NHS
Blood and Transplant

CQC Report Response

Action Plan

Caring Expert Quality

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Actions

Actions that MUST be taken to improve

Regulation 5:
Fit and Proper Persons: Directors

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The provider must ensure, people who have director level responsibility for the quality and safety of care, are meeting the fundamental standards are fit and proper to carry out this important role.

Responsible Director: Deborah McKenzie	**Responsible Group:** People
Requirements	**Response**
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	• A policy was approved by the Board and Executive in August 2022 which ensures Fit and Proper Persons Regulations (FPPR) compliance for new Executive team members. • New Board and Executive members will be tested for compliance with FPPR prior to appointment • Action will be taken to address any shortfalls identified as a result of a gap analysis into Executive and Non-Executive records of FPPR. • Responsibilities for FPPR annual checks to be built into the Terms of Reference for the People Committee
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to be put in place to check this?	• We are implementing the new policy which will also ensure annual checks take place. • Company Secretary will submit an annual paper and report to the People Committee confirming compliance.
What resources (if any) are needed to implement the change(s) and are these resources available?	• The existing People Committee will complete annual routine checks • The existing General Counsel and Company Secretary will be responsible for ensuring this takes place on an annual basis for in post Execs. • The People Directorate will ensure that all checks are completed as part of the recruitment process.
When will actions be completed by?	For existing Executives, by the end of December 2022 For NEDs, by the end of December 2022
How will people who use the service(s) be affected by you not meeting this regulation until this date?	The risk of doing nothing is that we have a perception that current Execs are missing key capabilities to discharge their role.

Regulation 17: Good Governance

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1. The provider must maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity.

Responsible Director: Deborah McKenzie	**Responsible Group:** People
Requirements	**Response**
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	• Action will be taken to address any shortfalls identified as a result of a gap analysis into Executive and Non-Executive records of FPPR • We will build checks into our assurance framework and report to Audit, Risk and Governance Committee
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	• Annual audits of records according to FPPR criteria will be built into an internal audit schedule for assurance of compliance
What resources (if any) are needed to implement the change(s) and are these resources available?	None additional
When will actions be completed by?	December 2022
How will people who use the service(s) be affected by you not meeting this regulation until this date?	The risk of doing nothing is that we have people working for NHSBT who are not maintaining their necessary qualifications required for their role(s)

Regulation 17: Good Governance

NHS Blood and Transplant

2. The provider must seek and act on feedback from relevant persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. (Post inspection notes: Confirmed with CQC that this pertains to staff feedback)

Responsible Director: Gail Miflin	**Responsible Group:** N/A
Requirements	**Response**
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	• We will continue to raise the awareness of the existing routes for feedback including such areas as Freedom to Speak Up, line management 1:1s etc • SMT meetings will include a standing agenda item to ensure staff feedback is reviewed and then collated through the Clinical Governance Committee where it relates to Patients; other issues will be directed to the most appropriate forum (e.g. Risk Management Committee; Health & Safety; EDI Council)
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	• We will define a mechanism to review, triage and allocate feedback and a management system to log and monitor.
What resources (if any) are needed to implement the change(s) and are these resources available?	• In the long term, we will need resource to co-ordinate and action the feedback. Resources will be requested by Business Cases for viable projects and/or agreed at Budget Build.
When will actions be completed by?	• Awareness of existing routes and SMT agenda revisions can be completed by the end of December 2022 • A gap analysis will take place before the end of January 2023 • The long term work plan will be a key objective for the incoming Director of Nursing once they have had a suitable induction period
How will people who use the service(s) be affected by you not meeting this regulation until this date?	• Not fulfilling this action will risk leading to suboptimal services for patients and the loss of opportunities to improve or reduce risks of patient or donor harm.

Regulation 17: Good Governance

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3. The provider must ensure that all staff including those with particular protected characteristics under the Equality Act, are treated equitably to ensure a fully inclusive culture

Responsible Director: Deborah McKenzie	**Responsible Group:** D&I team
Requirements	**Response**
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	• We have agreed three EDI organisational objectives. These are going through the internal process for ratification. • We have committed to completing the action plan identified from WRES, WDES and gender pat gap data. • Inclusive recruitment process is in place. Recruitment can only be completed following e-training, which includes a module in equality and diversity. • We are co-creating and implementing an anti-racism and anti-discrimination framework. • The Board is undertaking an expert-led training and coaching programme on anti-racism. • We have hosted sessions for senior leaders on creating a psychologically safe environment. • *Refer to Freedom to speak up actions below (slide 12)*.
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	Through the annual reporting via WRES, WDES and the Gender Pay Gap we track progress. Through the regular Board and Executive reporting we review differences for a range of measures and have targets to achieve equity.
What resources (if any) are needed to implement the change(s) and are these resources available?	Additional resources to lead and deliver a People and Culture transformation programme.
When will actions be completed by?	Phase 1 activities will be completed by the end of March 2023; the programme mandate and plan will be in place by the end of March 2023
How will people who use the service(s) be affected by you not meeting this regulation until this date?	Phase 1 activities are underway as a priority.

Regulation 18: Staffing

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1. The provider must ensure that staff receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.

Responsible Director: Deborah McKenzie		**Responsible Group:** People
Requirements	**Response**	**Target**
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	**Organisation-wide:** • We require all colleagues to complete statutory and mandatory training via ESR • We are implementing a Quality Team led Mandatory Training Group to address issues with completion of training • We have self-directed guidance available on the intranet around completion of appraisals which can be used as a refresher on how to carry out appraisals for colleagues and managers • We monitor both statutory and mandatory training and appraisal completion rates at SMT level and address issues • We are holding monthly 'Open House' development sessions for managers (and aspirational managers) on all subjects relating to effective leadership/management • We are developing a formal management development programme so our managers, supervisors and leaders can be their most effective. This will include both knowledge and skill-based development	• In place • March 23 • In place • In place • Commenced • Feb 23

Regulation 18: Staffing

NHS Blood and Transplant

1. The provider must ensure that staff receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.

Responsible Director: Deborah McKenzie/Exec Directors	**Responsible Group**: People
Requirements	**Response**
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	A monthly report is produced by the Leadership Performance and Culture Team for each People and Culture Partner (PCP) to discuss with each Directorate so action can be taken. All of the Management Development will be evaluated using the Learning-Transfer Evaluation Model (LTEM) to ensure effectiveness.
What resources (if any) are needed to implement the change(s) and are these resources available?	All resources available within the current Leadership Performance and Culture Team
When will actions be completed by?	Many of the actions referenced on the previous slide are already in place or have commenced. Implementation of Mandatory Training Group by March 2023 Development of Management Development programme by February 2023
How will people who use the service(s) be affected by you not meeting this regulation until this date?	Potential staff dissatisfaction and high turnover

Regulation 18: Staffing

NHS Blood and Transplant

2. The provider must consider how they can assist the donor centres who are not meeting their target for safeguarding level 2 training.

Responsible Director: Paul O'Brien	**Responsible Group:** Blood Donation
Requirements	**Response**
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	• We are completing a gap analysis to see who is non-compliant and why • All teams have been asked to address any non-conformance • We are arranging for blood collection teams to be provided with a laptop and wi-fi access to enable completion of all mandatory training, including Safeguarding • Measures have been put in place to ensure that Blood Donation meets its compliance target
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	• Regular checking of MT levels and safeguarding oversight group and any mitigation actions to assure compliance are taken (every 2 months). • Local managers to also ensure MT compliance via monthly MT reporting.
What resources (if any) are needed to implement the change(s) and are these resources available?	IT support, but falls within manager's responsibility to monitor and assure compliance. Mandatory training time is allocated to all teams (minimum 3 days PA) but will be reviewed as part of the revised Staffing Model.
When will actions be completed by?	IT (Laptops) - Q4 22/23 (TBC) Safeguarding Oversight Group actions - Dec 2022
How will people who use the service(s) be affected by you not meeting this regulation until this date?	All RNs are level 2 trained on session, compliance achieved with all level 1 training (97.5%). Currently 93.5% compliance with BD teams at level 2. Minimal impact. Supporting colleagues trained to level 3 and above.

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Actions

Actions that SHOULD be taken to improve

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1. The provider should consider ensuring that a board lead with accountability for Equality and Diversity is identified

Responsible Director AND Group
Deborah McKenzie

Actions	Target Completion Date
a. Chief People Officer (CPO) has executive accountability for EDI. The accountability for EDI is included in the job description for CPO.	Completed
b. People Committee Terms of Reference to include responsibility for assuring EDI compliance	March 2023

Well Led

NHS Blood and Transplant

2. The provider should consider further Freedom to Speak Up champions within its locations. The provider should ensure staff are made aware of The Freedom to Speak up Guardian, who this is and their role. Staff should also be made aware of who their regional Freedom to Speak up champions are

Responsible Director AND Group
Deborah McKenzie and People

Actions	Target Completion Date	Updates
a. We will recruit 1 additional Freedom to Speak Up (F2SU) Guardian which will be split into 2x0.5 WTE posts	Apr 2023	Funding has been secured and recruitment will commence by Christmas 2022
b. We will expand the Freedom to Speak Up Champion network by 50 people	Apr 2023	12 additional Champions have been recruited taking us to 17. We aim to have 25 in place by the end of the year and 50 by Easter 2023
c. Explore the possibility to provide a mobile application available to all colleagues to enable staff without NHSBT devices to raise concerns openly, confidentially or anonymously	Jan 2023	
d. An awareness campaign took place throughout October 2022 in line with Freedom to Speak Up month. An internal communications plan has been developed with the F2SU Guardian.	Completed	
e. SMT members will encourage members of the F2SU network to attend their Team Talk meetings at least once every 6 months to promote awareness	Ongoing	To discuss with Exec sponsor and Comms to include in standing agenda for Team Talk
f. Update Speak up / Whistleblowing Policy	Jan 23	
g. Speak Up and Listen Up training to become part of Induction and mandatory training	End March 23	

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3. The provider should ensure that it uses the Workforce Race Equality Standard (WRES) by collecting, monitoring and acting on information in a timely way to improve its WRES data and to agree and implement actions that will improve equality of experience for staff and/or donors with protected characteristics.

Responsible Director AND Group
Deborah McKenzie and D&I team

Actions	Target Completion Date
a. The WRES data has been collated and will be presented to NHSBT's Executive and People Committee on 6 December 2022 prior to publication.	Dec 2022
b. D&I dashboard data is published on our intranet each month	Completed
C We will commit to publishing the WRES data annually and by the deadline set	Feb 2023
d. We are actively sharing the WRES and WDES data with the organisation	Completed
e. NHSBT's commitment to D&I for all characteristics across the workforce We have created a template to record data on the experience of LGBT+ and female staff	Jan 2023
f. We have a set of recommended actions around inclusive recruitment, internal career progression and tackling racism which we will present to the Exec in December 2022.	Dec 2022
g. We are implementing a Reverse Mentoring initiative across NHSBT following a successful pilot within People.	Jan 2023

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4. The provider should consider the effectiveness of the clinical leadership at executive level to assure themselves that the leadership is in line with organisational requirements.

Responsible Director AND Group
Janet Kidd and Governance

Actions	Target Completion Date
a. The Board has approved a revised board level committee which will improve oversight (approved September 2022). We will implement a new Board level Clinical Governance Committee.	Jan 2023
b. We will audit the new Board level committee structure to ensure that it is effective and report to the Board.	Jul 2023
c. We will complete a gap analysis and review all other clinical committee structures that feed directly into board level committees to ensure the appropriate level of input and output.	Jul 2023
d. We will instruct all committees perform an effectiveness review within an agreed cycle. This will be included within their terms of reference.	May 2023
See action in nursing leadership effectiveness	End Q1 2023/24

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5. The provider should review its system to provide effective nursing leadership at executive level

Responsible Director AND Group
Wendy Clark

Actions	Target Completion Date	Updates
a. We will draft a Job Description and Person Specification for a Director of Nursing for evaluation and submission to DHSC	Dec 2022	• The aim is to finalise the JD, PS and org chart w/c 21st Nov to go to ET for discussion and approval. It will then go to DHSC who forward to NHSBSA for evaluation. • In parallel we will prepare the business case for DHSC RemCom. • Once we have the formal evaluation of the role we will need to ensure that appropriate remuneration benchmarking information is included in the business case – this will need to include public and private sector benchmarks (a specific ask from DHSC and Ministers).
b. We will submit a Business Case for approval	Feb 2023	• Business case for submission, ideally on the 6th Dec but if we miss this it will go in January.
c. We will commence recruitment for a Director of Nursing	End Q1 2023/24	• Once we get approval at this stage we will start the recruitment activity although preparation for recruitment can be done in parallel to the above

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6. The provider should ensure that it fulfils its public sector equality duty reporting obligations under the Equality Act 2010

Responsible Director AND Group
Deborah McKenzie and D&I team

Actions	Target Completion Date
a. NHSBT have published 3 specific and measurable equality objectives for the organisation to achieve in pursuance of one or more aims of the general equality duty.	Complete
b. NHSBT, its D&I team, and others functions will show due regard for 3 aims of general equality duty by organising year-round D&I events for staff, service users, and patients which provide education, awareness and reinforce duty to eliminate discrimination, advance equality, and foster good relations across characteristics.	Jan 2023
c. We will publish information showing compliance with general public sector equality duty, in relation to employees, and others affected by policies and practices e.g. donors, patients, and service users.	Jan 2023
d. We will produce a report detailing policies, practices and processes renewed, revised, or simply reviewed in past year, and details of how EIA was done on policies and when it was signed off.	Jan 2023
e. We will produce a summary of D&I-projects/initiatives at national, regional, directorate, or Board and Exec level. Include report on Directorate D&I plans, Staff Network plans, and D&I team plans. It will set out how they were designed, developed, delivered; how they measure impact; where updates are reported and include stakeholders.	Jan 2023
f. We will share the D&I calendar (12 anchor events in 12 months) of D&I shared moments and comms across NHSBT centres, directorates, staff networks, corporate and front line service	Jan 2023

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7. The provider should consider reviewing the record its internal clinical and internal audit to assure themselves it is complete and in line with organisational requirements.

Responsible Director AND Group
Carl Vincent

Actions	Target Completion Date
a. Finance will complete a review of our existing internal audit schedule to ensure there are no gaps	Jan 23
b. Finance will review our audit processes in line with our NHSBT strategy and ensure that audit processes are aligned (If required, we will design a new internal audit schedule to address findings)	Mar 23

Blood Donation

NHS Blood and Transplant

1. The provider should consider how they can help those donor centres who are not meeting their target for appraisals

Responsible Director AND Group
Paul O'Brien and Blood Donation

Actions	Target Completion Date
a. We will complete a gap analysis to assess who has not had an appraisal and the reason why or appraisals that have been completed but not recorded	Nov 2022
b. We will protect time for those who have not had an appraisals to complete them.	Feb 2023
c. We will promote the availability of existing resources to support development such as the Leadership Ladder	Nov 2022
d. We will complete a gap analysis to establish where more managers and supervisors are needed to complete PDPRs	Nov 2022
e. We will train more staff to enable them to carry out PDPRs.	Jun 2023
f. We are reviewing the Staffing Model and will identify an action plan for Blood Donation which will further improve the ability for PDPRs to take place.	Apr 2023

Blood Donation

NHS Blood and Transplant

2. The provider should consider how board members can be more visible to staff working in donor centres

Responsible Director AND Group
Janet Kidd (Board)
Naomi Saunderson (SLT)

Actions	Target Completion Date
a. We will produce organograms to display at each centre or base to ensure that all colleagues know who our Executive Team and Board members are	Jan 2023
b. We will assign Executive and Assistant Directors to a site or centre based on their home location.	Jan 2023
c. We will advertise and encourage all staff members to attend and/or watch NHSBT public Board meetings. Staff will have the opportunity to ask questions and scrutinise set agenda.	Jan 2023
d. We will add to the Audit, Risk and Governance Committee (ARGC) standing agenda, alongside the MHRA post-inspection visits, the opportunity for NEDs to meet staff	Jan 2023

Blood Donation

NHS Blood and Transplant

3. The provider should ensure staff with protected characteristics have their well-being met and reasonable adjustments are made for staff who require them.

Responsible Director AND Group
Deborah McKenzie and Blood Donation
(People to consider the organisation-wide implications)

Actions	Target Completion Date
a. Develop EDI plan with Blood Donation teams with a supporting engagement and communications plan	Mar 2023
b. Psychological safety training. Liaise with Leadership, Performance and Culture (LPC) to see how we can reach all colleagues.	Dec 2022
c. Implement top tips for inclusivity to be delivered to all Blood Donation colleagues. • Top tips to be delivered as part of the fortnightly Blood Donation webinars. • Top tips to be delivered across frontline teams as part of team training days / team engagement time.	April 2023
d. Freedom to Speak-Up included within fortnightly Blood Donation webinar.	Dec 2022
e. Flexible working / reasonable adjustments included within fortnightly Blood Donation webinar. This will increase awareness for all staff on what support is available.	Jan 2023
f. Progress “Our voice” actions.	Mar 2023

Blood Donation

NHS Blood and Transplant

4. The provider should ensure all staff and not just those with caring responsibilities are made aware of the flexible working policy to help them balance their hours.

Responsible Director AND Group
Paul O'Brien and Blood Donation
(People to consider the organisation-wide implications)

Actions	Target Completion Date
a. We will host webinars with Senior Sisters / Donor Centre Managers to go through real-life examples of how it can work and other important issues.	Jan 2023
b. We will ensure all new starters have a copy of the flexible working policy.	Nov 2022
c. We will work with our staff to review and identify opportunities for flexible working as part of the staffing review.	Apr 2023

Blood Donation

NHS Blood and Transplant

5. The provider should ensure their risk register includes any actions to minimise their risks and how long they had been on the register.

Responsible Director AND Group
Helen Gillan and Governance

Actions	Target Completion Date
a. We will review all existing risks and ensure that they have relevant actions associated with each one.	Jan 2023
b. Recruitment of a dedicated risk manager to support Blood Supply.	Jan 2023
c. We will create a mandatory training package for the organisation on Risk Management. This action will include creation, approval and implementation of the training package.	Mar 2023

Therapeutic Apheresis Service (TAS)

NHS Blood and Transplant

1. The service should ensure that all notifiable incidents are reported to CQC as set out in the Care Quality Commission (Registration) Regulations 2009 (part 4)

Responsible Director AND Group
Helen Gillan and Governance

Actions	Target Completion Date
a. We will create a new SOP to document the process for reporting to CQC including what we report, how we report and the escalation procedure *(Note: This SOP will also apply to Blood Donation)*	Feb 2023
b. We will update the overarching Incident Management process to include reporting to the CQC	Mar 2023
c. We will ensure that reportable incidents are appropriately identified and discussed at the relevant NHSBT CARE committee.	Dec 2022

Therapeutic Apheresis Service (TAS)

NHS Blood and Transplant

2. The service should strengthen its governance through the development of data and information systems.

Responsible Director AND Group
Gail Miflin and TAS

Actions	Target Completion Date	Updates
a. Discovery work to identify the gaps and potential suitable digital platform ongoing to identify scops and gaps.	Jan 23	
b. Define specification and agree strategic outline case	April 23	
c. Gap analysis of the extent of risk to include emergency treatment pathway (including referrals, patient treatment plan and prescription).	Jan 23	
d. Interim risk mitigations of data/information system; (I) consolidate existing risks into a single risk assessment. The risk register will subsequently be updated with appropriate control measures. (ii) Interim risk mitigation includes making sure all letters are reviewed by the authors before these are sent to patients for accuracy. (iii) reconciliation of referrals to ensure no missed referrals	Dec 22 Jan 23 April 23	
c. Audit of above risk mitigations using Tendable will be introduced following their implementation	Apr 23	
h. Governance: Use of existing quality/governance management system (QMS) to report, investigate and trends any non-conformances	In place	QPulse system currently in use
f. Assurance: All Tendable audit reports and/or escalations will be submitted to CS CARE and SMT (by exception)	In place	

Therapeutic Apheresis Service (TAS)

NHS Blood and Transplant

3. The service should ensure the deployment of sufficient numbers of staff across all units/locations so as to ensure and maintain staff well-being as well as patient safety and oversight of the service

Responsible Director AND Group
Gail Miflin and TAS

Actions	Target Completion Date
a. Daily and weekly planning of workload and capacity to determine adequate staffing needs	Completed
b. We created an action plan to address Our Voice survey results to improve retention and staff wellbeing. This is monitored at SMT monthly	Dec 22
c. Create a staff manual to support deployed staff attending unfamiliar units to their base (include information on available parking etc)	Mar 2023
d. Review the travel framework (provides guidance on safe practices for all staff) and create an action plan for any necessary changes	Apr 23
e. We will review our Recruitment and Retention Strategy with our People & Culture Partner (PCP and Nursing Council) and create an action plan to implement any required changes.	Jun 2023

Therapeutic Apheresis Service (TAS)

NHS Blood and Transplant

4. The service should ensure all staff receive a regular appraisal and development plan

Responsible Director AND Group
Gail Miflin and TAS (People need to consider the organisation wide implications)

Actions	Target Completion Date	Updates
a. Identify hotspots through ESR records and identify related staff and managers (monthly automatic reports are generated)	In place	
b. Understand the reasons for the gaps and provide support as required (e.g., training).	May 2023	
c. We will review our current appraisal process and implement improvements, including appraisal training programme to support staff development based on individual needs	May 2023	
d. Assurance; review of records and progress regularly at Clinical Services SMT and CARE meetings	In place	

Therapeutic Apheresis Service (TAS)

NHS Blood and Transplant

5. The service should ensure all Clinical staff providing care and treatment to children and young people receive level 3 child safeguarding training and those supervising those staff have training at a sufficient level in accordance with the intercollegiate guidance

Responsible Director AND Group
Gail Miflin and TAS

Actions	Target Completion Date
a. We have recruited a Safeguarding Lead for the organisation who is currently involved in this action plan	Complete
b. We will review the matrix for mandatory safeguarding training to ensure that the staff groups are completing the correct level for their role.	March 2023
c. We will link with HR to add the Safeguarding Level 3 to ESR for all TAS nurses at Band 6 and above, including new starters	March 2023?
d. We will design a Safeguarding level 3 bespoke training for TAS staff.	May 2023?
e. **Assurance**: We will monitor progress through Clinical Services SMT and CARE group meetings	In place