CONFIRMED MINUTES OF THE SOUTH WEST REGIONAL TRANSFUSION COMMITTEE
Wednesday 14 November 2018, 10:30 – 15:30
Oake Manor, Nr. Taunton

Attendance:

NHS HOSPITALS/ORGANISATIONS	
Derriford Hospital	Stuart Cleland (SCl); Caroline Lowe (CL)
Dorset General Hospital	Dietmar Hofer (DH); David Quick (DQ)
Gloucestershire Hospitals	Robert Orme (RO)
Great Western Hospital	Edward Bick (EB)
North Bristol Trust	Karen Mead (KM); Elmarie Cairns (EC); Tim Hooper (TH); Tim Wreford-Bush (TWB)
North Devon District Hospital	Susan Coulson (SC); Kathleen Wedgeworth (KW)
Poole General Hospital	Vikki Chandler-Vizard (VCV); Alison McCormick (AM)
Royal Bournemouth Hospital	Lorraine Mounsey (LM); Stacey Reichter (SR); Shane McCabe (SM)
Royal Cornwall Hospital	Stephen Bassey (SB); Kathy Clarke (KC); John Faulds (JF)
Royal Devon & Exeter Hospital	James Piper (JP); Barrie Ferguson (BF)
Royal United Hospital Bath	Sarah Wexler (Chair) (SWe); Dave Fisher (DF); Wayne Vietri (WV)
Salisbury District Hospital	Anne Maratty (AM)
Taunton and Somerset Hospital	Michelle Davey (MD)
Taunton and Somerset Hospital/Yeovil	Sarah Allford (SA)
Torbay Hospital	Patrick Roberts (PR); Alistair Penny (AP)
University Hospitals Bristol/NHSBT	Tom Latham (TL); Soo Cooke (SCo)
Weston General Hospital	No Attendance
Yeovil District Hospital	Alison Hill (AH)
PRIVATE HOSPITALS	
Nuffield Health Cheltenham Hub	Samantha Lewis (SL)
Nuffield Health Exeter Hub	No attendance
Spire Hospital, Bristol	No attendance
Patient Representative	Helen Witham (HW)
NHSBT	
Patient Blood Management Practitioner	Katy Cowan (KCo)
Consultant Clinical Scientist Trainee	Tom Bullock (TB)
Customer Service Manager	Rhian Edwards (RE)
Haematology Registrar	Rebecca Allam (RA)
RTC Administrator	Jackie McMahon (JM)

1. **Apologies:** Attached.

2. **Previous Minutes**
The minutes of the meeting held on 09 May 2018 were confirmed as a true record.

3. **Matters Arising (not covered in main agenda)**
None.

4. **Hospital Issues and Wastage Updates (KC)* (*all presentations are available on the SWRTC website)**
Issues for the first half of 2017/18 and 2018/19 were compared.
Rbc issues continue to decline in the majority of trusts and SWe suggested a review if this wasn't the case.
Platelet issues rose in two thirds of NHS trusts which contributed to a 4.1% increase regionally.
O-neg wastage was presented for the first time. JM find out if the data can be presented by category and SW reiterated that avoidable wastage should be investigated as a matter of good practice.
It was agreed to review the rbc and platelet wastage graphs with a view to presenting the information more clearly.
It was noted that CMV-ve issues to hospitals that send transplant patients to Southampton had started to reduce. RE to clarify if the figure for CMV–ve issues reflects units ordered or issued.
Forward any suggestions for presenting the data any differently to JM.

5. **National Blood Transfusion Committee update (SWe)**
SWe highlighted some of the topics discussed:
    - Intraosseous samples are not suitable for cross matching. Some hospitals within the SW RTC have an SOP for grouping using intraosseous samples but do not use for crossmatching.
    - Differences between RCI and BSH guidelines on anti-D. TB to feedback to RCI to make sure their guidelines are in line.
    - Annual national meeting for TPs. BF confirmed that there are plans to organise and fund a TP training day.
    - Sharing of special requirements between trusts in light of new GDPR rules and information governance. This prompted a discussion during which it was highlighted that one trust's IG team had stopped them using SpICE. NHSBT has also identified a problem with EDN when patient details are entered on OBOS and is looking at how to move to more secure transfer. RUH still use EDN and SpICE as they consider the risk to the patient is greater by not using SpICE (there is an exception within GDPR for important clinical information). It was agreed that the message from the SW RTC is that if there is a risk to patient safety, we should continue using until there is an appropriate solution. This could be reinforced by carrying out a risk assessment.
      TL requested that any difficulties accessing NHSBT systems should be reported to RE.

- Confusion between MHRA/UKAS/HTA rules and regulations - one system would be preferable.
- SWe encouraged everyone to complete the 2018 PBM survey.
- Trusts are encouraged to continue to provide data to BSMS and encourage staff to attend roadshows.
- Amalgamation of NHSI/NHSE in 2019.
- Emergency contingency plan for transfusion – The RTCs were asked to feedback on what contingency plans are in place in their regions.
- NHSI's new plans for pathology across the country using the hub and spoke model. There was a presentation by Adrian Newland at the NBTC meeting.
  The south west has been split into 2/3 regions . A recent state of the nation report suggested that we were 90% towards achieving this goal. The NHSI model suggests we should be focussing most of our routine work at the hub and the spoke would be for emergency pathology only. The suggestion is that 40% of work from each spoke goes to the hub.
  SWe feels strongly this will have implications for pathology services across the country; with a disproportionate impact on transfusion, patient safety and on–call.
  KPMG modelled the savings and predict we will save a significant sum across the region.
  Spoke hot labs will still need a minimum number of staff which could result in the inefficient use of staff and equipment and there will be a cost element for transporting samples. DF felt there was a case for high cost specialist tests to be centralised.
  SWe concluded that we need to feedback we have concerns for patient safety and it may not appropriate for transfusion, which is a special area for consideration. SB said the message from the centre is comply or justify but it was pointed out that arguments against the system are not being addressed. Part of the problem is a lack of BMSs and unless that is addressed it is an issue we will be faced with anyway.
- Feedback was requested on anything that should be a priority for transfusion going forward and it was agreed that this should be the training of BMSs and maintaining a skilled workforce.
- Key recommendations from SHOT update: back to basics/ understanding what is compatible; pre-transfusion risk assessments for TACO; fully implemented IT systems for tracking.
- MHRA. Incident reporting to SHOT should not result in a finger-pointing exercise as this has resulted in a reluctance for people to report and investigate.
- Let SWe know if you would like anything else fedback to the NBTC. Next meeting in March 2019.
- JP queried what impact will the Fake Medicines Directive have on the transfer of blood products & components from one trust to another, since these products will have already been assigned to their original customer & not the hospital they are transferred to.

6. CSM Team Update (RE)

We will continue to receive Welsh blood until the new year; stocks of MB products will improve with the increase in supplies of imported plasma from December; no start date yet for full face labelling; OBOS reconciliation function roll-out commences 19 Nov 2018; everyone getting fresher blood – now 8 days as opposed to 12 days in 2012.

7. PBM Update (KCo)*

NCA

- Audit of maternal anaemia will be sent to maternity units - no TP involvement.
- Meeting in November to discuss future audits – the SW RTC responded to the request for suggested new or re-audits.
- Comments from discussion at the May RTC meeting were fedback. Lise Estcourt was unable to attend this meeting but is planning to come to the May 2019 meeting to discuss.

The SE Coast RTC has developed an audit tool for NICE quality standards compliance which is available in the audit section of the Hospitals & Science website: http://hospital.blood.co.uk/

2018 Database Survey (KCo)*

KCo summarised the database results. Two NHS trusts did not respond.

The following points were raised during the presentation:

- Variation in regional practice for prescribing EPO to non-renal patients as one trust's pharmacy won't allow. SWe suggested citing the Munoz study European consensus paper on PBM and the use of EPO to support its use in non-renal patients.
- IOCS in DGHs was discussed at NBTC and the challenges of maintaining trained/skilled staff in small hospitals due to the impact of PBM and less people requiring cell salvage.
- There was a query if the anti-D traceability question in the database survey related to doses allocated or administered. Post meeting note – the question asks "Approximately what percentage of anti-D doses issued is traceable to a named patient".
- TL queried if there was anything within the region that NHSBT should to be aware of - single unit transfusion is an ongoing initiative, although some trusts are unable to easily extract the data.
- One trust has a policy not to stock or pre-order platelets to reduce wastage and queried if this is still acceptable practice.

Survey of Platelet Wastage in Major Haemorrhage (KCo)

KC presented the results of the regional platelet survey. Nine trusts responded and all kept a stock unit of platelets. During the month surveyed there was 43 major and 14 obstetric haemorrhages. 38 platelet units were issued, 28 transfused and 6 wasted.

Proposed O-Neg Survey (DF)

DF outlined a proposed regional survey of O-neg for lab. managers. This was agreed and will be circulated.

8. Presentations/Audits*

Therapeutic Monoclonal Antibodies and Blood Transfusion (TB)

TB gave an overview of the information that is available for hospital transfusion laboratories, transfusion practitioners & haematology clinical teams.

The Joys of Living with DBA (Diamond Blackfan Anaemia) (HW)

Helen Witham, patient representative, gave a presentation on her journey with DBA.

9. SWPBM Group Update (JF)

IOCS database. We now have a set of data covering a three-month period from 8 hospitals. 1600 cases were reviewed with pre-op Hb recorded in 1300. The vast majority were obstetric cases (683), followed by orthopaedics and spinal. TXA used mainly in orthopaedics and spinal. Obstetrics was best for collection/processing. 28% of patients had salvaged blood reinfused (462 patients/290mls average). Two cases were reported to SHOT. Data will be compiled into a PowerPoint presentation for KC to share with her PBM team and the RTC. JF asked for a volunteer to write up a poster for presentation to NATA and will be happy to work with them.

The last group meeting was in September. Topics discussed included a new audit tool for anaemia screening; anaemia pathways; IOCS-SALVO outcomes; issues around obstetrics and cell salvage.

9. Hospital Presentations/Audits*

Cell Salvage #NoF Audit at NBT (EC)

EC outlined an audit in progress at NBT involving cell salvage and TXA in #NOF patients. Currently four months in and 74 patients had cell salvage. Data not yet analysed but could be a potential regional study.

Guidelines for TXA in #NoF/Trauma (EC)

EC outlined the steps taken by the RTC TXA Working Group to develop a regional guideline. Prior to implementing, it was suggested sending out a survey to all anaesthetic departments to gauge current practice and follow-up with the guideline. This was done at NBT and resulted in a large increase in the number of #NOF patients given TXA. We could then follow-up with a further survey to see how practice has changed. One trust within the SW region has already implemented TXA into their #NOF pathway.

10. Free Fetal DNA Testing Update

SWe gave an update on the number of trusts that have implemented testing with NHSBT. The RD&E has been doing their own testing for three years and JP asked what the % of false positive and false negative rates are within NHSBT. RE to respond.

11. Transfusion Laboratory Managers Update (DF)

Main discussion points:

- Brexit and the continuation of supply of non-UK plasma. RE confirmed that NHSBT is looking at this and will feedback when she knows more. This is not just an issue for NHSBT – all trusts are looking at the sourcing of blood products/medicines, etc and would like more guidance from SaBTO.
- Ongoing issue of potential logistical problems with re-supply to hospitals in mass casualty events. All trusts are being asked to provide category and number of patients they can accommodate. Some interest in exploring the potential for SWAST to have direct communication with NHSBT.
- Potential for the increase in the number of units requested with extended phenotyping for transfusion dependent patients to cause supply issues.
- Hospitals are requested to look at their AB unit demand to reduce the number of AB units being discarded to line up with a reduction in the collection of AB donations.
- Dave Fisher stepping down as Chair of the Group and James Piper taking over.

12. Transfusion Practitioner Group Update (BF)

Last meeting held in October and was attended by 50% of the TPs in the region. SC gave a SHOT reporting update, and incident reporting tools and recent incidents were discussed. The afternoon session focussed on the TP role and developing a series of competencies. Funding has been arranged for the next two meetings and the focus for the March 2019 meeting will be pre-operative and general anaemia management.

13. Education Sub-Group Update

Successful PBM in Surgery event held in November– nearly 100 attendees and positive feedback. Lab. Matters will run again summer 2019. Any suggestions for future educational events are welcome and should be emailed to Katy Cowan or Jackie McMahon.

14. Any Other Business

- EB asked if anyone had any concerns regarding Ferinject and hypophosphataemia.
- RO was interested in talking to someone about Rotem and TH agreed to talk to him after the meeting.
- SB raised the issue of the infected blood enquiry and would like NHSBT to provide a standard response for hospitals to give to anyone that contacts them.
- KM attended Advances in Transfusion Practice which showcased the Oxford NHS Trust's work within transfusion and PBM with particular reference to their electronic technology to support the transfusion process. They are very happy to be contacted for information or a site visit and VCV suggested asking someone from the trust to attend the next RTC meeting.

15. Date of Next Meeting

Wednesday 15 May 2019

South West Regional Transfusion Committee Meeting – 14.11.18 – Action Log

Ongoing actions from previous meetings		Actioner(s)	Status	Notes
	Feedback Southampton hospital's response re. non-compliance with SaBTO's CMV –ve guidelines			Close
	Send examples of how consent is discussed/documented to JM	All	Ongoing	
	Escalate issue with blood re-supply to NBT	RE	Ongoing	
Actions from meeting minutes				
4	Find out if regional O-neg data can be presented by category	JM		
4	Make wastage graphs clearer	JM		
4	Clarify if CMV-ve issues reflect units ordered or issued	RE	Complete	Ordered
4	Send any ideas for presenting data any differently to JM	All		Nothing received
5	Feedback to RCI differences with BSH anti-D guidelines	TB	Complete	
5	Complete 2018 PBM survey	All		
5	Continue to provide data to BSMS and encourage attendance at roadshows	All		
5	Provide feedback on emergency contingency plans for transfusion	All		
5	Feedback to NBTC concerns regarding NHSI's pathology plan	SWe	Complete	
5	Feedback to NBTC that training of BMSs and maintaining a skilled workforce should be a priority for transfusion going forward	SWe	Complete	
5	Let SWe have any other items to be fedback at next NBTC meeting (March 2019)	All		
9	Contact JF if interested in writing-up IOCS database poster for NATA	All	Complete	Poster rejected
12	Forward any suggestions for future educational events to KC/JM	All		

South West Regional Transfusion Committee Meeting

Wednesday 14 November 2018 at Oake Manor, nr Taunton

APOLOGIES

Hospital	Name
Musgrove Park	Nic Wennike
RUH, Bath	Susan Scott
Nuffield South West	Anna Gillard
Gloucestershire Hospitals	Colin Greig
Gloucestershire Hospitals	Sally Chown
Yeovil	Joseph Tyrrell
RD&E	Julie Mitchell
RD&E	Veronica Sansom
RD&E	Paul Kerr
Weston	Ana Pareja-Sanchez
Weston	Sharif Goolam-Hossen
RCHT	Carol McGovern
Nuffield South West	Iain Christie
RBCH	Ifraz Hamid

GLOSSARY OF ABBREVIATIONS

BMS	Biomedical Scientist
BSH	British Society for Haematology
CMV (-ve)	Cytomegalovirus (negative)
CSM	Customer Service Manager
DGH	District General Hospital
DNA	Deoxyribonucleic acid
EDN	Electronic Delivery Note
EPO	Erythropoietin
GDPR	General Data Protection Regulation
HTA	Human Tissue Authority
IG	Information Governance
IOCS	Intraoperative Cell Salvage
MB	Methylene blue
MHRA	Medicines and Healthcare Products Regulatory Authority
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
NHSE	NHS England
NICE	The National Institute for Health and Care Excellence
#NOF	Fractured Neck of Femur
OBOS	Online Blood Ordering System
PBM	Patient Blood Management
RBC	Red Blood Cell
RCI	Red Cell Immunohaematology
RD&E	Royal Devon & Exeter
RUH	Royal United Hospital, Bath
RTC	Regional Transfusion Committee
SaBTO	Advisory Committee on the Safety of Blood, Tissues and Organs
SALVO	Cell SALVage in Obstetrics
SHOT	Serious Hazards of Transfusion
SOP	Standard Operating Procedure
SpICE	Sunquest ICE Desktop electronic reporting platform
SWAST	South Western Ambulance Service
SWPBM	South West Patient Blood Management
SWRTC	South West Regional Transfusion Committee
TACO	Transfusion Associated Circulatory Overload
TLM	Transfusion Laboratory Manager
TP	Transfusion Practitioner
TXA	Tranexamic Acid
UKAS	United Kingdom Accreditation Service