Joint UKBTS Professional Advisory Committee Extraordinary Meeting

Extraordinary telecon to discuss the SaBTO recommendations regarding import of FFP for people born after 1 January 1996 held on Tuesday 8 October 2019 – 09:00 to 10:00

Present

Dr Neil Almond	**(NA)**	-	National Institute for Biological Standards and Control
Dr Janet Birchall	**(JB)**	-	Medical Director, Welsh Blood Service
Dr Akila Chandrasekar	**(AC)**	-	Standing Advisory Committee on Tissues and Cellular Therapy Products
Dr Stephen Field	**(SF)**	-	Medical Director, Irish Blood Transfusion Service
Dr Lisa Jarvis	**(LJ)**	-	Standing Advisory Committee on Transfusion Transmitted Infections
Mrs Angela Macauley	**(AM)**	-	Quality Manager, Northern Ireland Blood Transfusion Service representing the Quality Managers of the 4 UK Blood Services
Dr Sheila MacLennan	**(SM)**	-	Professional Director of JPAC **(Chair)**
Dr Gary Mallinson	**(GMal)**	-	Scientific Lead Safety Policy (JPAC/SaBTO)
Dr Edwin Massey	**(EM)**	-	Standing Advisory Committee on Immuno-haematology and Deputising for Dr Gail Miflin, Medical Director, NHS Blood and Transplant
Dr Gail Miflin	**(GM)**	-	Medical Director, NHS Blood and Transplant
Dr Helen New	**(HN)**	-	Standing Advisory Committee on Blood Components
Mr David Olszowka	**(DA)**	-	Medicines and Healthcare products Regulatory Agency
Dr Megan Rowley	**(MR)**	-	Standing Advisory Committee on Clinical Transfusion Medicine and Deputising for Prof Marc Turner, Medical Director, Scottish National Blood Transfusion Service
Miss Caroline Smith	**(CJS)**	-	JPAC Manager **(Minute taker)**
Dr Stephen Thomas	**(ST)**	-	Deputy Professional Director of JPAC
Dr Anna Vossenkaemper	**(AV)**	-	Human Tissue Authority (HTA)
Dr Angus Wells	**(AW)**	-	Standing Advisory Committee on Care and Selection of Donors

Due to repeated technical issues Prof Marc Turner could not stay connected to the telecon.

ACTION

1. Apologies received

Dr Rebecca Cardigan	**(RC)**	-	SAC on Blood Components
Mrs Linda Lodge	**(LL)**	-	Standing Advisory Committee on Information Technology
Dr Christian Schneider	**(CS)**	-	Director, National Institute for Biological Standards and Control
Prof Marc Turner	**(MT)**	-	Medical Director, Scottish National Blood Transfusion Service

2. Risk assessment of UK plasma for neonatal and paediatric recipients – consideration of pathogen inactivation – JPAC 19-61

- **Summary of SACTTI discussion – 17 September 2019 – JPAC 19-62 updated**
- **Comments from Dr Jonathan Wallis on pathogen inactivation of FFP – JPAC 19-64**
- **Comments from Dr Anne Kelly, Paediatrician – JPAC 19-65**

Accompanying JPAC 19-61 were a summary of SACTTI's discussion on the paper (JPAC 19-61) and comments received from Dr Jonathan Wallis (JPAC 19-64) and Dr Anne Kelly (JPAC 19-65). Both Dr Wallis and Dr Kelly had given permission for their comments to be circulated for this telecon.

SM summarised the background for JPAC. Following on from the SaBTO recommendation and subsequent approval by Ministers to cease importation of plasma for those born after 1995, the question has arisen as to whether pathogen inactivation of plasma for this age group should continue when UK plasma is used. It was noted that PI was implemented because of the recognised increased viral risk in countries from which the plasma was sourced.

The paper outlines that the highest risk is from hepatitis B although that risk is lower than prior to importation as NAT testing has been introduced since then. There is mention in the paper of reduction in efficacy of the component as a result of PI and increased cost of the pathogen reduced component although these criteria were not taken into account in the risk assessment.

LJ summarised the comments from SACTTI. The committee did not consider there were any significant safety concerns regarding the use of non-PI treated UK plasma for any age group.

MT joined the conference 09:12 but was unable to stay connected to the telecon because of technical issues.

The risk assessment paper was discussed. The 2013-2015 figures for HBV were considered more representative given the increase of HBV incident infections in UK donors in 2018 (n = 7 compared to a more reflective 2 or 3 cases per annum), has not been sustained in 2019 to date. JB noted that the calculations for 2013-2015 still suggested an increased risk for paediatric cryoprecipitate because of the pooling of 5 donations in the component. The risk assessment calculations were based on a worst-case scenario of the likelihood of developing chronic HBV following HBV infection in children. It was explained that the ABO patient risk matrix was used as a tool for assessing tolerability but that the use of a level of risk of 1 in a million to define tolerability was indicative rather than being formally recognised by SaBTO. A full formal ABO risk assessment had not been undertaken. It was commented that the incidence of HBV in the general UK population has declined,

ACTION

Children receiving cryoprecipitate would probably receive other components (which are not PI) and some groups of multi-transfused children would be likely to have received HBV immunisation.

It was noted that if a measure to reduce the risk to some or all recipients were to be considered it would need to be in the context of testing strategy and any potential introduction of pathogen inactivation technology – this would require a full risk assessment with health economics and stakeholder engagement. SaBTO is about to start a piece of work on HBV testing which could impact on the risks for all groups of recipients and has previously considered pathogen inactivation.

The need for doing further work including formal cost-effectiveness calculations and inclusion of the benefit of increased coagulation factor content of the component was discussed. It was agreed that if the decision was that the viral risk was not of significant concern then this is unnecessary.

Comments from the clinicians were noted. One considered the reduction in efficacy of PI treated components was a greater risk than that from virus transmission. MR agreed that improved efficacy was important. Also, that no distinction between neonates and older children was warranted.

SF commented that the discussions were useful as the Republic of Ireland is about to consider reintroducing Irish plasma for direct clinical use.

In conclusion, JPAC agreed that with the reintroduction of UK FFP and cryoprecipitate for those born after 1995, pathogen inactivation was not required for the following reasons:

- The key reason was that, following review of the calculations in the risk assessment paper, no significant concerns were raised by SACTTI regarding the use of non-PI-treated UK plasma for any age group. This decision was also based on the wider context of infectious risks regularly considered by SACTTI.
- The viral risk is noted to be highest for HBV, but this is low and decreasing; the risk is lower now than prior to importation of plasma due to introduction of NAT and PI was not recommended at that time. Data on HBV incidence in England from the literature including PHE annual reports since the UK started importing plasma in 2004 are as follows:

2018	0.68 per 100 000
2017	0.80 per 100 000
2016	0.82 per 100 000
2015	0.83 per 100 000
2014	0.91 per 100 000
2013	0.77 per 100 000
2012	1.04 per 100 000
2011	1.13 per 100 000
2005 – 2010	1.30 per 100 000

- Supporting points:
  - If PI is not done, then, as incorporated into the risk assessment calculations, plasma components for neonates/infants will only be made from repeat donors which reduces the risk further
  - The level of risk needs to be balanced against the considerable benefits for the patient of increased component efficacy and lower cost to the NHS
  - There is an ongoing HBV vaccination programme in the UK and increasing numbers of children are being vaccinated
  - Some groups of children who are multi-transfused will already have been vaccinated

ACTION

- Infants / children receiving FFP or cryoprecipitate are likely to receive other blood components which are not PI treated. In addition, they also already receive significant volumes of UK plasma which is present in apheresis platelet and exchange transfusion components.
- SaBTO is reviewing HBV risk (particularly occult HBV) and changes to testing algorithms may be considered to reduce risk further

6. Neonatal platelets in Plasma and Additive Solution, Leucocyte Depleted - New component specification – JPAC 19-63

This is a new component which will improve the quality of platelets for neonates.

JPAC approved this specification and HN will take forward.