South West Patient Blood Management Group Minutes
Tuesday 15th September 2020
Via Microsoft Teams

Present:
Elmarie Cairns, Chair (EC), Sam Timmins (ST), Christina Laxton (CL), Oliver Pietroni (OP), Carol McGovern (CM), Kelly O'Toole (KO), Lorraine Mounsey (LM); Michelle Davey (MD), Lisa Manser (LM), Ed Bick (EB), Caroline Lowe (CL), Ian Mowat (IM), Julia Pinder (JP), Jackie McMahon (JM), David Quick (DQ)

Apologies:
Barrie Ferguson, Alison McCormick, Vikki Chandler-Vizard, Lorraine Poole, Jan Howells, Christopher Smith, Ian Sullivan

1. Welcome & Apologies for Absence

EC opened the meeting, welcomed all those present and outlined the meeting format. Apologies are noted above. This was EC's first meeting as Chair and thanks were given to the outgoing Chair, John Faulds, for the excellent work he had undertaken on behalf of the group.

2. Summary of Previous Meeting & Matters Arising (not covered in main agenda)

Share BCC business cases: EC reiterated that the sharing of business cases for blood conservation posts and services provides a powerful tool for other trusts trying to progress PBM and encouraged participants to share if happy to do so.
Share information on Transfusion team WTE and bandings: Again, it was felt that this would be useful for anyone looking to expand their services. **The information received has been collated and will be re-circulated with the minutes.**
UKCSAG update/SWRTC representation at national level: ST fed back that the group is going through a period of re-structure and once this has been implemented, we can put forward a representative from the south west.

3. Regional Transfusion Team (RTT) & PBM Update, inc. PREVENTT Summary

RTT: Stuart Cleland, Consultant Anaesthetist at Derriford was appointed RTC Chair, effective January 2020. The RTT has also been strengthened with new members, including the appointment of Paul Kerr as Consultant Haematologist. The meeting prompted a review of the revised NBTC revised ToRs, the guidelines that all the regional RTCs and their working groups abide by. An area under review is outcome measures, which includes the provision of regional data and benchmarking, development of good practice guidelines, audits, education, (including education via the RTC working groups) and ensuring working groups' actions are completed by agreed deadlines. To enable this, all the RTC objectives and working group actions are amalgamated into the RTT Workplan, which is regularly reviewed. **Actions for the PBM group are to ensure timely publication of minutes on the JPAC website, and to demonstrate they are working in line with these ToRs. Outputs need to be clearly demonstrated in order to remain an RTC-funded group.**
PBM: The PBM Toolkit has been launched to support the application of key PBM activities. Coming soon is an online pre-surgery optimisation toolkit and a three-part anaemia e-learning package. A pilot of the Blood Assist app is underway – this goes through all actions of transfusion. The 'A Drop of Knowledge' and 'A Wealth of Knowledge' resource booklets are being updated.

NCA: The audit of major haemorrhage is now live and showed that practice has improved. The maternal anaemia audit is published but not yet live. Results show that screening for maternal anaemia is very good. HALT-IT recommends not to use TXA in GI bleeds.
PREVENTT: ST attended the Summary of Results webinar on 5.09.20 and presented a summary of the trial and its findings, which were not what we were expecting. As everyone is trying to build better anaemia services and give better patient care, ST invited comments on the potential impact on emerging or existing services:

- IM, RBCH: We haven't changed our iv iron policy since the publication of the trial but it highlights we are set up to fail in the system we work in. In vascular we have 8 weeks from referral to treating AAAs, so not enough time for them to be seen and assessed and get their iron treatment so the trail does reflect real life – if we don't have time to treat, should we be treating? We are trying to move pre-op anaemia screening to primary care to catch and treat earlier.
- OP, RCHT: A well-designed trial but not the result we were expecting. Perhaps if the iron deficient patients had been sub-grouped, it may have shown a better quality of life post-op as they are the group most likely to have had a better response to iv iron. We have been trying to drive recognition of IDA pre-operatively, particularly in cancer patients who have a short turnaround from pre-assessment to surgery, and I think whilst still important this probably takes the pressure off us to treat those patients pre-operatively and perhaps move the treatment of those patients to post-operatively. There is still a definite improvement in their Hb post-operatively through having received iv iron and it is really interesting that that doesn't correlate in an increase with patient reported quality of life because that does not fit with other studies and again the reduction in re-admissions was interesting as well so treating patients' anaemia does seem to reduce post-operative complications. Do not anticipate any big changes to current practice.
- CL, NBT: A disappointing result and does conflict with other studies which have shown an improvement in quality of life so that was the disappointing bit with the Hb results. However, it is about understanding the patient cohort – the trial included a lot of patients having quite major abdominal surgery so six weeks is pretty short to be evaluating quality of life and tiredness. We know from cardio-pulmonary exercise testing recovery can take up to three months so to be able to evaluate the impact on Hb rise or id correction would need a much larger cohort of patients. Not sure if these results are translatable to other specialities.
- ST: Agreed, and some patients potentially still undergoing other treatments which will impact how they perceive their quality of life.

Will it impact the setting up of pre-op services or affect those already in place?

- OP, RCHT: Pre-assessment and getting people ready for surgery is about assessing people and looking at their risk and then making an intervention to try and reduce their risk. We know that anaemia is a potent multiplier of adverse outcomes so we can't rely on the results of one trial to reduce that risk. Treating with iv iron is more cost effective than not treating and having more re-admissions.
- EC: It might show a move to treating more people with iron post-operatively – maybe beneficial for some patient groups with shorter treatment pathways, like cancer and vascular, to be optimised post- surgery with rapid iron.

- OP, RCHT: Do not have a clearly defined pathway but patients with a pre-op IDA that were not treated pre-operatively are given post-op iv iron in recovery. This also applies to surgeries where there has been major blood loss and Hb hovers at less than 90 in recovery, when it will be given rapidly over 20 minutes before they return to the ward. All recovery areas have a stock of iv iron and it is electronically prescribed. Have got a pharmacist onside who has helped drive forwards. Have had a few issues out of hours.

EC closed the discussion by reiterating that the group can offer support to anyone that does not yet have an anaemia service, or for any questions or queries.

4. Setting of Programme for Next 12 Months:

A well as providing benchmarking for the region and feeding back on project and audit collaboration, ST invited feedback on adding an educational element to the group, either via companies sharing some expertise or as a forum for other trusts to share their own audit or project work. We could have a day split into two sessions, e.g. pre- and post-op anaemia in the morning with cell salvage in the afternoon and people can choose which sessions to attend. **Is this what everyone wants or is there anything else the group should be providing?**

Two potential project options are Maternal Anaemia, which is a general RTC objective, and TXA which is a rolling regional objective. **Although everyone has a TXA policy in some form in place, is there any work to be done comparing how it is utilised in different trusts?**

EC re-emphasised the wealth of knowledge we have in the region with some great work going on so would be good to utilise this forum to share work people are doing within their trusts. **We would value people's opinions on what they would like to get from the group over the next 12 months and people are encouraged to email any suggestions to EC.**

5. Cell Salvage Survey

This has been running for a number of years and historically it has always been difficult to reach a consensus on data capture as it is not always the same people attending the meetings and there has been a lack of consistency with the data people are able to provide. Enthusiasm for the project has also waned due to the amount of data required, a lack of direction and clear outputs and a complicated list of procedure headings.

ST suggested that as the majority of trusts in the region use cell salvage, it would be worthwhile to carry on collecting data but in order to do so we need to know data can be provided and what outcomes are we aiming for. A short survey to find out what data trusts are capturing (6/17 trusts responded) showed the key things that everyone collects are patient id, procedure and volume of autologous blood reinfused. It then varies with specialties, types of procedure, volume of autologous blood that was reinfused. The majority of trusts did a pre-op Hb but did not necessarily capture a post-op or intra-operative Hb and, again, things like TXA, Rotem were not routinely recorded. Only two trusts responded with the specialties they used cell salvage in – ortho and maternity – so if we are going to take it forward it might be worth just basing it on one or two specialties.

Following discussion it was agreed that we redefine and minimize the data we want sent in each month and aim for a regional comparison of activity on what is

processed and returned which will give us regional pointers on who is doing what and this could be something that is rolling and reviewed twice a year. To have more impact, we would probably need to look more at patient outcomes which would mean trying to record post-op Hbs. The aims and goals are very much going to depend on what people can capture. If we can show the benefits and clear, defined outcomes from using cell salvage, we have the basis for delivering some really interesting information.

OP agreed that having a survey about the differences in the SW and what we are using cell salvage for would be interesting but in terms of collecting post-op HBs, etc, it would have to be in context for it to be useful so you would need to be able to look at cell salvage use against non-cell-salvage use for the same operation. So the cell salvage database could be useful for comparing what each trust is doing, blood loss, how often do we re-infuse patients, what are the volumes, etc, but the post-op outcomes need to be compared to people not getting cell salvage for them to be interpreted.

CL suggested that we could take a more targeted approach over a short period of time, focusing on hip replacements for instance, and then compare the outcome data regionally.

Action: ST/JM to review current headings and recirculate information we want to capture for regional data set. Going forward, we will review the data half yearly and look at potential regional outcomes once data collection is established. We can offer some help with recording the data and also have access to a data analyst if this is something we are going to take forward.

6. Open Forum/Discussion on COVID-19 Impact

- NBT: have had to put the business case for another anaemia practitioner on hold and due to the impact of the block contact arrangement on income from iv iron, the service isn't currently generating any income. However, the benefit is we can do one-stop clinic appointments as previously they had to come in as an in-patient to generate the tariff for iv iron. This is better for the patient as they can be treated with iv iron on the same day so unsure what we will do when block payments stop. Although CQUIN is on hold, have had a trainee anaesthetist look at current compliance with CQUIN targets and it has been good to re-look at our pathways. Happy to share any information around this.
- RCH: a lot of elective surgery went on hold during the COVID-19 peak which meant less pre-assessment which was just as well as the PBM team were relocated to take on other haematological services.

7. Any Other Business

Long empty cycle issues at NBT: Haemonetics are investigating and MHRA aware. Issue is with waste bag since latest software update, so have changed practice and re-trained operators which has currently stopped it happening. Not connected to the field safety notice about cracked bowls causing the long empty.
Black particles at RCH: CM/OP updated/gave some background. 11/1200 cases of black particles in the bag since January 2019 and is now on risk register. Only site in the world with this problem according to Haemonetics. OP strongly recommended thoroughly inspecting the quality of cell salvaged blood after it has been processed and reporting all issues through the correct channels**. OP also requested to be alerted if any other trusts experience similar issues.** Haemonetics slow to pick

quarantined packs up and sometimes the particles have disappeared by the time they get them. Analysis of one revealed a zein protein but Haemonetics don't use this in their process. Currently no closer to working out what it is and whether it is safe to give these black particles back to patients. Have tried putting one through a leucodepletion filter to see if the particles were disappearing within the blood itself which might be captured and retained in the leucodepletion filter but still waiting for feedback. Understand that Poole may have seen some so waiting to hear back from them. Real mix of cases – obs, gynae/oncology, ortho, paeds – but only with female patients.

Early Wash Triggers at RCH: This happened with a brand new machine so had it reconfigured but still an issue and operators are having to override if a wash is triggered before there is enough in the bowl. One instance of having to override 5 times which raises concern about supernatant being washed out. Again, Haemonetics don't know why it is happening. They have suggested it could be when haematocrit is high but it is happening in procedures where you would expect haematocrit to be low. **Please let CM know if you are experiencing similar problems.**

Incident Reporting: CM sought clarification that as well as reporting these incidents via the usual channels they also needed to be reported via the Yellow Card system on the MHRA website. EC confirmed that this was the case each time an incident was reported as it involved a medical device and also emphasised the importance of everyone following the correct reporting process, however onerous, to ensure we are getting the full investigations we need to be reassured what we are giving back to our patients is the best quality.

EC requested that everyone use the group to report any problems that they are experiencing with cell salvage.

8. Date of Next Meeting

January 2021

ST asked everyone to complete a short survey that will be circulated following the meeting so that we can use the feedback to make the next meeting as productive as possible.

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Action Log

Action	Actioner	Completed
Circulate information on Tx Team WTE/Bandings	JM	
Comments invited on education for the group, TXA survey, group outputs over next 12 months	All	
Circulate revised cell salvage data set headings	ST/JM	
Feedback any cell salvage quality problems	All	