NATIONAL COMMISSIONING GROUP (NCG) FOR BLOOD

Minutes of the NCG Meeting held on Friday 11th November 2016 at Department of Health

Room 1, Richmond House, 79 Whitehall, London, SW1A 2NS

Present:

DH

Triona Norman (TN)	Policy Lead for Organ Donation and Tissue Transplantation & Chair NCG
Debbie Lovett (DL)	Deputy Policy Lead for Blood, Organ and Tissue Transplantation
Jeremy Mean (JM)	NHSBT Sponsorship
John Reidy (JN)	Finance
Siobhain McKeigue (SM)	DH Analyst

NHSBT

Rob Bradburn (RB)	Finance Director
Carol Griffin (CG)	Executive Assistant to Dr Huw Williams (minutes)
Al Hunter (AH)	Frozen Component Manager
Dr Edwin Massey (EM)	Associate Medical Director, Diagnostic and Therapeutic Services
Mark Taylor (MT)	Assistant Finance Director – Planning and Performance
Paul Taylor (PT)	Assistant Director, Logistics
Louisa Robinson (LR)	Head of Financial Planning
Dr Huw Williams (HW)	Director of Diagnostic and Therapeutic Services

NHS Clinical and Laboratory

Dr Charles Baker (CB)	Consultant Anaesthetist, University Hospital of North Midlands NHS Trust
Stephen Bassey (SB)	Consultant Transfusion Scientist, Royal Cornwall Hospitals Trust
Dr Jonathan Wallis (JW)	Chair of NBTC and Consultant Haematologist, Freeman Hospital, Newcastle

NHS England

Rob Coster (RC)	National Programme of Care Manager – Blood and Infection
Claire Foreman (CF)	Senior National Programme of Care Manager
Jazz Nandra (JN)	Senior Manager, Contracting & Financial Analysis, NHS England

1. Welcome and Apologies

1.1 Apologies had been received from:
Kay Ellis, NHSBT Sponsorship, DH
Rupert Eggington, Finance Director, Nottingham University Hospitals NHS Trust
Neil Nisbet – Finance Director, Shrewsbury & Telford Hospital NHS Trust

2. Minutes of the Meeting Held on 1st July 2016 (Document: NCG-B1 2016-01)

2.1 The minutes of the previous meeting were agreed and accepted to be an accurate record.

3. Update on Actions from Last Meeting

3.1 Action 3.2: 'NHSBT to send DH a list of Finance Directors in key hospitals with the aim of expanding representation in time for the November 2016 meeting'. NHSBT contacted FDs to invite 1 or 2 to join the group however none were forthcoming.

3.2 Action 3.5 'NHSBT to provide an update on the potential supply issues of plasma to NCG-2'. This formed part of the NCG2 submission.

3.3 Action 4.1: 'NHSBT to update the NCG TORs and forward to the group for review prior to the November NCG meeting'. Carol Griffin amended and forwarded to the group on 8th September 2016.

3.4 Action 7.3: 'NHSBT to forward a paper on differential pricing of blood setting out the implications and various options due to the concern over high usage levels of 0 negative blood. Broad engagement with Clinicians should be sought and NHS England should also be consulted. This is to be an agenda item at the November NCG meeting'. This formed part of the NCG2 submission. Market research on the differential pricing of O D negative blood was undertaken in mid-2016. Differential pricing will not be implemented in 2017/18.

3.5 Action 7.7: 'NHSBT to consult with National Lab Managers regarding the cessation of "sale or return" of AB red cells and consider if this would increase costs?'. "Sale or return" will not be pursued, action closed

3.6 Action 7.8: 'NHSBT to prepare a proposal regarding the costs of 100% HEV screened blood and this should be an agenda item at the November NCG meeting'. NHSBT awaited the decision of SaBTO in November 2016 regarding universal screening. Discussed during the NCG2 meeting, and detailed in Item 7.5.

3.7 Action 7.9: 'Peter Lidstone from NHSBT will be asked to attend the November NCG meeting to give a presentation on the proposed zone based delivery system'. Paul Taylor (Assistant Director, Logistics) attended the November meeting and provided an update and detailed in Item 9.

3.8 Action 8.2: 'Forward the Cranfield report on the NHSBT Review of Logistics to the NCG group prior to the NCG meeting in November to review. Note as an agenda item to be discussed at the November NCG meeting'. Discussed during the NCG2 meeting and detailed in Item 9.

3.9 Action 9.1: 'NHSBT was requested to consider alternative approaches to the Clinical Benchmarking project and to feed back to the NCG group'. Discussed during the NCG2 meeting and detailed in Item 5.9.

3.10 Action 10.1: 'DH to advise NCG as to the best approach to NHS England to change the tariff for intravenous iron'. DH have forwarded a contact name to Dr Charles Baker who can advise on the process.

4. Updates/Feedback within the Group

4.1 JW provided an update from the NBTC. There was a comprehensive response to NHSBT's proposals regarding pricing for 2017/18, which were discussed later in the meeting. SB raised the question of the availability of funding from Health Education England for transfusion training. This has been applied for, awaiting response. If the funding is secured, training will be continued in 2017/18.

5. NHSBT Strategic Update (Document: NCG-B2 2016 02)

5.1 NHSBT presented the strategies in place for all strategic business units. A balanced strategic approach has been taken for blood supply to ensure all patients, including those with complex needs, have the right blood components available at the right time and are supplied via an integrated, cost efficient and best in class supply chain and service.

5.2 NHSBT restated their commitment to Patient Blood Management (PBM). PBM encourages blood to be used safely and appropriately. NHSBT is investing around £2m a year in PBM and funds 26 Consultant Haematologists plus scientists and nurses as well as a broad programme of education, research and audit to encourage best practice. Demand for red blood cells has fallen by 18% in the last 5 years. Red cell units issued are expected to continue to decline, creating a financial and supply challenge. Forecasting and predicting usage/demand is becoming increasingly difficult.

5.3 There has been a 10.7% reduction in red cell issues in the last 3 years. The year to date reduction in 2016/17 is 4.9% (to September month end). The average weekday issues were, however, down 7% in the month of September and 8% in the month of October. As such the forward visibility of demand is poor and forecasting difficult.

5.4 NHSBT has planned a period of major investment in IT systems funded from cash/ transformation capacity over the next 5 years. Three major pieces of work are the replacement of Pulse blood management system, desktop replacement and network/infrastructure improvements.

5.5 NHSBT has succeeded in keeping the blood price down for by implementing an £80m cost savings plan over the last 5 years. This has included the consolidation of manufacturing and testing and reducing estate footprint. Capacity has also been reduced in blood donation whilst efficiency has improved by focusing on better utilisation of larger fixed donor centres and fewer, larger (9 bed) mobile sessions. As a result certain parts of the country are visited less frequently. There is a balance to strike between the donors wishing to donate and costs associated with running less productive sessions. The next 3 years are challenging for NHSBT, in that demand is declining for both red cells and platelets and there is a need to invest in updating critical business systems and IT infrastructure. NHSBT remains committed to delivering ongoing efficiency savings but the projects are more complex, with longer payback times and involve greater risk to supply. The proposed price increase in 2017/8 reflects these pressures and will allow NHSBT to navigate the next 3-5 years of investment and demand decline and with the capability to drive further efficiency improvements in years 4 and 5 of the plan. It should be noted however, that despite the price increase the costs to the NHS of the blood supply will reduce by 1.8% in 2017/18 driven by the lower usage/demand. At this stage NHSBT is aiming to keep prices flat over the next 5 years, although this is based on existing demand assumptions and subject to revision.

5.6 JW stated he was grateful to NHSBT for their transparency in communication and for reducing the blood price and keeping it down over the last 6 years. He stated hospitals were also grateful for the rebate which NHSBT returns and will continue to do so, despite the deficit NHSBT will run this year.

5.7 NHSBT is committed to fund Clinical Benchmarking by £200K to clarify where blood is used in hospitals. Dr Kate Pendry is working up further plans which are more cost effective, however no formal proposal has been submitted as yet.

6. Demand Review Report (Document: NCG-B2 2016-03)

6.1 NHSBT presented the demand review report. Demand for red cells has declined steadily over the last 5 years, with an overall 18% reduction in demand versus the forecast for 2016/17. This trend appears set to continue into 2017/18 with a further 3.1% reduction anticipated (vs the 2016/17 forecast out-turn). At a product group level, NHSBT is also seeing a reduction in demand for platelets, which are anticipated to be 4% lower than plan in 2016/17, with a further 3% reduction anticipated in 2017/18.

6.2 Anticipating future demand is becoming increasingly difficult with demand fluctuating in-year and significant stepped reductions being seen year on year across the product groups. The drivers for these changes are proving difficult to identify with perhaps the recent NHS reset a factor. The changes in demographics with an increase in the population over 60 years old is expected to result in increased usage at some stage although this has not been seen yet. Issues per thousand population have fallen from c34 in 2011/12 to c28 in 2016/17. However, in this context

of falling overall demand, the trend for O RhD negative red cells ("O neg") has remained flat, and as a consequence continues to rise as a percentage of total issues. Demand for platelets has also seen an increasing preference for apheresis platelets, with some hospitals ordering100% of platelets as apheresis. This is also being compounded by a growing demand for A RhD negative platelets ("A neg"). Meeting product/group demand at these levels is very challenging and is increasing NHSBT's costs, with differential pricing a potential future option.

6.3 NHSBT has adopted a revised methodology for its forecasting based on "demand", i.e. the volume of components requested by hospitals, rather than the previous approach which was "issues" based and counted the number of components provided. This would have included instances where a requested component was not available and where a substitution was supplied in agreement with the requesting hospital. This "demand" based approach will provide NHSBT with improved data on which to base blood collection and manufacturing decisions.

7. Update on 2016/17 Performance and Commissioning Intentions for 2017-18 – Impact of Universal HEV Screening (Document: NCG-B2 2016-04)

7.1 NHSBT presented the summary of performance versus plan in the current year (2016/17) and also the pricing proposals for NHSBT's blood components and specialist services for 2017/18.

7.2 NHSBT's latest demand forecast for 2016/17, continues to evidence a reduction against plan for both red cells and platelets, however, the effect of the demand reduction reserve (DRR), which is built into the price of red cells, will result in a net rebate of £3.1m (incl. HEV at £2.4m).

7.3 In overall terms, the plan for 2017/18 will result in the cost of providing blood to the NHS decreasing by 1.8%. Taking Specialist Services into account (and associated demand increases) the total change in cost to the NHS will be -0.5%.

7.4 Although there will be an increase to the price of standard red cells to £122.35 p/unit in 2017/18 (vs £120.00 in 2016/17) the overall cost of blood to the NHS will be lower as a result of the impact of falling demand on NHSBT's cost base (Red Cells -4.3% lower versus 2016/17).

7.5 Currently, NHSBT provides HEV negative components for selected groups of patients based upon prevailing SaBTO guidance. On November 1st 2016, SaBTO advised that all patients should receive HEV negative components. Subject to receiving direction from DH to implement universal screening, as previously advised at NCG-1, NHSBT will need to amend the price of blood to cover any additional cost of universal screening. The cost of the additional testing is subject to the outcome of a tender process and is currently not finalised. As part of implementing universal HEV screening NHSBT would add the cost of screening to the unit price of all red blood. This would be offset, however, by removal of the current "added value" charge for screened components from the price list. NHSBT estimates that it will be able to introduce universal screening from June 1 2017 but is working towards implementation on April 1 if possible.

7.6 There are a number of hospitals which only order platelets collected by apheresis. Clinical guidance indicates that apheresis and pooled platelets are functionally equivalent and should be used interchangeably, with the caveat that those recipients born on or after 1st January 1996 should, when available, receive apheresis platelets.

7.7 NHSBT will therefore introduce individual prices for platelets produced by apheresis and for platelets produced by pooling in 2017/18 to reflect the differential cost of manufacture.

7.8 It is proposed that the price of apheresis-derived platelets will increase and be set at £219.30 compared with £178.19 for a pooled unit.

7.9 EM questioned whether BSH Guidelines are out of date in recommending a defined patient cohort using a defined cut-off date and suggested that this could cause issues if a clinician prescribed

pooled platelets to someone from that recipient cohort when the general view/evidence seems to suggest that pooled and apheresis are broadly equivalent in terms of efficacy.

ACTION: BSH guidelines on the use of apheresis vs pooled platelets may be out of date; CF will approach BSH on behalf of the Commissioners to question the statement in a table of the guidelines for neonates and older children. JW will also approach BSH on behalf of the NBTC.

7.10 NHSBT discussed potentially withdrawing the MBFFP component given that hospitals are moving on a large scale to OctaplasLG. This was not supported by hospitals.

8. Impact Statement (Document: NCG-B2 2016-05)

8.1 NHSBT's impact statements have been calculated slightly differently this year and are based on planned volumes for the current year and next year, to show a price and volume impact.

8.2 NHSBT has used actual hospital volume data by product for the last 12 months and applied that to planned volumes each year (e.g. if a Trust was 2% of issued volumes, NHSBT would apply 2% to the planned volumes to show what a likely planned volume reduction would be) and then multiply by the current and proposed prices for a indicative impact by Trust.

8.3 The sample net impact statements provide an indication of the likely impact for a typical large, medium or small Trust. Overall, large and medium Trusts can expect an average of £22k reduction over the year, and small Trust can expect an average of approx. £2k.

8.4 The individual Trust net impact statements and price lists will be sent out in December by NHSBT's Customer Services team.

ACTION a: NHSBT to include the prospective self-collect charge within the net impact statements (see Section 9).
ACTION b: NHSBT to provide NCG members with the detailed net impact statements.

9. NHSBT Review of Logistics Provision (Document: NCG-B2 2016-06)

9.1 The paper gave an update on NHSBT's progress with its logistics review. As part of this update, there was a recommendation on pricing, specifically the adoption of a charge where orders are prepared by NHSBT for self-collection by hospitals.

9.2 The increasing trend for the provision of orders to hospitals outside of normal routine arrangements is significantly impacting NHSBT's ability to manage the supply chain in an efficient manner. The level of self-collection of orders by hospitals has markedly increased and therefore reduced NHSBT's income from ad hoc delivery charges by a total of £2.51m since 2011/12.

9.3 NHSBT partnered with Cranfield University to undertake modelling work at the Sheffield, Manchester, Colindale, Tooting and Lancaster centres to address the level of reactive ordering and loss of income from self-collection. The sample analysed, as part of the study, involved c55% of NHSBT's overall customer base. This was regarded as a significant proportion of hospital customers on which to develop recommendations for future service provision.

9.4 Based on the modelling work undertaken in conjunction with Cranfield University, the introduction of a self-collect charge was seen as equitable method for recovering the cost of preparing these orders for self-collection by hospitals. The proposal to implement zoned ad hoc delivery charges received a mixed response from customers and it was decided that further work would be required before a proposal could be made.

9.5 Although recognising that hospital feedback is mixed, from 2017-18, NHSBT is proposing to introduce a fixed charge of £11 *per non-routine order* when prepared for self-collection by hospitals. The £11 charge reflects the costs of preparing the order for collection outside of routine, planned activity. It is estimated that this will generate an income of c£0.7m. Where multiple orders are submitted across the day, the self-collect charge will apply *per order* whether collected together or at different times. Current charges for ad-hoc and blue-light/emergency deliveries provided by NHSBT will remain at £52.15 per order, regardless of distance from the NHSBT supplying centre.

9.6 Once approved, the next steps will involve communication with NHSBT's customers and work with them to manage the impact of the policy change. Internal resource has been identified to review routine delivery schedules, increase routine utilisation and reduce reactive work to expedite the next phase of work to support NHSBT's customers.

9.7 The future provision and pricing of NHSBT's service remains under review and further proposal may be submitted for the commissioning round in 2018/19.

10. Outcome of Discussions on NHSBT's Pricing Proposals

10.1 After discussion, the pricing proposals set out in NHSBT's papers were approved by all members of NCG.

11. DH2020 – New Chairmanship Arrangements for NCG

11.1 TN was thanked for her contribution to the NCG. JM will take over chairmanship of the NCG going forwards.

12. Next Steps

12.1 TN outlined the options discussed during the meeting. The group recognised NHSBT's cost savings over the last 3 years, however with fixed overheads the cost savings couldn't continue. The cost which would be incurred with universal HEV testing compounded this. The universal testing for HEV would be implemented in June 2017 and the contract for this would be awarded following Board approval. With this in mind, a 2 stage approach to pricing communication was thought to be the best course of action; the first step being to communicate the red cell price of £122.35, with a second step to follow when the additional cost of HEV testing was known.

ACTION a: NHSBT/DH – NCG Outcome letter to be issued to hospitals in December (excluding universal HEV) with price lists and net impact statements.

ACTION b: NHSBT/DH – Supplementary letter to be issued in January/February 2017 (post HEV tendering process) with revised price list and revised net impact statements.

ACTION c: NHSBT/NHS England to consider having bilateral meetings in between the NCG process.

ACTION d: NHS England to progress the attendance of Finance Directors at future NCG meetings.

ACTION e: DH to consider if meeting twice a year is sufficient or more meetings are required?

ACTION f: NHSBT to review NCG TORs and update to reflect attendee changes.

13. AOB

13.1 SB/JW stated that hospitals greatly appreciated the provision of training and development support that NHSBT gave, as experts in matters of blood, to hospital colleagues (where expertise in blood matters is not always uniform).

ACTION: JW would like to find more ways of ensuring that NHSBT and hospitals could develop a better common/shared understanding of factors affecting the general "blood" agenda through ongoing and developing training and other knowledge-sharing initiatives.

14. Date of Next Meeting

14.1 The date of the next meeting of the NCG will be in July 2017, the date and venue are to be confirmed by DH.

ACTION: DH to confirm the date/venue for the NCG meeting scheduled in July 2017.

A. Papers for information - NCG Customer Consultation Paper (NCG-B2 2016-A)
Paper noted.

ANNEX A

National Commissioning Group for Blood

Actions from meeting held on 11th November 2016

Minute reference	Agreed Action	Responsibility	Completion/Review
7.9	BSH guidelines on the use of apheresis vs pooled platelets may be out of date; CF will approach BSH on behalf of the Commissioners to question the statement in a table of the guidelines for neonates and older children. JW will also approach BSH on behalf of the NBTC	CF/JW	ASAP
8.4 a	NHSBT to include the prospective self-collect charge within the net impact statements	NHSBT	December 2016
8.4 b	NHSBT to provide NCG members with the detailed net impact statements	NHSBT	December 2016
11.1 a	NHSBT/DH – NCG Outcome letter to be issued to hospitals in December (excluding universal HEV) with price lists and net impact statements	NHSBT/DH	December 2016
11.1 b	NHSBT/DH – Supplementary letter to be issued in January/February 2017 (post HEV tendering process) with revised price list and revised net impact statements	NHSBT/DH	February 2017
11.1 c	NHSBT/NHS England to consider having bilateral meetings in between the NCG process	NHSBT/DH	ASAP
11.1 d	NHS England to progress the attendance of Finance Directors at future NCG meetings	NHS England	ASAP
11.1 e	DH to consider if meeting twice a year is sufficient or more meetings are required?	DH	ASAP

Minute reference	Agreed Action	Responsibility	Completion/Review
11.1 f	NHSBT to review NCG TORs and update to reflect attendee changes	NHSBT	ASAP
12.1	JW would like more find ways of ensuring that NHSBT and hospitals could develop a better common/shared understanding of factors affecting the general “blood” agenda through ongoing and developing training and other knowledge-sharing initiatives.	JW	ASAP
13.1	DH to confirm the date/venue for the NCG meeting scheduled in July 2017	DH	January 2017