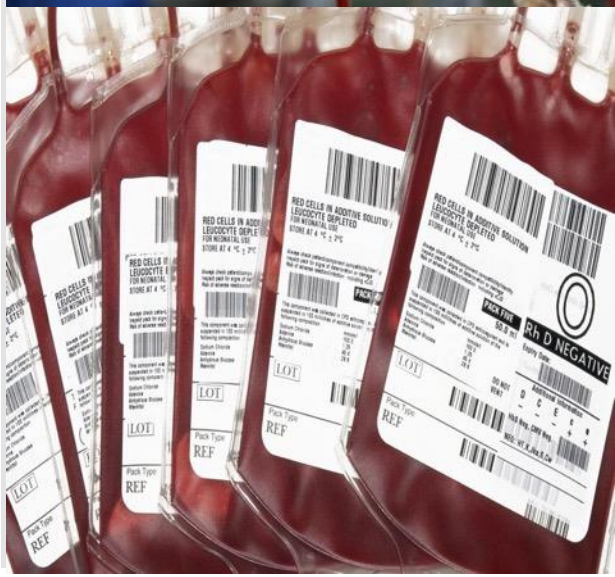
BHNOG

Grŵp Goruchwylio Iechyd Gwaed Cenedlaethol
Blood Health National Oversight Group

Blood Health National Oversight Group (BHNOG)

The story so far…..

Dr Brian Tehan, BHNOG Chair



Terms of Reference

BHNOG
Grŵp Goruchwylio Iechyd Gwaed Cenedlaethol
Blood Health National Oversight Group

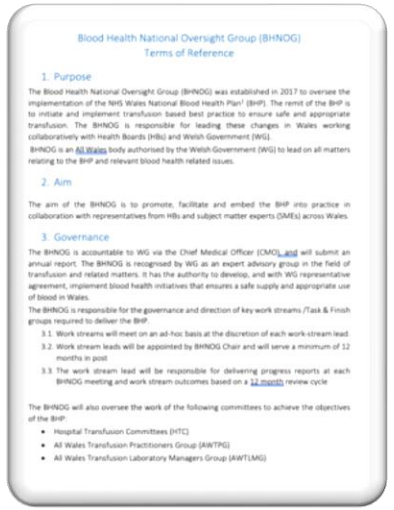
The aim of the BHNOG is to promote, facilitate and embed the BHP into practice in collaboration with representatives from HBs and subject matter experts (SMEs) across Wales.

BHNOG is an All-Wales body authorised by the Welsh Government (WG) to lead on all matters relating to the BHP and relevant blood health related issues.

It is owned by NHS Wales

It endorses the principles of patient blood management (PBM) which focus on a multi-disciplinary approach to implementing evidence-based transfusion practice

A national leadership group: Blood Health National Oversight Group (BHNOG) has been established to oversee and through the work of the Blood Health Team drive delivery of the BHP to realise expected outcomes



Blood Health National Oversight Group (BHNOG)
Terms of Reference

1. Purpose

The Blood Health National Oversight Group (BHNOG) was established in 2017 to oversee the implementation of the NHS Wales National Blood Health Plan[1] (BHP). The remit of the BHP is to initiate and implement transfusion based best practice to ensure safe and appropriate transfusion. The BHNOG is responsible for leading these changes in Wales working collaboratively with Health Boards (HBs) and Welsh Government (WG).

BHNOG is an All Wales body authorised by the Welsh Government (WG) to lead on all matters relating to the BHP and relevant blood health related issues.

2. Aim

The aim of the BHNOG is to promote, facilitate and embed the BHP into practice in collaboration with representatives from HBs and subject matter experts (SMEs) across Wales.

3. Governance

The BHNOG is accountable to WG via the Chief Medical Officer (CMO), and will submit an annual report. The BHNOG is recognised by WG as an expert advisory group in the field of transfusion and related matters. It has the authority to develop, and with WG representative agreement, implement blood health initiatives that ensures a safe supply and appropriate use of blood in Wales.

The BHNOG is responsible for the governance and direction of key work streams /Task & Finish groups required to deliver the BHP.

3.1. Work streams will meet on an ad-hoc basis at the discretion of each work-stream lead.

3.2. Work stream leads will be appointed by BHNOG Chair and will serve a minimum of 12 months in post

3.3. The work stream lead will be responsible for delivering progress reports at each BHNOG meeting and work stream outcomes based on a 12 month review cycle

The BHNOG will also oversee the work of the following committees to achieve the objectives of the BHP:

- Hospital Transfusion Committees (HTC)
- All Wales Transfusion Practitioners Group (AWTPG)
- All Wales Transfusion Laboratory Managers Group (AWTLMG)

Blood Health Plan

Llywodraeth Cymru
Welsh Government

WHC (2021) Number 027

WELSH HEALTH CIRCULAR

Llywodraeth Cymru
Welsh Government

Issue Date: 27 September 2021

STATUS: ACTION and INFORMATION

CATEGORY QUALITY & SAFETY

Title: NHS WALES BLOOD HEALTH PLAN

Date of Expiry / Review: September 2023

Action required by: September 2021

For Action by Health Boards/ Trusts:	For Information:
Chairs Chief Executives Board Secretaries Secretary to the Board Secretary Group Medical Directors Directors of Nursing Directors of Therapies &Health Science Director of Planning Renal Teams Directors of Public Health Infection Control Doctors and Nurses Hospital Chief Pharmacists	DG/Chief Executive NHS Wales Deputy Chief Executive NHS Wales Chief Scientific Officer Chief Pharmaceutical Advisor Professional and Policy Leads DHSS Operations Team DHSS Comms Team DHSS Digital Team NHS Direct Wales WSSP for distribution to GP practices, Community Pharmacies and General Dental Practices

Sender: Dr. Frank Atherton, Chief Medical Officer/ Medical Director, Sue Tranka, Chief Nursing Officer

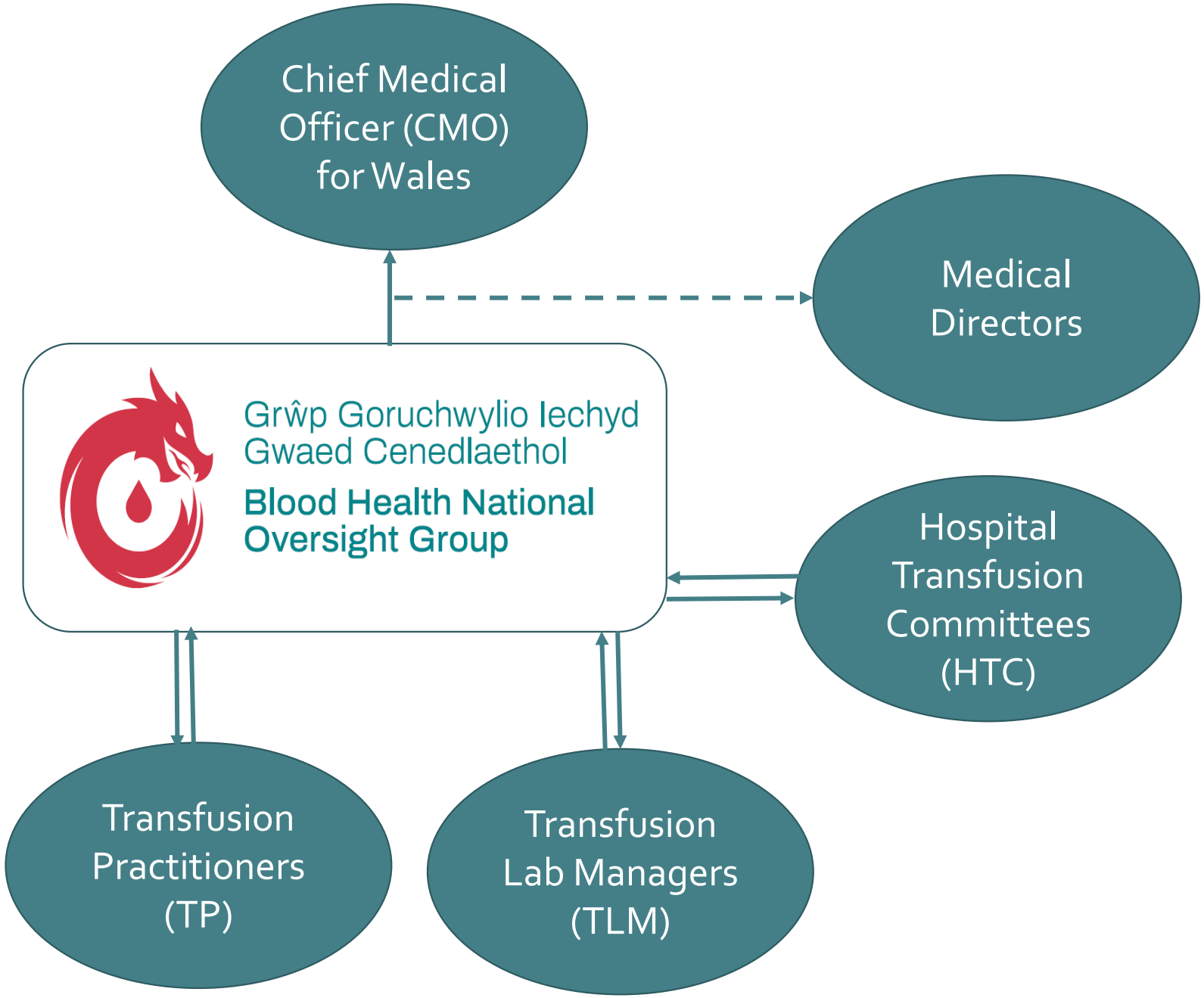
HSSG Welsh Government Contact(s): Debbie Tynen, Head of Healthcare Associated Infections and Blood Safety, Catherine Cody – Catherine.Cody@gov.wales 03000251443

Enclosure(s): NHS Blood Health Plan

BHNOG Reporting Structures

Dr. Brian Tehan

Consultant Anaesthetist, BCUHB & BHNOG Chair



BHNOG /BHP Relationships

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Health Board & Hospital Transfusion Committees

- The ***majority*** of Health Boards now have a HTC
- All Health Board HTC Chairs are now members of the BHNOG
- A clear emphasis, the Blood Health plan is our plan, incumbent on us all to deliver
- Becoming an integral part of HB Hospital Transfusion Committees. Establishing the link between the HTC and the BHNOG /BHP to drive improvement and initiatives across the HB setting.
- Sharing performance data between Health Boards generating a national team approach to achieve the best outcomes for patients and the optimal use of the donors' gifts
- Looking at opportunities to review and where appropriate challenge current practice to improve blood use e.g. in COVID policy change to use O D positive units in emergency settings (e.g. the Emergency Medical Retrieval and Transfer Service - EMRTS) for specific patient groups thus allowing us to conserve O D negative stocks.

BHNOG /BHP Relationships

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Our Labs

- Transfusion Practitioners and Transfusion Lab Managers represented on BHNOG
- Development of a competency framework for Transfusion Practitioners, approved by BHNOG December 2021
- The development of a collaborative agile approach across the clinical supply chain.

Covid19

BHNOG

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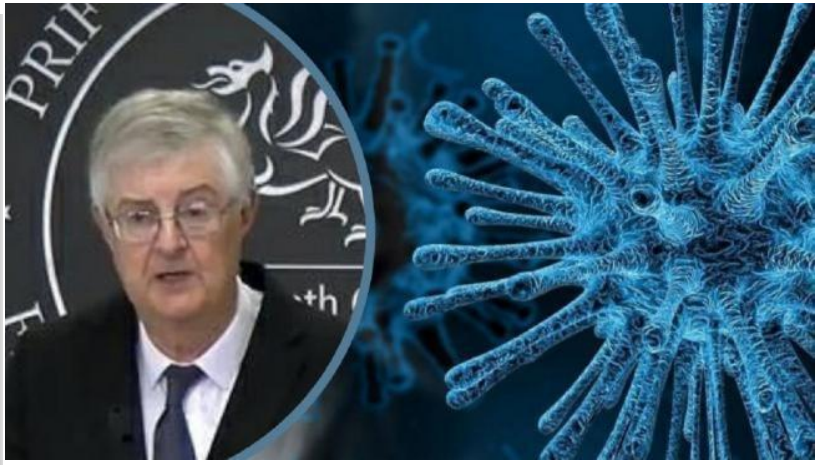

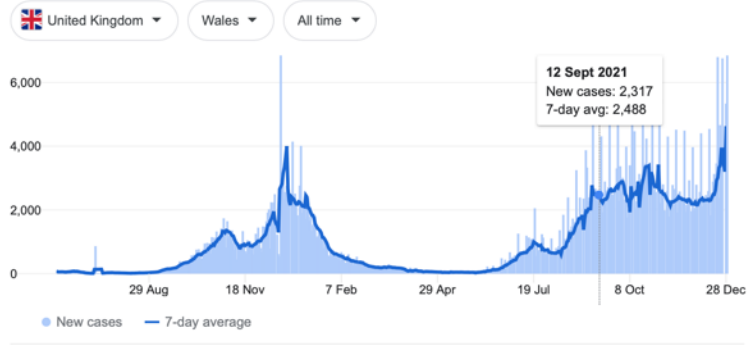

Key BHNOG Workstreams

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Appropriate Use of O D Neg

Anaemia Management

Appropriate Use of Platelets

Other Groups

- Serious Hazards of Transfusion (SHOT)
- Major Haemorrhage Working Group:
- Intra- Operative Cell Salvage (ICS)

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SHOT 2020 recommendations

Serious Hazards Of Transfusion SHOT

3 Key recommendations

- Prevent Transfusion delays
- Reduce the risk of errors associated with Laboratory IT
- Effective incident investigation

SHOT 2020 gap analysis - Wales

		Prevent transfusion delays including anticoag reversal							Transfusion information technology (IT) systems reduce the risk of errors at all steps in the transfusion pathway if they are configured and used correctly								Transfusion information technology (IT) systems reduce the risk of errors at all steps in the transfusion pathway if they are configured and used correctly					
		1.Ensure procedures are in place detailing ID, escalation and blood provision in major haemorrhage and trauma cases	2.Ensure procedures are agreed by relevant clinical and lab groups, are accessible and incorporated into regular training and simulation exercises	3.Ensure that procedures are in place detailing appropriate use of anticoagulant reversal agents without requirement for approval by consultant haematologist	4.Ensure appropriate use and access to anticoagulant reversal agents is incorporated into regular training for clinical and laboratory staff	5.Consider implementation of a fixed dose regime for PCC with rapid access for ICH cases	6.Ensure procedures are in place enabling rapid provision of blood components in complex situations, using concessionary release pathways	7.Ensure major haemorrhage, trauma and concessionary release procedures are incorporated into regular training and competency assessment for all staff working in transfusion labs	8.Ensure transfusion IT systems that support good practice and safe patient care, as recommended by the HTC or equivalent, are implemented across the organisation	9.Ensure systems are compliant with the relevant current national legislation, guidelines and recommendations	10.Ensure systems support safe practice using appropriate alerts with consideration to reduce risk of alert fatigue	11.Ensure that all transfusion IT systems are used to their full potential, are compliant with relevant national legislation, guidelines and recommendations and are regularly validated	12.Ensure that use and understanding of the tranfusion IT systems is incorporated into staff training and regular competency assessment	13.Consider that impact of changes to, or implementation of, any clinical IT system on the delivery of the transfusion service, including planned downtime events	14.Review opportunities to improve trnasfusion safety, from the decision to transfuse through to the administration and monitoring of the transfusion, by harnessing interoperability between clinical IT systems and transfusion IT systems.	15.Provide support and training for all staff involved in transfusion related incident investigation	16.Ensure procedures and templates are available that include consideration of human factors and a system-based approach to investigation, include plans for corrective and preventative actions and a process for reviewing the effectiveness of the actions	17.Provide a platform to share learning from transfusion errors and near miss events across the whole organisation	18.Ensure capacity plans include provision of adequate staffing to support robust investigation of all transfusion related incidents and near miss events	19.Ensure that staff involved in incident investigation have received adequate training, including human factors and a system based approach to investigation	20.Provide support with implementation of effective corrective and preventative actions, ensuring that these are forcing functions whereever possible
3	AB UHB	Compliant	Partially Compliant	Non Compliant	Partially Compliant	Non Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partially Compliant	Compliant	Compliant	Compliant	Not known	Compliant	Partially Compliant	Not known
4	BCUHB/GC	Compliant	Compliant	Compliant	Compliant	Not known	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5	BCUHB/G	Compliant	Partially complaint	Compliant	Compliant	Compliant	Compliant	Partially Compliant	Compliant	Compliant	Not Compliant	Compliant	Compliant	Compliant	Partially Compliant	Compliant	Compliant	Compliant	Partial compliance	Partially Compliant	Compliant
6	BCUHB/Wxm	Partially Compliant	Partially complaint	Partially Compliant	Partially Compliant	Non Compliant	Compliant	Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Compliant	Compliant	Compliant	Partially Compliant	Compliant	Partially Compliant	Not known	Partially Compliant	Partially Compliant	Compliant
7	C&V UHB	Compliant	Compliant	Compliant	Partially Compliant	Not known	Compliant	Compliant	Partially Compliant	Compliant	Compliant	Compliant	Compliant	Partially Compliant	Partially Compliant	Compliant	Compliant	Compliant	Compliant	Partially Compliant	Compliant
8	CT UHB	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partially Compliant	Compliant	Compliant	Compliant	Partially Compliant	Partially Compliant	Compliant
9	HD UHB	Compliant	Partially Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partially Compliant	Compliant	Compliant	Non Compliant	Compliant	Compliant	Non Compliant	Compliant	Compliant	Compliant	Partially Compliant	Compliant	Compliant
10	SB UHB	Compliant	Partially Compliant	Partially complaint	Compliant	Complaint	Compliant	Compliant	Complaint	Complaint	Complaint	Complaint	Compliant	Compliant	Non Compliant	Partially Compliant	Compliant	Compliant	Not known	Partially Compliant	Compliant
11																					
12	All Wales Compliance against individual actions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
13	Compliant	88	38	63	63	50	100	88	63	88	75	88	100	75	25	88	88	75	38	25	88
14	Partially Compliant	13	63	25	38	0		13	38	13	13	0	0	25	50	13	13	0	50	75	0
15	Non Compliant	0		13		25		0	0	0	13	13	0	0	25	0	0	0	0	0	0
16	NK	0				25		0	0	0	0	0	0	0	0	0	0	25	13	0	13
17		100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

SHOT 2020 gap analysis - Wales

	All Wales			
		Compliant %	Partially compliant %	Non Compliant %
Key recommendation 1		70	25	5
Key recommendation 2		73	20	7
Key recommendation 3		67	33	0
	Overall	70	26	4

SHOT 2020 gap analysis - Wales

- SHOT working group to issue individualised Health Board actions plans with responses required against any non compliances for the main standards.
- Follow up gap analysis scheduled May 2022 to determine whether change has occurred.

Going forward…

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Laboratory Information Network Cymru (LINC) & Vein to Vein (V2V) AssuranceThe AWTLM & AWTPG also feed directly into the BHNOG and representatives from these groups also sit on the BHNOG and submit quarterly update reports
The AWTLM & AWTPG also feed directly into the BHNOG and representatives from these groups also sit on the BHNOG and submit quarterly update reports

- Implementation of the LINC All Wales programme
- Development of a full V2V solution for Wales allowing full tracking of blood to every patient

Today

Future Nurse, Future Midwife

- Development of a standardised transfusion education programme for all student nurses and midwifes for all HEIs in Wales

BHNOG Website & Transfusion Patients & Professionals (TPP) website

- Current development of BHNOG website
- Future development (2022) of TPP website

Today

Blood Health Team (BHT)

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Blood Health National Oversight Group

Lee Wong, BHT Lead

Jo Gregory, Blood Health Adviser

Deb Underwood
Clinical Data Lead

Alister Jones
Blood Health Adviser

Steph Ditcham
Blood Health Adviser

Edwin Massey
Blood Health Physician

Thoughts for Today

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