

**Unconfirmed minutes of a meeting of the National Blood Transfusion Committee
Held on 17 March 2014 at the Royal College of Pathologists, London.**

Present:	Prof A Newland	AN	Chair
	Prof M Murphy	MM	Secretary
	Dr S Allard	SA	Royal College of Pathologists
	Mrs T Allen	TA	NHSBT Assistant Director Customer Services
	Dr S Allford	SAI	South West RTC
	Dr C Baker	CB	Patient Involvement Working Group
	Dr J Bamber	JB	East of England RTC
	Mr S Bassey	SB	Transfusion Laboratory Managers Working Group
	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 C Costello	CC	NHSBT Non-Executive Director
	Dr P Dadarkar	PD	South Central RTC
	Dr M Desmond	MD	North West RTC
	Mr G Donald	GD	Patient Representative
	Ms R Gallagher	RGa	Royal College of Nursing
	Ms A Harris	AH	NHSBT Regional Lead: PBM Team Midlands and South West
	Dr A Iqbal	AI	North East RTC
	Dr P Larcombe	PL	South East Coast RTC
	Ms L Mannion	LM	British Blood Transfusion Society
	Dr A McKernan	AMc	East Midlands RTC
	Prof J Martin	JM	National Clinical Director of Pathology, NHS England
	Dr S Morley	SM	Royal College of Paediatrics and Child Health
	Dr C Newson	CN	West Midlands RTC
	Mr D Palmer	DP	British Blood Transfusion Society
	Mr C Robbie	CR	Medicines and Healthcare products Regulatory Agency
	Dr C Ronaldson	CR	NHSBT Director of Blood Supply
	Dr Y Sorour	YS	Yorkshire and The Humber RTC
	Mr J Thompson	JT	Royal College of Surgeons
	Miss S Tuck	ST	Royal College of Obstetricians and Gynaecologists
	Mr D Watson	DW	Scottish Clinical Transfusion Advisory Committee
	Dr H Williams	HW	NHSBT Director of Diagnostic and Therapeutic Services
	Dr L Williamson	LW	NHSBT Medical Director
	Dr D K Whitaker	DKW	Royal College of Anaesthetists

Apologies:

	Dr M Allison	MA	Royal College of Physicians
	Prof M Bellamy	MB	Intensive Care Society
	Mr C Elliott	CE	Institute of Biomedical Science
	Ms R Gerrard	RG	NHSBT National Lead: PBM Team
	Dr L Green	LG	Blood Components Working Group

Ms M Jonkinen	MJ	Royal College of Midwives
Dr C Taylor	CT	NPSA SPN 14 Working Group
Dr D Thomas	DT	Blood Implementation Group, Wales
Dr J Wallis	JW	British Society for Haematology

01/14 Welcome and Introductions

The Chair welcomed Chris Newson as Chair of the West Midlands RTC, Stephen Basseby as Chair of the Transfusion Laboratory Managers Working Group, Charles Baker as Chair of the Patient Involvement Working Group and Douglas Watson, Secretary of the Scottish Clinical Transfusion Advisory Committee.

02/14 Minutes of the meeting of the full Committee held on 21 October 2013

The minutes of the meeting of 21 October 2013 were agreed as a correct record.

03/14 Matters Arising

03.1/14 Minute 40.4/13

LM asked whether SHOT had begun to link the proportion of Learnbloodtransfusion passes in each hospital with the number of SHOT reports. PB-M responded that this has not yet been done but remains under consideration.

03.2/14 Minute 44/13

GD asked about the 22 reporters, mainly private hospitals, who have never submitted a report.

CR explained that even though these hospitals had not submitted a report in the last year they are regularly monitored. They are all very small hospitals and so the number of adverse events is expected to be very low.

04/14 Regional Transfusion Committee (RTC) Chairs

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

- There is considerable audit activity at RTC as well as at national level.
- There continues to be concern about the effects of pathology modernisation on transfusion laboratories, particularly in relation to loss of skilled staff. Mergers of trusts across RTC boundaries were also causing some difficulty and in one case had resulted in the need to appoint a new RTC Chair.
- All RTCs are finding it difficult to attract patient representation.
- It remains challenging to engage hospitals in Patient Blood Management (PBM). The RTC Chairs consider that central drive and direction from NHS England is needed.
- There is concern about the delays in the updating of the NBTC and RTCs website on transfusionguidelines.org. It has not been possible to post minutes of meetings and other documents and

information since October 2013. It is hoped that the website will be fully operational by the end of March.

- The RTC Chairs had reviewed and provided comments on the latest draft of the Guidance for the Emergency Transfer of Blood and Components with Patients between Hospitals. During discussion the importance of conducting major haemorrhage drills was recognised as recommended in the NPSA Rapid Response Report (RRR) on Major Haemorrhage.
- It was noted that there continues to be limited NHSBT Customer Services support in the East of England.

05/14 Executive Working Group held on 27 January 2014

The minutes of the meeting were noted.

06/14 Blood Components Working Group

The current Chair is on maternity leave and a replacement is being sought.

07/14 Patient Involvement Working Group

Some Patient Information Leaflets have been updated and some new ones have been added.

The Working Group have requested to have dedicated patient information pages on the new transfusionguidelines website.

It has been decided to discontinue translation of leaflets into other languages due to a lack of demand and costs.

The Working Group is supporting the National Comparative Audit on patient information and consent which is currently taking place. The Working Group has also offered to provide patient input to relevant BCSH guidelines.

08/14 Patient Blood Management (PBM) Working Group

HW indicated that NHSBT had identified funding for 3 projects proposed by the PBM Working Group. The 3 projects are:

- 1) The expansion of the National Comparative Audit team to support national PBM audits (£34,000 per annum).
- 2) The implementation of preoperative anaemia management in the hospitals in the North West RTC (£26,000).
- 3) Clinical benchmarking to gain a better understanding of blood demand (£45,000).

A further project will explore developing a Smartphone Application to assist doctors with implementation of PBM. It is suggested that an application is made to NHSBT Trust Funds to support this work.

The NBTC Chair and Secretary had a positive meeting in October 2013 with Professor Sir Bruce Keogh, (National Medical Director) and Professor Keith Willett (NHS England Director for Acute Episodes of Care). Professor Jo Martin (NHS England Director of Pathology) is representing NHS England on the NBTC and will arrange to meet the Chair and Secretary to

progress some of the actions agreed at the October 2013 meeting.

Action: Chair / Secretary / JM

09/14 Education Working Group

It was noted that the Academy of Medical Royal Colleges has submitted an application to the General Medical Council for revisions to the Foundation Programme curriculum to include patient identification to address patient safety concerns raised by SHOT. A project is being developed for a competency assessment tool for Foundation Doctors in relation to transfusion practice. A pilot will be undertaken at the Royal Free Hospital.

A detailed review of the curriculum content for all acute postgraduate disciplines has been completed. Representatives of Royal Colleges on the NBTC have been tasked with pursuing the recommendations for enhancing the content and including more assessments in relation to blood transfusion. The Transfusion Training Portfolio for haematology trainees has been updated.

DP asked if there are any plans to develop a standard request form for blood transfusion, as the West Midlands RTC have discussed the potential of developing a regional form. The Secretary responded to indicate that the BCSH guidelines on IT, and standard terms for clinical diagnosis and justification for transfusion for blood ordering developed by the PBM Working Group, should help to address this.

It was agreed that the RCP and RCS should be asked to provide representatives for the Working Group to develop a Smartphone Application for PBM. **Action: JT and MA**

10/14 NPSA Working Group

An initial draft of the Review Groups recommendations relating to competency assessment has been circulated to Transfusion Practitioners for their comments.

It is intended that these are high level recommendations and there will be flexibility at trust level in how they are implemented.

It is recognised that there is further work to be undertaken including the development of core standards for transfusion training and assessment. There was discussion about which body is now responsible for overseeing the implementation of these recommendations. The Chair and Secretary discussed this with the NHS England Medical Director in October 2013 and it was agreed that JM will now consider which body should be responsible.

Action: JM

11/14 Transfusion Laboratory Managers Working Group

SB gave a progress report on behalf of the Working Group. The document Guidance for the Emergency Transfer of Blood and Components with Patients Between Hospitals was presented. It was agreed that SB would be willing to receive further comments from the members of the NBTC and would then finalise the Guidance for distribution to hospitals. **Action: SB**

Other matters on the workplan are the review and updating of the NBTC Red Cell and Platelet Shortage Plans and the recommendations on

Appropriate Use of O Negative Red Cells. The usage of the Electronic Delivery Note by hospitals will also be reviewed.

12/14 NBTC work plan 2013/14

The workplan has been updated and was presented for information.

13/14 Royal Colleges/Specialist Societies

ST reported on a number of concerns arising from the morning meeting:

- There continues to be concern about potential delays in the provision of blood in relation to the requirement in BCSH guidelines for a second sample for confirmation of the ABO group of a first time patient prior to transfusion unless secure electronic patient identification systems are in place. The recommendation does make it clear that this requirement should not impede the provision of blood in urgent situations.
- There was also concern about the provision of patient information and obtaining consent for transfusion, which is the subject of a current national comparative audit.
- In relation to training, there was specific concern about the training of nurses and midwives, and also ODPs and Interventional Radiologists.
- There were discussions about the recent recommendations from Behring warning about the lack of efficacy of anti-D in obese women with a BMI of over 30 requiring the use of intravenous anti-D for such patients. BCSH have recently updated its recommendations on the administration of anti-D, and has approached Behring for data supporting their recommendation. However, it has not been immediately forthcoming and SA has made a further request for this information.
- JT raised the concern about the lack of training for medical staff in the management of major haemorrhage.

14/14 Patient Blood Management (PBM)

14.1/14 Learnbloodtransfusion

- There are currently over 85,000 active users registered on LearnPro.
- Data were presented on the variation amongst Trusts in the number of users of Learnbloodtransfusion. Deanonymous data have not been provided as Trusts have not agreed to data being published. It was suggested that future reports could link data to the size of each hospital (using Blood Stocks Management Scheme categories). **Action: RG**
- A number of new courses are pending launch including the Management of Acute Transfusion Reactions, Good Manufacturing Practice and the use of anti-D.

14.2/14 Report from the National Comparative Audit Programme

MM indicated that completed audits included the use of red cells in cardiac surgery, the use of blood components in neurocritical care and the use of anti-D. Audits in progress include patient information and consent, and a national survey of the use of red cells. Future audits include the management of patients with haemoglobinopathies and lower gastrointestinal haemorrhage. The research programme AFFINITE is underway; its purpose is to assess the potential for national audits to influence change in transfusion practice.

MM stated that the use of data held in the national cardiac database hugely facilitated the conduct of the cardiac surgery audit. JM agreed to consider how to encourage other relevant registries to participate in national audits of blood transfusion. **Action: JM**

15/14 NBTC Budgets

AH described an underspend in the NBTC and RTC budgets. Any underspend at the end of the financial year will be used to support PBM activities.

16/14 NHSBT

TA stated that red cell demand has fallen by 4.2% in 2013/2014 and is projected to reduce by another 2-3% in 2014/2015. Issues of O RhD negative blood have increased by 0.6% to 11.1%, as have other universal components (A platelets and AB FFP). Demand for platelets has been stable after 2 years of increased demand.

There was discussion about the causes of the reduction in demand for red cells. The most likely cause is an increase in PBM activities in hospitals.

Routine deliveries have increased by 8% compared to 2012. There has been a 33% fall in the use of ad hoc deliveries from NHSBT to hospitals, and an 80% rise in collections. This is resulting in under recovery of NHSBT costs for delivering blood to hospitals.

There was a reduction in red cell investigation turnaround time at Tooting in June 2013 due to high levels of sickness amongst staff.

LW described a forthcoming reduction in the proportion of platelets prepared by apheresis as a result of recommendations by SaBTO. The first reduction will be from 80% to 60% and then possibly to 40% of platelets provided by apheresis.

17/14 National Commissioning Group for Blood (NCG)

The Committee noted a letter from the Department of Health dated 14th January 2014 setting out prices for blood components and specialist services for 2014/15.

18/14 Serious Hazards of Transfusion (SHOT)

SHOT update report.

The SHOT report will be presented during the SHOT symposium on July 9th in Manchester. One of the key note speakers is Professor Sir Bruce Keogh who will be talking on 'Human Factors – How can we change

practice?'. There will be two poster prizes this year.

Work is continuing to develop a combined Haemovigilance reporting system with MHRA.

There was discussion about the definition of the "Never Event" involving ABO incompatible blood transfusion. To meet the current definition of a "Never Event" there must be patient harm. PB-M agreed to write to NHS England requesting that this latter requirement is removed so that all ABO incompatible blood transfusions are recorded as "Never Events". **Action: PB-M**

19/14 Medicines and Healthcare products Regulatory Agency (MHRA)

CR presented an update on reporting to SABRE up to February 2014. The number of reports continues on a downward trend and there has been a significant fall in serious adverse events.

20/14 Chairman's Items

The Chair reminded the Committee that he will be retiring from the role when a replacement is found by NHS England.

21/14 Date of Next meeting

Monday, 29 September 2014 at the Royal College of Obstetricians and Gynaecologists in London.

22/14 For Information

Report from the Systematic Reviews Initiative.

Pathology Quality Assurance Review
<http://www.nhsconfed.org/priorities/Quality/Pages/PathologyQualityAssuranceReview.aspx>