South West Transfusion Practitioners (SWTP) Business Meeting
Via Teams
23rd February 2021

Attendance:	Trust
Stuart Lord (SL) (Chair)	Gloucestershire Hospitals NHS FT
Mooi Tay (MT)	North Bristol NHS Trust
Karen Mead (KM)	North Bristol NHS Trust
Egle Gallo (EG)	North Bristol NHS Trust
Sally Charlton (SC)	Great Western Hospitals NHS FT
Michelle Davey (MD)	Somerset NHS Foundation Trust
Julia Pinder (JP)	Torbay & South Devon NHS FT
Siobhan Hunter (SH)	Cornwall Partnership NHS FT
Pedro Valle-Vallines (PV)	Royal Cornwall Hospitals NHS FT
Helen Maria-Osborn (HM)	Royal United Hospitals Bath NHS FT
Alison Hill (AH)	Yeovil District Hospital NHS FT
Fran Morrison (FM)	Great Western Hospitals NHS FT
Lorraine Mounsey (LM)	University Hospitals Dorset NHS FT – Bournemouth
Barrie Ferguson (BF)	Royal Devon & Exeter NHS FT
Rebecca Oxley (RO)	Spire Hospital Bristol
Sarah Salisbury (SS) (HF Training)	Salisbury NHS Foundation Trust
Susan Scott (SSc) (HF Training)	Royal United Hospital Bath NHS FT
Sam Timmins	NHSBT
Jackie McMahon	NHSBT

Apologies:	
Julie Ryder	Great Western Hospitals NHS FT
Caroline Lowe	University Hospitals Plymouth NHS FT
Abi Parsons	Royal Cornwall Hospitals NHS FT
Julie Mitchell	Royal Devon & Exeter NHS FT
Laura Davenport	Northern Devon Healthcare NHS Trust
Anna Gillard	Nuffield South West
Nick Bills	Nuffield Cheltenham
Victoria Jones	Circle Healthcare, Bath
Greg Garrett	North Somerset Community Partnership

First full meeting since September 2019

Welcome, introductions and Teams Housekeeping:

Stuart Lord (GHNHSFT) introduced himself as Chair, followed by round-table introductions.

Round table COVID reflections

MT – Lessons learned from changing bedside checking practice to adapt to the COVID environment.
HM – Places that worked the best were the ones prepared to be flexible and agile - lots of positive experiences with people being amazingly adaptable but also experienced people being extremely rigid. Had to move all tx patients to local private hospitals which was quite a challenge. Constantly problem solving and having to allay anxieties and make sure people were comfortable with the processes. Had to

adapt to a fast changing environment with policies changing daily - our worst time and finest hour at the same time!
SC – Also moved all haem/onc day cases to private hospital. Highlighted amazing teamwork with the lab working really closely with the nurses and building really good bridges. TP team depleted by one colleague pulled back to clinical work but workload remained the same. Revamped tx training and competency assessment to accommodate social distancing by moving online and making it much more accessible – worked really well. Wards kept changing and also found there were not enough handheld scanners so had to revert to a manual process which tested our fallback paper processes and they worked really well. Good learning opportunity and great teamwork.
KM - Similar experiences as everyone else. Were at the start of quite an intense BloodTRack roll out when it started and lab. manager went off with COVID! At the same time were asked to support the Nightingale Hospital - given two weeks to get that up and running, could not speak to anyone on site or offer training and did not know which staff were going in. Was then never used. Then BloodTRack came back on board so had about three months to get everyone trained in the handheld PDAs and get that rolled out. From a ward perspective, some of the clinical areas were throwing out blood boxes if they went to a COVID patient's bedside but we weren't informed and didn't realise until they started to run out. National audit data showed that WBITs rose during first wave. Not NBT experience but that and incidents in general have increased during second wave but there are probably twice as many patients. Some of this can be attributed to system changes as a result of COVID.
SL - similar at experience with more incidents during second wave but have had to redeploy a lot more staff and employ more agency nurses.
BF - RD&E went live with EPIC and then two weeks later had to open a Nightingale Hospital. Had some processes established as were on standby for first wave but didn't include EPIC so had to alter our training and all our paperwork to include that it would now be an electronic patient record. Having a key contact within the Nightingale who knew instantly what to feedback in terms of competencies and training ensured enough staff were set up to take blood samples and put up blood. Did need to reinstate double independent checking and sending tags back but it has been safe and they have been supported to do that when the machinery or electronics let us down or there were not enough staff with the appropriate bar code. It was a real learning curve and have had more patients than we thought needing blood – very few in the first wave – but this was because the Nightingale was used after the acute COVID phase so often patients were arriving having been sick for a while with depressed bone marrow and falling FBCs.
JP, TDSDFT – similar sort of thing – lost a member of staff to theatres/ICU, trying to keep business as usual, wards changing, logistical nightmare.

NMA Review & Progression

ST led a discussion on the provision of a portfolio and competency to give ongoing support to delegates/mentors following completion of the NHSBT course. She had shared the Yorks and Humber workbook that SL helped put together as a member of their TP group and the NMP process which although for prescribing might lend itself quite well to the authorisation process. Would it be a good idea to create a regional pathway, building on the information and examples we have, to meet needs and provide better support and assistance?
KM – useful from her perspective to attend the course to see if there are gaps that need to be supplemented from the trust's point of view. NBT has recently updated policies for nurse requesting and authorisation which includes attendance on the NHSBT course and completion of the national framework competency workbook, etc and would be keen to share and work with others to develop something regionally.
ST – highlighted that the framework is very outdated and currently undergoing review.

SC – It would be a really good resource to support the trusts where nurse authorisation has not yet been set up, with guidance on how to monitor and ensure people maintain their competencies.
AH – nurse authorises at Yeovil are under the non-medical prescribing umbrella and have to comply with audit. It is really important that the people who authorise blood should be in an environment where they do it on a regular basis.
Accessibility to the NHSBT course has been an issue for trusts, particularly with the impact of COVID. ST confirmed that NHSBT are looking at how resources can be expanded to accommodate demand and alleviate the waiting list. As a region we could look at putting some questions together to make sure that only appropriate candidates are accepted onto the course.
ST asked anyone who was interested in participating in this piece of work to let her know via the Chat function.

Transfusion 2024
SL/ST gave an overview of the recommendations from a TP group perspective:

Documented competency framework for TPs – previously discussed at a regional level. SL to try and ensure we can get involved with any national decision-making and once the framework has been developed, discuss as a region and decide who will pilot.
The annual regional survey gives us a good baseline for benchmarking a lot of the recommendations and we are working to improve the functionality to better record compliance and also at making the data more accessible. This will hopefully help us to achieve 100% participation.
GIRFT/model hospitals – need a better understanding of what this looks like for transfusion and which hospitals are involved.
There is a big onus on the PBM team providing more support. ST asked for feedback on what this would look like to the TPs. The PBM toolkit launched last year was based on regional feedback.
From a lab. perspective we could ask more questions in the survey around skills mix and we have formed a BMS education group to revamp the training we offer. Our incident reporting is good.
Integrated systems - currently a pilot with RCI and the BRI – perhaps this could be discussed at RTC once completed.

IT – big part is vein to vein tracking and we have a regional baseline from the annual survey, that will be issued as part of the PBM benchmarking reports.

Our RTC Chair is very aware of the power of data and how we can use it to support the work in individual trusts

Any Other Business
Sharepoint. ST gave a quick demo on Sharepoint and outlined its potential uses for the RTC working groups