National Blood Transfusion Committee

Unconfirmed minutes of a meeting of the National Blood Transfusion Committee held on 22 April 2013 at the Royal College of Obstetricians and Gynaecologists, London.

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| **Present:** | Prof A Newland | | Chairman |
| | Prof M Murphy | MM | Secretary |
| | Dr S Allard | SA | Royal College of Pathologists |
| | Dr M Allison | MA | Royal College of Physicians |
| | Dr J Bamber | JB | East of England RTC |
| | 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 M Desmond | MD | North West RTC |
| | Mr G Donald | GD | Patient Representative |
| | Ms R Gerrard | RG | NHSBT National Lead: Patient Blood Management |
| | Dr L Green | LG | NBTC Blood Components Working Group |
| | Dr A Iqbal | AI | North East RTC |
| | Ms M Jonkinen | MJ | Royal College of Midwives |
| | Ms J Langham | JL | Medicines and Healthcare products Regulatory Agency |
| | Dr P Larcombe | PL | South East Coast RTC |
| | Ms L Mannion | LM | British Blood Transfusion Society |
| | Dr A McKernan | AMc | East Midlands RTC |
| | Dr S Morley | SM | Royal College of Paediatrics and Child Health |
| | Mr D Palmer | DP | British Blood Transfusion Society |
| | Dr P Roberts | PR | South West RTC |
| | Mr R Scrivener | RS | Royal College of Nursing |
| | Dr Y Sorour | YS | Yorkshire and The Humber RTC |
| | Mr A Stock | AS | South Central 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 |
| | Dr J Wallis | JW | British Society for Haematology |
| | Dr D K Whittaker | DKW | Royal College of Anaesthetists |
| | Dr H Williams | HW | NHSBT Director of Diagnostic and Therapeutic Services |
| | Dr L Williamson | LW | NHSBT Medical Director |
| **In Attendance:** | | | |
| | Dr K Pendry | KP | NHSBT and Central Manchester Hospitals |
| | Mr C Philips | CP | NHSBT Head of Hospital Customer Service |
| **Apologies:** | | | |
| | Mrs T Allen | TA | NHSBT Assistant Director Customer Service |
| | Prof M Bellamy | MB | Intensive Care Society |
| | Ms R Gallagher | RGa | Royal College of Nursing |
| | Mr J Hyare | JH | Transfusion Laboratory Managers Working Grp |
| | Mr A Morrison | AM | Institute of Biomedical Science |
| | Dr D Thomas | DT | Blood Implementation Group, Wales |
| | Dr C Costello | CC | NHSBT Non-Executive Director |

**01/13 Welcome and Introductions**

The Chair welcomed everyone to the meeting and introduced new members Daniel Palmer, Youssef Sorour and Huw Williams.

**02/13 Minutes of the meeting of the full Committee held on 24 September 2012**

The minutes of the meeting held on 24 September 2012 were agreed as a correct record.

**03/13 Matters Arising**

03.1/13 Transfusion Laboratory Managers (TLM) Working Group

GD referred to Minute 37/12 and requested an update on the review being carried out by NHSBT and the TLM working group to investigate a 32% increase in ad-hoc deliveries of blood components to hospitals over the preceding 12 months. An update would be provided to the next meeting.

**Action: TA**

**04/13 Regional Transfusion Committee (RTC) Chairs**

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

- Some RTCs have expressed concern about changes to pathology services in their regions and the impact on hospital blood transfusion laboratories. Specific issues noted were the potential loss of senior staff and expertise in transfusion laboratories and the detrimental effect on the quality of services and time for better blood transfusion initiatives.
- North West RTC has developed a toolkit to improve communications between the regional and hospital transfusion committee chairs which has been shared with all regions.
- The potential closure of the stockholding unit in Lancaster was highlighted as a concern by North West RTC but it was noted that NHSBT are not now pursuing closure and are exploring other options.
- The British Committee for Standards in Haematology (BCSH) guidelines requiring two separate blood samples for compatibility testing appears to be causing difficulties in some hospitals.
- Some regions are developing training passports for staff involved in blood transfusion.
- There was discussion on ways in which the Blood Stocks Management Scheme (BSMS) can produce data to encourage efforts to review blood usage and trends in hospitals.

**05/13 Matters Arising from the RTC Chairs meeting of 22 April 2013**

05.1/13 Pathology Modernisation

The Chair referred to specific comments on changes to pathology services and the need for the national and regional committees to monitor developments and their effect on blood transfusion services. The impact may vary across the RTCs dependent upon different regional structures. The

potential staffing losses and de-skilling of laboratories is worrying as SHOT have highlighted problems relating to unqualified laboratory staff particularly during out-of-hours periods.

PBM stated that the UK Transfusion Laboratory Collaborative (UKTLC) have repeated a survey of hospital transfusion laboratories in March 2013, previously carried out in 2011, and the results are expected shortly.

05.2/13 BCSH Guidelines on Compatibility Testing

JL advised that MHRA are aware that the requirement for two samples for compatibility testing may cause some problems and are requesting feedback on any difficulties. Each organisation should undertake risk assessment of its own arrangements with more focus on patient identification.

The Chair concluded that where there is good patient identification and secure pathways for taking blood samples, the BCSH guidelines should not impede good practice or the urgent delivery of blood components.

05.3/13 RTC Chairs

The Chair noted that Patrick Roberts and Anthony Stock were standing down as RTC Chairs having completed their term of office. He expressed the thanks and appreciation of the Committee for their hard work and commitment over the past four years.

**06/13 Minutes of the meeting of the Executive Working Group held on 24 January 2013**

The minutes of the meeting held on 24 January 2013 were noted.

**07/13 Blood Components Working Group**

07.1/13 Extending the Shelf-life for thawed Fresh Frozen Plasma (FFP)

Following a request from the NBTC to examine the evidence on the efficacy and safety of extending the shelf-life of thawed FFP to 48 or 72 hours, a questionnaire was distributed to all hospitals to assess the clinical demand for extending the shelf-life of FFP and the potential for FFP wastage reduction in hospitals should this product become available.

A total of 417 participants (66% clinicians, 22% laboratory staff and 12% transfusion practitioners) from 137 hospitals responded to the questionnaire. Approximately 45% of respondents thought that extending the shelf-life of post-thawed FFP would reduce delays in provision of the product; 50% of respondents were concerned about possible loss of efficacy beyond 24 hours; 35% and 15% would definitely use extended thawed FFP for massive haemorrhage and other indications respectively. On the reduction of FFP wastage, 30% stated that an extension of shelf-life would cause <5% or no reduction in wastage; 15% stated it would lead to between 6-30% reduction and 15% stated it would lead to >30% reduction in wastage.

Following discussion of the survey results, the Committee suggested that JPAC should consider the findings of the survey.

07.2/13 Pathogen Inactivation of Platelets

Systems for pathogen inactivation (PI) of platelets are CE marked and in routine use in several European Countries. NHSBT are planning to perform operational assessments of PI platelet systems in 2013/14, including issuing the platelet concentrate for clinical use.

07.3/13 Bacterial screening of platelets

Since the introduction of bacterial screening by NHSBT in February 2011, a total of 382,170 apheresis platelet packs and a further 66,870 pooled platelet packs have been screened.

For the last quarter of 2012, the current initial reactive rate is reported as 0.46% for apheresis platelets and 0.32% for pooled platelets; of these 0.02% initial reactive packs were confirmed as positive and a further 0.03% as indeterminate positive.

07.4/13 Donor testing for West Nile Virus (WNV)

The EU directive requires that donors who have travelled to WNV affected areas are deferred for 28 days' after return. Given concerns about the potential impact on the blood supply and the importance of the Olympics, the MHRA and Ministers accepted a policy of non-enforcement of this policy on the four UK Blood Services, if they chose to implement nucleic acid testing (NAT) of donations for WNV rather than deferring donors. Since the introduction of the NAT testing for WNV in May 2012, NHSBT has tested nearly 28,873 donations up to the end of December 2012 and all have been negative.

## 08/13 Patient Involvement Working Group

RG reported on the activities of the group over the previous six months:

- Dr Charles Baker, Consultant Anaesthetist at the University Hospital of North Staffordshire has taken over as Chair of the group.
- There has been further development of web content on blood transfusion for patients and the public on http://www.blood.co.uk/about-blood/information-for-patients/blood-transfusion/ and the NHS Choices website.
- The update of patient information leaflets has been finalised and is awaiting completion by the Marketing Department.
- The group continues to promote transfusion awareness in collaboration with specialist societies and other groups.

## 09/13 Patient Blood Management (PBM) Working Group

09.1/13 PBM recommendations

MM presented the initial recommendations produced by the working group setting out an evidence-based approach for the care of patients who might need a blood transfusion and how hospitals should start implementing PBM programme. The next step is for the NBTC to discuss the paper with Sir Bruce Keogh and agree the process of disseminating the recommendations to hospitals.

In response to a query from GD about the allocation of additional funding of £250,000 from the National Commissioning Group, MM stated there was as yet no decision on how that would be spent but it could be used to help with the establishment of benchmarking systems across hospitals.

09.2/13 KPIs and Transfusion Dataset

The paper circulated considered the key elements of the transfusion dataset for the development of performance indicators to establish a PBM programme in hospitals and benchmark practice between hospitals. It may be possible to collect data from registries for patients undergoing cardiac, vascular and joint surgery. The performance indicators need to be important, measurable and achievable. A feasibility questionnaire prepared by KP has been circulated to NBTC members.

**Action: KP**

09.3/13 AIM II Trial

KP reported that NHSBT have been working with 4 Trusts and America's Blood Centers (ABC) since September 2011 to implement a process for systematic data collection and analysis to support PBM. The process has proved problematic and it is likely that this system will not be suitable for large scale rollout in view of the complexities and resources required at hospital level. A meeting of the key stakeholders will take place in May 2013 to review the data analysis and lessons learned.

## 10/13 Education Working Group

SA reported that the first phase of the group's work to review transfusion training in relation to the curriculum content for undergraduate and postgraduate education for doctors, nurses and midwives has been completed. Results of the survey of medical and foundation schools confirmed a large variation with content, delivery and assessment in training in transfusion medicine.

For phase two, the group will promote improvements in transfusion education for all healthcare professionals and trainees.

## 11/13 NPSA Safer Practice Notice 14 Review Group

CJT reported that the group are reviewing the NPSA guidance with regard to transfusion competencies following SHOT reports that mistakes are being made by staff who have been competency assessed and concerns from transfusion practitioners that the assessment system is arduous. The intention is to make the process of competency assessment more workable while improving the depth of knowledge and understanding of those carrying out the tasks.

The first review document has been completed and will be circulated to transfusion practitioners for consultation.

## 12/13 Transfusion Laboratory Managers Working Group

No report was received.

## 13/13 NBTC work plan

The work plan for 2013/14 was provided to the meeting.

## 14/13 Royal Colleges/Specialist Societies

14.1/13 Minutes of the last meeting

The minutes of the meeting held on 24 September 2012 were noted.

14.2/13 Update from the morning meeting of 22 April 2013

ST reported on items arising from the meeting:

- There was recognition that explicit written consent for blood transfusion is already in place for surgical patients but not for medical patients. The National Comparative Audit for Blood Transfusion (NCABT) will audit how this is being implemented in hospitals.
- A new consent form is to be introduced. The DH consent form for surgical procedures is already very lengthy. There is a distinction between elective surgery and how it applies for emergency trauma patients and in those circumstances it is an issue of informing a patient retrospectively.
- SA provided an update on the work of the education group.
- There was concern about how the BSCH guidelines for compatibility testing would work in practice for neonatal patients.

## 15/13 Royal College of Nursing (RCN)

RS reported that the RCN has updated the guidance for improving transfusion practice 'Right blood, right patient, right time' and this is available on link: http://www.rcn.org.uk/__data/assets/pdf_file/0009/78615/002306.pdf The guidance will be launched at a fringe event of the RCN Congress being held from 22-25 April 2013. Tentative arrangements have been made for the RCN to meet with SHOT to discuss how the two organisations can work more closely together to improve nursing practice in all areas of transfusion practice.

## 16/13 Patient Blood Management

16.1/13 National Comparative Audit of Blood Transfusion

An update report of current audits was provided to the meeting:

- The audit of the use of red cells in Cardiac Surgery has been signed off and is due to report shortly.
- The report on the 2011 Audit of the Medical use of Red Blood Cells part 2 is nearing completion.
- The reports of the 2012 audit of blood sample collection have been distributed to hospitals.

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.

16.2/13 Learnbloodtransfusion

RG provided an update report on key achievements since September 2012:

- Module 1, Safe Transfusion Practice has been reviewed and updated and now includes a shortened revalidation element.
- The Consent for Transfusion course is now live on LearnPro with upload to NLMS and e-LfH in progress.
- The UK and Ireland BBT Network are in the process of more formally agreeing the 'Intellectual Property Rights' of learnbloodtransfusion with further clarification on issues around 'not for profit' organisations.

With regard to the paper provided by Oxford University Hospitals NHS Trust who are big users of learnbloodtransfusion and have made the eLearning assessments a mandatory requirement, it is noted that LearnPro enhanced their reporting functionality in January 2013.

MM stated that the data migration is still a manual system and electronic validation of staff details would be helpful as well as access from mobile technology to make the process slicker for hospitals and users.

**17/13 National Clinical Institute for Health (NICE)**

MM reported on progress in developing the guideline and quality standards for blood transfusion. These will focus on PBM and also on the safety of transfusion. Feedback on the initial draft scope has been received and it is hoped this will be finalised soon as well as the composition of the guideline writing group.

ST requested that the guideline considers the management of anaemia including pre-operative assessment clinics and their cost benefit.

**18/13 NBTC Budget**

RG reported on the financial position of the three budgets supporting the national and regional transfusion committees as at 31 March 2013.

18.1/13 NBTC – Main Operating Budget

The annual budget is set at £61,464, with a year-to-date expenditure of £47,599.

18.2/13 NBTC – Support Budget

This budget supports the administrative, website and audit staff and is currently set at £248,893 with the year-to-date spend of £216,428.

18.3/13 RTCs - Budget

The annual budget is £43,288 with a year spend of £47,988. The overspend was mainly due to additional PBM events staged by the RTCs.

**19/13 NHSBT**

19.1/13 Key Performance Indicators (KPIs)

CP presented an overview of NHSBT performance against key operating

standards for Quarter 3 2012/13, covering aspects of stock management, donations and sample testing:

- Following a slight increase in the average age of red cells at dispatch during quarter 1 due to the Olympics stock build, the performance has settled at around 14 days.
- There has been a considerable reduction in the number of red cells units issued with <12 days shelf life in recent years and this has been maintained over the reporting quarter.
- Demand for red cells issued has been falling significantly over the past 12 months with an annual reduction of 2.9%.
- The demand for platelets continues to rise but only by 1% in the last year.

19.2/13 Integrated Transfusion Services (ITS)

HW reported on progress with the ITS programme. A stock management project has been piloted at four hospitals trusts in Blackpool, Bournemouth, Liverpool and Oxford over the last six months and desktop pilots are planned with a wider group of hospitals.

Currently eight Red Cell Immunohaematology (RCI) laboratories are providing reference services. The laboratories are working longer hours from 07.00am to 11.00pm daily and most include Saturday shifts. The RCI test results are provided to hospitals electronically through the Sp-ICE reporting system.

19.3/13 Expert Panel

LW advised a major topic for the next Expert Panel meeting is the NHSBT 5-year research strategy which starts in 2015. Dependent on the outcome of discussions, a paper may be provided to the next NBTC meeting. The price of blood includes a small element for research including biological safety, appropriate use, systematic reviews and donor health.

**20/13 Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO)**

The Chair reported that SaBTO have provided a summary of their last meeting held on 10 December 2012. The use of a prion reduction filter for red cell concentrates made in 2009 has been rescinded. The use of 'Club 96' donations will be further considered in June 2013 and advice is being developed regarding the West Nile Virus (WNV) relating to transplanted organs and tissues.

**21/13 Department of Health**

The prices for blood components and specialist services for 2013/14 from NHSBT were received. It was noted that the red cell price of £122.09 is slightly lower than the previous year, RCI prices have increased by 3.8% and a RCI out-of-hours charge of £73.25 per test has been introduced from 1 April 2013.

## 22/13 Serious Hazards of Transfusion (SHOT)

PBM presented an update highlighting:

- The report for 2012 will be presented at the SHOT symposium on 10 July 2013 at the Royal College of Medicine, London.
- Work has continued with MHRA towards a combined haemovigilance reporting system.
- There is concern over hospital practice with suspected bacterial infections related to transfusions. Work is ongoing about how hospitals investigate suspected bacterial infections. Hospitals should contact their local Blood Centre immediately in the event of a severe bacterial infection and return any associated components undamaged.

## 23/13 Medicines and Healthcare products Regulatory Agency (MHRA

JL provide highlights of Serious Adverse Blood Reactions and Events (SABRE) update for the calendar year 2012.

A total of 1460 incidents were reported, 930 Serious Adverse Events (SAEs) and 342 Serious Adverse Reactions. There were 188 excluded reports. The top five SAEs were:

- Incorrect blood component selected and issued.
- Component labelling error.
- Sample processing error.
- Data entry error.
- Pre-transfusion testing error.

Haemovigilance activity planned for 2013 includes SABRE workshops, informal hospital visits and a reporting session at the SHOT symposium in July. Working is continuing with SHOT in the development of a single reporting system.

## 24/13 Chairman's Items

The Chair noted that Judy Langham, Principal Haemovigilance Specialist at the MHRA was leaving the organisation. He thanked Judy for her support and contribution to the NBTC over the last two years and wished her well for the future.

## 25/13 Date of Next meeting

The date of the autumn meeting was advised as Monday, 21 October 2013 at the Royal College of Pathologists.

## 26/13 For Information

- The NBTC Indication Codes for Transfusion have been updated and are available on: http://www.transfusionguidelines.org.uk/docs/pdfs/nbtc_2014_04_recs_indication_codes_2013.pdf
- A Systematic Reviews Initiative update detailing recently published and ongoing systematic reviews was noted: www.transfusionevidencelibrary.org

- Quality, Innovation, Productivity and Prevention (QIPP) example Publication of 11/0033r updated submission of Electronic blood transfusion: improving safety and efficiency of transfusion systems. http://arms.evidence.nhs.uk/resources/qipp/29453/attachment