	South West RTC Patient Blood Management Working Group 28th January 2020	
Attendees	Mark Pope, Poole Russell Way, Royal Bournemouth Lorraine Mounsey, Royal Bournemouth Alison McCormick, Poole Michelle Pearce, Musgrove Park Issie Gardner, UHB Paul Scates, Torbay Elmarie Cairns, North Bristol Karen Mead, North Bristol Chris Smith, Barnstaple Donna Davis, Glos Hospitals Sam Timmins, NHSBT	**Action**
Minutes of previous meeting	Minutes to be re-circulated with corrections to initials and all relevant links and attachments. CM @ RCH noted that it was previously agreed that the group would wait for updates on the national CS workbook to be issued before any regional approach was taken.	
ACTIONS	Trusts with a Blood Conservation Coordinator in post are invited to share their business cases for the role in order to support implementation in other trusts in the region. All to send data regarding staffing levels of TP's and BCC's as per band as WTE to ST/ JM NHSBT to compile alongside hospital size (beds and theatres) for comparison. Again, to support trusts in expanding services and support for PBM practice Trusts who routinely collect data on CS usage to send data capture titles to ST NHSBT to collate, in order to support decision making around the relaunch and redesign of the CS database by end of Feb. Sam to collate and circulate by end of April.	
	<u>Minutes</u>	
Anaemia	Discussion around various approaches and progress in implementation of pre surgical optimisation Service provision varies trust to trust. Some have specified anaemia nurses in place, others have services driven by existing pre op staff. Discussion around using regional data to support development in local trusts, can the upcoming annual RTC audit, as well as past annual audits, help provide such data and be functional information for the group. GIRFT meeting at NBT interest on anaemia and optimisation, may be another forum for trusts to gain support and momentum for implementation.	

	Equally funding varies; some hospitals have implemented services at own cost in the hope of negotiating funds in future, some have services in place under block contract, and others find there are variable tariffs in place for IV iron therapy (day case rate, consultation rate). Dependent upon the commissioners and negotiations. Capacity for treatment of pre op patients discussed, some attend existing services such as ambulatory care units, other have own specific pre op Iv iron clinic set up A.M @ Poole discussed the pan Dorset project. Collaborative approach of Dorset, Poole and B'mouth hospitals to implement joint pre op anaemia pathway. Currently in audit phase at present, which poses some challenges and variations in data due to variation in treatment Hb thresholds. Once audit complete, work on business cases will commence, although there was contact with a commissioner to be involved at the PANDA, this has now waned. At RBH, in endoscopy there is a system set up for virtual iron clinics, following blood analysis the virtual clinic would then contact the patient and have a prescribed oral iron for the patient to optimise prior to surgery. There is a nurse employed within the department to run these clinics. E.C discussed NBT ortho anaemia screening pathway- elective surgery can be deferred for a period of time to allow for optimisation if required. Question raised how this could be extended to support optimisation of trauma patients with the use if IV iron.	
VIFOR audit tool presentation	Speaker DNA Opportunity taken to review CQUIN outlines in relation to pre op anaemia. Most trusts looking to implement CQUIN into existing service provision or use to bolster business cases for service provision. Discussion around how to utilise oral iron in patients who are pre-op assessed in a greater time frame than that for IV iron use as per consensus statement. Dependent upon GP engagement, and who's responsibility it is to liaise and organise oral iron prescription and follow up prior to surgery. Noted there are some trusts who now have management responsibility of some GP practices, Yeovil and Swindon as example. Could these be opportunities to build bridges and links and audit the effectiveness of oral iron in pre-surgical optimisation? Discussed the potential for a Business manager to attend future meetings to deliver support on Business cases, but also discussion around CCG representation at the group for guidance on commissioning process outside of CQUIN There was a clear difference in which iron supplement each trust is using - Monofer and Ferrinjet most common. Question raised by E.C around any post-operative pathways for use of iron to optimise, practice varies, no trust has a clear pathway in place. Perhaps will be	

	opportunity to develop this once trusts have established pre op pathways successfully? Potential for audit work on post op care and blood use.	
TXA	Patients presenting to ED or theatre administration of TXA, for NOF patients Discussion around use of TXA in emergency surgery and the practicalities of prescribing and administration post op. There is a section on the CS database for data capture of TXA admin, is this used, or is this data widely collected? Information sent to S.T NHSBT will help clarify. Is there a need for a separate data collection to review use of TXA in line with NICE QS? If NCA are organising a CS comparative audit as is rumoured, it may be an alternative piece of work. Further potential for the updated annual regional survey to be of use for the group, it asks questions already re. TXA use using QS as a marker, may be a starting point for an over-view, and a good indicator for future audit. May also be useful to be feedback to HTCs? S.T could provide summary document along with HL report?	
Cell Salvage	Discussions as to use of CS in trusts. Is it used for all applicable procedures: Use varies on staff trained, machine availability, and surgeon buy in. Around half of the group appear to use for THR surgery. Discussion around how decision to return blood, i.e. do you return it if it is less than a certain amount of mls…. Is there value? P.S reports good effect even returning smaller volumes. There are codes from the CCG for cell salvage, one code for collection and one code for processing, again variation in cost codes, is this down to hospital use or agreement with the CCG? Errors and concerns cracking of the processing bowls by E.C @NBT, reports of black bits found in the blood bags by C.M @RCH, SHOT reporting on the SHOT website, this was updated last week. Quality control practice questioned. Varied from trust to trust as to who routinely QC's, should be HCT and anti 10 lab samples. Does not appear to be common practice, difficulties of labs can take on extra work requires MD approach. Clear documentation for the machine and when the machine is checked by the engineer and if it has a controlled clean. Discussion around resetting/ relaunching the C.S database. With an agreed goal for the database, set data capture time, and agreed data set captures. Everyone currently collecting data to share with S.T to collate so data capture headings could be agreed at the next meeting to begin with the data inputting asap. D.D G&CFT- raised questions re. swab washing in CS, what solution - most of the group use saline. Also raised question regarding use leukocyte filters - most of the group use for malignancy, infection or metal on metal surgical procedures.	**All/ST**

	D.D New to post as BCC, and working hard to set up service, improve training and accessibility to CS. Discussion around approaches to training. Most of the group find the E-LfH module too long and laborious and slightly outdated. Some trusts are moving to make their own package. Most still use CS workbook but some are adapting as also do not find it entirely practical. Sam to approach senior staff who sit on UKCSAG for updates on workbook and e-learning and to enquire about further SWRTC representation at a national level. E.C @NBT writing policy for use of CS for vaginal bleeding collection, especially for JW in theatres: it will be down to the clinician's decision if to use the cell salvage for PV bleeds, explanation around draping and maintaining sterility of procedure and the potential use and considerations of septic patients	**ST**
General	Variation in transfusion & PBM services and staff resources between trusts and not always representative of size of hospital or service provision: re number of TP's Specialist ODP's for CS, and BCC. S.T & J.M @NHSBT - data capture around staff numbers in relation to beds, and theatres for UHB. Request for trusts to share their business cases for Blood Conservation Coordinators S.T @ NHSBT has relaunched twitter account: @SW_RTC in order to promote regional and individual trust work and best practice, also uses it to communicate new information for various forums, articles and other key messages in place of Katy's monthly emails. Please all find and follow.	**All** **All**
Next meeting:	Meeting date to be set for September and also the chair for this meeting: interim chair for meeting, shared chair for future meetings	