

National Blood Transfusion Committee

Confirmed Minutes of a meeting of the National Blood Transfusion Committee
held on 21 October 2013 at the Royal College of Pathologists, London.

Present:	Prof A Newland		Chair
	Prof M Murphy	MM	Secretary
	Dr S Allard	SA	Royal College of Pathologists
	Dr S Allford	SAI	South West RTC
	Dr M Allison	MA	Royal College of Physicians
	Dr J Bamber	JB	East of England RTC
	Prof M Bellamy	MB	Intensive Care Society
	Dr P Bolton-Maggs	PBM	Serious Hazards of Transfusion
	Dr G Cho	GC	London RTC
	Mr A Cope	AC	Royal College of Emergency Medicine
	Dr P Dadarkar	PD	South Central RTC
	Dr M Desmond	MD	North West RTC
	Mr G Donald	GD	Patient Representative
	Ms A Harris	AH	NHSBT Regional Lead: PBM Team
	Mr J Hyare	JH	Transfusion Laboratory Managers Group
	Dr A Iqbal	AI	North East RTC
	Ms M Jonkinen	MJ	Royal College of Midwives
	Dr P Larcombe	PL	South East Coast RTC
	Ms L Mannion	LM	British Blood Transfusion Society
	Dr S Morley	SM	Royal College of Paediatrics and Child Health
	Mr C Robbie	CR	Medicines and Healthcare products Regulatory Agency
	Dr Y Sorour	YS	Yorkshire and The Humber RTC
	Dr C J Taylor	CJT	West Midlands RTC
	Mr J Thompson	JT	Royal College of Surgeons
	Miss S Tuck	ST	Royal College of Obstetricians and Gynaecologists

Apologies:

	Mrs T Allen	TA	NHSBT Assistant Director Customer Service
	Dr C Costello	CC	NHSBT Non-Executive Director
	Mr M Dawe	MD	Medicines and Healthcare products Regulatory Agency
	Ms R Gallagher	RGa	Royal College of Nursing
	Ms R Gerrard	RG	NHSBT National Lead: PBM Team
	Dr L Green	LG	Blood Components Working Group
	Dr A McKernan	AMc	East Midlands RTC
	Mr D Palmer	DP	British Blood Transfusion Society
	Dr C Ronaldson	CR	NHSBT Director of Blood Supply
	Dr D Thomas	DT	Blood Implementation Group, Wales
	Dr D K Whitaker	DKW	Royal College of Anaesthetists
	Dr H Williams	HW	NHSBT Director of Diagnostic and Therapeutic Services
	Dr L Williamson	LW	NHSBT Medical Director

27/13 Welcome and Introductions

The Chair opened the meeting and welcomed all attendees, in particular new members Dr Sarah Allford, South West RTC and Dr Pushkar Dadarkar, South Central RTC.

28/13 Minutes of the meeting of the full Committee held on 22 April 2013

The minutes of the meeting held on 22 April 2013 were agreed as a correct record.

29/13 Matters Arising

29.1/13 Minute 03.1/13

GD asked when there was to be an update on the review to investigate the increase of ad hoc deliveries of blood components to hospitals.

Action: TA

29.1/13 Blood Components Working Group

The chair of this group is on maternity leave and the NBTC is awaiting information on a temporary replacement. With regard to the issue of extending the post-thaw shelf-life of Fresh Frozen Plasma (FFP), the Joint Professional Advisory Committee have stated that at present there is no consensus to support the extension of the shelf-life of thawed FFP beyond 24 hours.

29.2/13 National Commissioning Group (NCG) funding for PBM (NCG)

In response to query from GD regarding the allocation of NCG funds for PBM activities, MM confirmed proposals were under consideration to allocate funding for the audit programme, benchmarking for blood usage activity and a project on the management of pre-operative anaemia in the North West region. However, to date, no monies have yet been spent from the NCG allocation.

The Chair advised that a meeting with Sir Bruce Keogh is scheduled this month and this will plan how the PBM recommendations will be implemented in hospitals.

30/13 Regional Transfusion Committee (RTC) Chairs

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

- The reorganisation of pathology services in trusts is affecting transfusion laboratory services and appears to be leading to a reduction in the number of senior experienced staff in hospital laboratories.

- Two regions reported no dedicated NHSBT Customer Service support with East of England region advising that only ad hoc cover has been provided over the past 3 years. The RTCs feel it is important to have appropriate levels and continuity of support.
- The transfer of blood with patients is being reviewed by the East of England region arising from concerns about the large amount of wastage of blood components even when correct processes are followed.
- The RTC Chairs supported a proposal by the North West region for a project on the identification and management of pre-operative anaemia.
- A national NCA audit of how red cells are used in England and North Wales will take place for one week during February 2014 and another week in May 2014.
- The NBTC and RTC pages on the transfusionguidelines website are undergoing significant changes with a new site expected to go live in November.

31/13 Executive Working Group – 3 June 2013

The minutes of the meeting held on 3rd June 2013 were noted.

32/13 Patient Involvement Working Group

SA provided updated on the work of the group over the last six months including:

- Further development of patient information leaflets on blood transfusion <http://www.blood.co.uk/about-blood/information-for-patients/blood-transfusion/>
- Promoting transfusion awareness in collaboration with specialist societies and other groups including attendance at the conference of the Royal College of Midwives and the Annual Schools Science Conference.
- Providing support to other organisations and representation on research studies.

Action: Dr Charles Baker, Chair of the group, should be invited to the next meeting.

33/13 Education Working Group

SA reported that following the completion of the first phase of work to review the curriculum content of transfusion training for undergraduate and postgraduate education for doctors, nurses and midwives as reported to the last NBTC meeting, the group has:

- Provided the results of the survey to medical schools together with recommendations for change to undergraduate teaching.
- Corresponded with the Director of the UK Foundations School programme recommending inclusion of specific training about positive patient identification.
- Participated in the Delphi exercise on core competencies for Foundation Doctor in Pathology via the Royal College of Pathologists.

A review of the GMC curriculum content for all acute postgraduate disciplines showed considerable variation in the level of content, delivery and assessment in relation to training in transfusion medicine between specialities. The results have been discussed with NBTC representatives of the relevant Royal Colleges for action within their specialities.

34/13 NPSA SPN 14 Review Group

CJT provided an overview of the work of the group and the key recommendation that the format and frequency of the competency assessment should be revised with a greater emphasis placed on knowledge based tests. A workshop held in September was attended by 18 transfusion practitioners from each RTC region representing the full range of hospital trusts providing transfusion services. The outcome of the workshop was:

- Majority agreement for a one-off practical competency assessment followed by minimum 3-yearly update training with knowledge based testing.
- The proposal for 3-yearly update training will need discussion with the MHRA who require 2-yearly training, in order to harmonise the training timing and frequency.
- The training will need to be delivered electronically with an option for paper format to take account of the different systems in hospitals.
- Four small sub-groups were formed at the workshop and these will continue to work together to develop a set of core principles and standards.
- The need to develop a core knowledge based test that is transferable between trusts.
- The learnbloodtransfusion (LBT) competency should be updated to reflect the core knowledge requirements and could become an acceptable method of assessment. It is however noted that LBT does not integrate with all hospital systems.
- The requirement for 100% of all relevant staff to be competency assessed is not achievable and there is a need to recognise this and to allow for staff turnover.
- Following the disbandment of the NPSA, the NBTC should take ownership of the SPN via NHS England.

The group request that the NBTC endorse the change from 3-yearly practical competency assessments for staff as set out in the SPN to be replaced by knowledge based tests subject to hospitals undertaking risk assessments to ensure appropriate interim measures are in place to ensure patient safety.

GD asked for evidence that knowledge based assessments were better than practical ones. He appreciated that the present system of assessments was not working but did not want to see this replaced by a new system that also did not work.

The Chair referred to the regular concerns highlighted by many hospitals experiencing difficulties in fully implementing the competency based assessments. Advice would be sought about which NHS body

has responsibility for the NPSA recommendations for safe transfusion practice as they require revision and update.

Action: Chair/Secretary to discuss with NHS England.

35/13 Transfusion Laboratory Managers Working Group

JH reported that the working group had not met since the last NBTC meeting but contact is being maintained via email and telephone. Changes in pathology reorganisation were impacting on laboratory managers and integration of transfusion laboratories in trusts meant some staff were having to re-apply for their jobs. JH would provide a report following today's meeting.

Comments were made that the changes in hospital transfusion laboratories may require some reconfiguration of the laboratory managers group.

36/13 NBTC work plan 2013/14

The updated work plan was noted.

37/13 Reports From The Royal Colleges/Specialist Societies

37.1/13 Royal College of Anaesthetists

The college continues to promote best transfusion practice and has started an Anaesthesia Clinical Services Accreditation (ACSA) scheme for NHS and independent sector organisations for quality improvement through peer review. The service was launched in June 2013 by Sir Bruce Keogh. Full details are available on: <http://www.rcoa.ac.uk/acsa>

The European Board of Anaesthesiology (EBA) Safety Committee have drafted recommendations for pre-operative anaemia and PBM to raise the profile amongst anaesthesiologists in Europe.

37.2/13 Royal College of Emergency Medicine

The main transfusion issues relating to the College are:

- The membership is unhappy about the guideline requiring two separate blood samples for compatibility testing prior to transfusing a patient – this is not practical in emergency situations.
- Most emergency departments have a regionally approved massive transfusion protocol.
- The East of England region is currently developing a paediatric massive transfusion protocol.
- Transfusion is included in the curricula for both the member and fellow examinations.

37.3/13 Royal College of Obstetricians and Gynaecologists

ST referred to:

- Recurring errors in the administration of anti-D prophylaxis and

in the administration of intrauterine transfusions for fetal anaemia. There are also ongoing concerns for the correction of anaemia in pregnancy and in gynaecological patients.

- Massive haemorrhage is a big issue and drills are part of induction and annual training for all medical and midwifery staff as required by the Clinical Negligence Scheme for Trusts (CNST) Maternity standards.
- The use of cell salvage is increasing.

37.4/13 Royal College of Paediatrics and Child Health

SM advised the key issues for the college include:

- Completion of the paediatric guidelines for transfusion with ongoing concerns in maintaining safest practice for children – high potassium levels in irradiated red cells.
- The use of Octoplas and whether this is appropriate for children.
- Production of platelets and the continuing availability of single donor platelets for children.
- There has been a variable uptake of the 2-sample guidance.
- Patient identification is a clinical issue in an emergency setting.

37.5/13 Royal College of Pathologists

SA reported that:

- Transfusion issues affecting the college include discussion on the future of haematology as a specialty, pathology modernisation and the impact on delivery of service and training and modernising scientific careers.
- There are concerns around the laboratory training provision for haematology registrars and scientific staff.
- A transfusion symposium is planned for 2014.

37.6/13 Royal College of Physicians

The British Society of Gastroenterology is sponsoring a UK-wide audit on the use of blood components in patients with hepatic cirrhosis.

37.7/13 Royal College of Surgeons

JT stated that the main transfusion issues for the College are:

- The PREVENTT study on use of intravenous iron to treat anaemia in major surgery is nearly underway.
- Identification and management of pre-operative anaemia.
- Concern about consent for transfusion in the emergency setting.
- Concern about non-trained staff using cell salvage equipment.

37.8/13 The Intensive Care Society

MB reported that the main transfusion issues affecting the society are:

- Ongoing concerns regarding transfusion triggers and appropriate Hb target in critical illness.

- Ongoing research in gastro intestinal haemorrhage
- The “Age of blood” and its impact on clinical outcomes: the ABLE study is currently recruiting.
- Ongoing work on appropriate use of haemostatic products in intensive care practice.

37.9/13 British Blood Transfusion Society

The Society has been working on a project to provide members with assessments aligned to the Modernising Scientific Careers initiative and many education programmes.

38/13 Royal Colleges/Specialist Societies

38.1/13 Minutes of the last meeting

The minutes of the meeting held on 22 April 2013 were noted.

38.2/13 Update from the meeting of 21 October 2013

ST reported on items arising from the morning meeting:

- There was discussion about the BCSH guidelines and the requirement for two separate blood samples which is of particular concern for patients in Accident and Emergency Departments. The main issue is correct patient identification and what systems of identification might be set up for emergency patients.
- Patient consent to transfusion and patient information leaflets; the group want to promote patient information and consent with specific issues for paediatric patients.
- There is a query on cell salvage and who authorises training of the operators.
- The continuing concerns on the impact of reorganisation of pathology services.
- Impact of transfusion practitioners whose time is taken up educating others. There is inconsistency as some are part of biomedical sciences structure where jobs are at risk and others are part of the nursing directorate.

39/13 Serious Hazards of Transfusion (SHOT)

39.1/13 SHOT Update Report

PBM presented on key highlights from the 2012 SHOT report published on 10th July 2013.

- Participation in SHOT continues to increase with 98.7% of NHS organisations submitting reports.
- More than half of all reports analysed in 2012 relate to errors and the key messages are correct patient identification at all stages of the process and better communication and handover.
- SHOT also recommends zero tolerance for the incomplete and inaccurate labelling of pathology samples and that labelling should be carried out by the bedside.
- There were 9 transfusion associated deaths in 2012, with one

definitely related to transfusion.

- There were a number of errors in the provision of suitable blood groups and components for transplant patients.

39.2/13 Harmonisation of haemovigilance reporting

PBM advised that during 2012 SHOT had worked with MHRA towards a combined haemovigilance reporting system. MHRA have now advised they are consulting on introducing a yellow card single reporting system for all reporting to the MHRA including adverse events with medicines, medical devices and adverse blood reactions/events. Consultation on the proposal is via an online survey.

In discussion, the Committee agreed that SHOT have developed a unique identity and a proven haemovigilance reporting system for blood transfusion. The feedback and analysis which SHOT provides on adverse events and incidents has improved transfusion practice and is crucial to patient safety. There is no point in disrupting a system that works. A link to the yellow card reporting survey would be circulated to members and all were encouraged to complete this by 25 October.

It was noted that several hospital trusts are merging their blood transfusion services and in such situations the laboratory is responsible for working with clinicians in all the hospitals it provides services for.

40/13 Patient Blood Management (PBM)

40.1/13 National PBM survey

MM outlined the key headlines from the national PBM survey:

- 146/149 (98%) of Trusts responded
- 24% Trusts have <1 whole time transfusion practitioner
- About 65% of transfusion practitioners spend 30% or less of their time on PBM activities
- Most Trusts have a consultant haematologist responsible for transfusion but about 50% of these haematologists have no assigned programmed activities for transfusion
- 40% of Hospital Transfusion Committees do not include PBM in their remit or mention the development of a PBM working group
- The participating hospitals have 36 different types of transfusion laboratory IT systems; many have poor functionality to support PBM e.g. only 50% can record the reason for transfusion to facilitate audit
- Less than 50% of Trusts have a process for reporting blood usage to clinical teams
- Only 53% of Trusts undertake local audits of blood use
- About 50% of Trusts indicate that 40% or more of patients who might need transfusion are not given patient information leaflets or have consent documented in the clinical records.
- Only 78% of Trusts provide arrangements for the identification and management of anaemia before elective surgery
- Only 25% of Trusts use near patient haemostasis testing
- Only 25% of Trusts have a policy to minimise the volume and frequency of blood samples to minimise iatrogenic anaemia
- Only 73% of Trusts use tranexamic acid for trauma patients

- (despite the results of reduced mortality in the CRASH-2 trial)
- No Trusts use tranexamic acid for greater than 40% of surgical patients
- Only about 50% of Trusts are using intraoperative cell salvage for orthopaedic surgery
- Only 29% of Trusts have implemented a policy of transfusing one unit of red cells at a time in non-bleeding patients followed by reassessment of further need for transfusion

40.2/13 Clinical benchmarking, KPIs and transfusion dataset

Documents on clinical benchmarking, key performance indicators and a standard transfusion dataset were circulated. Members were requested to provide feedback by 4 November.

Action: All members.

40.3/13 National Comparative Audit of Blood Transfusion (NCABT)

An update of current audits was provided to the meeting:

- The 2013 audit of the use of blood components in neurocritical care – data entry is now complete and the target date for reporting is Spring 2014.
- The report on the 2013 audit of the use of Anti-D is expected at the end of December 2013.

NCABT have also supported the distribution, analysis and reporting of the PBM survey.

Planned audits for 2014 include patient information and consent, the management of patients with haemoglobinopathies and 'Where does blood go'.

40.4/13 Learnbloodtransfusion

AH presented an update report on key achievements since April 2013:

- *Transfusion Laboratory – Safe Practice* course was launched at the start of May.
- Revised *Safe Transfusion Practice* course incorporating a revalidation element was launched in mid-May.
- *Animated Sampling Unit*, a 12 minute animated demonstration video (no assessment involved), is due for launch imminently; it will be promoted for use along side the sampling unit of the *Safe Transfusion Practice* course, as well as independently with transfusion sampling competency training.
- *Management of Acute Transfusion Reactions* course content development group has been assembled.
- *Good Manufacturing Practice* course content currently undergoing scheduled review.
- *A Consent for Transfusion* course was launched in March 2013.

With reference to the stated number of 80,917 current users registered under NHS England for the LearnPro NHS learning management system, a request was made for the usage data to include denominator

figures by trust and staff groups to enable better measure on the level of participation.

Action: RG

41/13 National Clinical Institute for Health and Care Excellence (NICE)

MM reported that the final scoping document for the blood transfusion guideline had been agreed in the summer and the development process is progressing well. Publication of the guideline is expected in May 2015.

<http://guidance.nice.org.uk/index.jsp?action=byld&o=13785>

42/13 NBTC Budget Report

AH reported on the financial position of the three budgets supporting the national and regional transfusion committees at 31 August 2013.

- NBTC Main Operating Budget: The annual budget is set at £63,974 with year-to-date expenditure of £26,749.
- NBTC Support Budget: This budget supports the administrative, website and audit staff and is currently set at £253,149 with the year-to-date spend £91,539.
- RTCs Budget: The annual budget is £49,696 with the year-to-date spend of £8,853.

43/13 NHSBT – Key Performance Indicators

The report for quarter 1, 2013/14 was noted. This showed a continuing fall in red cell demand and an increase in platelet usage.

44/13 Medicines and Healthcare products Regulatory Agency (MHRA)

CR provided an update of Serious Adverse Blood Reactions and Events (SABRE) as at September 2013.

A total of 720 incidents have been reported; 482 Serious Adverse Events (SAEs) and 238 Serious Adverse Reactions (SARs). Figures to date are projecting a decrease in the number SAEs but an increase in SARs over the year. The majority of SAEs are associated with human error involving storage of blood, its transport, labelling of components and blood sample collection.

There are 22 reporters, mainly private hospitals, who have never submitted a report.

45/13 National Commissioning Group for Blood (NCG)

A letter dated 22 July 2013 communicating the update from the NCG meeting to hospitals was noted. This confirmed a significant reduction in red cell demand below the level at which NCG prices were agreed and therefore no rebate to hospitals is planned for 2013/14.

46/13 Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO)

46.1/13 MSM Donor Selection Review

On 17 October SaBTO published Tissues and Cells: MSM Donor Selection Review (MSM: men who have had sex with men). SaBTO reviewed the evidence base for the selection of living and deceased donors of cells and banked tissues in the UK, in relation to MSM behaviour. The review included haematopoietic stem cells, from family and friends, unrelated adult donors and cord blood; pancreatic islets and hepatocytes; banked tissues (corneas, heart valves, amnion, bone, skin and tendon) and sperm, eggs and embryos. SaBTO concluded that some changes to the current criteria were warranted, for unrelated adult donors of haematopoietic stem cells, cord blood donors, and for donors of banked tissues. Its recommendations are detailed in the report that has just been published, together with information on the methodology used, and the evidence considered.

The report Tissues and Cells: MSM Donor Selection Review is now published, and can be found at <https://www.gov.uk/government/publications/donor-selection-criteria-for-men-who-have-had-sex-with-men>.

46.2/13 Sourcing blood plasma for import into the UK

In April this year, SaBTO published advice on the countries from which single donor plasma should be sourced for transfusion, based on new work to assess the risk of variant Creutzfeldt-Jakob disease (vCJD). It is published at <https://www.gov.uk/government/publications/sourcing-blood-plasma-for-import-into-the-uk>

46.3/13 Collection of 80% of platelet donations by apheresis,

At its meeting in September SaBTO discussed removing the requirement on NHSBT to produce 80% of platelets by apheresis. A Ministerial decision is awaited.

47/13 NBTC Red Cell and Platelet Shortage Plans

The two plans were referred to the Transfusion Laboratory Managers working group for review and update.

Action: Transfusion Laboratory Managers Working Group

48/13 Institute of Biomedical Science (IBMS)

Allan Morrison has stepped down as the IBMS representative and the Chair expressed the thanks and appreciation of the Committee for his contributions over the past four years. The IBMS will nominate a new representative in the near future.

49/13 Dates of meetings for 2014

The meetings for 2014 will take place on Monday, 17th March and Monday, 29th September commencing at 1.00pm.

The following papers were provided for information.

- Update report from the Systematic Reviews Initiative
- The relaunched Transfusion Evidence Library is accessible at www.transfusionevidencelibrary.com
- Transfusing Blood Safely and Appropriately, BMJ article
- NBTC bookmark – guidance for the use of blood components
- <http://www.transfusionguidelines.org.uk/Index.aspx?Publication=NTC&Section=27&pageid=7671>
- Transfusion Training Day – 23 November 2013.