Joint SOUTH THAMES & North London TRANSFUSION SCIENCE TA(D)G.

Minutes of meeting - 2nd April 2014

St Georges Hospital, London.

Present:

Name	Based at
Malcolm Robinson (MR)	Chair; West Sussex
Carol Cantwell (CC)	Co-Chair; Imperial
Peter Struik (PS)	Admin Support
Emma Clenshaw (EC)	Darent Valley
Leslie Delieu (LD)	Darent Valley Hospital
Pauline Bigsby (PB)	Darent Valley
Robert Reilly (RR)	Maidstone & Tunbridge Wells
Julie Cole (JC)	RSCH, Brighton
Pam Glinski (PG)	Princess Royal, Hayward's Heath
Graham Smith (GS)	Surrey Pathology Services
Kirsten King (KK)	Spire Gatwick Park
Rashmi Rook (RR)	East Surrey
Tim Maggs (TM)	Guys & St Thomas'
Carlos Galamba (CG)	Guys & St Thomas'
Matthew Free (MF)	Kings College Hospital
Barbara Umlauft (BU)	King's College Hospital
Sue Rudd (SR)	Epsom and St. Helier
Andrea Ferrige (AF)	Darent Valley Hospital
Julia Cheeseman (JCh)	Royal Marsden

Sally Procter (SP)	NHSBT
Richard Whitmore (RW)	NHSBT Tooting
Martin Redman (MRed)	NHSBT Colindale RCI
Jen Heyes (JH)	NHSBT
Antonia Hyde (AH)	NHSBT
Edmond Lee (EL)	NHSBT Colindale RCI
Jeyanthy Nicholas (JN)	Medway Maritime
Matt Denmead (MD)	Croydon
Tracey Tomlinson (TT)	Hammersmith
Lloyd Noble (LN)	Charing Cross
Clare Milkins (CM)	UKNEQAS
Chloe Orchard (CO)	St Georges
Penny Eyton-Jones (PEJ)	Great Ormond St
Samantha Marston (SM)	Whittington
Barry Hearn (BH)	Princess Royal, Orpington
S. Uthayakumar (SU)	Hillingdon

Apologies for Absence :

Malcolm Needs (MN)	NHSBT Tooting

1. Co-chairpersons' opening remarks:

MR welcomed everyone to the meeting.

CC thanked Malcolm and Richard Whitmore for arranging the meeting.

The combining of the two TAGs was discussed. There were felt to be both advantages and disadvantages in aligning the TAG with the RTC.

Combining would lead to a higher attendance and members meeting a larger network of people, although some people feel inhibited in speaking in a larger group.

It is easier to find suitable venues within the region for smaller meetings which can thus be held at more different hospitals, often allowing visits to their laboratory and, being more local, for people to attend for part of the meeting if they can't be away from work for a whole day. It is easier to find sponsors for larger meetings but a combined group covering a larger area entails greater travelling distances.

Comments and feelings should be e-mailed to the respective TAG Chairs so that any options put forward to vote on are representative of the feelings of the group.

The TAG is about the business of hospitals and an important forum for NHSBT input and the opportunity to feed back to them.

There was much discussion about how to ensure the BMS voice is heard at the RTC as strongly as those of Consultants and TP's, who it was felt because of their more flexible workload were more easily able to attend meetings and make their views heard.

2. New UKAS (CPA) Gap Analysis Document 15189

[See Appendix 1]

MR discussed the need for the document and how it could be used.

Trusts must first decide whether they want full accreditation – management backing is essential as a considerable investment of time and money is required.

Staff shortages need to be documented and made known to Senior Management. Minimum staffing levels are usually set at what is required to 'get the work out of the door' not what is required to provide a quality-managed Transfusion service.

Accreditation is now per test – the process needs to be fully validated from ordering consumables to sending out the report, with full traceability throughout.

Audits are required to provide evidence and everything must feed into a Quality Management System with full CAPA. There is a need to show continual improvement which involves all staff, who are expected to play an active role – there needs to be an active suggestion process (a suggestion box counts!)

All audits must be done and up to date so it is important to ensure that plans are achievable.

Training and competence needs to be documented and robust and include OOH staff.

Internal Trust SLA's are required for IT, Engineering Department etc although as this is a Pathology-wide requirement it is not the sole responsibility of the Transfusion Manager.

All equipment non-conformances must be documented with CAPA if necessary. The need for such equipment as a timer used for a Kleihauer test to be calibrated to a national standard with documentation evoked a response which suggested that many of those present were less than overjoyed at the prospect.

There was discussion about the need to be able to identify which individual bottle of a batch of reagents is in use at a particular time – it being suggested that if not possible a risk assessment could be done.

There needs to be a 'Measure of Uncertainty' which probably doesn't apply to a blood group but does to e.g. a Kleihauer where it includes the uncertainty of people not all following exactly the same procedure, in how the timing is done etc - although not all variation is significant. Anyone performing a test must understand the limits of uncertainty – this includes when issuing products based on results from another Department.

It was suggested that a TAG area could be set up on the NHSBT website to allow useful documents etc to be shared.

Action: Quality Sub group of the TAG: EC: BU: CG

3. Education: UKNEQAS (14R1)

Clare Milkins discussed the results from this recent 'weak D' exercise which required participants to carry out D typing and interpret the results in context of the age and gender of the patient – a 30 year old female for patient 1 in this exercise. (Exercise results and learning points are available on the NEQAS website)

Analysis of the results showed that not all laboratories were following guidance in the BCSH 'Pre-transfusion Compatibility Testing Guidelines' 2012 which provide an algorithm on how to deal with reporting and transfusing patients reacting variously with anti-D reagents.

This exercise underlined the importance of NEQAS samples being treated as 'typical' samples as had results been checked before returning we wouldn't have this national picture of what is happening on a day-to-day basis.

Those wishing to explore the subject further are recommended to read

'Daniels G, Poole G, Poole J (2007;

'Partial and Weak D – can they be distinguished ?

' Transfusion Medicine,17,145-146

Competency Assessment update.

NEQAS will be launching TACT, a knowledge-based on-line training and competency scheme, this year. Each exercise would offer a basic scenario, with slight variations for individual participants, covering, for instance, application of sample acceptance

criteria, group and antibody screen interpretation, identification panel interpretation and unit selection etc.

A pilot exercise for about 40 laboratories is planned in July with full launch of the scheme in October at an as yet undecided price. The basic scheme will, if successful and income comes in, be developed to offer higher levels of sophistication.

All staff would be registered as users and they could then take part as often as they wished although a minimum level of participation would be set. Managers would have a dashboard showing performance of their staff, if critical points were failed and how long they spent on the exercise etc.

Although NEQAS are providing this they will not be able to see which of your staff are competent, but will be able to offer benchmarking data allowing comparison of individual laboratories against national performance.

4. **Supplier Audit**

At the last joint TAG it was agreed that there would be a critical supplier audit, the idea being for a single quality survey to be sent to each company from the group rather than multiple requests from individual laboratories. The template drawn up by King's College Hospital was found to have worked well and was felt suitable for use by the group.

It will require someone to check the replies and ensure they are acceptable, to decide the criteria for judging acceptability, and to decide actions to take should a supplier be deemed unacceptable. The MHRA website has a list of suspended licenses and this could also be checked. Hospitals need to identify their critical suppliers and submit a list to Barbara Umlauft at King's.

Action: All to supply critical suppliers list to Quality **Sub group of TAG: BU: EC: CG**

5. **Temperature Mapping Gap analysis:**
   Postponed until next meeting

   [See appendix 2]

6. **Interesting cases:**
   [See appendix 3]

7. NHSBT Strategic update:

MB cryoprecipitate should be available from the end of April 2014 with a shelf-life of 2 years; pools containing 6 rather than 5 lots to compensate for the loss of activity through the MB process.

Pathogen Inactivated Platelets are undergoing a validation exercise. They are manufactured at Filton but available generally – the barcodes should be on laboratory computer systems. They are contra-indicated in patients with a history of allergic response to amotosalen or psoralens and for neonates in receipt of blood components treated with the Intercept system to avoid the theoretical possibility of erythema. Although only certain hospitals are receiving Intercept platelets there is a potential problem with hospitals receiving such neonates as the laboratory may not be informed of their previous treatment.

There is a BSMS pamphlet based on a consensus of Laboratory Managers making recommendations about red cells for emergency use.

NHSBT has a new CEO, Ian Trenholm, from Defra.

Brentwood centre will remain open until the DoH decides changes can be made. Some hospitals will be re-assigned to other centres between May and June 2014.Overnight delivery rounds will be introduced at about the same time for hospitals which require them. By the end of July rounds will be re-organised to offer every hospital 2 rounds per day.

A new Head of RCI, Dr Mark Williams from Leeds will start in August, overlapping with Gordon Burgess who is retiring.

After a recent 'reporting event' RCI reports will be revamped.

Some RCI units are having DNA based genotyping platforms to facilitate investigations when phenotyping isn't possible. The Haemoglobinopathy Strategy Group have a plan to widen accessibility of genotyping patients with haemoglobinopathies thus allowing improved selection of units and patient management. Samples would be referred direct to IBGRL for genotyping, free of charge for 2 years. There is a need to set up a workable process - a system for identifying patients and referring samples for putting on a national database. Liaison with sites doing regional infant haemoglobinopathy screening was suggested.

Introduction of printing historical blood types on pack labels where there are two previously recorded results has been delayed as software bugs have not yet been sorted.

8. Feedback from other meetings

NBTC TLM meeting:

The 'Transfer of Blood Between Hospitals With a Patient' document has been agreed.

There is still concern that sufficient M negative units are available for patients with anti-M antibodies not confirmed by RCI as not active at 37C. The NHSBT have been asked to confirm what percentage of units have been M typed.

There was concern that Laboratory Managers are spending too much time doing benchwork and not having time to attend relevant meetings.

The programme for the last BBTS meeting was generally felt not to be attractive to BMS members, which the BBTS have taken on board

NHSBT Training courses as part of SLA with NHSBT.

This is being considered following the model of NEQAS where attendance at their annual meeting is part of the NEQAS SLA.

BCC Meeting

MHRA/SABRE have been asked to produce an annual report, as SHOT does, and provide benchmarking date e.g. the number of hospitals using electronic traceability and the percentage traceable.

The MHRA 'Good Practice Guide' (replacing the orange book) is in final draft and ways of distributing it are being looked at – although it is available on the internet and can be found by searching under its more official if less descriptive title of 2005/62/EC.

9. AOB

Under the LPP there will be a new tender for albumin from 14th April 2014 – price not yet given.

10. Dates of Next Meetings

North London - 11th June – Brompton Hospital

South Thames - 19th June – Worthing Hospital