


London Regional Transfusion Committee

London & South East Trauma & Haematology Group

Draft Minutes

Wednesday 29th November 2017

St Mary's hospital

Topic													Action
Attendance/Apologies													A=Apologies P= Present N= Not present *= Not invited
Trust	Name	19/01/16	25/07/16	15/11/16	27/07/17	29/11/17	Trust	Name	19/01/16	25/07/16	15/11/16	27/07/17	
Imperial	Brian Robertson	P	P	N				Alek Mijovic	N	N	N	N	
	Denise McKeown	N	P	A	P	P	OUH	Nikki Curry	P	A	A	N	
	Simon Eaglestone	N	N	N	N	N		Sue Hemmatapour	N	A	A	A	
(NHSBT)	Fateha Chowdhury	*	*	*	P	P		Julie Staves	P	A	A	P	
Barts	Paul Grist	N	N	N	N	N		Claire Guest	N	N	N	N	
	Julia Lancut	N	A	P	A	A	BSUH	Julie Cole	N	N	P	P	
	Pascal Winter	P	P	P	A	N		Peter Larcombe	N	N	N	N	
	Jo McCullagh	N	N	N	A	N	Addenb rooks	Dora Foukaneli	N	N	N	A	
	Nidhi Sharma	P	N	N	A	N		Claire Newsam	N	N	P	A	
	Christy Doughty	*	*	P	A	P		Katherine Philpott	N	N	N	A	
	Laura Green	P	*	A	A	A		Ruth Smith	P	P	N	A	
	Shubha Allard	N	A	A	A	A	GOSH	Rachel Moss	*	*	P	A	
KSS	Gary Wareham	N	A	P	P	A	GSTT	Tim Maggs	*	*	*	A	
SGH	Steven Wiltshire	P	P	P	P	P		Sue Robinson	*	*	*	P	
	James Uprichard	P	P	P	P	P		Vanessa Fulkes	*	*	*	P	
	Bassey Williams	N	N	P	P	N		Charlene Furtado	*	*	*	P	
	Matt Free	P	A	P	N	P		Dharshana Jeyapalan	*	*	*	N	
	Sarah Carr	N	N	N	N	N	NHSBT	Al Hunter	P	P	P	P	
	Kelly Feane	N	P	P	A	N		Jen Heyes	A	P	N	A	
KCH	Emily Carpenter	P	P	P	P	P		Clare Denison	N	N	P	A	
	Jen Heyes	*	*	*	*	P		Richard Whitmore	P	A	P	A	
	Malcolm Tunnicliff	N	A	N	N	N		Helen New	*	*	*		
	Ken Amenyah	P	N	P	A	D		Anwen Davies	*	*	*	*	
								Sasha Wilson	*	*	*	*	
Guests/deputies: Adedayo Okunadez (KCH), Mariam Ammoun (Imperial)													
Updates – Major Trauma Centers													
<div></div> <div>MTC updates Nov 2017 v2.docx</div> <div>MF also provided us with an update from his visit to the Manchester MI learning event. His notes from the meeting are embedded below; alongside the clinical debrief notes from Chris Moran.</div>													



Manchester Attack Lessons Learned
summary of key point Manchester MF notes

Previous minutes were reviewed and accepted.

Previous actions and updates:

Action	Owner	Feedback
Share MI alerting system	JS	Carried forward
Share MI alerting system	VF	Complete: Shared via email
Complete Organisational Audit from SW	ALL	Only partial submissions. EC to resent audit and send reminders. All to complete by 14 th Feb 2018.
Embed JS's PowerPoint into minutes for distribution	EC	Complete: Embedded in draft minutes
Send previous trauma group decision on taking blood to scene	EC	Complete: Shared via email
Share Oxford policy on taking blood to scene.	JS	Obsolete: Feedback that in Oxford this is part of a policy rather than a complete one, and does not require sharing.
Research new system and report back at next meeting	JS	Carried Forward Company chased but awaiting response

Transferring Blood to Scene (action review)

This example policy had been sent to the group discussed before in 2014. It was discussed again after a request at the last meeting to re-circulate. It was noted that even since the advent of Blood On Board (BOB), this was a very rare situation and requests for blood from hospital directly to site has not increased with availability of BOB. In most of the cases that blood would be required at scene, BOB (in helicopter or response car) would be automatically deployed due to the clinical details. Therefore the hospital's requirement to transfer blood directly to scene would only be in cases when the patient is both trapped, and close to the hospital. It was noted by the example policy that unless the police were involved to transport it, blood could be withheld or delayed in getting to the scene. Although it was decided that this was such a rare incident that it probably did not warrant a policy, it was decided that JU would write to NHSBT to find out if they could deliver blood directly to scene if required as they have liveried vehicles. This may well depend on the area, as in most cases BOB would be more appropriate.

It was noted that Heidi Doughty's NBTC Emergency Planning document is being reviewed, but no comments were made at this time. Dr Fatts Chowdhury had sent round the document for comments prior to this meeting.

JU to write to NHSBT to see if they could deliver blood directly to causality on scene, not involving a hospital prior.

SMH experience of Major Incidents – Dr Fatts Chowdhury

Dr Fatts Chowdhury gave the group a presentation of the SMH experience of Major Incidents which sparked discussion amongst the group about our similarities and differences.

Key points:

- 4 MIs declared since Jan 2017 activating SMH

<ul style="list-style-type: none"> • Interesting case involving an MI WBIT : <ul style="list-style-type: none"> ➤ Group and screen sample was split into two samples by a FY Doctor, and labelled as being 90 minutes apart. Despite this the false information, BTL still suspected there was only 1 venepuncture event and rejected 1 of the 2 samples narrowly avoid blood issue on a pair of WBITS. ➤ Discussed moving to calling it the 'group check' or 'confirmatory group' rather than '2nd sample' to aid understanding. Several other MTCs have also made this move. Some knowledge issues identified in staff, with confusion that the analyser has read the wrong group rather than the sample being a WBIT. ➤ Decided not to issue blood on 1 sample during MI. • NHSBT have only needed to supply 1 blue light delivery per incident. Although they were able to supply sufficiently in all cases, it did deplete NHSBT stocks and they would have had to move blood from other centers. • Trials with predicting numbers of patients, and volume of blood. Also changes on which MTC/MTU the patients might be going to. 	
<p>Major Incident cards</p> <p>Each MTC supplied their own major incident cards and/or policies which were discussed. Key points below:</p> <p>SGH</p> <ul style="list-style-type: none"> • Stand-alone MI policy • Roles documented for chem/haem/reception staff • Biochem activate phone tree • Split into core hours and 'out of hours' (ooh) • Stock Co-Coordinator role • Blood Co-Coordinator role in draft for ED, plans to also have one in theatre • Set up new MI WhatsApp group. Strict rules for MI use only not shift swaps etc. <p>SMH</p> <ul style="list-style-type: none"> • Triggers Coag cons and NHSBT consultant • Group discussed that consultants often get missed off and should ensure their activation is tested in drills • Haem BMS immediately goes to Tx lab whilst extra staff travel in • Updated to need 2 samples due to WBIT risk • 20 O RBCs supplied directly to ED and put in their ED fridge • TPs aren't on MI call out, but informally called in <p>Oxford</p> <ul style="list-style-type: none"> • Don't use action cards • Do have MI SOP • Dedicated A4 page for telephone log • Haem Reg and Senior BMS take initial control whilst more senior staff alerted • TP not on call • Contact Haem/Tx Cons on call in first instance <p>Royal London</p> <ul style="list-style-type: none"> • Have MI policy and action cards 	

<ul style="list-style-type: none"> • No division between ooh or core hours • 3 clinical roles – ED, BTL and theatres. Aim for each area to have a blood coordinator, priority to ED, followed by BTL followed by theatres. • Blood Coordinator could be Cons/Reg or TP • TPs don't cross cover sites, so SpRs vital • Also use WhatsApp group, but noticed that during the cyber attack users removed themselves due to the frequent messages not all of which were relevant to all individuals. This is a problem as they may be required later in the MI, or in the next MI. • Noted that with a bigger Trust, it's easy to activate the wrong site. <p>Cambridge</p> <ul style="list-style-type: none"> • Never been involved in MI • MI SOP coordinated by BMS, involves Consultant at first instance • MI policy action card now outdated, plans to update • Telephone tree triggers via senior at home • NHSBT stock distance noticed <p>KCH</p> <ul style="list-style-type: none"> • Action cards part of Trust MI Policy • Relevant action cards duplicated in BTL SOP • No official Blood Coordinator role, but has been filled by Patient Blood Manager in recent MIs with good response from ED. Would like to formalise but difficult to be able to guarantee staff availability especially out of hours. • Haem BMS activates telephone tree • Immediately deactivate ED fridge and return blood to main issues fridge • Supply 6 O neg, 6 O pos and 6 thawed plasma in first instance. • Stop accepting individual Code Red calls from ED during MI • MI mobile kept charged and working for MI use only <p>GSTT (Trauma Unit)</p> <ul style="list-style-type: none"> • Utilise Everbridge as alerting system • Ooh – TP not accessible, TPs also work cross site so maybe on the other site even if MI is in core hours • Have a tabard for blood coordinator • Blood Coordinator – Utilise BMS staff, careful to give additional support • Supply 20 O Neg and 20 Pos • Have a phone that they could take down and plug into certain place as mobile reception is bad in ED • Can do 3 simultaneous MHP traumas at once in BTL • Use big white CliniMed boxes with 10 units in each, validated for 2 hours. Noted that NHSBT validated boxes might be superior. 	<p>RW to report back if NHSBT can supply some big temperature validated boxes to MTC/MTUs.</p>
<p>Any other business including date for next meeting</p> <ul style="list-style-type: none"> • Oxford has started using 5 day plasma on everybody. • Royal London are working with HEMS and NHSBT in the new year to start a trial of platelet depleted whole blood on board. Topic to be on the agenda at the next meeting. • Julie Cole and Laura Green invited to speak at next meeting • LG is in Singapore 10th Feb -3rd March, so date expected mid March, date TBC. 	