NHS Blood and Transplant

# NHSBT Board Meeting in Public - 22nd July 2021

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| **Schedule** | Thursday 22 July 2021, 9:30 — 12:00 BST |
| **Venue** | Via video-conference |
| **Description** | NHSBT Board Meeting in Public |
| **Notes for Participants** | Apologies received from Jo Lewis & Ian Bateman |
| **Organiser** | Rebecca Vickers |

## Agenda

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|---|---|---|---|
| 9:30 | 1. Apologies and announcements<br>For Reference - Presented by Millie Banerjee | (10 mins) | 1 |
| 9:40 | 2. Declarations of conflict of interest<br>For Reference - Presented by Millie Banerjee | | 2 |
| 9:40 | 3. Board ways of working (21-40)<br>For Reference - Presented by Millie Banerjee | | 3 |
| 9:40 | 4. Minutes of the previous meeting (21-41)<br>For Approval - Presented by Millie Banerjee | | 5 |
| 9:40 | 5. Matters arising from previous meeting (21-42)<br>For Report - Presented by Millie Banerjee | | 13 |
| 9:40 | 6. Patient story (21-43)<br>For Discussion - Presented by Anthony Clarkson | (15 mins) | 15 |
| 9:55 | 7. Chief Executive's Board report (21-44)<br>For Report - Presented by Betsy Bassis | (20 mins) | 19 |
| 10:15 | 8. Clinical Governance report (21-45)<br>For Report - Presented by Gail Miflin | (20 mins) | 29 |

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| 10:35 | 9. Board Performance Report (21-46)<br>For Report - Presented by Rob Bradburn | (20 mins) | 33 |
| 10:55 | 10. Finance Report (21-47)<br>For Report - Presented by Rob Bradburn | (10 mins) | 44 |
| 11:05 | Tea/Coffee Break | (10 mins) | 53 |
| 11:15 | 11. Strategy Update (21-48)<br>For Discussion - Presented by Tracey Barr | (20 mins) | 54 |
| 11:35 | 12. Blood Tech Modernisation Programme Update (21-49)<br>For Report - Presented by Wendy Clark | (10 mins) | 62 |
| 11:45 | 13. Reports from the UK Health Departments | (10 mins) | 73 |
| 11:55 | 13.1. England (no written report provided)<br>For Reference | | 74 |
| 11:55 | 13.2. Northern Ireland (21-50a )<br>For Reference | | 75 |
| 11:55 | 13.3. Scotland (21-50b)<br>For Reference | | 77 |
| 11:55 | 13.4. Wales (no written report provided)<br>For Reference | | 79 |
| 11:55 | 14. For information | (5 mins) | 80 |
| | 14.1. Annual Health, Safety & Wellbeing Report (21-51)<br>For Reference - Presented by Patricia Grealish | | 81 |

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| | 15. Any Other Business<br>Presented by Millie Banerjee | 106 |
| 12:00 | 16. Date of Next Meeting: Thursday, 30th September 2021 | 107 |
| 12:00 | 17. Resolution on Confidential Business<br>Presented by Millie Banerjee | 108 |

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# 1. Apologies and announcements

For Reference

Presented by Millie Banerjee

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# 2. Declarations of conflict of interest

For Reference

Presented by Millie Banerjee

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# 3. Board ways of working (21-40)

For Reference

Presented by Millie Banerjee

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# 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

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# 4. Minutes of the previous meeting (21-41)

For Approval

Presented by Millie Banerjee

Draft for approval
Status - Official

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# Minutes of the One Hundred and Third Public Board Meeting of NHS Blood & Transplant

**Zoom Videoconference**
**Thursday 27th May, 9:30-12:30**

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| **Present** | Millie Banerjee (MB) | Dr Gail Miflin (GMi) |
| | Betsy Bassis (BB) | Charles St John (CSJ) |
| | Rob Bradburn (RB) | Piers White (PW) |
| | Anthony Clarkson (AC) | Jo Lewis (JL) |
| | Helen Fridell (HF) | Prof Deirdre Kelly (DK) |
| **In attendance** | Ian Bateman (IB) | Richard Crossen (RC – Item 11) |
| | Wendy Clark (WC) | Christie Ash (CA – Item 13) |
| | Katie Robinson (KaR) | Kay Ellis (KE – until item 11) |
| | Rosna Mortuza (RM) | Michael Gallagher (MG – from item 11) |
| | Dean Neill (DN) | Sharon Grant (SG – until item 11) |
| | Katrina Smith (KS) | Pat Vernon (PV) |
| | Alia Rashid (AR) | Joan Hardy (JH) |
| | Tracey Barr (TB – Item 11) | Alice Williams (AW - Minutes) |
| | Shane White (SW – Items 9 & 11) | |

| | | Action |
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| 1 | Announcements and apologies | |
| | Apologies were received from Patricia Grealish, Phil Huggon, and Greg Methven. It was confirmed that Paresh Vyas would be joining the meeting at a later time.<br><br>M Banerjee welcomed Dean Neill as Greg Methven's deputy for the day's Board meetings and all observers via the Live Stream. | |
| 2 | Declarations of Conflicts of Interests | |
| | There were no further declarations of interest from the Board. | |
| 3 | Board Ways of Working (21-28) | |
| | The Board ways of working were noted. | |
| 4 | Minutes of the previous meeting (21-29) | |
| | The minutes of the previous meeting on the 25th March were approved as a true record. | |
| 5 | Matters arising from previous meeting (21-30) | |
| | Members confirmed that all outstanding matters from previous meeting were closed. | |
| 6 | Patient Story (21-31) | |

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| | GMi introduced the donor/patient story of an individual who had survived Covid-19 and began donating his plasma first for Convalescent Plasma, and then for Plasma for Medicines.<br><br>Board members discussed the feedback from returning plasma donors and it was highlighted that individuals have been highly motivated to donate and are becoming more aware of the drive for self-sufficiency for plasma within the UK and that these insights are continually being used to improve tools and the donor experience.<br><br>The Board reiterated their gratitude to Darren Buttrick for his continued donation and role in promoting the importance of plasma donation for NHSBT, and it was agreed that a letter of thanks would be sent on behalf of all Board members. | |
| 7 | CEO report (21-32) | |
| | B Bassis provided an update on the organisational priorities and challenges since the last Board meeting, commented on the easing of restrictions and the road to recovery and outlined the context for the proposed discussions on corporate strategy and the new D&I workforce metrics pack.<br><br>BB shared reflections on the ambition to make NHSBT a great place to work for everyone. Remarking on a recent visit to Colindale, BB shared that it had been a positive experience and that she had left the centre feeling moved and inspired by the people with whom she spoke. BB reiterated that although there are green shoots of progress, there is a lot more work to do and the more comfortable people feel in speaking up about their lived experience, the more issues are uncovered around our policies, processes and people practices. It was confirmed that an external review of NHSBT's progress against the recommendations set out in the Globis report has been commissioned and is expected in coming weeks. BB also reported upcoming senior leadership changes and the need for NHSBT and search firms to ensure that candidates from diverse backgrounds are sought to fill these positions.<br><br>Board members also queried whether NHSBT is utilising the feedback from exit interviews to shape the ongoing work to make NHSBT a great place to work. BB agreed to share this insight with P Grealish and ensure this is happening in a consistent manner.<br><br>The Board were also informed of pending DHSC and CO approval for paid marketing plans for the year, and that whilst NHSBT is not the only ALB in this position, it was reported that this does pose a risk to donor recruitment and fill rates. Board members queried what mitigations had been put in place to support donor recruitment. DR shared the detail of the three levers in place to mobilise donors, and assured the Board that performance is currently on track and that the team will be reviewing the plans in the short term to consider whether more can be done to utilise existing donor pool. On the wider issue of approval, it was highlighted that the initial submission form did not allow for further briefing/context on the role paid media has in supporting wider partnerships and activities and other zero cost activities and that a further submission is planned which places the role of the funding in this wider context. | |
| 8 | Clinical Governance Report (21-33) | |
| | GMi presented the Clinical Governance report to the Board, summarising the discussions from the most recent CARE meeting. Within the reporting period of February 2021 and March 2021 there were no new Serious Incidents (SIs) were reported but subsequent to this reporting period, two new SIs had been reported | |

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| | to the Board - OTDT: INC5466 (heart retrieved without the donor family's agreement) and OTDT: INC5477 – (Eye tissue retrieved despite Coroner's restriction to the retrieval of corneas).<br><br>The Board discussed the organisation's role in educating Coroners on the processes and benefits related to organ donation and transplant and agreed to consider further education and promotion work with coroners to support the relationship local NHSBT teams have with Coroners across the UK.<br><br>Board members were also informed of a whistleblowing incident to the CQC of alleged poor clinical practice at one donor centre. 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. Board members were assured that sufficient action was taken in response to the incident.<br><br>The Board also queried an ongoing ICO complaint regarding Organ Donation deemed consent, and members were assured that the case will soon be closed. | |
| 9 | Board Performance Report (21-34) | |
| | KaR introduced the newly revised Board Performance report, revised for the new financial year 2021/22 to a shorter, structured and more focused report on headline KPIs and also enabling clearer progress tracking. Directors, and S White deputising in PG's absence, provided both an overview of the format and the contents of the directorate level performance information/ Board members were asked for feedback on these two areas.<br><br>Board members commended the work undertaken to revise the structure of the report and suggested that a section on major strategic risks should be included; and that focus is given in future reports on highlighting any trends.<br><br>There was discussion on the demand and supply for Ro, noting that whilst demand levels are reasonably stable, an increase in demand might be expected over the summer as non-sickle cell demand ramps up again. DN agreed to revise the scale of the chart to better display the data and to clarify the gap between supply and demand, and DR agreed to share an Ro programme update with the Board in September. DR also shared that the team is beginning to integrate and track external donor experience data, such as the BBMR data, and that this will be incorporated into the next phase of the operating model review.<br><br>Board members discussed the reported level of consent for organ donation and the number of transplants and queried what impact Covid had in the decrease in number. It was commented that the consent rate was higher during the pandemic and that all case where consent is not gained are examined. Similarly the reasons for not accepting an organ for transplantation are recorded, monitored and followed up if appropriate. Concerns were raised regarding some early signals of staffing issues in transplantation units and AC agreed to raise this issue at the next Organ Utilisation group. It was also highlighted that targets for Living Donations have not yet been set due to the unknown impact of the pandemic. It was agreed that consideration will be given to including organ utilisation data showing the variations between units as a potential quarterly report.<br><br>It was highlighted that internal targets are typically set at SMT level and scrutinised, and then reviewed by the Executive team – the new charts and | AC |

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| | performance report format will potentially provide greater clarity on the areas which may require greater challenge and focus.<br><br>SW clarified that the performance in filling vacant roles has significantly improved in the last month, potentially due to people being more readily available and having shorter notice periods, and added the People team are undertaking a review of the recruitment processes to revamp the employee proposition and to highlight NHSBT as a great place to work. SW also agreed to incorporate the feedback from the Board and improve the presentation of the data on case resolution. | SW |
| 10 | Finance Report (21-35) | |
| | R Bradburn presented the standalone Finance report, highlighting that the format will be reviewed in time for the next Board meeting and will also report on Covid related costs in the first quarter. It was also highlighted that NHSBT had been asked to input ideas in advance of the 2021 spending round process, to achieve 5-10% cost reductions by 2024/25.<br><br>Board members also discussed the work undertaken to reduce the number of overdue payments and to resolve irrecoverable payments, the role of the Finance & Performance Committee in monitoring these and the improvements made in recent years. | |
| 11 | Corporate Strategy Development (21-36) | |
| | K Robinson and T Barr presented an update on the development of the Corporate Strategy and summarised the emerging strategic themes and shared highlights from a recent Executive Strategy workshop session. Members were invited to provide feedback on the progress so far and to also highlight their preference for engagement in the ongoing strategy development.<br><br>Board members welcomed the large amount of work done to date and acknowledged the importance of the Corporate Strategy in setting out NHSBT's core purpose, ambition, and delivery, and encouraged Executive members to continue to shape the work. Executive members also shared their reflections from recent workshops and reiterated how insightful and inspiring the conversations had been.<br><br>Board members suggested better defining the actions, time frames and milestones within the strategy, starting by clarifying the 10-year horizon and working backwards to the present day with early focus required on those actions that will deliver the foundations for next year. It was also suggested that there should be clear outcomes for the corresponding overarching themes, and that their timeframes should be defined and realistic within the strategy.<br><br>Executive members were encouraged not to understate the role of data in the strategy in the medium to long term, and to ensure the upcoming series of technological medical developments (genomics, PMM, organ research, stem cells are also sufficiently reflected as these will help drive outcomes for patients.<br><br>Board members also commented that there is more work to be done in articulating the ambition for system leadership to reflect NHSBT's unique position and work done to date in this area.<br><br>Lastly, members highlighted the benefits of external engagement, and suggested that the strategy should make greater reference to the external environment such as the upcoming changes in the NHS, which may have | |

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| | implications on pricing/delivery and stakeholder engagement, the future of workplaces and the sustainable use of assets and resources.<br><br>**Outcome:** Board members commended the work to date and it was agreed that Executive Directors would advise on the next steps for Board engagement, and to offer small group or one to one discussions with NEDs. | |
| 12 | D&I Metrics update (21-37) | |
| | R Mortuza presented a progress update on the D&I programme of work following the last Board meeting and S White & R Crossen joined the meeting to provide greater context and to support the explanation of the work undertaken so far to develop the D&I Metrics pack. Board members were asked to comment on the structure and contents of the new D&I pack.<br><br>SW highlighted the challenge in developing the pack and the limited number of self-declarations brought about by either/or or both the reporting category restraints within the current NHS platform, and/or a lack of trust and assurance from staff in sharing their information. It was reported that NHSBT has made significant calls on the system builders to amend the categories for self declaration to support all staff, and building trust is a key aim as part of the D&I delivery framework.<br><br>Board members acknowledged the work and efforts undertaken to produce the inital metrics pack and noted the opportunity provided to start to confirm/undertake actions to make positive and lasting changes.<br><br>Referencing the earlier conversation on Strategy, it was suggested that the outcomes of the delivery framework should be highlighted alongside the proposed actions and activities. Board members offered support/guidance via a faciliated discussion to help determine the timescales for such outcomes.<br><br>Members discussed the role of recruitment in 'shifting the dial', and how a focus on those roles that can make the most difference to the composition of the workforce could help enable faster change. DR shared his reflections on his own recent experiences in recruiting senior leaders within the Donor Experience directorate, and the importance of focusing on both diversity and inclusion in the pay bands below senior management.<br><br>In support of behavioural change, members queried whether there is a missing level of 'intimacy' in interactions with staff and whether measurements and data could be taken from team meetings or individual meetings to measure progress and behavioural change. Exec directors assured the Board that the focus is beginning to shift in this direction, and that the developing directorate level plans are starting to have an impact. Directors reflected that they are being challenged on how they are learning from lived experiences and some shared examples of how they are using safe spaces for such discussions, and to greater understand/tap into staff's personal motivations.<br><br>Lastly, Board members encouraged further benchmarking of staff pay across disciplines to understand NHSBT's position as both a national and local employer in support of its ambition to be a great place to work.<br><br>It was confirmed that the D&I metrics will correlate with the questions within the staff surveys, and also with the directorate level plans – enabling localised plans and team level engagement. | |

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| | **Outcome:** Board members were also offered the opportunity to join development sessions with RM to hear more about the lived experience of colleagues and people outside of the organisation, behind the metrics. | |
| 13 | BTM Programme Update (21-40) | |
| | W Clark and C Ash presented the second update to the Blood Technology Modernisation Programme, and reported that the project is currently delivering the approved scope on plan and within budget.<br><br>CA also provided an update on the continued management of four significant risks, the highest being the impact of new demand from new initiatives such at Plasma for Medicine. | |
| 14 | Reports from the UK Health Departments | |
| | England | |
| | M Gallagher recorded the DHSC's thanks to NHSBT for support and work undertaken in recent months, including to L Hontoria Del Hoyo for her role in leading the work on the Plasma for Medicines business case and submitting for Treasury approval, and the organisation's role in the newly established Organ Utilisation Group. | |
| | Northern Ireland (21-38a) | |
| | J Hardy highlighted the progress on the opt out legilisation, recent positive engagement with the Northern Ireland Ethics Forum and the combined effort of NI and NHSBT to restart the Kidney Transplant Service in Belfast and on the Renal Recovery Plan. | |
| | Wales (21-38b) | |
| | In addition to the written report, P Vernon highlighted that there is a new Health Minister in post in the Welsh Government, and reiterated the Department's thanks to NHSBT for support on Organ donation communications. | |
| | Scotland (21-38c) | |
| | The submitted written report from Scotland was noted. | |
| 15 | For Information (21-39) | |
| | Board members commended I Bateman and the Quality Directorate for the presentation and contents of the Annual Management Quality Report. | |
| 16 | AOB & Questions from Observers | |
| | MB reported that the following question had been received by the Board and invited BB to answer:<br><br>*As the Data Protection Act has already been breached when the inaccurate confidential document was leaked, can NHSBT now publish the results of any follow-up investigation by Clive Lewis of Globis?*<br><br>In reply, BB sought to clarify that the question referred to the Organisational Diagnostic Report commissioned from Clive Lewis from the Globis Mediation Group which had identified that the lived experience of many colleagues at the Colindale centre was unacceptable.<br><br>BB stated that it was unfortunate that someone had chosen to leak the report to the press a couple of days before the intended publication date in June last year and that it was investigated and reported to the Information Commissioner at the time.<br><br>It was confirmed that NHSBT have carefully considered the nine recommendations in the report and had taken significant action over the last year to address issues raised. In addition, it was reiterated that as reported previously in this meeting an independent review of progress has been | |

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| | commissioned from another external party which is due to report back in the coming weeks. | |

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# 5. Matters arising from previous meeting (21-42)

For Report

Presented by Millie Banerjee

**NHSBT Public Board Action Log – Updated post May Board**

NHS Blood and Transplant

| Action Reference | Date Action Arose | Agenda Item | Item | Owner | Expected Close Date | Progress/Comments | Status |
|---|---|---|---|---|---|---|---|
| B18 | 27.05.2021 | 9 - Board Performance Report | AC agreed to raise the issue of early signals of staffing issues within transplantation units at the next Organ Utilisation group | AC | Jul-21 | | Closed |
| B19 | 27.05.2021 | 9 - Board Performance Report | SW also agreed to incorporate the feedback from the Board and improve the presentation of the data on case resolution. | PG | Jul-21 | Following the feedback received at the Board the metrics on the previous report relating to Case Type and Case Distribution have been removed. They have been replaced with a new metric that measures the incidence rates of case by directorate and protected characteristic. The revised measure has been produced for the July report (based on June data). In addition, we have added a section on Freedom to Speak Up contacts and themes to start to identify the 'softer intelligence' about what is happening within the organisation prior to escalation to a formal case. Within the recruitment metrics Net increase/decrease scores have been added for the total workforce and for Band 8a and above appointments. | Closed |

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# 6. Patient story (21-43)

For Discussion

Presented by Anthony Clarkson

**NHSBT Board Meeting**
**July 2021**

# A Patient Perspective:
# Living donor kidney transplantation - the art of the possible

Living donation and, in particular, living donor kidney transplantation is one of the organ donation and transplantation success stories of this millennium. For patients with end stage kidney disease, living donor transplantation offers the best chance of a successful transplant. From a threefold increase in activity during the first 10 years of this century to the subsequent development of the UK Living Kidney Sharing Scheme and non-directed altruistic kidney donation, the opportunities for patients to receive a living donor kidney transplant have increased immeasurably.

Despite significant increases in deceased donation, 39% of all donors are living donors, of whom 98% donate a kidney, which accounts for almost a third of all kidney transplants in the UK. Today, within the letter of the law, a living donor can be a close family member, friend or a complete stranger.

As well as excellent recipient, donor and transplant outcomes, one of the benefits of living donor transplantation in comparison with deceased donor transplantation is the opportunity to plan a transplant and, where possible avoid the intrusion of dialysis treatment. The freedom to plan transplantation in advance has become more and more important to patients and their families, when so little about life with a chronic illness is predictable.

Paul's 'career' as a patient started in 1980 when he was 24 years old and first diagnosed with calcium deposits in his kidneys (nephrocalcinosis). By 1984, this, unusually paired with polycystic kidney disease, had progressed into chronic kidney disease. He was in his first job post-university, working at Marconi Radar as a Production Engineer and the prospect of needing dialysis or a transplant within the next 15 years was not part of his life plan.

Over time, 6-monthly monitoring confirmed deteriorating kidney function but mind and body were not aligned - it was difficult for Paul to reconcile the inevitability of end stage kidney disease whilst he continued to feel well and could do the things that he wanted to do. He adopted 'a circle of wagons' approach to protect himself and his young family from reality.

The realisation that something was really wrong came suddenly in October 1999. A keen sailor, Paul capsized his boat during a race and, whilst trying to

free himself, experienced his first feelings of being out of his depth - not in the water, but in what lay ahead.

By this time, I had already met Paul and his wife, Sally, in the advanced kidney care clinic to discuss treatment options. With two small boys (2 and 4 years) in the mix, Sally was committed to living donation and under-going donor assessment. Paul was struggling to come to terms with the idea but recognised that by supporting Sally to donate, he could offer his whole family the best chance of a future. Soon after the sailing incident, a clinic appointment and further blood tests confirmed that Paul's kidney function had deteriorated beyond repair and it was time to 'batten down the hatches'.

Narrowly avoiding dialysis treatment, four months later, in February 2000, Sally donated her kidney to Paul. Paul describes the mental challenges of getting to this point - very much his own person, his 'let's get things done' approach meant that he relied on those he trusted at home and within the clinical team - to support him with the minimum of fuss and the maximum of efficiency. Talking about things and expressing feelings were definitely not his style. He and Sally were very much a team and giving up was not an option.

All these years later, Paul can recall his in-patient experience in vivid detail, his innate sense of humour allowing him to reflect on his own situation, his fellow patients and his appreciation of morphine 'on demand' for the first time in his life.

The next few years did not go as smoothly as he hoped. The life of his transplanted kidney was cut short by BK virus- at the time, little known, hard to identify and difficult to treat. Although Paul kept his kidney at the time and the virus was brought under control, lasting damage meant that he found himself approaching the need for dialysis just 9 years later.

Coping but not thriving on dialysis and with few options for transplant other than a long wait ahead, Paul's mother-in-law, Margaret offered to donate. As Sally's mother, Margaret shared human leukocyte (HLA) antigens to which Paul had developed HLA antibodies from his first transplant. This meant that Margaret was not compatible with Paul.

Before the UK Living Kidney Sharing Scheme was introduced in 2007, Margaret would either have been discounted as a donor or antibody incompatible transplantation, involving more intervention and poorer outcomes for Paul, would have been the only option to pursue.

In 2009, the UK Living Kidney Sharing Scheme looked very different from today - matching runs only included incompatible donors and recipient pairs were predominantly matched in combinations of 2-way (paired) and rarely in 3-way (pooled) exchanges to facilitate blood group and HLA compatible transplants. Non-directed altruistic donor initiated 'chains' of transplants were only introduced later in the scheme.

However, for Paul and Margaret luck was on their side and, in January 2009, they were matched in a 2-way kidney exchange with another couple in the same situation. Both donors donated and, indirectly, each recipient received a kidney transplant. Despite the added complexity of the scheme, being 10 years older and needing more tests to assess his suitability for a transplant, Paul remembers this as a smoother process in comparison with his first transplant experience.

Transplantation is a treatment not a cure. Although it is still the best option available for a dialysis-free life, Paul describes it as 'a difficult life choice' and one that should not be under-estimated. There are consequences associated with having a suppressed immune system - coping with the side effects of the drugs, susceptibility to other health issues such as cancer and viral infections and constant visits to hospital.

You will have an opportunity to hear directly from Paul about what the last 21 years of life with a transplant have meant to him, his family and close friends. It has not all been plain sailing, but would he have done it differently?

A short video will be played during the Public Board Meeting.

**Author**
Lisa Burnapp – Clinical Lead, Living Donation

**Responsible Director**
Anthony Clarkson – Director of Organ and Tissue Donation and Transplantation

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# 7. Chief Executive's Board report (21-44)

For Report

Presented by Betsy Bassis

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NHSBT Board

**22 July 2021**

Chief Executive's Report

Status: Official

Last year was a period of intense change. However, our people and operating model proved resilient, allowing us not only to maintain security of supply but also accelerate delivery of our strategic ambitions - from the introduction of agile working and new digital technology to expansion into new product areas such as plasma for medicine.

As for the first quarter of the new financial year, it has flown by due to an increase in activity, as well as the significant effort required to ramp up Plasma for Medicine. Operations have been complicated by increasing COVID cases (leading to staff absences) coupled with ongoing social distancing and other COVID-secure measures constraining capacity. With new COVID guidelines coming into effect on 19 July, we are working through the implications and developing guidance for staff and donors. Our first priority will be to maintain staff and donor safety, and continued security of supply. Our hope is that from the Autumn we can also start to open our offices back up to colleagues who have been working from home and wish to come in on a periodic basis for face-to-face collaboration.

The impact of the pandemic on mental health and wellbeing – particularly in the NHS – has been widely reported. Having made the wellbeing of colleagues a priority, it was encouraging to receive the results of a recent pulse survey which found a good and increasing score on 'my manager cares about my wellbeing'. The median score was 9 out of 10, with 44% of responders giving it a full 10 marks. The survey also highlighted that there is a broad awareness of our wellbeing offer and that they are classed as effective by those who have taken them up.

**Political and Regulatory**

Following his appointment as Secretary of State for Health and Social Care, we have written to Sajid Javid to introduce NHSBT, invite him to visit one of our sites and seek an initial meeting. With Mark Davies retiring this month, we will shortly be seeing changes at the official level as well. It has just been confirmed that William Vineall will be our new Director-level sponsor. We also understand that, due to a re-organisation underway in DHSC, our sponsor team will move under a new Director General responsible for NHS Policy and Performance. It will be important to establish new relationships quickly, particularly given that we are heading into a Spending Review and are reliant on our sponsor team to help us secure funding for ODT, Plasma for Medicine and Stem Cells.

The Board will be aware that the Government recently published its Health and Care Bill, as well as a new Life Sciences Vision. The Corporate Affairs team have summarised the main themes and highlights here: https://sway.office.com/oTSCFDcBomYIXrvf?ref=Link.

On the regulatory front, the MHRA completed their first "in person" audit of our Blood Establishment Authorisation at our new Barnsley Centre and its associated sites in early June. This was a successful inspection with only three "Other" non-conformances raised; the inspector was very complimentary about the site and all of the staff involved. There has been a renewed and sustained focus on overdue event management and additional resource has been allocated from the Continuous Improvement team to support this work.
Our Nominated Individual for the CQC has passed from Catherine Howell to Helen Gillan (Assistant Director – QA), thus bringing responsibility for all our regulatory activity into the Quality directorate. The Company Secretariat, Risk Management and Business Continuity functions also transferred into the Quality Directorate during June.

**Blood Supply**

Recent red cell demand has been c2-3% above pre-COVID levels, as hospitals have restored services and rescheduled activity postponed during the pandemic. This is lower than the c5% increase that we originally forecast, but we are monitoring this closely as around one fifth of hospitals (representing c25% of red cell demand) have secured additional funding from NHSE to catch-up on activity that was postponed during the pandemic. Whilst no notable increase in demand has been observed in this group of hospitals so far, there is a risk that this could change in the coming weeks and months. We are therefore focussing our efforts on increasing collection activity.

Unfortunately, this has proved challenging due to a combination of the social distancing and lower appointment fill rates, particularly in some donor centre locations. The delay in receiving DHSC and Cabinet Office approval for our paid-for-marketing has also limited our ability to increase new donor registrations, which has contributed to a c20% shortfall vs our new donors donating target YTD. Approval was finally received on 9 July, however the conditions require DHSC to approve and No 10 to see the campaign creative before we launch.

As a combined consequence of these challenges, red cell stocks have fallen from c8 to c5 days of stock over Q1. Stocks of O neg, O pos and B neg have declined below these levels. Whilst this does not present an immediate supply concern, we are taking a range of direct marketing activity targeted at active donors where we have appointment availability in order to re-build stock levels. This includes an extensive programme of email and SMS messages and increased dialling capacity at our National Contact Centre, which led to a c30% increase in call centre bookings and c3k appointments in the first week. We are also reviewing opportunities to increase the number of donation appointments following updated government guidance on social distancing.

Despite the continued challenges of the pandemic, we have maintained supply of blood components to hospitals with record levels of "On Time, In Full" (OTIF) performance of 98.8% in Q1. We have also responded to requests for support from neighbouring blood services to whom we have supplied a total of 1,895 blood components over Q1 (1,407 to Scotland, 364 to Wales, 115 to Republic of Ireland and 9 to Northern Ireland).
To ensure security of supply during the pandemic, we have incurred additional cost in the form of extra staff, larger and additional venues, and extra cleaning. We have started to develop plans to reverse out of these changes in order to mitigate above inflation price increases for next year. However, our current view is that it would not be prudent to implement these plans until we get through the winter and have more certainty on hospital demand and ongoing supply constraints.

In the meantime, work continues to improve the donor experience. We have introduced a new Donation Safety Check which, together with our new 'Check You can Give' online tool, supported the FAIR changes. They are also our first step in a wider effort to reduce on-session deferrals. We have launched an 'Ro Champions' pilot in two centres and two mobile teams

and provided additional training to call centre agents. This, together with our United By Blood and other campaigns targeted at Black donors, are designed to help close the Ro supply/demand gap. Of 36k new registrations in June, over 2k (6%) were from Black donors. Whilst below plan (due to lack of paid marketing), this was markedly better than previous months.

**Plasma for Medicine**

The Plasma for Medicines (PFM) business case was approved by DHSC and HMT in June, with funding of £53m for 21/22. Funding for future years will be subject to the outcome of the Spending Review.

We are on track to begin stockpiling recovered plasma from early August. We have successfully repurposed 11 convalescent plasma centres to collect source plasma. Despite the lack of paid marketing, we collected 7358 litres in Q1 against a business case target of c6k and stretch target of 9k. As our ability to meet the volumes set out in the business case is dependent on paid marketing, I have discussed with our sponsor team the need to re-baseline our volume targets once we receive approval to launch our campaign.

We are doing everything we can to ensure that the plasma we collect and recover is suitable for fractionation. As we have advised DHSC and NHSE, however, we will effectively be collecting at risk until a fractionator is appointed by NHSE and confirms their specification. The mitigating action we are taking for this and other risks will be reviewed at the Audit, Risk and Governance Committee (ARGC) on 9 July, with a read-out provided in the private section of the Board.

We are in the process of moving this major programme into BAU by establishing a new Plasma Directorate, reporting directly to me. We have gone through a robust process to design the operating model, governance and associated organisational structures, which we will start to appoint into over the coming months. We continue to get invaluable advice and support on all aspects of PFM from our ABO colleagues in Canada and Australia, as well as the International Plasma and Fractionation Association, which we will shortly be joining.

**Organ and Tissue Donation and Transplantation**

The Northern Ireland Organ Donation Bill has been given approval by the NI Executive to enter the Assembly for committee and debate stages, which will take place during the Autumn/Winter of 2021. If the Bill passes those stages it will be put forward for Royal Assent, potentially coming into force in late 2022 or early 2023. The Isle of Man Bill is awaiting Royal Assent as it passes through their legislative processes. We are continuing to support and advise on secondary legislation and codes of practice, and to deliver training to ensure a successful transition. Guernsey's law became an Act in 2020, however we await confirmation of a planned implementation date. England and Scotland continue the embedding and monitoring process now that their respective programmes have transitioned to BAU. To date, there have been 828 life-saving transplants coming from deemed consent/ authorisation (809 in 12 months in England and 19 from 2 months in Scotland). Wales have submitted a revised version of the 'excluded materials' to deemed consent to the Senedd and when time is allocated, will be debated before approval.

In recognition of our campaign effectiveness, the latest organ donation work 'Leave them certain' has been awarded Campaign of the Month by the Government Communication Service (GCS). Judges commented on the application of detailed insight to achieve a methodical, layered and innovative campaign to ultimately save more lives. '*Its simplicity is hugely effective. The results, are impressive and exceeded most benchmarks.*'

Q1 saw organ donation broadly return to pre-Covid levels of activity. A strong recovery in deceased organ donation saw a 20% increase in Q1 on Q4 activity and performance is close to that seen in 2019. Living donation is recovering more slowly (-15%) and the number of all transplants remains lower than 2019 (-9%). We are working closely with transplant units and NHS delivery bodies to support improvements in organ utilisation and the sustainability of the service. Cardiothoracic transplantation has been under particular pressure over the last month with a number of units needing to limit activity due to resourcing constraints. We are working in collaboration with the commissioners and the transplant units to ensure patients receive the transplants they need. The main risk over the rest of the year remains the impact of further pandemic pressures and / or further viruses (e.g. flu) on the system.

Tissue donation and issues have also broadly recovered to pre-pandemic levels. We are, however, focusing efforts on achieving a sustainable number of eye donors required to meet clinical demand. Among our improvements is an initiative to maximise the benefits from the integrated OTDT Directorate by increasing the number of organ donors who also donate tissue and maximising the referrals for tissue donation through the established organ donation referral pathways.

Organ utilisation forms a key plank of our new strategy. As such, we have established an Organ Utilisation Programme to oversee and align utilisation projects. The focus for the programme this year will be:

- Continuing the Clinical Leads for Utilisation (CLUs) pilot to drive improvements at both local and national levels and increase collaboration across units;
- Bringing commissioners, Health Departments and clinicians together to explore the options for establishing Assessment and Recovery Centres (ARCS); and
- Rolling out the current organ decline notifications processes, to better understand and then address reasons for variations in organ offer decisions.

In addition, NHSBT is providing Secretariat support for the Organ Utilisation Group (OUG), which was established by DHSC to make recommendations on ways to improve organ utilisation. The OUG, chaired by Stephen Powis (NHSE's National Medical Director), held its first meeting on 1 July and agreed a range of activities to ensure that stakeholders are given the opportunity to contribute to the work of the group and receive updates about progress. This will include working groups, workshops and an online call for evidence.

It goes without saying that our ability to deliver the new strategy will be dependent on our spending review settlement. We are working with DHSC to develop a bid ahead of the Autumn.

**Clinical Services**

Activity in our diagnostics laboratories is returning to pre-pandemic levels with the exception of investigations related to matching for organ and stem cell transplantation. Our stock position in relation to pipettes and other critical consumables is more stable. However, there are still reported pressures in global supply chains and we continue to monitor critical consumables proactively.

From 1 August, management of the National Frozen Blood Bank will transfer to the Pathology department, bringing together and strengthening our rare donors programme to better meet patient needs in the UK and internationally.

We have now received a draft specification for the Our Future Health (OFH) upcoming tender which is seeking to contract genotyping services for up to 5 million people. We are still deciding whether or not to bid. In parallel, we have been working with OFH to agree how

NHSBT might recruit up to 500k blood donors for this ambitious research programme. The feasibility study to test the recruitment and consent process went live on 5 July. Learnings from this pilot will be incorporated ahead of the larger scale recruitment planned for next year. Hand-over of the new CBC gene therapy manufacturing facility in Filton is on track for July. We have received c£400k of additional funding from DHSC for targeted BBMR minority ethnicity donor recruitment and some discovery work in CMT for improved stem cell cryo-preservation, which has increased in importance more recently with COVID related disruption. The British Bone Marrow Registry (BBMR) was virtually inspected by the Word Marrow Donor Association (WMDA) for its ongoing international accreditation. The inspection went very well with no findings or observations and just one recommendation. The BBMR team are now working closely with colleagues in Donor Experience to increase the annual donor recruitment of high value potential blood donors to join BBMR as we increase from our previous annual target of 10,000 up to 30,000.

The RECOVERY trial team have recently published the results for the REGN-COV2 monoclonal antibody treatment, which showed that it saves the lives of around 6% of hospitalised patients who have not yet developed antibodies against COVID19. This trial was in the same arm of the RECOVERY trial as Convalescent Plasma and, as such, NHSBT played an important role. Specifically, without the antibody testing that was done on all trial participants, the trial wouldn't have been able to show a benefit from monoclonal antibodies. Sir Peter Horby took the time to thank the NHSBT teams involved:
*'You have done an amazing job under difficult circumstances and made a critical contribution to improving care for COVID patients; not just in the UK but worldwide. I know we made some challenging demands, but they were always met - incredible.'*

The results are highly significant and pave the way for guidelines for the use of monoclonal antibodies for hospitalised patients with COVID-19. The work has also re-opened interest in the targeted use of other antibody therapies. We are studying whether a proportion of vaccinated convalescent plasma donors generate high levels of cross-reacting antibodies to variants. Results will be reviewed by funders to consider the potential for further trials of convalescent plasma in targeted groups of patients with COVID-19.

**Strategy and Transformation**

As previously reported, we have started work to develop a corporate strategy that will underpin our plans for the coming years. Our thinking continues to evolve as we distil input from NEDs and external stakeholders. Key themes are included in a separate paper, together with our high level emerging priorities which I would summarise as follows:

1) We must hold tight to the things that have made us trusted for safety and reliability and respected for our productivity and efficiency. This will require continued focus on quality, clinical governance, and risk management as well as the application of new technology and continuous improvement. Given the fiscal climate, we will need to bear down on costs and demonstrate value for money.

2) Recognising that everything we do depends on the public being willing and able to donate, we must reinvigorate our approach to donor engagement to ensure we have the right volume and mix of donors to meet new requirements (e.g. plasma for medicine) and evolving clinical demand. Increasing the diversity of our donor base will be our key contribution to improving health equalities.

3) In parallel, we will look to raise the profile and impact of the work we do across the health system, where we leverage our national footprint and specialist expertise to drive improvements in clinical outcomes and use of resources. We do this through:
    - training and education;

- research and development;
- data and actionable insights; and
- guidelines and standards.

This systems-level work has historically happened 'below the radar' and, as such, risks going unrecognised, undervalued and unoptimised – both internally and externally. We will seek to correct this given the untapped potential for us to have even greater impact as an organisation.

4) Finally, we will seek to make NHSBT a great place to work *for everyone*. This will pick up our D&I work, but also our broader investment in leadership and talent development; strategic workforce planning; and sustainability. We aim to be a destination of choice for top talent within the NHS.

I expect this narrative will evolve further as we seek additional input and refine our thinking. We hope to be in a position to bring a final set of priorities to the Board for approval in September, after which we will look to flesh out more detailed plans and a multi-year roadmap.

In the meantime, we are focused on delivering this year's business plan, stabilising our operations and supporting our people to recover after what was a challenging 20/21.

**People and Culture**

Our people agenda has grown extensively over the past two years as a result of the pandemic and the need to keep people safe; a step change in our activity (e.g. plasma); changes to our operating model; and our work to increase diversity and inclusion. To increase capability and capacity in our people function, a consultation is currently underway on a new organisational structure more closely aligned to our strategic priorities, including talent attraction, leadership and culture, and strategic workforce planning. We have already kicked off work in several key areas:

- Talent: we are reviewing the way we plan campaigns and attract applications from diverse candidates. Central to this work is developing a compelling Employee Value Proposition which distinguishes our mission, conveys our passion and sets out the rich opportunities for people to thrive at NHSBT. We have also introduced 'talent enhancement workshops' aimed at providing existing employees with the necessary skills and knowledge on the application and interview process.

- Leadership and Culture: throughout the pandemic, we have continued to bring together our senior leaders for regular development sessions. Our focus in May and June was on 'connection' and building strong relationships, recognising the significant changes to this community over the past year, as well as the challenges of working virtually. As we head into the Autumn, we will begin to focus on values, behaviours and the role of leadership in shaping our culture.

  Both we and the NHS Leadership Academy paused much of our wider leadership development activity during the pandemic in order to focus on operational requirements. However, we have now started planning new offers with the first of those, *Inclusive Leadership*, live in Blood Supply. A debrief and lessons learnt from the first 100 participants is planned before the programme will be launched to the wider leadership community in Blood Supply and other directorates

- Positive Relationships: As previously reported, we have introduced an externally resourced complex case unit to provide short term capacity to help manage an

increase in caseload and to upskill our own HR teams. As part of our work to adopt a 'resolution' approach to conflict (Discipline, Grievance and Dignity at Work), we will be redesigning our policies and processes and refreshing training for our investigators, panel members, HR teams and Trade Union colleagues. We have already introduced case commissioning and tracking to improve confidence and resolve issues more quickly.

- Engagement: we have decided to experiment with a new approach to tracking engagement which will see us using a digital tool (Peakon) to source feedback on a monthly basis. This will give us real time data to identify issues and measure the impact of our efforts. This new approach is being trialled with the Executive and Senior Leadership teams in July and August, respectively, before being rolled out to the wider organisation in September

**Digital, Data and Technology Services**

Critical projects and programmes are on track. The Shared Server and Storage project has reached a critical point: 10% of workloads have already been migrated to the new infrastructure with the remaining scheduled over the next few months. We continue to experience performance problems with the current environment so migrating at pace is important and will require the on-going support of business units as we migrate their services. When the migration is complete, the likelihood of Strategic Risk NHSBT-05 will reduce.

The Datacentre Co-location Full Business Case has been approved by the Executive Team. Changes since the Board approved the Outline Business Case in May include a reduction in costs and a short extension on timescales negotiated with the supplier providing NHSBT with welcomed additional flexibility. Blood Technology Modernisation is delivering to scope and plan but has had to access some contingency due to permanent staffing issues that have required us to engage additional external testing capability.

New mobile digital capabilities are being deployed to Collection teams via the Session Solution project. The pilot across 8 centres has been completed; the root cause of the previously reported technical issue has been established and full implementation has commenced.

A new Give Blood app will be launched in July with 5000 users being invited to join a private beta with full release scheduled for August if feedback is strong. The new app will make it easier to book appointments, is built on modern scalable technology and utilises the NHS design system principles and style making it easier to integrate services in the future.

Congratulation go to Wendy Clark for being named CIO of the Year by Women in IT, as well as to Marian Zelman and Cat Odgers who were shortlisted for other categories.

# Key Risks to Red Cell Stocks

| Risk Description | Risk Mitigations |
|---|---|
| **Demand could increase** to higher levels than forecast as hospitals restore services and catch up on postponed activity, e.g. approximately 1/5 hospitals representing around a 1/4 of red cell demand have secured additional funding to catch up on waiting lists. | ▪ Demand forecasts are reviewed weekly by the Demand Planning team and NHSBT clinical colleagues. Inputs to inform forecasting include:<br>✓ Insight gathered by PBM colleagues from a variety of sources including NHS England, blood transfusion networks, specific hospital trusts<br>✓ Latest NHS planning and COVID recovery guidance from NHSE<br>✓ Review of hospital stock levels and demand data at national, regional and hospital level<br>▪ Recent planning guidance focuses on accelerating elective surgical activity which is high volume, low complexity (low blood component use)<br>▪ Staffing and operational factors in hospitals, together with potential resurgence of COVID admissions, will constrain ability to increase activity |
| **Collection performance may decrease** due to an increase in COVID-19 cases leading to more staff absence due to sickness/isolation, and/or due to lower donor responsiveness (e.g. lower fill rates, higher deferrals during warmer weather). | ▪ Collection and stock forecasts are reviewed on a weekly basis by the Supply Planning team and Blood Supply and Donor Experience colleagues. Adjustments to operational activity are made as required.<br>▪ Significant challenges or issues are escalated to BOLT, who provide oversight of stock performance. |
| **Some neighbouring blood services have experienced low stocks and require support from NHSBT.** A total of 1,895 blood components have been exported over quarter 1 of 2021-22 (1,407 to Scotland, 364 to Wales, 115 to Republic of Ireland and 9 to Northern Ireland). | ▪ Each request is reviewed and only approved where NHSBT ability to supply is not compromised.<br>▪ Total stock provided to other services over Q1 totals <0.4 for NHSBT |

# Forecast Total Days of RBC Stock by end-August

Returning collection to plan (c29.3k/week) would ensure stocks return to target levels, even if demand increased to current forecast

**Forecast Total Red Cell Days of Stock by end-August**

| Average Weekly Collection Scenarios | Average Weekly Demand Scenarios: Pre-COVID Demand (c26k) | Recent Performance - 2% above pre-COVID (c26.6k) | Current Demand Forecast - 5% above pre-COVID (c27.4k) | High Demand Scenario A - 7.5% above pre-COVID (c28.1k) | High Demand Scenario B - 10% above pre-COVID (c28.8k) |
|---|---|---|---|---|---|
| Collection deteriorates - 7.5% below plan (c27.1k) | 4.9 | 4.1 | 2.9 | 1.9 | 0.9 |
| Collection at forecast - 4% below plan (c28.1k) | 6.2 | 5.4 | 4.2 | 3.2 | 2.2 |
| Collection to plan (c29.3k) | 7.9 | 7.1 | 6.7 | 4.9 | 3.9 |
| Increase collection above plan 2.5% above plan (c30k) | 8.9 | 8.1 | 6.9 | 5.9 | 4.9 |

Recent demand and forecast collection

Demand to forecast and collection to plan

- If current demand performance continues and collections are forecast at recent levels of performance (c28.1k/week), total stocks will hold steady at c5.4 DOS (high amber). If we balance the blood group mix, this will ensure continuity of supply, but resilience would be limited if demand were to increase.
- Returning collection consistently back to the business plan levels (c29.3k/week) would return stocks to target levels, even if demand increased to forecast. With current 45-46k appointments/week, fill rates of c94% and conversion of c69% would be required to meet plan (currently c92% and c67% respectively).
- If demand were to increase beyond forecast levels, we would need to increase collection to >30k/week to keep stocks to target. This would likely require more collection capacity.

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# 8. Clinical Governance report (21-45)

For Report

Presented by Gail Miflin

NHS Blood and Transplant

**NHSBT Board Meeting**

**22nd July 2021**

**Status:** Official

**Summary and Purpose of Paper**

This paper summarises the clinical governance issues discussed at NHSBT CARE meeting held 24th June 2021.

- There are two open SIs in OTDT, both of which are linked to retrieval, these have previously been reported to the Board and remain under investigation. Root Cause Analysis (RCA) meetings have been held and the teams are now working on a corrective plan of action.

- A potential safety concern has been raised anonymously to the Care Quality Commission (CQC) regarding the use of Scinomed machines collecting plasma. Th concern related to the ability for air to collect in the 'lines' between the donor and the machine and how these were managed. A detailed response outlining the actions taken to manage these events has been sent to the CQC and we continue to be in correspondence with them over this matter. The machines are not being used currently. Both Scinomed and NHSBT reported these incidents to the Healthcare products Regulatory Agency (MHRA).

- It was highlighted that NHSBT has not been compliant with Prevent training since its inception under section 26 of the Counter-Terrorism and Security Act 2015. This training aims to ensure the safeguarding of children, adults and communities from any threat of terrorism. This issue was raised at Executive Team (ET). We will be introducing this to our mandatory training portfolio in the near future.

- In relation to the Infected Blood Inquiry (IBI), an NHSBT executive level steering group has started meeting to oversee our preparation and interaction with this important inquiry as we move towards the next round of witness hearings. This group agreed a change in the governance route and will itself report to ET, approving and escalating events to the ARGC and the Board as appropriate. The IBI will therefore not be reported through CARE in the future.

- As governmental restrictions change, the social distancing measures are being reviewed in Blood Donation sessions, as we ensure we are in a position to collect blood. We will be reducing social distance to $1^{+}$ metre but remaining within guidance with our additional mitigations. Further conversations at ET have considered the wider government changes announced this month.

**Action Requested**

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

**1. Serious Incidents (SI)**

1.1 During April and May 2021, two new Serious Incidents (SIs) were reported. These two SIs have been reported to the Board in the previous report and are under investigation:

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

Multi-organ donor was facilitated in April. There was a contraindication for heart donation due to a previous heart valve replacement and the family did not consent to heart donation. However, the heart was retrieved and went to a heart valve bank. The specialist nurse organ donation (SNOD) who had accepted consent for other organs later noted the error and the heart was returned to the donor's body.

The Root Cause Analysis (RCA) indicated that there were multiple factors that led to the heart being retrieved without consent in place. The unusual situation, testing requirements, and logistics appear to have contributed to a lack of adequate handover taking place. These may also have provided distraction and the consent form was not appropriately reviewed and fully comprehended by the SNODs involved and the Retrieval team.

- ***OTDT: INC5477*** *– Eye tissue was retrieved despite Coroner's restriction to the retrieval of corneas*

Consent for solid organ and tissue donation was given by the family and corneal donation was also agreed. However, despite an objection from the coroner to corneal donation, a referral was made to the National Referral Centre (NRC) for cornea and tissue donation and the corneas were removed. The family and the coroner have been sent letters of apology.

The RCA indicated that there were multiple factors that led to the corneas being retrieved despite Coroner's restriction. The main factor is that the SNOD and NRC processes were not aligned leading to the information regarding Coroner restrictions not being identified prior to retrieval. The team are currently working on corrective actions and improving documentation processes.

## 2. Care Quality Commission (CQC) update

2.1 A potential safety concern has been raised anonymously to the CQC regarding the air-in-line incidents during donation of plasma using the Scinomed machines within Convalescent Plasma (CVP)/ Plasma for Medicine (PFM). The concerns surrounded the malfunctioning of the machines but also concerns about the management of the incidents. A detailed response outlining the action taken to manage these events has been sent to the CQC and we are awaiting their response.

2.2 We are in discussion with our DHSC Sponsor team over regulation regarding organ allocation algorithms in the CQC framework. Discussions are ongoing on this in terms of who would be best to regulate this activity.

## 3. Risk Management

3.1 It was highlighted that NHSBT has not been compliant with Prevent training. Since 1st July 2015, all specified authorities have a responsibility to ensure that they demonstrate compliance to Prevent duty, as outlined under section 26 of the Counter-Terrorism and Security Act 2015. This training aims to ensure the safeguarding of children, adults and communities from any threat of terrorism. Work is currently underway to address this gap in training in NHSBT. This issue was raised at ET. We will add this to risk register whilst we put this training in place.

3.2 The strategic level (parent) risk: NHSBT-01, Safety and Quality of Clinical Care, was reviewed and has 50 recorded functional (child) level risks, with no high scoring, priority 1 risks (risks with a residual score =/>15). The current 'worst child' score is moderate. Since the previous risk report, the three directorates have reviewed and updated their risks in the risk register, Pentana. There are no new risks added with a high score.

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## 4. Infected Blood Inquiry (IBI) Update

4.1 The NHSBT Executive level steering group has started meeting. This group agreed a change in the governance route and will itself report to ET and approve reports to the ARGC and the Board as appropriate. The IBI will therefore not be reported through CARE in the future.

4.2 NHSBT continues to draft responses to Rule 9 Requests received from the IBI. Papers will be brought to the ET in the coming months on matters where we feel the Inquiry may wish to concentrate questioning of our witnesses

## 5. Clinical Governance

5.1 The 'For the Assessment of Individualised Risk' (FAIR) group changes have been successfully implemented on 14th June. This event received a lot of media attention.

5.2 Social distancing measures are being reviewed in Blood Donation sessions, the Infection, Prevention and Control (IPC) Committee and BOLT recommended reducing social distance to $1^{+}$ metre, including considering additional mitigations. Further conversations at ET have considered the wider government changes announced this month.

5.3 An incident in OTDT( ODT INC 1184) has been reviewed by internal and external stakeholders. All actions and recommendations discussed with the Executive team. Agreement and consensus that all the required actions have been completed and the incident can now be closed.

5.4 As a result of RCA for previous near misses and SIs, work is being completed within OTDT to look at the number of manual workarounds in the OTDT Hub and Information Services before any offers go to transplant centers, and the impact of these. Having a number of work arounds provides a significant risk and impacts on both patients and teams. Preliminary work has been completed. The provisional findings have been escalated to the OTDT Medical Director and the Chief Digital and Information Officer. The next step is to consider how to prioritise the IT solutions required for manual workarounds.

## 6. Clinical Audit

6.1 A total of twelve audits due for completion within 2020/21 and these are on track to be completed as planned.

## 7. Information Governance (IG)

7.1 The Data Security and Protection Toolkit (DSPT) is measured across ten Data Standards and NHSBT's 2021 submission demonstrates improvement in maturity and capability over 9 Standards.

7.2 IG maturity is high, with Cyber maturity growing (due to the Cyber measures being relatively new in comparison with the IG measures).

7.3 Data Protection Training compliance is 99.8% as of 31 March 2021.

## 8. Safety Policy

8.1 NHSBT is working with the Joint United Kingdom Blood Transfusion Services Professional Advisory Committee (JPAC) and Medicines and Healthcare products Regulatory Agency (MHRA) to put in place a UK wide position statement in order to help answer requests from members of the public who wish to have the option to receive blood from non-vaccinated donors should the need arise.

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# 9. Board Performance Report (21-46)

For Report

Presented by Rob Bradburn

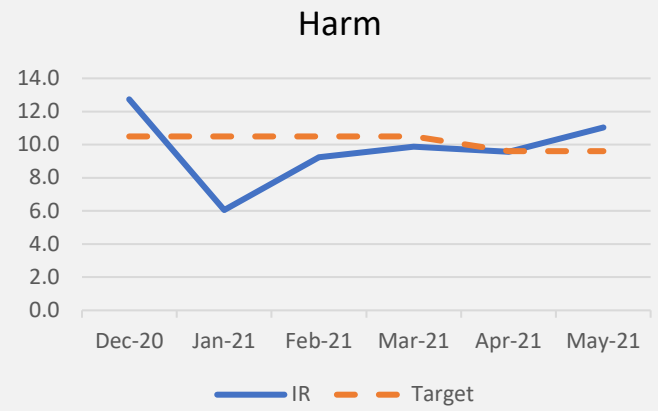
NHS Blood and Transplant

# NHSBT Board Performance Report

## June 2021

# HEALTH, SAFETY & WELL-BEING: Director Report – June 2021

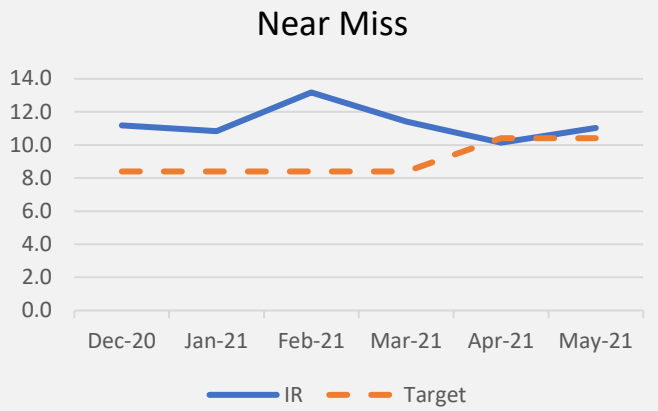
## Safety and Wellbeing




**Harm IR - May 21**
**(Target = 9.6 G= better than target, R = worse then target )**
**11.0**

- An increase in accidents in TES for April and May in Liverpool is being closely monitored by TES SMT
- Increase in accidents in BD in May is being reviewed by BD Assistant Directors
- Target change for new financial year

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



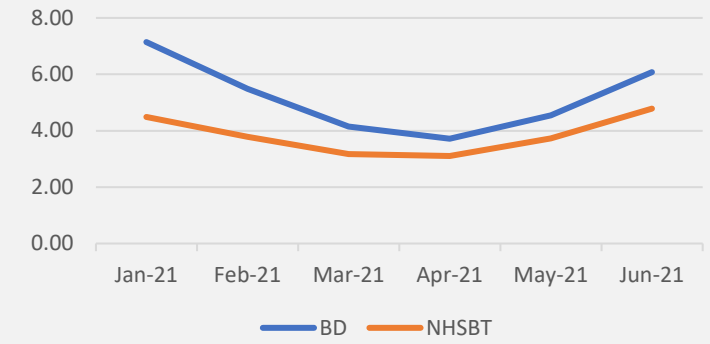

**Near Miss IR May 21**
**(Target = 10.4 G= on or better than target, R= under target )**
**11.0**

- Near Misses have increased to better than target due to campaigns in OTDT and CS
- Target change for new financial year

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 % - 30/06/21**

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

**NHSBT 4.78%**

**BD Sickness Absence % 30/06/21**
**(Target = 5% G=5, A= 5-5.5, R = > 5.5%)**

**BD 6.08%**

- Absence levels increased by from 3.73 NHSBT and 4.55 BD back to levels seen in January. PPE Group has reformed and will monitor all absence levels as well as COVID-19, with particular focus on Blood Donation.
- Sickness Absence targets were set at 5% for Blood Donation (Pre pandemic)
- Definition of sickness absence is % of absence related to sickness of total number of employees

## COVID Vaccination

- COVID First vaccination rate is still increasing however the rate is slowing. Less focus on this due to successful Covax campaign.
- COVID Second vaccination rate is increasing; managers are being asked to encourage colleagues to report as vaccination rate likely to be under-reported.
- Vulnerable Colleagues (identified via HSW risk assessment) have all been asked if they have had the vaccine).
- Patient Facing Colleagues – covers colleague in ODT and TAS and is at a high level.

**% of staff 1st COVAX Vaccination – 30/06/21**
**86.4%**

**% of staff 2nd COVAX Vaccination – 24/06/21**
**63.7%**

**% of vulnerable staff 1st COVAX Vaccination – 30/06/21**
**91.9%**

**% of patient facing staff 1st COVAX Vaccination – 30/06/21**
**93.1%**

# QUALITY DIRECTORATE: Director Report – June 2021

## Key risks, issues and actions for attention:

- EU In-Vitro Device Regulations (IVDR) implementation - project status remains rated as 'amber' with late completion of some tasks due to resource issues, the Project Board has requested a re-baselined plan in July so risks to delivery can be fully assessed.
- Plasma for Medicines (PFM) – QMS requirements being determined to mitigate the risk of plasma not being accepted by a fractionator.
- Overdue Events – following a 21% decrease last month, June saw a 20% increase. CI activity has been increased, led by QA, and will need multi-directorate support to be effective.

### External Inspection Performance:

Barnsley MHRA BEA and WDA (H) – No Critical or Major events. 3 Others

### Upcoming Inspections:

Filton, Southampton and Liverpool - documents requested by MHRA submitted. Awaiting further information from regulators on inspection plans for 21/22.

**External Majors (Target = 0)**

Nil ⟷

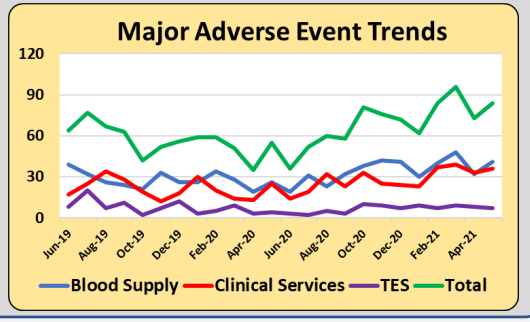
Y-T-D raised = 0

### Serious Incidents (SIs): Y-T-D = 2

- **0 SI events raised in June**

### Major Adverse Events:

- There was an increase in Major adverse events (Quality Incidents and Complaints) raised this month in both Blood Supply and Clinical Services.
- The biggest increase was in M&L who saw a rise from 11 to 24. 5 of these were recall related, this cause is subject to ongoing CI. 4 are testing issues related to Syphilis – MSL investigating.




### Regulatory Radar:

- **EU In-Vitro Device Regulations (IVDR) -** Options are being sought for recruitment of additional resource to get the project back on track. Priority is being given to tasks that need to be completed by the date of application (26th May 2022) such as Post Market Surveillance, Vigilance and implementation of Unique Device Identification (UDI) which are mandatory under the EU IVDR. The project is being re-baselined this month. ⟷

### Licence Update:

No licence updates for June to report.

### Externally Reported Events:
### (Serious Adverse Blood Reaction & Event / Serious Adverse Event & Reaction)

**SABRE: Y-T-D = 5**

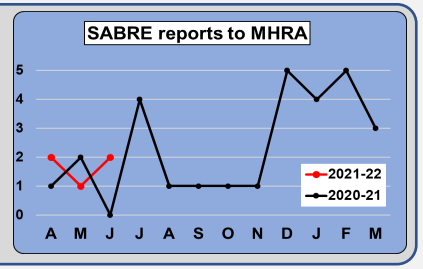
2 events in June

- 2 late recalls

**Events being managed. No clinical impact.**

**SABRE events (Target </= 5)**

2 ↑




**SAEAR: Y-T-D = 23**

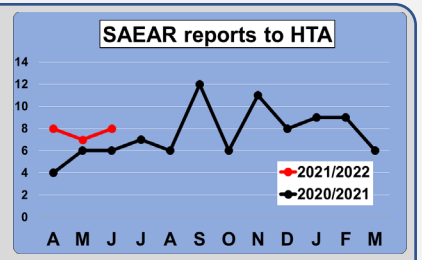
8 events in June

- 4 bacteriology positives
- 2 graft failures
- 1 transfusion reaction
- 1 testing – results unavailable

**Events being managed appropriately**

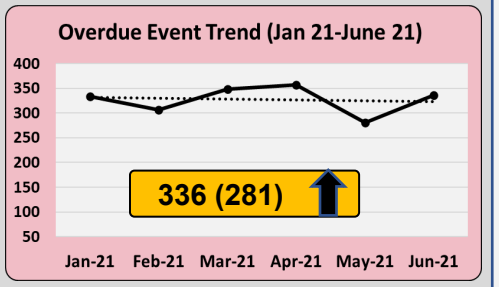
**SAEARs events (Target TBA)**

8 ↑




### Overdue Quality Management System Event Performance:

- 20% increase in overdue events in June.
- Weekly "Overdue Event" reviews by Senior Team and QA Direct established.
- New Incident Management process implemented on 1st June 2021.
- CI activity is underway led by QA and will need multi-directorate support to be effective.

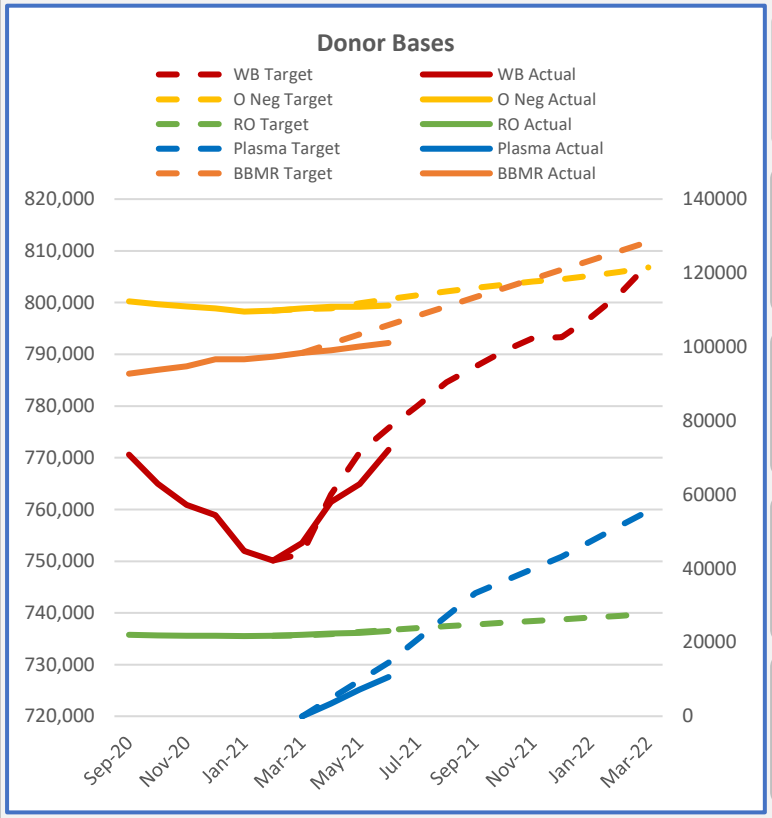


# DONOR EXPERIENCE: Director Report – June 2021

Key: Current performance | FY22 target

## Key Headlines, risks and mitigations

- The WB Blood donorbase continued to grow, reaching 4k below the original plan for end of June. The smaller base continued to be a residual effect from the removal of a large number of NDD opportunities in April. Rate of donorbase growth in June was 0.9% v 0.5% in May due to improved numbers of NDD, with contributions from the introduction of FAIR in National Blood Week and the United by Blood (UBB) Campaign. New Black Donor numbers were particularly strong thanks to the UBB Campaign. As demand for blood increased throughout the month an additional 5,600 appt slots were included in the programme to increase capacity and majority filled.
- Levels of Opting In to the ODR fell in June after a peak in May but still above target. Opt outs continued to rise, exceeding 36k driven by an further increase in NHS App users, equivalent to two thirds of all Opt Outs. It is anticipated these figures may continue to rise as long as the App is being used as a Covid-19 pass. We remain below the 8% predicted at the change of legislation with only 3.2% of the population opting out overall.
- WB Deferrals rose in June driven by an increase of HB deferrals during a spell of hot weather, changes to donor demographics e.g. male donors over 60 donating , increased new Black donors from the UBB



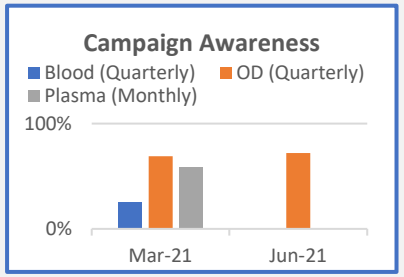

**WB 12M Donor Base (FY22 Target = 807k Jun 21 Target = 776K)** 772k

**O neg Donor Base (FY22 Target = 121k Jun 21 Target = 113k )** 111k

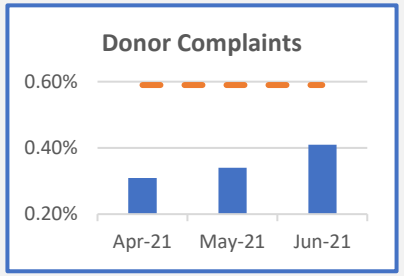
**Ro Donor Base (FY22 Target = 28k Jun Target = 23.4k )** 23.1k

**Plasma Donor Base (FY 22 Target = 55k TBC Jun 21 Target = 14.5k)** 10.6k

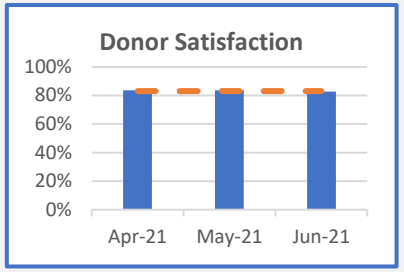
**BBMR Donors (FY22 Target: = 130,000 tbc Jun 21 Target = 106k )** 101k



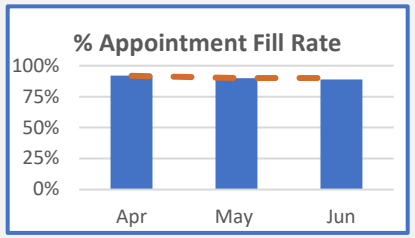

**% Plasma Awareness (FY22 Target TBC)** Unavailable



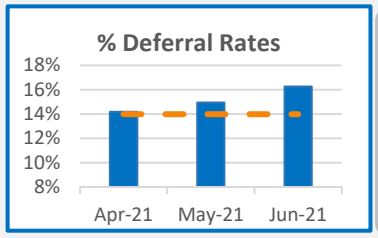

**% Donor Complaints (FY22 Target 0.59%)** 0.41%



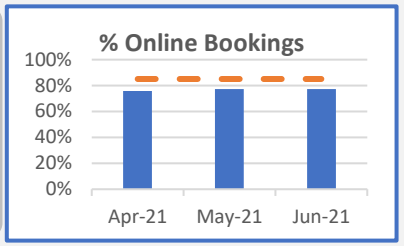

**Donor Satisfaction (FY22 Target 83%)** 83%



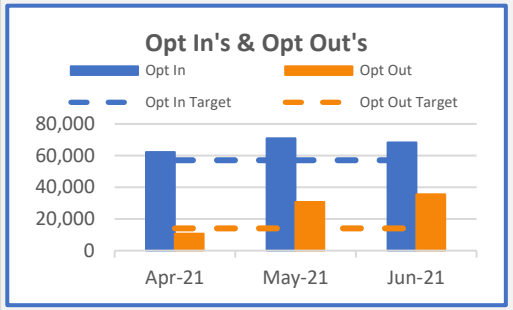

**% Fill Rates (FY22 Target= 94% Jun 21= Target 90%)** 89%




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




**% Online WB Bookings (FY22 Target 85%)** 77%




**Organ Donation Opt In's (Monthly Target 57k)** 68k

**Organ Donation Opt Out's (Monthly Target 14k)** 36k

### Delivering the Volume of Donor

- The donorbase has expanded at an increased rate in June but remained under monthly target (99.5% of YTD). The highest NDD in over 2.5 years, together with meeting planned retention and improved numbers of donors returning, have contributed to the donorbase growth.

### Delivering the Mix of Donors

- The O-negative and Ro donorbases observed a 5th consecutive month of growth, now at 98.5% and 98.8% of their respective YTD targets.
- June's Ro NDD was the highest in over 5 years representing a 75% month-on-month increase. This excellent level of recruitment was aided by the 'United by Blood' activity/sessions.

### Improving our donors' experience

- Donor Satisfaction achieved target in June but fell slightly against May down to 83%. Possibly due to increased waiting times which dropped from 64% satisfaction to 59% in June. Complaints have risen for a second consecutive month.
- WB online booking rate remained stable but below target at 77%

### Building a plasma base for the future

- The plasma for medicine donorbase continues to grow but currently sits at 73% of the YTD target.

RAG: Above Target, Within 2% of Target, More than 2% Below Target

# BLOOD SUPPLY: Director Report – June 2021

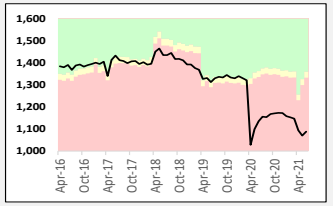
## Key risks, issues and actions for attention:

- *Overall red cells stocks have averaged 5.5 days of stock (DOS) over June, which is at the lower end of the target range. O pos, O neg and B neg have been below target of minimum 5.5 DOS. While this does not present an immediate supply challenge and OTIF performance has remained strong, an increase in current levels of demand or reduction in recent collection levels may cause further stock decline. Actions to increase appointment capacity and increase donor bookings are being overseen by BOLT.*

## Productivity

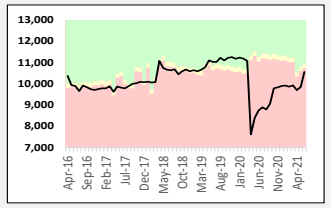
**Collection Productivity**
**YTD Target = 1,360**

**1,088** ↑



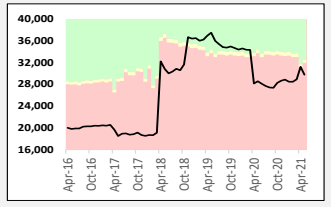

**Processing Productivity**
**YTD Target = 10,959**

**10,562** ↑



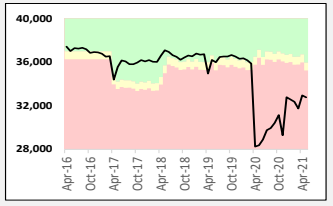

**Testing Productivity**
**YTD Target = 33,009**

**30,488** ↓



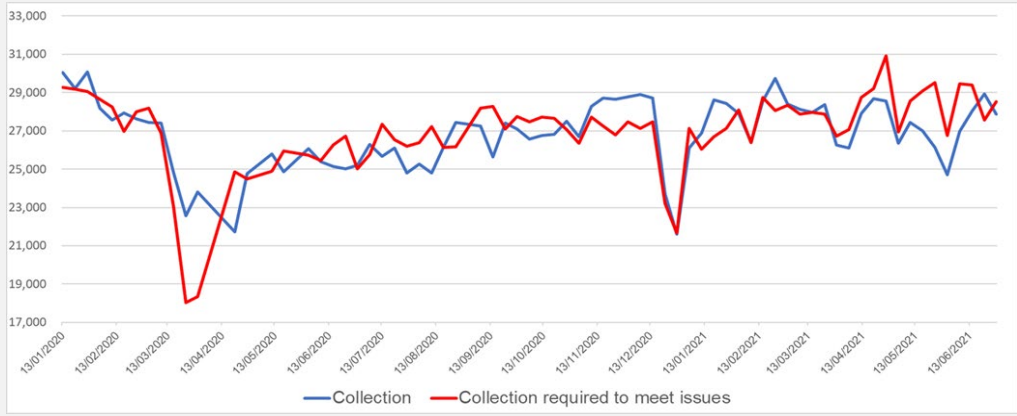

**Hospital Services Productivity**
**YTD Target = 36,532**

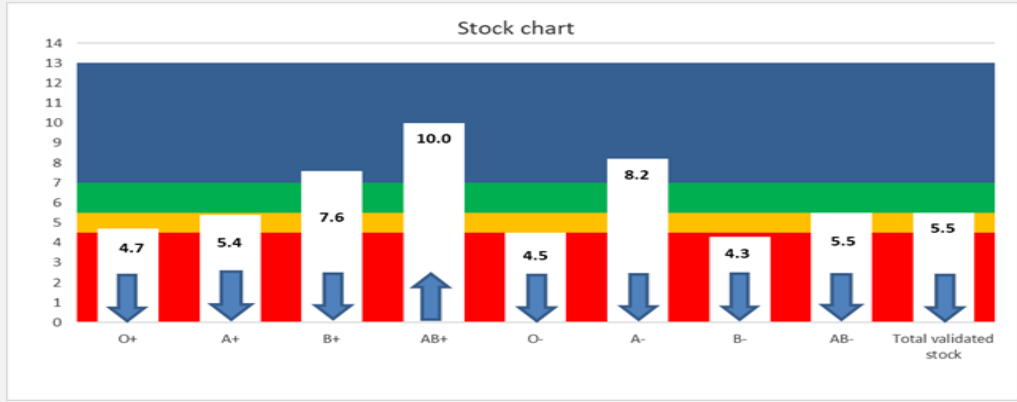
**32,976** ↓




Collection and processing productivity increased vs. last month's performance as volumes in June increased to support lower stocks. Collection productivity remains c20% below target as a result of high agency and overtime spend to support COVID-secure measures in place on blood sessions.

## Collection Performance and Stock



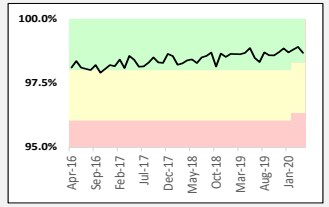

Red cell demand has been c2-3% above pre-COVID expectations for the period. A demand increase from June was anticipated in our demand forecast.

Collection levels have increased during June, but further action is required to return low stocks of some blood groups back to target levels. Over June, O pos, O neg and B neg have averaged below minimum target levels of 5.5 days of stock (DOS). Actions to increase appointment capacity and increase donor bookings are being overseen by BOLT.

## Service

**OTIF Excl. Ro Fails**
**YTD Target = 98.3%**

**98.7%** ↓




OTIF performance remains above target levels.

# CLINICAL SERVICES: Director Report – June 2021

**Key risks, issues and actions for attention:**

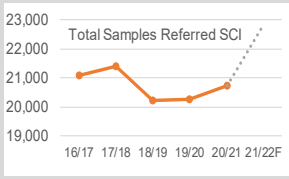
- *Demand for Clinical Services products/services has improved during the year to date across most operational areas; no impact evident at this stage from the pandemic's third wave*
- *Ongoing issues relating to consumables supply, driven by suppliers supporting the pandemic response, continue to be managed*

## Stem Cells and Therapeutics

- **Cellular and Molecular Therapies (CMT)** routine SCI service activity 15% above plan in the year to date (YTD), income 5% above
- The number of stem cell transplants supported YTD was 445 and above target of 422
- Clinical Biotechnology Centre income equal to plan YTD; forecast equal to budget, with the majority of income set to deliver later in the year
- **Stem Cell Donation and Transplantation** (SCDT) cord blood issues 2 above plan YTD
- International issues 3 below plan, UK issues 5 ahead; 14 units issued YTD compares to 13 issued at the same point last year
- British Bone Marrow Registry (BBMR) donor to patient matches above plan by 14 units
- International matches 9 ahead of plan; UK matches 5 ahead; 35 units issued YTD compares to 28 issued at this point in 2020
- SCDT total income 16% above plan YTD
- Donors recruited to the BBMR 'Fit panel' behind plan YTD; plans in place to improve recruitment
- **Therapeutic Apheresis Services (TAS)** overall activity above plan by ca 15% YTD driven by increased Plasma Exchange activity across multiple units; income 20% above plan

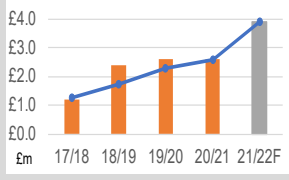
**SCI Service Activity YTD Target 4,829**

**5,540 ↔**

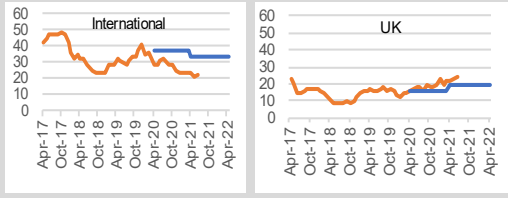



**CBC Sales YTD Target £0.37m**

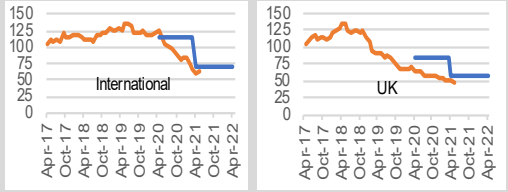
**£0.37m ↔**




**Cord Blood Issues YTD Plan = 12** **14 ↑**

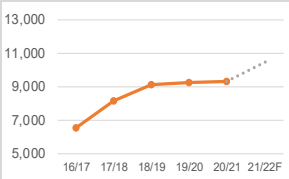



**BBMR Matches YTD Plan = 21** **35 ↔**




**TAS Activity Volume YTD Target 2,207**

**2,541 ↔**

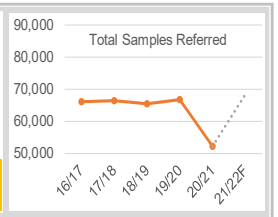



## Pathology Services

- **Histocompatibility and Immunogenetics (H&I)** total activity 3% above plan YTD and well above last years pandemic hit period
- However, solid organ (8%) and stem cell related investigations (29%) below plan; drives 4% adverse income variance YTD
- Sample turnaround times remain better than target
- **Red Cell Immunohaematology (RCI)** activity 7% above plan YTD (income 4% better than budget)
- Sample referrals also above comparative periods in 2019 and 2020
- Sample turnaround times remain better than plan
- **International Blood Group Reference Laboratory (IBGRL)** sample turnaround times above target for Fetal RhD and Patient Genotyping
- Ongoing consumable supplier issues continue to be managed across Pathology Services

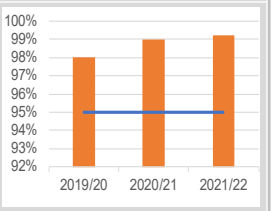
**H&I Service Activity YTD Plan 16,084**

**16,504 ↔**



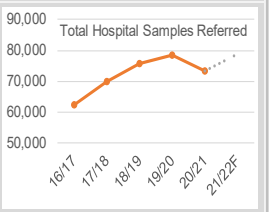

**H&I Turnaround Time YTD Plan 95%**

**99% ↔**



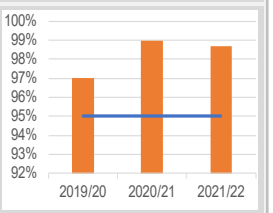

**RCI Service Activity YTD Plan 18,033**

**19,379 ↔**




**RCI Turnaround Time YTD Plan 95%**

**99% ↔**




**IBGRL Fetal RhD Turnaround Time YTD Plan 98%**

**100% ↔**

**IBGRL Patient Genotype Turnaround Time YTD Plan 85%**

**100% ↔**

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

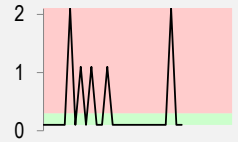
# OTDT: Director Report – June 2021

**Key risks, issues and actions for attention:**

- Recovery towards pre-pandemic donation levels largely continued in June. However, we are not yet achieving all our new targets - to exceed best-ever performance in support of NHS system recovery. We continue to see increased demand for key tissue and eye products, sales, and a growing organ transplant list. Low ocular donation rate in-month expected to impact ocular sales, with expectation of some operations being cancelled.
- Consent/authorisation rates (in particular where deemed criteria applied) were short of our ambitious target in June – but proceeding deceased donors continued trending upwards in month and on a "Moving Annual Total" (MAT) basis. Transplants per deceased donor was very low in June but may be due to extracting data earlier than usual; we will know more next month. Living donation is being gradually re-established by NHS partners.
- We are continuing to learn from these experiences and 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)**

2 ⇔

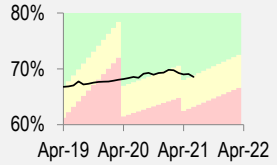



## Serious Incidents (SIs) related to OTDT

- There were no SIs in June. The YTD total remains at 2 and will be red for the rest of the year.

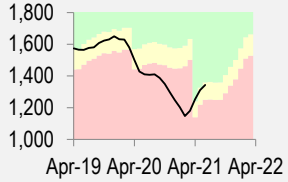
**Consent/Authorisation (Target 74%)**

66% ⇩



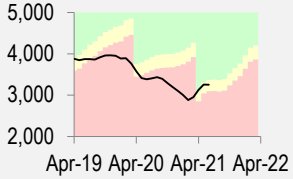

**Deceased Donors (Target 404)**

358 ⇧



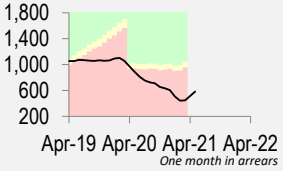

**Deceased Transplants (Target 1,022)**

838 ⇩



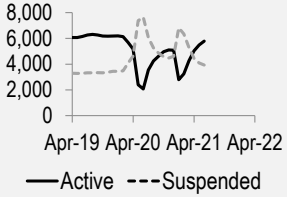

**Living Transplants** *month in arrears*

139 ⇧




**Active Transplant List**

5,790 ⇧




## Organs

### Donation

Deceased donors trended up in-month and MAT.

- Referral and SN-OD presence remain strong at 95% and 93%, respectively.
- Low consent/authorisation rate in-month: 63% for both DBD and DCD (red). Continued slight downward trend MAT into the amber zone (69%). Deemed consent/authorisation rate was particularly low in-month at 54%.
- 1,343 deceased donors MAT. Although still amber, the trajectory remains close to the green threshold. To return to green MAT we need at least 147 proceeding deceased donors in July.

### Transplants

Deceased donor transplants trended down in month and the MAT trend is flat (but remains amber against the MAT target).

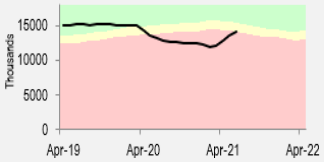
- 3,254 deceased donor transplants MAT. To return to green MAT, we need at least 445 transplants in July (extremely unlikely).
- 583 living donor transplants MAT. Trending up in-month and MAT.

### Transplant List

- Further increase in active Transplant List, with an expectation that re-activations will continue.

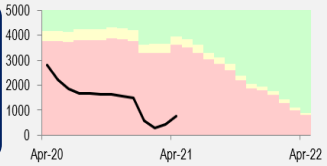
**TES - Income (Target = 1,207k)**

£1,313k ⇩



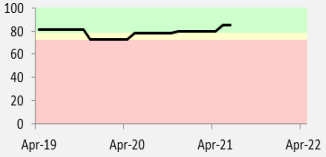

**TES – Contribution (Target = £4,017k)**

TBC



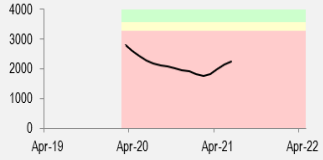

**Customer Satisfaction (Target = 80%)**

85% ⇔



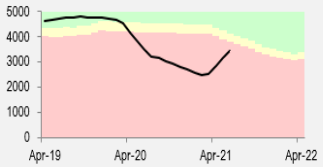

**Cornea Donors (Target = 300)**

206 ⇩




**Cornea Issues for Transplant (Target = 280)**

382 ⇧




## Tissues and Eyes

### Donation

- Ocular donations in June were down in-month.
- We are continuing to focus on increasing ocular donations further through Level 1 Organ-Donating Hospitals.
- Quality assurance and initial analysis of audit of ocular consent from organ donors has been completed. Initial finding is a high rate of ODR overrides. Of 250 expressed opt-in approaches for eyes, 71 (28%) were unsupported, c.f. 10% for solid organs.

### Issues / Income

- TES income for June 2021 is £107k ahead of target (subject to confirmation).
- Low ocular donation rate in June expected to impact ocular sales in July, with expectation of some operations being cancelled.
- Hospitals reported that their elective capacity was c.90% in June, with an expectation to increase by 5% a month.
- Within a positive overall income position, some products (notably serum eyedrops) failed to reach target due to capacity issues – action plans are in place to recover production.

## Key notes

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

**Charts:** ODT & TES- Activity against Moving Annual Total (MAT) targets. (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 – June 2021

**Key risks, issues and actions for attention:**

*Collective Consultation on the new People Operating Model continues this month – it is expected that the collective phase will close and move to individual consultation in July.*

*Inclusive Leadership Programme in 'roll out' with 100 Blood Supply colleagues and wider access planned over the remainder of the year*

*Complex Case Unit currently handling 6 cases and work is now underway following release of funds by D&I Board to redesign policy, roll out investigator and panel training for managers, TU colleagues and HR*

## Recruitment

- Time taken to recruit increased from 9.99 weeks to 10.97 weeks.
- Successful vacancies filled decreased slightly from 91% to 86% over this month.
- Turnover saw an increase to 12.48%.
- 85 new starters with 17 colleagues from an ethnic minority background. 60 leavers, 12 from an ethnic minority, representing a net increase of 5 ethnic minority colleagues.
- In Band 8 there were 6 leavers, 2 colleagues from an ethnic minority. 6 new Band 8 starters with 1 starter from an ethnic minority – a Net decrease of 1.

**Monthly Net increase in BAME staff +/- for all staff (Band 8a plus in brackets)**
+5 (-1)

**% new starters who are BAME (and Number Band 8A & Above in bracket)**
20% (16%)

**Time to Recruit –Req to Start (G= <14, A= >14, <15, R= >15)**
10.97

**No of vacancies filled (G= >90, A = <90, >75, R= <75%)**
86.33%

**Turnover G= <12, A = 13-20, R = >20%**
12.48%

## Leadership, Learning & Engagement

- PDPR up by 1% to 86%.
- 11 started leadership programmes, 2 in Inclusive leadership & 9 on the ALM
- 100 leaders in Blood Supply have commenced the Inclusive leadership programme, with Clinical Services starting their programme in July
- New style Peakon (People Survey) roll out Exec (Jul), SLT (Aug), whole organisation September

| Course | BME | % | Not Stated | % | White | % | Total |
|---|---|---|---|---|---|---|---|
| Advanced Line Manager | 2 | 22% | 0 | 0% | 7 | 78% | 9 |
| The Inclusive Leader | 0 | 0% | 0 | 0% | 2 | 100% | 2 |
| Total Delegates (May) | **2** | 18% | **0** | 0% | **9** | 82% | **11** |

**No. commencing leadership programmes**
11

**PDPR Compliance (G= >95, A= >80, <95, R= <80)**
86% ↑

**MT Compliance (G = >95, A=>80, <90 R= <80%)**
91% →

**NHSBT Engagement Score (n out of 10)**
7.8 →

## Case Resolution

- Live cases at month end June = 18 cases. 14 in SLA.
- 4 cases over-running vs SLA. 1 in BS– M&L and 3 in BS-Blood Donation.
- 3 of over-running cases are DaW, all associated with the same BD team and 1 is a Collective in BS – M&L.
- 1 of the 4 over-running cases involve BAME colleagues
- A total of 3 Dignity at Work/Grievance or counter grievances are registered for one Blood Donation team.
- 10 new cases in June 2021 = 3 Disciplinary, 4 Grievance, 2 DAW and 1 Probation.
- 12 cases closed in June with an average case time-line of 72 calendar days (skewed by one long-running case of 256 days).

**Protected Characteristics Live Cases month end**

| 5 BAME (28%) ↓ | 1 Disability (6%) ↔ | 1 LGBT+ (6%) ↑ | 10 Female (56%) |
|---|---|---|---|

## Freedom to Speak Up Themes

- 3x (unlinked) concerns about lack of supportive/safe
- working environment
- Concern around inclusive language
- Concern around support for a return to work

## Next Steps

- 'Speak Up' policy being updated.
- Permanent FTSU Guardian recruitment commenced.

**No. of new cases last period (last month in bracket)**
10 (3) ↑

**No. of closed cases last period (G = 80%+, A = 70-80%, R= less than 70%**
12 (83%)

**No. of live cases month end**
18 ↓
Current live cases within SLA (G= 80% plus, A = 70-80%, R= less than 70%)
14 (78%)

**No. of new FTSU cases last period (last month in bracket)**
5 (7)

**No. of cases closed in month**
6

**Av days open in Q1**
23

**No of Live cases**
3

# PEOPLE SERVICES: Director Report – Case Incidence Rates June 2021

**New this month**

## Cases Live at month end – June 2021

| Headcount | | Jan | Feb | March | April | May | June |
|---|---|---|---|---|---|---|---|
| 2,051 | BS - BD | 8 | 7 | 9 | 12 | 9 | 7 |
| 1,212 | BS - M&L | 3 | 5 | 5 | 4 | 5 | 6 |
| 671 | OTDT | 0 | 1 | 1 | 0 | 1 | 1 |
| 1,016 | CLINICAL | 2 | 1 | 2 | 2 | 2 | 0 |
| 188 | DEXP | 2 | 1 | 2 | 2 | 1 | 1 |
| 749 | GROUP | 1 | 3 | 4 | 5 | 2 | 3 |
| **5,887** | **NHSBT** | **16** | **18** | **23** | **25** | **20** | **18** |
| 908 | BAME | 5 | 3 | 5 | 7 | 8 | 5 |
| 4,055 | Female | 9 | 9 | 12 | 13 | 10 | 10 |
| 1,832 | Male | 5 | 6 | 9 | 11 | 8 | 6 |

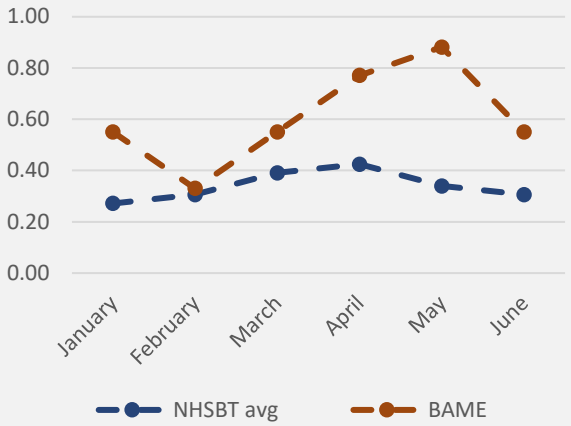
## Incidence Rates – June 2021

| Headcount | | Live Cases | Incidence Rate/100 Employees | Employees per Case |
|---|---|---|---|---|
| 2,051 | BS - BD | 7 | 0.34 | 293 |
| 1,212 | BS - M&L | 6 | 0.5 | 202 |
| 671 | OTDT | 1 | 0.15 | 671 |
| 1,016 | CLINICAL | 0 | 0 | N/A |
| 188 | DEXP | 1 | 0.53 | 188 |
| 749 | GROUP | 3 | 0.4 | 250 |
| **5,887** | **NHSBT** | **18** | **0.31** | **327** |
| 908 | BAME | 5 | 0.55 | 182 |
| 4,055 | Female | 10 | 0.25 | 406 |
| 1,832 | Male | 6 | 0.33 | 305 |

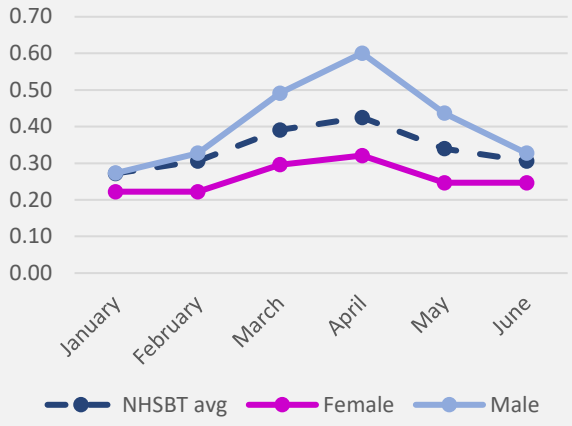
*Data includes conflict resolution casework (disciplinary, grievance, dignity at work, capability, probation). Excludes other forms of casework undertaken by the HR function.*

- *Protected characteristic definitions based on categories recorded in the NHS Electronic Staff Record (ESR) system.*
- *Reporting is limited to the category definitions*
- *available.*
- *Data is shown as live cases as month end*
- *and a live case may take more than one month to be closed.*

BAME - Live Cases at month end per 100 colleagues

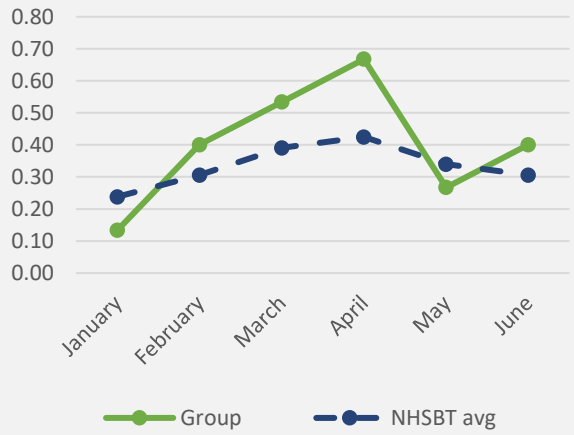



Male/Female - Live Cases at month end per 100 colleagues




**NB** – Directorate graphs showing the live cases at month end per 100 colleagues are available but not included due to space considerations – an example for Group Services is shown here – should these be included in future?

Group - Live Cases at month end per 100 colleagues



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

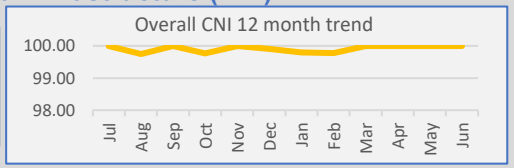
## Key DDTS Updates and Risks

- All key systems met their availability targets in June, but there was a service outage that caused business disruption within OTDT. Business continuity processes were implemented while the problem was resolved
- Strategic programmes remain on track, highlights include the Shared Server and Storage project migrating the first workloads successfully, Session Solution is moving into full implementation phase, the new Blood Donor app being prepared for launch into public beta in July and Blood Tech Modernisation delivering to plan.
- A first draft of a Data Strategy for NHSBT has been produced, reviewed with the Executives and is now being elaborated further with input from across all business areas
- A new release of capability to the Liver and Intestinal matching runs was delivered successfully and the monthly release of ServiceNow improved automation and implemented changes to the asset recovery processes
- DDTS and Donor Experience featured in Tech4Good magazine with a story and videos that will be used to support recruitment of donors and DDTS staff & our first 2 graduates were onboarded to the team.

## Key Systems Availability

### Critical National Infrastructure (CNI)

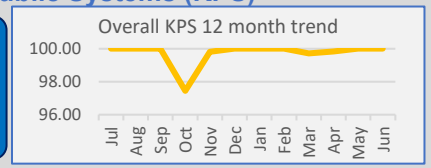
**Overall CNI Availability**: 100.00% ⇔




| Pulse (Target = 99.95%) | Hematos (Target = 99.95%) | National Transplant Database (NTxD) (Target = 99.95%) | Organ Donor Register (ODR) (Target = 99.95%) |
|---|---|---|---|
| 100% ⇔ | 100% ⇔ | 100% ⇔ | 100% ⇔ |

### Key Public Systems (KPS)

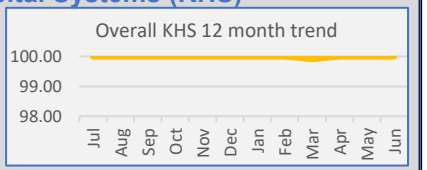
**Overall KPS Availability**: 100.00% ⇑




| Donor Portal (Target = 99.90%) | Corporate Websites (Target = 99.00) |
|---|---|
| 100% ⇔ | 100% ⇔ |

### Key Hospital Systems (KHS)

**Overall KHS Availability**: 100.00% ⇔

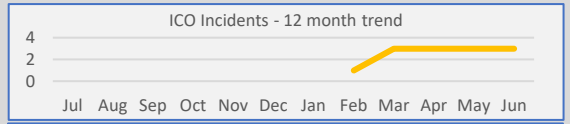



| Transport Mgt (Target = 99.70%) | Online Blood Ordering System (OBOS) (Target = 99.90%) | SO99 (Target = 99.90%) |
|---|---|---|
| 100% ⇔ | 100% ⇔ | 100% ⇔ |

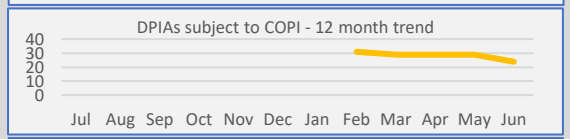
- All key services met their availability in June.
- A hardware failure affected Electronic Offering System (EOS) Web and Mobile services that are used to provide SNODs and Transplant Centres with core Donor Information and Medical and Social History information when offering organs. A standard workaround for EOS failures is for SNODS to contact the Organ Donation Hub and this workaround was implemented. ODT Online (Organ Donation Transplant Online Donor Registration system) was also affected, and recipient centres were not able to register new patients, update existing registrations or send patient follow-up and reverted to paper-based systems. Replacement of the hardware component restored service with additional hardware purchased to increase processing capacity with an anticipated July installation date.

## Cyber and Information Governance

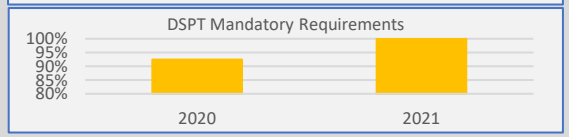
**ICO Incidents (Target =<5)**: 3 ⇔




**DPIAs subject to COPI**: 24 ⇓




**DSPT Mandatory Requirements (G = 100%; A = >90%; R = <90%)**: 100% ⇑




- **ICO Incidents:** Reportable Information Commissioner's Office (ICO) incidents from July 2020 until June 2021: there have been three reportable incidents. These are being actively managed by the Information Governance team in conjunction with the relevant affected Directorate. This metric is amber due to the long-running nature of one of the ICO incidents.
- **DPIA's subject to COPI:** The Data Protection Impact Assessments (DPIA) subject to Control of Patient Information (COPI): 31 data flows were reliant upon the COPI notice of which seven have been converted to remove reliance on COPI. The master DPIA for the NHS Digital data set (that underpins a majority of the COPI notices data flows) has been signed-off which allows for an expedited conversion process of the remaining 24 COPI-reliant data flows.
- **DSPT Mandatory Requirements:** The DSPT has seen a dramatic improvement on Training levels with a 99.2% compliance position for this category which is a marked improvement upon last years submission of 92.4%. NHSBT has met the minimum base-line standard for the DSPT return (i.e. mandatory requirement). Work over the current year will focus on strengthening the underlying capabilities and controls and satisfying the non-mandatory requirements.

NHS
Blood and Transplant

# 10. Finance Report (21-47)

For Report

Presented by Rob Bradburn

NHS Blood and Transplant

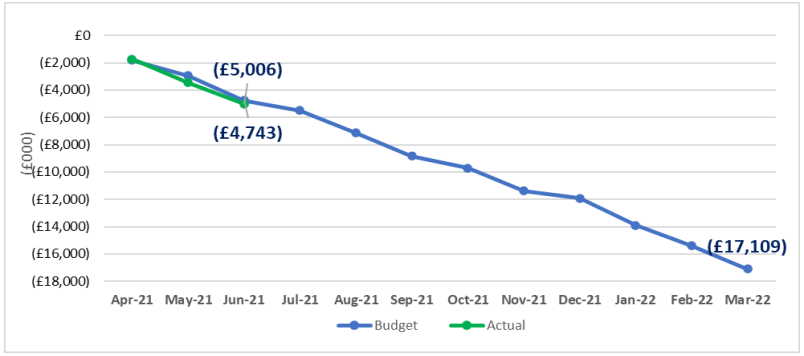
# NHSBT Finance Report

## June 2021

# 2021/22 Financial Performance Summary - June 2021

## Year to Date surplus of £0.6m (£4.0m ahead of plan)

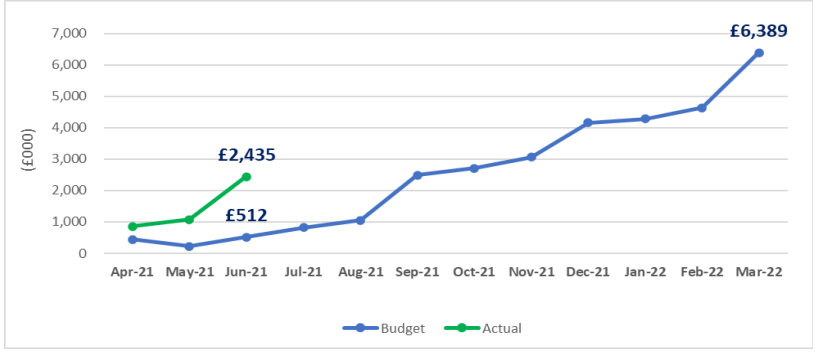
### Blood and Group: Net Income & Expenditure *(excl. Change Programme)*




**In line with plan but overspends in Blood Supply offset by positive variances in group services.**

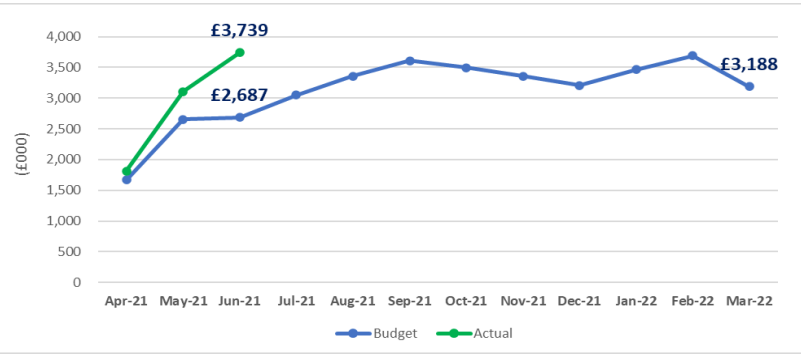
### Clinical Services Net Income & Expenditure

(excludes R&D and Directorate costs – reported as group services)



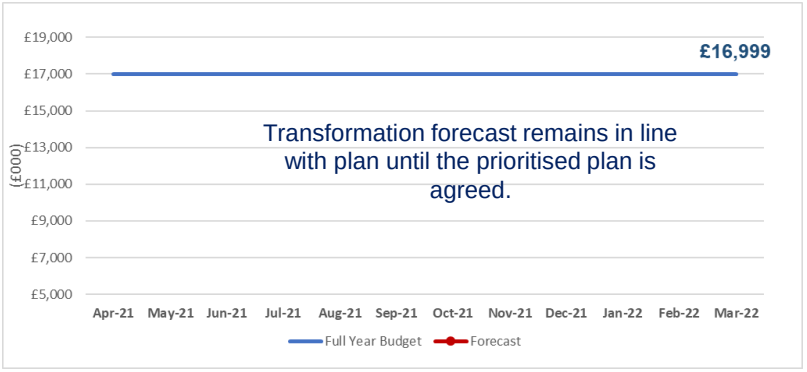

**£1.9m favourable variance – activity higher than (conservative) plan across most Business Units**

### Organ Donation & Transplantation: Net Funding & Expenditure



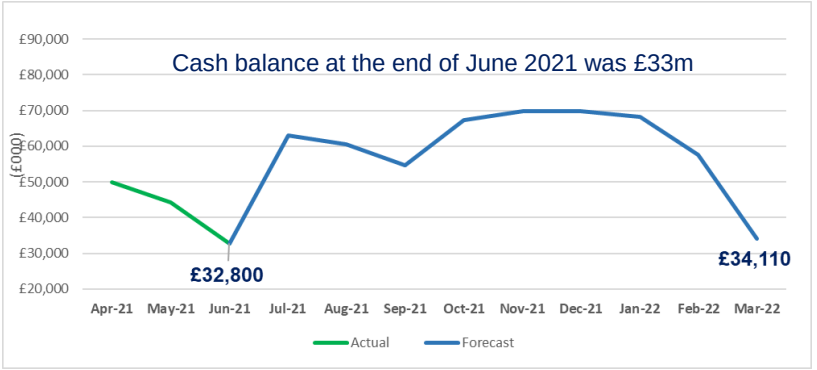

**£1.1m favourable variance due to lower activity and associated expenditure**

### Blood and Group Change Programme: Full Year Forecast



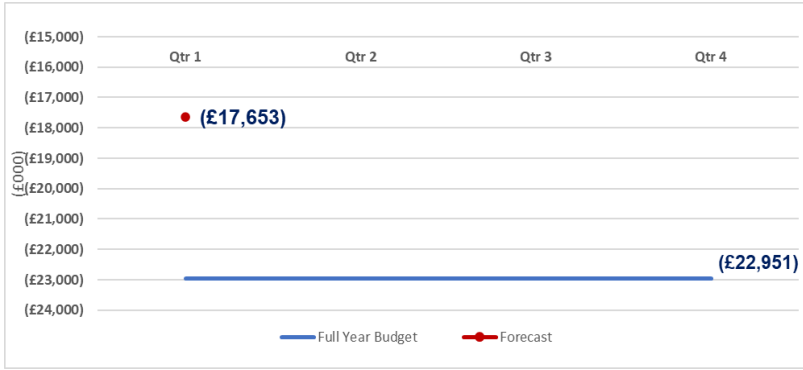

**Full Year budget is £17m.**

### NHSBT Cash Flow 2021/22



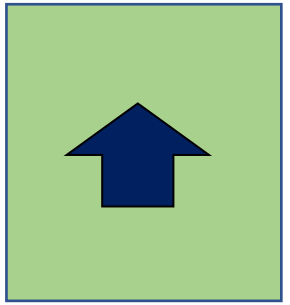
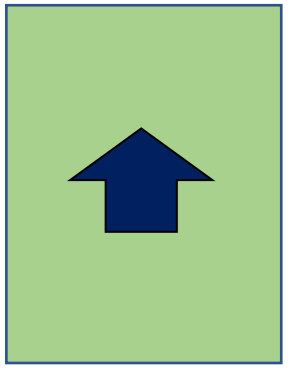
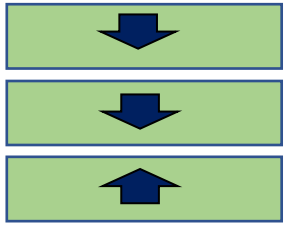

**Forecast closing cash balance at the end of March 2022 is £34.1m reflecting the Q1 reforecast**

### NHSBT I&E: Full Year Forecast




**Full year forecast is a deficit of £17.7m - £5.3m better than plan. Overspends in Blood Supply more than offset by positive variances in other Divisions.**

# 2021/22 NHSBT Financial Performance Headlines - June 2021

| | | | |
|---|---|---|---|
| Year to date I&E Position | +£0.6m surplus | **NHSBT reporting a surplus of £0.6m, £4.0m better than plan.**<br>• **Blood and Group** – in line with plan, albeit significant overspends in Blood Supply (£2.4m) offset by positive variances in group services. See page 5 for detail.<br>• **Clinical Services (+£1.9m)** – increased activity (income) versus a conservative budget.<br>• **ODT (+£1.1m)** –lower expenditure as a result of lower activity levels than plan.<br>• **TES (+£0.9m)** – increased sales income (mainly Bone and Ocular) versus a conservative budget. |  |
| Full year forecast | -£17.7m deficit | **Forecast full year outturn is a deficit of £17.7m, £5.3m better than plan**<br>• **Blood and Group (-£4.3m) –** full year effect of adverse Blood Supply expenditure plus a decline in red cell stock (fixed cost movement is stock).<br>• **Clinical Services (+£1.6m) –** activity higher than conservative plan (especially Stem Cells, RCI and TAS)<br>• **ODT (+6.2m)** – lower activity expenditure (forecast based on 1,550 donors, 147 lower than plan). In addition, income includes the cost of an additional NORS team that is not being mobilised.<br>• **TES (+£1.8m) –** full year effect of higher sales income versus a conservative plan**.** |  |
| Cash and Debtors | Cash balance £33m | • Debtor days finished at 14 days - 8 days ahead of target.<br>• 90+ overdue remains at £0.5m (in line with target).<br>• Closing cash balance at the end of June 2021 is £33m. The forecast cash balance at the end of March 2022 has increased to £34m. |  |

**Budget** – following review and approval by the Finance and Performance Committee the budget has been amended to reflect the correct / agreed DHSC funding for ODT (increasing the budget deficit from £18.4m to £23.0m). The budget has also been updated to include funding and expenditure for Plasma for Medicines and further cross Directorate transfers driven by the Operating Model changes (both have nil net effect).

**Covid -19** - costs of £8.5m were included in blood prices (and budget) to cover anticipated Covid costs. This included £1.5m for additional touch point cleaning, £2.0m for additional collection staff, £0.7m higher venue costs and £0.8m for additional pop up venues, with the balance being for contingency (£2m) and to cover a potential lost/uncovered contribution in TES. At Q1 the estimate is £6.5m reflecting yet higher costs in blood collection being more than offset by release of contingency and a higher TES contribution. Underlying this the primary issue is understanding what baseline cost for blood collection will be carried forward in 2022/23 prices given major uncertainties re how social distancing/infection control will impact the operating model and related costs.

*Arrow direction indicates the direction of performance vs previous month. Colour demonstrates performance against standards and expectations*

# Financial Performance by Division – Year to Date June 2021 (full I&E statement on page 6)

## Surplus of £0.6m (£4.0m better than plan)

| Blood Supply | Year to Date | | |
|---|---|---|---|
| (£)m | Bud. | Act. | Var. |
| Income | 73.7 | 74.3 | 0.6 |
| Plasma Funding | 0.0 | 9.1 | 9.1 |
| Expenditure | (40.3) | (43.3) | (3.0) |
| Plasma Expenditure | (0.0) | (9.1) | (9.1) |
| **Surplus/(Deficit)** | **33.4** | **31.0** | **(2.4)** |

Excluding the impact of lower stocks (cost of sales) Blood Supply was overspent by £1.7m in Q1 driven by high temporary staff and overtime usage. It also includes higher venue hire costs (and a larger venue hire team), as existing venues continue to be excluded for use on safety grounds, and the impact of unwinding the closure of the CVP project. This has been fully analysed, with excess costs now being reduced, but leaving an overspend for the year currently estimated at £2.7m.

| Group Services | Year to Date | | |
|---|---|---|---|
| (£)m | Bud. | Act. | Var. |
| Income | 4.0 | 4.0 | 0.0 |
| Expenditure | (42.0) | (39.9) | 2.1 |
| Blood and Group Transformation | (2.1) | (1.7) | 0.4 |
| **Surplus/(Deficit)** | **(40.2)** | **(37.7)** | **2.6** |

Small surpluses against budget across most Group Services. Cost are, however, under pressure due to additional resources needed to support high transactional volumes as a result of ongoing changes and plasma/OFH initiatives. Note that £0.6m of unallocated Covid contingency is reported with in the Group YTD position, partially offsetting overspends in Blood Supply.

| | | | |
|---|---|---|---|
| **Blood and Group Surplus/(Deficit)** | **(6.9)** | **(6.7)** | **0.2** |

| Clinical Services | Year to Date | | |
|---|---|---|---|
| (£)m | Bud. | Act. | Var. |
| Income | 16.1 | 17.1 | 1.0 |
| Expenditure | (14.9) | (14.5) | 0.4 |
| Change Programme | (0.7) | (0.2) | 0.5 |
| **Surplus/(Deficit)** | **0.5** | **2.4** | **1.9** |

Activity is higher than (a conservative) plan – especially in TAS and RCI.

| Organ Donation & Transplantation | Year to Date | | |
|---|---|---|---|
| (£)m | Bud. | Act. | Var. |
| Income | 20.4 | 19.9 | (0.5) |
| Expenditure | (16.5) | (15.3) | 1.2 |
| Change Programme | (1.2) | (0.9) | 0.3 |
| **Surplus/(Deficit)** | **2.7** | **3.7** | **1.1** |

Activity levels are highly variable but overall >10% lower than plan and hence driving operational underspends. This includes NORs costs where income assumes an additional team, although this is not currently being planned for 2021/22.

| Tissues and Eye Services | Year to Date | | |
|---|---|---|---|
| (£)m | Bud. | Act. | Var. |
| Income | 3.4 | 4.0 | 0.6 |
| Expenditure | (3.1) | (2.9) | 0.3 |
| **Surplus/(Deficit)** | **0.2** | **1.1** | **0.9** |

Activity is higher than (a conservative) plan – especially in corneas, bone and skin.

| | | | |
|---|---|---|---|
| **NHSBT Total** | **(3.4)** | **0.6** | **4.0** |

# Financial Performance by Division – Full Year Forecast as at Q1 2021 (full I&E statement on page 6)

## Deficit of £17.7m (£5.3m better than plan)

| Blood Supply | Forecast Full Year Outturn | | |
|---|---|---|---|
| (£)m | Bud. | Fcst. | Var. |
| Income | 295.1 | 295.2 | 0.1 |
| Plasma Funding | 46.0 | 53.0 | 7.0 |
| Expenditure | (156.8) | (161.8) | (5.0) |
| Plasma Expenditure | (46.1) | (51.9) | (5.8) |
| **Surplus/(Deficit)** | **138.2** | **134.5** | **(3.8)** |

The full year effect of the overspends seen in Q1 will be limited to £2.7m as much of the excess cost is reduced. This cost pressure is partially offset by the remaining Covid contingency that is reported in Group Services (£1.3m).

The forecast also assumes an adverse (non-cash) variance for cost of sales of £2.3m based on forecast red cell stock of 26.3k units at March 2022 (versus an opening stock of 42.5k units).

| Group Services | Forecast Full Year Outturn | | |
|---|---|---|---|
| (£)m | Bud. | Fcst. | Var. |
| Income | 16.0 | 16.3 | 0.3 |
| Expenditure | (171.3) | (172.2) | (0.9) |
| Blood and Group Transformation | (17.0) | (17.0) | 0.0 |
| **Surplus/(Deficit)** | **(172.4)** | **(172.9)** | **(0.5)** |

Key expenditure movements against budget;
- People & Finance (-£0.8m) – use of temporary staff and consultancy predominately responding to operating model changes and support required for plasma / OFH bid etc.
- Buying/selling annual leave cost pressure (-£1.3m).
- Covid Contingency (+£1.3m) – partially offsets the adverse variances in Blood Supply.

| Blood and Group Surplus/(Deficit) | (34.1) | (38.4) | (4.3) |
|---|---|---|---|

| Clinical Services | Forecast Full Year Outturn | | |
|---|---|---|---|
| (£)m | Bud. | Fcst. | Var. |
| Income | 70.9 | 72.0 | 1.1 |
| Expenditure | (60.8) | (60.6) | 0.2 |
| Change Programme | (3.7) | (3.3) | 0.4 |
| **Surplus/(Deficit)** | **6.4** | **8.0** | **1.6** |

Full year effect of higher activity, especially in RCI, TAS and Stem Cells.

| Organ Donation & Transplantation | Forecast Full Year Outturn | | |
|---|---|---|---|
| (£)m | Bud. | Fcst. | Var. |
| Income | 81.5 | 81.0 | (0.5) |
| Expenditure | (66.3) | (63.4) | 3.0 |
| Change Programme | (12.0) | (8.2) | 3.7 |
| **Surplus/(Deficit)** | **3.2** | **9.4** | **6.2** |

Full year effect of reduced activity directly driven by Covid and the favourable impact from not increasing NORS.
The forecast assumes 1,550 donors versus a plan of 1,697.

| Tissues and Eye Services | Forecast Full Year Outturn | | |
|---|---|---|---|
| (£)m | Bud. | Fcst. | Var. |
| Income | 14.3 | 16.0 | 1.7 |
| Expenditure | (12.7) | (12.7) | 0.0 |
| **Surplus/(Deficit)** | **1.6** | **3.3** | **1.8** |

Increased sales income across most products (against a conservative plan).

| NHSBT Total | (23.0) | (17.7) | 5.3 |
|---|---|---|---|

| Period Budget £k | Period Actual £k | Period Variance £k | Blood and Group | Year to date Budget £k | Year to date Actual £k | Year to date Variance £k | Full year 2020-21 Actual £k | Full year Budget £k | Full year Q1 Forecast £k | Full year Variance £k |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1,652 | 1,652 | Programme Funding - Convalescent Plasma | 0 | 9,083 | 9,083 | 57,623 | 0 | 6,956 | 6,956 |
| 0 | 0 | 0 | Programme Funding - Plasma for Medicines | 0 | 0 | 0 | 0 | 46,044 | 46,044 | 0 |
| 958 | 958 | 0 | Programme Funding - Corporate | 2,725 | 2,725 | 0 | 11,061 | 10,900 | 10,900 | 0 |
| 24,402 | 24,500 | 98 | Blood & Components Income | 72,862 | 73,339 | 477 | 280,280 | 291,747 | 291,854 | 107 |
| 287 | 350 | 63 | Blood Supply Other Income | 801 | 928 | 127 | 3,165 | 3,313 | 3,313 | 0 |
| 186 | 164 | (22) | Clinical Services - Research & Development | 559 | 528 | (31) | 2,000 | 2,377 | 2,567 | 190 |
| 87 | 62 | (25) | Clinical Services Income - Medical | 260 | 239 | (21) | 1,228 | 1,042 | 879 | (163) |
| 140 | 163 | 23 | Group Services Other Income | 406 | 490 | 84 | 3,385 | 1,652 | 1,973 | 321 |
| **26,062** | **27,850** | **1,789** | **Blood and Group Income** | **77,613** | **87,332** | **9,719** | **358,742** | **357,075** | **364,486** | **7,411** |
| (440) | (1,099) | (659) | Cost of Sales - Blood Component Stock Movement | (1,089) | (2,431) | (1,342) | (515) | 0 | (2,267) | (2,267) |
| 0 | (1,637) | (1,637) | Convalescent Plasma | (22) | (9,090) | (9,068) | (57,623) | (22) | (6,956) | (6,934) |
| 0 | (18) | (18) | Plasma for Medicines | 0 | (18) | (18) | 0 | (46,044) | (44,944) | 1,100 |
| (5,469) | (5,402) | 67 | Blood Supply: Blood Donation | (16,386) | (17,216) | (830) | (61,816) | (65,267) | (66,673) | (1,406) |
| (6,079) | (6,103) | (23) | Blood Supply: Manufacturing, Testing & Issue | (17,787) | (18,279) | (492) | (68,195) | (71,831) | (72,656) | (825) |
| (1,797) | (1,714) | 82 | Blood Supply: Logistics | (5,027) | (5,360) | (333) | (20,293) | (19,693) | (20,191) | (498) |
| (65) | (54) | 11 | Chief Executive and Board | (194) | (157) | 37 | (644) | (780) | (780) | 0 |
| (1,969) | (1,388) | 581 | Donor Experience | (4,863) | (4,003) | 860 | (18,252) | (20,531) | (20,757) | (226) |
| (700) | (656) | 44 | Quality | (1,767) | (1,637) | 131 | (5,625) | (7,208) | (7,218) | (10) |
| (3,538) | (3,564) | (27) | Estates & Facilities | (10,743) | (10,534) | 210 | (45,278) | (44,767) | (44,384) | 383 |
| (472) | (539) | (67) | Finance | (1,654) | (1,755) | (101) | (6,982) | (6,641) | (7,112) | (471) |
| (157) | (178) | (21) | Strategy and Transformation | (573) | (656) | (83) | (1,871) | (2,283) | (2,554) | (270) |
| 200 | 168 | (32) | Business Transformation Services | (152) | (191) | (39) | (1,675) | (616) | (533) | 83 |
| (825) | (1,035) | (210) | People | (2,475) | (2,761) | (286) | (9,510) | (10,112) | (10,398) | (286) |
| (3,416) | (3,240) | 177 | Digital, Data and Technology Services | (9,754) | (9,362) | 392 | (34,923) | (40,448) | (40,777) | (329) |
| (792) | (956) | (164) | Change Programme | (2,126) | (1,694) | 432 | (12,701) | (16,999) | (16,999) | 0 |
| (394) | (356) | 38 | Clinical Services: Research & Development | (1,177) | (1,066) | 111 | (4,835) | (5,346) | (5,536) | (190) |
| (1,498) | (1,358) | 140 | Clinical Services: Medical | (4,320) | (4,069) | 251 | (15,600) | (16,971) | (16,436) | 535 |
| (1,241) | (1,234) | 8 | Miscellaneous and Capital Charges | (4,371) | (3,754) | 617 | (32,073) | (15,625) | (15,735) | (110) |
| **(28,652)** | **(30,362)** | **(1,710)** | **Blood and Group Expenditure** | **(84,482)** | **(94,033)** | **(9,551)** | **(398,412)** | **(391,183)** | **(402,905)** | **(11,721)** |
| **(2,591)** | **(2,512)** | **79** | **Blood and Group Total** | **(6,869)** | **(6,700)** | **168** | **(39,670)** | **(34,108)** | **(38,419)** | **(4,310)** |
| | | | **Clinical Services (DTAS)** | | | | | | | |
| 130 | 130 | 0 | Programme Funding - Diagnostics, Therapeutic Apheresis & Stem Cells | 1,040 | 1,040 | 0 | 4,173 | 4,162 | 4,162 | 0 |
| 5,624 | 6,203 | 580 | Diagnostic and Therapeutic Services Income | 15,063 | 16,087 | 1,024 | 58,602 | 66,747 | 67,810 | 1,063 |
| **5,754** | **6,334** | **580** | **Clinical Services Income** | **16,103** | **17,127** | **1,024** | **62,774** | **70,909** | **71,972** | **1,063** |
| (5,125) | (4,830) | 295 | Clinical Services: Diagnostics, Therapeutic Apheresis and Stem Cells | (14,911) | (14,469) | 442 | (53,520) | (60,780) | (60,624) | 156 |
| (340) | (149) | 191 | Clinical Services: Diagnostics, Therapeutic Apheresis and Stem Cells Change Programme | (680) | (223) | 457 | (903) | (3,740) | (3,326) | 414 |
| **(5,465)** | **(4,979)** | **486** | **Clinical Services Expenditure** | **(15,591)** | **(14,692)** | **899** | **(54,423)** | **(64,520)** | **(63,949)** | **570** |
| **289** | **1,355** | **1,065** | **Clinical Services Total** | **512** | **2,435** | **1,923** | **8,351** | **6,389** | **8,022** | **1,633** |
| | | | **Organ Donation & Transplantation** | | | | | | | |
| 5,216 | 5,726 | 510 | Programme Funding - Organ Donation & Transplantation | 17,157 | 17,160 | 3 | 62,327 | 68,627 | 68,627 | 0 |
| 0 | (443) | (443) | Programme Funding - Organ Donation and Transplantation - Opt Out | 0 | (304) | (304) | 11,509 | 0 | 0 | 0 |
| 278 | 78 | (200) | Organ Donation & Transplantation - NHSE Income | 833 | 525 | (308) | 1,617 | 3,333 | 2,185 | (1,148) |
| 1,123 | 1,018 | (105) | Organ Donation & Transplantation - UKHDs & Other Income | 3,220 | 3,060 | (160) | 12,553 | 12,879 | 12,371 | (508) |
| **6,617** | **6,379** | **(238)** | **ODT Income** | **21,210** | **20,441** | **(769)** | **88,006** | **84,839** | **83,183** | **(1,656)** |
| (5,608) | (5,027) | 581 | OTDT - Organ Donation and Transplantation | (16,476) | (15,299) | 1,178 | (55,260) | (66,350) | (63,360) | 2,990 |
| (975) | (719) | 257 | OTDT - Organ Donation and Transplantation Change Programme | (2,046) | (1,403) | 643 | (14,860) | (15,302) | (10,413) | 4,889 |
| **(6,583)** | **(5,745)** | **838** | **ODT Expenditure** | **(18,523)** | **(16,702)** | **1,821** | **(70,120)** | **(81,652)** | **(73,773)** | **7,879** |
| **34** | **633** | **599** | **ODT Total** | **2,687** | **3,739** | **1,051** | **17,886** | **3,188** | **9,411** | **6,223** |
| | | | **Tissues and Eye Services** | | | | | | | |
| 1,207 | 1,376 | 170 | Tissue & Eye Services Income | 3,377 | 4,016 | 639 | 11,994 | 14,298 | 16,000 | 1,703 |
| (83) | (83) | 0 | Programme Funding - Tissues Services | 0 | 0 | 0 | 0 | 0 | 0 | |
| **1,123** | **1,293** | **170** | **TES Income** | **3,377** | **4,016** | **639** | **11,994** | **14,298** | **16,000** | **1,703** |
| (63) | (64) | (2) | Cost of Sales - Tissues Stock Movement | (188) | (107) | 81 | (727) | (750) | (750) | 0 |
| (1,002) | (1,019) | (17) | OTDT - Tissue and Eye Services | (2,957) | (2,773) | 183 | (10,850) | (11,967) | (11,917) | 50 |
| **(1,064)** | **(1,083)** | **(19)** | **TES Expenditure** | **(3,144)** | **(2,880)** | **264** | **(11,577)** | **(12,717)** | **(12,667)** | **50** |
| **59** | **210** | **151** | **TES Total** | **233** | **1,136** | **903** | **417** | **1,580** | **3,333** | **1,753** |
| | | | **NHSBT Summary** | | | | | | | |
| **39,556** | **41,856** | **2,300** | **Income** | **118,303** | **128,916** | **10,613** | **521,516** | **527,121** | **535,641** | **8,521** |
| **(41,764)** | **(42,170)** | **(406)** | **Expenditure** | **(121,739)** | **(128,307)** | **(6,567)** | **(534,532)** | **(550,072)** | **(553,294)** | **(3,222)** |
| **(2,208)** | **(314)** | **1,894** | **NHSBT Surplus/(Deficit)** | **(3,436)** | **610** | **4,046** | **(13,016)** | **(22,951)** | **(17,653)** | **5,299** |

# Cash Flow – as at June 2021

| | Actual Apr-21 £k | Actual May-21 £k | Actual 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Opening bank balance** | **53,211** | **49,942** | **44,169** | **32,800** | **62,978** | **60,303** | **54,372** | **66,802** | **69,597** | **69,590** | **68,049** | **57,511** | **53,211** |
| Receipts | | | | | | | | | | | | | |
| Debtors & Other Receipts | 33,878 | 35,028 | 37,837 | 34,526 | 30,228 | 35,953 | 38,825 | 33,948 | 33,600 | 35,432 | 33,786 | 38,352 | 421,392 |
| Revenue Cash Limit | 0 | 0 | 0 | 24,267 | 6,067 | 6,067 | 6,067 | 6,067 | 6,067 | 6,067 | 6,067 | 6,067 | 72,800 |
| Revenue Cash Limit - Pensions Uplift | 824 | 0 | 0 | 3,633 | 908 | 908 | 908 | 908 | 908 | 908 | 908 | 908 | 11,724 |
| Revenue Cash Limit - Plasma for Medicines | 0 | 0 | 0 | 9,880 | 5,390 | 5,390 | 5,390 | 5,390 | 5,390 | 5,390 | 5,390 | 5,390 | 53,000 |
| Capital Cash Limit | 0 | 0 | 0 | 3,000 | 0 | 0 | 5,000 | 0 | 3,000 | 0 | 5,000 | 5,000 | 21,000 |
| **Total Receipts** | **34,702** | **35,028** | **37,837** | **75,306** | **42,593** | **48,318** | **56,190** | **46,313** | **48,965** | **47,797** | **51,151** | **55,717** | **579,916** |
| Payments | | | | | | | | | | | | | |
| Staff Expenses | 15,253 | 20,370 | 20,881 | 20,871 | 20,120 | 20,419 | 20,564 | 21,584 | 23,012 | 20,577 | 21,064 | 27,006 | 251,723 |
| Other Revenue Payments | 22,286 | 19,669 | 27,681 | 23,635 | 24,425 | 22,822 | 22,173 | 21,180 | 24,521 | 26,822 | 26,500 | 44,212 | 305,927 |
| 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 | 762 | 644 | 500 | 600 | 700 | 900 | 1,000 | 1,500 | 2,000 | 4,000 | 7,962 | 21,000 |
| **Total Payments** | **37,971** | **40,801** | **49,205** | **45,006** | **45,145** | **54,125** | **43,638** | **43,764** | **49,033** | **49,400** | **61,749** | **79,180** | **599,017** |
| **Closing bank balance** | **49,942** | **44,169** | **32,800** | **63,100** | **60,547** | **54,740** | **67,292** | **69,841** | **69,773** | **68,171** | **57,572** | **34,110** | **34,110** |

| | | | |
|---|---|---|---|
| **Debtor Days (Target is 22 days)** | 16 | 17 | 14 |
| **YTD BPPC By Value % (Target is 95%)** | 92.2% | 97.5% | 91.3% |
| **YTD BPPC By Number % (Target is 95%)** | 94.3% | 99.2% | 94.9% |

| **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** |
|---|---|---|---|---|---|
| **Total Overdue Debtors** | **4,533** | **2,451** | **571** | **497** | **8,052** |

| **Notional Split** | **£m** |
|---|---|
| Blood | 14.2 |
| Clinical Services | 6.3 |
| ODT | 13.6 |
| | **34.1** |

| | **May-21** | | | **Jun-21** | | |
|---|---|---|---|---|---|---|
| **Top 5 > 90 days Overdue Debtors £000's** | **>90 Days overdue £000's** | **Total Overdue £000's** | | **>90 Days overdue £000's** | **Total Overdue £000's** | **Comments** |
| LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | | | | 141 | 519 | Challenges in relating to Blood and Component billing. Escalated to Trust DoF. |
| LEEDS TEACHING HOSPITALS NHS TRUST | 65 | 325 | | 54 | 123 | |
| MID AND SOUTH ESSEX NHS FOUNDATION TRUST | | | | 45 | 153 | |
| GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST | 48 | 225 | | 34 | 129 | |
| GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUN | 40 | 173 | | 33 | 72 | |
| UNIVERSITY OF BRISTOL | 77 | 77 | | | | |
| BUCKINGHAMSHIRE HEALTHCARE NHS TRUST | 20 | 352 | | | | |
| **Total 5 Overdue Debtors** | **249** | **1,152** | | **307** | **997** | |
| Other Debtors | 217 | 8,566 | | 191 | 7,055 | |
| **Total Overdue Debtors** | **467** | **9,718** | | **497** | **8,052** | |

| **>90 DAYS OVERDUE** | **Profile by Month** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Target Range Between £0.5m and £1.0m** | **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** |
| **Ledger Balance at month end** | **369** | **467** | **497** | | | | | | | | | |
| **Target** | **500** | **500** | **500** | **500** | **500** | **500** | **500** | **500** | **500** | **500** | **500** | **500** |

# Contribution Statement - as at June 2021

| Year to date Actual £m | Blood & Components inc. R&D | Diagnostics | | Stem Cells | | | TAS | TES | ODT | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| | | RCI | H&I | CMT | CBC | SCDT | | | | |
| **Income** | | | | | | | | | | |
| Prices | 74.1 | 5.1 | 3.1 | 2.7 | - | 1.1 | 3.2 | 4.0 | - | 93.3 |
| Central Funding from DHAs | - | - | - | - | - | - | - | - | 3.0 | 3.0 |
| Grant in Aid | 11.0 | 0.1 | 0.1 | 0.1 | 0.0 | 1.1 | 0.1 | 0.1 | 17.4 | 30.0 |
| Other | 1.4 | 0.2 | 0.1 | 0.1 | 0.4 | 0.0 | 0.1 | - | 0.6 | 2.9 |
| **Total Income** | **86.6** | **5.4** | **3.3** | **2.9** | **0.4** | **2.1** | **3.3** | **4.1** | **20.9** | **129.1** |
| | | | | | | - | | | | |
| **Expenditure** | | | | | | - | | | | |
| Variable Costs | | | | | | | | | | |
| Consumables | (6.7) | (0.5) | (1.0) | (0.5) | (0.3) | (0.2) | (0.8) | (0.6) | (0.8) | (11.4) |
| Other | - | - | - | - | - | - | - | - | - | - |
| **Total Variable Costs** | (6.7) | (0.5) | (1.0) | (0.5) | (0.3) | (0.2) | (0.8) | (0.6) | (0.8) | (11.4) |
| **Variable Contribution** | **79.9** | **5.0** | **2.2** | **2.4** | **0.1** | **1.9** | **2.6** | **3.5** | **20.1** | **117.7** |
| Direct Costs | | | | | | | | | | |
| Cost of Sales | (2.4) | - | - | - | - | - | - | (0.1) | - | (2.5) |
| Pay | (29.9) | (2.4) | (1.7) | (1.3) | (0.4) | (0.8) | (1.1) | (1.8) | (8.0) | (47.2) |
| Non Pay | (12.9) | (0.1) | (0.2) | (0.3) | (0.0) | (0.3) | (0.2) | (0.7) | (7.2) | (21.9) |
| **Total Direct Costs** | (45.2) | (2.5) | (1.8) | (1.6) | (0.4) | (1.0) | (1.3) | (2.6) | (15.2) | (71.7) |
| **Direct Contribution** | **34.7** | **2.5** | **0.4** | **0.8** | **(0.4)** | **0.9** | **1.2** | **1.0** | **4.9** | **46.0** |
| Direct Support | | | | | | | | | | |
| Operational Directorate costs | (4.2) | (0.7) | (0.2) | (0.2) | (0.1) | (0.1) | (0.1) | (0.2) | (0.7) | (6.4) |
| Logistics | (4.8) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (4.9) |
| Clinical | (2.4) | (0.1) | - | (0.0) | - | (0.1) | (0.1) | (0.0) | (0.3) | (2.9) |
| Attributable Estates costs | (5.7) | (0.4) | (0.2) | (0.3) | (0.0) | (0.1) | (0.0) | (0.3) | (0.2) | (7.3) |
| Attributable IT costs | (5.0) | (0.3) | (0.2) | (0.1) | (0.0) | (0.1) | (0.0) | (0.1) | (1.1) | (6.9) |
| Depreciation / Cost of Capital | (0.4) | (0.2) | (0.1) | (0.1) | (0.0) | (0.0) | (0.1) | (0.1) | (0.1) | (1.1) |
| **Total Direct Support** | (22.4) | (1.7) | (0.7) | (0.8) | (0.1) | (0.4) | (0.3) | (0.8) | (2.4) | (29.5) |
| Notional Internal Income Uplift | (0.5) | 0.1 | 0.5 | 0.0 | (0.0) | (0.1) | - | 0.0 | (0.0) | 0.0 |
| **Contribution to Unallocated Costs** | **11.7** | **0.9** | **0.2** | **0.1** | **(0.5)** | **0.4** | **0.9** | **0.2** | **2.6** | **16.5** |
| **Total Allocated Costs** | **(74.8)** | **(4.5)** | **(3.1)** | **(2.9)** | **(0.9)** | **(1.8)** | **(2.4)** | **(3.9)** | **(18.4)** | **(112.6)** |
| Unallocated Costs Apportioned | | | | | | | | | | |
| Directorate costs | (5.3) | (0.5) | (0.3) | (0.3) | (0.1) | (0.2) | (0.3) | (0.4) | (2.3) | (9.8) |
| Estates costs | (1.3) | (0.1) | (0.1) | (0.1) | (0.0) | (0.0) | (0.1) | (0.1) | (0.5) | (2.3) |
| Depreciation / Cost of Capital | (0.3) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.1) | (0.5) |
| **Total Unallocated Costs** | (6.9) | (0.7) | (0.4) | (0.4) | (0.1) | (0.3) | (0.3) | (0.6) | (2.9) | (12.6) |
| **Operating Net Surplus / (Deficit)** | **4.9** | **0.3** | **(0.2)** | **(0.4)** | **(0.6)** | **0.1** | **0.6** | **(0.3)** | **(0.4)** | **3.9** |
| Transformation Costs | (1.7) | (0.1) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | - | (1.4) | (3.3) |
| **Total Allocated Costs Inc Transformation** | **(76.5)** | **(4.6)** | **(3.1)** | **(2.9)** | **(0.9)** | **(1.8)** | **(2.5)** | **(3.9)** | **(19.8)** | **(116.0)** |
| **Net Surplus / (Deficit) Inc Transformation** | **3.2** | **0.2** | **(0.2)** | **(0.4)** | **(0.7)** | **0.1** | **0.5** | **(0.3)** | **(1.8)** | **0.6** |
| **Budget (YTD)** | **2.6** | **(0.3)** | **(0.1)** | **(0.7)** | **(0.7)** | **(0.3)** | **(0.1)** | **(1.2)** | **(2.7)** | **(3.4)** |
| **Variance** | **0.6** | **0.5** | **(0.2)** | **0.3** | **0.0** | **0.4** | **0.6** | **0.9** | **0.9** | **4.0** |
| **RAG STATUS (Actuals V Plan)** | **G** | **G** | **R** | **G** | **G** | **G** | **G** | **G** | **G** | **G** |

**Notes:**
1 Unallocated costs are apportioned based on the aggregate of all Allocated Costs.
2 Clinical services management and Transformation costs allocated prorata across Clinical Services Operting units using allocated costs as a basis.
3 IBGRL & Reagents now included in RCI and SCDT includes BBMR & CBB.
4 This report is indicative and subject to ongoing review/update as per the work plan below:
Q2-Q3 2021/22 - Operating model changes and Support Cost driver updates, to be reflected from M01 2022/23
Q1 2022/23 - Costing principles relating to overhead allocations resulting from impact of Plasma for Medicines
Q1 2023/24 - Costing principles relating to Direct Cost allocations resulting from impact of Plasma for Medicines

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# Tea/Coffee Break

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# 11. Strategy Update (21-48)

For Discussion

Presented by Tracey Barr

NHS Blood and Transplant

**NHSBT Board**

**Corporate Strategy Development**

**Progress Update and Emerging Strategic Priorities**

22 July 2021

**Status - Official**

## 1. Summary and Purpose of Paper

To inform the development of the corporate strategy we have spoken to key opinion leaders to understand how NHSBT is perceived by our partners in the health and care system and to get their insights on the changing landscape we are operating in, the role we play and how we can maximise the value we add and the impact we have. We have also spoken to each of the Non-Executive Directors to hear their thoughts on questions the corporate strategy must answer, the challenges and opportunities the strategy must respond to and the issues it must address and get their perspective as to what makes an 'excellent' corporate strategy.

The purpose of this paper is to update the Board on where we are in the process, to share the work we have done on mapping the eco-systems we operate in, to provide a synthesis of what we have heard and the insights we have gleaned from our discussions and to share and test our early emerging thoughts on the strategic priorities.

## 2. Action Requested

We would very much welcome a discussion on what we heard from our interviews and the insights we have taken from these. The Board is asked to provide feedback on the emerging strategic priorities to inform our ongoing work

## 3. Corporate Development Strategy: Where we are in the process

In May 2021 we kicked-off the process to develop a corporate strategy for NHSBT for the next 3 to 5 years. Our aim is to formally launch the strategy in March 2022. The first stage of our process is to develop an overarching set of strategic priorities for the organisation which we will bring to the Board in September 2021.

To inform and shape these priorities we are progressing four key areas of work:

- **Horizon Scanning**: Review of the changing external landscape to identify the key opportunities and challenges the strategy will need to respond to together
- **Interviews**: A programme of interviews with Non-Executive Directors and key opinion leaders across the system to get an external perspective into how the organisation is perceived and the key issues that the corporate strategy must address.
- **Workshops**: A series of workshops have been held with Executive Team, structured around the 4 strategic shifts – system leadership, proactive and clinically responsive, modern and agile and a top choice for talent/great place to work for everyone.
- **Stocktake:** Review of the corporate strategy work that was completed pre-Covid and a stocktake of the strategy work that is underway within the individual services and functional areas and mapping of their emerging priorities to the 4 strategic shifts.

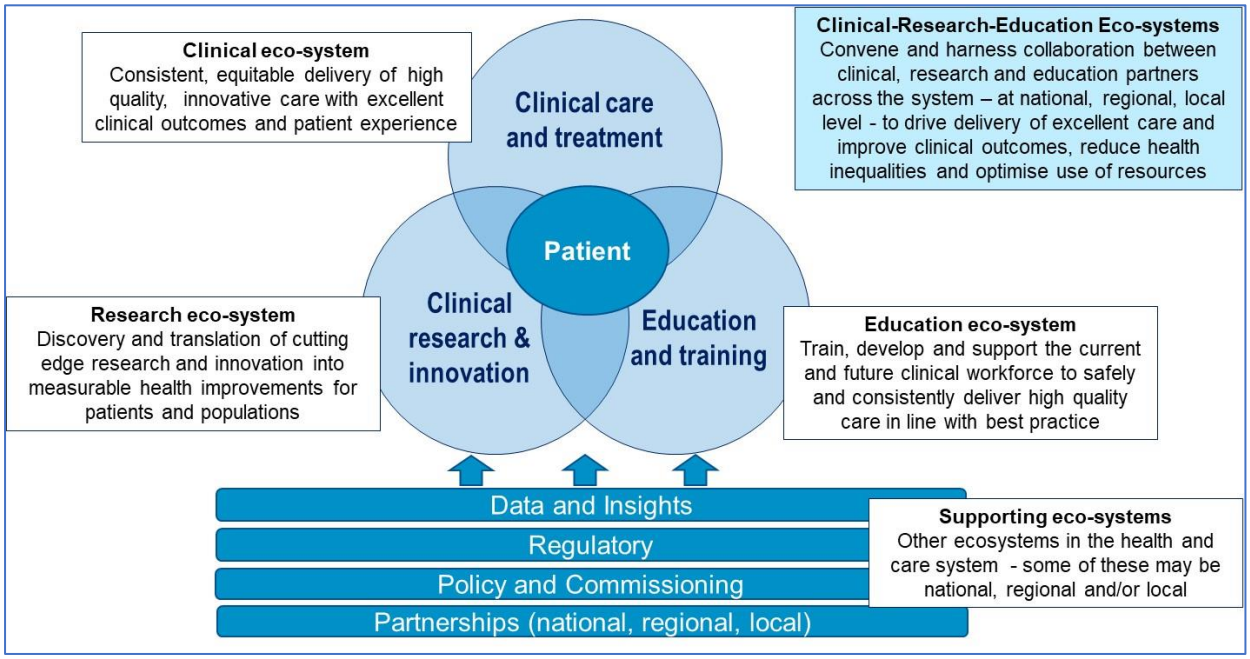
The following sections of this paper provide an update on the ecosystem mapping work we have progressed, the interviews we have undertaken and the key insights we have gleaned from those together with our emerging thoughts on the strategic priorities.

## 4. Our role in the system:

As a health care organisation NHSBT has a responsibility that extends beyond being an efficient, effective supplier of products and services. Our role extends to ensuring their proper, effective use by clinicians and in helping tackle complex problems that span boundaries in those eco-systems we operate in, especially where there is a vacuum or lack of clear leadership, or responsibility, for bringing parties together to resolve them.

Following the May Board, we have mapped the eco-systems across which NHSBT operates. This highlights that our work spans three interlinked eco-systems – clinical, research and education – with the patient at the centre. We are also part of other supporting eco-systems in the health and care system – including data and insights, regulatory, policy and commissioning, partnerships – which underpin the three patient facing systems.

Figure 1: The eco-systems we operate in




We already play an important role in each of these eco-systems in those areas where we have deep specialist expertise – transfusion, transplantation, therapeutics – and play a very distinctive and unique role as a national specialist provider of donor products and services. However, internally we spend the majority our time talking about the clinical ecosystem and, externally, some of the work we do in clinical care and treatment and much of what we do in research and education flies below the radar.

Raising the awareness of what we do and increasing our influence in the system along with ensuring that within NHSBT our clinical, research, education and supporting strategies are

aligned will enable us to improve clinical outcomes, reduce health inequalities and optimise the use of resources and deliver our mission 'to save and improve even more lives'.

## 5. Synthesis: Insights - Non-Executive Directors Interviews

Since the May Board meeting we have conducted 1:1 interviews with each of the Non-Executive Directors to hear their thoughts on the questions the corporate strategy must answer, the challenges and opportunities the strategy must respond to and the issues it must address and their perspectives as to what makes an 'excellent' corporate strategy.

The key insights we have taken away from these discussions are summarised below:

- **An excellent supply chain and an excellent health care organisation:** We are at the heart of the NHS family. Being an excellent supplier of critical products and services to the NHS is the foundation for - and underpins our ability to be - an excellent health care organisation. Being lean, efficient and best value is important but we are also uniquely placed to use our data and insights to identify variation in performance, quality and access and gaps in provision and use our role and relationships to reduce variation and drive improvements in patient care where we have specialist knowledge and expertise.
- **Clarity and alignment:** The corporate strategy must provide clarity and alignment amongst the Executive Team and the Board, as well as for those partners across the system, as to the type of organisation we are, the level of our ambition, the strategic choices we have and which of these will be our priority areas of focus for the next 3 to 5 years and why. It must be outcome-led and clearly define the 'end' point, the impact, and outcomes we are looking to achieve and what success will look like.
- **Realistic in our ambitions:** Being ambitious is welcomed but we need to be realistic and recognise we will be operating in an environment where resources are constrained and that we have a lot of work to do internally. We need to be careful not to try to take on too much and make sure we have our own house in order before we progress to being a systems leader. Given limited resources we will have to make difficult strategic choices about where we will focus on in the next 3 to 5 years and where we will not.
- **The NHSBT 'glue':** A key question the corporate strategy needs to address is 'what are the connections between the individual businesses that sit beneath the NHSBT umbrella and what are the synergies that come from those connections?'. What makes NHSBT unique as an organisation, and underpins all our businesses, is the donor and donation. Delivering a consistently excellent donor experience and ensuring we have the right mix and volume of donors is fundamental to the success of all our businesses, although the experience is very different between the individual businesses. We also need to set out what we see to be other synergies, such as research, education and corporate services.
- **Data and Insight:** We need a clear data strategy aligned to the corporate strategy. Speed and access to data, and our efficient use of it, will be key to driving productivity and continuous improvements across our businesses. It will also provide us with the flexibility to respond quickly to changes in supply and demand. There is a lot of data across the system that we are not owners of but are uniquely placed to leverage to provide actionable insights that we can use to influence the system, drive improvements and innovations in patient care. We also have important data that is very valuable to the system that can be used to predict future diseases, to identify underlying changes in population health and to extend our research reach and impact.

- **Efficiency and Productivity:** Productivity has slipped off the agenda, but it is important that we increase our focus on it again. During Covid-19 a lot of cost has been added into the organisation (and the system) but, as we move into the recovery phase, the need to focus on our cost base and take costs out will be high on the DH agenda. Given a high proportion of our costs are people, modernisation of our roles, practices and ways of working and optimising the use of automation and digital will be important. We also need to ensure we are optimising the use of our footprint and physical infrastructure.

- **Quality and Safety:** Quality, safety and resilience are paramount and underpin everything we do and needs to be explicitly recognised. There is a concern that by focusing our discussions around the strategic shifts that this will get lost. Covid-19 has demonstrated the resilience of our services and our ability to continue to deliver care while NHS Trust services had to close. Our corporate strategy must balance quality, safety, resilience and sufficiency of supply with being lean, efficient and cost effective.

- **Actively promote the NHSBT Brand**: We need to build and promote our reputation and brand and better articulate the entirety of what NHSBT does (all our clinical services and our research and education activities which are integral to what we do), the role we play and the impact we have in the system. We have a strong international reputation and standing and well-established relationships which we should promote and continue to leverage to have a greater impact.

- **Elevate the conversations:** We need to elevate the conversations from being largely operational and transactional in nature to a more strategic level, within and outside NHSBT. We also need to shift the focus internally from being centred on blood supply and pricing to broader conversations that embrace the whole organisation. We engage widely and have excellent relationships at local levels, but our current approach to stakeholder management is fragmented and operationally focused. We need to elevate these conversations to a strategic level and ensure we are having the a joined-up conversation with the right people and the NHSBT voice is heard at the top table.

- **Greater collaboration:** We need to strengthen our relationships with strategic partners across the system and demonstrate how, through working closer together, we could help them to deliver their clinical and research priorities and how they could help deliver ours. With the structural changes that are happening in the NHS it will be particularly important to stay close to NHS England and make sure that we are at the table and involved in decisions that will impact the organisation and our individual businesses. We should also work closer with academic bodies to anticipate and influence proposed changes in clinical practice that will impact demand for our products and services.

- **Research and Innovation:** We are well-placed to drive advances in clinical practice that improve clinical outcomes in our areas of expertise and our research capabilities and connections are strong. Plasma, stems cells and therapeutics and genotyping in particular all offer opportunities for growth but we can’t do everything. We need to consider our core competencies, decide where we want to play, where we are best placed to have an impact and where others may be better placed. We need to look forward beyond the 5-year horizon and outward from NHSBT to anticipate how future trends will impact our core business and think about it from the perspective of NHSBT overall. We also need to develop a consistent way across the business to commercialise our research and knowledge to scale and translate it into practice.

- **Workforce and Culture:** This needs to be broader than diversity and inclusion and responding to the Globis report. It should cover all the elements from the cost base and operational needs, through to the skills, capabilities and behaviours we need to develop to deliver the strategy, including both the hard technical skills and softer leadership and influencing skills across the organisation, as well as the entire career pathway life cycle within NHSBT. Hybrid ways of working are here to stay. Our focus over the past year has been on the technical infrastructure to support it but we need to shift culturally to embedding and embracing it.

- **Prevention and Health Inequalities:** Tackling health inequalities has to very much be on our agenda and is a key priority for the system as a whole, We have a role and responsibility, using our data and insight, to support the development of prevention strategies and reduction of health inequalities with a focus on those areas where we can impact. We need to shift the weight of our conversations from internally focused ones on diversity and inclusion to more externally focused ones on tackling health inequalities.

- **Strategic Roadmap and Measures of Success:** We need to set out a strategic roadmap with timelines and milestones for the short (12 months), medium (1 to 3 years) and long (3 to 5 years) term together with clear metrics to enable us to track and monitor progress in implementing the strategy and measure success. The detailed actions, deliverables and responsibilities for the next 12 months should set out the most important elements that will be critical to the delivery of the longer-term plans.

## 6. Synthesis: Insights - Key Opinion Leader Interviews

We are also progressing a programme of interviews with key opinion leaders from across the health and care system. These interviews have been led by the CEO, supported by the interim strategy lead. To date we have spoken to the following:

- Prof. Steve Powys, CMO, NHS England
- Chris Wrigley, CEO, Genomics England
- Prof. Gillian Leng, CEO, NICE
- Matthew Gould, CEO, NHSX
- Allan Marriott-Smith, CEO, Human Tissue Authority

The emerging insights from the discussions we have so far are summarised below:

- **Well respected and trusted:** NHSBT is widely seen to be a solid, safe, reliable and trusted organisation, a very safe pair of hands that is doing a good job. We are well-respected and seen to play a core and fundamental role (‘a part of the fabric’) in the health and care system as a supplier of critical products and services. Our people are seen to be passionate about, and committed to, the best possible outcomes for patients.

- **An international leader:** We have a well-earned international reputation and are seen to be world-leading in in our blood and transplant services, for example in technological innovation (in transplantation) and in ethics, quality and safety. However, we may be better known and more visible internationally than we are in our national market.

- **Below the radar**: However, we are not seen to be innovative, an influencer or strategic as an organisation and much of the work we do, especially in research and innovation and in education and training is below the radar. However, people know from individual conversations at a personal level that we are innovators in our field. A challenge for

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NHSBT will be to find the right balance between being safe, reliable and everyday ('cake') vs. being exciting and innovative ('icing on the cake').

- **Poor understanding of NHSBT:** All those we spoke to did not have a good understanding either of (i) the breadth of businesses and activities that are undertaken within NHSBT or (ii) the 'wiring' and how all the different elements sit, or fit, together (a capillary system of veins). In fact, the feedback was that the name 'NHSBT' in itself is confusing - some think the 'T' is transport, not transplantation. We need to do a much better job of articulating who we are, what we do and how we are 'wired.
- **Raise our profile:** Our deep, narrow specialist expertise means that we don't have the regular engagement with partners at the senior level nationally that other ALBs have and, as a result, are not included in the top table forums where decisions are being made. We need to get much closer to our key partners and ensure the NHSBT 'voice' is represented at top table, especially with NHS England which is becoming increasingly important. Building relationships with [one of] the Regional NHSE Directors would be a good route to this as they are involved in every discussion and decision.
- **Align with system priorities:** Recovering elective services and tackling the Covid backlog will dominate the agenda for the health and care system in the short-term. NHSBT needs to be able to clearly articulate the contribution it can make to 'building back better' and demonstrate the impact it has. Our work on convalescent plasma is very high profile and crucially important to both NHSE and NHSBT. Longer term the two NHS England priorities that our strategy must align to and support delivery of are (i) tackling health inequalities (inc. equality of access to blood and organs) which has risen up the agenda during the pandemic; and (ii) delivery of the NHS Long Term priorities, including cardiovascular and respiratory disease, stroke, prevention and anti-microbial resistance. However, the appointment of a new NHS CEO might change these.
- **Collaboration and Co-production:** Our low visibility in the system means we are missing opportunities to collaborate with our partners in areas that would benefit both parties as well as the wider system. Each conversation has identified opportunities for working closer together on shared priorities. The work on organ utilisation review (Steve Powys is the Chair) is a great opportunity to build a stronger and more strategic relationship with NHS England. There are opportunities to collaborate with NICE on the development of best practice guidelines to drive the reduction of variation in clinical practice in transfusion, transplantation and therapeutics, drawing on our data and evidence; and there are opportunities to engage in NHS England's Evidence Based Interventions programme to reduce unwarranted variation in clinical practice.
- **Data and insight:** NHSX is driving interoperability and data standards to support end-to-end data integration and traceability and there is an opportunity for NHSBT to be an exemplar in the system on integrating data and using it to generate insights to drive improvement. However, we will need to be very clear and set out the data that we need. We are also well placed to drive a learning perspective across the system from a safety and quality perspective, but this will require a culture of more openness earlier.

## 7. Emerging Strategic Priorities

Building on the diagnostic work we have done, the workshops we have with Executive Team between May and July and reflecting on our conversations we have had with key opinion leaders and Non-Executive Directors, we have started to document some early thoughts on the strategic priorities for the organisation which we are keen to test with the Board.

**Please note these are very much work-in-progress but we are keen to share and test our emerging thoughts with the Board.**

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We currently see four emerging priorities for the corporate strategy:

1. **Operational Excellence:**

   **We will maintain our reputation as a safe, reliable, resilient and cost-effective provider of critical donor products and services to the NHS**

   We are trusted in the NHS for our safety and reliability and admired internationally for our cost effectiveness, productivity and innovation. This will require a continued focus on quality, clinical governance and risk management, an enhanced focus on efficiency and productivity as well as investments in new technology and continuous improvement.

2. **Donor Management:**

   **We will strengthen our donor base to ensure we have the right volume and mix to meet evolving clinical demand**

   We recognise that everything we do depends on the public being willing and able to donate. We will reinvigorate our approach to donor engagement to ensure we have the right volume and mix of donors to meet new requirements and evolving clinical demand.

3. **System Leadership**

   **We will leverage our unique position and what we know to drive improvements in clinical outcomes and health equalities across the system**

   We will look to raise our profile and the impact of the work we do across the rest of the health system, leveraging our national footprint and specialist expertise to drive improvements in clinical outcomes, health equalities and use of resources. We will do this through training and education; research and development; the provision of data and actionable insights; and working with partners to minimise variation in clinical access and outcomes.

4. **Workforce and Culture**

   **We will make NHSBT a great place to work *for everyone***

   We will improve the diversity of our workforce and develop a psychologically safe and inclusive culture. We will invest in leadership, culture and talent development and look to modernise our ways of working. We will develop strategic workforce plans to ensure we have the right people, skills and capabilities to deliver our plans.

## 8. Next steps

We will continue the work to develop, test and refine the strategic priorities across the organisation, building on what we have heard from the interviews and the work we are doing internally with the individual services and functions.

We are running a workshop on 11th August with the leads of the service strategies and enabling strategies to ensure that the emerging 'top down' corporate strategy priorities and 'bottom up' service priorities are aligned and that the enabling strategies reflect and support their delivery. In September we will bring an updated set of corporate strategic priorities together with underlying strategic objectives and proposed measures of successes that have been approved by ET to the Board for review, discussion and approval.

**Tracey Barr, Interim Strategy Lead**

**14 July 2021**

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# 12. Blood Tech Modernisation Programme Update (21-49)

For Report

Presented by Wendy Clark

NHS Blood and Transplant

**NHSBT Board/Committee**

**Blood Tech Modernisation Programme – Status Update**

22nd July 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. This paper provides the board with an update on progress. Progress remains consistent with the Full Business Case as approved at the Jan 21 Board.

## 2. Action Requested

The Board is asked to note that:

the programme is delivering to plan.

- a Change Request to use £315k of contingency funds has been approved by the Portfolio board; and
- the overall programme risk position has improved.

## 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. The next major release of capability is due in September and the first release of new converted code in January 2022.

There were challenges this period with unplanned absences within the test team. Impact to plans is being mitigated by a contract let to Edge for test support. Change request (CR) of £315K (from contingency) approved within the tolerances of the Portfolio Board. September's final release of Legacy changes has been delayed by 1-week, due to this issue but there is no knock-on impact to future release schedule.

The overall programme risk position has improved. The risk of new unplanned work arising from Plasma for Medicine (PFM) has reduced as we understand more about their requirements. The risk of not securing new resource has also diminished as a result of a successful campaign, which has seen a diverse mix of new joiners and internal progressions appointed to the team.

Discovery work to provide the Business with improved access to Pulse data through the Integration Modernisation and Data Ecosystem workstreams has started earlier than initially planned.

Finance approved budget includes the £315K approved CR for temporary test augmentation. There is £185K remaining contingency from a total of £500K for FY21/22. We are currently forecasting at £80K over budget (within contingency for FY21/22), we expect to mitigate this through cost actions.

**Sign off**

Next Board report September 2021. 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: July 21**

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## Blood Technology Modernisation

# NHSBT Board Report

# Programme Summary - July

**Reporting date: 09/07/2021**
**SRO:** Wendy Clark
**Accountable Exec**: Christie Ash

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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 until Sep/Oct as estimate assumptions are tested and validated. Forecasts have been estimated for remaining programme incremental scope complete from Sep onwards to meet targets.
- Discovery work has started to provide the Business with access to Pulse data through the Integration Modernisation and Data Ecosystem workstreams.
- Change request of £315K (from contingency) to manage delays in testing due to unplanned resource constrains in testing team approved within the tolerances of the Portfolio Board. Contract awarded to test partner, Edge who have started to provide incremental capacity. See appendix for detail.
- September's final release of Legacy changes has been delayed by 1-week, due to delays to testing resourcing issues. No knock-on impact to future release schedule.
- A diverse mix of new joiners and internal progressions have been appointed to the team. Recruitment campaign continues to plan.
- We continue to work closely with the Plasma Programme Team to understand and Impact Assess any new demand. Expecting a decision on scope by the end of July.
- Finance approved budget includes the £315K approved CR for temporary test augmentation. Over forecast of £80K (within contingency) expected to be mitigated through cost actions
- The overall programme risk position has improved; the risk of new unplanned work arising has reduced as a consequence of greater certainty of Plasma for Medicine (PFM) demand; the risk of not securing new resource has also diminished as a result of a successful recruitment campaign.

Key Performance Indicators

| Progress against plan | | | Budget/spend | | | Scope | | | Quality | | | Benefits | | | Leadership Continuity | | | Vendor Relationship | | | Engagement Scores | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | Engagement | | | Enablement | | |
| 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 |
| G | G | ↘ | G | G | ⇨ | G | G | ⇨ | G | A | ↗ | G | G | ⇨ | G | G | ⇨ | G | G | ⇨ | G | G | ⇨ | G | G | ⇨ |
| 25.4 Delayed by 1-week Expected downward trend due to possible CRs from PfM | | | £315k of revenue contingency approved to fund unforeseen testing resource cover | | | | | | QA processes for Testing taking longer to agree than planned, causing testing delays | | | Benefits defined and baseline measurements taken | | | Several leadership vacancies | | | No concerns | | | February – 5.0<br>April – 5.1<br>May – 4.7<br>(out of 6) | | | February – 5.1<br>April – 5.1<br>May – 5.0<br>(out of 6) | | |

Risks and Issues

| Type | ID | Description | Inherent Risk | | Mitigation Actions / Resolutions | Residual Risk | Owner |
|---|---|---|---|---|---|---|---|
| | | | Impact | Likelihood | | | |
| R | Prg-071 | 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 | 3 | • Reducing likelihood due to increased confidence in ROM estimates following completion of a growing number of detail specifications. Actual effort consistent with detail estimates. | Very High | CA |
| R | Prg-070 | 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. | 3 | 4 | • Reducing impact owing to deployment of new ways of working (i.e.: detail release plans enable rapid impact assessments to support decisioning and mitigation planning).<br>• Reducing likelihood due to improved long-term planning (i.e.: deployment of an effective demand management process and increased visibility of potential PfM demand). | High | CA |
| R | Prg-079 | 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 | 3 | • Reducing impact and likelihood due to appointment of key roles and a smaller residual proportion of roles being vacant. CR raised and approved by Programme Board to align residual recruitment with detail delivery plans. | High | CA |

Budget Update

| Summary (Jun) | |
|---|---|
| Approved budget (£k) | **£ 4,483** |
| May Spend (£k) | **£ 264** |
| Cumulative Spend (£k) | **£ 577** |
| Forecast for this FY (£k) | **£ 4,564** |
| **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 |

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

NHS Blood and Transplant

**Reporting Date: 09/07/2021**
**SRO:** Wendy Clark
**Accountable Exec**: Christie Ash

# Progress against scope

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 Plan | Jul '21 Actual | 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% | 84% | 92% | 96% | 100% | **100%** | 100% | | | | |
| Legacy Delphi Delivery | | n/a | **51%** | 51% | 51% | 51% | 70%* | 51% | 100% | 100% | **100%** | 100% | | | | |
| C# Upgrade | - Requirements Definition | 15% | **13%** | 13% | 25% | 30% | 30%* | 46% | 46% | 53% | **57%** | 50% | 80% | 95% | 100% | |
| | - Design and build | 5% | **6%** | 6% | 7% | 8% | 10% | 10% | 14% | 17% | **tbc** | 25% | 50% | 75% | 100% | |
| | - Test | 0% | **0%** | 0% | 2% | 0% | 3%* | 0% | 9% | 10% | **tbc** | 20% | 45% | 70% | 100% | |
| | - Accept and Deploy | 0% | **0%** | 0% | 0% | 0% | 0% | 0% | 0% | 10% | **tbc** | 15% | 40% | 65% | 100% | |
| | - Decommission | 5% | **0%** | 0% | 0% | 0% | 0% | 3% | 3% | 5% | **9%** | 10% | 30% | 55% | 80% | 100% |
| Data Ecosystem & Power BI | | 0% | **0%** | 0% | 0% | 0% | 1% | tbc | tbc | tbc | **20%** | 20% | 75% | 100% | | |
| Database Modernisation | | 0% | **0%** | | | | | | | | | 0% | 5% | 25% | 50% | 100% |
| Integration Modernisation | | 0% | **0%** | 0% | 0% | 0% | 1% | tbc | tbc | tbc | **5%** | 5% | 10% | 25% | 75% | 100% |
| Budget % of overall (excl. VAT) | | n/a | **12%** | 15% | 15% | 19% | 19% | 22% | 26% | 29% | **31%** | 31% | 47% | 64% | 80% | 98% |

84% July actual for Product Centre Enablement due to the pushback on Business enablement activities whilst we re-establish the test team capability

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.

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

**Key Delivery Milestones**

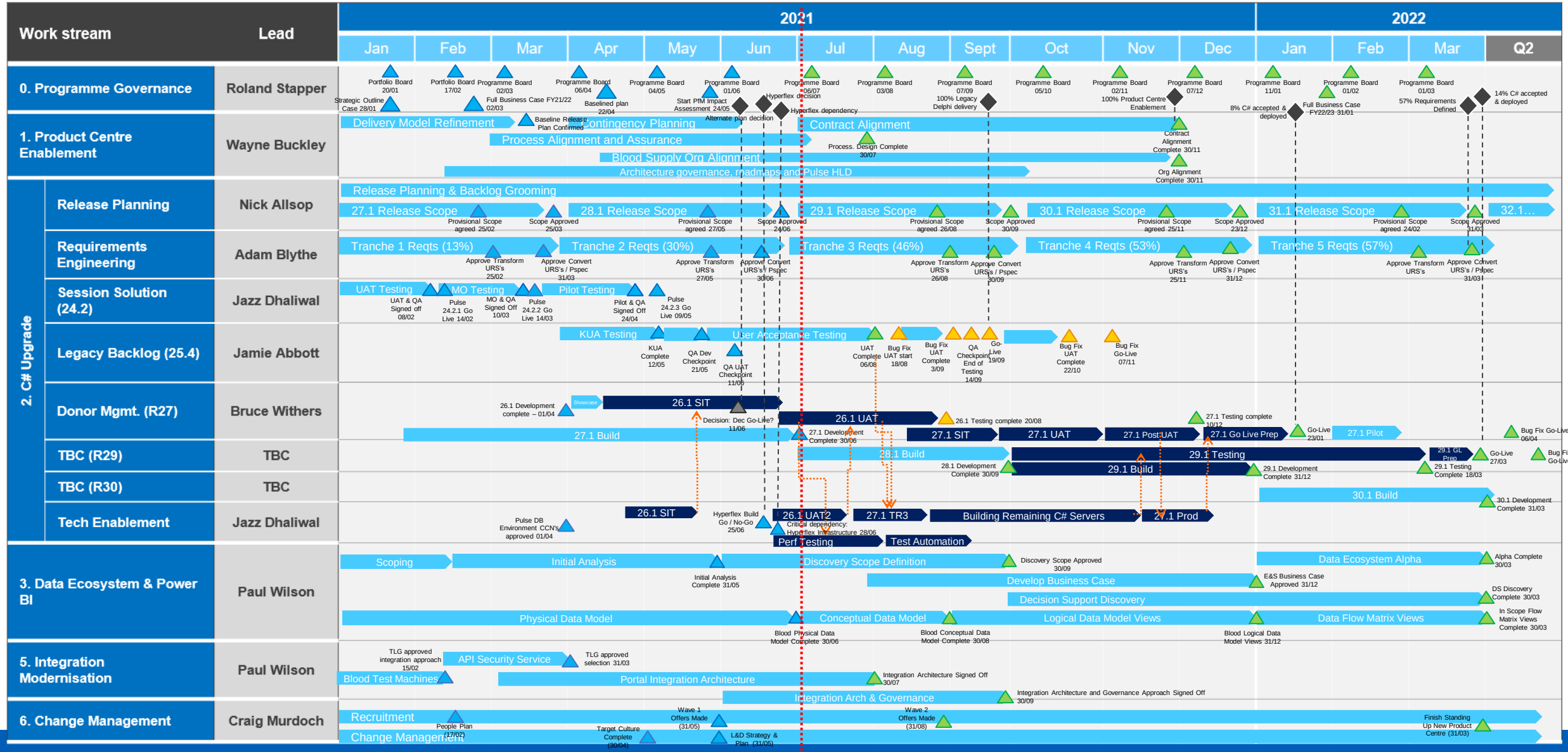
| Workstream | Milestone Description | Baseline Date | Forecast Date | RAG | Commentary |
|---|---|---|---|---|---|
| C# Upgrade | Donor Management (R27) Build Complete | 30/06 | 30/06 | C | Complete |
| Change Management | Wave 1 Offers Made | 31/05 | 31/05 | C | Complete |
| Legacy Delphi Delivery | 25.4 Go Live | 19/09 | 26/09 | A | Anticipate 1-week delay to go-live due to resource constrains |
| C# Upgrade | Donor Management (R28) Build Complete | 30/09 | 30/09 | G | |

# Integrated Programme Plan

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

Key: Milestone; Activity; Critical path; Key dependency

NHS Blood and Transplant



NHS Blood and Transplant

# Supporting slides

NHS Blood and Transplant

# A1: Key performance indicators explained

| KPI | Measure | Green | Amber | Red |
|---|---|---|---|---|
| **Progress against plan** | 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%. |
| **Budget/spend** | Budget remaining vs. forecast to end of FY | Finances are under control and within tolerances set.<br>**Under-spend**: If no tolerances set, then any favourable variance is within 90 -100% of Budget. | **Over-spend (forecast or actual)**: 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.<br>**Under-spend**: If no tolerances set, then any favourable variance forecast is between 85% & 90% of Budget. | **Over-spend (forecast or actual)**: 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.<br>**Under-spend**: If no tolerances set, then any favourable variance forecast is below 85% of Budget or £100K under-spend whichever is smaller. |
| **Scope** | 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. |
| **Quality** | 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. |
| **Benefits** | 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%. |
| **Leadership continuity** | % 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. |
| **Vendor relationship** | 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. |
| **Engagement scores** | 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% | 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% | 100% |
| 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

- 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.

## How Product Centre Enablement delivery % is measured

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

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

- Blood Power BI and Integration Modernisation are mobilising in Q2. Initial activities will be discovery and detailed deliverables planning.
- The delivery percentage plan was based on a high-level estimate and will be firmed up as planning gets under way.

## How Budget % is measured

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

# A3: Alt Test Sourcing Model CR - BTMCR-2021.01

| Ref | Title | Description | Drivers | Budget |
|---|---|---|---|---|
| BTMCR-2021.01 | **Alt Test Sourcing Model** | We will temporarily augment the Testing team with up to 6 partner resources through a Government Cloud tender.<br><br>The trained resources need to be supplied very quickly and stay through to Go-Live of the first C# release early 2022.<br><br>In anticipation of this CR being approved, a zero-commitment tender was issued to seven potential partners; with responses due back on 22/06. Resourcing Partner, Edge was appointed on 28/06 with the new team mobilising from 5th July. | An acute resource shortage in the Testing team developed, due to several factors:<br>• Upcoming maternity leave (BTM Test Manager)<br>• Resignation of existing skilled resource<br>• Contracts of existing FTC resources ending with individuals not committing to extend<br>• Unplanned absence due to ill health<br>• The recruitment of new Perm and FTC resource taking longer than anticipated<br>• A backlog building up in Testing team due to current resource shortage | The approved budget for FY21/22 excluding VAT and contingency is £4,168,000. Contingency for the year is £500,000.<br><br>This CR is for a FY21/22 budget increase of £315,000. This is made up of a total tender value of £459,000 and a contribution out of the existing budget for Testing of £143,000. The £143,000 relates to funding previously allocated to test resource not presently in post and the deferral of some FTC post appointments to better align with release delivery plans. Of the £315,000 increase, £95,000 relates to maternity leave cover which would normally be handled as a BAU cost pressure.<br><br>The increase of £315,000 is within the Revenue budget contingency of £400,000, and within the £700,000 approval authority of the Portfolio Board.<br><br>Approval of this CR will increase the approved FY21/22 programme budget from £4,168,000 to £4,483,000.<br><br>This CR has no impact on the budget of future years. |

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# 13. Reports from the UK Health Departments

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# 13.1. England (no written report provided)

For Reference

NHS
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# 13.2. Northern Ireland (21-50a )

For Reference

**NHSBT Board Meeting – 22 July 2021**

**Written update from Northern Ireland**

Introduction of an Opt-out System for Organ Donation

Following confirmation of support from the First Minister and deputy First Minister, the draft Organ and Tissue Donation (Deemed Consent) Bill had its first reading in the NI Assembly on 5 July 2021.

This will now allow subsequent stages to be timetabled within the remainder of the mandate and, subject to Assembly agreement, the Bill would be passed into law in the Spring of 2022.

Officials will now work with NHSBT and other relevant stakeholders in preparation for the upcoming scrutiny stages of the legislative process.

Organ Donation Promotion

The NI Organ Donation Promotion Manager continues to work with various stakeholders to roll out a series of promotional events.

The focus in the coming weeks will be on Organ Donation Week in September; however, given the recent introduction of legislation in the Assembly, initial plans are also being developed for public information campaigns both before and after implementation of an opt-out system for organ donation.

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Blood and Transplant

# 13.3. Scotland (21-50b)

For Reference

**NHSBT BOARD**
**SCOTTISH GOVERNMENT UPDATE**

## Donation and Transplantation Plan for Scotland: 2021-2026

- The implementation plan continues to be developed with the establishment of working groups, along with their memberships and terms of reference and an update will be provided at the Scottish Donation and Transplant Group (SDTG) meeting on 19 August.

## Donation and Transplantation in Scotland

- Due to increasing pressures on the NHS elective activity in the Royal Infirmary of Edinburgh has been cancelled until the end of July. This includes living kidney donation.

- All other Transplant units in Scotland are open and functioning as normal

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

- The final Opt out Programme Board meeting took place on 02 June where highlights from an evaluation of the law change public awareness campaign was presented.

- An update on the evaluation of the programme will be provided at the SDTG meeting on 19 August before the Monitoring and Evaluation Plan, Baseline Report, and Qualitative Study with NHS staff are published in September 2021.

**Scottish Government**
**July 2021**

NHS
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# 13.4. Wales (no written report provided)

For Reference

NHS
Blood and Transplant

# 14. For information

NHS
Blood and Transplant

# 14.1. Annual Health, Safety & Wellbeing Report (21-51)

For Reference

Presented by Patricia Grealish

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# Annual HSW Management Review 2021

# 1. Summary and Purpose of Paper

The purpose of this paper is to meet the management review requirement of the International Standards Organisation ISO45001 quality standard for Occupational Health and Safety. The review by top management is to establish health, safety and wellbeing continual improvement, by the Executive Team and Audit Risk and Governance Committee (ARGC) before provision to the board for information. The year has shown a good performance with migration to ISO45001 certification achieved and good safety protocols for COVID-19 being maintained through the year. The Executive team reviewed the report on 16/06/2021 and ARGC on 09/07/2021, recognising the achievements in the past year and approving the report for issue to NHSBT board for information.

# 2. Action Requested

That the NHSBT board note the report for information.

# 3. Background

## 3.1 Status of actions

- Migration to ISO45001 was approved by our external auditor BSI in March 2021 as planned. Closed.
- The HSW plan is revised to include the work as a result of findings in inequalities data. A health inequalities advisor joined us in May 2021 and is evaluating the accident data provided to the Executive Team in December 2020, with further work planned to identify causes for the inequality with further recommended action expected as a result. Executive review of this work is planned for September 2021. We have confirmed with EAP that a person with trauma through racism can request a counsellor with experience of working with communities and racism. Closed.
- The Wellbeing Survey has been evaluated, with conclusions in this report (Section 4.3, page 3) and the recommendations form part of the NHS Charities together paper. Closed.
- Accident intervention plans in London and SE for any area that has had a lost time accident has been implemented in Colindale and Tooting Hospital Services Depts, Blood donation (Brighton, Milton Keynes teams and West End Donor Centre) and a Transport Tooting plan is being agreed with managers. Closed.
- The Executive HS&W scorecard has been updated with details of accident and near misses for directorates in line with the board performance report changes. Closed.

# 4. Detail of report

## 4.1 Changes in External and Internal Issues

Through the COVID-19 pandemic our first priority has been the safety and wellbeing of our donors, patients and colleagues. The HSW team supports our response to COVID-19 providing advice and risk assessment support to frontline operations to ensure colleagues feel safe and supported. Ensuring that our vulnerable colleagues continue to work safely in COVID-19 secure premises. The focus on Black, Asian and Minority Ethnic (BAME) colleagues at greater risk of COVID-19 is met with a successful manager led risk approach to ensure support for their immediate safety and also long term wellbeing. Patient facing colleagues successfully supported the wider NHS during the first wave of the pandemic and have returned to other duties with appropriate ongoing critical incident debriefing and psychological support to help them cope with any potential trauma they have suffered. Our collections teams work incredibly hard to provide a safe working and donor environment in our donor centres and mobile sessions and not only keep to operational targets but successfully implemented a whole new product of convalescent plasma. Outbreaks on teams are well managed by our internal test and trace system with lessons learnt and implemented in other areas on breaks, touch point cleaning and travel to sessions. Laboratory services, aided by Estates and Facilities in shared areas, continue to meet COVID-19 secure status with only one large outbreak in CMT Birmingham (see appendix 1 for COVID-19 reported diseases at work).

### Post Pandemic Working

A project is running to establish how to safely open sites to persons wishing to return to centres from homeworking, with a short term view to maintaining COVID-19 safety and to be able to feed into a longer term view to maintain flexibility and support great place to work in a hybrid model.

## 4.2 Health Safety and Wellbeing Policy and Objectives

The extent to which HSW policy and objectives are met is reviewed in our HSW plan 2018-23 by the HSW team, approved by the HSW Policy and Strategy Group (PSG) and discussed with trade unions on a quarterly basis. The plan is showing green for the three themes of prevention culture, wellbeing and communications and amber for leadership. Of the 81 actions 71 are green and 10 are amber. Amber actions are:

- Video clips for behavioural safety campaign;
- Videos of key Safe Systems of Work;
- Base line metrics for behavioural safety campaign
- Client reviews based on scorecards
- Personal health needs assessment
- Development of Mandatory training which is below 95%;
- Best practice identified by co-ordinators;
- Senior Management Team (SMT) member visits after HSE reported accidents;
- SMT member safety observations;
- Lost time accident in blood supply (over 3 days absence) target not reached but all lost time (one day or more) has decreased as an incidence rating as more people have been taken on in this area.

These activities have been affected by the coronavirus pandemic with operational directorates working on pandemic controls and leaders not being able to visit centres and teams under lockdown measures however it still represents a good performance against plan.

## 4.3 HSW Performance

### Migration to ISO45001

This was approved by BSI, our external auditor, in March 2021 as planned. This followed a two and one-half year planned migration from a British standard of 18001. The audit confirmed positive evidence to verify; 'that the system is demonstrating the ability to support the achievement of statutory, regulatory and contractual requirements and the organisation's specified objectives' this is a significant achievement putting NHSBT as the first ABO member to attain certification and one of the first in the NHS.

### Wellbeing Survey

Carried out to provide more information on concerns regarding burn out and stress and whether NHSBT have the appropriate wellbeing response, the survey was returned by all areas achieving a return rate of 27% (above target return rate of 20%). The results have been analysed (appendix 2) and form part of the NHS Charities Together paper.

The wellbeing survey analysis is provided appendix 2, the conclusions are:

- Response rate was good, from home workers and blood donation, with good levels in scores generally 8 out of 10;
- We had a good level of response on disability and long-term conditions of 20%, with ESR figures of 3% and UK adult population figure at 16%;
- The question My Manager Cares About My Wellbeing has gone up from 8 to 9 since last pulse survey in 2020;

- The working at NHSBT questions highlight good levels of resilience on stress and mental health and the majority of people feel they can have time off when unwell (but only 56% indicating issues with sickness presence);
- Senior leaders scores (anyone other than line manager) are lower but results not surprising considering not able to provide visible leadership through the pandemic;
- It highlights the importance of managers training and communications, as they are highest rated for source of information for colleagues;
- It shows a high level of impact of wellbeing webinars and workshops;
- There are some low levels of awareness of services e.g. physio and OH portals;
- There are high levels of positive effects for user of services e.g. physio 82%;
- The figures show the Internal Communications Link strategy worked well, with a greater emphasis and ease of access to wellbeing info meaning this scored well.

## Incident Performance Against Targets (Appendix 3)

For the purposes of this annual report plasma for medicine colleagues have been included in blood supply figures to reflect the organisation structure in place at the start of the year. Colleagues working on plasma have had a very low lost time accident rate with only 1 lost time accident recorded possibly reflecting the success of the recruitment campaign. The number of HSE reported and Lost Time Accidents increased in blood supply in 2020/21 (appendix 3) but the incidence rate has decreased when all lost time of one day or more are taken into account (appendix 4a). Two Clinical Services lost time accidents occurred against a target of three or less.

The trend continues with proportionally more accidents in London and South-East, which contributed 21 out of 42 (8 in the North and 13 in the West). Local action plans are in place for: Colindale and Tooting Hospital Services Depts; Blood donation with the focus on Brighton and Milton Keynes teams and West End Donor Centre. A further plan is being agreed for Transport Tooting. The additional HSW advisor in L&SE, fixed term contract to March 2021, is introducing behavioural safety observations and coaching managers in this area. The extra resource and focus in L&SE is designed to ensure that all lost time accidents are understood and mitigated for the future.

The number of serious accidents is up in blood supply, with an increase in blood exposures and needlesticks. A deep dive in January 2021 found that in blood donation 42% of these injuries were for people with 12 months or less service reflecting the number of new people brought into service in the last 12 months. The number of needlesticks and blood exposures was 87 out of 104 serious incidents in blood supply, meaning that other causes are rare. This led to the decision to target all harm incidents rather than just lost time and serious, as the previous focus has reduced serious accidents to blood exposures and needlesticks and we now need to act on other types of injury, which were previously classified as minor. The other change is to provide in incidence rate to account for increases in numbers of colleagues (Appendix 4b).

Reporting of Minor and Near Misses recovered in blood supply from early lows, with reporting of COVID-19 near miss incidents against our infection, prevention and control guidance. Minor and near miss incidents in other areas is lower reflecting the decreased numbers of people in the workplace in these areas.

Benchmarking with the Alliance of Blood Operators (ABO) is available for 2019-20 (appendix 5) and shows an increase in cases of lost time but also shows a continued strong performance in blood collections on length of time off (severity rates). This means the number of cases is higher than the previous year but work to bring people back (through physiotherapy, Occupational Health, Counselling and management support) works well and is the lowest in the ABO. Slips, trips and falls have risen (which is a whole organisation metric not just collection colleagues) and needlesticks and manual handling are low.

A review of causes of accidents highlights the need for corrective action on blood exposures, manual handling and slips, trips and falls (see Appendix 6). This includes review of guards for heat sealing and pressing blood packs, with the latter planned implementation in July 2021.

Donor incidents remain in control with a decrease from 108 to 96 despite an increase in Convalescent Plasma donors. The reduction is due to a decrease in donor faints resulting in injury, with increases in other causes from low numbers (See Appendix 7).

## Evaluation of Legal Requirements and Other Standards

Evaluation of legal requirements and other standards against our register shows we have maintained this appropriately through the year, as reviewed at PSG. Mandatory training compliance is as per Appendix 8, a 6-month grace period was agreed until October 2020 to help with COVID-19 workload pressures. The figures have increased from the level seen in November 2020 by one point and further action will be taken to support managers and encourage colleagues to achieve the 95% target level. The BS performance with the extra numbers of staff recruited in the year has been good.

## Audit Results

The audit programme was restarted after the end of the first lock down and continues to support the organisation appropriately, with no major non-conformances raised. Third-party audits by BSI confirmed that we have achieved certification to ISO45001 and the extra standards on participation, wellbeing and top management commitment. (See appendix 9 for numbers of reports).

## Consultation and Participation of Workers

The national HSW committee continues to work proactively and reviews HSW performance in partnership. A weekly call with trade unions to pick up COVID-19 issues and deal with them effectively has been carried out throughout the pandemic. Joint working on social distancing and COVID-19 secure premises has worked well and a joint management and trade union letter to all staff was issued in November.

## Risk and Opportunities Including Continual Improvement

The risk and opportunities to the HSW management system are:

- HSW Advisor resource in the London and Southeast area to meet the increase in incidents and non-conformances raised here has been actioned with an extra HSW Advisor resource for 12 months
- Absence levels increased with COVID-19 in the first wave but the organisation continued to work well. Monitoring of absence levels is done weekly to ensure managers are supported with the possibility to return to redeployment should levels rise. Shielding resulted in 250 individuals working from home in the first wave and 89 are affected in the second wave. Sickness absence levels have gone back to target in March 2021 at 3.17%, with target of less than 4%
- COVID-19 secure workplaces have been maintained by identifying suitable controls and working with our Infection Prevention and Control lead. Outbreaks in centres and teams have remained low, with most cases caused by not following social distancing and when training staff. No staff transmission has taken place since February 2021 with the outbreak on Nottingham team
- Coronavirus routine asymptomatic testing has been implemented successfully and covax rates are high at 84% for first vaccine
- Our fire safety and evacuation procedure has been combined and agreed with trade unions, which will allow us to begin the identification and re-training of persons in charge for each of our centres. This will enhance our fire safety processes to ensure an appropriate emergency response whatever the issue.

### 4.4 Adequacy of Resources

The adequacy of resources is being tested by the coronavirus pandemic, with the following increases in resource as a response:

- two new fixed term HS&W advisors, one permanent Health and Wellbeing Advisor have been recruited and an Inequalities Advisor fixed term post have been recruited.

These are in addition to the team of 10 professional advisors.

### 4.5 Relevant Communications with Interested Parties

The Health and Safety Executive (HSE) has investigated three complaints, two from members of the public and one from a member of staff. These were investigated and closed appropriately by the HSE with no enforcement action. The HSE visited our plasma donation centre in Bexley Heath and contacted our Essex teams, with all enquiries answered and no action taken.

## 5. Recommendations

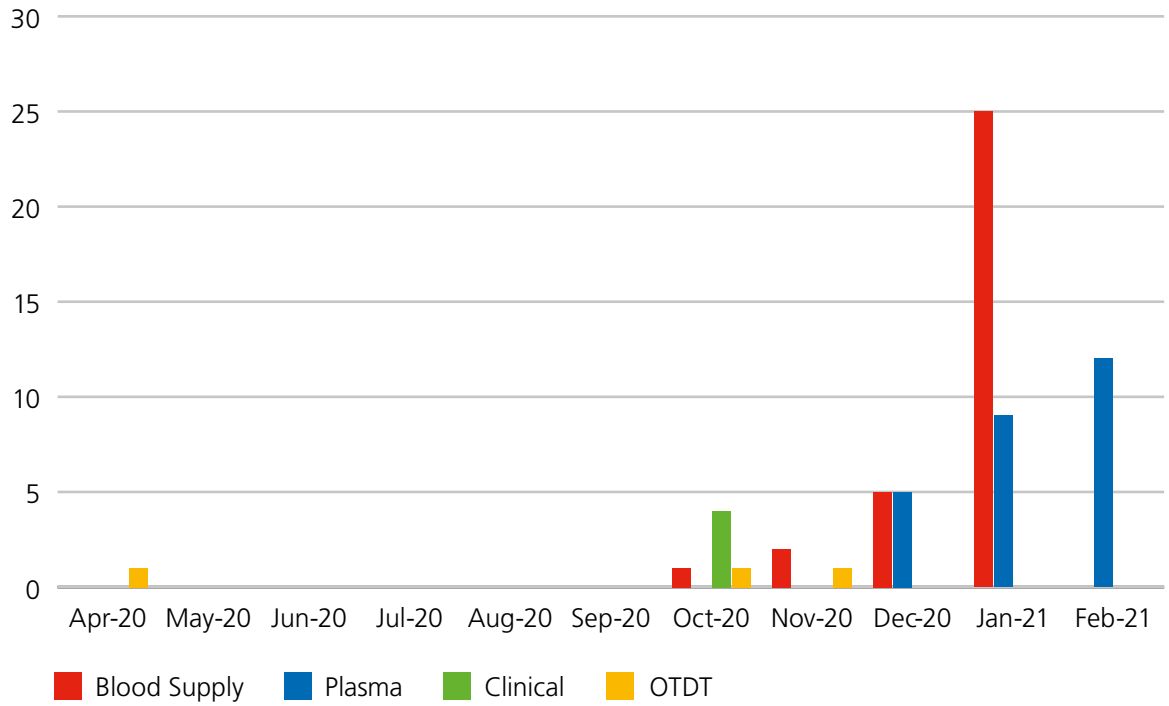
### 5.1 Mandatory training to be targeted by directorate SMTs to achieve 95% compliance.

### 5.2 Wellbeing recommendations are included in the NHS Charities Together paper.

## 6. Sign off

Author: Phil Tanner Assistant Director HS&W
Responsible Director: Patricia Grealish
Approved by: Betsy Bassis
Date: 16/06/2021
ARGC Review: 09/07/21

# Appendix 1 COVID-19 Reported Diseases at Work




Commentary in 4.1 and page 3

# Appendix 2 Wellbeing Survey Recommendations

- Targeted comms approach for lower scoring services e.g. on physio, optimise and EAP portals
- For centres with lower engagement re-engage with connect to a region and directors on sites (senior leadership scores)
- Visits to teams and depts by HSW, HR and senior leaders (using experiential info/actively engage), produce road show package with stories
- Provide blogs, 2 minute films, wellbeing webinars workshops, wellbeing campaign, use engagement time on teams
- Provide easy to search on line resource about wellbeing
- Ask same questions in future surveys and benchmark against peakon database
- Do further analysis into data on health inequalities through review against demographics and provide data to directorates to review and take relevant action
- Comms Step 1 feedback on results, step 2 celebrate figures locally at centre partnership committees, reinforce local initiatives re wellbeing e.g. Birmingham done well due to strong engagement, step 3 involve Logistics, BS and Finance in trial visits and the development of the on line resource, also involve the good areas Quality, OTDT etc where working well.

# Appendix 3 Accident and Near Miss Performance

| | 18/19 | | | | 19/20 | | | | 20/21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level | HSE Rep | Lost Time | Serious Accident | Minor/ Near Miss | HSE Rep | Lost time | Serious Accident | Minor/ Near Miss | HSE Rep | Lost time | Serious Accident | Minor/ Near Miss |
| Blood Supply | 16 | 5 | 150 | 1,121 | 17 | 9 | 83 | 1,078 | 26 | 14 | 104 | 1,194 |
| Clinical Services | 1 | 0 | 15 | 71 | 1 | 2 | 10 | 75 | 1 | 1 | 8 | 71 |
| OTDT | 0 | 0 | 17 | 96 | 0 | 3 | 12 | 91 | 0 | 0 | 10 | 49 |
| Donor Experience | 0 | 1 | 0 | 8 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Group Services | 0 | 1 | 3 | 74 | 1 | 0 | 1 | 97 | 0 | 0 | 2 | 75 |
| **Total** | **17** | **7** | **185** | **1,370** | **19** | **14** | **106** | **1,342** | **27** | **15** | **124** | **1,389** |

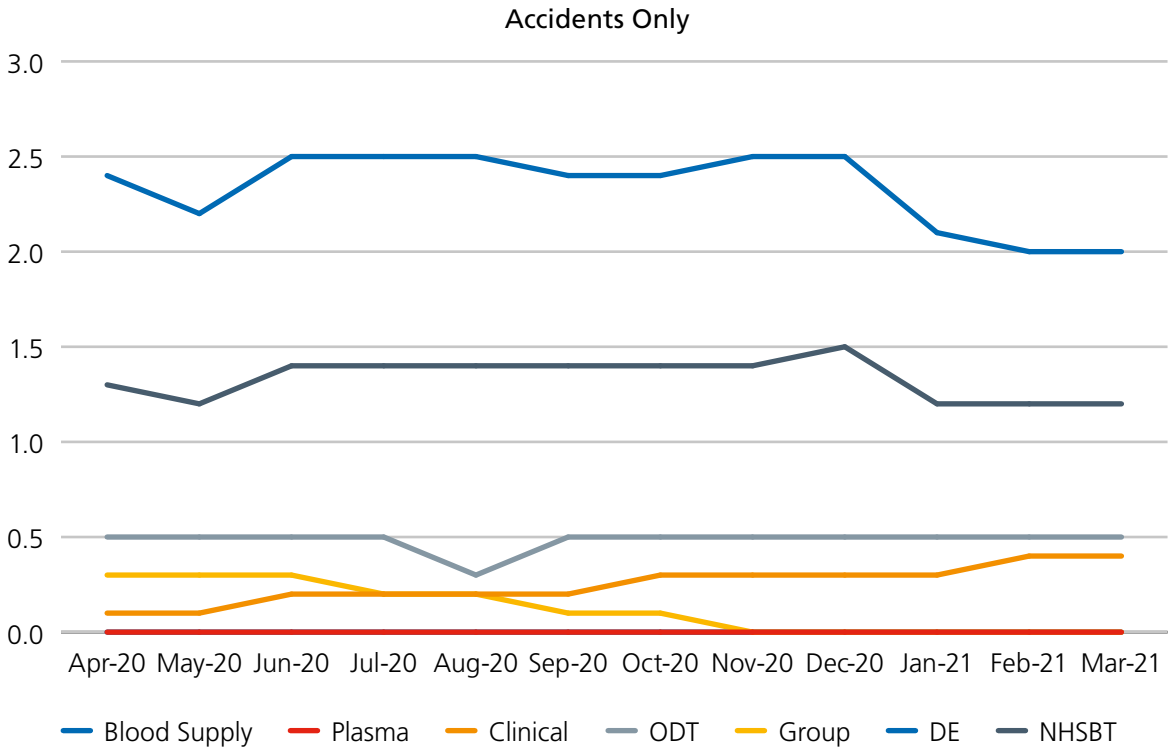
**HSE Rep –** over 7 day lost time injuries or specified injuries reported to the Health and Safety Executive (HSE) e.g. fractures or injuries requiring an over 24 hours stay in hospital.

**Lost Time –** over 3 but less than 8 day lost time injuries.

**Serious Accident –** injuries or near miss incidents graded as serious by Health Safety & Wellbeing (HSW) Department based on their severity and likelihood of reoccurrence.

**Minor/Near Miss –** minor injuries or all other near miss incidents where no injury to staff.

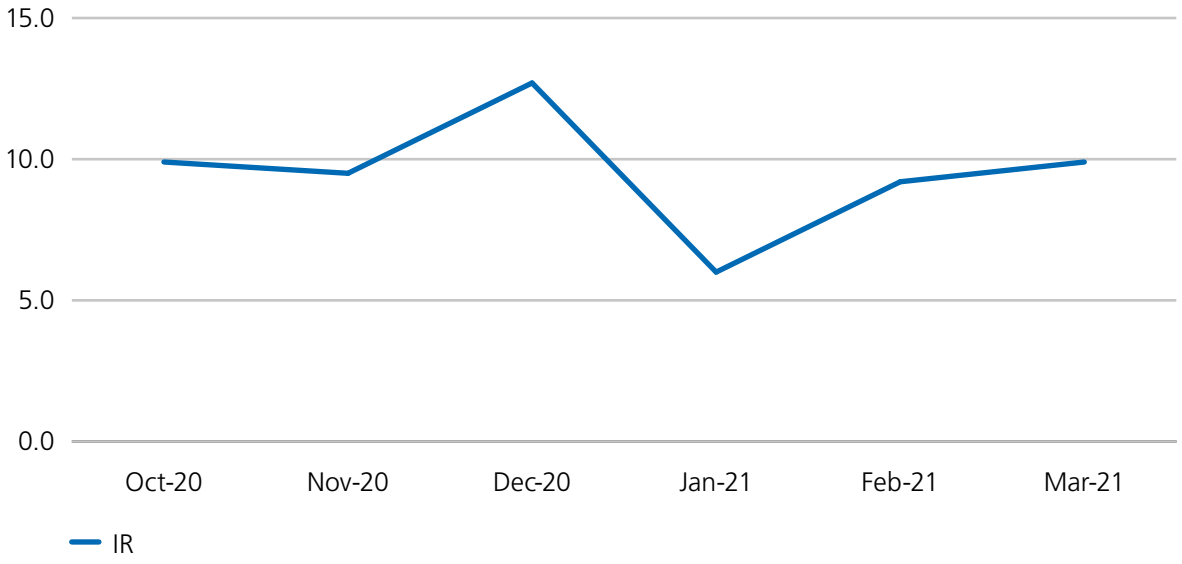
# Appendix 4a Lost Time Accident Incidence Rate



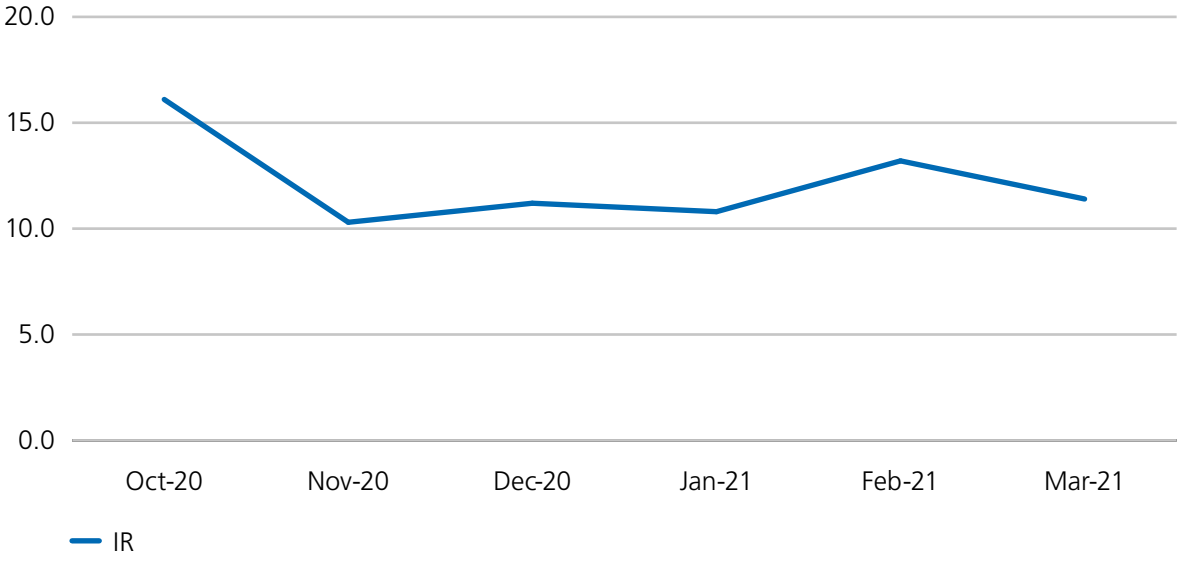

Number of lost time injuries of one day or more divided by headcount x by 1,000

# Appendix 4b NHSBT Health Safety and Wellbeing Incident Rates

## Harm

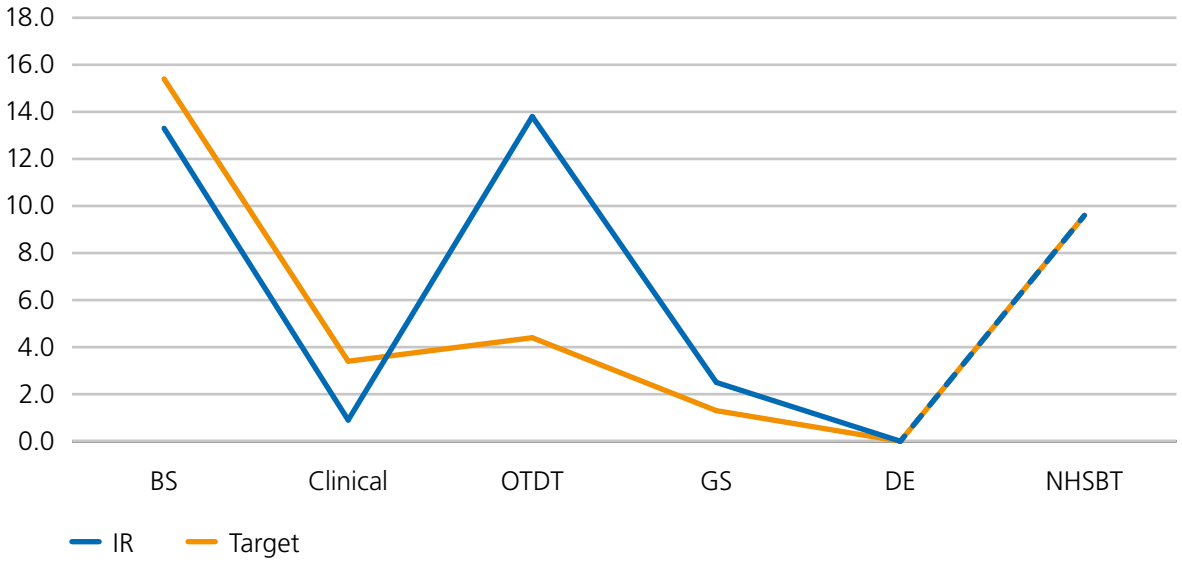



## Near Misses

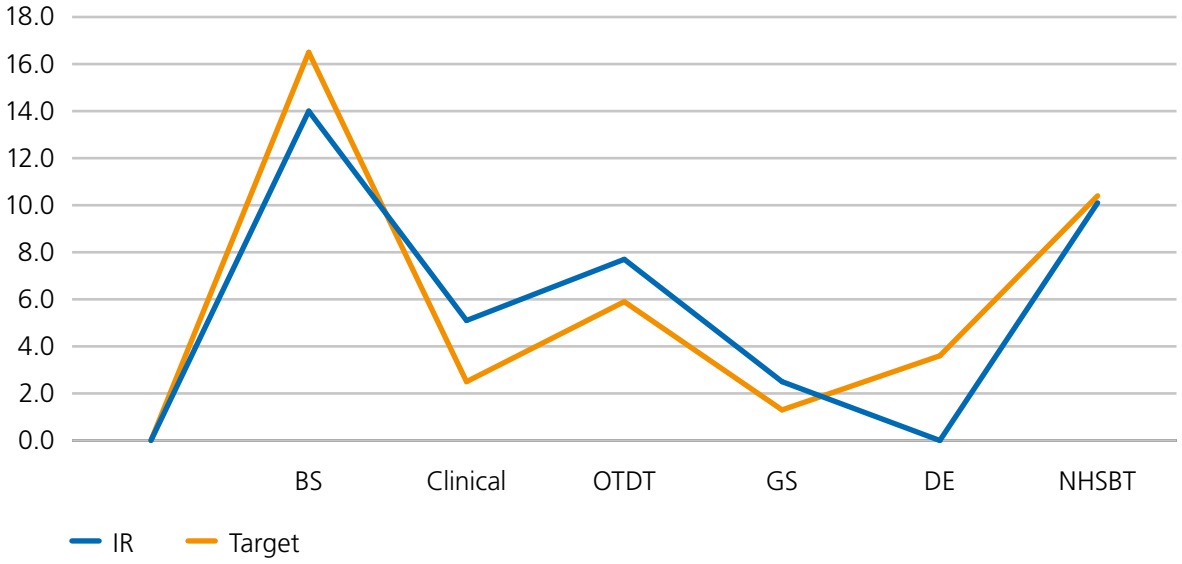



Harm Incidence Rate April 2021 (target 5% Decrease) Near Miss Incidence Rate April 2021 (target 5% Increase)

## Incidence Rate by Directorate Harm



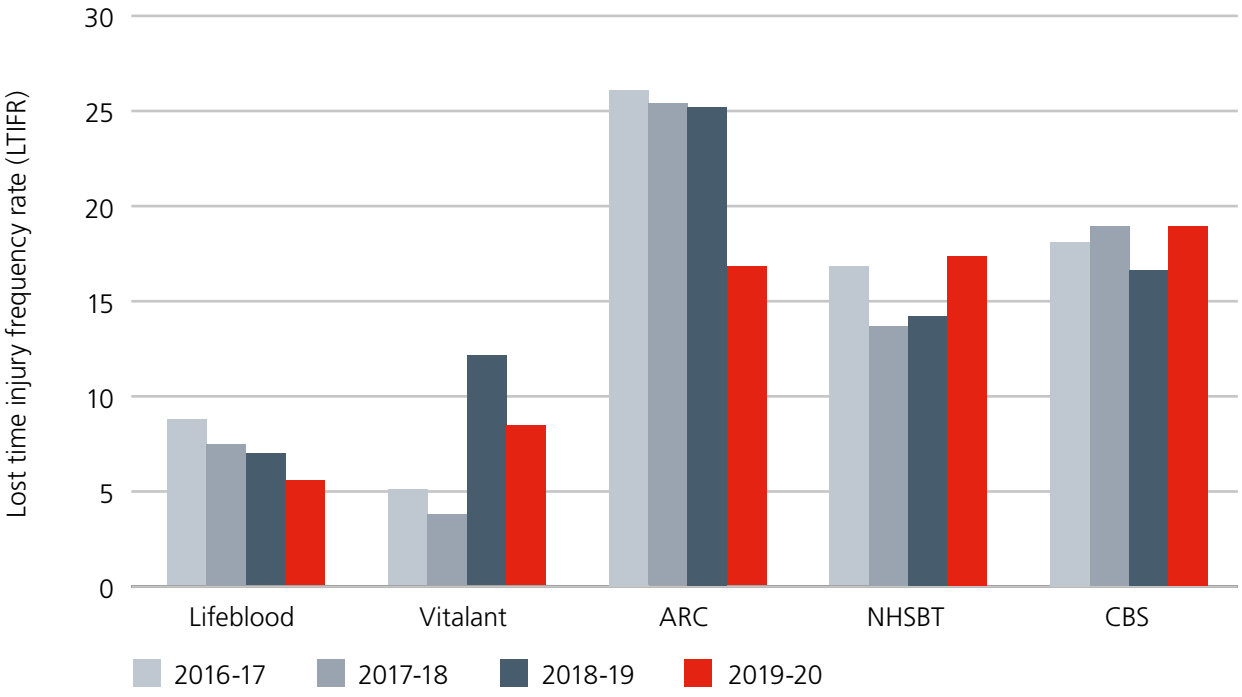

## Near Miss Incidence Rate by Directorate



# Appendix 5 ABO Benchmarking 2019-20

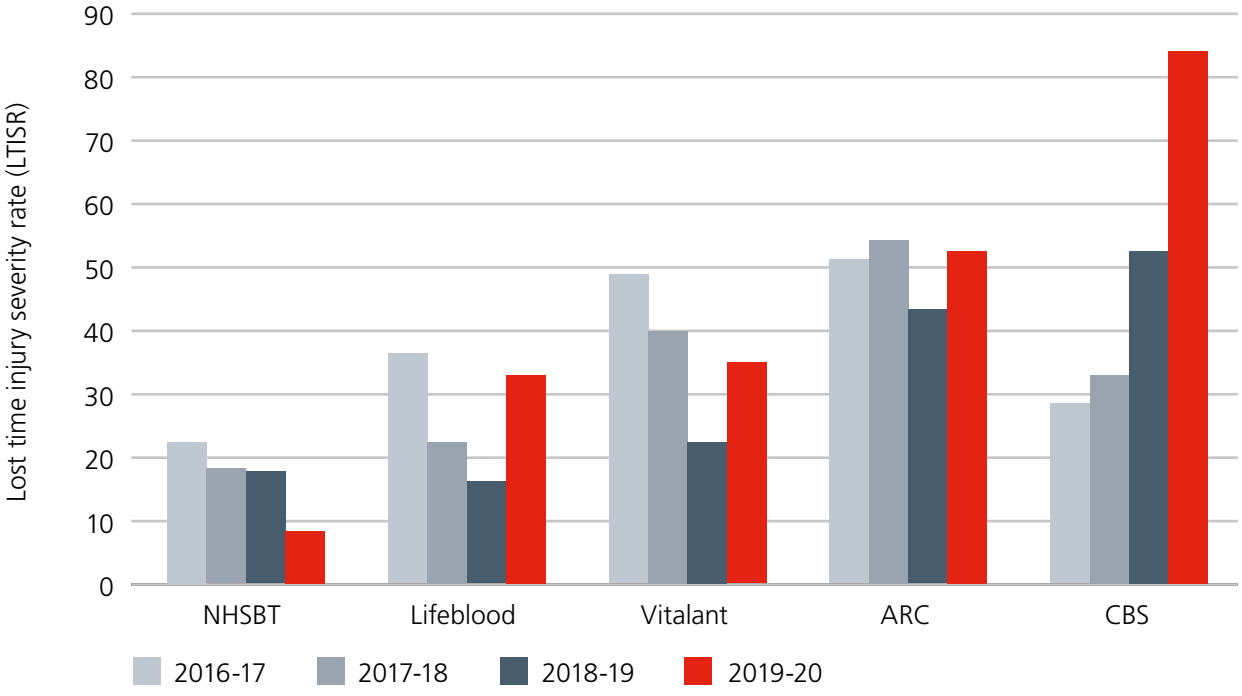
## ABO Stats

### Lost time injury frequency rate (LTIFR) in collection



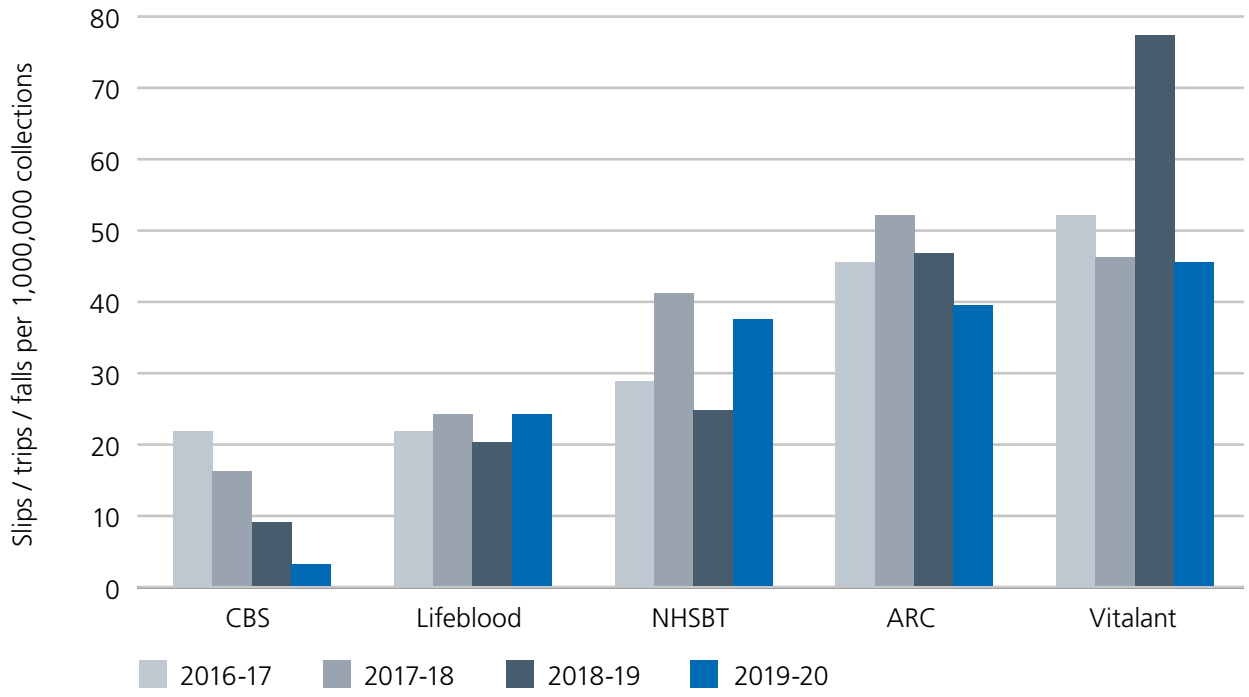

## ABO Stats

### Lost time injury severity rate (LTISR) in collection



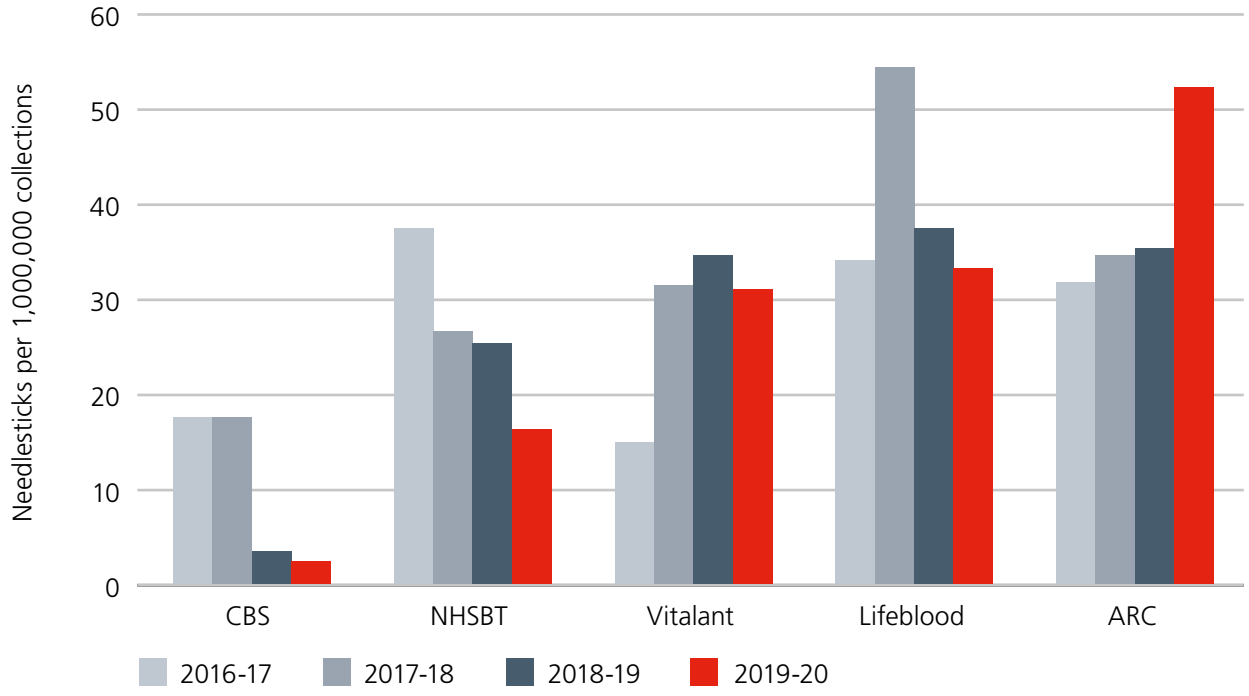
## ABO Stats

### Organisation wide Slips, Trips and falls per 1,000,000 collections



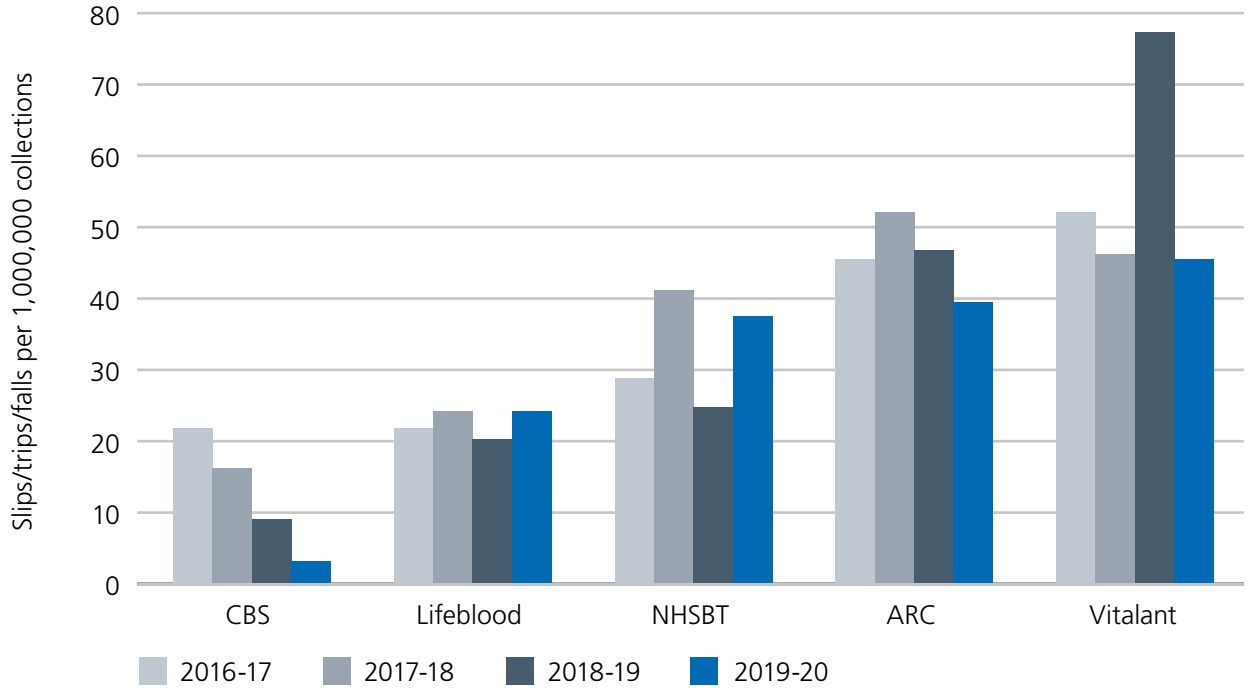

## ABO Stats

### Needle stick events per 1,000,000 collections



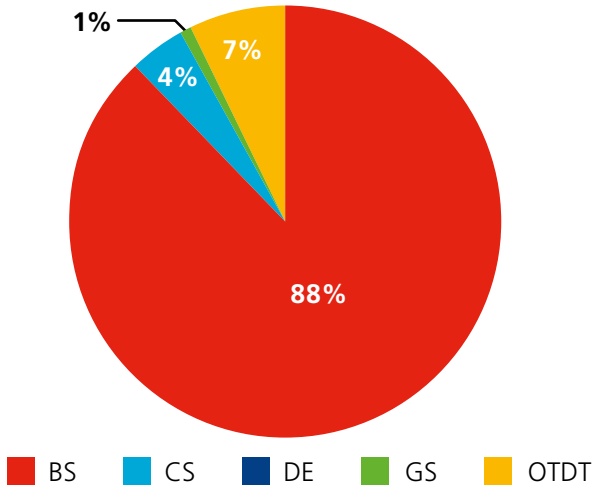
## ABO Stats

### Organisation wide manual handling injuries per 1,000,000 collections



# Appendix 6 HSE Reported, Lost Time and Serious Accident Causes Trend Analysis 2019/2020

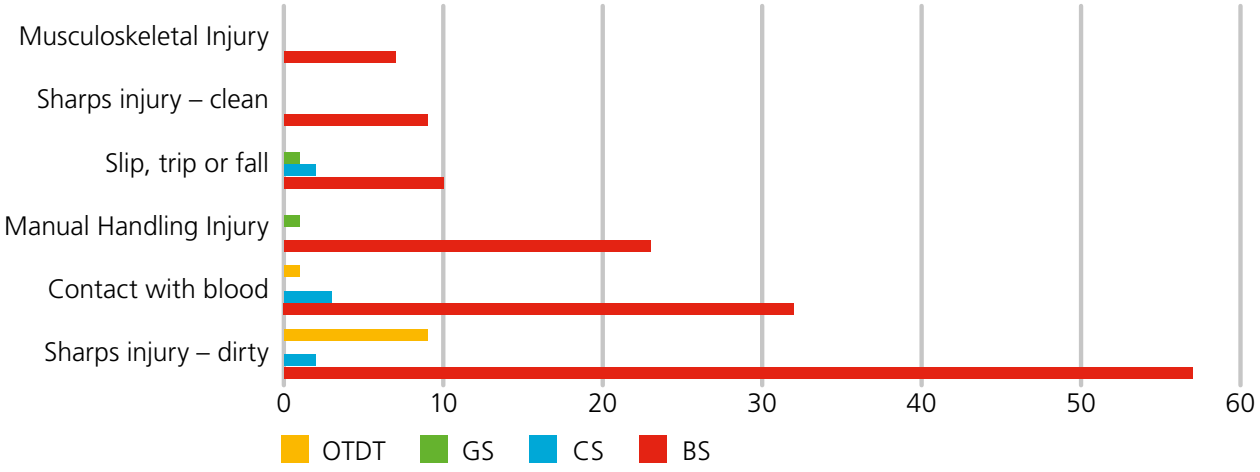
| HSE reportable, Lost time and Serious incidents | | | | | | |
|---|---|---|---|---|---|---|
| **Directorates** | BS | CS | DE | GS | OTDT | Total |
| **Apr – Jan 19/20** | 105 | 13 | 0 | 2 | 18 | 138 |
| **Subcategory** | BS | CS | DE | GS | OTDT | Total |
| **Sharps injury – dirty** | 57 | 2 | | | 9 | 68 |
| **Contact with blood** | 32 | 3 | | | 1 | 36 |
| **Manual Handling Injury** | 23 | | | 1 | | 24 |
| **Slip, trip or fall** | 10 | 2 | | 1 | | 13 |
| **Sharps injury – clean** | 9 | | | | | 9 |
| **Musculoskeletal Injury** | 7 | | | | | 7 |
| **Total** | 138 | 7 | 0 | 2 | 10 | 157 |
| **%** | 88 | 4 | 0 | 1 | 7 | |




Of the 157 incidents in 202/21, 104 have been blood exposure incidents. This is either a dirty sharps injury or blood exposure incident. This accounts for 66% of all the harm incidents nationally. This is marked increase.

Work to reduce blood exposures Consider use of eye protection at specific high risk points in the processes. E.g. when breaking the lines. Disposable eye protection is available on procurement.

HSW will be checking if the other recommendations made for the last 12 months have been implemented in an attempt to drive these figures down.



# Appendix 7 Donor Accidents Causes 2014–2021

| Donor Accidents | 2019–2020 | 2020–2021 |
|---|---|---|
| Dermatitis – Skin soreness, itching, etc | 1 | 0 |
| Donor Faint Resulting in Injury | 61 | 43 |
| Electric Shock | 0 | 0 |
| Equipment Fault/Failure | 0 | 4 |
| Exposure or Contact with Blood | 1 | 1 |
| Exposure or Contact with chemical | 1 | 3 |
| Exposure or Contact with Cold | 3 | 0 |
| Exposure or Contact with dust/fumes | 0 | 0 |
| Exposure to heat/hot surfaces | 3 | 1 |
| Fall from Height | 4 | 8 |
| Ill health, fit or faint | 16 | 4 |
| Impact against stationary object | 3 | 8 |
| Injury from Sharp Object | 4 | 4 |
| Hit by Moving object | 0 | 4 |
| RTA with stationary/or fixed object | 0 | 1 |
| Sharps injury from clean needle or scalpel | 0 | 2 |
| Sharps Injury from dirty needle/scalpel | 1 | 1 |
| Donor Accidents | 2019–2020 | 2020–2021 |
| Slip, trip or fall on level | 10 | 12 |
| Trapping | 0 | 0 |
| **Total** | **108** | **96** |

# Appendix 8 Health and Safety Mandatory Training Compliance

| Directorate | Compliance % Nov 2020 | Compliance % April 2021 |
|---|---|---|
| Blood Supply | 89 | 90 |
| Clinical Services | 92 | 92 |
| DDTS | 83 | 89 |
| Donor Experience | 81 | 82 |
| Finance | 89 | 92 |
| OTDT | 87 | 86 |
| People | 91 | 95 |
| Quality | 93 | 93 |
| Strategy and Transformation | 85 | 87 |
| **NHSBT MT Total** | **89** | **90** |

# Appendix 9 Audit Performance

BSI surveillance audits conducted at:

- Lancaster in Jan 20 – 2 minor non-conformances, all closed
- Colindale in Jan 20 – 3 minor non-conformances, all closed
- Southampton in Feb 20 – 2 opportunities for improvement
- Filton in Feb 20 – nothing reported
- Manchester in Jul 20 – 1 minor non-conformance, closed
- Oxford in Jul 20 – nothing reported.
- Tooting in Jul 20 – 5 minor non-conformances, all closed
- Emerald Park Warehouse in Aug 20 – 3 opportunities for improvement
- ODT in Stoke Gifford in Oct 20 – nothing reported
- Liverpool in Jan 21 – nothing reported
- Colindale in Jan 21 – 2 minor non-conformances – all closed
- Filton in Jan 21 – Nothing reported

No major trends identified in the types of non-conformances.

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Email: enquiries@nhsbt.nhs.uk
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# 15. Any Other Business

Presented by Millie Banerjee

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16. Date of Next Meeting:  Thursday, 30th September 2021

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# 17. Resolution on Confidential Business

Presented by Millie Banerjee