NHS Blood and Transplant

Board Meeting in Public
Tuesday, 28 March 2023

Title of Report	Care Quality Commission (CQC) Action Plan Report		**Agenda No.** 3.2
Nature of Report (tick one)	☒ Official	☐ Official Sensitive	
Author(s)	Iroro Agba, Assistant Director of Quality		
Lead Executive	Helen Gillan, Director of Quality		
Non-Executive Director Sponsor (if applicable)	N/A		
Presented for (tick all that applies)	☒ Approval ☒ Assurance	☒ Information ☐ Update	

Purpose of the report and key issues

The purpose of this paper is to provide information and assurance to the Board on the progress being made by NHSBT against its CQC action plan, following the Well-Led and regulated activity inspections in June & August 2022.

There was a total of 32 actions created to mitigate all 6 MUST (Well-Led) findings. 20 actions have been closed. No action is overdue its target date. There are requests for amendments to actions within this paper which the Board are asked to consider.

Significant progress is also being made with the 16 SHOULD findings.

Previously Considered by

The action plan is considered by the Executive Team on a weekly basis.

Recommendation	The Board is asked to the progress made against the action plan and raise comments or recommendations where necessary.

Risk(s) identified (Link to Board Assurance Framework (BAF)Risks)

BAF 09: Regulatory risk

Strategic Objective(s) this paper relates to: [Click on all that applies]

☐ Collaborate with partners ☒ Invest in people and culture ☐ Drive innovation

☐ Modernise our operations ☐ Grow and diversify our donor base

Appendices:	CQC Report Action Plans 1. Well Led Action Plan 2. Blood Donation Action Plan 3. Therapeutic Apheresis Services Action Plan

1. Background

1.1 Between June and August 2022, the CQC performed an organisation-wide Well Led inspection and inspected the regulated activities in Blood Donation (BD) and Therapeutic Apheresis Service (TAS). The final report was received in late October 2022.

1.2 There were 6 MUST and 16 SHOULD findings raised in total. Each finding has sub-actions associated with it.

1.3 The action plan was sent to the CQC in line with their requirements and progress is reviewed at Executive Team meetings. This enables conversations so that good practice is shared across the directorates.

2. Summary of Open Actions / Requests for amendment

2.1 There are 12 open 'MUST' actions from the Well-Led inspection.

2.2 Most actions are expected to be closed within their due dates. There are 5 "MUST" actions where we are requesting amendments to ensure actions are completed effectively.

2.3 19 'SHOULD' actions remain open across the Well-Led, Blood Donation and Therapeutic Apheresis Service (TAS) findings. We are requesting amendments to 3 actions.

	For Board Consideration - Amendments Requested:
1.	**Must 1e: Fit and Proper Persons Check (INC85234 SA6)** Action: Company Secretary will submit an annual report to the People Committee Current Due date 30/4/23 Extension requested as People Committee is scheduled on 7th June New closure date proposed 30th June 2023
2.	**Must 5d: Fully inclusive culture (INC85238 SA5)** Action: Co-creation and implementation of an anti-racism and anti-discrimination framework Current Due date 31/3/2023 Amendment to action requested: This wording does not reflect the work currently ongoing (reference the Board paper "People and Culture Programme"). The Board paper outlines the plan to co-create and implement an anti-racism and anti-discrimination framework. It is requested that an amendment is made to this action to close it on the basis that actions will be tracked through the People and Culture Programme.

3.	**Must 5b: Fully inclusive culture (INC 85238 SA3)** Action: Complete the action plan from WRES / WDES / Gender Pay Gap data Current Due date 31/3/23 Amendment to action requested: The wording of this action is intended to read to "produce an action plan" rather that "complete an action plan". The action plan is on track to be completed within the timescales.
4.	**Must 5e: Fully Inclusive Culture (INC 85238 SA6)** Action: Board to complete expert-led training and coaching programme on anti-racism Current due date: 31/3/23 Amendment to action requested: Action partially completed. The Board have completed their anti-racism coaching. Expert-led training will be arranged when new NEDs start. Request to close the action around coaching. Open a new action to monitor the completion of the Expert-Led training in anti-racism. Proposed new date: end of September.
5.	**Must 5i: Fully Inclusive Culture (INC 85238 SA10)** Action: Update the whistleblowing policy to mirror the National Guardian Office recommendations Current due date: 31/03/2023 Amendment to action requested: The policy has been approved by Policy Subcommittee (joint meeting with management and staffside). The change to the policy will be reviewed at Staff Partnership Committee on 18/05/2023. Proposed new date for closure: end of May.

6.	**Should 3e: Workforce Race Equality Standard (INC 85242 SA6)** Action: Create a template to record data on the experience of LGBTQ+ and female staff. Amendment requested: After reviewing this action it was felt that it had been superseded and should be de-prioritised to enable the EDI team to focus on the WDES action plans. Disabled staff experience is ranked worst across NHSBT. Proposal is to close this action and focus on WDES action plan.
7.	**Should 3g: Workforce Race Equality Standard (INC85242 SA8)** Action: Implement a Reverse Mentoring initiative across NHSBT following a successful pilot within People Directorate Current due date: 31/3/2023 Amendment requested: Pilot has been completed and is being evaluated. A proposal will be prepared for Executive Team to determine the scope of a Reverse Mentoring initiative. This action should be closed when the proposal is presented to the Executive Team by end of May 2023. Revised due date 31/5/2023
8.	**Should 4b: Public Sector Equality Duty (INC85243 SA3)** Action: We will publish information showing compliance with general public sector equality duty, in relation to employees and others affected by policies and practices. Current due date: 31/3/2023 Amendment requested: This action has been impacted by changes to the team, request to reassess timelines and then revert to Board for approval (Deb McKenzie).

3. Sample of closed actions

CQC Findings	NHSBT Action	Impact	Evidence of closure
		Well-Led	
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.	SMT meetings to include a standing agenda item to ensure staff feedback is reviewed, discussed, collated and escalated through Clinical Governance Committee or appropriate forum.	✓ Targeted and proactive service improvement from better insight. ✓ Improved staff engagement. ✓ The development of service area plans by co-design.	✓ Directorate SMT agenda / meeting minutes.
		Blood Donation	
The provider should consider how they can help those donor centres who are not meeting their target for appraisal.	We will protect time for those who have not had an appraisal to complete them.	✓ 95% appraisal target achieved by the team. ✓ Leadership working to reach 100% compliance, ✓ The continuous improvement team are working to create a workload tracker to enable an even spread of appraisals for completion across the year.	✓ BD mandatory training and PDPR monthly report.
		Therapeutic Apheresis Service	
The service should strengthen its governance through the development of data and information systems.	Perform a discovery to identify the gaps and potential suitable digital platform / solution.	✓ A clear user requirement (URS) for TAS has been outlined from the discovery (collaborative piece between TAS and TPX Impact). ✓ URS has informed the architect team exploration of suitable solutions. ✓ A business case is being developed for Q1 23/24.	✓ Discovery report. ✓ Architecture impact assessment report.

4. Next steps

4.1 The Assistant Director – Quality will continue to regularly review with stakeholders to monitor progress and collect objective evidence.

4.2 Following discussion at the Audit, Risk and Governance Committee, there is an action to arrange a follow up "well led" audit to assess our status. The timing and scope will be determined by the Director of Quality (Nominated Individual for CQC) and Company Secretary.