

**The Chief Medical Officer's  
National Blood Transfusion Committee**

Confirmed minutes of a meeting of the National Blood Transfusion Committee  
held on 24 September 2012 at the Royal College of Pathologists, London.

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<b>Present:</b>	Prof A Newland	Chairman
	Prof M Murphy	Secretary
	Dr S Allard	Royal College of Pathologists
	Dr M Allison	Royal College of Physicians
	Dr J Bamber	East of England RTC
	Prof M Bellamy	Intensive Care Society
	Dr J Birchall	South West RTC
	Dr P Bolton-Maggs	Serious Hazards of Transfusion
	Dr G Cho	London RTC
	Mr A Cope	Royal College of Emergency Medicine
	Dr M Desmond	North West RTC
	Mr G Donald	Patient Representative
	Ms R Gerrard	NHSBT Head of Better Blood Transfusion
	Dr C Harrison	London RTC
	Dr A Iqbal	North East RTC
	Ms J Langham	Medicines and Healthcare products Regulatory Agency
	Dr P Larcombe	South East Coast RTC
	Ms T Lee	Department of Health
	Ms L Mannion	British Blood Transfusion Society
	Dr A McKernan	East Midlands RTC
	Dr S Morley	Royal College of Paediatrics and Child Health
	Mr A Morrison	Institute of Biomedical Science
	Mr A Stock	South Central RTC
	Dr C J Taylor	West Midlands RTC
	Dr D Thomas	Blood Implementation Group, Wales
	Miss S Tuck	Royal College of Obstetricians and Gynaecologists
	Dr D K Whitaker	Royal College of Anaesthetists
	Dr L Williamson	NHSBT Medical Director
	Mr C Philips	NHSBT Head of Customer Services

**Apologies:**

Mrs T Allen	TA	NHSBT Assistant Director Customer Services
Ms R Gallagher	RGa	Royal College of Nursing
Dr L Green	LG	Blood Components Working Group
Ms S Harle-Stephens	SHS	British Blood Transfusion Society
Mr J Hyare	JH	Transfusion Laboratory Managers Working Grp
Ms M Jonkinen	MJ	Royal College of Midwives
Dr C Ronaldson	CR	NHSBT Director of Blood Supply
Mr J Thompson	JT	Royal College of Surgeons
Dr Y Sorour	YS	Yorkshire & The Humber RTC
Dr J Wallis	JW	British Society for Haematology

**28/12      Welcome and Introductions**

The Chair welcomed members and introduced Gavin Cho, the new Chair of London RTC. He stated that attendance numbers were slightly depleted as some members have experienced travel difficulties due to the adverse weather and certain NHSBT representatives are unable to attend due to flooding at the Filton blood processing centre.

**29/12      Minutes of the meeting of the full Committee held on  
26 March 2012**

The minutes of the meeting held on 26 March 2012 were agreed as a correct record.

**30/12      Regional Transfusion Committee (RTC) Chairs**

CHA summarised key issues arising from the discussions at the morning meeting of RTC Chairs:

- A major concern is the lack of involvement of blood transfusion in the current modernisation of pathology services. It is important to have a thorough assessment of the risks associated with the loss of capacity and staff expertise in hospital transfusion laboratories.
- Concerns about the practicalities of implementation of SaBTO guidance on patient consent for transfusion.
- Agreement for the evaluation and approval of RTC audits to now be undertaken by the National Clinical Audit (NCA) Steering and Programme Implementation Groups. RTC Chair representation is sought on the group although the time commitment to attend quarterly meeting in London was of concern to the RTC Chairs who requested this process is dove-tailed onto an existing meeting.
- There were two presentations of platelet transfusion audits from the South West and East of England RTCS. All regions are continuing to monitor and promote appropriate use of all blood components.
- The results of a survey of HTC Chairs were reviewed with 52% of respondents indicating attendance at regional events was limited by work commitments. An information pack will be developed to enhance and support communications between the hospital and regional committees.
- The first joint regional Patient Blood Management (PBM) event has taken place in the London and South East Coast RTCS and other regions are planning local events over the next few months.

MD raised an issue from the North West region regarding the SaBTO recommendation for the supply of cytomegalovirus (CMV) tested blood components in pregnancy. ST confirmed that CMV seronegative red cell and platelet components should be provided for elective transfusions during pregnancy.

Summing up, the Chair referred a letter from the Chief Medical Officer to hospital trusts stating that support for national committees was an important requirement and needed to be factored into job plans. With regard to pathology modernisation, blood transfusion is barely mentioned in many reviews and the NBTC will continue to raise the implications of the loss of

skills and expertise in hospital transfusion laboratories and the effect on out-of-hours provision including increased calls for assistance with Red Cell Immunohaematology (RCI) serology from NHSBT.

**31/12 Minutes of the meeting of the Executive Working Group held on 28 May 2012**

The minutes of the meeting held on 28 May 2012 were noted.

**32/12 NPSA Safer Practice Notice 14 Working Group**

CJT advised that the group are reviewing and updating the competency framework with a bias towards knowledge based tests to underpin competency assessments and provide a better understanding of transfusion medicine. To date, two meetings of the group have taken place and a framework has been drafted. Some good training and resource material is available in the trusts and it is therefore a concern that SHOT findings continue to highlight errors by staff who have been competency assessed. A report will be provided to the next meeting.

**33/12 Education Working Group**

SA reported on the first phase of work to review the training and education of health care professionals in blood transfusion.

**33.1/12 Undergraduate Medical Schools**

A survey on transfusion training was circulated to 31 UK medical schools and a total of 24 (77%) responded. The responses indicate that transfusion medicine is covered in all undergraduate training with haematologists delivering the majority of training. E-learning developed by the UK Blood Services was used in 33% of schools and formal assessments in transfusion were carried out in 50% of schools. Paediatric transfusion was covered in only 4 schools.

**33.2/12 Foundation Schools**

A survey questionnaire was circulated to 25 foundation schools and a total of 10 (40%) responded. All schools covered transfusion medicine and in 70% this was grouped with other aspects of clinical training. Transfusion practitioners delivered training in 80% of schools complemented by haematologists in 70%. E-learning is used by 80% of schools.

**33.3/12 Training for Nurses, Midwives and Operating Department Practitioners**

Over 100 surveys were sent out to named individuals responsible for the curriculum design and delivery but only 7 completed surveys were received. Of those who responded, all stated that transfusion training was taught but delivered at different stages in different institutions.

The group will re-define the next phase of work based on the findings to date with specific recommendations for transfusion education in the core curriculum for healthcare professions pre and post registration. SA is stepping down as Chair of the group and a new Chair is sought.

## **34/12 Blood Components Working Group**

### **34.1/12 Fresh Frozen Plasma (FFP) Importation**

SaBTO has agreed that no further importation of FFP is required in addition to patients born after 1 January 1996 and for those with Thrombotic Thrombocytopenic Purpura (TTP).

ST enquired about responsibility for the provision of imported FFP to patients born after 1 January 1996 as this will now fall under the care of a variety of specialist clinicians. It was confirmed that the transfusion laboratories are responsible for providing the correct product for this group of patients.

### **34.2/12 Methylene-blue treated FFP (MBFFP)**

France has withdrawn the use of MBFFP due to a perceived increase in the rate of allergic reactions to the product. The UK haemovigilance data relating to this component has been reviewed by SHOT and JPAC with no demonstrable significant increase in the rate of reactions to MBFFP as compared to standard FFP and did not support immediate withdrawal of the product. SHOT will continue proactive monitoring of FFP reactions.

### **34.3/12 Extended Shelf-life for thawed FFP (< 5 days)**

In response to a query from MB about progress with extending the shelf life of FFP after thawing, MM stated that NHSBT have requested written feedback from the NBTC on why this is considered important.

In discussion views were expressed that even a short extension to the shelf life of FFP post-thaw would smooth the process and make clinical situations easier to handle. It would enable more transfusion laboratories to store the thawed products and minimise wastage.

#### **Action: LG**

## **35/12 Patient Involvement Working Group**

Content for patient information on the webpages is being updated and expanded and the group is looking to develop more patient focussed information in conjunction with specialist patient groups. SA is standing as Chair of the working group and Dr Charles Baker will take over this role.

RG presented the publicity material to be used in a forthcoming UK Patient Awareness campaign 'Do you know who I am?' The campaign is aimed at patients and healthcare staff and addresses recommendations from the SHOT Annual Report of 2009 and inclusion of mis-identification by DH as a 'never event'. Further details and access to the range resources and guides is available on:

<http://www.transfusionguidelines.org/Index.aspx?Publication=NTC&Section=27&pageid=982>

## **36/12 Patient Blood Management (PBM) Working Group**

MM stated that one of the agreed outcomes from the seminar held on 18 June 2012 was the establishment of a working group to develop the initial recommendations for the implementation of PBM. The terms of reference for the working group as presented were approved with an additional note that

membership should include a patient representative.

In the longer term, the National Institute for Health and Excellence (NICE) have been tasked with developing guidelines and quality standards in blood transfusion.

### **37/12 Transfusion Laboratory Managers Working Group**

AM reported that membership of the group is now more comprehensive with representation aligned to the RTCs. The main areas of work highlighted are:

- The sharing of data on red cell and platelet issues and wastage with some evidence that this is impacting on changing practice.
- The difficulty experienced by NHSBT in recruiting group AB donors to produce sufficient FFP and cryoprecipitate.
- A review with NHSBT to investigate the 32% increase in ad-hoc deliveries of blood components and how this can be reduced.
- Assisting SHOT and MHRA with the harmonisation of the two systems for haemovigilance in the UK.
- The re-organisation of pathology services is of great concern and requires close monitoring to ensure the safety of blood transfusion practice is maintained.

### **38/12 Reports from the Royal Colleges/Specialist Societies**

#### **38.1/12 Royal College of Anaesthetists**

DKW highlighted the number of publications on PBM related issues in the College Journal. There is confusion about the practical application of SaBTO guidance on consent for transfusion in some urgent clinical situations.

#### **38.2/12 Royal College of Obstetricians and Gynaecologists**

Education initiatives include the anti-D administration check list on the SHOT website and massive haemorrhage drills as part of induction and annual training for all medical and midwifery staff required by Clinical Negligence Scheme for Trusts (CNST) maternity standards.

#### **38.3/12 Royal College of Paediatrics and Child Health**

Important issues include changes in the guidance on the use CMV seronegative blood components. Paediatric transfusion is included in the curriculum for all paediatric specialties but is rarely formally taught.

#### **38.4/12 Royal College of Pathologists**

Concerns include the review of performance in the transfusion section of the FRCPath examinations and the provision of training for haematology specialist registrars.

38.5/12 Royal College of Physicians

The NICE guidance on Acute Upper GI bleeding indicates that the transfusion threshold for red cell transfusions is unclear in the absence of a randomised clinical trial.

<http://guidance.nice.org.uk/CG141/Guidance/pdf/English>

- Transfuse with blood, platelets, and clotting factors in line with local protocols for managing massive bleeding.
- Base decisions on blood transfusion on the full clinical picture, recognising that overtransfusion may be as damaging as undertransfusion.
- Do not offer platelet transfusion to patients who are not actively bleeding and who are haemodynamically stable.
- Offer platelet transfusion to patients who are actively bleeding and who have a platelet count of  $<50 \times 10^9 / L$ .
- Offer fresh frozen plasma to patients who have (a) a fibrinogen concentration  $<1 g/L$  or (b) a prothrombin time (international normalised ratio) or activated partial thromboplastin time that is more than 1.5 times the normal level.
- Do not use recombinant factor VIIa except when all other methods have failed.

38.6/12 British Blood Transfusion Society (BBTS)

The BBTS provides regular information on relevant topics to members via the website and quarterly newsletter. This includes study guides and examinations in Transfusion Practice Science and Cell and Tissue Transplantation as well as information on Continuing Professional Development (CPD).

38.7/12 Intensive Care Society

Blood transfusion will be a major part at this year's State of the Art annual meeting. The activity in transfusion-related research, publications and training in Intensive Care Medicine reflect a high level of interest and awareness in this field.

## **39/12 Royal Colleges/Specialist Societies**

39.1/12 Minutes of the last meeting

The minutes of the meeting held on 26 March 2012 were noted.

39.2/12 Update from the morning meeting of 24 September 2012.

ST reported on items from the meeting:

- The updated guideline on epidurals, thrombocytopenia and coagulation therapy is to be published soon by the Association of Anaesthetists of Great Britain and Ireland.
- Members are trying to promote transfusion awareness, including pre-operative and pre-delivery anaemia. It was asked if these would be included in the NICE guidelines. MM considered that the guidelines

- would cover the whole of PBM and include management of these issues.
- The SaBTO recommendation on patient consent to transfusion is of concern to some Colleges with regard to the practical implementation. It was considered that it needs to be realistic and relevant to the circumstances of the different specialties.
  - There were queries about the factsheet on platelet transfusions. Members suggested that it would be benefit from a sentence explaining its source and who produced it. It could helpfully begin with a statement that platelet transfusions are over-used and that they carry risks.

## **40/12      Better Blood Transfusion (BBT)**

### **40.1/12    Patient Blood Management (PBM)**

MM presented summary reports of the presentations and workshops from the seminar held on 18 June 2012 which provided examples of practical and successful initiatives of PBM in practice. The output from the seminar will be used by the PBM working group to develop recommendations for hospitals.

The summary reports are available on the NBTC webpage at:

[http://www.transfusionguidelines.org.uk/docs/pdfs/nbtc\\_pbm\\_2013\\_11\\_pres\\_summaries.pdf](http://www.transfusionguidelines.org.uk/docs/pdfs/nbtc_pbm_2013_11_pres_summaries.pdf)

### **40.2/12    National Comparative Audit (NCA) of Blood Transfusion**

RG presented an update report on current and planned audits:

- Audit of the Use of Red Cells in Cardiac Surgery - data collection is now complete and a report has been drafted.
- Audit of Medical Use of Red Cells Part 1 - final report has been submitted to the project group and the regional slide show is in preparation.
- Audit of Blood sample collection and labelling - data analysis is ongoing.

Planned audits for 2013 include use of anti-D; patient information and consent; management of patients with haemoglobinopathies and the use of blood components in neurocritical care.

An application to the National Institute for Healthcare Research (NIHR) for research funds for "the development and evaluation of enhanced audit and feedback interventions to increase the uptake of evidence-based transfusion practice" has been successful. Full details of the programme and its interaction with the NCA will be released in due course.

### **40.3/12    Learnbloodtransfusion (LBT)**

RG provided an update report advising that:

- The Safe Transfusion Practice, Blood Components and Indications for Use courses are undergoing 2-yearly review.
- The content for a new Patient Consent course is under development and will be available later this year.

- A timetable has been agreed to develop courses on the Management of Transfusion Reactions, Anaemia and Sampling.
- LBT passes show an increase of 20% on 2010/11.

MM reported that the LBT e-learning modules have been a mandatory part of clinical competency at Oxford University Hospitals NHS Trust since 2006 with highly positive results in relation to the quality of the learning materials and assessments. However, the trust is experiencing difficulties in accessing the modules from their new internal learning management system and in migrating data assessment passes to its Electronic Staff Record (ESR) for compliance monitoring. This requires recording LBT module passes by manual data entry.

A solution suggested would be enhancement to LearnPro's learning records in order to lend themselves to automated data migration or an opening up of the LBT learning packages to more local learning management systems.

RG advised that LBT is a UK-wide initiative and legal rights for hosting the modules on local hospital platforms have not been formally agreed. However, this is being reviewed by the UK BBT Network group and a formal response will be advised.

#### **Action: RG**

#### **40.4/12 Framework for Transfusion Practitioners (TPs)**

The Committee endorsed a framework to support the professional development of transfusion practitioners subject to comments that:

- Ensuring patient safety should be included under 'opportunities to develop' heading.
- The education section should include a link to the MHRA website.
- Supportive documents should be included under stage 2.

AMc stated that the East Midlands TP group have asked about a national accredited scheme for the framework and RG advised on initial discussions to making the course in Newcastle available in other areas.

#### **41/12 NHS Litigation Authority (NHSLA)**

With regard to the proposal to remove blood transfusion from the risk management standards for 2013/14, the NHSLA have now advised that they are reviewing their assessments and there will be no change to the standards next year. The NHSLA will consult further in due course.

#### **42/12 NBTC Budget**

RG provided a statement on the financial position of the three budgets supporting the work of the national and regional transfusion committees as at 31 July 2012.

**43.1/12 Key Performance Indicators**

CP presented Key Performance Indicators for the 1<sup>st</sup> Quarter 2012/13 advising that:

- The average age of red cells at dispatch had increased slightly due to the Olympics stock build.
- The percentage of single donor platelets issued at 87% against a target of 80% was a significant achievement.
- All centres are now achieving 85%+ turnaround times for RCI reference samples within 5 days of receipt.
- NHSBT are considering options to reduce the need for ad-hoc deliveries.

In response to a query from AC on the effect of the Olympic and Paralympic Games on blood stocks, it was noted that there were no major incidents during this period. NHSBT will carry out a retrospective review of its arrangements.

**43.2/12 Tracking Clinical Use of Blood**

MM presented an update on the Trial of AIM II, a collaboration between the America's Blood Centers, NHSBT and four NHS Hospital Trusts to provide a detailed understanding of where and why blood components are transfused. Three out of four hospitals have now submitted one month's data which is currently being validated. Following this, it is hoped that 2 years' data will be submitted for analysis.

The AIM II trial would welcome support from the NBTC to develop a national benchmarking programme for blood utilisation.

**43.3/12 Integrated Transfusion Services (ITS)**

MM presented an update report on the ITS programme which includes three initiatives covering stock management, transfusion innovation and sales and operational planning to support the modernisation of hospital transfusion services and maximise the efficiency of the blood supply chain.

Data collection commenced at the first stock management pilot at Blackpool Teaching Hospitals NHS Foundation Trust on 31 July 2012 and agreement has been reached for a second pilot with data collection likely to begin in October 2012.

**43.4/12 Blood use in England versus other countries**

A report on blood usage in England and North Wales compared with other European countries was provided to the meeting.

**43.5/12 Clinical Research**

LW reported that NHSBT have called for outline applications for clinical research proposals designed to inform best practice regarding the optimal use of blood components and their alternatives. Studies in all clinical areas

relevant to the use of blood components or alternatives will be considered. However, the priority for this call will be given to studies on the use of platelets for transfusion. The closing date for outline proposals is 30 November 2012.

#### **44/12      Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO)**

##### **44.1/12    Cytomegalovirus (CMV) Tested Blood Components**

MM presented a graph on the usage of CMV negative red cells and platelets following the SaBTO guidance of 9 March 2012. This showed a reduction in the issue of both components based on 5 months' data up to end of August 2012. Whilst there is some variation in implementation of the CMV seronegative components in hospitals, there are indications that the large centres are changing or planning to change in line with the SaBTO recommendations.

##### **44.2/12    Patient Consent for Blood Transfusion**

RG reported that work was progressing with the implementation of the SaBTO guidance through the NBTC Patient Involvement Working Group and the NHSBT Better Blood Transfusion Network. Standardised patient information leaflets are in preparation and a national audit of patient information and consent is planned in 2013.

In discussion on the issue of a standard patient consent form concerns were expressed about the practical issues of implementation. Whilst information can be provided for planned transfusions, consent issues should not delay life-saving transfusions in emergency situations.

#### **45/12      National Commissioning Group (NCG) for Blood**

MB reported on the meeting held on 20 July 2012. A summary of the meeting is available at:

[http://hospital.blood.co.uk/library/pdf/ncg\\_letter\\_12\\_07\\_30.pdf](http://hospital.blood.co.uk/library/pdf/ncg_letter_12_07_30.pdf)

#### **46/12      Serious Hazards of Transfusion (SHOT)**

PBM presented an update report highlighting the following:

- The SHOT annual report was published on 6 July 2012.
- Eight deaths were associated with transfusion in 2011; two definitely and possibly six related to transfusion.
- About 50% of reported events are due to mistakes with failure to identify the patient and blood samples not labelled at the bedside.
- Acute transfusion reactions are the commonest pathological event.
- A recommendation was made that the present system where individuals with sickle cell disease carry three different cards is simplified.
- There are increasing reports of delayed transfusions.
- There are reports of increased anti-D errors with most being late or omitted doses.

- Hannah Cohen has stepped down as Chair of the Steering Group and is replaced by Dafydd Thomas.
- The next annual symposium will take place on Wednesday, 10 July 2013 at the RSM in London.

#### **47/12 Medicines and Healthcare products Regulatory Agency (MHRA)**

JL provided the highlights of Serious Adverse Blood Reactions and Events (SABRE) for the period 1 January to 31 August 2012. (It was noted that the figures have not yet been verified).

A total of 748 incidents were reported, 520 Serious Adverse Events (SAEs) and 224 Serious Adverse Reactions (SARs).

The top five SAEs were:

- Incorrect blood components issued.
- Data entry errors in laboratories.
- Component labelling errors at point of issue from the laboratory.
- Pre-transfusion testing errors.
- Sample processing errors.

#### **48/12 Dr Claire Harrison**

The Chair, on behalf of the Committee, expressed thanks and appreciation to Claire Harrison who was standing down from the London RTC and as Chair of the RTC Chairs group. Mike Desmond will take over the role of Chair of the RTC Chairs.

#### **49/12 Dates of meeting for 2013**

The meetings for 2013 will take place Monday, 22 April and Monday, 30 September commencing at 1.00pm. Venue to be advised.

#### **50/12 For Information**

- The NBTC Indication Codes for Transfusion have been updated in line with standardisation of haematological reporting units recommended by Pathology Harmony. These are available on:  
[http://www.transfusionguidelines.org.uk/docs/pdfs/nbtc\\_2013\\_10\\_recs  
indication\\_codes\\_2012.pdf](http://www.transfusionguidelines.org.uk/docs/pdfs/nbtc_2013_10_recs_indication_codes_2012.pdf)
- A Systematic Reviews Initiative update detailing recently published and ongoing systematic reviews was noted:  
[www.transfusionevidencelibrary.org](http://www.transfusionevidencelibrary.org)
- A statement from the Welsh Government dated 13 June 2012 on the intention to progress towards an all-Wales Blood Service by 2016 was noted.
- The RCPPath Transfusion 2012 meeting would be held on 29 and 30 November 2012.