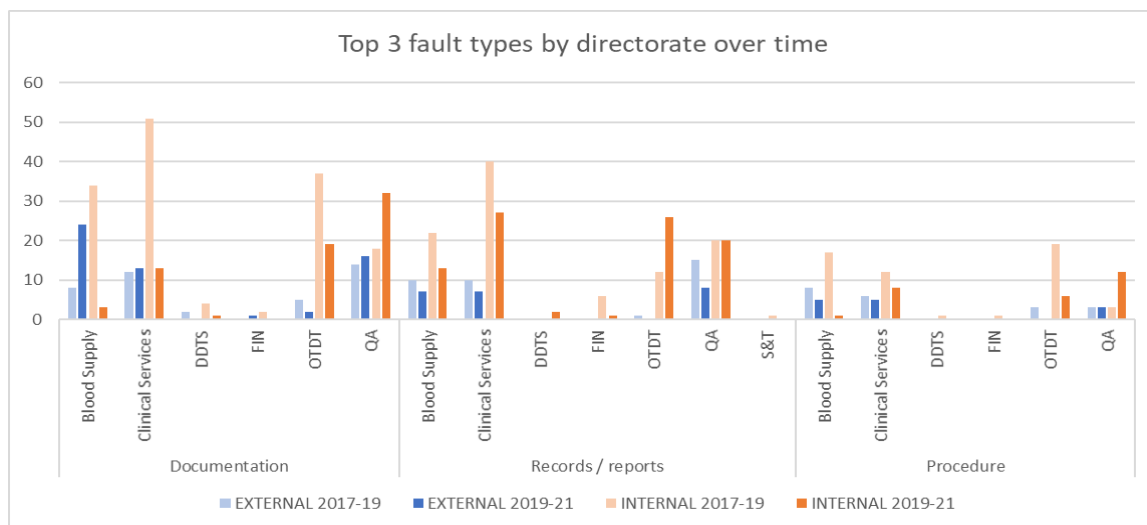
The highest number of audit findings are detected in processes that are common across all areas of the business and are audited in every department at every site. The increase in 2019-21 in internal findings in QA, is due to the increased focus on this area during desktop and remote audits.



The most prevalent fault types are outlined below and are detected across all areas of the business. Training was in the top 3 during 2017-2019 but has had a sustained drop to 5<sup>th</sup> place during 2019-21 due to a bigger reduction, (70%) in the number of findings compared with the a 25-40% reduction in other fault types.



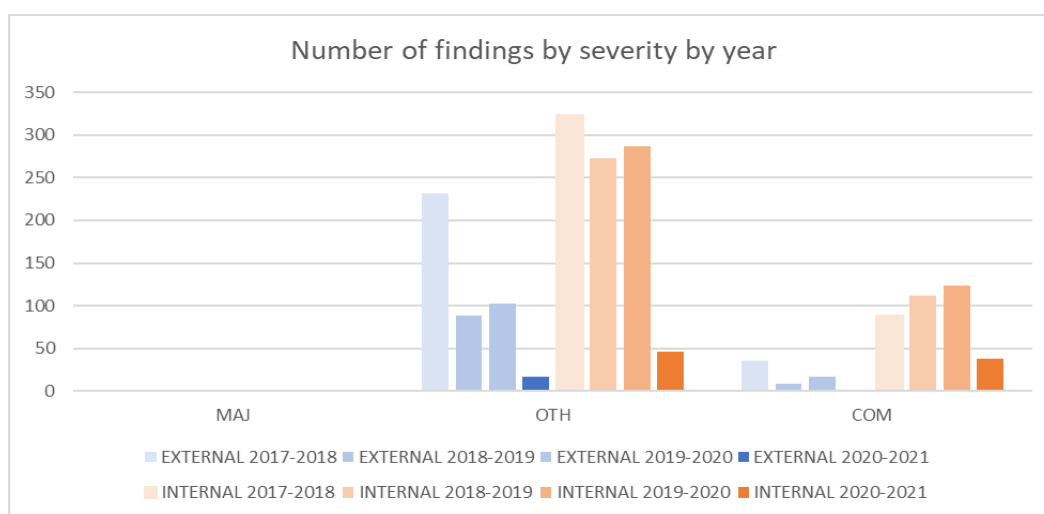
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### Section 2: Accreditation audits

**We have again identified more findings internally over the audit cycle than were found by external inspections.**

This is to be expected and is consistent with self-inspection being more focused and identifying improvement opportunities which are raised as either deficiencies or comments. This is again good assurance that our internal inspection system is effective.

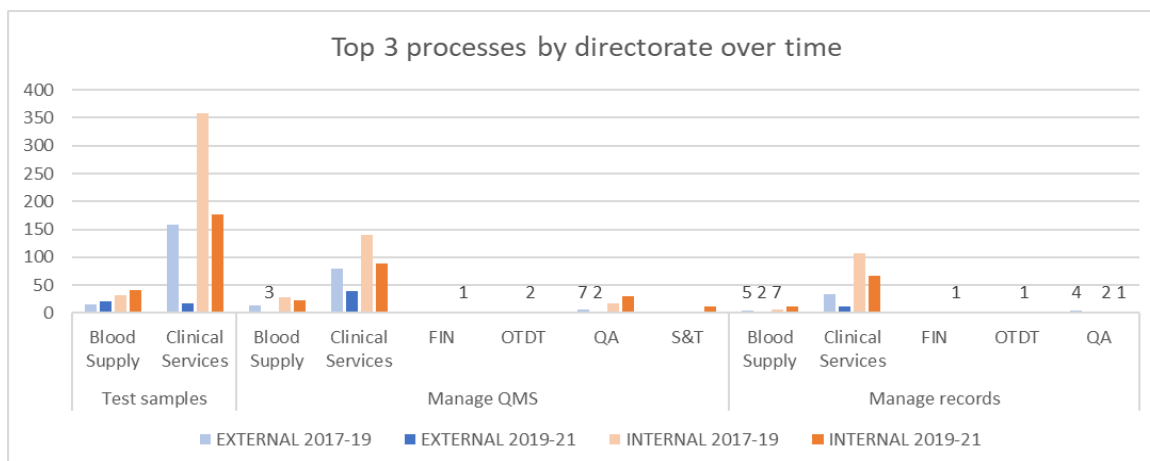


**Internal and external findings show a similar profile across both processes and fault type (all audit findings are recorded against the process they impact and the kind of error that has led to the finding)**

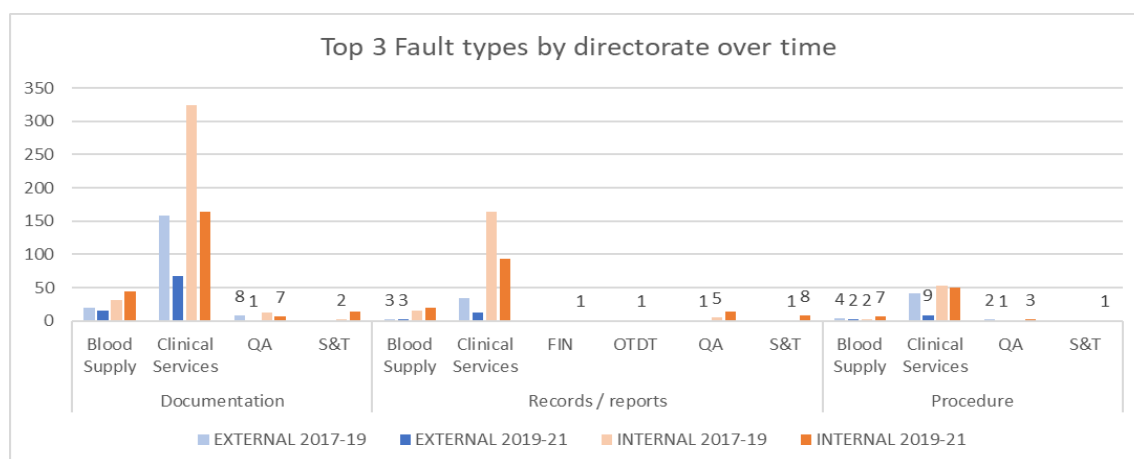
The highest number of accreditation related audits and findings are against ISO15189 accreditation of laboratory activities; thus, it is not unexpected that the highest number of findings relate to testing of samples within Clinical Services.



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The most prevalent fault types are outlined below and are detected across all areas of the business.



### Conclusion

NHSBT is legally required to comply with the Blood Safety and Quality Regulations (BSQR), Tissue Quality and Safety Regulations (TQSR) and Organ Quality and Safety Regulations (OQSR).

To comply with these regulations, we must have a Quality Management System (QMS), a key part of which is the self-inspection process. **This report shows strong correlation between internal and external inspection findings**, as expected, which provides assurance that our self-inspection process is effective, and we are meeting our legal obligations.

Self-inspection provides a continual source of information for continuous improvement to take place, with the aim of reducing repeat events and avoiding event wherever possible. The top three fault types are the same for external and internal findings because they are common across all areas of the business and are audited in every department at every site.

## 16. Any Other Business

Presented by Millie Banerjee

17. Date of Next Meeting: Thursday,  
22nd July 2021 ( via video-conference)

## 18. Resolution on Confidential Business

Presented by Millie Banerjee