

CONFIRMED MINUTES OF THE SOUTH WEST REGIONAL TRANSFUSION COMMITTEE

Wednesday 10 May 2017, 10:30 – 15:30
Oake Manor, Nr. Taunton

Attendance:

NHS HOSPITALS/ORGANISATIONS	
Derriford Hospital	Wayne Thomas (WT); Sophia Wrigley (SW); Stuart Cleland (SC); Caroline Lowe (CL)
Dorset General Hospital	Maraneka Greenslade (MG); Lorraine Poole (LP); David Quick (DQ); Dietmar Höfer (DH)
Gloucestershire Hospitals	Rob McGowan (RM)
Great Western Hospital	Edward Bick (EB)
North Bristol Trust	Janet Birchall (JB); Karen Mead (KM); Elmarie Cairns (EC); Tim Wreford-Bush (TW-B)
North Devon District Hospital	Maggi Webb (MW)
Poole General Hospital	Vikki Chandler-Vizard (VCV); Alison McCormick (AM)
Royal Bournemouth Hospital	No attendance
Royal Cornwall Hospital	Kathy Clarke (KC); John Faulds (JF); Stephen Basse (SB)
Royal Devon & Exeter Hospital	Barrie Ferguson (BF); James Piper (JP)
Royal United Hospital Bath	Sarah Wexler (Chair) (SWe); Dave Fisher (DF); Helen Maria (HM)
Salisbury District Hospital	Effie Grand (EG)
Somerset Partnership NHS Foundation Trust	No attendance
Taunton and Somerset Hospital	Alison Timmins (AT); Nic Wennike (NW)
Taunton and Somerset Hospital/Yeovil	Sarah Allford (SA)
Torbay Hospital	Paul Scates (PS)
University Hospitals Bristol	Soo Cooke (SC)
Weston General Hospital	Dawn Gibbon (DG) ; Louise Jefferies (LJ)
PRIVATE HOSPITALS	
Nuffield Health Cheltenham Hub	No attendance
Nuffield Health Exeter Hub	Iain Christie (IC)
Spire Hospital, Bristol	Roger Evely (RE)
New Hall Hospital, Salisbury	Karen Herring (KH)
Patient Representative	
	Helen Witham (HW)
	Kay Rouse (KR)
NHSBT	
Management Graduate	Hollie McKenna (HMc)
RTC Administrator	Jackie McMahon (JMc)

- 1. Apologies:** Attached.
- 2. Previous Minutes:** The minutes of the meeting held on 17 November 2016 were confirmed as a true record.

3. Matters Arising (not covered in main agenda)

Orthogeriatrician representation on HTC: Although some trusts are happy that their orthogeriatrician colleagues are working within guidelines, there is a perception across the region that this is not always the case. JB suggested waiting for the results of the NCA PBM re-audit before considering further action.

GP representation on RTC: GP engagement has been discussed at length, with some trusts having more success than others. It was agreed a better approach would be to target new GPs during their hospital rotations rather than concentrating on changing the practice of established GPs. It was still felt to be worthwhile to have GP representation at RTC.

Patient representative: Kay Rouse was welcomed as a new patient representative to the RTC alongside Helen Witham.

Southampton hospital's CMV-ve requirements for transplant patients: JB has attempted to follow-up but their new haematologist responsible for transfusion is currently on maternity leave.

4. Questions from Circulated Documents: Hospital WAPI, RBC, Platelet and CMV-ve Updates (JB)* (*all presentations are available on the SWRTC website)

Platelet and rbc issues from the last three years were reviewed. Rbc issues have declined year on year, with a 14% decrease over the three years, compared to a national reduction of 8.6%. Platelet issues are more variable but overall have decreased on par with national use. There is significant variation across the region.

O D neg issues are increasing. This is exacerbated by the overall drop in red cells but reinforces the necessity for trusts to implement policies to at least transfuse O D Pos to men in an emergency when blood group is unknown. Some hospitals receive some of their stock as O D neg substitutions but this is very small.

CMV-ve. Year on year the amount we are requesting is coming down and since 2012/13 to date we have regionally saved just over £96,000 on rbc and platelet requests.

Wastage: Accuracy dependant on trusts submitting data. Easier for the bigger users to stick to the percentage wastage targets.

5. Feedback on Trust Highlight Report

Circulated monthly in addition to the issues and wastage data attached to HTC reports. The consensus was that it is useful to get both reports. The Highlight Report is probably more useful to lab-based staff.

6. National Blood Transfusion Committee update (SWe)

The main focus of the meeting concerned the difficulties being faced by hospital transfusion labs around the country: Many are facing increasing workloads whilst struggling to recruit appropriately qualified staff. A lot of labs are training their own staff. The ISO15189 (UKAS instead of CPA) accreditation is proving to be a challenge. SWe fed back that UKAS has added to the workload of labs and SB mentioned that a UKAS senior assessor sits on the national lab. managers group.

7. What is Available to Improve Use of Blood? (JB)*

JB highlighted some of the material that is currently available, including the updated indication codes poster and bookmark, and the blood components app. PBMP/CSM will take a copy of the material to all HTC meetings/hospital visits which will include the recent amendment to the BSH major haemorrhage guideline changing the recommendation from using Group A platelets in patients with unknown blood group to the use of any ABO platelets negative for high titre agglutinins. RhD negative platelets should be used for women under 50.

8. Apheresis Road Map Live (HMc)*

HM gave an update on the implementation of the Apheresis Road Map for the south west region. This is now up and running and can be accessed via the Hospitals and Science website. Trusts need to ensure that it is publicised internally and NHSBT will maintain the accuracy of the data via an annual communication with trusts. Several comments were made and SWe concluded by congratulating HM on an excellent piece of work and suggesting it would be useful to follow-up in a year's time to see how many times the site is visited.

9. Lab Function Survey (JB)*

In line with the view that hospital transfusion labs are struggling, the survey aimed to highlight common problem areas and any links with increased SABRE reporting or NEQAS errors, i.e. inadequate staffing levels resulting in errors. So far, not enough responses received for the data to be meaningful and JB encouraged everyone to ensure they had completed the survey. If we get a good representation of the regional picture, SW can then take it to the next NBTC meeting.

SB mentioned that Chris Robbie, MHRA's Haemovigilance Specialist can produce a SABRE report summary for the south west which might reflect some of the feedback from the survey and that the 2016 SAE data for the south west is available if anyone is interested in seeing it.

10. 2017 Database Survey

This will be distributed in June/July via the SNAP survey tool.

11. Proposed Survey of Platelet Wastage in Major Haemorrhage (JB)

The proposal is for a simple lab-based survey to look at platelet use in major haemorrhage calls by reviewing data from 5 major/5 obstetric haemorrhages (or calls received over one month in smaller hospitals). The aim of the survey is to find out where platelets are being wasted. Evidence already suggests that platelets should not be sent out initially for obstetric haemorrhage. This will be taken forward by Katy Cowan.

12. SW PBM Group Update (JF)*

Last met in March 2017. Discussed concern around potential for anaphylaxis with Monofer. One trust trialled and stopped using after three reactions in obstetric patients. Other Monofer users had no issues. PBM group agreed to monitor and encouraged people to report any iv iron reactions using the Yellow Card scheme.

Following an incident with Ferinject, when a patient sought legal advice following a suspected iron leak, JF contacted the manufacturer requesting a change to the wording of their patient information leaflet. It currently states that incorrect administration can cause leakage when this is not the case as it is a known risk.

Discussed pre-op practices within the region and varying systems for checking blood results.

Cell Salvage Database: Currently working on streamlining to make it easier to report and the revised headings will be sent out via the Group. NBT are by far the best contributors. To consider presenting at NATA.

TXA Algorithm: This can progress now that the WOMAN trial has reported. Exeter hip fracture TXA study proposals have been submitted and they will let everyone know if funding is approved.

13. Hospital Presentations/Audits*:

Salisbury Platelet Wastage Audit (EG): SDH is a medium-sized hospital and do not keep platelets on site. Audit took place over four months and although the graph showed an upward trend in the number of platelets issued, this did not continue. The majority of wastage occurred in major haemorrhage calls. They have changed practice and do not routinely order any platelets for obstetric haemorrhage. When platelets are ordered the lab checks that they are still required before accepting the delivery.

During the discussion that followed, it was suggested that having an SLA in place to allow the movement of blood products between sites can help with reducing wastage. One trust did not have the support of their finance department to do this.

IOCS service at Torbay Hospital (PS): PS outlined how a successful 24/7 cell salvage service has been implemented at Torbay.

Post meeting note: Several trusts have subsequently contacted Torbay with a view to emulating the service.

PBM at NBT – 2 year review (EC): The appointment of the Blood Conservation Co-ordinator has allowed for an increase in time available to support clinical areas and improve the efficiency of the service. Improvements to the service have so far contributed to an estimated £115,072 (2015/16 financial year) saving with a significant reduction in surgical blood transfusion.

14. Update on SW RTC LIMS Project (TWB)*

TWB provided an update on the collaboration with Clinisys to audit appropriate red cell use with pre- and post-transfusion Hb readings. Readings can be retrieved by speciality but further validation is required. This has been fed back to Clinisys. There is still work to be done but the project has great potential.

15. Transfusion Practitioner Group Update (VCV)

Consent Sticker/Transfusion Record: TP working groups have been set up via e-mail with interested parties, and project leads will be appointed at the TP meeting on 18 May. Any existing records/stickers/aids have already been shared around the group.

Creation of knowledge-based framework in a bid to standardise transfusion training: TPs to discuss adapting the draft BSH guidelines key action points flow diagram (for blood administration) as a starting template to either develop gap analysis for existing training or utilise for setting up new training. VCV is the project lead.

16. Education Sub-Group Update (BF)

The rolling programme of events continues. The suggested topic for the main education event in the autumn is the management of emergency blood use. As this is a huge topic involving people from different disciplines, RTC members were asked to discuss with their teams and feedback to JM any topics/themes they would like to see covered. There is also a lot of new data around platelets and O D neg. SW mentioned that there had been very positive feedback within her trust from colleagues that had attended PBM in Surgery, both from a content and value for money perspective. Some junior doctors had been unable to attend due to exams taking place.

17. Transfusion Laboratory Managers Update (MW)

Last met in April. Discussions included SHOT and SABRE incidents; National Lab. Managers group considering the merits of UKAS and MHRA inspections; following an observation from MHRA, most labs now have something in place for manual second checking; all rbc units will be HEV-ve from 1 May; a lot of interest from labs in IBGRL's free fetal DNA testing – paper reports costs £1.00 but some dissatisfaction with this as IT system not working properly; RCI now has full UKAS accreditation.

18. Any Other Business

JP volunteered to feedback at the next RTC meeting on the results of RD&E's blood tracking remote allocation pilot.

DF raised the recording of gender re-assigned patients on LIMS.

AM raised the SHOT recommendation that every patient who has a transfusion is TACO assessed. SC said UHB has incorporated a question to cover this on their prescription charts and it was suggested the results from the TACO audit should help inform hospitals.

19. Date of Next Meeting

Wednesday 15 November 2017.

South West Regional Transfusion Committee Meeting – 10.05.17 – Action Log

Action from the minutes		Actioner(s)	Status	Notes
Meeting on 10.05.17				
3	Orthogeriatrician representation on HTC	On hold		Await outcome of NCA
3	Engage with new GPs during hospital rotation to reinforce transfusion guidelines	All		
3	GP representation on RTC : all to consider if they know any GPs who would be keen	All		C/f as rolling action
3	Approach Southampton hospital re. their requirement for CMV-ve products for transplant patients	JB	Haematologist currently on mat. leave	JB pursuing
9	Complete lab function survey if not already done so	TLMs		
16	Feedback to JM potential topics for emergency blood use study day	All		
18	Feedback at next RTC meeting on RD&E's blood tracking remote allocation pilot	JP		

South West Regional Transfusion Committee Meeting

Wednesday 10 May 2017 at Oake Manor, nr Taunton

APOLOGIES

Hospital	Name	
North Bristol NHS Trust	Christina	Laxton
Nuffield Health Cheltenham	Sam	Lewis
RD&E	Paul	Kerr
Royal Bournemouth	Jason	Mainwaring
	Julie	Johnson
	Shane	McCabe
Royal Cornwall	Nicki	Jannaway
RUH	Susan	Scott
Salisbury	Anne	Maratty
	Ian	Jenkins
Somerset Partnership NHSFT	Robin	Payne
Somerset Partnership NHSFT	Liz	Berry
Somerset Partnership NHSFT	Katy	Baker
Torbay	Alistair	Penny
	Patrick	Roberts

GLOSSARY OF ABBREVIATIONS

BSH	British Committee for Standards in Haematology
CMV (-ve)	Cytomegalovirus (negative)
CPA	Clinical Pathology Accreditation
CSM	Customer Service Manager
DNA	Deoxyribonucleic Acid
GP	General Practitioner
Hb	Haemoglobin
HEV (-ve)	Hepatitis E Virus (negative)
HTC	Hospital Transfusion Committee
IBGRL	International Blood Group Reference Laboratory
IOCS	Intraoperative Cell Salvage
ISO15189	International Organisation for Standardisation
KPI	Key Performance Indicator
LIMS	Laboratory Information Management System
MHRA	Medicines and Healthcare Products Regulatory Authority
NATA	Network for Advancement of Transfusion Alternatives
NBT	North Bristol NHS Trust
NBTC	National Blood Transfusion Committee
NCA	National Comparative Audit
NCG	National Commissioning Group
NEQAS	National External Quality Assessment Service
NHSBT	NHS Blood and Transplant
PBM	Patient Blood Management
PBMP	Patient Blood Management Practitioner
RBC	Red Blood Cell
RCHT	Royal Cornwall Hospitals NHS Foundation Trust
RCI	Red Cell Immunohaematology
RD&E	Royal Devon & Exeter Hospital
RUH	Royal United Hospital, Bath
RTC	Regional Transfusion Committee
SABRE	Serious Adverse Blood Reactions and Events
SaBTO	Advisory Committee on the Safety of Blood, Tissues and Organs
SAE	Serious Adverse Event
SDH	Salisbury District Hospital
SHOT	Serious Hazards of Transfusion
SLA	Service Level Agreement
SWRTC	South West Regional Transfusion Committee
TACO	Transfusion Associated Circulatory Overload
TLM	Transfusion Laboratory Manager
TP	Transfusion Practitioner
TXA	Tranexamic Acid
UHB	University Hospitals Bristol
UKAS	United Kingdom Accreditation Service
WAPI	Wastage as Percentage of Issues
WOMAN	World Maternal Antifibrinolytic Trial