South West Blood Conservation Group (SWBCG)
Minutes of the Inaugural Meeting, Monday 31 October 2011
Royal Devon & Exeter Hospital

Present:

John Faulds (Chair), Royal Cornwall Hospitals NHS Trust (JF)
Dr Daryl Thorp-Jones, Plymouth Hospitals NHS Foundation Trust (DTJ)
Dr Biddy Ridler, Royal Devon & Exeter NHS Foundation Trust (BR)
Dr Christina Laxton, North Bristol NHS Trust (CL)
Carol McGovern, Royal Cornwall Hospitals NHS Trust (CM)
Ian Sullivan, Royal Cornwall Hospitals NHS Trust (IS)
Sara Staddon, Royal Cornwall Hospitals NHS Trust (SS)
Michelle Smith, Plymouth Hospitals NHS Foundation Trust (MS)
Bernard Crotty, National Finance Manager, NHSBT (BC)
Dr Lars Jakt, Royal Cornwall Hospitals NHS Trust (LJ)
Dr Catherine Ralph, Royal Cornwall Hospitals NHS Trust (CR)

JF welcomed everyone to the meeting and referred them to the letter that he had circulated containing the topics to be suggested topics for discussion at the meeting.

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1. Direction of the Group
   Blood conservation has a number of elements, and the South West RTC has suggested the SWBCG look at pre-op. anaemia. It is proposed however to start the group off with the focus on cell salvage, and then progress on to looking at issues around iron deficiency in due course.
   JF commented that the UKCSAG produces a lot of material for the implementation of and best practice in cell salvage, however individually hospitals are still doing their own thing.
   It would be good to standardise training, but in a way that will work for each hospital with local adaptation.
   RCHT are doing extra surgical lists where they want to use ICS – but it is not viable for them to invest in the extra machines and training required. SWBCG could look at becoming an ICS service organiser to hospitals in situations such as this. Agreement could be drawn up between hospitals. If there is an assurance of a good package / availability of competent staff this could be better and cheaper than using a private ICS provider company.
   Action: gauge interest in SW hospitals for such a service (AJ/JF).

2. Education – training & competency
   It was agreed that some standardisation of training and competency across the south west region would be useful. It was commented that some trusts are fairly behind in developing an ICS service so having support with this would be useful.
   It was agreed that the initial phase would be to standardise training – MS and CM to lead – and then also to develop a South West ICS training & competency forum (concerned with training, maintaining and proving competency).
   MHRA would like to regulate cell salvage, but because it falls outside BSQR/EU reg.s it is not currently a requirement, it is felt that this will come however. Promoting the use of standardised and recognised training & competence would support hospitals undergoing scrutiny of ICS practice, as would use of quality control and assurance and effective recording of ICS use.

3. Procurement of consumables
   A level playing field is needed across the South West region, by reducing the cost of consumables in some places.
   BC commented that a national contract was in existence 10 years ago with costs approx. 50% higher than they are now.
   We should aim for the cost of consumables to be the same no matter where you are or how many units you use. There are different makes and machines in use around the region – Haemonetics Cell Saver 5 being perceived as the most common. JF said that companies are willing to look at this but we need to take it forward. All present agreed to this. BC noted the recent commercial review of NHSBT, suggesting that this idea fits in with the recommendations from it, and that possibly the NHSBT procurement department could help with input into this. The way forward is to negotiate as a collective.
   Action: arrange meeting with key stake holders to open discussion on this (JF/AJ).

4. Quality Assurance & Control
   JF to give a presentation on this during the ICS study day.
   Quality assurance and control in cell salvage is an issue that is becoming bigger as use is increasing, and yet very little QA/C appears to be in place in hospitals. There is a need to know ICS product is safe to give back to a patient. RD&E have made good progress with this, and a good relationship with the lab. is considered very important (as lab. input is essential to QA/C process). Looking at the papers that are coming out, QA is one of the things that ICS users want, and we should use SWBCG members shared experience to draw up a paper and say that this is what we want. A UKCSAG document on QA will be available shortly which will support this objective.
   Action: disseminate UKCSAG QA document when it becomes available (JF).

5. Lead roles within SWBCG
   JF suggested CR and DTJ take the lead in ICS in ob.s.
   CM to lead on education and competency training.
   JF to lead on QA/QC.
   BR to lead on recording of ICS.
   Any other SWBCG member who have any particular interest, or are currently running studies on ICS would be welcomed to take a lead in the group.

6. Recording of ICS performed – practice and strategies
   RD&E are using a form with data fields agreed by UKCSAG to audit and record ICS activity. If we are all recording ICS data, would it be better if this is standardised, and instead of working separately, a collated database could generate strong evidence on ICS use. BR to send the RD&E form to the group (via the SWBCG website).
   Action: submit RD&E ICS data collection form for posting on website (BR).

7. Company rep. participation in SWBCG activities
   Do we want company/rep. participation in the group – it was agreed that this should be by invitation only.