1. Welcome and Introductions

HD welcomed everyone to the teleconference:

In attendance:

HD) Heidi Doughty (Chair) | NHSBT
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(FC) Fatts Chowdhury (Secretary) | NHSBT & Imperial College Healthcare NHS Trust
(SB) Stephen Bassey | Royal Cornwall Hospitals Trust and NBTC
(LB) Lydia Baxter | Salford Royal Foundation Trust
(P-BM) Paula Bolton–Maggs | Serious Hazards of Transfusion (SHOT) UK haemovigilance scheme
(TC) Tom Cowdrey | Business Continuity, NHSBT
(AJ) Ant Jackson | Transfusion Practitioner (representing BBTS)
(MS) Martin Smith | Salford Royal Foundation Trust
(YS) Yousef Sourer | Barnsley Hospital NHS Foundation Trust and NBTC
(JS) Julie Staves | Oxford University Hospitals NHS Foundation Trust
(JW) Jim Wesson | Royal Albert Edward Infirmary & Salford Royal Hospital
(CW) Craig Wilkes | Customer Service, NHSBT
(SK) Sue Katic (Minutes) | NHSBT

Apologies:

(SR) Susan Robinson | Guy’s and St Thomas’ NHS Foundation Trust
(JU) James Uprichard | St George’s University Hospitals NHS Foundation Trust.
(AW) Anne Weaver | Barts Health NHS Trust

2. NBTC acceptance of TORs

The TORs were presented at the NBTC meeting on 19 March 2018. Confirmation is required from the NBTC on whether the TORs were accepted.

Need to provide a draft of the recommendations of the Emergency Planning Working Group for the NBTC meeting on 10 September 2018 – to be produced by the group by 3 September.
Comments on the TORs:
- PB-M asked for CBRN to be spelled out. Agreed.
  
  **Action:** HD to add a sentence to state that this document should not cover CBRN.

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<th>3. Preparation for revised version of the recommendations</th>
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The group was initially planned to be short-lived but after the events of 2017, a request was received to maintain a long term working group. Feedback was received from the NBTC Chair and the membership of the group was increased.

- FC had helped to arrange and presented at the RTC Education Event - “Mass Casualty Incidents” on 17 May in London.
- HD and FC attended ISBT in Toronto, June 2018 and shared the work of the group to gain international feedback.
- HD took the work to transfusion teams in the West Midlands via a regional workshop. The feedback was very useful and suggested that TLMs, TPs and consultants wanted more detailed information.

Comments on the main document:


Overview. MS felt that the document is clear and good for non-haematologists.

**Page 2 – penultimate paragraph**

- Action Cards should be in the toolkit. It is important for people to know where these are kept. The text in the penultimate paragraph should be amended from “Each ward and department should hold their own action card” to “Each ward and department should hold their own action card, examples for transfusion are available in the toolkit.”
- FC will ask St Mary’s Blood Bank to send their MI Action Card box, to be shared with the group and incorporated into toolkit by SB and FC.
- TC suggested finding someone who has a plan that follows the document and the putting this on the toolkit. HD suggested Wolverhampton New Cross. Members should try to obtain other examples.
- MS felt that the expectation is that you have already read your own action card, under emergency preparedness.

  **Action:** MS to send wording for this to FC

**MS**

**Page 3 – first paragraph**

- Final sentence “Additional training may be available” change to “Additional training will be available”

**Page 4 – third paragraph.**

- The document should mention what will be done with components that are not used. NHSBT cannot currently take blood components back. Many Trusts are
on multiple sites and should consider the re-distribution of red cells and platelets across sites. Trusts should look at what different sites use a lot of.  
*Action: FC to strengthen the paragraph.*  
*Action: SB / FC put examples in the toolkit and in Blood Bank Managers guidance.*

Page 5 – fifth paragraph

- This should mention the pre-emptive thawing of plasma. The group noted that Octaplas now has a 5-day extension.  
  *Action: JS to choose link and wording. Make clear that not everyone needs to thaw; only those trusts receiving critically injured patients.*

- Dispersal plans include patients going to non-major trauma units. This should be extended to trauma centres and trauma units; everyone should be prepared.

Page 6 – Selection and issue of blood and blood components:

- PB-M highlighted that the recommendation that Group O FFP be given only to group O patients. She recommended including an appendix/compatibility chart to explain this. NHSBT Customer Services teams have produced a chart, as have staff at Salford Royal Foundation Trust.  
  *Actions: CW and LB to send the compatibility charts to FC who will produce a chart to be incorporated into document as an appendix.*

- Consider LIMS requirements for the block issue of shock packs. JS to also think about this for the IT Guidelines.  
  *Action: JS to draft the wording as tracked changes and send it to FC.*

- Prioritise emergency O blood for P1 category patients only. P2 and P3 patients should have samples sent to get group specific blood components. However, it is recognised that triage status may rapidly change, and systems should be flexible.  
  *Action: MS/LB to provide FC with the wording.*

- Discussion around the training of TPs and blood bank staff if they are going to move forward and undertake a role in ED / theatres to support clinical staff. AJ to consider the training needs of TPs. LB to review the requirements for BMSs.  
  *Action: AJ/LB to review training requirements.*

- Staff should only work in areas they are both trained, competent and current in. Guidance for TPs assisting in the lab during a major incident will be dependent on the background of TP i.e. biomedical scientist background or nursing.

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<th>4. Any Other Business</th>
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<td>• Yousef Sorour stated that he thought the document was well-written. He pointed out that he is not yet shown as a member on the TORs. The TORs (including membership) will be updated, with the final version representing the comments from the NBTC meeting on 19 March.</td>
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- From an NHSBT perspective, a plan is required regarding the delivery of products during lockdown. Staff need to know that NHSBT vehicles would be able to access hospitals at this time.

- TC stated that the communication cascade comes from NHS England. If a Level 3 or 4 incident occurs then the National Critical Incident Manager will be contacted. It is expected that the ambulance service will inform Trusts. They in turn, should inform NHSBT. NBTC contact phone numbers should be inserted within the toolkit.

*Action: CW to send the information to FC.*

*Action: HD would like NHS England to know what we are doing. TC to provide contact.*

- The group will be guided by Shubha Allard as to the route that the NBTC would like to take for further consultation and communication of the document.

- AJ is already a member of the Transfusion Practitioner Regional Chairs network and will facilitate coordination with the group.

### 5. Timelines

- FC asked for all tracked changes to the document to be sent to her by 8 August.
- The document is to be updated and sent to the NBTC Secretary by 10 September.
- The NBTC’s autumn meeting is scheduled for 24 September.

### 6. Next Telcon

- Sub-groups to meet as required
- Main group TBC

Draft circulated for review 30/07/18
Minutes confirmed 13/08/18