National Blood Transfusion Committee

Minutes of the National Blood Transfusion Committee

14th March 2016

Hotel Russell, 1-8 Russell Square, London, WC1B 5BE

Present:

Dr J Wallis	JW	Chair
Dr K Pendry	KP	Secretary
Dr S Allard	SA	Royal College of Pathologists
Mrs T Allen	TA	NHSBT Assistant Director Customer Services
Dr C Baker	CB	Patient Involvement Working Group
Mr S Bassey	SB	Transfusion Laboratory Managers Working Group
Mrs C Bernstrom	CBe	EA to NBTC
Dr P Bolton-Maggs	PB-M	Serious Hazards of Transfusion
Dr C Carroll	CC	North West RTC
Dr J Cort	JC	for Dr Youssef Sorour, Yorkshire & The Humber and East Midlands RTC
Dr A Crossley	AC	Representing Rose Gallagher Royal College of Nursing
Dr A Dodds	AD	North East RTC
Mr G Donald	GD	Patient Representative
Mrs S Harle-Stephens	SHS	British Blood Transfusion Society, Plymouth
Dr J Graves	JG	Infectious Disease and Environmental Hazards Department of Health
Dr N Jones	NJ	East of England, RTC
Ms M Jokinen	MJ	Royal College of Midwives
Dr P Kelly	PK	London RTC
Dr C Newson	CN	West Midlands RTC
Dr A Morrison	AM	Scottish Clinical Transfusion Advisory Committee
Prof M Murphy	MM	Consultant Haematologist NHSBT
Mr C Robbie	CR	Principal Haemovigilance Specialist, MHRA
Dr N Sargant	NS	South Central RTC
Ms L Sherliker	LS	for Rebecca Gerrard, NHSBT National Lead: PBM Team
Dr K Shreeve	KS	for Ann Benton, Blood Implementation Group, Wales
Dr D K Whitaker	DKW	Royal College of Anaesthetists
Dr L Williamson	LW	Medical Director NHSBT
Dr H Wakeling	HW	South East Coast RTC
Dr S Wexler	SW	South West RTC

Apologies:

Dr A Benton	AB	Blood Implementation Group, Wales
Mr A Cope	AC	Royal College of Emergency Medicine
Dr C Costello	CC	NHSBT Non-Executive Director

Mr C Elliott	CE	Institute of Biomedical Science
Ms R Gallagher	RGa	Royal College of Nursing
Ms R Gerrard	RG	NHSBT National Lead: PBM Team
Ms G Gray	GG	Royal College of Obstetricians and Gynaecologists
Dr L Green	LG	Blood Components Working Group
Dr S Morley	SM	Royal College of Paediatrics and Child Health
Mr S Penny	SP	Assistant Director National Operations Blood Supply (NHSBT)
Dr Y Sorour	YS	Yorkshire and The Humber RTC
Mr J Thompson	JT	Royal College of Surgeons
Dr H Williams	HW	NHSBT Director of Diagnostic and Therapeutic Services

01/16	**Welcome and Apologies**
	Apologies were noted.
02/16	**Minutes of the meeting of the full Committee held on 28th September 2015.**
	Agreed as a correct record.
03/16	**Regional Transfusion Committee (RTC) Chairs**
	Feedback from each region was included with the papers for the committee.
	Dr Jon Cort highlighted key points from the morning RTC Chairs meeting:
	Evidence of education at regional level.
	Discussions took place on increased use of regional audits where we can share our own audit pathways and proformas. The intent being regions can work together on areas of mutual interest to gain better understanding and reduce replication of audit tools. This will result in faster audits, with greater patient numbers better displaying current practice and performance.
04/16	**NBTC Workplan**
	KP reviewed the 2015 /16 workplan and requested feedback from members of the working groups to demonstrate that the objectives contained within the document have been achieved. An annual report will be prepared and a workplan developed for 2016/2017; this will be discussed at the EWG in June 2016
	Action: Working group chairs to provide feedback on 2015/2016 workplan.
	Action: KP / JW to prepare Annual report 2015/16.
	Action: Draft NBTC workplan 2016/2017 to be prepared by KP/JW for discussion at EWG June 2016
05/16	**Updated ToRs for NBTC and RTCs**
	1.2 KP pointed out that Prof Jo Martin's post will be disbanded from April 2016 and further clarification re NHS England, NHS Commissioning and DH is

	required	
	5.5 DW suggested increasing Patient Representatives to two or three. GD agreed adding that he has been an Patient Representative for 8 years and he has other commitments sharing the representation would be preferable.	
	JW invited any Regional Transfusion Committee Chairs to contact Dr Kate Pendry with their recommendations of a Patient Representative.	
	Action: RTC Chairs	
	KP is also exploring the opportunity to find a patient representative from the sickle cell / thalassaemia societies.	
	KP to amend wording regarding numbers of Patient Representatives.	
	Action: KP.	
	10.2 There was agreement in the change of the wording to clarify the requirement for the RTC Chair to be medically qualified	
	Action: KP to finalise ToR and arrange to be posted on website	
06/16	**Minutes of the meeting of the Executive Working Group held on 18th January 2016**	
	Comments were invited from the meeting. KP added that any significant points raised were Agenda points for discussion today.	
07/16	**NBTC Working Groups**	
	<u>Blood Components Working Group</u>	
	Extending the shelf life of thawed FFP.	
	The recently published BCSH guideline *"A practical guideline for the haematological management of major haemorrhage"* recommends that hospital transfusion laboratories seeing many massive haemorrhage cases associated with trauma should consider having pre-thawed plasma on standby to allow FFP to be immediately available for the management of major bleeding.	
	SACBC and Tissue Transplantation Services' Professional Advisory Committee (JPAC) have reviewed the available data on FFP with the view to extending the shelf life of pre-thawed FFP to > 24 hours and have agreed that: 1. the shelf life of pre-thawed Methylene Blue treated FFP should remain the same (i.e. 24 hours) and not be extended 2. the shelf life of pre-thawed FFP can be extended from 24 hours to 120 hours, to enable rapid clinical provision of FFP for the management of major haemorrhage without excessive wastage	
	The change will be enacted by NHSBT once an addendum to the BCSH	

	FFP Guidelines has been published (in press)	
	Patient Involvement Working Group	
	o Further develop information on blood transfusion for patients and the public. o Ensure patient information leaflets (PILs) relevant and up-to-date – concerns were raised about these not being accessible enough. KP noted that the one listed is dated 2013 and that there is a more up-to-date version that should be uploaded. o Promote Transfusion awareness in collaboration with specialist societies and groups. o Provide support to other organisations. o Promote Implementation of SaBTO guidance on consent.	
	Workplan - CB noted we are indebted to GD but we need more patient availability in the form of Patient Representative.	
	Patient Blood Management Working Group	
	Draft of PBM survey is out for comments/feedback and will be published shortly.	
	Education Working Group	
	Medical Undergraduate Training: Plenty of uptake with undergraduates attending training on a Saturday. SA wants to review the quality matrix and link with universities and educational institutes to look at training.	
	Learnbloodtransfusion report	
	LS outlined editorial changes to courses available on blood transfusion. Learnpro has 112,204 users. It was noted that more work is to be done to increase uptake.	
	Transfusion Laboratory Managers Working Group	
	Meet via telecon every other month. Still concerns with staffing and skill mix.	
	Transfusion Request Specification Working Group	
	The group is made up of representatives of the NBTC PBM working group, Consultant Haematologists, TLMs, the Blood Stocks Management Scheme and Health and Social Care Information Centre (HSCIC).	
	The main areas of work:	
	a. Agreement on specification for transfusion request: this will link into the work being undertaken by the UK Terminology Centre and the RCPath Pathology Informatics Group b. Update of National Indication codes, to be in line with new NICE and BCSH guidelines c. Development of a list of truncated codes to be part of the transfusion request to support best practice decisions at the time of blood ordering d. Development of the minimum dataset for Patient Blood	

	Management e. Development of the Key Performance Indicators for Patient Blood Management	
	The group will become the project steering group for the Clinical benchmarking feasibility study to be developed with NHSBT and HSCIC.	
	The committee agreed in principle with the updated National Indication Codes which reflect the recent NICE Clinical Transfusion Guidelines and forthcoming BCSH platelet guidelines.	
	The committee requested that the short codes to be used as part of order comms should match the national indication codes. KP will reword the short codes and send out both documents to RTC chairs for one final review with deadline for feedback of 27th April 2016.	
	Action: KP	
	Action: RTC Chairs	
08/16	**Recommendations for Training and Assessment in Blood Transfusion (replacement for NPSA SPN 14) and Ratification of National Standards for the Clinical Transfusion Project)**	
	This document was ratified subject to two small amendments.	
	1.5 in appendix: add “take the sample”.	
	Change timing of first transfusion observations to approximately 15 minutes.	
	Action: KP will make these amendments	
	Action: JW will ensure the final versions are hosted on NHS Improvement website with link to NBTC webpage	
	Action: KP / JW to agree course of action re Skills for Health Transfusion competencies which now no longer match the NBTC version	
09/16	**National Comparative Audit of Blood Transfusion Programme**	
	<u>Current audits</u>	
	o Audit of the use of red cells in CABG o 2013 audit of the use of blood components in neurocritical care o 2013 audit of the use of Anti-D o 2014 audit of patient information and consent o 2014 audit of transfusion in children and adults with Sickle Cell Disease o 2015 Audit of Patient Blood Management in adults undergoing scheduled surgery o 2015 audit of the use of blood in patients with lower GI bleeding o 2016 Audit of red cell and platelet transfusion in adult haematology patients	
	<u>Future audit topics</u>	
	We are in the initial stages of planning 3 audits, to be offered during later 2016 and through 2017:	

	• Audit of red cell transfusions in palliative care • Audit of Transfusion Associated Circulatory Overload • Audit of blood sampling and labelling, collection of blood from blood bank and administration to the patient (known as the Vein to Vein [V2V] audit.	
	AFFINITIE	
	The AFFINITIE team is preparing to distribute a questionnaire to hospitals to evaluate the use of the audit reports and accompanying materials for the 2015 audit of PBM in scheduled surgery. Also they are beginning to work with the Healthcare Quality Improvement Partnership on how the AFFINITIE approach might be used in a national, state-funded programme of audits. Work is also beginning on fidelity and cost-evaluation studies	
10/16	**Royal Colleges/Specialist Societies**	
	DW gave overview of key points from the morning meeting reiterating that Dr Susan Tuck has stepped down and that the PBM Newsletter was positively received.	
	CR added that staffing issues are an area taken seriously by the MHRA. They encourage everyone to report when staffing or education are contributory factors in errors reported to MHRA.	
11/16 & 12/16	**Delivering Quality Transfusion Services**	
	The Choosing Wisely Campaign is a US initiative with clear statements about practice; a UK version is in development, being overseen by the Academy of Medical Royal Colleges	
	MM highlighted the Nice Transfusion Quality Standards and encouraged stakeholder participation in their development.	
	MM led a discussion on the benefits of a hospital undertaking PBM accreditation; there was no firm consensus. There was also preliminary discussion about the impact of pathology networking on Transfusion laboratories and the opportunities for quality improvement in Transfusion medicine service delivery will be discussed further in the NBTC PBM working group in June 2016 and the NBTC in Sept 2016.	
	Action: KP to add to NBTC Working group and NBTC agendas	
	MM explained the James Lind Alliance and that it's aim is to get input into tops for research prioritised for those not involved in trials. Including patients. MM asked for the Royal Colleges & Specialist Societies and RTC Chairs to request a response from its members to the survey via links below.	
	How do I take part? The survey is available at http://tinyurl.com/h6jf52l or contact the James Lind Alliance Project Manager at the Oxford Biomedical Research Centre to request a paper version (voicemail 01865 223298, e-mail sandra.regan@ouh.nhs.uk).	

	http://www.jla.nihr.ac.uk/priority-setting-partnerships/blood-transfusion	
13/16	**NBTC Budgets**	
	Budget update report was received	
14/16	**NHSBT**	
	TA highlighted the Core Systems Modernisation programme in NHSBT which will be a major piece of work to enable update of all NHSBT IT systems by mid 2018. This is a significant transformation project which could impact the output of NHSBT on other projects.	
	Key Performance Indicators for NHSBT:- TA to pick up with Stephen Bassey For detailed discussion in TLM group	
	TA gave a brief overview of:	
	Update on Blood Stock Projects and Integrated Transfusion Services.	
	Update on Supply Modernisation Project for North of England.	
	Update on Leeds / Sheffield project.	
	Emergency planning documents for red cells and platelets: these are now finalised and will be made available on the Hospitals and Science WebPages.	
	Action: TA to liaise with SB re NHSBT KPIs.	
	Action: KP to liaise with TA to ensure documents are uploaded online.	
15/16	**Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO)**	
	<u>Introduction of Hepatitis E Screening</u>	
	SaBTO ruling	
	The DH Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO) advised in July 2015 that solid organ transplant recipients and stem cell transplant recipients should receive Hepatitis E PCR negative blood components and this advice has been accepted and endorsed by the Department of Health based on the costings presented. The NHSBT has additionally elected to provide the same to neonates though these were not included in the original recommendation. Subsequently, SaBTO recommended extension of use of Hep E PCR negative components for those awaiting transplant.	
	SaBTO recommends selective testing to provide HEV tested blood components for patients having solid organ and allogeneic (donor) stem cell transplants. From March 2016, screening will be carried out on pools of 24 donations and donors who test positive will have a 6 month deferral with testing for viral clearance before return to donation. This is not expected to have a significant effect on supply of blood components.	
	JW highlighted the considerable cost burden to hospitals with a large transplant load that is currently unfunded. Discussion took place around the decision-making process and current recommendations for selected screening rather than universal screening. Jonathan Graves, representing SABTO noted that stakeholder engagement in the decision on Hepatitis E	

	had been imperfect and that ongoing review of the policy was planned. Also that a final clarification of the current policy would be issued from SaBTO shortly. LW highlighted high costs for NHSBT to test all units but JW commented that if Trusts ran dual inventories this cost could also be considerable for hospitals. JW asked RTCs to feedback with any issues encountered particularly ancillary costs.	
	Reporting via SHOT/MHRA of failure to provide hep E screened components to patients should be according to locally agreed protocols for use. A suggestion that reporting should be delayed for a period whilst the implementation was underway was discussed. CR on behalf of MHRA said this would be discussed at the BSQR meeting coming shortly *Post meeting note 8th April 2016: a delay has not been agreed; see latest MHRA guidance here: https://www.gov.uk/guidance/blood-authorisations-and-safety-reporting#reducing-the-risk-of-transfusion-transmitted-hepatitis-e-virus-infections-in-patients-undergoing-solid-organ-transplantation-and-haematopoietic-stem-cell-transplantation*	
16/16	**Serious Hazards of Transfusion (SHOT)**	
	SHOT symposium scheduled for July 7 2016. The focus is on Human Factors.	
	Progress with a combined haemovigilance reporting system: Phase 1 went live in October 2015. Phase 2 is designed to incorporate the SHOT categories and questionnaires into a single system with the MHRA.	
	Strategic review (Working Expert Group and Steering Group invited participants). The strategic planning session took place in October 2015. Three questions were widely circulated in advance across the UK to seek views on the past, present and future for SHOT. These were: 1. What are the key attributes and activities that have made SHOT successful in the past? 2. What do you consider the current challenges are for SHOT based on both how the organisation currently functions and the external environment it operates in? 3. What do you consider to be the key things SHOT needs to do to continue to be successful in the future? These generated many helpful responses, It is clear that there is a great deal of support for what SHOT has done and continues to do, particularly for hospital practice. It is clear that SHOT's **professional independence** is essential, and SHOT has agreed to work with the Academy of Medical Royal Colleges to see if this organisation would oversee SHOT as it does for other confidential enquiries. **'Stop, Start, Continue':** SHOT reviewed with the WEG and SG which if any reporting categories could cease. Reports of alloimmunisation are no longer collected from January 1 2016, but no other categories will be stopped. There are no suggestions for additional categories, but as 78% of our reports relate to error, SHOT are introducing an extra page to the current questionnaires to ask some questions to help understand these 'human factors'.	

	Cost-effective analysis and cost-benefit considerations: it is not generally possible for SHOT to perform such analyses with current resources. SHOT's role is to identify where practice can be made safer and it is for the Blood Services and Hospitals to consider how and whether to put the recommendations into practice.	
	Review of all previous recommendations: The 31 recommendations made to Blood Services for the duration of SHOT were reviewed by Sheila MacLennan and she noted that most have been completed (e.g. those related to bacterial transmission and TRALI). Other more general ones (e.g. about following guidelines for donor selection) are not measurable. These have been considered from the NHSBT perspective rather than UK-wide.	
	UKTLC Laboratory survey report.	
	Summary:	
	1) Laboratory reorganisations have been/are substantial, 100/178 (56%) laboratories affected. 2) Information about staff leaving demonstrates that the largest number have been made redundant together with a number of early retirements. These may be related to mergers. 3) There are staff shortages with dependence on locum and agency staff. Vacancies have been present in some laboratories for significant periods of time. The highest number of vacancies are for Band 6 biomedical scientist (BMS) posts with many vacant for 2 or more years. 4) It has become more difficult to train and mentor staff, and resources for training are reducing. 5) Future staffing: 56 laboratories have one or more members of staff over the age of 60 years and about 140 have staff aged 50-69 years. As these members of staff retire much specialist knowledge will be lost. 6) Comments about changes in training with the advent of Modernising Scientific Careers (MSC) suggest that knowledge and competency at the time of qualification have changed so that newly appointed staff need extra training and supervision which may be difficult to provide.	
	PB-M suggested that the report needed to be brought to the attention of the Department of Health and will discuss the appropriate distribution with JW.	
	Action PB-M/JW/KP	
17/16	**Medicines and Healthcare Products Regulatory Agency (MHRA)**	
	SABRE update report was presented by CR.	
18/16	**Chairman's Items**	
	JW took the opportunity to announce that Dr Lorna Williamson will be	

	retiring as Medical Director of NHS Blood and Transplant. He thanked her for her work and attendance at the NBTC and praised the high quality of the NHSBT under her stewardship. The group conveyed their gratitude and best wishes. Dr Williamson will be succeeded by Dr Gail Miflin.	
19/16	**Any Other Business**	
20/16	**Date of Next meetings**	
	NBTC/RTC Chairs – Autumn meeting Monday, 19th September 2016 at Royal College of Obstetricians and Gynaecologists, (Rooms on Regents Park) 27 Sussex Place, Regents Park, London, NW1 4RG	

Summary of Agreed Actions: Meeting held on 14 March 2016

Minute Ref	Agreed Action	Responsibility	Completion /Review
04/16	**NBTC Workplan**		
	Working Groups to feedback on objectives contained within the document and whether they have been achieved.	**WG Chairs**	
	An annual report will be prepared and a workplan developed for 2016/2017.	**KP/JW**	
	Add to agenda for NBTC - EWG in June 2016.	**CBe**	
	Draft NBTC workplan 2016/2017 to be prepared by KP/JW for discussion at EWG June 2016	**KP/JW**	
05/16	**Updated ToRs for NBTC and RTCs**		
	Regional Transfusion Committee Chairs to contact KP with their recommendations of a Patient Representative.	**RTC Chairs**	
	Wording to be amended regarding numbers of Patient Representatives.	**KP**	
	ToRs to be finalised and posted on the website.	**KP/CBe**	
07/16	**NBTC Working Groups**		
	Transfusion Request Specification Working Group		
	KP will reword the short codes and send out both documents to RTC chairs for one final review with deadline for feedback of 27th April 2016.	**KP/RTC Chairs**	
08/16	**Recommendations for Training and Assessment in Blood Transfusion (replacement for NPSA SPN 14) and Ratification of National Standards for the Clinical Transfusion Project)**		
	Amendments to be made.	**KP**	
	Ensure the final versions are hosted on NHS Improvement website with link to NBTC webpage.	**JW**	
	Agree course of action re Skills for Health Transfusion competencies which now no longer match the NBTC version.	**KP/JW**	
14/16	**NHSBT**		
	Key Performance Indicators for NHSBT:- TA to	**TA**	

	pick up with Stephen Bassey For detailed discussion in TLM group		
	Ensure documents are uploaded online.	**KP**	
16/16	**Serious Hazards of Transfusion (SHOT)**		
	UKTLC Laboratory survey report.		
	The report is to be brought to the attention of the Department of Health and distributed accordingly.	**PB-M/JW/KP**	