National Blood Transfusion Committee

Confirmed notes of the thirteenth meeting of the NBTC representatives of the Royal Colleges and Specialist Societies, held on Monday 21st October 2013 at the Royal College of Pathologists, London.

Present:	Miss Susan Tuck, Chair	ST	Royal College of Obstetricians & Gynaecologists
	Dr Shubha Allard	SA	Royal College of Pathologists
	Dr Miles Allison	MA	Royal College of Physicians
	Prof Mark Bellamy	MB	Intensive Care Society
	Dr Paula Bolton-Maggs	PB-M	Serious Hazards of Transfusion
	Mr Andrew Cope	AC	Royal College of Emergency Medicine
	Ms Mervi Jokinen	MJ	Royal College of Midwives
	Ms Lynne Mannion	LM	British Blood Transfusion Society
	Dr Sarah Morley	SM	Royal College of Paediatrics and Child Health
	Mr John Thompson	JS	Royal College of Surgeons
Apologies:			
	Mr Graham Donald	GD	NBTC Lay member
	Ms Rose Gallagher	RG	Royal College of Nursing
	Mr Daniel Palmer	DP	British Blood Transfusion Society
	Dr Jonathan Wallis	JW	British Society for Haematology
	Mr David Whitaker	DW	Royal College of Anaesthetists

07/13 Minutes from the last meeting held on 22 April 2013

The Minutes were accepted as a correct record of the meeting.

08/13 Matters Arising from the Minutes

08.1/13 <u>BCSH guideline requiring two separate blood samples for compatibility testing</u>

This recommendation is continuing to cause some practical difficulties in clinical settings. Compliance with the guideline needs to be on the basis of balancing the risk of inadvertent mismatching of blood against the risk of delay in administering blood in each case. Each hospital is advised to make its own risk assessment on this issue. The focus of this assessment should be on the reliability of mechanisms for patient identification. PB-M informed the group that there will be a meeting of SHOT to discuss how to set up a system for the reliable identification of Accident & Emergency department patients.

08.2/13 Patient consent to blood transfusion

The Patient Involvement Working Group have up-dated patient information leaflets which are available on www.blood.co.uk/about-blood/information-for-patients/blood-transfusion and the national audit of implementation of explicit patient consent to transfusion will start in January 2014. LM suggested that the members of this group should promote the use of the e-module for staff training on learn-blood-transfusion. SM indicated that the issues relevant to Paediatrics need specific discussion.

08.3/13 Education Working Group

SA gave an up-date on the review of training arrangements for different clinical staff groups, which was also presented to the main meeting of the NBTC as Paper D 2. The Working Group feel that curricula for all clinical groups should include the key principles of the safe and appropriate use of blood and blood products, patient information and consent, the recognition of and management of transfusion reactions, the management of anaemia, and the alternatives to blood transfusion. The College representatives have helped to confirm the accuracy of information about training curricula and have provided information on how changes to curricula could be achieved in the various specialties.

SA again reported difficulties about establishing any consistent arrangements for the education and training of nurses and midwives. MJ explained that the NMC (Nursing and Midwifery Council) sets skeletal core curricula, but has no control over the training programmes of individual universities.

A query was raised about arrangements for the training of ODP's (Operating Department Practitioners) regarding blood transfusion. SA indicated that this staff group is intended to be in the remit of the review, including specific reference to the use of cell salvage equipment during surgery, and JT undertook to enquire further about this. ODP's have no professional body or national training authority to refer to for educational standards. Their training is by various courses run by local polytechnical colleges.

AC indicated that the curriculum for postgraduate training in Emergency Medicine is already long and is "mapped" to GMC requirements. Suggestions from the Education Working Group are being considered by the curriculum committee, including posing examination questions for trainees on transfusion matters. There was a particular concern about appropriate training on the care of patients taking newer warfarin-like preparations.

JT reported that a new curriculum has been written for training in vascular surgery which includes all the core components regarding blood transfusion recommended by the Education Working Group. There is, however, an overlap in the conditions treated by vascular surgeons and those treated by interventional radiologists, and it was not known whether they also included transfusion training in their curriculum requirements. SA undertook to contact the Royal College of Radiologists concerning this.

The specific training issues relevant to Obstetrics and Gynaecology identified by the Education Working Group were those of patient information and consent, awareness of alternatives to transfusion, the proactive investigation and

management of anaemia, with particular reference to iron deficiency, the appropriate use of cell salvage and the use of anti-D prophylaxis for Rhesus D negative women. The RCOG Curriculum Review Group is considering these matters, to see what might be appropriately removed and added to various modules of the curriculum, both to avoid repetition and also an excessively lengthy document. The Chairman of the RCOG Curriculum Committee comments that some core skills and knowledge about transfusion issues are embedded in Foundation doctor training, and are likely also to be included in the developing moves to generic early specialty training (between Foundation training and Specialty Training).

SA is awaiting feedback from Anaesthetics and Paediatrics. She asked that the topic remain as an Agenda item for the group's next meeting, to assist the monitoring of how these revisions are progressing, including the relevant competency requirements in Foundation doctor training.

A query was raised as to whether the new NICE guideline on transfusion would include the management of anaemia.

08.4/13 Evidence based care of patients needing transfusion

The group queried how the Patient Blood Management Group's recommendations on evidence based care of patients who might need transfusion were to be disseminated to hospitals. This was answered by the NBTC Chairman in the afternoon meeting, indicating that he was still waiting for a meeting with Sir Bruce Keogh, National Medical Director for NHS England, to authorise an agreed process for this

08.5/14 NPSA Safer Practice Notice

The National Patient Safety Authority having now been disbanded by the government, the group queried who would pick up the concerns raised about the effectiveness of staff tests of competency concerning blood transfusion. Data from SHOT and others have repeatedly demonstrated that errors are often made by supposedly "competent" staff. The preference would be to move to a system requiring 3 yearly knowledge-based testing, such as those provided by Learn Blood Transfusion, and reducing the testing of practical procedures. The group discussed how up-dates of training should be delivered, with a preference for e-learning. The current assessment system is arduous for Transfusion Practitioners, and is being reviewed. There is a particular concern about the significant reduction in Transfusion Practitioner posts as a consequence of national changes in Pathology services. There is also a meeting planned between SHOT officers and the RCN on the issue of competency assessment requirements.

09/13 Feedback from Colleges and Societies

Annual reports from the College of Emergency Medicine, the Royal College of Obstetricians and Gynaecologists, the Royal College of Pathologists, the Royal College of Physicians and the British Blood Transfusion Society had been prepared for the meeting of the full NBTC (Papers F 1 – 5), highlighting transfusion issues particularly relevant to each group. The Royal College of Anaesthetists also reported informally on the development of an Anaesthesia Clinical Services Accreditation scheme which has been through a successful

pilot exercise, and includes standards relating to blood transfusion. These are that blood storage facilities should be in close proximity to emergency operating theatres and should contain O Rhesus D negative blood, that equipment should be available for fluid and blood warming and for rapid infusion, and that cell salvage equipment and trained staff should be available for appropriate patients. In addition the European Board of Anaesthesiology has produced recommendations for the timely evaluation and treatment of pre-operative anaemia.

10/13 Key points from the SHOT Report for 2012

PB-M summarised that the main messages from the analysis of adverse incidents in 2012 were unfortunately the same as they have been for the past 16 years. These involve the correct identification of patients, the importance of complete communication between departments, the recognition of transfusion reactions when they occur, and the problems of transfusion associated circulatory overload. There were significant incidents involving complications from the use of intravenous immunoglobulin, and from the failure to use the correct specific blood products required for special circumstances, such as the intrauterine transfusion of fetuses, and for transfusions to transplant patients and stem cell recipients.

PB-M reported that the SHOT Committee had been trying to combine with the MHRA for haemovigilance monitoring, but the MHRA mechanisms have become more complicated, because they are in the process of including the reporting of adverse events relating to the use of all products, drugs and devices under the "yellow card" system. This appears to be in response to a recent European Union Directive concerning the monitoring of all medical devices and procedures, including those such as assisted conception techniques, and the use of subcutaneous hormone implants. Members of the group agreed that the "yellow card" system is already known to be under-utilised, and therefore giving significantly incomplete data, and expressed concern at these proposals, which appeared to suggest that this system intended to take over the role of SHOT, which had a much stronger reputation and achieved much more complete incident reporting.

11/13 Any other business

11.1/13 Royal College of Pathologists' symposium

SA drew members' attention to a symposium on blood transfusion to be held at the Royal College of Pathologists in November 2014. She would be circulating more details to members of the group, so that they could encourage wide participation in the meeting. She also asked for members of the sub-committee to suggest particular topics, which their colleagues would find useful, for inclusion in the symposium.

11.2/13 Changes to Pathology services

Changes to Pathology services planned in some regions in England will have a significant impact on hospital blood transfusion laboratories. There will be potential loss of staff, including Transfusion Practitioners, half of whom are currently biomedical scientists rather than nurses. There is the potential for staff of laboratories to lose skills in transfusion related techniques, and for problems

with the use of unqualified laboratory staff, especially out-of-hours. PB-M described the results of a survey of hospital transfusion laboratories in March 2013, by the UK Transfusion Laboratory Collaborative, indicating a smaller number of staff permanently working in transfusion laboratories, reduced funding for staff education, and that not all Trusts review transfusion related standards in their governance systems.

MB indicated that new standards are being drawn up, but he doubted that there would be any effective mechanism for their obligatory implementation through the new NHS commissioning system.

12/13 Date of next meeting

Monday, 17th March 2014 at 11.30am at the Royal College of Pathologists, London.