CONFIRMED MINUTES OF THE SOUTH WEST REGIONAL TRANSFUSION COMMITTEE
Wednesday 15 May 2019, 10:30 – 15:30
Oake Manor, Nr. Taunton

Attendance:

NHS HOSPITALS/ORGANISATIONS	
Derriford Hospital	Wayne Thomas (WT)
Dorset General Hospital	Maraneka Greenslade (MG); Lorraine Poole (LP)
Gloucestershire Hospitals	Robert Orme (RO)
Great Western Hospital	Edward Bick (EB)
North Bristol Trust	Elmarie Cairns (EC); Tim Wreford-Bush (TWB)
North Devon District Hospital	Kathleen Wedgeworth (KW)
Poole General Hospital	Vikki Chandler-Vizard (VCV)
Royal Bournemouth Hospital	Lorraine Mounsey (LM)
Royal Cornwall Hospital	Oliver Pietroni (OP)
Royal Devon & Exeter Hospital	James Piper (JP); Barrie Ferguson (BF)
Royal United Hospital Bath	Sarah Wexler (Chair) (SW); Wayne Vietri (WV); Kyle Day (KD)
Salisbury District Hospital	James Milnthorpe (JM)
Taunton and Somerset Hospital	Michelle Davey (MD); Nic Wennike (NW)
Torbay Hospital	Alistair Penny (AP)
University Hospitals Bristol/NHSBT	Tom Latham (TL); Regina Nolan (RN)
Weston General Hospital	No Attendance
Yeovil District Hospital	Joe Tyrrell (JT)
PRIVATE HOSPITALS	
Nuffield Health Cheltenham Hub	Samantha Lewis (SL)
Nuffield Health Exeter Hub	No attendance
Spire Hospital, Bristol	No attendance
Patient Representatives	No attendance
NHSBT	
Patient Blood Management Practitioner	Katy Cowan (KCo)
Customer Service Manager	Rhian Edwards (RE)
Customer Service Manager	Emma Taylor (ET)
Hospital Services Manager	Adrian Marsh (AM)
Business Continuity Manager	Claire Chang (CC)
NCA Clinical Lead	Lise Estcourt (LE)
RTC Administrator	Jackie McMahon (JMc)

1. **Apologies:** Attached.

2. Previous Minutes

The minutes of the meeting held on 14 November 2018 were confirmed as a true record.

3. Matters Arising (not covered in main agenda)

Send examples of how consent is discussed/documented to JMc: JP queried if anyone had consent as part of their blood tracking and order comms systems.
RE confirmed the figures for CMV-ve orders represent units requested.
SW indicated that concern regarding NHSI's pathology plan is reflected nationally and there is also a lot of concern about KPMG's savings predictions.
The IOCS database poster for NATA was rejected, with no feedback given.

4. Hospital Issues and Wastage Updates (KC)* (*all presentations are available on the SWRTC website)

Regionally orders of rbc and platelet units declined by 2.4% and 0.6% respectively compared to 2017/18.The percentage of O-neg remained the same.
It was agreed to include a comparison of units ordered (gross data) against units transfused (net data) at future meetings.
It was agreed to keep the current format for the wastage graphs but split graphs with a large number of hospitals to make them clearer.

5. National Blood Transfusion Committee update (SWe)

The March meeting was Transfusion 2024 - a symposium looking at setting a 5 year strategy for clinical and laboratory transfusion practice. Many aspects were explored including modernising scientific careers. Issues with education for both lab. and clinical staff were highlighted. Improvements are necessary to ensure staff arrive in post with the skills required in the future. Currently our requirements and the university curriculum do not match. NBTC are pursuing this and we are also looking at what can be done from an NHSBT perspective. The role of consultant scientist was discussed and the potential for it to increase with the predicted drop in the number of medical consultants specialising in transfusion.
The symposium produced a lot of ideas for setting the agenda going forward but no definitive plan as yet. SW will arrange for the minutes to be circulated once they are available.

6. CSM Team Update (RE)

RE highlighted there had been some problems with giving sets for red cells and asked to be advised if anyone had experienced this. The universal plasma project survey has launched and RE asked everyone to respond. It was pointed out that there is some data gathering involved and the survey will take longer to complete than it states. The project will help determine demand and which patients groups will benefit.

7. Audits and Surveys

NCA (LE)
LE outlined the NCA programme going forward and hoped the RTCs felt that their feedback had been listened to. The number of audits performed on an annual basis will be reduced and this year's will be the re-audit of the medical use of blood (excluding haematology), in conjunction with the Royal College of Physicians. This is the audit that was chosen by the RTCs and it will be launched in the autumn. The aim going forward is to develop a toolkit following each audit to facilitate educational and quality improvements and then re-audit. Problem at the moment is that there are a number of re-audits pending.

It was acknowledged that in the past some audit results had been published too late and not changed practice but this is largely due to the the audit leads not being released from their jobs to analyse data and complete report writing.
The O-neg audit is awaiting sign-off and will be out soon.
An interim report on the audit of FFP and cryoprecipitate in children and neonates went out in December as there is still ongoing discussion which needs to be resolved before the report can be finalised. If there is going to be a delay in producing the final reports, the NCA will endeavour to circulate an interim report.

Two audits are proposed for Spring 2020. One is aimed at specialist paediatric centres and the other is looking at the use of FFP/Cryo and PCC - this prompted a discussion among the group about policies for the reversal of DOACs.

RTCs will be asked in the summer for audit suggestions for autumn 2020.

2019 Database Survey (KCo)*
The 2019 survey will be circulated in the summer. The usefulness of the follow-up letters to trusts with outlying practice was discussed and this led to a discussion on the effectiveness and support of the HTCs, constraints, and the different reporting structures around the region. To be effective, it is important there is a formal reporting route and it was agreed to add a question to the 2019 survey asking who the HTC reports to.

RO suggested that it would be helpful to have standard regional guidelines and agreed actions and timelines that HTCs can work towards implementing, i.e. anaemia management, cell salvage, consent, MH protocols and that HTC Chairs meet once a year to discuss this.

SW suggested a good starting point is to look at how we are doing with PBM as a region and unifying some of the pathways already in place. The data collected from the database survey will highlight any areas that need improvement and we can use the results to agree a way forward and use it as a tool to drive trusts to support it better. To help achieve this, SW requested the 2019 survey be completed as

accurately as possible by all trusts and although it is generally completed by the TPs, JMc will cc in the HTC Chairs so they are aware when it has gone out. The next steps can then be agreed at the November RTC meeting. It was suggested we should focus on three 'big topics' and add on as each one is finished. RO emphasised we should focus on what is most important for the RTC to achieve and it has to be something that affects everyone.

SW will document this initiative in her next NBTC update.

SW also encouraged better participation in the cell salvage database as even trusts with well established cell salvage services are not contributing data.

8. Presentations/Audits*

Regional Survey of O negative blood use and wastage (TW-B)

TW-B summarised the survey results. Overall, only six trusts responded and JP thought that if some of the questions had been changed participation may have been better.

- Some trusts are still using O negative for everyone and one trust won't be changing their policy as no scope to achieve big savings and switching to O positive for some patient groups will result in a transfusion reaction at some point;
- Blood tracking system cannot diffentiate between male and female patients;
- Treat according to biological gender;
- The numbe of times O negs are returned to normal stock could be an indication of over ordering;
- Demand still exceeds availability.

NBT Single Unit Project (EC & KC)*

The aim of the project, carried out in conjunction with NHSBT, was to increase single units transfusions in the elective orthopaedic and #NoF patient group. Savings of £22,000 were achieved and subsequent findings suggest that the length of stay for elective patients is shortened.

Awareness was raised with flyers in the wards and on the transfusion record, along with open sessions giving talks on TACO and transfusion alternatives, the myth around having to give 2 units, and new doctors were encouraged to question peers. A single unit transfusion was classed as either only one unit being transfused or where two were given, a full patient assessment was carried out before the second unit.

The results will be presented as a poster at an NBT Quality Improvement event which EC is happy to share with the RTC.

It was suggested rolling the project out regionally with each trust choosing the group of patients they feel is the most over-transfused.

9. SWPBM Group Update (KC)

Discussed anaemia and cell salvage services.
Variations in the region with regard to primary care involvement and how people work with CCGs.
Very little hospital input to the cell salvage database so feel we need to show the analysis of the data and feedback to the group to encourage participation.

TxA in #NoF (EC)*

EC fed back on the regional survey to ascertain practice in the region. 85.7% of respondents regularly give TXA to hip fracture patients. Is the next step a regional guideline? EB is happy to share GWH's guideline once it has been agreed.
LE mentioned there will be some evidence coming out in the future as a meta-analysis is underway looking at TxA and bleeding in hip fractures. This is in progress but will be a while before publication.

10. Transfusion Laboratory Managers Update (JP)

Topics discussed:

- Customer satisfaction survey results.
- Full face labelling delay.
- Platelet ordering process for first time patients/apheresis platelets
- Resilience planning and MI review.

11. Transfusion Practitioner Group Update (BF)

Last meeting focussed on anaemia and had talks from three TPs in the region who are trying to set up and run community anaemia services.
Received feedback from the UK TP Group re developing and securing the role of TP.
JT queried how many TPs have a dual TP/PBM role and the ensuing discussion revealed quite a lot of variation. Expectations can vary dependant on background – BMS or nurse – and management structure. It is recognised the role needs more definition and development and LE said that a group has been set up by the NBTC to look at core TP competencies.

12. Education Sub-Group Update

Lab. Matters on 26th June. Human Factors postponed until new PBMB in place.

13. Any Other Business

KD – highlighted that Learnpro for GMP does not cover good practice guidelines. MG pointed out that the MHRA will give training on this to the labs and will share contact details.

14. Major Incident Workshop

Afternoon session led by James Piper and Sarah Wexler. JP outlined a scenario and everyone was asked how their hospitals would respond.

JP has provided the following notes with the key points highlighted in bold:

Goals to highlight expectations and quirks* in communication or preparedness when dealing with an MI
Plan to talk through each stage with Clinicians, BT lab staff & NHSBT to check continuity of process

Clinical area:
Steps covered / checked by Clinical team on MI alert
Resource staff (inc mobilise from outside) *** ensure some staff are held back for following day**
Available Theatres
Action cards distributed
Check ITU for spaces & free up to wards
Check & clear ongoing operations
Cancel pending ops

Expect P1s to have 8 unit RBC, 8 FFP, 2 plts
P2 to have 2-4 RBCs & 2-4 FPS
P3 no blood required

Concerns with telephone access to BT lab* to get orders & with blood runners/Porters availability*
Therefore lab to dispatch Haem consultant to help direct Tx units to most needed, and a member of BT lab staff to dispatch units & keep blood provision clear

Lab area:
On MI alert BMS, (should be at same time as ED etc)
Calls BT co-ordinator & extra staff * **Ensure staff available for next day shifts**
Co-ordiantor in touch with control room
*** Suggest walkie talkies (in case phones lines down)**
*** Tabards for key staff** (also suggest yellow MI badges (?with Action Points on for all staff)
BMS **order MI blood requirements immediately from NHSBT**
BMS i**nform NHSBT** of MI
*** Decision logs need to be made during process (use dictaphones & loggist as per Torbay MI recommendation*)**

NHSBT area:
On pm weekday Hospital servers can dispatch 100 units in 20 mins (may take unto 45m) via blue light.
On night duty 50-60 units in 20mins, ***will divert staff from production area to Isues dept if they know MI called.**
Can operate faster if 50-60 units ordered at a time, small multiple orders (will use up drivers quicker so will switch to TNT who have Z cards)
(**need pictures of Z card example for hospital if lock down occurs**).

* **NHSBT need to be informed if lockdown & correct entrance in those cases**
Use of Army to deliver blood only in cases of >2000 casualites

Final clinical area revisit:
Of three sites (Swindon, Tuoro, Glos) all stated would send staff' runners' **Use one fridge for collection**
***BT should have dedicated staff at that fridge able to dispatch group O blood (+ for males or - for females)**
Prelabel blood as EDU (emergency designated units) but currently use paper system to check out units to patients
* **Pre register patients (50?) in LIMS/PAS so that wrist bands available early** (can be used with blood tracking software if present)
Staff ID badges may benefit from action card points on reverse of badge
TP staff may be used at control room, to lab controller .

Recommendations for Blood Bank Managers:

- Dummy run with NHSBT
- Pre thaw 3 x4 FFP for 'packs'
- In 15 minutes from MI being called Blood for ED needs to be in ED with staff
- Recommend MTO/ATO as Stock monitor who checks and orders more stock
- Recommend BT manager/Haem consultant in ED as good go between (will need walkie talkie to Lab)
- Don't stand down too soon!
- Regualry check call out list of staff
- NHSBT prefer many small orders (driver permitted)
- Return of unused blood not viable in these cases (blood boxes may only be 3 hour unopened rated)

TW-B presented feedback/learning points from NBTs MI exercise.

KC and RE gave a presentation produced by the Transfusion Lab staff at Salford Royal Hospital following their response to the Manchester Arena bombings.

14. Date of Next Meeting
Wednesday 6 November 2019

South West Regional Transfusion Committee Meeting – 15.05.19 – Action Log

Actions from meeting minutes		Actioner(s)	Status	Notes
4	Produce comparison data for rbc units odered and transfused at future meetings	JM		
4	Split wastage graphs with large numbers of hospitals	JM		
5	Circulate Transfusion 24 minutes	SW		
6	Advise RE of any problems with red cell giving sets	All		
6	Complete universal plasma project survey	All		
7	Add question to 2019 database survey re. HTC reporting structure	JM		
7	Copy the HTC Chairs when the 2019 database survey is circulated	JM		
7	SW to document SW RTC database initiative in next NBTC update	SW		
7	SW encouraged trusts to submit data for the cell salvage database	All		
8	EC to share NBT's single unit project poster	EC		
13	MG to share MHRA rep. contact details with TLMs	MG		

South West Regional Transfusion Committee Meeting

Wednesday 15 May 2019 at Oake Manor, nr Taunton

APOLOGIES

Hospital	Name
Derriford	Stuart Cleland
Dorset	David Quick
GHNHSFT	Sally Chown
GWH	Freya Collings
NDDH	Susan Coulson
NBT	Karen Mead
	Tim Hooper
NHSBT	Mike Murphy
Patient Rep.	Helen Witham
	Kay Rouse
Poole	Rebecca Maddams
	Alison McCormick
RBCH	Shane McCabe
	Stacey Reichter
RCHT	Richard Noble
	Carol McGovern
	Nicki Jannaway
RD&E	Veronica Sansom
	Julie Mitchell
RUH, Bath	Jerry Nolan
	Sue Scott
	Helen Maria
Salisbury	Anne Maratty
UHB	Soo Cooke

GLOSSARY OF ABBREVIATIONS

BBTS	British Blood Transfusion Society
BMS	Biomedical Scientist
CCG	Clinical Commissioning Group
CMV (-ve)	Cytomegalovirus (negative)
Cryo	Cryoprecipitate
DOAC	Direct Oral Anticoagulant
ED	Emergency Department
FFP	Fresh Frozen Plasma
HTC	Hospital Transfusion Committee
HTT	Hospital Transfusion Team
GMP	Good Manufacturing Practice
GWH	Great Western Hospital
IOCS	Intraoperative Cell Salvage
MH	Major Haemorrhage
MHRA	Medicines and Healthcare Products Regulatory Authority
MI	Major Incident
NATA	Network for the Advancement of Transfusion
NBT	North Bristol NHS Trust
NBTC	National Blood Transfusion Committee
NCA	National Comparative Audit
NHSBT	NHS Blood and Transplant
NHSI	NHS Improvement
#NOF	Fractured Neck of Femur
PBM	Patient Blood Management
PCC	Prothrombin Complex Concentrate
RBC/rbc	Red Blood Cell
RTC	Regional Transfusion Committee
SaBTO	Advisory Committee on the Safety of Blood, Tissues and Organs
SWAST	South Western Ambulance Service
SWPBM	South West Patient Blood Management
TACO	Transfusion Associated Circulatory Overload
TP	Transfusion Practitioner
TXA	Tranexamic Acid