'UNCONFIRMED' MINUTES OF THE SOUTH WEST REGIONAL TRANSFUSION COMMITTEE

Thursday 9 May 2013, 10:30 – 15:30
Oake Manor, Nr. Taunton

Attendance:

NHS HOSPITALS	
Derriford Hospital	Caroline Lowe (CL); Georgina Vincencova (GV)
Dorset General Hospital	David Quick (DQ)
Gloucestershire Hospitals	Charles Garcia-Rodriguez (CG-R); Paul Turner (PT)
Great Western Hospital	Doug Smith (DS); Julie Ryder (JR)
North Bristol Trust/NHSBT	Janet Birchall (JB)
North Bristol Trust	Tim Wreford-Bush (TW-B)
North Devon District Hospital	Maggi Webb (MW)
Poole General Hospital	Sue Redfearn (SR)
Royal Bournemouth Hospital	Julie Johnson (JJ)
Royal Cornwall Hospital	Stephen Bassey (SB)
Royal Devon & Exeter Hospital/ North Devon District Hospital	Paul Kerr (PK)
Royal Devon & Exeter Hospital	James Piper (JP); Sarveen Gajebasia (SG)/Caren Chu (CC)/Amy Holman (AH) – p.m. only
Royal United Hospital Bath	Sarah Wexler (SW); Susan Scott (SS); Dave Fisher (DF); Lesley Shipway (LS)
Salisbury District Hospital	No attendance
Taunton and Somerset Hospital	Alison Western (AW)
Taunton and Somerset Hospital/Yeovil District Hospital	Sarah Allford (SA)
Torbay Hospital	Patrick Roberts (Chair) (PR); Alistair Penny (AP); Sophie Whelan-Johnson (SW-J) – p.m. only
University Hospitals Bristol	Tom Latham (TL); Adele Wardle (AWar); Soo Cooke (SC); Champa Manchanayak (CM)
Weston General Hospital	Francoise Dollery (FD)
PRIVATE HOSPITALS	
Nuffield Health Cheltenham Hub	Mary White
Nuffield Health Exeter Hub	No attendance
Spire Hospital, Bristol	No attendance
Patient Representative	Bob Lang
NHSBT	
Patient Blood Management Practitioners	Peter Thompson (PTh); Alister Jones (AJ)
Customer Service Manager	Claire Chang
RTC Administrator	Jackie McMahon

1. Apologies: Attached.

2. Previous Minutes: The minutes of the meeting held on 22 November 2012 were confirmed as a true record.

3. Matters Arising

3.1 4. Questions from Circulated Documents

JB reported that Adrian Copplestone's suggestion for a tool to predict short term platelet requirements to assist demand planning could not be progressed. Action closed.

4. Questions from Circulated Documents* (CC)

[*All presentations are available on the RTC website]

RBCs: The national downward trend in red cell issues was noted and CC explained that NHSBT is trying to identify if demand from hospitals can be better predicted. There are financial implications as the cost of blood is based on estimated volume of future issues. CC requested that she be contacted if hospitals are aware of any changes affecting use. The higher than average red cell expiries at Plymouth Blood Centre was attributed to the small number of hospitals supplied (4), thus variation in demand having a bigger impact.

Nationally, 11.5% of issues for 2012/13 were O RhD Negative.

Platelets: Nationally issues have been increasing since 2008. In the South West, following significant activity by the RTC to reduce inappropriate use, issues have fallen for the last two years. Oxford and Filton Blood Centres are above the wastage target of 6.5% - a lot of work is being undertaken to review management and distribution of platelets to other sites. Apheresis donations are continuing to reduce donor exposure.

Frozen components: The steady increase in issues in the South West since 2008 has been attributed to changes in treatments, massive haemorrhage protocols, inappropriate use, and more use of cryoprecipitate (due to greater clinical awareness).

CG-R queried the shortest date at which red blood cells can be issued as a few studies have suggested that younger red cells are better for critically ill patients. JB confirmed that testing is done within 24 hours and release can occur after that. JB pointed out that there is also evidence that suggests fresh blood may be associated with problems but that the report from the ABLE study should provide further clarity. JP said that his Trust try to keep wastage to a minimum by holding fresher stock.

5. National Blood Transfusion Committee Update* (PR)

RTC Chairs' Meeting Summary

- HTC Chairs Toolkit/HTC reporting tool presented (regionally, it was agreed that the Toolkit was a good idea but there was no support for the reporting form. BL highlighted that a patient representative was missing from the list of suggested HTC members).

- CUSUM data was suggested as a method to present platelet use data to hospitals however this was not widely supported.

NBTC Meeting Summary

- Extended shelf-life for thawed FFP to be discussed at next JPAC meeting in June.
- Pathogen Inactivation system for platelets being investigated for UK – already used in several European countries.
- Overview of existing/forthcoming Patient Information Leaflets (PILs).
- Patient Blood Management (PBM) – draft recommendations on implementing PBM imminent with more focus on treatment of anaemia and preventing transfusion.

6. BCSH Acute Transfusion Reaction Guidelines* (JB)

JB presented a summary of the guidelines on the management of ATRs (the second largest SHOT category).

7. Summary of BCSH Compatibility Guidelines* (TW-B)

TW-B summarised major changes:

- Two samples for a first time patient or consider giving group O
- Sample validity (72 hours)
- Sample storage (3 days post transfusion)

8. Blood Conservation Group Update (AJ)

The Group is currently undertaking an exercise to quantify annual ICS consumable usage in the region with a view to negotiating some kind of tiered tariff system for consumables with manufacturers; information has been circulated re national 'SALVO' study of cell salvage in obstetrics; cell salvage database will now be captured within PBM database which may delay progress; UKCSAG developing quality control protocol/guideline for using cell salvage machines.

JB took the opportunity to request copies of other Trusts' cell salvage and pre-op assessment guidelines as her Trust wants to develop their own but do not want to "re-invent the wheel". This prompted a discussion regarding the pooling of resources in this way for any other Trusts wanting to develop policies/ guidelines. It was pointed out that this resource already exists on the SW RTC website Policies section and that the annual database survey also captures what policies/guidelines are in use. SW suggested providing a direct link to Trust websites policy pages within the RTC website to facilitate access to other Trust's policies/guidelines.

9. Education Sub-Group/E-Learning (AJ)

The Midwives Study Day in March was well attended and positive feedback was received; new educational resources on the website include a powerpoint presentation on blood fridge management, specifically aimed at off-site blood fridges; a basic serology presentation is also available but is too big for the website and can be requested via the RTC Administrator – a copy has been distributed to TPs; next

planned event is a lab staff-based study day similar to the previous empowerment event but strengthening some baseline knowledge to help reinforce appropriate use, and Lab Managers have been asked to suggest useful agenda items.

Learnbloodtransfusion e-learning (LBT) – 'Consent for transfusion' course is now live on all platforms. A revised 'Transfusion Lab' course (replacing 'Safe Transfusion Practice in the Lab') is now live on LearnPro. 'Safe Transfusion Practice' has been updated and there is also now a revalidation element enabling users to complete a shortened assessment the second time around. Development of this revalidation element for other courses is under consideration. Writing group being assembled for Management of Transfusion Reactions.

Following queries, AJ confirmed:
(i) It is possible to monitor e-learning uptake - Trust administrators can access and capture reporting data from LearnPro and on NLMS, the information is captured via Learning & Development departments within the ESR system.
(ii) LearnPro modules can be modified to suit different learning requirements but it is not possible on NLMS.

10. TLM meeting update (FD)

- SHOT & SABRE: Still a lot of WBIT; providing further evidence for new two-sample rule.
- Ongoing problems around anti-D.
- MHRA – only one recent inspection – issues around training and traceability picked up on.
- CPA inspections becoming more MHRA-like.
- No feedback from National TLM meeting.
- Update from customer service and transport teams.
- BSMS feedback.
- RCI feedback re: Sp-ICE and getting Caldicott guardians on board; pilot study on extending NHSBT RCI working hours.
- NBTC bookmark review overdue.

11. TLN/TP Update (PTh)

PTh fedback on the TP Development Day; the recent TP meeting (21.03.13) was well attended, with two educational sessions; the next meeting is planned for 11.07.13.

12. RUH Audit of Blood Use in Orthopaedics (SS)*

An audit triggered by financial issues and patient care incidents. As well as identifying patients with undiagnosed anaemia, RUH are now picking up other disorders much earlier. Use of TA particularly effective in TKR and has reduced use of cell trans drains in both TKR and THR with associated cost savings. Cost savings now being achieved in blood use and patient care has improved. Other hospitals around the region reported similar projects, one citing TA as making a big difference.

13. Patients undergoing elective Laparoscopic Cholecystomy do not need a Group & Save sample (SW-J)*

SW-J presented the findings of an audit undertaken at the Royal Devon & Exeter Hospital - of 273 patients reviewed, only two needed transfusing peri-operatively.

14. RD&E Audit on Patient ID at Transfusion (SG, AH, CC)*

The audit followed the process from collecting blood from the lab to administration to the patient. Action is being taken to move to one person checking and to remove the pink compatibility form.

15. Report from NCA Medical Use of Blood (JB)

JB summarised the findings of Part 1. Part 2 sent further questionnaires out to a random selection re: patients who were deemed to have had potentially avoidable transfusions. The data from Part 1 suggests that 13% of all transfusions were inappropriate. JB outlined a proposal to investigate anaemia management in medical and surgical patients in the south west region in the form of a two-page questionnaire that would identify what anaemia protocols are in use, and how common the use of IV iron is. All present were in agreement and the questionnaire will be circulated at the beginning of June.

Action: JB/AJ/JM

16. Report from NCA Labelling of Blood Samples for Transfusion (AJ)

Error rates indicate that training and education are not enough and that other methods need to be explored. One Trust is piloting personal printing stamps with an identifier number on them that will be used for everything that requires a legible signature. DS queried the minimum dataset lab managers will accept to process a Group & Save sample and the national standard was confirmed as date of birth, hospital number, first name and surname

17. 2013 Database Survey

JB took the opportunity to make sure that everyone was still happy to participate in the survey and advised that the 2013 survey would be distributed with the meeting minutes.

Action: JM

18. Any Other Business

This was PR's last meeting as Chair and he was thanked for his contribution over the last four years. SA was introduced as the new Chair. Farewell also to PTh who retires from NHSBT at the end of May. He was thanked for his commitment and input to the RTC.

19. Date of Next Meeting

Tuesday 19 November 2013

GLOSSARY OF ABBREVIATIONS

ABLE	Age of Blood Evaluation
ATR	Acute Transfusion Reaction
BSMS	Blood Stocks Management Scheme
CPA	Clinical Pathology Accreditation
ESR	Electronic Staff Record
FFP	Fresh Frozen Plasma
HTC	Hospital Transfusion Committee
IV	Intravenous
JPAC	Joint United Kingdom Blood Transfusion Services and National Institute of Biological Standards and Control Professional Advisory Committee
LBT	Learnbloodtransfusion
MHRA	Medicines & Healthcare Products Regulatory Agency
NBTC	National Blood Transfusion Committee
NCA	National Comparative Audit
NHSBT	NHS Blood and Transplant
NLM	National Laboratory Managers
NLMS	National Learning Management System
NPSA	National Patient Safety Agency
PBM	Patient Blood Management
RBC	Red Blood Cell
RCI	Red Cell Immunohaematology
RTC	Regional Transfusion Committee
SABRE	Serious Adverse Blood Reactions & Events
SHOT	Serious Hazards of Transfusion
Sp-ICE	Specialist Services electronic reporting using the Sunquest ICE web browser
TA	Tranexamic Acid
THR	Total Hip Replacement
TKR	Total Knee Replacement
TLM	Transfusion Laboratory Manager
TLN	Transfusion Liaison Nurse
TP	Transfusion Practitioner
UKCSAG	UK Cell Salvage Action Group
WBIT	Wrong Blood in Tube

South West Regional Transfusion Committee Meeting

Thursday 9 May 2013 at Oake Manor, nr Taunton

APOLOGIES

Hospital	Name	
Barnstaple	Kathleen	Wedgeworth
Circle Bath	Norjin	Pejcic
Derriford	Adrian	Copplestone
	Sophia	Wrigley
Gloucestershire Hospitals	Sally	Chown
Nuffield Exeter	Daniel	Durdin
Prospect Hospice	Julie	Dickens
Royal Bournemouth	Shane	McCabe
RD&E	Biddy	Ridler
	Jeni	Davies
	Veronica	Sansom
Royal Cornwall	Nicki	Jannaway
	Deb	Thomas
	Richard	Noble
	John	Faulds
RUH	Jerry	Nolan
	Helen	Maria
Salisbury	Caroline	Mathews
	Anne	Maratty
Somerset Partnership NHS Foundation Trust	Nina	Vinall
SPIRE Bristol	Bernadette	Jones
UKSH Emersons Green	Claire	Husain
Weston General Hospital	Louise	Jefferies