

NOT FOR PUBLICATION

STEERING GROUP ON MANAGEMENT SERVICES STUDY OF THE NBTS

MINUTES OF MEETING OF 16 DECEMBER 1986

Members

Mr G A Wilson (Chair)
Mr T A Binns
Dr R Finney
Dr I Fraser
Mr M A Harris
Mr R Nicholls
Prof J A Scott

In attendance

Mr R Jordan
Mr T Kelly
Mr S Saunders

Secretariat

Dr A Smithies
Dr R Moore
Mr M H Arthur

Apologies for Absence

1. All members were present.

Minutes of previous meeting

2. The minutes of the meeting of 11 September 1986 were agreed, but Professor Scott reiterated that the need to increase supply in time of war should not be overlooked in considering options.

Matters arising from the minutes

3. None.

Oral Progress Report by NHS MS Study Team

4. The study team indicated that the BGRL reference laboratories and 5 RTC's including 2 of the 3 London centres had yet to be visited and therefore no conclusions could be offered to members at this stage. An abridged version of the verbal reports given by Mr Kelly and Mr Saunders is as follows:-

Management and Functions

- i. There was a lack of effective and common management information particularly in the realms of performance and costs. This presented all tiers of management with difficulties in assessing options and was an obstacle to accountability.
- ii. A key area for consideration was whether and how the concept of general management should be introduced; management requirements would need to be related to defined functions of the organisation.
- iii. There was presently no clear remit defining NBTS activity.

Blood Collection by RTC's

- i. The average collection team varied from 10 - 16 staff, and the average number of donors attending sessions varied from 80 - 180.
- ii. Ratios of donors bled per team member per session varied from 5:1 to 11:1.

iii. Team size did not appear to be related to the efficiency of the teams; but throughput, bleeding times and the activities of team members during sessions had not been examined in detail.

iv. Regions had different criteria for determining which donors to bleed.

v. If all Regions bled at the maximum percentage of donors attending sessions identified, then an additional 58,000 donations could have been collected throughout the regions visited so far.

Transfusion Microbiology

i. All Regions visited tested donations for syphilis, hepatitis B and HIV; however the types of test and their price together with operational arrangements for re-testing varied considerably.

ii. All Regions visited test varying percentages of donations for cytomegalavirus, anti-tetanus and anti-HBS.

iii. Some Regions do bacteriology work.

iv. Variances seem to be determined by scientific and personal preference as much as cost, and operational demands.

v. Developments in test procedures seem to happen largely at the discretion of RTCs or as a result of demands made upon them. Co-ordination may produce resource savings.

Blood components/products

i. All RTCs produced the major components; over 20 blood products, excluding reagents, had been identified.

ii. The percentage of red cells issued as SAG(M) varies widely.

iii. Other products were produced by RTCs to greatly varying degrees. The decision to make these products seemed to be governed by factors of local RTC policy, cost, and clinical demand.

Equipment

i. The major items of fixed equipment eg grouping machines and centrifuges, were held in different quantities by RTCs.

ii. Some had centrifuges in excess of requirements; some were holding equipment which was dilapidated and which they could not afford to replace.

iii. There did not appear to be any attempt to produce a "best-buy" policy.

iv. Standardisation/bulk purchasing could offer savings.

Blood Bags

i. Each Region visited negotiates separately with the manufacturer to obtain their own deals/discounts.

ii. There appeared to be potential in the concept of a national approach to bag purchase.

Reagents

- i. Although BPL diagnostics make 24 products, more than 60% of these are also manufactured by RTCs.
- ii. Nine products have provisionally been identified as being made by RTCs but not by BPL.
- iii. A total of at least 24 staff were employed in reagent production at the 9 RTCs visited so far.
- iv. BPL provisionally estimate they might be able to produce the requirements for England and Wales with an additional 15 staff.
- v. It was hoped to produce an estimate of how much commercial reagent was purchased.
- vi. Reorganisation of reagent production could lead to staff and cash savings; it would provide an opportunity to consider standardisation of procedures and the quality of reagents.
- vii. Little cost benefit analysis had been done by RTCs on the relative advantages of in-house as opposed to central production.

Research

- i. Five of the 9 RTCs visited had designated research departments; however, with the possible exception of one centre research and development activity was identified in all centres visited.
- ii. Most research was applied or developmental.
- iii. Of 25 identified areas of research, 11 are being duplicated in at least 3 RTCs.
- iv. The CBLA does:
 - a. Production research related solely to the manufacturing process.
 - b. Research of relevance to RTCs as well.
- v. No formal mechanism exists to co-ordinate R&D. One RTC admits launching a project already researched in another Region.
- vi. Co-ordination would use resources more effectively and could lead to savings.

Regional Services

- i. Each RTC visited had provided additional services, eg antenatal and tissue typing; this involved about 100 staff in total.
- ii. Some of the services the RHA was required to provide including patient treatment could be based other than at RTCs.
- iii. The future location of these services and their place in any reorganised structure together with the question of the extent to which RTCs should be involved in patient treatment will have to be addressed.

Quality Assurance/Quality Control

- i. Some RTCs had discrete sections but, in most, resources devoted to QA/QC were difficult to disentangle.
- ii. The national NEQUAS scheme is considered by many RTCs to be inadequate. Some have established regional proficiency schemes to supplement this.
- iii. Most RTCs believe more QC is needed.
- iv. There is a case for uniformity and standardisation particularly since BPL and RTCs are both involved in the QC process on plasma. Increased resources may be required and therefore QC activity should be co-ordinated.

Transport

- i. Types of vehicles, fuel and livery varied from region to region.
- ii. Some RTCs were entirely responsible for all aspects of their fleet; others had arrangements with RHA/DHA/private contractors.
- iii. Grade ASC 6 (driver/clerk) was standard but not all regions made use of the opportunity provided by this grading to use drivers for clerical/technical work. Transport was seen as sensitive in industrial relations terms.
- iv. Standards of vehicle refrigeration varied from cold boxes to full refrigerated units.
- v. All RTCs visited make routine deliveries to hospitals; arrangements for ad hoc or emergency deliveries vary: some RTCs expect hospitals to collect, one has recently instituted a charge for some deliveries.
- vi. Transport is another area where the advantages of bulk purchase could be explored.

Supply and Demand

- i. With the exception of London regions most RTCs could cope with hospital demand. However, help from the provincial Regions to alleviate the London shortfall was becoming limited because of financial constraints.
- ii. Plasma supply to BPL was less adequately satisfied. Of 9 regions visited 2 had not attained the start point target for April 1986.
- iii. Some RHAs were unhappy with the plasma targets originally allotted by the Department; others were unhappy with the timescale for increasing plasma output and had set their own.
- iv. Increased plasma yield had been sought by:
 - a. Collecting more donations (with excess red cell implications)
 - b. Increasing the percentage of SAG (M) blood issued
 - c. Plasmapheresis
- v. The extent to which one or a combination of these was used varied. Some RTCs had invested in plasmapheresis machines which were underutilised for plasma collection.
- vi. There was little evidence of a detailed consideration of plasma collection options.

- vii. It seemed sufficient raw material was available to meet present demand for clinical RTC products. Some regions could 'export' and one had destroyed 4,500 surplus red cell packs in 1986.
- viii. Some regions suggested that with extra resources, collections could be increased by 20%.
- ix. One region was prepared to bleed on a contractual basis for other regions.
- x. Solutions to the supply problems suffered by London RTCs could not be quantified until the other two London RTCs were visited.
- xi. Platelet demand was increasing at an estimated 10-15% per annum. This would impact on plasma harvesting and the organisational structure required to meet it.
- xii. There was no great evidence of wastage or profligacy. Return rates of whole blood and FFP were in the 4-17% range.
- xiii. Wastage did not appear to be directly related to the rate of medical intervention at the issue stage, or the amount of the blood supply in each region.
- xiv. Even if all regions had the most efficient observed return rate, the plasma harvest would only be increased by 3%.
- xv. The major thrust for improvements in efficient use of blood must be directed at hospitals. Computerised stock control was helping as this allowed clinicians demands for blood to be monitored.
- xvi. The Study Team had been unable to adduce much evidence to support the theory that charging hospitals for blood would reduce wastage.
- xvii. Making the clinician user financially responsible for the blood and blood products used might be effective in achieving optimum usage.
- xviii. The Study Team were examining albumin usage in particular, against accusations this was profligate. A usage of 6,300 kg against an estimated self-sufficiency level of 10,000 kg did not suggest this nationally, particularly since 30-40% had presently to be purchased.

Relationship between CBLA and RTCs

- i. CBLA and RTCs were presently run largely independently with little communication between them.
- ii. Little central planning had gone into how the threefold increase in plasma would be achieved.
- iii. The plasma target set by the Department had taken no account of RTCs ability to achieve it; no financial help had been given to regions for plasma procurement.
- iv. Lack of communication meant RTCs had little idea when BPL might come on stream. Delay had caused some RTCs to postpone plasma procurement plans.
- v. Some RTCs were maximising the plasma which could be frozen within 8 hours to increase Factor 8 yield; others were not. BPL's move to pooled batch production brought into question the need to devote resources to maximising 8 hour plasma.

- vi. CBLA needed to keep RTCs informed of new product planning.
- vii. RTCs needed to tell CBLA of clinicians problems with existing products and of their needs for new products.
- viii. There seemed to be no mechanism through which jointly agreed plans could be implemented. An example of the failure to implement agreed plans is the proposed use of freezer trailers to transport plasma to BPL: at least one RTC had ignored this.
- ix. A minority of RTCs bore the brunt of specific plasma collection. Better RTC co-ordination would ensure maximum collection of this scarce resource.
- x. CBLA's advocacy of the wedge-pack bag seems to have been without full appreciation of the implications for RTCs (collection and processing blood). Uptake of the wedge pack bag has not therefore been universal.
- xi. Both communication and co-ordination are hampered by the fact that CBLA must negotiate with 14 RTCs separately rather than one representative body.
- xii. RTD meetings should fulfil this role but do not appear to do so. More effective liaison should be possible within the present framework.

Interrelated nature of decisions for the future of RTCs and CBLA

- i. Cross charging was cited as an instance. CBLA believed the benefits to them would include control of quality, quantity and continuity of plasma supply and that the effective collection and use of finished product would be encouraged.
- ii. There was no consensus view of the merits of cross-charging amongst RTCs. If increased plasma production could be achieved without it, all RTCs visited and CBLA would be content not to pursue it.
- iii. Once self-sufficiency was achieved, Factor 8 issue should be related to the haemophiliac population which was not evenly distributed between Regions.
- iv. There was a suspicion that regions who supply large amounts of plasma against general population targets already have a surplus of some products.
- v. CBLA's pro-rata distribution initiative did not produce a predictable return of product to individual RTCs. This was because the amount of product received is a function of the total plasma supplied as well as of each Region's contribution. Some Regions would reach targets early which would benefit them initially. But the product return would fall as other Regions caught up.
- vi. It is clear that some Regions are subsidising others and this will be made apparent once self-sufficiency is achieved.
- vii. Degree of CBLA/RTC liaison did not match the special inter-relationship which existed.

Computers

- i. All RTCs used computers to some extent but only 2 were fully computerised, ie from donor call-up to blood product issue.
- ii. There had been no co-ordination of the computerisation process resulting in considerable hardware/software variation.
- iii. Common functions, eg blood banking, had been computerised differently.

- iv. Few if any systems were compatible.
- v. Management information provided was not uniform.
- vi. Only the barcode system for blood bags/products was uniform.

Computer System design

- i. RTCs had tackled system design differently. Some designed in-house; some utilised RHA expertise; some bought commercial packages.
- ii. Financial restraint had restricted options here as elsewhere.
- iii. Some RTCs have recognised that co-ordination with hospital blood bank computerisation is desirable; most however had developed in isolation.

Computers as a management tool

- i. Computerisation offers the opportunity to produce effective Management Information Systems.
- ii. In the short term neither commonality nor compatibility are practical propositions because of the large capital investment already made in existing systems.
- iii. A more clearly defined organisational structure for the NBTS would allow the benefits of computers to be fully recognised.

Overall

- i. The general observations that we would wish to make at this stage are that the variations, overlaps and duplications of functions suggest the need for greater co-ordination or organisational change to produce:

savings, standardisation of materials and procedures, better products and service and equality of service, and in relation to plasma and platelet requirements and the supply problems in London to ensure the rational and maximum exploitation of basic raw materials.

Some tentative solutions

To beef up the existing organisation via greater and more effective co-ordination. This would require a degree of voluntary compulsion but overall the question of funding could be a potential and continuing problem.

Alternatively to re-organise based on a location or locations in Regions - it would be a question of what functions are done where, how managed, what levels of decision making and what lines of accountability need to exist. Also consideration of how to fund and where CBLA fits in.

Discussion of Progress Report

- 5. The Chairman thanked NHSMS for their Tour de Force.
- 6. Members advised the Study Team of some of the reasons for regional variations in practice and procedures. Selection of donors was determined under Guidance for the Selection, Medical Examination and Care of Blood Donors; RTCs were governed by RHA policy in determining "best buys"; RTCs preferred their own products to BPLs in some cases; geography determined the method of plasma collection. RHA funding determined computer systems.

7. Central planning was absent, but Dr Fraser said equal status with CBLA was necessary to achieve this. With 14 RHAs there could be little uniformity. It was accepted that Doctor to Doctor ordering was already having a beneficial effect upon albumin consumption.
8. Professor Scott advised that average consumption figures for albumin did disguise the outliers on users of this product. He hoped the Study Team would also record instances of good practice, for recommendation in the final report. Mr Jordan advised that organisational changes would be recommended, but he could not yet advise the key indicators.
9. In response to a query from Mr Binns about blood issue policy, Dr H Gunson's book "Future Trends in Blood Transfusion" was recommended.
10. It was confirmed to Mr Nicholls that cross-charging as a policy had been suspended pending the final NHSMS report. He was surprised that quality control varied so widely nationally.
11. It was agreed that the disturbance factor in re-organisations should not be underestimated.
12. The Chairman called for final comments of a general nature.
13. Members considered that requirement for blood would increase and be hampered by continuing concern over AIDS.
14. Dr Fraser considered managers of RTCs should be medically qualified.
15. The NHSMS team said that the Service needed to be more effectively managed; by whom was for members of the Steering Group to consider.
16. It was considered by Dr Fraser that the output from BPL had not matched expectations, although plasma had been supplied to them by RTCs. The Centres had lost credibility with RHAs as a result.
17. The Chairman hoped that the minutes, which would include a summary of the reports given, would be in the hands of members within the next few weeks.
18. NHSMS would hope to prepare a draft report, with some recommendations and to be sent to members before the next meeting.

Any other business

19. There was no other business.

Date of next meeting

20. The next meeting was arranged for 2.00pm on 28 April 1987 at a venue to be notified by the Secretariat.