The Chief Medical Officer's
National Blood Transfusion Committee

Confirmed minutes of a meeting of the National Blood Transfusion Committee held on 26 March 2012 at the Royal College of Pathologists, London.

Present:	Prof A Newland		Chairman
	Prof M Murphy	MM	Secretary
	Dr S Allard	SA	Royal College of Pathologists
	Mrs T Allen	TA	NHSBT Assistant Director Customer Services
	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 M Desmond	MD	North West RTC
	Mr G Donald	GD	Patient Representative
	Mr R Elshaw	RE	Yorkshire & Humber RTC
	Ms R Gerrard	RG	NHSBT Head of Better Blood Transfusion
	Dr L Green	LG	Blood Components Working Group
	Ms S Harle-Stephens	SHS	British Blood Transfusion Society
	Dr C Harrison	CHa	London RTC
	Mr J Hyare	JH	Transfusion Laboratory Managers Working Group
	Dr A Iqbal	AI	North East RTC
	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 A Morrison	AM	Institute of Biomedical Science
	Dr P Roberts	PR	South West RTC
	Dr C Ronaldson	CR	NHSBT Director of Patient Services
	Mr A Stock	AS	South Central RTC
	Dr C J Taylor	CJT	West Midlands RTC
	Miss S Tuck	ST	Royal College of Obstetricians and Gynaecologists
	Dr J Wallis	JW	British Society for Haematology
	Mrs S Wright-Hogeland	SWH	Patient Representative
	Mrs T Little	TL	NBTC Administrator

In attendance:

Mr A Hadley	AH	NHSBT General Manager for Specialist Services
Dr M Lopez	ML	Hospital del Mar i Espeanca, Spain

01/12 Welcome and Introductions

The Chairman welcomed everyone to the meeting and introduced new members Laura Green, NBTC Blood Components Working Group; Peter Larcombe, South East Coast RTC; Lynne Mannion, British Blood Transfusion Society and Mark Noterman, Department of Health.

02/12 Apologies for Absence

Apologies for absence were received from Andrew Cope, Royal College of Emergency Medicine; Rose Gallagher, Royal College of Nursing; Catherine Howell, NHSBT Chief Nurse Patient Services; Mervi Jokinen, Royal College of Midwives; Dafydd Thomas, Blood Implementation Group, Wales; John Thompson, Royal College of Surgeons; David Whitaker, Royal College of Anaesthetists and Lorna Williamson, NHSBT Medical Director.

03/12 Minutes of the Last Meeting

The minutes of the meeting held on 3 October 2011 were agreed as a correct record.

04/12 Regional Transfusion Committees (RTCs)

CH reported on the extent and variety of work being carried out by the RTCs and highlighted the main topics of discussion at the morning meeting of RTC Chairs:

- There is a rolling programme of education events in each region which over the past 6 months has included massive haemorrhage/trauma, medical anaemia and intra-operative cell salvage.
- There was much discussion about the increased demand for platelets. RTCs are scrutinising blood component usage in hospitals in their regions and several regions have established blood conservation groups.
- The recent appointment by NHSBT of a Data Analyst and Audit Manager is welcomed and will provide support for regional audits and national surveys.
- Initial results of a survey of Hospital Transfusion Committees (HTCs) aimed at improving interaction and engagement with RTCs were reviewed. The survey is ongoing and a final report will be brought to the next meeting. There may be a need to formalise some of the duties of an RTC Chair.
- Some regions have found audience response systems to be very useful for improving delegate interaction at education events. A business case on the cost and feasibility of purchasing a single system as shared resource for use across the RTCs will be prepared.
- Concerns were noted about the changing job role of the NHSBT Customer Service Managers and how they will continue to support the RTCs with a request for clarification of their role.
- The RTC Chairs template report will be amended to note the changes and impact of Integrated Transfusion Services (ITS) in the regions.

- There are continuing constraints and difficulties for NHS staff to be given time off work to attend meetings.
- All regions have good administrative support.

05/12 Minutes of the Executive Working Group

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

06/12 Safer Practice Notice (SPN) 14 Review Group

CT presented the report of the Review Group which had been chaired by Dr Di Harvey.

CT stated that the remit of the group was to review training and the competency assessments set out in SPN 14 published in 2006 and the evidence for their effectiveness, difficulties encountered in implementation and suggest practical recommendations for the future. The group held one meeting with the membership comprising representatives from hospitals, NHSBT and SHOT and with additional input from a group of transfusion practitioners.

The background is that the requirements of the SPN for competency assessments have proved difficult to implement and their effectiveness in improving patient safety of incorrect blood components transfused has been questioned. The working group's key recommendation is that the competencies should remain as these are important to patient safety but the format and frequency of the assessments should be revised with a greater emphasis placed on knowledge and understanding. Other recommendations included:

- The SPN competency assessment frameworks need revising and updating in line with recent British Committee for Standards in Haematology guidance on the administration of blood components and BSQR regulations.
- There is a requirement for a national framework of standard knowledge tests transferable between Trusts and a proposal for an NBTC working group to review the current competence framework and theory based assessments.

The Chair stated that this is important to the whole area of patient safety and should not be taken off the agenda. The initial recommendations needed further consideration as well as a better understanding of which national body is going to carry on the work of the NPSA. He proposed the recommendations should be honed into smaller core sets and include MHRA input. The issue was referred for discussion at a forthcoming meeting with the Department of Health (DH) and NBTC Executive.

Action: NBTC Executive will consider the re-establishment of the Working Group.

07/12 Education Working Group

SA reported on progress with Phase 1 of the work to review transfusion training in England in relation to the curriculum content including methods of assessment used for undergraduate and post graduate training for doctors, nurses, midwives and operating department practitioners (ODPs).

A survey of transfusion training has been circulated to 32 UK medical schools with the questions based on standards as stated in the General Medical Council (GMCs) publication 'Tomorrow's doctors' 2009 and also the recommended content of the undergraduate curriculum in haematology developed by the British Society for Haematology (BSH) in 2010. A questionnaire has been compiled for the 25 foundation medical schools about the transfusion training content of their curriculum including its mode of delivery. The questions are based on the 2010 foundation curriculum which sets out clear expectations regarding transfusion medicine.

To date, 16 responses from medical schools and 12 responses from foundation schools have been received. All non-responders will now be sent a reminder with a further extension to the survey deadline date.

RG reported that a similar survey is being carried out with the three professional areas of nursing, midwifery and ODPs. To date, only a small number of replies have been received.

The Royal College of Nursing (RCN) has agreed to review and update their transfusion standards: *'Right blood, right patient, right time – RCN guidance for improving transfusion practice'* (2005). The revised version will be available on the RCN website by June 2012.

08/12 Transfusion Laboratory Managers Working Group

JH provided a verbal report summarising activity over the past six months.

- The membership structure is developing with a lead representative and deputy for each region. A review of the terms of reference is progressing.
- The Online Blood Ordering System (OBOS) has been implemented and is functioning in more that 90% of hospital transfusion laboratories.
- The group has secured two places on the MHRA Blood Consultative Committee.
- There seems to be lack of awareness and compliance with the NHSBT document on the transfer of blood components with patients. The consensus is that the document is too lengthy. The group will review this document including the packing of blood for transport and publish a more concise and usable summary paper.
- The issue of antibody cards is under review with data gathering to assess current practice.

09/12 Patient Involvement Working Group

SA gave an update on progress in developing information on blood transfusion for patients and the public:

- Designated web space with content is now uploaded on *http://www.blood.co.uk/about-blood/information-for-patients/* and details of the new website have been provided to 58 organisations.
- Development of patient focussed information in conjunction with specialist societies and action agreed to develop patient information in conjunction with the Sickle Cell Society.
- Participation in the annual display at National Science Week promoting awareness and knowledge on transfusion issues to schoolchildren and promoting careers in the NHS.
- Participation in the Royal College of Physicians Open Day in July 2012 with emphasis on interactive displays and linkage with Olympics 2012.
- Supporting SaBTO led recommendations on patient consent for transfusion and development of clinical resources to promote patient information and consent for multi-transfused patients.

10/12 Blood Components Working Group

LG presented a paper advising on updates on key issues:

10.1/12 Fresh Frozen Plasma (FFP)

At present, clinical fresh frozen plasma (FFP) can be stored for 24 hours at 4^{o}C after it is thawed. Studies to verify the safety and efficacy (in terms of changes in blood coagulation factors) of extending the shelf-life to 5 days were completed by the Blood Components Development Laboratory and were reviewed by the SACBC and JPAC; clinical input from the BCSH Haemostasis and Thrombosis Task Force was also obtained. After careful consideration it has been recommended that the shelf life of FFP following thawing should **not** be increased to 5 days due to concerns regarding efficacy and safety.

It was agreed to consider whether the shelf life can be increased to 48 or 72 hours.

Action: LG to discuss with NHSBT.

10.2/12 Bacterial screening of platelets

Automated bacterial screening (BactAlert) of all platelet components across England and North Wales began in February 2011 and was completed in July 2011. Since its introduction over 144,000 apheresis platelet packs and a further 26,000 pooled platelets have been screened.

Of the 17 confirmed positive cultures reported in the final quarter of 2011, there was 1 organism of high pathogenicity (E coli) where a possible serious transfusion-transmitted infection was prevented. 6 organisms of "low to moderate pathogenicity" were identified and the rest were low pathogenicity organisms such as P acnes.

10.3/12 Pooled granulocytes in platelet additive solution

Granulocyte transfusion is mainly used in neutropenic patients with antibiotic-resistant soft tissue infection after intensive chemotherapy. This recently developed component successfully completed safety and *in vitro* quality studies and should become available for clinical use in October 2012. It will replace conventional Buffy coat transfusion as a purer source of granulocytes.

11/12 Pathology Modernisation/IT Working Group

The Group are continuing to work with NHSBT to develop plans for Integrated Transfusion Services. A presentation would be given later in the meeting.

12/12 NBTC Work plan 2012/13

An updated work plan was provided to the meeting.

13/12 Royal Colleges and Specialist Societies

13.1/12 Minutes of the meeting held on 3 October 2011

The minutes of the meeting held on 3 October 2011 were noted.

13.2/12 Update from the morning meeting of 26 March 2012

- ST reported that the group had reviewed the draft guidance document produced by a joint working party of the Association of Anaesthetists of Great Britain and Ireland, Obstetric Anaesthetists' Association and Regional Anaesthesia UK on Patients with Abnormalities in Coagulation concerning epidurals, spinal anaesthesia, and thrombocytopenia and other coagulation disorders (including patients on thromboprophylactic therapy), and will submit comments. It is hoped that publication of the final document will be followed by a patient information leaflet.
- With regard to medical education, the focus is on post graduate education and training in blood transfusion and consideration of how much standardisation there could be and whether there might be some core element of what could be consistent.
- A specific request from the NBTC on how the members feed back to their colleges/societies was considered. There is a standard format for annual reports which are submitted to the NBTC autumn meeting and it was agreed that the template report would be revised and extended.
  Action: MM
- The transfusion platelet fact sheet and bookmark were reviewed and the group suggested that the fact sheet should include reference to the evidence base and examples of which fields of clinical practice there is a tendency for platelets to be overused.
- With regard to the suggested revision to the Blood Conservation Policy document, this has been deferred pending the forthcoming Patient Blood Management seminar.

14/12 Better Blood Transfusion (BBT)

14.1/12 'Patient Blood Management' Seminar

MM presented the programme for the 'Patient Blood Management' seminar to be held on 18 June 2012 at the Royal College of Pathologists. The seminar will be opened by Professor Sir Bruce Keogh, NHS Medical Director and Lynda Hamlyn, Chief Executive of NHSBT. All members of the NBTC are invited to attend.

Whereas the last Better Blood Transfusion seminar in 2007 focussed both on safety and appropriate use of blood, the focus for this event is on avoidance of unnecessary transfusion. The output will include practical recommendations for hospitals supported by a website toolkit. The morning presentations will be followed by workshops in the afternoon.

It is proposed to record the presentations for use in subsequent regional workshops and produce a report for publication in the Royal College of Pathology bulletin.

14.2/12 National Comparative Audit of Blood Transfusion

MM presented an update on current and planned audits:

- Audit of the Use of Cardiac Surgery - analysis and reporting to start in April 2012.
- Audit of Medical Use of Red Cells – part 1 will report in April 2012. Part 2 will report by September 2012.

The audits planned for 2012 are:

- Audit of Sample Collection and Labelling commencing in May 2012.
- Audit of the Use of Anti-D commencing in September 2012.

14.3/12 Learnbloodtransfusion (LBT)

RG provided an update report advising that the Good Manufacturing Practice course for hospital transfusion laboratories and a new Learn Cell Salvage course are both now live on LBT on all e-learning platforms. The test site for the 'consent for transfusion' course should be available by the end of March 2012. Future courses planned for development in 2012/13 are on obstetrics and adverse event management.

15/12 NHS Litigation Authority (NHSLA)

MM referred to the work of the NHSLA which produces risk management standards for NHS organisations designed to address organisational, clinical and non-clinical or health and safety risks. Compliance with the standards at the different levels results in a reduction in costs for hospital trusts.

The NHSLA are considering removal of the current standards for blood transfusion in 2013/14 as the number of claims relating to blood transfusion is quite small although there is a query as to whether the claims are being correctly coded.

PBM stated that SHOT receive more reports each year of incidents of wrongly labelled samples and in 2011 there were almost 1,000 reports of near misses.

The NBTC and SHOT will prepare a joint response to the NHSLA. MA stated the Royal College of Physicians would also respond.

Action: PBM, Chair, MM, MA.

16/12 NBTC Budget

RG presented a report on the financial position of the three budgets supporting the NBTC and RTCs as at 29 February 2012. It was noted that whilst all budgets are showing an overall underspend, the allocation for travel costs is overspent.

17/12 Blood Demand Drivers

TA reported that overall demand for red cells has remained fairly stable and the early projection for 2012/13 indicates no expected increase in demand. The major challenge is managing demand at a group mix level and issues of group O RhD negative red cells to hospitals have increased from 10.5% of total red cell demand to 11.1% during last year.

At the start of 2011/12 the platelet demand forecast was 261,000 units and during the first half of the year demand rose by 10.1%. The rate of increase however has fallen in the second half of the year and the expected year on year increase is likely to be close to 5.6%.

The NBTC is requested to support initiatives to reduce inappropriate use of platelets and group O RhD negative red cells.

Post meeting note: The final year end platelet increase was 8.3% versus 2010/11.

18/12 Key Performance Indicators

TA presented a report on NHSBT performance against key indicators for the 3rd quarter 2011/12. There has been a continued increase in the proportion of single donor platelets and the national average is now above the target of 80%.

In response to a query on the high percentage of Group AB issuable platelets expiring at Filton, TA advised that due to stock movement all the components of this group expire in the South West.

19/12 Tracking Clinical Use of Blood

TA provided an update on the trial which is utilising software developed for America's Blood Centers (ABC) as AIM II and has already been

introduced into several hospitals in the USA. AIM II will be used to collect patient level data on blood and blood component usage by extracting the required data elements in an encrypted format into a data warehouse for analysis and report production.

If AIM II is found to be practical for NHS hospitals, it will be possible to generate benchmarking data to support appropriate blood use initiatives. NHSBT will benefit because the collection of these data will support the better understanding of where and why blood and blood components are being used in hospitals informing strategic demand planning to ensure sufficiency of supply, information to evaluate safety decisions and support emergency planning.

Four hospitals are participating in the trial which will be completed by mid June 2012.

20/12 Olympic Preparedness

The Committee noted a letter sent by NHSBT to hospitals outlining preparations for the 2012 London Olympic and Paralympic Games. Management plans will be developed with each hospital based on local storage capacities. The planning arrangements will consider the key areas of staffing levels and staff's travel arrangements in the South East of England, increased stockholding of blood and blood components and movement of stocks, changing delivery patterns and reducing unnecessary transport.

Communications with hospitals will increase as the events approach.

21/12 Integrated Transfusion Service programme

AH presented on the programme of work being undertaken by NHSBT. There have been discussions with some hospitals to analyse the potential savings and improvements to the blood supply chain and modelling how pathology modernisation may affect the current configuration of transfusion laboratories. Forthcoming initiatives will include reconfiguration of transfusion services with integration of NHSBT Red Cell Immunohaematology services and hospital transfusion in some centres.

22/12 Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO)

The SaBTO position statement on the provision of cytomegalovirus (CMV) tested blood components together with a detailed report of the CMV Steering Group were provided to the meeting.

22.1/12 <u>Importation of Fresh Frozen Plasma</u>

On 9 March 2012 SaBTO reviewed current assessment of the risk of vCJD transmission from blood components and recommended that there should be no extension of the importation of FFP beyond those for whom it is currently used – i.e. those born since 1 January 1996 and high-usage adult patients.

22.2/12 Prion Filtration

On 9 March 2012 SaBTO reviewed its provisional view on the use of prion filtered red cells for those born after 1 January 1996, which was subject to satisfactory completion of a clinical trial to assess safety. The trial has been completed and on the data available show that the use of the PCapt filter does not reduce the overall safety of transfusions. However, before making a final decision the committee has requested final and fully validated results from an important study on the efficacy of the filter which will finish in late 2012. SaBTO expect to review the evidence again after that efficacy study is completed.

23/12 Serious Hazards of Transfusion

PBM presented an update report highlighting the following items:

- Preparation of the SHOT annual report is in progress with data collected in 2011 indicating that the number of events reported has continued to increase including near miss events which are now more than 1,000 accounting for approximately one-third of all reports.
- An additional chapter in this year's report will focus on events in patients with haemoglobin disorders due to the number and severity of events particularly in sickle cell disease.
- A draft transfusion checklist will be published in the SHOT report with the recommendation that hospitals adapt it for local use.
- The annual symposium will take place on Thursday, July 5th 2012 at the Lowry centre in Manchester.

24/12 Medicines and Healthcare products Regulatory Agency (MHRA)

JL reported the highlights of a Serious Adverse Blood Reactions and Events (SABRE) update to the MHRA Blood Consultative Committee in March 2012. A total number of 1556 incidents were reported during 2011 which is a slight decline on the previous two years.

During this period 236 SABRE reports were referred to MHRA inspectors with the referrals relating to:

- Incorrect blood component issued 137
- Pre-transfusion testing errors 44
- Late reports 18
- Repeat incidents 18
- Failed recalls 12
- Processing errors 7

The top five Serious Adverse Events (SAEs) identified human error as the root cause:

- Distraction/interruption/concentration lapses
- Incomplete/ineffective training
- Rushing/cutting corners/under staffing
- Over-riding IT alerts
- Inappropriate or out-of-date Standard Operating Procedures

25/12 NHSBT Prices for Blood Components 2012/13

JH reported that hospital transfusion laboratory managers have not yet received notification of the NHSBT prices for blood components and specialist services effective from April 2012. These are urgently required to assess the impact on budgets. TA confirmed that the price lists had been sent to the Directors of Finance in hospitals several weeks ago but it may be that these had not been circulated to the Transfusion Laboratory Managers.

Action: TA

26/12 Date of Next Meeting

The next meeting of the Committee will be held on Monday, 24 September at the Royal College of Pathologists in London commencing at 1.00pm.

27/12 For Information

A Systematic Review Initiative update detailing recently published and ongoing systematic reviews was noted.
www.transfusionevidencelibrary.org

National Blood Transfusion Committee

Summary of Agreed Actions: Meeting held on 26 March 2012

Minute Ref	Agreed Action	Responsibility	Completion/Review
06/12	**Safer Practice Notice 14**		
	Discuss the re-establishment of the Working Group.	**NBTC Executive**	May 2012
13.2/12	**Meeting of Royal Colleges/Specialist Societies**		
	Update template for annual reports.	**MM/TL**	September 2012
10/12	**Blood Components Working Group**		
	Discuss with NHSBT whether the shelf life of FFP following thawing can be increased to 48 or 72 hours.	**LG**	September 2012
15/12	**NHSLA**		
	Respond to the NHSLA on their proposal to remove the current standards for blood transfusion in 2013/14.	**NBTC/SHOT**	September 2012
25/12	**NHSBT Prices for Blood Components**		
	Advise price list details for 2012/13 to Transfusion Laboratory Managers	**TA**	Completed