

# NHS Blood and Transplant

## Inspection report

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## Ratings

### Overall trust quality rating

Inspected but not rated ●

Are services well-led?

**Inspected but not rated** ●

# Our findings

## Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

## Overall summary

### What we found

#### Overall trust

NHS Blood and Transplant (NHSBT) is responsible for the supply of blood, organs, tissues and stem cells. It collects and supplies blood to hospitals in England and is the organ donation organisation for the UK. NHSBT is a special health authority, sponsored by the Department of Health and Social Care.

Not all activities undertaken by NHSBT are regulated by CQC, for example, laboratories where blood donations are processed into components, tested, stored and distributed. This is because these activities do not involve direct contact with donors or patients. The Medicines and Healthcare products Regulatory Agency (MHRA) also regulate NHSBT which includes the manufacture of medicinal products for example, medicinal blood components like albumin and platelets.

This is the first inspection of this service. This was a reactive focussed inspection but was not rated as CQC does not have a duty to apply ratings to NHS Blood and Transplant.

We carried out this short notice, announced, reactive, focused inspection at NHS Blood and Transplant (NHSBT) to undertake an assessment of how well led this organisation is.

We took this approach because we had received information giving us concerns about the culture within the organisation and unacceptable behaviours at a very senior leadership level. This can have an impact on the quality and safety of any service.

In June 2022 we inspected the well-led key question for the provider overall.

In August we inspected Birmingham, Bristol, Gloucester, Oxford and Plymouth donor centres based on concerns we had following our well led inspection. These were focused inspections where we looked at some aspects of safe, effective, caring and well led.

This was the first inspection of the Birmingham, Bristol and Gloucester donor centres. Oxford and Plymouth donor centres were last inspected in February 2014.

# Our findings

In August 2022 we inspected Bristol Therapeutic Apheresis Unit and Oxford Therapeutic Apheresis Unit; based on concerns we had following our well led inspection. These were focused inspections where we looked at some aspects of safe, effective, caring and well led.

This was the first inspection of the Oxford and Bristol Apheresis Units. Our inspections of both NHS and independent health organisations have shown a strong link between the quality of overall management of an organisation and the quality of its services. For that reason, in this circumstance, we looked at the quality of leadership at assistant director level and above.

We also looked at how well NHS Blood and Transplant managed the governance of its services.

Our findings are as follows;

- Staff were proud to work in the organisation, people told us that “we save and improve lives”, it was a mantra that staff believed in and one we heard consistently.
- All of the people we spoke with demonstrated both a personal and organisational commitment to provide high-quality services.
- The board and executive leadership team had a vision and set of values that were at the heart of the work within the organisation. They had worked to ensure staff at all levels understood them in relation to their daily roles.
- The organisational strategy was directly linked to the vision and values of the organisation. The organisation involved staff at all levels, donors and groups from regional and local communities in the development of the strategy and from this had a clear five-year plan.
- The organisation had a structure for overseeing performance, quality and risk, and improvements had been identified and were being enacted.
- The board reviewed performance reports that included data about the services.
- The organisation made sure that it included and communicated with donors, staff, the public, and local organisations. It supported the divisions to engage with the organisations communication and engagement strategies and encouraged staff to get involved with projects affecting the priorities of the organisation.
- The organisation had maintained a safe service during the pandemic. Staff had contributed to decision-making and changes to routines to help avoid pressures from the pandemic compromising the service provision.

However:

- The organisation had experienced significantly high turnover in the senior leadership team.
- We saw some silo working. This meant, potentially those working and leading those areas may not have oversight of issues facing the service and those who rely on its products. Furthermore, this may impact in levels of responsiveness when services needed more support.
- Recruitment processes and records were poor with a lack of scrutiny, resulting in the required employment checks not being undertaken for those employed at executive level. Where checks had been completed for some executives, these had only been undertaken at initial recruitment and not annually. This did not meet the requirements of the Fit and Proper Person Regulation.
- Some staff did not have confidence in HR processes and provided examples of the organisation’s policies in relation to recruitment and selection and staff grievance procedures not being followed.

# Our findings

- The induction staff received did not equip them with the knowledge required to integrate them into the organisation. Some donor centres were not meeting the provider's targets for appraisals.
- Not all staff at the donor centres were meeting their target for safeguarding level 2 training.
- Some staff told us of poor experiences at work. This included fear of reprisal and discrimination.
- Board members recognised that they had work to do to improve diversity and equality across the organisation and at board level.
- There was not an effective overarching equality, diversity and inclusion strategy in place. There had been some work on equality, diversity and inclusion within the organisation, including the development of divisional strategies, but this work had not led to meaningful improvements.
- We heard from staff, employed at various levels within the organisation that some leaders were not approachable, some staff experienced fear, many did not feel respected, valued or supported, and we heard that some staff were bullied and harassed by leadership.
- Staff felt some senior staff above regional level were not visible, this included members of the board.
- There were mechanisms for people to raise concerns, but these were not as effective as they could be.
- The provider had a risk register to document their risks at the donor centres, however, these did not include any actions to minimise these or how long they had been on the register.

## How we carried out this inspection

We carried out this short notice, reactive, focussed inspection of the well led key question at the providers main location of Filton for NHS Blood and Transplant (NHSBT) as part of our continual checks on the safety and quality of healthcare services.

We also conducted this inspection because a number of former and current staff whistle blowers had contacted us to raise concerns about the quality and safety of some services. During the inspection staff raised a number of significant concerns in relation to how they or their colleagues were treated, and reports of a toxic and unhealthy culture were also raised to us prior to, during, and post the inspection site visit.

As part of the well led inspection, we spoke with over 60 staff across all disciplines, this included meeting with most of the senior leaders, including the Chief Executive, Chair and Non-executive directors, we also met with some assistant directors. We met with staff representative groups, including those with protected characteristics.

We undertook a staff survey for staff employed at NHS Blood and Transplant and received over 350 replies.

We looked at a range of performance and quality reports, audits and action plans. We reviewed previous public and private board meeting minutes, committee papers, annual reporting to board, board assurance framework and papers to the board. We looked at investigations of internal and externally commissioned reports, serious incidents, complaints and sought feedback from staff and key stakeholders.

You can find further information about how we carry out our inspections on our website: [www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection](http://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection).

# Our findings

## Areas for improvement

Action the provider **MUST** take is necessary to comply with its legal obligations. Action a provider **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

### **Action the provider **MUST** take to improve:**

We told the provider that it must take action to bring services into line with six legal requirements. This action related to our well led assessment at provider level.

#### **Provider Level.**

- 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. Regulation 5: Fit and proper persons: directors
- 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. Regulation 17: Good Governance
- 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. Regulation: 18 Staffing
- 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. Regulation 17: Good Governance
- 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 Regulation 17: Good Governance
- The provider must consider how they can assist the donor centres who are not meeting their target for safeguarding level 2 training. Regulation 18: Staffing

### **Action the provider **SHOULD** take to improve:**

#### **Provider level.**

- The provider should consider ensuring that a board lead with accountability for Equality and Diversity is identified.
- 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.
- 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.
- The provider should ensure that it fulfils its public sector equality duty reporting obligations under the Equality Act 2010.

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

## **Blood Donation Centres.**

### **Location Level** - Birmingham, Bristol, Gloucester, Oxford and Plymouth locations

- The provider should consider how they can help those donor centres who are not meeting their target for appraisals.
- The provider should consider how board members can be more visible to staff working in donor centres.
- The provider should ensure staff with protected characteristics have their well-being met and reasonable adjustments are made for staff who require them.
- 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.
- The provider should ensure their risk register includes any actions to minimise their risks and how long they had been on the register.

## **Therapeutic Apheresis Service.**

### **Location Level** - Oxford and Bristol Apheresis locations.

- The service should ensure that all notifiable incidents are reported to CQC as set out in the Care Quality Commission (Registration) Regulations 2009 (part4)
- The service should strengthen its governance through the development of data and information systems.
- 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.
- The service should ensure all staff receive a regular appraisal and development plan

## Is this organisation well-led?

### **Leadership**

**The organisation lacked evidence as to whether executive leaders had the necessary experience, knowledge, capacity or integrity to lead effectively. There was high turnover in leadership roles which resulted in significant changes to the board. Not all leaders were visible or approachable.**

The board and executive leadership team had seen some significant changes in the last few years, including restructuring, new appointees, promotions, change of job roles or role titles and associated portfolios. There was a new chair of the trust who joined in May 2022. The turnover at a senior leadership level over the 2 years prior to our

# Our findings

inspection was 21% which was higher than that across the organisation (18.1%) which was in turn higher than the normal turnover in the organisation (11%). Some staff were troubled by the high turnover of executives, they felt executive leadership was unstable and people believed people were leaving due to poor board behaviours and people leaving before they were 'pushed'.

The diversity of the board was limited. Of the board members only one of the 17 board members were from a Black, Asian or minority ethnic group, this represented 5.9% of the board in comparison to 8.4% for wider NHS Trusts (2020) (1 April 2019 – 31 March 2020) and 7.6% for other arm's length bodies Data (1st April 2019- 31st March 2020).

There were significant gaps in the recruitment files for some board members which demonstrated that checks had not been carried out in accordance with 'Fit and Proper Person' requirements. The files lacked evidence of a competency based interview, disclosure and barring checks, references, a check of qualifications, and checks on membership of professional bodies. Also missing were checks for bankruptcy and having been disqualified or prohibited from being a director. The organisation relied on self-declaration rather than obtaining evidence to provide assurance. In addition, there had been no audit of executive or non-executive personnel files and no action taken in respect of the significant areas of deficit in these files. The chair of the board had identified this during our inspection process and informed us of the actions being taken to address this at pace.

Leaders understood the challenges to quality and sustainability in respect to the supply chain for blood and transplants in the UK and had identified actions to address them.

Staff knew who their leaders were but did not consistently feel that all leaders were approachable. Some staff lacked confidence in leaders' abilities to lead effectively and said risks to performance were not always addressed. An example shared with us was that the bullying nature of a senior leader had led to a number of staff leaving the organisation, we corroborated this with evidence provided during the inspection. This impacted on continuity of service, project delays and financial costs to the organisation.

There were pockets of compassionate, inclusive leadership, however many staff expressed fear of reprisal for raising issues and concerns and described an unsupportive leadership environment.

The organisation had over 700 nurses employed as well as 1500 donor carers. There was a lack of nursing, clinical leadership and accountability at executive level. Whilst there was a leadership role at director level, we did not see evidence of the difference this made in practice. Nurses at assistant director level were not managed by a nurse at a director role, and there was a lack of nursing voices being heard at board.

There were priorities for ensuring sustainable, compassionate, inclusive and effective leadership, following the 2021 review which was set out in the resolution framework dated 7 July 2022. Some actions to support these priorities had occurred, for example, the implementation of a conflict resolution framework and code of practice. However, the pace of implementation of the resolution framework was slow and had yet to have a positive impact on the culture and lived experience of staff. Further implementation work was being scoped and developed at the time of our inspection.

## Vision and Strategy

**NHS Blood and Transplant had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of the organisation and was aligned to plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

# Our findings

There was a strategy for achieving the priorities and delivering good quality sustainable care. The strategic plan for 2017-22 stated the five key objectives, and there was also a focus on continuing to modernise the service. Areas for innovation were included.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, donors, and external partners. Staff knew and understood the vision, values and strategy and their role in achieving them. Staff told us they felt proud to work for an organisation whose purpose was to “*save and improve lives*”.

Whilst staff held the values strong, they did not feel all leaders lived the values, in particular that of caring. Staff told us some leaders did not demonstrate the same level of commitment as other staff to the values.

## Culture

**There was a mixed response from staff in relation to the culture and wider concerns were raised with us in respect of poor organisational cultures. Not all staff felt respected, supported and valued.**

Many of the leaders in the organisation said that they were not a healthcare organisation, but more like a pharmaceutical manufacturing organisation. This did not lead to a culture which was centred on the needs and experience of people who used services. That said, the organisation, did collect information about the experiences of donors in their blood donation centres.

Some staff told us of poor experiences at work. These included experience of detriment where they raised issues or concerns; inequality and discrimination of staff with protected characteristics, particularly but not solely those from a Black, Asian and Minority Ethnic background. Whilst leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, the culture did not encourage openness and honesty at all levels and learning or action was not always taken as a result of concerns raised.

There were mechanisms for people to raise concerns, through the Freedom to Speak Up Guardian. The Freedom to Speak Up Guardian role was implemented in the organisation in 2019 and expanded to a full-time role when the current guardian was appointed in 2021. There were six Freedom to Speak Up Champions based across the organisation. However, there were insufficient Champions to provide support to staff across all 41 sites. Also, not all staff had access to the Freedom to Speak Up intranet to access tools, resources and signposting for staff.

There had been some work on equality, diversity and inclusion within the organisation, but there was not an overarching organisational equality, diversity and inclusion strategy in place. There were, however; separate individual directorate strategies. The organisation did not provide us with evidence that they had met their public sector Equality Duty because there had not been an update since the NHS Blood and Transplant’s 2015-2019 Single Equality Scheme.

The most recently published Workforce, Race, Equality Standard (WRES) data (1 April 2019-31 March 2020) showed similar results when compared with Arms-Length Bodies and also NHS trusts, although in some standards NHS Blood and Transplant had better results. There was no national data compiled for the year between 1 April 2020 and 31 March 2021, but the organisation measured some of the standards. Whilst recommendations were made for actions, board papers showed that the data was incomplete, analysis had not been completed and there was no action plan.

Staff at various levels raised concerns about the culture in relation to diversity and inclusion – particularly for those from a Black, Asian and Minority Ethnic background. In numerous forums, staff provided examples of how they were disrespected, discriminated against and their views were disregarded. These centred particularly on recruitment,



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development and fair treatment. Staff told us that the work on diversity and inclusion felt tokenistic and didn't lead to sustained improvements. They also said progress was slow with staff (particularly those from a Black, Asian and Minority Ethnic background) continuing to experience inequality at work. This was felt to be a long-standing problem for which staff felt that no meaningful solutions or improvements had been implemented. The concerns were further compounded by a feeling of silo working, with each directorate having a separate equality, diversity and inclusion strategy. This meant the organisation did not have a consistent approach to equality, diversity and inclusion and hence was not consistent in the approach to improving experiences for staff.

A new lead for equality, diversity and inclusion joined NHS Blood and Transplant three months prior to our inspection.

There was not an embedded culture of collective responsibility between teams and services. Whilst there were positive relationships between staff and teams, conflicts were not always resolved quickly and constructively, and responsibility was not always shared. Some staff told us they were reluctant to bring issues to board due to the unprofessional conduct of others which had interfered and undermined staff performance, impacted on relationships and had adversely affected the functioning of teams.

There were processes for providing staff at every level with development, however, there were areas for improvement. These included: ensuring induction is meaningful and provides a good foundation to equip and integrate new staff into the organisation; and provides assurance of the competency of the new starters.

## Governance

**There were governance systems and processes, throughout the organisation. However, they did not always operate effectively and were hampered by cultural difficulties. Staff were clear about their roles and accountabilities and had regular opportunities to meet and discuss the performance of the organisation.**

There was a board and committee structure within the organisation. However, there was a lack of objectivity created by the way in which committees were able to communicate with the board. Furthermore, we were given examples of when differing opinions impacted on professional relationships and created a culture of reluctance to share and hear negative information. Reports to board were described as giving false assurance, creating an undue burden and being impenetrable. We saw that the report packs for board often contained over 350 page papers, with embedded documents. The new chair was actively reviewing the committee structure, to ensure clear assurance to the board. This included the introduction of a people committee and plans to separate clinical governance from the audit and risk committee as a standalone committee. There was a board assurance framework, however, it was in its infancy having been implemented in early 2022. Other areas of improvement had been identified by the organisation including the length of papers to board.

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were set out, understood and effective. These were regularly reviewed at board and committee level. Staff were clear about their roles and accountabilities.

There was some silo working where committees didn't always interlink to share information about governance, quality and risk. This meant potentially those working and leading those areas may not have had oversight of issues facing the service and could have an impact on levels of responsiveness when services needed more support.

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Recommendations of past internal audit reports and consultancy reviews from regulatory and accreditation bodies had been implemented. These were managed in the Quality IT System (Q-Pulse) with action owners and target dates tracked across various levels. This included a recent governance and leadership review.

Staff were clear about their roles and understand what they are accountable for and to whom. Staff at all levels were committed to providing a good, safe service for those accessing their service.

There was a record of staff training which included safeguarding. All staff completed safeguarding awareness and level 2 safeguarding training every three years. The training figures sent to us by the provider demonstrated all five donor centres we visited were 93% and above for compliance with safeguarding awareness training. For safeguarding level 2 compliance, two of the centres were 64% and 77% which was below the target of 95% compliance with this training. The Birmingham location had 100% compliance for both safeguarding trainings.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance but these were not always effective. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

There were assurance systems, where performance issues should have been escalated through clear structures and processes via committee meetings and board. However, we weren't assured that the committee was using this process transparently to bring issues to board and had concerns that board may not be sighted on issues that needed addressing.

There was a programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken, however, these were not always clearly accounted for. Although the provider had in place a 3-5 year audit plan dates audits were completed or actions to be reviewed were not evident. The audit plan covered over 100 areas for review and covered corporate governance and risk, financial and commercial, information governance, clinical, facilities, people, donors and quality compliance.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The board assurance framework (BAF) is a document demonstrating the link between strategy, risk and assurance and was a tool for the board to hold the organisation to account and gain assurance that the organisation was able to meet its objectives. The Board approved the strategic risks and BAF structure in January 2022 and this was formally introduced into the organisation in March 2022. There has been an ongoing process that the risk team have undertaken to embed the BAF into NHS Blood and Transplant's governance toolkit.

There were nine recorded strategic corporate risks, with 4 of these risks being rated at 16, the highest level. Risks were aligned to the strategic priorities of the organisation with an executive lead identified, controls and assurances were recorded alongside an associated action plan.

Potential risks were taken into account when planning services, for example: the risk of failing to meet the demand for essential products and services, caused by disruption and/or variability of external factors. These external factors included donor behaviour, fluctuations in hospital demand, third party supplier shortages or adverse weather.

At location level, there were arrangements for identifying, recording and managing risks, issues and mitigating actions. At the five donor locations we visited managers were able to tell us locally what their main risks were. These included,

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for example, staffing and covering sickness. The provider sent us a copy of their manual on how managers could escalate risks on to the risk register. We were also sent a copy of the August 2022 blood donation risk register. Each risk had been assessed and given a rating of red, green or amber with red being the highest risk. One of the main risks was from COVID -19 and how this impacted on the supply of O negative blood due to social distancing and reduction in donors. The risk register included details of the risk, causes and consequences but it did not contain any actions to reduce the risk or how long the risk had been on the register.

All incidents occurring across NHS Blood and Transplant were formally investigated by a designated team and reported to the relevant Directorate Director or Deputy who oversaw the completion of the action plans. Incidents were reviewed at directorate and corporate clinical audit, risk and effectiveness (CARE) groups to ensure organisational learning and minimise the risk of a similar incident occurring.

## Information Management

**The organisation collected reliable data and analysed it. Staff could find the data they needed, to understand their performance, make decisions and improvements, although this risked being constrained by directorate structures. The information systems were secure.**

Accurate information was processed, challenged and acted upon. There was an understanding of data by the organisation's leaders and teams. It was used to measure performance. Staff received data which supported them to adjust and improve performance as necessary and performance information was used to hold managers and staff to account.

The information used in reporting, performance management and delivering the services was accurate, valid, reliable, timely and relevant, with plans to address any areas of deficit.

There was a risk created by directorate working that meant it was difficult to understand who, or which team in the organisation held collective oversight of organisation-wide operational information. There was not a chief operating officer or similar role that held responsibility or oversight of pan-organisation performance and this risked issues being lost when competing pressures arose.

Quality and sustainability both received sufficient coverage in relevant meetings at all levels, staff had sufficient access to information.

There were arrangements, including internal and external validation to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

## Engagement

**Leaders and staff actively and openly engaged with donors, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

We saw examples of how people's views and experiences were gathered and acted on to shape and improve the services. A targeted approach had been undertaken with people who had sickle cell and families in the African Caribbean community. This was to address concerns about access to specialist blood requirements and considered how the organisation could better support treatment for this illness. However, this did not always lead to or demonstrate measurable improvements.

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The organisation had an Equality, Diversity and Inclusion Council (EDIC). There were some specific networks which fed into this council, such as the LGBTQ+, the DAWN (disability), GRacE (Black, Asian and ethnic minority group) and women's network.

Staff from the networks told us of good collaborative relationships. Those we spoke with were committed to providing a safe space and there was a will to raise awareness of issues within the wider organisation. We were told that there had been recent developments within the EDIC council. However, it was too early to see any measurable improvements at the time of our inspection.

Staff from the networks highlighted support for staff who wished to raise concerns such as signposting people to contact the Freedom to Speak Up Guardian. We were told of varied experiences of staff, including those who might face discrimination or disadvantage because of more than one protected characteristic. Many people told us they had experienced bullying, harassment and discrimination not just on the grounds of race, disability and gender.

The staff-side team did not feel they were given the opportunity to engage well in the recruitment process and were not heard when there were issues raised around fairness and equity. We were given several examples of concerns that had been raised around whether short-listing and appointment processes were equitable. These were yet to be addressed.

We also saw that this had been raised via the freedom to speak up route, with the board being sighted on this, yet board had not responded to the report and no action plan had been put into place to review and address these concerns.

In 2022 the provider carried out its annual survey of all colleagues across a three-month period. The survey is called Our Voice – Let's Talk. Results from the May 2022 survey identified that in the previous 12 months 15% of staff from a Black, Asian or minority ethnic background had experienced discrimination from their line manager/team leader or other colleague in comparison with 7% for those from a white British background.

In relation to the question "in the past 12 months I have experienced harassment bullying and abuse from managers and colleagues", for Black, Asian or minority ethnic staff (BAME) staff this stood at 15% whilst for those from a white British this was 12%. It was also higher for those with a disability (15%) compared with non-disabled staff (13%).

We undertook a staff survey for staff employed at NHS Blood and Transplant and received over 350 replies. We asked people to rate the organisation in respect of the employment and development opportunities available to them and their ability to influence and shape the organisation as well as asking for a view about the organisational approach to risk and governance. Responses were mixed and well balanced, with an underpinning rationale for the response provided.

## **Key External Stakeholders.**

There were relationships with external partners and a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. Prior to our inspection we contacted the Human Tissue Authority (HTA) and The Medicines and Healthcare Products Regulatory Agency (MHRA) who regulate medicines, medical devices and blood components for transfusion in the UK, who confirmed a professional working relationship with the provider.

## **Complaints.**

# Our findings

The May 2022, complaints overview, report for board, recorded that since 2019 there had been an increase in complaints for some key areas of the donor experience, however, overall, the total number of complaints remained around 8,000 a year.

Complaints were well managed however; the timeliness of response had meant delays for some complainants. A root cause analysis of complaints raised by donors identified seven key themes. The top area of concern identified was donor session service and experience (25%).

In the previous 12 months (for a variety of reasons) NHSBT had cancelled appointments for over 116,000 donors. We saw that the provider had plans to address areas of concerns identified, which included a new marketing platform with improved personalisation which would improve communication.

## **Learning, continuous improvement and innovation**

**There was a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.**

We saw examples of how NHSBT worked to continuously improve and innovate. Quality improvement methodologies were embedded to drive improvement and efficiency in blood supply, and we saw evidence of this at the Filton site blood processing facility.

NHSBT is a partner in the Serious Hazards of Transfusion (SHOT) organisation to improve patient safety in blood transfusion by learning from transfusion adverse events and sharing with the clinical community.

We heard of examples of research and innovation. For example, NHS Blood and Transplant work in partnership with the National Institute of Health and Care Research (NIHR) to fund five NIHR Blood and Transplant Research Units. For example, the Blood and Transplant Research Units (BTRU) in Donor Health and Behaviour research unit at the University of Cambridge will investigate ways to improve blood donor health and ensure a steady supply of blood to the NHS. It will conduct research to address major challenges identified by NHS Blood and Transplant, such as finding ways to encourage a more ethnically diverse range of people to donate blood.

NHS Blood and Transplant supported a number of studies including, during the Covid-19 pandemic, the NIHR funded TRACK-COVID study. The NHS Blood and Transplant clinical trials unit worked with partners to develop a supply of convalescent plasma for clinical trials including RECOVERY and REMAP-CAP. Post pandemic innovation in plasma for medicines has continued, alongside changes in the plasma medicines regulation, and NHS Blood and Transplant is working with Department of Health and Social Care, and NHS England and Improvement, to create a long-term domestic supply of plasma in England.

## Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

