National Blood Transfusion Committee

Meeting of the NBTC representatives of the Royal Colleges and Specialist Societies, held on Monday 22nd April 2013 at the Royal College of Obstetricians and Gynaecologists, 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
	Dr Paula Bolton-Maggs	PBM	Serious Hazards of Transfusion
	Mr Andrew Cope	AC	Royal College of Emergency Medicine
	Mr Graham Donald	GD	NBTC Lay member
	Ms Mervi Jokinen	MJ	Royal College of Midwives
	Ms Judy Langham	JL	Medicines and Healthcare products Regulatory Agency
	Ms Lynne Mannion	LM	British Blood Transfusion Society
	Dr Sarah Morley	SM	Royal College of Paediatrics and Child Health
	Mr David Whitaker	DW	Royal College of Anaesthetists

Apologies:

Prof Mark Bellamy	MB	Intensive Care Society
Ms Rose Gallagher	RG	Royal College of Nursing
Dr Jonathan Wallis	JW	British Society for Haematology

01/13 Minutes from the last meeting held on 24 September 2012

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

02/13 Matters Arising from the Minutes

02.1/13 Correct patient identification

The resources developed as part of the "Do you know who I am?" campaign aimed at patients and staff are available at the website www.transfusionguidelines.org/Index.aspx?Publication=NTC&Section=27. This is a UK campaign in response to recommendations made in the 2009 SHOT Report, and also the designation of patient mis-identification as a "never event" by the Department of Health.
DW pointed out that there is still no consistent way of identifying patients in the NHS, e.g. whether the given name or surname is put first.

02.2/13 Patient consent to blood transfusion

The implementation of the SABTO recommendations concerning specific patient consent to blood transfusion is a matter of ongoing discussion. SA explained that it is regarded as the responsibility of individual NHS Trusts to organise

appropriate local arrangements to comply with this. There is to be an audit of the conduct of this under the aegis of the National Comparative Audit, run collaboratively by the Royal College of Physicians and NHSBT. The proposed audit tool is currently being piloted. The intention is to audit organisational arrangements, and clinical cases, together with the administration of a patient questionnaire, with an attempt to link the responses to the relevant prescriber. MA informed the group that in Wales a new consent form for procedures is to be introduced which includes a lot of information about blood transfusion.
AC emphasised that the SABTO guidance should apply to transfusions in the context of elective procedures only. However the group agreed the importance of patients being given information about blood and blood products they had received in an emergency, albeit retrospectively.

03/13 NBTC Education Working Group

SA reported on Phase 1 of the group's project to gather information on the arrangements for the teaching and assessment of knowledge concerning blood transfusion for medical students, doctors, nurses and midwives. The findings are summarised in Paper B1. The main findings are that arrangements in Medical Schools are broadly satisfactory, but those in Foundation Training Schools for newly qualified doctors are not good. There is a large variation in how and whether knowledge is formally assessed. The key recommendations of the group are that Medical Schools and Foundation Schools should always include safe prescribing of blood and blood products in their curricula, together with knowledge of transfusion reactions, the skill of positive patient identification, imparting information to patients for informed consent to transfusion, and special considerations for specific patients such as children and those receiving multiple transfusions. The e-learning system provided by "learnbloodtransfusion" should be included in all undergraduate curricula and formal assessments should be a mandatory requirement.

The group had attempted to liaise with the national nursing and midwifery bodies and found that in England there is no core system for deciding their training curricula, which is a matter devolved to the individual training schools.

MJ explained that when a previous government decided to move nursing and midwifery training to Higher Education institutions, the authority for curriculum development was also devolved. The Nursing and Midwifery Council does not monitor any specific content of courses, although it does issue guidance. GD asked for clarification as to whether the NMC lacked the power to exercise oversight or whether it chose not to. MJ indicated that since the NMC took over the task of validation from the RCN and RCM, local inspections of training schools no longer happened.

PBM pointed out that SHOT investigations found that 70% of the staff who made clinical errors with transfusion had their competency certificates, highlighting that errors occurred as much from problems such as distractions or haste, as from the lack of formal training. She reported that a collaborating document on transfusion safety is now being launched with the RCN.

SA summarised the findings of the group concerning the specific requirements for postgraduate training relevant to blood transfusion for the different medical specialties, which are tabulated in Paper B2. The table includes suggestions for enhancements and additions for each specialty, and SA asked each Royal College representative to look at these recommendations and to give feedback to her. Each Royal College representative should advise on the best way to make progress with these matters and to inform SA of the relevant key contact

people on curriculum matters for their College.

GD advised that it would be important to avoid overloading curricula, and also suggested that there should be some standardisation of the relevant content. MJ commented that the use of electronic learning packages is the most helpful method for such aims, and easy for trainers to use.

04/13 Paediatric transfusion guidelines

SM reported that the Royal College of Paediatrics and Child Health is up-dating, with the BCSH, the guideline concerning massive blood transfusion in children, with particular emphasis on issues concerning trauma situations.

05/13 BCSH guideline requiring two blood samples before transfusion

SM highlighted that the recommendation from the BCSH for two separate blood samples to be tested from a patient before issuing blood for transfusion is a practical concern in paediatric and newborn patients. Since historical samples are unlikely to be held in the laboratory for children, the requirement can cause significant delays, as well as subjecting the child to unwelcome additional venepuncture procedures. The group agreed that there is variability in the implementation of this recommendation in different NHS Trusts. The view was that it should be regarded as guidance, and open to local interpretation, as appropriate. However some further guidance on the room for interpretation would be helpful. DW asked if a cost-benefit analysis of the policy had been assessed, and wondered if the same benefit in safety could be achieved by spending the money for the additional costs incurred on other activities, such as more widespread use of pre-operative anaemia clinics, to reduce the need for transfusions. In relation to children, most hospitals do not have pre-operative clinics for paediatric surgical patients. As a general principle, doctors are discouraged from taking blood samples from children, because of the distress caused by the procedure.

06/13 Date of next meeting

Monday, 21st October 2013 at 11.30am at the Royal College of Pathologists, London.