

Written on behalf of Stuart Cleland RTC chair and the RTT

*"Autumn leaves don't fall, they
fly"*

As we say goodbye to the summer and welcome autumn, it would be easy to think that regional activity dwindles over the holidays but this newsletter should show the significant amount of work undertaken in the back ground to prepare for the meetings and events planned for Autumn and Winter. Thank you to all involved for your hard work and input with the planning and preparations and we hope you, the region, enjoy the upcoming events.

I'm sure many of us have been focusing on our plans in response to the Patient Safety notice issued by SHOT and we hope you are making good progress. Thank you again, to the NBT team for sharing their flowchart to support the adoption of the recommendations. If anyone has any other ideas or suggestions they would like to share, do not hesitate to contact us. We look forward to seeing you all Face to Face in November, but for now enjoy this update.



South West RTC Newsletter

August 2022

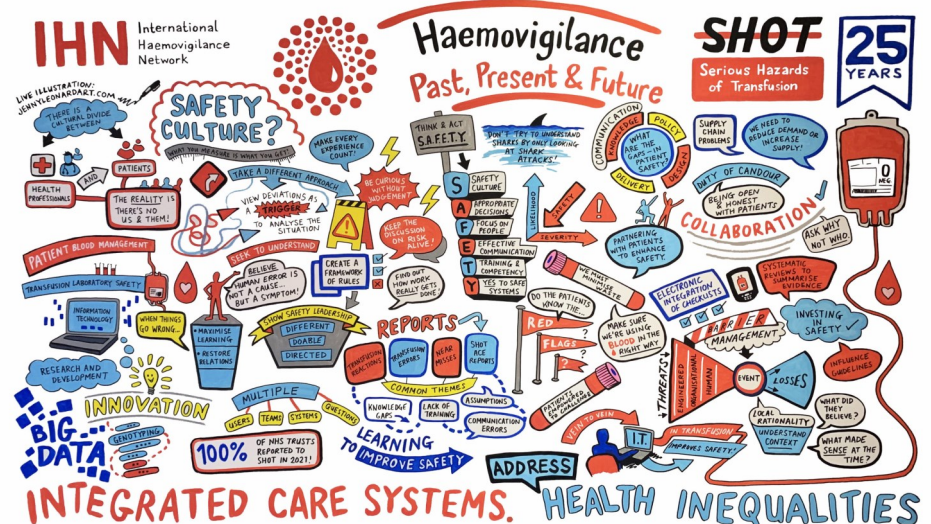
SHOT

Serious Hazards
of Transfusion

2021

Symposium

This years symposium, held in Brighton, saw a collaboration between the International Haemovigilance Network and SHOT to review the past, present and future of haemovigilance in recognition of 25 years of SHOT in the UK.



Day 1 saw an interesting and insightful panel session from Julie Coffey, Dr Mary Townsend, Katie Davison and Alex Liversidge titled; Rethinking Gender, focusing on the need for inclusivity, the impact on donor selection and transfusion. The session examined definitions of gender and emphasized the difference between sex and gender, highlighting the need for inclusivity, compassion and awareness as much as science and evidence. There was a focus on the challenges from a laboratory perspective, highlighting the issues in each step of the testing process. From the lack of disclosure or the insufficiency of requisition forms at the point of testing to the lack of guidance and data supporting testing procedures and appropriate reference ranges, as well as little evidence and data on the effect of hormone therapies and gender surgeries to support clinical interpretation.

2021

On **Day 2** Professor Cheng-Hok Toh delivered “ Better Blood Transfusion in the NHS— challenges and actions”. Highlighting the strategic approach outlined in Transfusion 2024 to improve practice in review of the current environment, including staff levels, skill mix, the impact of COVID, and the changing needs of our ageing and increasingly unwell population. Professor Cheng-Hok reviewed other key changes including legislation updates such as the Health and Care Act 2022, calling for us to look forward with optimism at the opportunities these developments present.

The **final day** saw Dr Barbee Whitaker open the session presenting the work of WHO in developing tools and resources to support countries to implement national haemovigilance schemes, and to improve and assure schemes already in place. A survey identified key priorities; Education and training, Infrastructure support and technology up-grades, and financial support. The WHO resource identifies a stepwise approach to implementation and has pooled international resources from developed schemes to aid implementation and development.



Report Highlights

- ◆ 2021 saw the first time at least one report was submitted for every trust/ health board, a continuing sign of a healthy reporting culture
- ◆ Errors accounted for over 80% of reports
- ◆ Between 2016 and 2021 there were 19 reports of ABO incompatible red cell transfusions, but 1778 ABO incompatible near miss events
- ◆ Non infectious complications continue to be the main cause of transfusion related death, with delays and TACO being the leading issues, contributing to 77.1% of transfusion related death reports
- ◆ Inadequate staffing, poor training, lack of supervision and lack of safety culture were key themes in numerous reports, as were the issues of overriding LIMS alerts and flags.
- ◆ ACE reporting continues to shine a light on exceptional and innovative practice, supporting learning from examples of transfusion practice done well.

Events

Regional:

07.09.22 (virtual)

Obstetrics & Maternity: What's Blood Got To Do With It?

04.10.22 (virtual)

SW PBMG Business & Education Meeting

» Fibrinogen Concentrate And Poster Presentations

11.10.22, Oake Manor, Taunton

SW TP Business & Education meeting

» Major Haemorrhage Simulation education & Work shop

Postponed- 08.12.22 (virtual)

Transfusion Still Matters: Experienced BMS Education

23.11.22, Oake Manor, Taunton

SW RTC Business & Education Meeting

» Dealing with a Major Incident from a Blood Transfusion Perspective

» Where Does Blood Go

National:

13-15.09.22, SECC, Glasgow
BBTS Annual Conference

27.09.22 (virtual)

RCPATH Not in the Textbook Study Day

23&24 November 2022 (virtual)

RCPATH & SHOT Advances In Transfusion Medicine Symposium

24.11.22, Birmingham

UK NEQAS BTLP/BBTS Blood Bank Tech SIG joint meeting

Recommendations



Partnering with patients to enhance safety

Staff must ensure that they involve, engage and listen to patients as 'partners' in their own care, including transfusion support. Engaging patients, their families, and carers as 'safety partners' helps co-create safer systems, identify, and rectify preventable adverse events



Investing in safety

Healthcare leaders must ensure that systems are designed to support safe transfusion practice and allocate adequate resources in clinical and laboratory areas to ensure safe staffing levels, staff training in technical and non-technical skills and appropriate equipment, including IT systems.



Just and learning safety culture

All healthcare leaders must promote a just, learning safety culture with a collective, inclusive, and compassionate leadership. Effective leaders must ensure staff access to adequate training, mentorship, and support. All staff in clinical and laboratory areas have a responsibility to speak up in case of any concerns and help embed the safety culture in teams.

Infographic taken from July 2022 SNAPSHOT newsletter. Follow the link to subscribe to the newsletter <https://www.shotuk.org/newsletter/>

BSMS Smarter Inventory
Management
Dates & Details:

[Education events - Blood
Stocks Management Scheme](#)

NHSBT Training Courses

Virtual NMA NHSBT Course
2022/23 Dates (via MS Teams)

17 - 21 October

6 - 9 December

7 - 10 March

Details of all NHSBT Clinical &
Scientific Courses:

[Clinical courses - Hospitals and
Science - NHSBT \(blood.co.uk\)](#)

[https://hospital.blood.co.uk/
training/scientific-courses/](https://hospital.blood.co.uk/training/scientific-courses/)

National BMS Empowerment
& Discussion Group

Last Weds of the Month

TEAMS

(registration required, details
will be circulated to TLM's via
email)

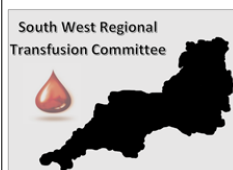
Other Transfusion

Training Courses:

MSc Applied Transfusion and
Transplantation – UWE. [https://
courses.uwe.ac.uk/C99S12/
applied-transfusion-and-
transplantation-science](https://courses.uwe.ac.uk/C99S12/applied-transfusion-and-transplantation-science)

Regional Updates:

The RTC



Another successful virtual RTC meeting was held in May, with 48 committee members able to join us for updates from NBTC, NHSBT and a review of the hospital reports to the RTC. Dr Oliver Pietroni presented an analysis of cell salvage activity across the region based on 6000 cases from 8 hospitals in 2019. Bruce Daniel, NHSE&I gave a detailed breakdown of current work themes, and areas for collaboration to make transfusion more visible were discussed. Dr Alison McCormick gave a summary of the POISE-3 trial and Paul Davies presented the results from the 2019 re-audit of the Medical Use of Red Cells. The November meeting will be held in person at Oake Manor, nr Taunton.

The Annual Survey

Work to update the annual survey is nearing completion, but due to development issues, the launch is likely to be delayed until the RTC meeting in



November. The update will hopefully see questions more pertinent to supporting your practice and service development, set out in a format that allows the right person to complete the survey improving data collection and ease of participation. We will continue to work to present this data in ways that are useful and functional for your hospital teams, and welcome any suggestions

The O+ Objective



Thank you to all trusts involved for your ongoing commitment and consideration for this objective. Salisbury Hospital now have O+ for male emergency transfusion in place, and Bournemouth hospital have developed their action plan to move forward with this initiative. The Royal Devon University Healthcare NHS FT hope to begin planning toward the end of the year. This item will likely be moved to ongoing business next year as we continue to follow up and support trusts to implement, and look at how successfully we as a region are using our policies and SOP's. This means there will be room for a new regional focus in the near future, what do you think we should be collaborating on next?

The Maternal Anaemia Objective



The maternity and Obstetric, What's Blood Got to do with it event has had huge interest, with nearly 800 registrants!

Other Transfusion

Training Courses:

New online short course
'Transfusion Medicine' Derby University <https://www.derby.ac.uk/short-courses-cpd/online/transfusion-medicine/>

12wk 'Blood Transfusion' course
<http://www.biomedonline.co.uk/courses.html>

Robert Gordon University, Aberdeen
MSc in Biomedical Science



This will hopefully go some way to supporting the adoption of best practice. We also hope that the updated obstetric questions in the annual survey will highlight areas of focus for future regional work.

Education

The second run of our BMS education programme for junior staff, Transfusion Matters, ran in July. We had 13 delegates attend including some of our colleagues from NHSBT Filton and an overall score of 4.8 out of 5. Planning is underway for the next experienced BMS session, Transfusion Still Matters, due in November.



The Maternity and Obstetric event is seeing great interest, and the RTT will soon begin planning the next offering from the SW region for the NBTC national education programme. Do you have a topic in mind you would like us to cover? Get in touch

The TP working group



Anne Davidson, Education Lead for the PBM Practitioner team provided an update on the development of the new Transfusion modules to replace the Learn Blood Transfusion modules at the June informal meeting. It was agreed the next meeting in October 2022 will be face to face. Following feedback from the group's members, key topics were discussed to identify a TP regional project with major haemorrhage and sample rejection quality improvement receiving the most appetite. Exciting plans are already in motion for a simulation education session and workshop at the next TP meeting in October, with the aim of supporting TP's to organise and run major haemorrhage SIMs and provide transferable skills that may be utilised for other scenarios benefiting a SIM approach.

In SharePoint there is a Sample Rejection toolkit folder where trusts who have completed sample rejected QI projects can share their approached and supporting documents to provide TP's across the region a toolbox of methods as and when sample rejection rates rise. This will be supported further by the up coming NCA audit.

The PBM working group



An informal meeting held on the 8th of June welcomed new members Lisa Martin and Maria Tiplady from the Ramsay Duchy

Contact us

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Rhian Edwards- SW CSM

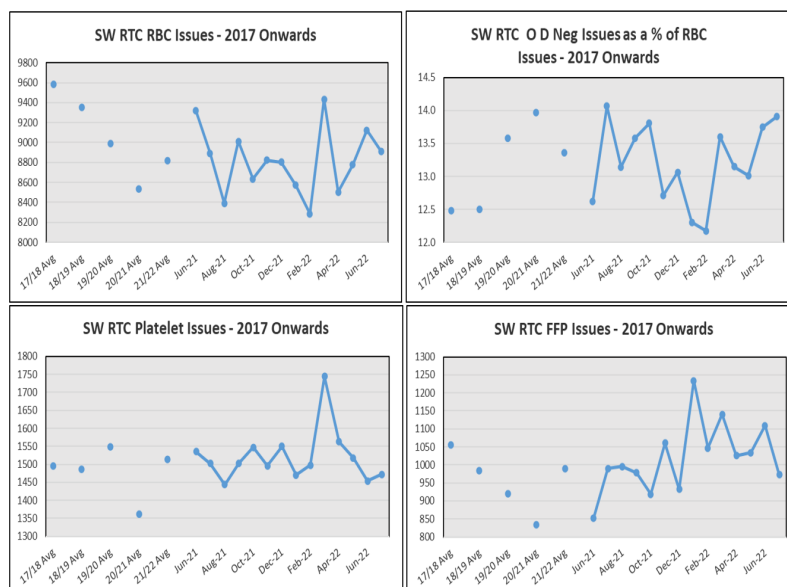
Rhian.edwards2@nhsbt.nhs.uk

Hospital and Annette Byon from Taunton to the group. Cell salvage data collection for 2020 and 2021 was discussed and the group approved recollection of data for regional auditing. Please can this be submitted as previously done via SharePoint. The next formal meeting has been moved due to BBTS and will now be on the 4th October via teams from 10am-12pm. Educational themes for the meeting are Fibrinogen concentrate and NATA poster presentation from group members.

The TLM/User Group

11 members attended the July meeting with a new member from Dorset introduced to the group. The meeting started with discussions around recent UKAS/MHRA inspections. Since the last meeting several hospitals have had UKAS assessments, which generally went well. One hospital had a MHRA inspection, with the non-conformances progressing. It was recommended to share MHRA reported serious adverse events with the group to support shared learning. When undertaking investigations and SABRE confirmation is still outstanding, members stated that they add a footnote to keep MHRA updated on progress. MHRA feedback has suggested they are seeing the same reported root causes (e.g. low staffing) which shows that corrective/preventative actions are not being actioned. The Blood Compliance Report was submitted in April, and of the members present at the meeting, no significant concerns were raised regarding the submission of the report. The proposed regional manufacturer hospital stock pro-forma has now been completed and distributed to all. This may assist hospitals with any emergency stock issues. Finally, a summary of the recent National TLM was discussed, which included organ retrieval and external staff performing transfusions, thalassaemia antibody database, NHSBT charges and upcoming NHBST training courses.

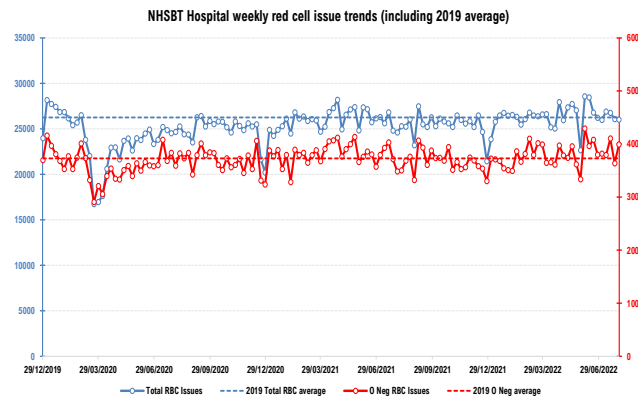
Regional Issue data



NHSBT Update

NHSBT Component Update – National picture

Red Cell Issues (Total RBC & O Neg) represented as weekly issue total – all NHSBT hospitals

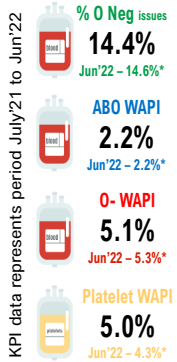


Get in touch by email at bsms@nhsbt.nhs.uk



Blood and Transplant

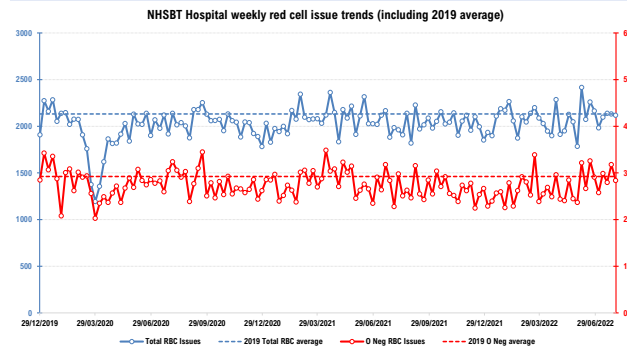
Current National component issue & wastage trends (WAPI for last 12 months & current month)



*Wastage data includes all submissions up to and including Jun-22 reported to date (this figure may be an under representation)

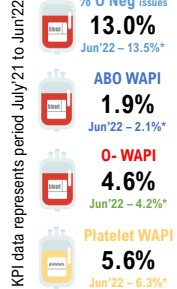
NHSBT Component Update – SW RTC picture

Red Cell Issues (Total RBC & O Neg) represented as weekly issue total – South West region ONLY



Blood and Transplant

SW RTC component issue & wastage trends (WAPI for last 12 months & current month)



*Wastage data includes all submissions up to and including Jun-22 reported to date (this figure may be an under representation)



Hospitals within the SW RTC shows similar component usage trends when compared to the national picture. Red Cell wastage over the last 12 months has been below the national average for both ABO WAPI and O- WAPI; however Platelet WAPI has been above the national average for the same period.



The PBM team are working hard to deliver the first set of e-learning modules that will replace Learn Blood Transfusion. The initial modules will deliver all the required training content to assure continuity and availability of resources, while the next iteration will deliver functionality and engagement for the learner. Look out for further updates!



There are several resource reviews underway including all e-learning modules, and several of the PIL's. We will notify you once the reviewed documents go live.

Transfusion and PBM publications



The BSH Major Haemorrhage Guidelines are now out. The lab supplement is online only and Julie Staves from Oxford has written a gap analysis that she is happy to share. The BSH IT Guidelines are expected later this year.

Copies of the following- articles are attached to the circulating email



Survival in autoimmune hemolytic anemia remains poor, results from a nationwide cohort with 37 years of follow-up



Tranexamic Acid in Patients Undergoing Noncardiac Surgery



Preoperative fibrinogen before the repair of type A aortic dissection: Are the results too good to be true?



Resuscitation of an exsanguinated obstetrics patient with HBOC-201: A case report

Have your say.....

We all know how important the sharing of best practice and new ideas can be to keep improving patient care, so let us know what you are working on! Whether it's transfusion or PBM related, an audit, project, or success story, get in touch and share it with the region at one of our meetings or in the next newsletter. You can also contact us if you have ideas for topics or items for meetings or the newsletter
