EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Wednesday 23rd February 2022 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
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
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
Caroline Lowe **CL**	TP	Milton Keynes
Carol Harvey **CH**	EPA Network Manager	NNUH
Jasmine Beharry **JBe**	TLM	Milton Keynes
Frank Baiden **FB**	TLM	Queen Elizabeth, KL
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
Ellen Strackosch **ES**	TP	Luton & Dunstable
Lisa Cooke **LC**	Consultant Haematologist	Queen Elizabeth KL
Sue Brown **SB**	Transfusion Administrator	Queen Elizabeth KL
Charlotte Alford **CA**	TLM	Luton & Dunstable
Benjamin Sheath **BS**	Transfusion Practitioner	Watford
Swati Pradhan **SPr**	HTC Chair	Bedford Hospital
Joseph Barry **JB**	TLM	West Suffolk
Claire Sidaway **CS**	TLM	Hinchingbrooke
Te-Ahna Hans **TH**	Senior	West Suffolk
Tom Bull **TB**	Consultant Haematologist	West Suffolk
Julie Edmunds **JE**	TP	Lister
Krupa Amin	Blood Sciences Manager	Watford

Apologies: Tracy Nevin **TN,** Tanya Bancroft, Trisha McClure, Helen Thom, Isabel Lentell

1. **Welcome: DF** welcomed everyone to the meeting. **DF** is chairing the meeting in the absence of a Chair. Introductions were made by those in attendance. I am hoping this will be the last time that I chair this meeting. We are working hard to try to fill the RTC Chair position. We last met in October 2021. I would like to acknowledge meetings have been difficult during the pandemic. Workloads and priorities have been very different for colleagues across hospitals and NHSBT. We would like to

continue encouraging participation in these meetings form colleagues. We hope that once we have a RTC Chair in post we can move forward with projects, training, audits and regional guidelines.

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

Actions from previous meetings:

- **DF** we would like to have ideas for presentations and case studies for meetings. We are planning to run a virtual event 'Special Blood for Special People'. **FS** these meetings are here for the RTC so please let us know what topics you would like to hear more about. **MR** are we going to keep meetings virtual or return to face to face? **FS** I think this is up to the RTC to decide. We can send a quick survey around to the RTC for comments. **CH** I miss the networking. **SD** I have found the previous venue difficult to get to. **FS** we are looking at venue options and possibly alternating these around the region. If you have any comments, please comment in the chat or email **CNeal**. **DF** We may need to alternate between both virtual and face to face so we can meet the needs and priorities of everybody.
- **DF** finding an RTC chair is the biggest issue. **FS** we have not had any formal nominations. I would like to highlight to you all that this role has a wide support from the Hospital Liaison Team. **DF** Please consider this role and the deputy role. The RTC Chair needs to be a doctor. Any member can be a deputy chair. It is important to have a non NHSBT chair.

2. Regional Updates

FS presentation attached.

DF it was good to see where we stand against other regions. This is the time where we need interaction and need to revisit chronic problems, the distance from the centres, products people need to keep but cannot always use. Does anyone have any comments? **LM** we excluded Addenbrooke's, have any other regions excluded a hospital? **FS** we have done this in the past. Blood stocks have a good dashboard where they can look at data by user group or profile and if we are doing a comparison rather than looking at region they will look at this. East of England has quite a mix within the region. We are the only region that doesn't have a motorway between it's hospitals. **JB** It is great to look at this data, it would be good to look at population for those areas too. **LM** haematology patients are moved a lot and transferred out of the South West region. **FS** if anyone wants anything looked at data wise, we can ask blood stocks to pull this for us to present at a later meeting. **DF** knowing how we work in the region and identify our own options and solutions to regional issues. It is impossible to bring it down to 0% without exposing patients to risk but if we can lower it that would be great. **FS** there was a drop for the initial 2020 data however, after that there wasn't too much difference. **DF** I don't want to put anyone on the spot but has anyone got any comments. **CH** I think the distance from the stock holding centre is key. AT Kings Lynn / Norwich we are quite far away so our stock holding is different because of the distance we have so it would be good to reflect that to other regions as well.

FS since Royal Papworth has moved, their wastage has dramatically reduced. **FS** asked **MM** whether this is due to the move or something else? **MM** because of our proximity to the NHSBT Centre we try to run on limited stock but use our Associate Practitioners to go over and do our collects. We have saved on adhoc fees between £600 - £1000 a month. We also have a co-operative relationship with Addenbrooke's Hospital, where we offer them products that only have 3 days left on the date. There is no cost benefit to Royal Papworth but reduces the wastage. This has been very effective. **FS** the reduction is massive. **CH** I think this shows that the distance to the centre makes a difference. **JB** I know the National Blood Service won't take back stock from Hospital Blood Banks, but having a regional dashboard to know what products other hospitals have that could be used elsewhere would be helpful to help reduce wastage. **DF** so your suggestion is a dashboard of stocks that can be moved about the region to prevent wastage. **CS** I agree that it works well with platelets but not necessarily red cells, simply due to the amount of stock we hold. **DF** it is a difficult discussion. I wonder if the TADG group needs to revisit this question. **LM** from a clinical point of view, a platelet dashboard would be reassuring as we may want platelets put aside sometimes but actually to know that you are holding a platelet that could get wasted rather than holding platelets that might get wasted unnecessarily. If we

are holding a platelet that might get wasted anyway then it makes us feel reassured to carry on. If we knew that platelets were going out of stock somewhere it is easier to put them aside but now I know I may want platelets but they are too far away for me to start. **CS** if you have a dashboard where you are showing what you have got. We get them in for specific patients and can't release them anywhere else until somebody has decided they will not be used. **LM** whereas if I knew you had them half an hour away, I could use them. If they were coming from Cambridge that could take hours. **CS** It depends on transport between the two sites too. Some deliveries are going have a cost implication to the Trust too. The logistics of it may not be easy. **CS** UKAS would need to be considered, but we can take it to the TADG meeting to discuss further. **DF** we can leave it for the TADG Group to look at it. It is an idea for an ongoing project.

FS thank you to **TN** for the hard work she has done as TP Network Chair. **JH** and **JJ** are now the current joint TP Chair.

SPr Are there any anaemia modules aimed for paediatrician. **FS** there isn't anything at the moment. **SP**r I think there is a gap there. It would be good to have an e-learning module. **FS** there's no plans but we are always open to ideas for resources so I will take that back to my team to feed back. **LM** do you mean general or pre-op anaemia? **SPr** general anaemia for children. **LM** I have not heard of anything. **SPr** there are lots of children having regular transfusions. **DF** we have all come across children that have become anaemic. Also there is a question of the impact of anaemia of adolescent girls when they become young mothers. So one aspect is the question of anaemia of children and avoiding transfusions and the other is managing people with transfusion dependent chronic anaemias. **FS** I will send the question forward, we do have a gap for paediatric resources.

JJ TP Update presentation attached. **DF** we have always had a very active TP group which I am sure this will continue. **ML** I have sent the work we have done at Addenbrooke's on competencies to Aimi, National TP Network Chair. We have had a successful 18 months first round of competency assessments. The next 18-month round will be on the same topics but will be taking a slightly different approach. It will involve case studies. It is nice to know they have something in place. **MM** I just wondered whether the draft job roles / specifications are available for when we recruit TP's. **JJ** we have got some draft ones but I am hoping we get some more formal ones following the meeting. **LF** we had a MHRA inspection in December so I can share that at the TP meeting. **SN** I was hoping that there is still capacity in the job descriptions for those of us that are neither nurses or BMSs to continue our role. **JJ** I believe they are quite open. I will need to look at them again. **SN** I have been a TP since 2003. **JJ** these were put together by the National Group and I know we were asked to input into these. I am not sure what input others gave. **DF** I think this needs to be discussed at the TP Network. **DF** any questions for **JJ**. There were no questions.

3. **NHSBT Update**

MR presentation attached. **DF** thank you **MR**. Any comments or questions for **MR**? We should respect the request from NHSBT to give 24 hours notice for special products. That should not stop selecting the best available product if the transfusion is available. No patient should be refused transfusion whilst waiting for the ideal product. Please be familiar with the notice and understand alternatives.

SP we have a patient who requires washed components after having a reaction. One of the consultants mentioned that they were not clearly marked in their labelling. Irradiated blood is clearly labelled. The washed units don't look that different in their labelling. If this patient received an unwashed unit they would have a severe reaction. Is there any way of making these more distinct in labelling? **MR** please email me this and I can investigate this further.

4. **Discussion – CAS Alert**

DF I am sure that you have received the information regarding the recent CAS alert. All hospitals should work to give a response by 15th July 2022. We need to demonstrate that we have actions in place and options for rapid release of products for major haemorrhage. We need to demonstrate

compliance with SHOT, NICE and BSH guidelines. We need to have criteria for rapid release PCC. Release of best matched blood for patients with red cell antibodies if blood is required urgently. Criteria and pathways for laboratories to escalate to Haematologists where transfusion is urgent and treatment of patients who are refusing blood. We need to have guidelines in place to recognise bleeding, the importance of communication, process for activation of major haemorrhage protocols, major haemorrhage simulations, de-briefs and training. The third stage is to look at audits to look at transfusion delays and actions for improvement. This is the summary of the CAS alert. I would like to hear your experiences, views or hospital plans. Is there something we can put in place to support the region. Do we need a generic tool for the region? **JH** we have started looking at and we have tried to do drills for years. We hope this will re-energise this. We are going to video to show how to activate major haemorrhage. We are about to audit the use of OptiPlex. We are looking at whether we are releasing it in a timely manner. **LM** I would love to see your audit on this. There is a block somewhere. I think this will be useful. We have been looking at overhauling our policy for a long time. **TB** I remember having a major haemorrhage drill at Royal Papworth in 2014 which was useful and well thought out. There were a lot of teams involved. I don't know if the person who done that would have the information and have a package they can share with us. **LM** larger hospitals struggle with safety issues. **LF** I was invited to observe one when the doctors did one in the Emergency Department. We are going to do some obstetric major haemorrhages. Our private hospital - we do yearly simulations with them. We need to document them. **SD** we have had a lot of discussions regarding the CAS alert at our HTT meetings. There has been delays in issuing of blood for people who have autoimmune haemolysis who presented with low haemoglobins. We have just updated our SOP so that the BMS can issue blood that is compatible but not cross matched without having to go through a Haematology Consultant. We agree we will do the concessionary release when we catch up with the patient. **DF** this is something I have asked the TADG to look at. We come across this at NHSBT. We are contacted on-call to touch base with the hospital to ensure people are aware and an emergency plan is in place. Hospitals need to have an emergency plan in place and how that can be triggered. I suspect there are different eventualities. **LF** there is a NICE trauma guidelines on PCC. We keep some in the emergency department so there are not any delays in issuing. **DF** we have come across some delays but mainly due to the dosage. **KP** is not on the line so she cannot comment on the possible regional guidelines but I suspect this is something we need to look at. **LM** we do find that the most of the issues we have relating to delays are always because the clinicians don't understand what the BMSs do and vice versa. People don't realise that there is only one BMS working. **DF** we need collaboration from different angles even to remind people to look at SOPs. I agree it is difficult. **DF** are there any other comments? We need to carry on working at this.

ACTION: DF please share audits in relation to PCC.
ACTION: DF if people have a documented drill plan it would be really useful to share this with others.

5. **Presentation – When the Inspector Calls**

BS, DB-S, KA presentation attached. **CH** thank you very informative. How did you engage with the hospital, taking the errors back to the source? **BS** it is really hard and have to except that transfusion isn't everything. There is so much other work going on and so many other pressures. What we try to do and will continue to do is go to our heads of departments. Speaking to key individuals to find a way of how we can feed information in and trying to incorporate into meetings such as quality improvement programmes. It will be an ongoing piece of work but raising awareness is so important. **DB-S** rejection figures are sent out. We have set a percentage where if they are consistently over this rate, this will be triggered. **DF** excellent presentation and really informative. I am sure we all have issues and points to learn. **JB** please can you add your email into chat so I can follow up some inspection questions. **DF** thank you for sharing your experiences, I am sure this can be followed up at the TADG meeting.

6. **Presentation – Major Haemorrhage**

DF we have Ollie Firth **OF**, one of our Haematology Trainees who performed an audit and he will share some pre-liminary findings of this audit with you now. Presentation attached.

DF thank you so much for this information. Some of the data was discussed yesterday. Many people need to see and digest this information. Any questions or comments for **OF**? **MM** very interesting data and very thorough research. We have been investigating this ourselves at Royal Papworth. The anaesthetists feel confident in handling this type of situation so they felt that they didn't need to speak to a haematologist until the situation became quite complex so as long as they had access to the blood products as guided by their information which they have in theatres they hang off contacting the haematologist. We have also found during our morbidity / mortality meetings that it's not usually not keeping up with transfusions that's causing death, it's the effects of hypoxia and added complications that lead to multi-organ failure. **OF** touching on anaesthetists feeling comfortable with major haemorrhage, this is not quantitative data but I have ploughed through so many notes with this audit. I would agree that the anaesthetic teams seem incredibly good at managing major haemorrhage. Cases may be slightly different at Royal Papworth because of the types of cases coming through. Certainly the obstetric anaesthetic team are almost entirely independent of the haematology department and their cases are completely by the book and that may be because of their patient group or because they are further away from the transfusion lab so they are drilled to ensure there aren't any delay. Anaesthetics are good at maintaining the major haemorrhage pathway. A lot of issues seem to be more around A&E, ward based or change of settings patients. Those were the ones where ratios weren't maintained and there was obvious room for a haematologist to be involved. We saw some of that but haven't put the data in for that.

JB interested to hear what haematologists and clinical colleagues on the call feel. From the lab perspective how can lab get involved in making sure that conversation is happening between clinical and haematology colleagues. I feel there still should be a conversation between those two parties and how the lab can be involved in this. **OF** the lab has a major role in keeping track of how many units of what are going out. There are a lot of very good transfusion practitioners and biomedical scientists in Addenbrooke's and often we find is that if a major haemorrhage appears to be becoming out of control then the lab they will speak to the haematology registrar to advise what they have taken. I think that is a fantastic way to help as they have in depth knowledge of what is leaving the lab. The haematologist should be there to smooth the gaps between the two (lab and clinical staff). **DF** the way this protocol has been introduced, we ask the clinical area to have a single point of contact and that would be the lab. The labs responsibility would be to make the initial activation of haematologists. We remind clinical areas to touch base with haematology to close the loop. It is a challenging situation. **LF** we have a major haemorrhage activation form in the lab which has all the information on which has how much as gone out and whether the haematology department have been involved, however, we have two locum consultants so trying to get them for major haemorrhage. Their bleep will go off so they will know a major haemorrhage is happening but I am the single point of contact between the and consultants. If I am not on duty then a nurse will be the first point of contact. That is what we have advised all departments. **BSh** the challenge will be that we have to bear in mind that 9 out of 10 times when this happens there may only be one person covering several areas so trying to be that re-layer as well as doing all that work. We need the clinical team to liaise with the haematology team. It is getting the clinical team to understand that there is quite often only one person in the lab.

SD in our laboratory they inform us when they reach pack B or if they go beyond the number of red cells issued in pack A without FFP being given as well. That works well and we can intervene quickly. We contact the clinical area and offer our help. **OF** does the major haemorrhage pathway get activated in your hospital because someone has called to activate it or does it also get activated because a large amount of blood leaving the lab? **SD** you go beyond a number of red cells from pack A, our lab will suggest to the clinical area that there is a major haemorrhage and will let us know if FFP is not going out in ratio. **OF** so even if someone hasn't formally activated a major haemorrhage protocol, if an operation is taking place and large amounts of blood are being requested, that will trigger in the lab. **DF** I would suggest people continue to reflect and think, putting down notes of practice. We can look at

whether as a region or individual hospitals need to make steps for modification or improvements. Thank you very much for this information.

7. HTC Updates

DF I would like to invite members to discuss projects, audits that are taking place in the region. It would be nice to hear from everyone in the region.

8. AOB

JH we wanted to bring up as a Trust issues around transgender. We are struggling to know what to do and would appreciate some guidance. **DF** we need to wait for NBTC. **FS** it went via National Lab Group to NBTC but haven't heard anything since.

JT since COVID every time we cross match blood, FFP, platelets to go out to wards or theatre. We put them in an extra plastic bag, advising not to open until needed otherwise will be quarantine. I am quite keen to stop this practice. What are others doing? **MM** we have just issued in standard bags, if a product was returned from a COVID patient it had to be double wrapped. **DF** it is worth contacting **KP** to see if she has more information regarding this.

CL we put all our audits on the Trust audit base for pathology and Q-Pulse and Terri and I update every month to update on actions so we can. We audit every single batch of OptiPlex that leaves the lab on the back of an audit that took place the year before. We have taken that all the way through to the patient safety board to get improvement in the practice. Someone earlier was talking earlier about samples and getting your actions fed through, we have meetings with the two lead matrons monthly and we attend the band 7 meetings and we liaise with matrons and attend the patient safety board every 3 months so we can feedback from any actions / audits we are doing.

SB we record a lot of our audits, incident logs on a shared drive. Does anyone think that the MHRA will feel that that is an adequate way of being available rather than it being stored on Q-Pulse. **DF** I think this should be discussed at the TADG meeting. Is it possible for this to go the other next meeting.

DF thank you very much for your participation. I would like to remind you about nominations for the RTC Chair and Deputy Chair Roles. We are going to meet in June and October. Please remain contacted throughout the various groups.

Date of Next Meeting and Close: Wednesday 22nd June 2022 and Thursday 13th October 2022.

Actions:

No	Action	Responsibility	Status/due date
1	RTC Chair / Deputy Chair Nominations to CNeal	**ALL**	ASAP
2	Share audits in relation to PCC (CNeal to collate information)	**ALL**	Ongoing
3	In response to CAS Alert – share documented drill plan (CNeal to collate information)	**ALL**	Ongoing
4	Ideas for presentations / audits for RTC Meetings	**ALL**	Ongoing