NHS
Blood and Transplant

NHSBT Board Meeting

Chief Executive's Report

19 July 2022

Status: Official

We all hoped that 2022 would see a return to stability. Unfortunately, this is not yet the case with COVID cases once again on the rise and our workforce under serious pressure from increased sickness and turnover. I would like to start this report by thanking our people for continuing to give their everything to our mission of saving and improving lives. And to our donors who – without their patience and continued altruism – we would not be able to ensure continuing of supply.

1. Clinical Governance

We reported one Serious Incident in May. This involved the incorrect ABO blood group being entered onto DonorPath, which led to an incorrect offer of organs (liver and kidneys) for transplantation. The incident did not result in patient harm as the error was discovered prior to patients being admitted for transplantation. We will continue to explore opportunities to automate results transfer in line with our strategic priority to modernise our operations. Unfortunately, given the number of different systems in use across the NHS, this will prove challenging to deliver in the short term. In the meantime, we undertook a process mapping exercise which reaffirmed the best practice process. This includes the 3-point patient ID check with the hard copy of the ABO results being carried out at the bedside and checked against DonorPath. All 12 Organ Donation teams have had a training session on ABO compatibility and the impact of getting this wrong, and a video demonstrating best practice has been recorded and shared.

A clinical audit of the Tissue Donor Referrals process provided limited assurance and was discussed in depth at the July ARGC. The audit indicated that only 2.1% of hospital referrals for potential ocular tissue donation had all relevant fields on the appropriate documentation completed. This was attributed to undue complexity in the process with multiple and different forms for referral. This creates significant work for our TES team to get the missing information. Moreover, having multiple forms in use, with key information in different places, risks staff interpreting them incorrectly. A review of the E2E process is underway, with an improvement plan to be shared with local Trusts.

The Safeguarding Annual Report was brought to the July ARGC for review. The report gave assurance that there are effective processes in place to ensure NHSBT meets its statutory and regulatory requirements and standards. However, it also highlighted an area for improvement. Specifically, only 64% of relevant employees had completed their online Level 3 mandatory training. Completion of Level 1 and Level 2 mandatory training performed better at 95% and 91%, respectively. Regular workshops have been established to enable completion of the face-to-face elements of the Level 3 training. In addition, monthly safeguarding forums are available for peer supervision and learning, and accessible for all staff in the organisation.

There were 30 Safeguarding incidents reported in 2021/22 compared to 16 incidents in the previous year. We believe the increase in reporting is the result of raised awareness following the launch of the new MPD and policy. Of the 30 incidents reported, all related to adults: 14 were NHSBT colleagues and the rest involved patients, donors or members of the public. An internal review has

found that all 30 incidents were appropriately managed with 18 incidents requiring a referral to external agencies.

We have successfully started screening blood donations for Occult Hepatitis B and are aiming to screen all donors by March 2023. In the first month of screening over 28k donations were screened for anti-HBc, which equates to 24% of all donations taken. To date, 63 donors have been withdrawn, which is slightly lower than our initial forecasts of 0.3% positivity. We are monitoring the blood type of this cohort to identify any rare blood groups where a further clinical risk assessment may be warranted. Plans are in place to commence lookback as donors with OBI and hepatitis B DNA are identified. We are currently following up one donor in this group but expect to identify more donors which will require a lookback as screening ramps up.

Following the recently reported cases of Monkeypox, a rapid assessment for solid organ transplantation has gone live; details are on the ODT website. A JPAC risk assessment and position statement has also been published and blood donors are now deferred for 28d following a diagnosis of monkeypox and 21d following contact with an individual with monkeypox.

2. Quality and Regulation

This period has been particularly busy for regulatory inspections. We were given 14 days notice of our first ever CQC Well Led inspection, which took place in Filton on 22 and 23 June. Since then they have:

- held a series of virtual interviews with individuals who were not available over the initial two days;
- visited our Newcastle site to review HR records; and
- arranged focus groups with staff from our BAME, LGBT+, Disability and Women's networks.

Preparing for this inspection has proved a good exercise. By working through the key lines of enquiry, we were able to recognise areas of strength and best practice, but also flush out areas for further work and improvement. We look forward to reading the CQC's report which we have been told to expect by the end of July or early August.

The MHRA inspected our new Clinical Biotechnology Centre at Filton, as well as the existing CBC at Langford. The outcome was very positive with only 4 other non-conformances raised. We anticipate receipt of our new licence following agreement of our corrective actions. This is an excellent result and is testament to the hard work of the project team to deliver a new build whilst continuing to operate in the existing site.

3. Blood Supply

As already reported to the Board, blood stocks have once again come under focus with red cell inventory for some ABO groups below target levels and close to 2 days of stock (DOS). This is the threshold where NHSBT considers standing up the advanced stages of our stock shortage protocol with hospitals. This protocol contains an 'amber' alert phase, triggered when red cell stocks fall to two days. This phase would see NHSBT working with hospitals to manage demand. This could include asking them to consider postponing elective activity.

Were things to get worse (stocks <1 day), a 'red' alert phase could be triggered which would result in an instruction to hospitals to cancel non-urgent activity and consider other treatments for patients normally requiring transfusion. In our history, NHSBT has never declared either of these formal shortages for red cells (although we briefly declared an amber alert for short shelf-life platelets, following the 'beast-from-the-east' weather event in 2018).

We are not the only blood operator to be experiencing supply challenges. Though we have managed to meet periodic stock requests from the devolved nations throughout the pandemic, we have had to decline recent requests for support from Scotland and Wales. Across continental Europe, other

services have seen their stocks fall and the American Red Cross has recently declared a blood shortage.

Whilst we continue to observe lower appointment fill rates and higher donor non-attends, acute workforce shortages represent the main reason for our recent decline in stocks. This is driven by two factors. Firstly, sickness absence rates are once again rising as COVID-19 cases increase. Secondly, we are observing accelerated workforce turnover in some areas (particularly but not exclusively in London and the South-East). This presents a significant challenge because while donor carers only need to provide us with four weeks' notice of their intention to leave the organisation, it typically takes us >16 weeks to recruit and fully train replacements. The combined effect of this accelerated turnover and rising sickness absence is that some of our teams are perpetually short-staffed and therefore unable to deploy their planned capacity. As a result, we have been cancelling 2,000-3,000 donors per week – often at very short-notice.

As well as contributing to our immediate supply problem, this regrettable level of cancellations represents a significant risk to longer term donor loyalty and retention, with complaints about cancellations up 50% in June and now accounting for 20% of all complaints. Donor feedback has highlighted the consequences of these cancellations, with reduced motivation to book, many enrolees giving up and confusion from our continued appeals. We have offered our apologies through a dedicated email and included details on our plan to resolve the situation.

Our workforce issues, whilst particularly acute on our blood collection teams, are also being felt in other parts of our supply chain. We have stood-up a team to provide urgent support to our front line. This is initially focused on three areas:

- Firstly, we are mobilising a combination of redeployed NHSBT volunteers and external staff (e.g. agency) to perform the "Front-of-House" role on session, freeing up our clinically trained staff to focus on blood collection;
- Secondly, we are producing a team-by-team workforce plan for each area of the supply chain to demonstrate how we will get each team back to its budgeted establishment (and maintain them there); and
- Thirdly, we will be investigating the root cause of increased staff attrition and absence and reviewing our recruitment, retention and training policies/processes appropriately.

We are communicating regularly with our stakeholders about the evolving situation. Internally, we have launched a series of webinars to acknowledge the workforce problems and made public our commitments to fix them. Externally, we are working with the hospital community via transfusion practitioners and the National Blood Transfusion Committee. I have been providing DHSC with regular updates and have penned an article for publication in the Health Service Journal, in response to some of their recent coverage around low stocks.

Our plans for this rapidly evolving situation are still being developed to full sufficiency and at this stage we cannot state with certainty that we will avoid a stock shortage, or by when we will recover. However, we have stood-up the required critical response infrastructure to fully develop and execute these plans and will provide regular updates to the Board on progress.

It is worth noting that, given higher deferral rates from new donors, we have been prioritising existing donors to help us rebuild stocks. This has impacted our delivery against new donor targets and is not sustainable in the long run. To grow and diversify our donor base in London, we have launched a new campaign in partnership with TfL calling on 'LonDONORS' to sign up and give blood at one of our local centres.

(https://www.timeout.com/london/news/theres-an-appeal-for-more-londoners-to-give-blood-070822).

4. Plasma for Medicine

In April, Australia lifted its ban on donors who had previously lived in the UK. In May, the United States did the same. The EU has yet to follow this emerging global consensus, but we continue to advocate for policy change through the International Plasma and Fractionation Association (IPFA), the Plasma Protein Therapeutics Association (PPTA) and the European Blood Alliance (EBA). Plasma supply remains a high priority for governments across Europe as evidenced at the recent International Plasma Protein Congress in Berlin. With global plasma demand increasingly outstripping supply, a key focus of the conference was how countries could work together to address ongoing plasma shortages.

We continue to support NHSE's efforts to appoint a fractionator. At the moment, UK plasma is only approved for the production of immunoglobulin, but the MHRA will be reviewing the use of UK plasma for the production of albumin later this year.

In the meantime, we continue to stockpile both recovered and source plasma. We are currently behind our collection targets due to workforce shortages in manufacturing (being addressed as part of the wider Blood Supply plan referenced above) and the need to grow our donor base for source plasma. Our 'back to green' plans – including an innovative donor recruitment pilot with the NHS app – should see us recovering lost volumes by year end.

Regarding convalescent plasma, NHSBT is leading the REMAP-CAP trial for immunocompromised patients in hospital. Patients have been recruited in the UK and New Zealand, and recruitment is now open in Europe. In addition, NHSBT will be supporting an outpatient trial of CVP in high-risk immunocompromised patients, which is currently recruiting in Europe and will now also be available to UK patients.

5. Organ and Tissue Donation and Transplantation

Organ donation activity continues to recover. Indeed, May saw the third-highest ever month of deceased donor transplants. Consent rates are continuing to recover but remain below target, meaning that current progress is being driven by higher rates of organ utilisation. Clinical Leads for Organ Utilisation (CLUs) play a critical role in driving improvement at the local and national level, by:

- identifying and addressing barriers to organ acceptance;
- effecting culture change;
- increasing transplantation; and
- improving collaboration and shared learning across units.

Whilst our funding settlement does not include monies to continue this scheme, it was agreed that we should continue to fund the CLUs until at least the end of September to allow discussions about supporting the scheme on a permanent basis to conclude.

The DHSC-sponsored Organ Utilisation Group (OUG), chaired by Professor Sir Stephen Powis, are finalising their recommendations on how to deliver improvements in organ utilisation, reduce inequities in access to transplantation, support the sustainability of the service and drive innovation. NHSBT provided secretariat support to the OUG and we look forward to working with NHSE and DHSC to implement the actions in the report, once published.

In the meantime, the size of the transplant waiting list continues to grow, despite the increase in living and deceased donation activity. Without increased funding in the coming years, it is unclear whether we will be able to maintain current activity levels, let alone deliver the increases set out in the strategy published last year. The implications of our flat funding settlement will be discussed in the private section of the Board.

May and June saw sales for tissue and eye products up £500k, or 14% ahead of target. This was partly driven by an increase in ocular donation, thanks to the action plan referred to in my last report. Unfortunately progress has now plateaued which, together with increasing demand, means that we

expect cornea supply to fall in the coming weeks. We have therefore gone back to the drawing board to identify new actions to deliver the step change in referrals we need. This includes raising the importance of tissue and eye donation with the Organ Donation Committees in Trusts, ensuring that ocular donation is a key feature of SNODs consent conversation, and introducing KPIs for ocular donation into performance management.

Serum eyedrops continue to perform well (8% ahead of target in May & June) as do sales of Tendons, Processed Bone and Heart Valves (6% ahead of target). The donation of hearts for Heart Valves was also above target during this period, enabling us to meet demand.

Northern Ireland's Opt-Out law will come into force in Spring 2023 and we continue to support the development of the secondary legislation and the Human Tissue Authority Codes of Practice. Guernsey have announced their Opt-Out law will come into effect on 1st Jan 2023 and we are working with them to develop implementation plans to ensure we are ready for 'go-live'. On the Isle of Man, progress has been paused due to recent events in Public Health which is impacting the administration's local capacity. A short delay is expected before work resumes after the summer.

6. Clinical Services

In September 2020, we shared with the Board the *Transfusion 2024* report which we co-developed with the National Blood Transfusion Committee. It set out key priorities for future clinical and laboratory transfusion practice to enable safe patient care across the NHS. We had to pause work on implementation due to the pandemic but are now establishing a formal programme to take forward discovery work on the recommendations assigned to NHSBT. These include:

- A resource plan for Patient Blood Management;
- An education offer for transfusion medicine;
- Development of data linkage between our pathology systems and the National Haemoglobinopathy Register;
- Pilot projects on e-requesting/e-reporting and remote interpretation of test results;
- Work to define options for our future approach to Vendor Managed Inventory and the Blood Stocks Management Scheme; and
- An options appraisal on the benefits of establishing a clinical trials network in transfusion.

Further work will be shared with the Board in due course.

NHSBT has submitted recommendations and information to the IBI Chair on areas that may require more evidence to be considered prior to the completion of the Inquiry's final report. These have been shared with the Board.

The Perfused Liver Utilisation Study (PLUS), led by Prof Peter Friend of the University of Oxford and run by NHSBT Clinical Trials Unit, has recently opened to recruitment. This national study will evaluate if availability of normothermic machine perfusion (NMP) in extended criteria livers improves utilisation without compromising outcomes. Importantly, it will also collect cost information, so that the NHS can decide whether NMP is good value for money.

We are delighted that our new Chief Scientific Officer, Vicki Chalker, has joined us from UKHSA. This is a new role that we envisioned when reviewing our operating model back in 2020. It was designed to provide professional leadership for our scientific workforce, and to drive our external training and education strategy, linking with HEE (now NHSE) and the wider academic community.

7. People and Culture

As summarised above, our most urgent priority is to address the workforce issues affecting Blood Supply. Turnover remains uncomfortably high at 27%, and absence in Blood Donation increased from 6.86% in May to 7.63% in June. Absence in the Manufacturing and Logistics also increased over the same period, from 6.41% to 6.64%. We are pulling on resources from across the People

Directorate to support resourcing and absence management. Whilst the current focus is to fill vacancies, we will be developing plans to tackle the root abuse of such high turnover.

Absence across the wider organisation is increasing, as well – from 4.64% in May to 5.07% in June. Following NHSE advice and consultation with staff and donors, masks were made optional across the organisation from 20th June, including in CQC regulated areas (unless dealing with immune-suppressed patients). However, with COVID infections rising across the country, our Infection Prevention and Control team reviewed our policy again. As a result, donors and donor-facing staff have now been advised to wear masks. We are keeping our COVID secure measures under active review and will reintroduce mandatory mask wearing if NHSE guidance changes.

As reported in May, our recent Our Voice survey had a response rate of 55% and indicated an overall engagement score of 7.5 out of 10, which remained unchanged since our last survey two years ago. This is a good result, given the challenges of the pandemic. However, like all averages, the 7.5 figure masked significant variation between directorates. Quality scored high at 8.2, with Blood Supply and Donor Experience coming in lower at 7.3. Even within directorates, there was significant variation. For example, the overall score in OTDT was relatively high at 7.9. However, it would have been even higher if not for TES, which scored only 6.8. Directors have gone away to develop action plans, tailored to the results in their own teams.

In addition to looking at survey results by directorate, we also looked at them through a diversity lens. Whilst there was no difference by ethnicity or sexual orientation, we found lower levels of engagement among staff with reported disabilities (7.1 vs 7.5). As such, we have highlighted this as one of our corporate engagement priorities for the coming year. We were also concerned that 14% of our people reported bullying and harassment – a figure that was even higher amongst our BAME and disabled colleagues. As such, it was agreed that this would be another corporate priority. Finally, reward was one of the lowest scoring areas of the survey. Whilst pay is set outside of NHSBT, we have gone away to consider what – if anything – can be done to improve this area of staff concern – particularly for our lower banded staff where engagement is lowest.

8. Finance

The audit of the Annual Report of Accounts (ARA) for 2021/22 has been completed with no adjustments to the draft account . It has emerged, however, that a number of employee related matters, especially with regard to exit arrangements, require retrospective approval from Treasury. As a result, we will not now be able to meet our timetable for laying our accounts before Parliament pre-recess in July. We now expect to lay our accounts in October.

The financial results for May 2022 show that we continue ahead of plan, with a reported surplus of £4.3m versus a budget surplus of £0.9m. This was primarily driven by positive variances in Clinical Services (higher activity levels / income), ODT (lower activity / costs) and Group Services & Change Programme (albeit mostly phasing differences with expenditure expected to catch up through the remainder of the year). The cash balance at the end of May was £75m and capital spend to date was £0.9m.

At the time of writing, the results for quarter one are being prepared, ahead of the first reforecast of the year. Once confirmed, these will be used in conjunction with the long term assumptions and plans to inform the 2023/24 pricing and budget cycle. This round of planning will be particularly challenging based on the significant pressures we are currently facing given inflationary risks, the focus on building and maintaining blood stocks and the subsequent impacts on capacity.

9. Digital, Data and Technology Services

The project to build a new Data Insights Platform has mobilised: three prospective industry partners have been shortlisted and a partner will be selected in July. Ahead of the industry partner being selected a foundational platform is being built and will onboard some basic data sets. In parallel we are bringing together all the data required to manage Blood Stocks into a single repository and creating automated dashboards to aid decision making. We expect the demand for data insights to

grow when people see what's possible and will examine at mid-year whether we should fund additional investment this financial year.

The Datacentre Programme is continuing to deliver new capabilities that reduce our risk and improve performance. The Shared Service and Storage £10m capital project was formally closed with the benefits reviewed at the Finance and Performance Committee. Preparations for the move of our secondary data centre to a new facility are proceeding well with migration activities planned to happen in October/November 2022. Whilst the move of a datacentre is a significant undertaking, we have an experienced team in place to lead the change and maintain strong links with key business areas to ensure that everyone is consulted before systems are moved. Additionally the work that we are doing to move the Oracle eBusiness Finance solution to cloud based infrastructure is progressing with plans to migrate the service in November. The business case for the Connectivity Project will be presented to Board in September and is an important contributor to delivering efficiencies.

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