Memorandum

To: KeithPaley, Charles Lister, Tony Moyle NHSE

From: Tom Kelly

Date: 13 February 20001

Re: Public Accounts Committee – notes etc

I have given Tony our comments on the transcript. The following deals with the 3 final notes which I owe you.

1. The letter from the committee alleging a failure to disclose information around vCJD. We have agreed that the response should be from Nigel rather than Martin. I had in mind something along the lines of the following:

> "…This matter was not withheld from the committee, it was not raised by them during the proceedings. The matter is in the public domain, it had been the subject of media interest prior to the committee hearing, and had a relevant question been asked it would have been answered. Neither the NBS nor the NHS is responsible for the timing or content of news stories in the media …"

We could add:

> [For information the facts are as follows: on December 12th 2000, Bio Products Laboratory (BPL) was notified that a donor who gave plasma during 1996 and 1997 had since been diagnosed as suffering from vCJD. The plasma from this donor was fractionated into several batches of different products. BPL notified all hospitals and customers that had received products from these batches. Other regulatory bodies and haemophilia centres were also contacted.
>
> This notification was purely a precautionary measure as the possible transmission of vCJD via plasma products is unknown at present based on the best scientific evidence available. In 1998/1999 BPL also carried out a programme of recovery and replacement in order to remove, wherever possible, any remaining products using UK plasma. All these products which could be affected by this donor's plasma are now past their expiry date. Since 1999, BPL has sourced all its plasma for fractionation from the US, where there has been no recorded incidents of vCJD or BSE.]

2. Modernising services to donors - the following encompasses the points Martin made at the hearing but beefed-up a little:

"The infrastructure around our services to donors has, until recently, suffered from a relative lack of investment and attention. This has resulted in outdated working arrangements and reward systems for staff not geared to a donor-focused service.

These factors, coupled with the increase in blood safety measures, have resulted in a large modernisation agenda. In the short-term, there will be continuing tension between the drive for the lowest possible risk blood products and processing donors in a manner and time acceptable to them. We began to address this agenda in 1999 through the Donor 2000 Project. Its main achievements were:

- Investment in new collection team equipment.
- For the first time, a real understanding of the donor database.
- ID cards for donors.
- New Postcode leaflets and better information to donors.
- Testing new recruitment and retention (administrative) methods.
- A Meeter/greeter on most collection teams (which largely replaced the loss of volunteers).

It did not result in any changes at session but laid the foundation for a modernisation programme to improve the service to donors, and thus donor retention rates. In addition, the Stakeholder Communication project undertook extensive research on relationships with key stakeholders, aimed at delivering the most effective communications with, and best possible service to, stakeholders. The results of the work will begin to be rolled out in 2001/2002. New management structures now provide the clarity to deliver modernisation, the main features of the programme are:

- **Appointment systems** - Although helpful are not a panacea e.g. pilot studies show only a proportion of donors want appointments - many do not. Appointment systems create donor expectations of service levels that cannot currently be adequately supported and will take up to 30 months to provide. Currently around 10% of donors donate by appointment.
- **Donation Review -** Examining all aspects of a session – can the process be speeded up - in particular, waiting times reduced - without compromising blood or donor safety? The vision is for regular donors to be in and out within 30 minutes. Begun in January 2001, completion anticipated by January 2002, with subsequent implementation partly subject to progress on new terms and conditions for collection staff.
- **Session Opening hours review -** Starts April 2001 for 6 months, taking views of managers, staff and donors. The session programme is set 6 months ahead so implementation begins April 2002. Some changes subject to staff agreeing to change historical working practice.
- **Review of Volunteers -** Existing levels of volunteer support vary, what level of support can be expected and sustained (both help at sessions and recruiting donors)? Starts April 2001, lasts 6 months, implementation could begin April 2002.
- **Donor Focus Groups -** will be established to feed information into other reviews. Plan to start April 2001.
- **New Working Arrangements**. Start piloting some new working arrangements to develop more flexible ways of running teams/sessions next year; for example, to boost staffing at peak periods and to meet anticipated peaks and troughs of donor attendance. Start date April 2001; end April 2002 with implementation thereafter, but partly subject to outcome of other reviews and terms and conditions package.

3. Potential profiteering on blood by the non-NHS sector. There is not currently a contract clause requiring non-NHS hospitals not to make a profit, hence the reply given to question 90 (page 27 of the transcript) on blood is inacurate (the note given to Martin during the proceedings was incorrect). The facts are:

- Charging for the private sector was introduced in 1984 under HC(84)5; a clause in the circular required RHAs to make it a condition of supply that "the non-NHS hospital is to make no profit on the material supplied". There is no mechanism for policing the system, arguably therefore a contract clause is needed.
- Such a clause was in L&SE zone contracts but not in the other two zones. LSE are the biggest suppliers to the non-NHS sector. We can therefore say that the majority of blood issued to the private sector was covered by a contract clause prohibiting profiteering.
- Such a clause is not in the standard national contract, which took effect from 1st April 1999.

I suggest therefore that the following note be provided to the committee:

> "I wish to clarify the response given to question 90 from Mr Campbell about whether the non-NHS sector could be making a profit from blood supplied by the NBS. As a condition of supply, non-NHS hospitals are required not to make a profit on the material supplied. This condition was part of the arrangements when charging was introduced in 1st April 1984 under Circular HC(84)5. Such a condition was a feature of contracts governing the provision of the majority of blood supplied to the non-NHS sector under the previous zonal contracts used by the NBS. Inadvertently this clause was omitted from the standard national contract introduced by the NBS from 1st April 1999. The NBS will make arrangements to rectify this omission immediately. There is no reason to believe that non-NHS hospitals have attempted to make profits on blood either before or since. Immediate action would be taken on evidence of any breach of this long-standing system"

I am responding John Step's letter about item 3 above.

Happy to discuss

Tom