EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Thursday 14th October 2021 via Microsoft Teams, 10:00am – 13:00pm

Attendance:

Name	Role	Hospital
Dora Foukaneli **DF**	Consultant Haematologist	NHSBT / Addenbrooke's
Frances Sear **FS**	PBMP	NHSBT
Clare Neal **CNeal**	RTC Administrator / Minutes	NHSBT
Mohammed Rashid **MR**	Customer Services Manager	NHSBT
Susan Turner **ST**	TP	Colchester
Stephen Wilson **SW**	HTC Chair	Norfolk & Norwich
Loraine Fitzgerald **LF**	TP	Bedford Hospital
Katherine Philpott **KP**	TLM / TADG Group Chair	Addenbrooke's
Suzanne Docherty **SD**	Consultant Haematologist	Norfolk & Norwich
Joanne Hoyle **JH**	TP	West Suffolk
Julie Jackson **JJ**	TP	James Paget
Tina Parker **TP**	TP	Broomfield
Donna Beckford-Smith **DB-S**	TP	Watford
Alison Rudd **AR**	TP	Norfolk & Norwich
Georgie Kamaras **GK**	HTC Chair	Luton & Dunstable
Danielle Fisher **DF**	TP	Luton & Dunstable
Jane Tidman **JT**	TLM	Lister
Lisa Cooke **LC**	Consultant Haematologist	Queen Elizabeth, KL
Caroline Lowe **CL**	TP	Milton Keynes
Carol Harvey **CH**	EPA Network Manager	NNUH
Kaye Bowen **KB**	TP	North West Anglia – Hinchingbrooke and Peterborough
Ilyaas Guure **IG**	Data Analyst	NHSBT
Jasmine Beharry **JBe**	TLM	Milton Keynes
Helen Dakers Black **HDB**	TP	Addenbrooke's
Frank Baiden **FB**	TLM	Queen Elizabeth, KL
Sheila Needham **SN**	TP	Lister
Maria O'Connell **MOC**	TP	Basildon
Martin Muir **MM**	TLM	Royal Papworth
Michaela Lewin **ML**	TP	Addenbrooke's
Sarah Parson **SP**	TLM	James Paget
Emily Rich **ER**	TP	North West Anglia – Hinchingbrooke and Peterborough
Lynda Menadue **LM**	HTC Chair	North West Anglia – Hinchingbrooke and Peterborough
Claire Atterbury **CA**	TP	Queen Elizabeth KL
Monzeer Ibrahim **MI**	TP	Addenbrooke's
Sharon Kaznica **SK**	TP	Ipswich
Ellen Strackosch **ES**	TP	Luton & Dunstable
Isabel Lentell **IL**	Consultant Haematologist	West Suffolk
Sophie Blow **SB**	Clinical Operational Lead	Leeds Teaching Hospital NHS Trust

Apologies: Nicola Jones **NJ,** Tracy Nevin **TN,** Anne Nethersole, Karen Baylis, Teresa Green, Laura Wilmott, Dharini Chitre, Angelo Giubileo, Tanya Bancroft, Jane Preston, Allan Morrison, Joseph Barry

1. **Welcome: DF** welcomed everyone to the meeting. **DF** is chairing the meeting in the absence of **NJ**. Introductions were made by those in attendance.

   Minutes of last meeting: Minutes were agreed as correct. Please forward any amendments to **CNeal**.

2. **NBTC Update**

   DF I do not have an update, however, we received a summary.

   - **DF** The biggest discussion is around Transfusion 2024. It has been accepted for publication. In parallel with that the NCA is preparing an audit against the standard. Some hospitals have committed to the pilot stage. The teams are working on the development of a checklist in a way to translate the principles of 2024 in a more manageable table to easily perform a gap analysis in a simplified way.
   - **DF** Transfusion education is very much part of the agenda. The Haematology curriculum as recently been revised. Transfusion is a significant element of the curriculum in all areas. We are looking at guidance on how this curriculum is being delivered at a hospital level and how to support haematology trainees.
   - **DF** The block contract was introduced as part of COVID and is due to finish. Negotiations are ongoing. I don't have specific information about that but hopefully you will receive further information at a later date. **MR** will discuss more focused NHSBT.
   - **DF** I do not have specific updates from RTC chairs. We are at a stage where we need to elect a new chair for our RTC. The term for the Chair is maximum of 4 years, we are beyond this. The pandemic has delayed this. We are being advised by NBTC / RTC Chairs to start this process now. The chair needs to be a Clinician. We would like you to start nominating yourselves or colleagues. A list of nominations will need to be approved by the NBTC and then we will hold elections via email. The hope is to have a chair in place for the February meeting. The chair can then help to put in place deputy chairs. They will need to maintain dialogue between the RTC and NBTC and attend both regional RTC and RTT meetings. **FS** we will send out further communication to the RTC. Please do go back to your hospitals in case there is anyone else is interested. **DF** I would very much encourage as many to put forward recommendations. **CA** can it be anyone or do they need to have a transfusion background. **DF** it would be nice if the Chair or one of the Chairs / Deputy Chairs is a Haematologist. There is no rule to exclude or include any staff groups for Deputy Chairs.

3. **Regional Update – Feedback from TP and TADG Group**

   FS Presentation attached. **DF** any questions for **FS**.

   DF I want to ask those with interest to join the Education Working Group. There is a lot of emphasis in education. I would like to introduce educational events in such a way that have a sustainable impact for the future like the Mums, Babies and Blood. It has been suggested to look at aiming some education at more senior BMSs 3-4 times a year. Another area of need is TPs themselves, we had good representation from TPs at the meeting. I know **ML** has a good list of competencies. This is under continuous discussions nationally but if we can put something in place. **LM** if you could join future meetings so we can capture doctors within existing structures. We can discuss this further when we meet at the next Education Working Group in November. Any comments at this stage?

   <u>TP Update</u> - **JJ** don't think there is any major changes. **DF** we will leave the TP Update from this meeting.

   <u>TADG Update</u> – **KP** the joint meeting is taking place next week. Both Addenbrooke's Hospital and Norwich are providing blood on air ambulances. There is a national shortage of lyoplas so we are issuing FFP instead, which has its issues due to shelf life. MAGPAS have signed up for the whole blood trial so we are not supplying them currently. There are some national recommendations for

major haemorrhage protocols so we may need review these. We will take to the TP / TADG meetings to review. UKAS surveillance visits are delayed due to serious staff shortages. We were due a visit in April but still haven't had a visit. They are currently working through that. There are new UK TLC guidelines being ratified at the moment, they will be out in due course. BSH IT guidelines are also being reviewed. We have concerns on sample shortages and will be discussed at the joint meeting as this is affecting us all at the moment. From the national group there will be another lessons learned document. The national group is working closely with UKAS around calibration and uncertainty of measurement to have a national document.

4. NHSBT Update

MR presentation attached.

- Tube Shortages - **MR** what are hospitals experiences of tube shortages? **DF** asked **KP** if there is any feedback. **KP** I don't have any immediate response but is something we need to look at during the TP / TADG meeting. Those who are using Sarstedt don't have a major problem, it's some of the other suppliers that is causing the problems. **CH** we are not doing too badly at the moment. We haven't seen as much of a reduce in usage as we had expected. Colleagues are being spoken to on an individual basis regarding unnecessary samples. **DF** what I would like to ask everyone if you aware of any impact on patients. I think that this can be discussed at the joint meeting and fed back to the wider RTC. **KP** there are areas nationally where there is a problem. **DF** asked **KP** to collect information next week and circulate as necessary.
- Barcode Labels - **FB** we had a conversation about a unit that we had a problem with because we rely on PDA, it went onto the ward and the ward was unable to scan it. I am not sure if any other hospital has experienced the same. **MR** the incident you mentioned, when we investigated we found that it wasn't related to this new supplier. If you do come across anything like this, please do get into contact with us.
- O D Negative for Emergency Stock – **DB-S** why has the age changed to 51? **DF** the discussion of 60 has come in, in general for the childbearing potential, not only for transfusion but for all other issues in hospital. Subsequently, after intensive consultation nationally and internationally the age of 50 was agreed as the natural spontaneous childbearing potential. In general, this is the rule applied for all transfusion. **LF** I had a query from a Consultant regarding children, males under the age 18 why they are given O Negative. **DF** in general this is the recommendations, it is up to the local hospital to make them more specific. What we aim to achieve is preserve O D Negative for those that need it the most. For children, we don't want to cause sensitisation in someone at such a young age. It is not catastrophic to give a 17 ½ year old O D Positive but you have to have a cut of somewhere. **LF** for platelets we treat them as children up to the age of 16 and then adults after. Is that a problem? **DF** I don't think it is a problem. **DF** asked **KP** what she thought. **KP** I think our guidance says 16. I will check this. **DF** I think if we have specific questions, please put in writing and we will investigate further.
- Convalescent Plasma – **DF** hospitals need to do a risk assessment and if the stock is causing problems, you need make decisions at a local level. There is a new trial that is due to start to offer convalescent plasma to immunocompromised patients to prevent development of COVID. Most likely FFP will be collected from patients who have antibodies from vaccine. We do not have guidance at the moment.

DF are there any questions or comments for **MR**? I suspect that the joint meeting may generate some dialogue so this can be fed back to **MR**.

5. Presentation – Quality Improvement in pre-operative anaemia

SB presentation attached.

DF thank you very much for this presentation, really impressive piece of work. Are there any questions for **SB**? **LC** fantastic piece of work, the key is working in environment with access to information. **JH** can I ask again, what PLICS were again? **SB** it is the Patient Level Information Costing Service, which are usually sitting within the finance department. **DF** we have done a similar piece of work showing similar findings and impact on length of stay. We started with colorectal surgeons to identify pathways before the pandemic. It is difficult to engage teams to propose a solid pathway. You cannot impose or

suggest, it has to come from them. Are you happy to share your slides? **SB** I am happy to share slides. If anyone would like to talk anything through you are more than welcome to contact me. **DF** thank you so much for joining us today **SB**.

6. Discussion – Issuing of Blood on Air Ambulance

JH we are a small district hospital, so we don't supply the air ambulances, but we do have people dropping in and then transferring but potentially having blood products. When we do we have issues around traceability. **DF** do you think it is better to have a more comprehensive discussion at the joint meeting and look at the scale of problem and potentially see what can be put forward. **FS** it came up last week, the regional transfer of blood document is up for review too so this may tie in the same discussions. **DF** if time does not permit at the joint meeting, then a smaller group can move this forward. **DF** can I leave this for the joint meeting? **JH** will email **KP** details to bring up.

7. Presentation & Discussion - Sample Labelling Audit – Non-Compliance with BSH Guidelines for Sample Labelling

CH / SD presentation attached. **CA** I am under the impression you sometimes transfuse on one sample which others don't. **CH** no we don't anymore. **CA** I wonder what would happen if something happened and how you would be able to justify it if it's on an addressograph and the national guidelines say no to this. **SD** we have got evidence that looks like it's safer. **LC** I think that if you have evidence and you monitor it, I wouldn't change a system that is working. **LM** has that original audit been presented nationally? Are there any other hospitals that do what you do? I haven't seen anywhere else that does. It is very interesting. **SD** as far as I am aware we are the only centre. I want to re audit and then take it nationally via a BSH conference. **LM** I would be really interested. I have so many pictures of people labelling samples in random places. **IL** what do you do with an addressograph that are not properly printed, for example, the end of the DOB get cut off. **CH** we reject. **IL** what about signing for these, do you have any record? **SD** the signature would be taken from the form. **KB** we have had some problems in out labs with analysers and labels so if people are not attaching them correctly, the label has got stuck in the machine. It can be difficult for the equipment may struggle to read the sample. It might be what we are using or if this is a wider problem. **CH** we have a problem in blood sciences with labels on the analysers but not in transfusion. **JJ** I don't like the use of pre-printed labels as it does have the potential for increased errors. I know in blood sciences we had a WBIT due to an ICE form being used incorrectly. This is down to clinicians are not necessarily doing the patient checks correctly. **SW** the other thing is that I am constantly amazed that people try to bend the safety rules. I have been involved in transfusion and the RTC for a long time and we still discussing the same issues. The latest is taking the samples at the same time and labelling at the same time. It constantly bewilders me. **CA** welcome to the TP world. We use pretty successfully the bloodtrack system, but it doesn't stop it, but we can work out what they are doing. **IL** does anyone else in the region have a close loop system for transfusion sample labelling. We were hoping the pilot would begin the autumn, but this will be the New year. Has there been any issues? Is that would NNUH would consider doing? **CH** it would be and that is the system that we are trying to use when we are talking about the PDA's. Where there has been more use on other sites we have had a couple of WBITs. **IL** the company has assured us that this is not possible. **ML** I just wanted to state that the Addenbrooke's closed loop system is far from perfect. We still get WBITs and probably more than we should be getting. We have problems with equipment availability. In some ways I wish we were still on a paper-based system that was easily accessible for clinical areas. **MR** are you having to issue specific advice for NHSBT samples? **CH** we specify they have to be handwritten. I am really happy to answer all questions via email. **DF** I would recommend benchmark not only your practice but historical records where addressographs were used more widely. There is no doubt NNUH had robust transfusion practice in

many ways, ensuring this culture is sustainable in the future. Thank you very much, that presentation raised some interesting discussion.

8. Presentation - COVID Experience with ECMO Patients

MM presentation attached. **DF** thank you for your feedback to the region. It is very unique to the region.

9. HTC Updates

DF I would like all hospitals to have the opportunity to share any experiences / practices they have.

- **CL** Milton Keynes are doing a lot of work on the issuing of Octaplex. We have completed a retrospective audit and an audit over the last few months. We are going to present at the HTC next week and would be happy to present to RTC at a later date to show you the audits and implementation of our checklist. **DF** thank you; this is very much in line with SHOT recommendation. It would be really valuable for us to hear and a very welcoming step for everyone.
- **JT** I have recently done a lot of work around training. We have MDT training within the lab and that's a lot of training that we have to do. We have risk assessed our processes and re-written the training SOP. We are putting this is place at the moment and will hopefully reduce our training burden. **DF** thank you very much.
- **DB-S** I wanted to say Ben and I are working together mainly with the maternity department as we are having an issue with students taking group & save. There is momentum that we training them. We are in discussions at the moment. We went out to the region who gave us some valuable information about what they do about students. It looks like we will need to deliver some kind of training package and competencies for year 3 students. We hope to get that up and running early next year and will keep you informed.

DF as mentioned earlier we are looking at putting on an education session 'Special Blood for Special People'. If you have any ideas for subjects / presentations, please let us know and we can develop ideas around that.

DF my recommendation for the new chair is to go through each hospital at the meetings in order to give everyone an opportunity to update the region. We may not be able to capture every hospital at every meeting.

SW just one thought. I hear a lot of information about training. Training needs to be efficient. We feel that we have to fill up a certain amount of time, however, we need to ensure that it is pointful and actually efficient. This will allow more engagement. **DF** we want to make anything we deliver to be effective and engaging.

10. AOB

DF thank you very much for today's meeting. I would like to invite you to express our gratitude to **NJ** for chairing the RTC for the last 5 years. **NJ** has led some excellent events. We expect the new committee will be able to continue to drive this forward. Hopefully by the February meeting we will have a new chair in place and be able to elect deputy chairs.

Date of Next Meeting and Close: 23rd February 2021, a meeting invite will be circulated.

Actions:

No	Action	Responsibility	Status/due date

1	Circulate information regarding RTC Chair Nominations	**FS / CNeal**	ASAP
2	Ideas for presentations – Special Blood for Special People	**ALL**	Ongoing
3	Ideas for presentations, case studies and discussions	**ALL**	Ongoing
4	Circulate rules for RTC Chair nominations Send nominations to CNeal	**FS / CNeal** **ALL**	5th November 2021 End November 2021