EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Thursday 22nd October 2020 via Microsoft Teams, 10:00am – 12:00noon

Attendance:

Name	Role	Hospital
Nicola Jones (Chair) **NJ**	Consultant, RTC Chair	Royal Papworth
Martin Muir **MM**	Laboratory Manager	Royal Papworth
Julie Jackson **JJ**	TP	James Paget Hospital
Gilda Bass **GB**	TP	West Suffolk
Claire Sidaway **CS**	TLM	Hinchingbrooke
Teresa Green **TG**	TLM	Southend & Basildon
Cathryn McGuinness **CMc**	TLM	Princess Alexandra
Donna Beckford-Smith **DBS**	TP	Watford
Dora Foukaneli **DF**	Consultant Haematologist	NHSBT / Addenbrooke's
Sharon Kaznica **SK**	TP	Ipswich
Mark Stoker **MS**	HTC Chair	Peterborough
Debbie Asher **DA**	EPA Network Manager	NNUH
Kaye Bowen **KB**	TP	Peterborough
Stephen Cole **SC**	HTC Chair	Colchester
Helen Cook **HC**		Luton & Dunstable
Lisa Cooke **LC**	Consultant Haematologist	Queen Elizabeth, KL
Suzanne Docherty **SD**	Consultant Haematologist	Norfolk & Norwich
Roberto Garcia Consuergra **RC**	Consultant Haematologist	James Paget
Noha Gasmelseed **NG**	Consultant Haematologist	Luton & Dunstable
Brian Hockley **BH**		NHSBT
Joanne Hoyle **JH**	TP	West Suffolk
Kath Philpott **KP**	TLM	Addenbrooke's
Andy King-Venables **AKV**	TP	Hinchingbrooke
Isabel Lentell **IL**	Consultant Haematologist	West Suffolk
Loraine Fitzgerald **LF**	TP	Bedford Hospital
Natalie Outten **NO**	TP	Southend
Swati Pradhan **SP**	HTC Chair	Bedford
Alison Rudd **AR**	TP	Norfolk & Norwich
Sheila Needham **SN**	TP	Lister
Rebecca Smith **RS**	TP	Ipswich
Tina Parker **TP**	TP	Broomfield
Stephen Wilson **SW**	HTC Chair	Norfolk & Norwich
Clare Neal **CN**	RTC Administrator / Minutes	NHSBT
Susan Turner **ST**	TP	Colchester

Apologies: Mohammed Rashid **MR**, Frances Sear **FS,** Jane Preston, Karen Baylis, Niven Akotia, Claire Atterbury, Tracy Nevin, Rupinder Kaur, Dharini Chitre

1. **Welcome: NJ** Welcomed everyone to the meeting. There is not a formal agenda for this meeting but would like to give everyone the opportunity to discuss how Trusts have been coping since the previous meeting and how they will prepare for the challenges ahead over the coming months.

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

2. **Update – NBTC / RTC Chair Group**
   NJ PowerPoint presentation attached.

- RTC Boundaries. Currently 10 RTC's. Proposing to align to the 7 NHS regions. **NJ** cannot see any great changes for the East of England region. There may be some slight changes on the boundaries. There will be a consultation process about this. We can share with the minutes. **DF** from what I can see the South Essex and Milton Keynes areas may be where we expand. We might become slightly bigger.
- Virtual education. Proposal put forward that RTC's collaborate more to put together virtual education accessible Nationally. There was support, however, concerns that events that have been held locally on a regular basis may be under threat. **NJ** there was discussion about webinar technology may be beneficial for large numbers but this can be costly. It would be good to have ideas from the region on what we can do and what may be beneficial to the region. What can East of England do? Is having a meeting like this a good idea? Options for meetings and training could include:-
    - Larger events
    - Smaller, shorter events
    - Pre-recorded training
- **BH** has had discussions with other RTC's about running Audit Webinars. Would there be any interest within the region? There was lots of interest.
- TP Framework. There wasn't a finalised draft of the TP Framework for us to look at. The ideas are to make it more standardised. **DF** advised that **ML** has been developing competencies. If that piece of work is about to finalised it would be nice for **ML** to share this. **JJ TN** is unable to attend the meeting; however, the first draft has been sent out to national TP groups and they are progressing with this at the moment. The job description is using KSF and agenda for change. It is being discussed with HEE / NHSI. **JJ** will see if a copy can be shared with the minutes.
- National Audits. **BH** NCA main programme delayed until May 2021. Couple of reports are being finalised. Beyond that there is another National Cell Salvage survey that's imminent. Regional work in terms of audit has been put on hold. Still completing education evaluations if required. Refining WBIT tool so should be ready by next week.
- Incident Reporting. **NJ** there has been less reports in 2020, this was magnified further during COVID period. There was an overview of the SHOT report.
- Blood Components. There was a workshop on new blood components that colleagues may be interested in.

<u>Supply and Demand Red Cell data during COVID</u>. **NJ** shared a presentation. This shows the impact of COVID from March and a projection of what might be seeing presently and going into 2021. O neg has continued to rise. What has it been like for individual hospitals? Has anyone had any particular problems with supplies?

- **KP** had low demand from April. From May elective and transplant surgery re-started. Demand for platelets during May / June was phenomenal. It was initially unknown if this was down to haematology patients not coming into hospital during April due to COVID. Demand has been growing. September Addenbrooke's ordered their highest level ever of platelets from NHSBT. Unsure why this is. O neg has increased. We have cut down our emergency O Neg usage. The next project it to put O Pos in emergency fridges.
- **GB** West Suffolk have looked at usage July - September and has had100% increase in platelet use probably due to haematology patients. We have had a 22% increase in all blood components since last year. We have spoken to surgeons about this and this is based on increases from last year. Emphasises the need to not waste blood.
- **MM** at Royal Papworth during the first COVID process platelet demand dropped by 30%. With 6 theatres open we are seeing a big increase for surgical and critical care platelets.
- **JJ** Norfolk and Norwich had a big increase last month but had several ill AML patients.
- **TP** Broomfield has noticed an increase of O Neg in A&E. Patients are attending more unwell than usual due to patients not attending hospital earlier due to COVID. A&E seniors looking into this currently.

- **DF** Can I ask what prevention of transfusion with utilisation of alternatives such as iron has been stopped? We have a lot of obstacles on tis such as space and infection control. Anticoagulant clinics have changed from Warfarin.
- **LC** we are having a lot of late presentations in haematology patients. Seems this is similar across the sites.
- **TG** July and August Southend had a three-fold increase in platelets requirements. We have also had an increase in haematology patient deaths. September back to normal.
- **AKV** red cell use is definitely stable this is on a background of continued reduction for years. Would need to look in depth but we have had a few sick haematology patients and higher platelet use.
- **SW** patient maybe anxious about presenting to hospital for iron therapies. It is a shame we seem unable to encourage primary care to give iron therapy in the community.

NJ we have been asked to reinforce message and advise whether there is any anticipated changes or demand regionally which could help forecasts and preparations. Is there anything locally that you are doing?

- **JJ** has reduced O neg stock but cannot go any lower. Every month this is reviewed. What has been found is that transfusion is taking place to avoid expiry which showed our stock was too high so O Neg has now been reduced.
- **MM** Royal Papworth have had a close look and implemented all the recommended suggestions. Royal Papworth are at the bottom end of how much they can drop. 33% of O Neg is being issued to O Neg patients. 10% is being issued to women of child-bearing age.
- **DF** Sometimes it is not easy to reduce stock with no guidance, maybe liaising with stock management scheme would help influence decisions. It is important for NHSBT to collect information that is impacting on services. **DF** suggested having a standardised form that everyone can complete every few weeks so that any major changes are picked up on this to be fed back to NHSBT. Experiencing variability for each area. It is important for NHSBT to know this and the impact of services. Some services may slow down, some may increase.
- **DA** really important question is how low should our O Neg stock be as we all really worried that there may be an obstetric major haemorrhage. NHSBT were sending out a questionnaire but this stopped, very happy to be prompted to advise them what we know is happening locally. KP would encourage us to look at what we are doing with O Neg's if we are completing regular questionnaire.
- **JJ** Norfolk and Norwich keep very few O neg if the laboratory request replenish for a number of units then we tend to get the same expiry date and then we tend to use for non O neg patients to avoid time expiry. This was fed back to NHSBT. We just need a variety of expiry dates when receiving multiple units.
- **NG** discussed implementing of the pre-op assessment and management of anaemia clinic and think this will help transfusion requirements in surgical settings.
- **CMc** there is a National Steering Group on use of O Pos instead of O neg and upcoming regional audit - **TN** is involved in this. DA national guidance of when we could switch would be really beneficial.
- **SD** distance from blood centre is a real issue that feeds discomfort for O Neg stock holding.
- **BH** could create an online data collection survey. You are currently doing similar with WIBIT. **JJ** TP group would be willing to be involved. **BH** the package that we have does incur a cost of £10. **DF** assuming it is the same package that is used for national surveys. Sure the costs can be absorbed by the RTC budget. There are options for remote access so that data can be uploaded once you are connected to WIFI. **JJ** anything, we can do to increase education around this would be really beneficial.

- **LF** Bedford are the last drop off and only once a day so no delivery at weekends so we can't reduce due to potential PPH's.
- **JH** major haemorrhage over activation also is a factor, perhaps more education events on that for medical staff.

NJ It may be useful to share some of these slides with your teams. A lot of clinicians have moved around areas that they have not worked in previously so is important to look at training and support that they need.

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

FS is unable to attend the meeting. Andrea Marshall has kindly forwarded an update. This will be circulated with the minutes. **NJ** went through this update.

- Please direct queries to **CN** or to Customer Services whilst **FS** is off.
- Component Demand. This will be discussed later in the meeting.
- Safe Return Policy – units returned from COVID areas. Has anyone had experiences of wastage or put anything in place? **DF** Addenbrooke's has experienced some wastage especially in theatre when blood boxes were opened. That was inline with the overall policy of the Trust in how to handle drugs and materials. I believe this has now been clarified through infectious diseases teams. This is essential. **KP** this was at the beginning when we didn't know how we could work with this; we don't have a policy for bringing blood back. Policy was that if a patient was in theatre with COVID it would all be wasted if not used. If it was handled near a patient with COVID at the bedside then it would not come back. If it goes out then it comes back to us with the trust that it has not been handled near a patient with COVID. We are wearing gloves and are utilising as we can. We are not wasting products unnecessarily and we have not had any concerns that we are aware of. **NJ** we had plans at Royal Papworth last night to do a plasma exchange but 4due to the patient's condition, this was cancelled. **MM** we have a quarantine policy at Royal Papworth but it was only required for an episode of FFP and HAS. We requested that any products returned to us from a COVID patient / area was returned to us in a plastic bag. We could quarantine for 72 hours before returning to use. We had a quarantine area in our stock fridge. **NJ** how has that worked? **MM** we hardly had any returns, we wiped any with a clinell wipe before starting the quarantine process. We didn't have any red cells or platelets returned. **DF** is quarantine enough? Do we need to disinfect? Is 3 days enough in a fridge? We might need to have infection control guidance. **NJ** I haven't sent anything nationally. **GB** we had some guidance initially, we had incidents on ITU. Referred to national guidance but this doesn't have any further information. Concerning if we are all doing something different. **KP** there was some information from NHSBT that they don't see there will be a problem wiping the bags with clinell wipes but they won't take any responsibility for doing so which is why Addenbrooke's doesn't it. **DF** it sounds unlikely wiping the bags will affect it, however, the barcodes on the bag are important. **NJ** Please advise if your Trust comes across any information. **DF / NJ / KP** to raise via various local / national groups.
- Platelet Demand – remained steady. Thank you to everyone for their hard work.
- Introductions to new members of PBM Team.
- Education. Non-medical authorisation of blood component course is now a virtual 4-day event. **DF** has not been involved in this format of the course. It gives flexibility to encourage more people to join. **NJ** It is being run monthly.
- Links to toolkits. There are some anaemia e learning modules and monthly SHOT webinars.
- BMS Empowerment and Discussion Group.

4. **Data Collection**

BH has retired but returned, currently working 22.5 hours a week and can support any RTC audit and survey activity. This data collation around COVID patients was an idea by Mike Murphy in February starting as a low-key attempt to get a handle on blood product use for patients admitted with this illness. It snowballed, with 30 Trusts submitting data on spreadsheets in various formats so has been moved online. This was done in relation to what was anticipated at the time about the effect of the pandemic on blood supply, distribution and donors. The introduction slide shows a 20% reduction in blood donations.

- Data has now been collected since late February.
- Data shown relates to the online data submitted as the spreadsheet data has been hard to collate.
- Data is still being added, we do not have a finish date for this at present.
- Over 3000 submissions between March and August. These are transfusion episodes.
- Data submitted from various sites that provide ECMO. Huge amount of data from Royal Papworth.
- Looked at use of blood components on wards. Pattern matches admission and blood components issued.
- Some of the higher volume patients may have received these blood products regardless of COVID as could have been haematology patients or trauma patients.
- Conclusion is that further analysis required.
- **BH** NHS England issued an updated spreadsheet on admissions of patients with COVID and will send a link to the spreadsheet if useful.
- The level of transfusion requirements was small. Elective surgery continuing so may affect this.
- Picked a couple of organisations at random on two separate dates. The Trusts on the left have bed occupancy and number of transfusions on the same day.
- Will be continuing with data collection and will provide a report when we stop collecting data.

NJ thank you so much for this information. Any questions or comments for **BH**. **MM** 55% of Royal Papworth COVID patients received one or more red cell unit. **BH** asked whether those patients would have received transfusions anyway? **MM** all our elective surgery went down, there were some emergency procedures that took place, we would need to look at the data in more depth. **BH** didn't really collect any of the background medical data. Difficult to determine if they would have had that blood anyway. You are going to have an increase if admissions increase. **NJ** half were directly relating to COVID. **BH** ECMO patients received more blood products. **NG** Luton & Dunstable has seen a couple of younger patients with COVID-19 HLH like features needing frequent red cells and platelet transfusions. **NJ** it will be good to present some of these patients and look at literature. **MS BH** makes a valid point that during the first wave of COVID elective services slowed down along with the demand for blood. It currently shows in the North West that elective activity will continue alongside COVID activity.

5. HTC Updates

NJ we have spoken a lot at previous RTC's about skill mixes, vacancies and rotas. I can only imagine what it has been like at times across the previous months with sickness, isolation and people working in unfamiliar areas. It would be nice to hear from everyone how it has been in your areas, what has been difficult, what has worked well and if there are any lessons learnt.

- **DA** lab we were lucky, workload crashed and staffing was ok. Nervous about winter months and if the workload stays the same that could increase pressure. Practically we hadn't thought of was that we use electronic blood tracking but badges couldn't be taken into COVID red areas. We completed a risk assessment and went with a generic barcode on red COVID areas. We maintained traceability but lost the ability to track who has used the system. This is recorded within the notes. It would be helpful to have national guidance on quarantining and wiping of units.
- **KP** Addenbrooke's had less staff in at the beginning. Tried to work in team bubbles and split staff in half so they worked 2 on and 2 off, 12 hour shifts but were very tired. We have started to go back to a normal working pattern. Senior staff are going to continue with working a 4-day working week. We saw normal, plus some, workload through the summer. We have 6 TP's but they can only have 3 in at once due to social distancing and now getting on wards training is not happening. Our train the trainer had to be curtailed for the time being. Any face-to-face training has ceased so difficult to complete normal workload. **DF** approaching people and training has become challenging. I have done more regular training for Haematology Registrars on Wednesday mornings via zoom. If you feel that your trainees would benefit from this, they would be welcome to join. NHSBT training mostly on on-line platforms. We need to maintain regular training where possible. This is new to everyone.

- **JJ** the TP group are planning a regional audit to look at various training methods used so we can standardise what everyone is doing, i.e. platforms, how we are providing training. We are having bitesize sessions for TP's.
- **MM** Royal Papworth allowed additional 3 months during the COVID surge for staff to be reassessed. It didn't lead to any errors during this time. We had to train new starters and competency assess face-to-face. Induction sessions were replaced by PowerPoint and quiz which was successful. We still maintained traceability rates. Group and save rejected increased during April but has settled down. There were redeployment and stresses which impacted this. We did not see other incidents rise and is credit to CCA transfusion links. We are involved in both convalescent plasma arms of the REMAP/CAP and recovery trials but we haven't had any activity as yet. All projects were placed on hold, this was disappointing as we were about to implement the blood track TX for bedside electronic checks. Only just resumed testing on this. Our current TP's are both retiring, with this and the surge in COVID the blood track TX has been delayed. Blood wastage has been low as Addenbrooke's Hospital have accepted our due to expire red cells / platelet. We had zero sickness in the lab but a couple of isolation incidents due to travel restrictions / secondary contact. We have a small lab so have to be careful in the lab so we share the lab space as well as working at home.
- **GB** West Suffolk has been very much the same, there were issues with traceability initially. Initially there were concerns with handling specimens in the lab which took a while to sort out. Home working is in place due to small office so we don't cross over anymore but we use zoom a lot. **JH** going through dissolution with Ipswich and Colchester so the lab staff will be employed by West Suffolk. We haven't had any convalescent plasma recovery activity.
- **CMc** Princess Alexandra were the same as everyone else. TP is working from home. We have our new hospital being built in the next 5-10 years. Pathology procurement in full swing, we have put in our initial needs, looking at the contract being awarded next year. COVID hasn't been affected too much, but I was helping with phlebotomy.
- **JJ** James Paget had very few cases and little impact. We are on both trials. We have had one recovery on first wave and 4 on the second wave. Most issues were issues that were there before COVID. We have been very lucky.
- LF Bedford merged with Luton and Dunstable. Training is in the form of workbooks. Doctors induction training has been via zoom. There has been no real change apart from a lot of analysers. COVID has not been too bad. We now have a COVID fridge for convalescent plasma. Bedford and Luton HTC have merged into one.
- **MS** Peterborough we have had similar problems due to the reduction in face to face training and assessments. We are working on streamlining online training. As a non-trauma centre, our obstetric major haemorrhages are of considerable demand on the out of hours services. Recently we have had 2 ladies bleeding simultaneously on the labour ward which puts a strain on the lab. This was exacerbated by the fridge not working on the labour ward. As an HTC we have contributed to the development of a more robust ferinject patient information and administration bundle. This is after an episode where a patient sustained quite bad skin staining.
- **CS** Hinchingbrooke being a smaller MDT site, whilst our transfusion work went down, we've had to introduce PCR techniques. I now have members of staff running E-Plex and doing all sorts of COVID testing that we never thought we would have to do. Multidisciplinary staff are being stretched.
- **SC** Colchester would echo what everyone has been saying. We would like to recruit an extra TP, interesting to hear about framework. Like elsewhere we saw a fall and rise in transfusion activity. We are still trying to keep normal elective surgery activity going. We seem to of seen a spike in platelet transfusion. We have had 10 patient's convalescent plasma therapy. We initially hoped to do this during daylight hours but have had to extend this.
- **TG** Southend and Basildon have had similar issues to everyone else. Initial concerns about samples safety and handling. We did still see a wastage at Southend. We have still got problems with paper-based systems for traceability and have still got problems trying to ascertain where some blood products went to. One TP for each site. Projects were put on hold. NO traceability has been a problem. It is worrying going into second phase. My line

manager was deployed. I was given financial requests responsibility, impacted on my workload. We have had a reduction in WBITs, however always get a spike in November. There was an increase in collection errors. We are merging 3 sites and our workload is varied across the sites. We are looking at demand of red cells and waste. We have new staff, some are ex NHSBT staff in the lab and they have been brilliant and enthusiastic.

- **SN** we had a few incidents where staff had been redeployed and hadn't got up to date competencies so had to deal with these. In the later stages our routine surgeries were taking place at the private hospital so had to ensure the right details were correct with hospital numbers. Traceability went down as they weren't sending tags back. We do not have a laboratory manager at the moment. Phlebotomy training is e-learning online. Everyone else is face-to-face but less people and social distanced.
- **RS** Ipswich during COVID we moved our entire haematology oncology department out to a private hospital. We had a volunteer doing a round robin all day, picking up samples, collecting blood from the blood bank. It has moved back, not sure if this will change again. Had the same issue with traceability. Seen a rise in incidents as well as a rise in activity. We have nearly moved to all online training with some videos.
- **CMc** a big thank you to Essex Voluntary Blood Service. They have been and are still providing a 24/7 service.
- **KP** Addenbrooke's had a UKAS inspection online in April, worked well. MHRA are also doing virtual inspections. Haven't heard of anyone that has had one.

6. AOB

MR was unable to attend the meeting. If there are any urgent issues that need communicating, this will be circulated before the next meeting. Please look out on the Hospital Science Website for any updates.

GB asked if NHSBT are developing any more APPs? **DF** I am not aware of any.

NJ thanked everyone for attending the meeting.

Date of Next Meeting and Close

To be confirmed. Dates will be circulated as soon as they are finalised.

Actions:

No	Action	Responsibility	Status/due date
1	Training – ideas / suggestions on content, platforms	ALL	Next Meeting Discuss at RTT
2	Audit Webinars	BH / RTT	Arrange if useful Discuss at RTT
3	Online Data Collection – changes in workload / issues that may impact demand	RTT	Discuss at RTT Collate relevant questions for BH