**ADL - Leigh McJames 1#**

Good morning. I acknowledge the traditional owners on the land on which we are meeting, I pay my respect to their elders past and present and the elders from other communities who may be here today.

I thought those who are in doubt of why we are here today, hopefully that opening video reinforced in your mind why the standard is important.

My name is Leigh McJames. I am the General Manager of the Blood Authority. I'm also your MC for the day and as I said at the first symposiums, treat me gently, it's not my regular day job.

On behalf of the National Blood Authority, the Australian Commission on Safety, Quality and Health Care and the South Australian Department of Health it is my great pleasure to welcome you to this inaugural national blood symposium in Adelaide. We appreciate your time and interest and we have an agenda that is cram packed with speakers.

First up though I will cover off a few administrative details. You may have noticed the agenda is very full. That has implications for timing and generally the presentations are between 30 and 40 minutes so could I ask you to be pretty prompt on the breaks. We'll try and make sure we can fit in what questions we can but it will depend on speaker by speaker. What I can say though is we've allowed a fair bit of time at lunch and morning tea and afternoon tea for you to network. The reason for that is most of the implementing of the standards is done from learning from each other or the people actually doing the job out there. There is a lot of good work going on in hospitals across the country and so I would encourage you to use that opportunity to network. It's probably one of the great values of these symposiums.

Where we do have time for questions we have a microphone runner. They will run a microphone to you. We are filming all the presentations of all the symposiums and they will be loaded on our website in a couple of weeks so we just need to be able to record you so that those people that aren't here and want to watch the presentation can hear what your questions are.

Those people concerned about being photographed, there is a blank area up here in the left hand corner so if you're photo allergic or you don't want your photo taken that's where you should sit. If you need to prove that you're here today move out of there somewhere else.

The rest rooms are to the right just where the coffee stand is there and you veer to your right. We're actually going to have the meals here in the presentation room, so we'll just see how that works and I ask for your tolerance with that.

The speakers we have got today and we have a range of them, to keep things on time there will be a mysterious man standing at the back with five minutes to go who will hold his hand up like that or it may even be a lady, so watch for the person with their hand up, they're not actually asking questions, they're warning you, you've got five minutes to go.

The other thing in a day we can't possibly cover all the topics in the detail that you need to cover so the purpose of this is to whet your appetite and provide you with other sources of information. We have a range of staff here at the registration desk and also at the back that can point you in the direction for more information and I'll cover off on a little bit of that as we go through.

In terms of my presentation, I'm going an overview of what the day's about and that will start with why do we need these symposiums, why do you need the standard and how does it affect you and that will be from the National Blood Authority's perspective. We've got Dr Michael Smith from the Commission who will follow me and give the Commission's perspective. I'll then talk about the symposium aim and the program and then perhaps the more important element is whet your appetite on what materials are either in existence now or under development to support you in implementing the program.

In terms of the need, the National Blood Authority's perspective is we've got a very clear vision of what the need for the standard or implementing the standard is and what it would deliver for our part of the business. National Blood Authority is responsible for ensuring Australia has a safe, affordable and secure supply of blood and blood products. The standard was developed or certainly we contributed and assisted the Commission in developing the Standard 7 on blood and blood products. We continue to work with the Commission and these symposium series are co-sponsored with the Commission.

Our part, the standard and I think most people now have gone through accreditation, looked at it, it's changed the game in terms of blood and blood products. It is actually, you are getting transfusion committees are not just something that happens and it's a bit of a process. The outcomes from transfusion committees now should or will be, through accreditation, considered at the actual management level or executive level of a health service.

Probably the first priority for me and as the video clip indicated, is the outcome we're looking for is improving appropriate use. Why did I put that number one? Well it's because current practice is causing harm and so we see the standard as a way of implementing patient blood management or supporting the implementation.

The second one is to reduce wastage through improved inventory management.

In terms of the first one, as indicated by Professor Isbister in the video clip, we think there's a real urgency in improving appropriate use of blood and implementation of a standard.

The quote on the screen is from the PBM guidelines which are based on a systematic world wide review of all available evidence. Those patient blood management guidelines and the third speaker is Daryl Teague and he'll actually talk to it but these guidelines are world first and are bench mark materials.

In more direct terms to the quote on the screen and you would have heard this before but blood transfusion is a liquid transplant, it can cause measurable harm with each exposure. The evidence suggests that current clinical practice is resulting in unnecessary transfusions and a potential for patient harm.

The second outcome of interest to us is to reduce unnecessary wastage. I personally think this is a no brainer. Currently wastage rates are very significantly compared to best practice. The total national cost of wastage of blood is in the order of $30M. This is simply unacceptable not only in terms of cost but perhaps more importantly in relation to the waste of a donor's time and effort. On current figures approximately 70,000 or more than 70,000 donations, so that's individuals that have given up their time and effort to donate and we're throwing out 70,000 of those donations. Obviously some wastage is necessary to ensure availability but to be honest we are a long way from what I would deem acceptable.

In terms of the aim of the symposium it's pretty simple, it's to support you to implement Standard 7 on blood and blood products. As I said it's not going to answer all your questions and may create more questions but it will give you the basics and the guidance on where to go next.

The National Blood Authority and the Commission, I know the South Australian government, we want to support you in any way we can. So as you're sitting hear listening to the presentations today and saying that's all very well but it's a pity they didn't do this, I am keenly interested to hear what else you want us to do.

The actual program, we've got a range of very impressive speakers that will provide you with, in the first instance, an overview of the National Safety and Quality Health Service Standards followed by a clinical perspective of the standards of the practice. This will provide you with a foundation for a series of structured presentations around the four criteria and those presentations are pitched to give you practical real tools, at least benchmark examples of what other health services have done to successfully, to give you some practical demonstrations of how it can be done.

Criteria one on governance and systems for blood and blood products prescribing use very much talks to the appropriate use objective and requires health services to have in place systems for the safe and appropriate prescribing and clinical use of blood and blood products.

Criteria two, documenting patient information, requires the clinical workforce to accurately record the patient's blood and blood product transfusion history. Based on the earlier symposiums this is a really hard area for a lot of health services and I highlight each of these criteria because these presentations have differed in each Melbourne, Sydney and here, if your area of responsibility or interest is for example patient information I would encourage you to look at those presentations given in the other capital cities to give you further ideas.

Criteria three, managing blood and blood product safety, is very much about the wastage objective and requires health service organisations to have systems to receive, store, transport and monitor wastage of blood and blood products safely and efficiently.

Criteria four, another problematic one and if anyone's got a patient consent form where there's universal agreement this is the solution I would love to meet you because it seems to be a very hard area to get consensus.

In terms of that particular criteria, obviously it's more than just a tick on a form

that someone consents, it's actually that the patient has been told about the risks in relation to transfusions, the benefits and the alternatives and what plan the health service has in place to manage the patient.

Then we're going to move onto other support that's available. In the next 12 months the National Blood Authority will be publishing a range, my apologies I've jumped a page, the National Blood Authority in collaboration with the Commission and other states and territories and other key stakeholders such as the Blood Service are developing a range of measures to support you. These fall into three year programming which is divided between two strategies and shown on the screen, one a national blood wastage reduction strategy and the other a national patient blood management guidelines implementation strategy, obviously reflecting the two key objectives the National Blood Authority is interested in. Generally the supporting measures fall into four major groups which are awareness and promotion, the symposium forms part of those measures; best practice tools, education and training and data.

Now I'm going to give you a quick overview of what is under each of those categories and their various stages of development. As I started before, the National Blood Authority will publish a range of best practice tools on their website to support implementation of improved inventory management and patient blood management. Those who have happened upon our website would have seen some of those tools already in existence and available for download. These will form part of a national reference set that draw on the work being done across Australia and states and territories by key stakeholders such as the Blood Service.

What we're trying to do here at a national level is avoid replication, make life as easy as we possibly can for you so rather than you having to sit in your hospital in isolation and produce something from first principles there is a source here that you can go to download, badge as your own, change as you see fit, recognising that we're all individuals and we're all special and it will be based on best practice across the country and we've got some great best practice across the country. We have the luxury of sitting in Canberra and we can see the best practice from Brisbane right across to Perth. So what we're trying to do is draw down on where that is and create this reference set where you can pull it down and claim it as your own.

We're also recognising a full PBM program is a significant piece of work. I'd probably put it out there. No one has successfully got a full PBM program in place yet but certainly hospitals have elements of it. So what we've done is we've tried to frame the rollout of these tools where there's an early win, so you may not be able to implement a full PBM program but you maybe be able to, for example, introduce a restricted use protocol in your hospital. The intention is success builds on success. Small steps at the start provides the foundation for larger steps and builds confidence.

As mentioned one of the first tools and it was one of the first tools because we see it as a nice discrete package you could think about implementing is restricted use policy. A number of hospitals have already successfully implemented such a program and it's based on those successful programs. It's been subject to extensive clinical review and also public consultation. It's extensive, it's got all sorts of stuff in there, you may not need it all, so you can tailor it to your particular

needs. It provides you with templates you can download and modify for your hospital including badging and as said it's easier to implement than a full blown PBM program. Your satchels include some material on this tool.

In the same vein and exactly for the same reasons, one coming fast on its tail is interoperative cell salvage. The protocols and guidance for that are currently out for public consultation. We expect the full package to be released in October.

Cell salvage is important because it's a recommended alternative to allogeneic blood transfusion and the reality is your own blood is better than allogeneic blood or someone else's blood.

You may also if you have happened to cross our website is seeing a growing number of case studies on the website how other hospitals have delivered improvements. What we're trying to do is facilitate our network across the country where you can draw on best practice. As part of that program there are four shown and you will note that one of them is from South Australia in terms of benchmark transfer arrangements or project and today's presentation, so the point here is we're keen to hear your good stories. So if you've got a benchmark story let us know we actually want to use it to celebrate it and put you up there in lights for other health services to draw down on your experience.

As indicated the NBA will be publishing over the next 12 months a total of about 20 or so tools, the first two I've mentioned. This includes everything from draft business cases and I'm aware that's a key problem when you try and implement change, lack of a price on blood makes it difficult to get money, through to patient consent templates. Each of them is based on existing work by state and territory which is then refined for you to download.

We also recognise that what works for one hospital may not work for another. It's quite interesting those case studies I put up there before, if you actually watch two of them, one hospital does something diametrically apposed to the other hospital yet they both achieve outstanding results. So we're not arrogant enough to think we have the perfect solution, it's an example that just depends on the people, the power centres in the hospital, a whole range of factors.

As mentioned, these tools will be put out for public consultation. There's a lot of material, as we develop these materials out, if you have an interest or it's a particular area of speciality for you we'd welcome your comment. Certainly before the tools go out for public consultation they've had some review by our special friends and our special friends are people that generously give us their time to actually develop the tools but then there's an opportunity that if you have a particular interest you can provide comment before they're actually published.

We also welcome your ideas. The change we're trying to implement is there is no silver bullet here. We are advancing on a wide front along with governments, along with the Commission. Improving appropriate use and inventory management, I don't know any single measure that will solve the problem so if you have something that you can suggest to us and we've had a range of suggestions in the first two symposiums. Let us know, we're willing to take it up and work on it.

The example shown there is a little thing, the price on a unit of blood. Some

people would debate what affect is has, I acknowledge that but my view is it has some affect and so if you have a good idea let us know.

On the data front we've progressed a range of new BloodNet reports and you'll hear a little bit more about that this afternoon. That's to support you to actually, particularly in the wastage space at this moment, appropriate use is a little bit more problematic, so you can see where you are at the moment, see how you're progressing and measure your actual performance. We also expect to provide you with some benchmark data to support businesses cases in 2014.

This is a picture of the BloodNet user group. There may even be some individuals who are here that participate in this group, are there Peter? So welcome and thank you. We're very keen to engage with you at the hospital and to make sure what we deliver matches your need and this particular group is an example of that and we appreciate their time and contribution in developing the user requirement for the reports.

Another significant area is BloodSafe eLearning. This is in the education and training space. This is really our flagship at this stage, although we have a range of other measures in terms of engaging the colleges and societies and the front end of training but BloodSafe eLearning is our flagship and they currently have a range of PBM tools under development. And I might mention here the downloads of the people participating using these modules run into the hundreds of thousands now and some hospitals are actually mandating their training modules as part of their internal accreditation process. So well done to that team because they are based here in South Australia.

My presentation was intended as an introductory once over lightly of what the aim and program for the day is and some of the wider support available.

My last slide is a good news story and hopefully it encourages you. The chart shows that we are already making progress and if you look at that bar there from July 2012 demand for fresh red cells in July compared to 12 months before, it was going up at 4% and that's how it's been going across the years, although it started tapering. Twelve months on, this is August 2013, in the month of August 2013 compared to 12 months ago demands for red cell had fallen, real demand, not budget, by 13%. It's very impressive. That change has happened in every state and as reflected nationally. There's a lot of room for improvement though. I have a great debate and I even have bets. I think Stephen is here and from the Blood Service when we discuss how the Blood Service is going to manage this decline and so there are administrative discussions but we actually have a bet because I'm a believer we've got a lot more room for improvement. Certainly it's a crystal ball though as to what the final base could be.

As I say we think this is only the start of a change where you could put Australia in the forefront of best practice blood management.

I'd just conclude by saying implementing the standard is a critical element of achieving those first two objectives I mentioned. The beauty of it though is it's a win/win. It saves scarce resources by reducing unnecessary mortality and morbidity. It's an easy argument to mount.

That concludes my overview. Are there any questions? Daryl?

*How did you arrive at the $345.45? That must be the Woolworths special price for blood I think.*

One of the and just a little bit of background because unfortunately everyone forgets history. When any organisation does something the prices and I know there are some disparities in terms of pricing, that was the first hit, the prices never used to be available. So our first hit, by the time you took overheads and they're loaded across different products, there are some areas that could be improved Daryl would be my short answer. So I'm not saying, really their order of magnitude and you're absolutely right, some of them are skewed. One of the ones that I know the anaesthetists are hot onto the NBA about is the price of cryoprecipitate, which I think is at $40. Well obviously it's not $40. So we're aware of that. We're doing a review of pricing with the Blood Service at the end of this year so you'll see some adjustments.

I think on the main units of blood and plasma and cryoprecipitate, they're sort of in an order of magnitude and I know there are problems for example in paediatric units compared to adult units. We're aware of that. There will be probably a new pricing coming out early next year. Is that fair Stephen? Yep. Any other questions?

*Can I go on with that? In this state we don't have it actually costed back to hospital budgets etc. but it is in other states and perhaps you might say something about that. Is it going to happen in South Australia? Can we expect it? Is this a national policy that's going to gradually be introduced?*

I'll do some introductory remarks and we've go Sue Ireland here. I'll give a warning, I'm going to throw some heat on her for the South Australian perspective. From a national perspective, we've currently engaged the Independent Health Pricing Authority who does the pricing for activity based funding and everyone's aware of that. The lack of blood in that is a problem. If you're putting a business case up for sell salvage machines, the ongoing overhead for training staff, look I'm really sympathetic, I worked in a hospital before this job, so get your business case up. If you can't show the dollars it's damn hard because you sort of get deaf ears when you say "it's good for the patients" "yeah, yeah, yeah, okay but where's the dollars". We're acutely aware of that.

At this stage the first phase of that project is to look at technical feasibility. Everyone here would be aware data on blood use, specifically where it's used and why, some hospitals may have it nailed but most don't and most of it's paper records. So that's the technical problem we've got with putting the price under the national arrangements.

I would say nothing is going to happen nationally for three years to be perfectly frank. Even once it's technically feasible and we're pushing hard for it to be done to support you at a hospital level, we've still got to get over some policy issues. Now the current legislation mandates that blood is a free, voluntary remunerate system and blood is free. That's government policy. To change that will take a fair bit of effort.

I'll come back, I'll invite Sue now just to comment on the South Australian perspective and then I'll come back to say there is some good news though Mr

Frodo. Sue.

**Sue Ireland**

Hi, I'm Sue Ireland. I manage blood organ and tissue programs in SA Health and SA Health has been looking at the lead taken by Queensland New South Wales and Tasmania in which within the public sector there has been some what they call devolution of budget so the hospital have a budget for blood and there is some accountability introduced at that level. So yes, SA Health's actually reviewing that at the moment. There potentially good be a process put in place for public sector but as Leigh has so eloquently shown, it's complex for the private sector because of the funding and the policy arrangements and I think we'll have to wait probably for some lead from the Independent Health Pricing Authority before it will impact on private hospitals. So I would say we will be having a look at that over the next six months and what's this space.

**Leigh James**

Thanks Sue.

The good news, the product is the minor part of a business case. We're actually doing a project at the moment that shows the product sits about let's say $400 per unit. It's an inverse pyramid. The second tier is the administration. There's been some really good work done by Linley Bielby in the Blood Matters program at the cost of actually tracking all the overhead costs, administering, the transfusion nurse costs, the time it takes to actually do a transfusion. All those overheads have a cost; and the top one and this inverse pyramid is just, it will blow your mind, we've got some initial figures, of what is the cost of adverse affects of transfusion, the extra day in ICU. It only has to be a day and you're talking in the order of 10 to $20,000. It doesn't take much to justify a business case if you can demonstrate and point to an authoritative document that said for every transfusion it costs this in adverse events because of extended stay in wards, extend stays in ICU, that is the way we will put out material that will support your business case. So the product cost frankly it's a minor cost. Some of the figures we're looking at, the fresh blood costs in the sector is running at about $350M at the moment per year. Our figures on the cost of adverse events which result prolonged stays, readmissions, extra time in ICU, run in the order of $3-$5B nationally. So what we're trying to do is produce some authoritative stats for you to use and say "this is the saving" and we think it will easily demonstrate the cost effectiveness of cell salvage of a transfusion nurse. I mean you all know that transfusion nurse saves money just on product alone, so we're pretty confident this will be a very strong data to support business cases in the hospital.

I'm going to have to conclude there because I'm taking up more time than I should have.

I am very pleased to introduce our next speaker. It's my great privilege to introduce Dr Michael Smith. He's the clinical director at the Australian Commission on Safety and Quality in Healthcare, he has been a medical practitioner for 37 years, he's got a clinical background as a senior palliative care specialist in a tertiary hospital and a community based practice in three states. In 2002 Dr Smith was appointed the Director of Clinical Operations for Western Sydney and in 2004 was subsequently appointed as a Director of Patient Safety

and Clinical Quality for New South Wales Health. As I said before the Commission, your strong partners and we very much appreciate Michael coming across to give the Commission's perspective of implementing standards.