EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Wednesday 17th October 2018 from 10.00 am to 1.00 pm at the Hallmark Hotel, Cambridge

Attendance:

Name	Role	Hospital
Donella Arnett **DAr**	Transfusion Practitioner	Watford
Debbie Asher **DAs**	EPA Transfusion Team Leader	Norfolk & Norwich
Claire Atterbury **CA**	Transfusion Practitioner	Queen Elizabeth
Karen Baylis **KBa**	Transfusion Practitioner	Lister
Kaye Bowen **KBo**	Transfusion Practitioner	Peterborough
Millie Conway **CC**	Transfusion Lab Manager	Ipswich
Suzanne Docherty **SD** *left 12.15*	Consultant Haematologist	Norfolk & Norwich
Julie Edmonds **JE**	Transfusion Practitioner	Lister
Loraine Fitzgerald **LF**	Transfusion Practitioner	Bedford
Dora Foukaneli **DF**	Consultant Haematologist	Addenbrooke's & NHSBT
Carol Harvey **CH**	Transfusion Lab Manager	Colchester
Julie Jackson **JJ**	Transfusion Practitioner	James Paget
Nicola Jones **NJ** *RTC Chair*	Consultant Anaesthetist	Papworth
Georgie Kamaras **GK**	Consultant Anaesthetist, HTC Chair	Luton & Dunstable
Claire Latham **CL**	Assistant TP	Queen Elizabeth
Hamish Lyall **HL**	Consultant Haematologist	Norfolk & Norwich
Cathryn McGuinness **CMG**	Transfusion Lab Manager	Princess Alexandra
Katherine Philpott **KP**	Transfusion Team Leader	Addenbrooke's
Mohammed Rashid **MR**	Customer Services Manager	NHSBT
Ali Rudd **AR**	Transfusion Practitioner	Norfolk & Norwich
Frances Sear **FS**	PBM Practitioner	NHSBT
Nick Sheppard **NS**	Transfusion Lab Manager	Broomfield
Ellen Strakosch **ES**	Transfusion Practitioner	Luton & Dunstable
Laura Wilmott **LW**	Transfusion Lab Manager	Peterborough
Jane O'Brien **JO'B** *Minutes*	RTC Administrator	NHSBT

Apologies:

Debo Ademokun CH Ipswich
Sharon Kaznica TP Ipswich
Becky Smith TP Ipswich
Charlotte Alford TLM LDUH
Joanne Hoyle TP WSH
Alex Hudson TP Papworth
Cathy Flatters TP Papworth
Lynda Menadue CA PCH
Claire Newsam TLM Addenbrooke's
Michelle Reece SBMS Hinchingbrooke
Kathleen Ford TP NNUH
Sarah Clarke TP Ipswich
Janet Pring TP NNUH
Lisa Cooke CH QEHKL
Tracy Nevin TP Princess Alexandra
Natalie Outten TP Southend
Gilda Bass TP WSH
Martin Muir TLM Papworth
Andy King-Venables TP Hinchingbrooke
Michaela Lewin TP Addenbrooke's

1. **Welcome:** NJ welcomed everyone to the meeting and introductions were made around the table.
2. **Minutes of last meeting:** Minutes agreed as accurate.
   Matters arising:
   - Action 1: The regional algorithm on the identification and treatment of iron deficiency anaemia in primary and secondary care has been completed and distributed to all RTC members for further circulation. *NB: Now also on EoE pages of JPAC website*
   - Action 3: DF said that NHSBT are making changes to the donation procedure.

3. TP, TADG & RTT updates: FS gave this presentation. **Attachment 1**
Regional algorithms: JO'B has produced Word versions of the regional algorithms for major haemorrhage (3 algorithms) and acute transfusion reactions. This is so that they can be easily edited when alterations are required due to changes in practice or updates to National Guidelines. However, they can now also be altered in line with individual hospital guidelines; we ask that hospitals replace the EoE RTC logo with their own, but credit the RTC. This is so that hospitals take responsibility for the information on the guideline.
WBIT regional bench marking data 2018: A brief presentation of the results of the WBIT incident reporting for January to June this year was included. Full results were presented at the joint TP/TADG meeting in September. During the period 17 out of 18 NHS hospitals reported. *NB: the attached presentation has anonymised results. Please contact JO'B if you wish to know your hospital's code.*

- It was noted that, compared with 2017, there was a decrease in incidents involving doctors and nurses and a corresponding increase in incidents involving midwives at almost 40% of the total.
- CMG said that Princess Alexandra have been tracking WBIT in all Blood Sciences which are referred to Critical Incident Management. They have produced an incident pathway, an A4 sheet which has to be completed by those responsible for incidents in order to help determine the root cause. CMG agreed to share this pathway **Action 1**
- DF said she thought that the findings of the continued benchmarking (which began in 2015) should be written up as an academic paper. It was the subject of a poster presentation at the SHOT Symposium in 2017. DF also said that conclusions should be formulated; for example, how the 2 sample policy is helping to detect these incidents and that the process is in place to help prevent the results of genuine human error.
- CA said that WBIT at QEH were picked up on the first sample for 2 patients by a BMS on night shift who realised that the co-morbidities of one patient meant she couldn't possibly have had the blood results she did.
- CH said she thinks it is unfortunate that labs are having to police poor clinical practice and DAs said she thinks that the process has been complicated by an additional step. DAr said that Watford do not have a 2 sample policy and this was risk assessed. She said Watford have no more incidents than other hospitals. DF said that internationally very few countries rely on a single sample.
- LW said that pre-operative assessment staff were reporting that some patients are querying why a second sample needs be taken and at times refusing, so the lab are developing a leaflet to explain the safety reasons behind 2 samples to be given to those patients who ask or object.
- HL said that NNUH have encountered the same problem in paediatrics and asked what other hospitals do. DF said usually the second sample is taken just prior to the operation while the child is under anaesthetic.
- It was agreed that the future of WBIT reporting and the sharing of reporting tools and results be discussed at this afternoon's RTT meeting. **Action 2**

4. EoE snapshot staffing survey results: CH gave this presentation **Attachment 2.**

- This survey covered 4 time frames on each of 3 weekdays, a Bank Holiday and a Saturday in May 2018.
- Overall, most transfusion labs are fully staffed during nights, weekends and Bank Holidays because most operate on the minimum possible staff (e.g. one BMS to cover Blood Sciences). However, during core hours, labs are seriously understaffed

and the situation worsened as the week progressed. Please see the presentation for the full results.

5. **NBTC & RTC Chairs update:**
   - NJ said that the EoE RTC has been reporting on short staffing problems since 2012 and now most other regions also report the same issues in their bi annual reports.
   - A 2-page summary report of the EoE snapshot staffing survey was distributed prior to the RTC Chairs and NBTC meetings held on the 24th September and discussed at both meetings.
   - Professor Adrian Newland, who is leading the National Pathology Optimisation Delivery Group to co-ordinate implementation of the Carter Review, was present at the meeting. He, or a member of his team, will attend the next RTC meeting to hear first hand the issues the region has faced and to gain input on future developments.
   - NJ said that a National survey is planned and she was asked if the region would share our survey as they were impressed with some of the detail we used. Paula Bolton-Maggs will be leading on behalf of the UK Transfusion Laboratory Collaborative (UKTLC). All present agreed that the design of our survey can be shared. **Action 3**
   - CH suggested that labs might find it useful to conduct the survey annually e.g. for MHRA audit.
   - DF said that pathology modernisation within this region had been based on a very low perception of what constituted adequate staffing levels and staff numbers are still well below establishment. She thinks that it has affected Biomedical Science as a profession. She asked if others thought we need to involve IBMS, for example with regard to the number entering the profession out of university. DAs said that UKTLC has representatives from IBMS, RCPath, BBTS and SHOT and they do feed into the Dept. of Health. KP said Addenbrooke's had 2 Band 5 training posts for which there were no applicants.
   - LW said that Peterborough have a pool of staff who rotate through transfusion, haematology and coagulation. Sometimes other areas are left very short staffed because transfusion has to be covered; something not reflected by the snapshot survey.
   - CA said she thinks that pathology modernisation staffing was based on an urban model which doesn't necessarily work in rural areas where the nearest hospital might be 40 miles away.

6. **Case study:** CH gave a presentation of a case study of a patient with anti Ata **Attachment 3.**
   - CH said she thinks that NHSBT clinical consultants are an underused resource and that their advice is very valuable.
   - KP said Addenbrooke's have a virtual MDT (multi-disciplinary team) meeting with obstetrics teams in which the latest results, expectations, risks etc. of individual patients are discussed. DF said that every Tuesday a list of antenatal patients with antibodies, together with their due dates, expectations etc. is circulated to ANCs, foetal medicine, obstetrics etc. and kept in the lab.
   - HL asked what other labs do if there is a baby at known risk of HDN. CH said that she will ensure that an appropriate neonatal unit is in stock around the time of the expected delivery date. DF said units are kept at NHSBT to be irradiated when required and sent to the hospitals. DAs said that the delivery time to Norfolk & Norwich means that there is often a delay in transfusion. There was a question as to whether IV immunoglobulin should be given while waiting for the units to arrive.

CA said that plans need to be developed for individual patients from 28 weeks gestation with co-operation between the lab and neonatal and obstetric departments.

7. **Wastage Campaign:** FS gave this presentation. **Attachment 4.**
   - This is probably the final presentation of the wastage campaign in this format. The campaign began with the data for Q1 2016 -17 and initially focused on the cost of units wasted in the EoE.
   - For most of the campaign period 17 out of 18 NHS hospitals reported consistently so valid comparisons could be made between the total units wasted during each quarter of the campaign period. However, it should be noted that one of our larger users did not report in Q4 17-18 and Q1 18-19 and this should be taken into account when viewing the total wastage data.
   - For platelets and O D negative, we looked at the total campaign period, rather than focusing on the latest data (Q1 2018-19). Two hospitals showing the lowest overall platelet WAPI each only exceeded the National target of 4% in one out of the nine quarters of the campaign.
   - It was noted that most hospitals switch to O D positive for male patients and women over child bearing age of unknown blood group but most issue from the lab and do not stock O D positive in emergency fridges.
   - DF said there are 2 parameters in O D negative wastage; units actually wasted and those given to patients to avoid time expiry which is more difficult to quantitate. She said that the National audit has proven that one recipe does not fit all and the percentage of O D negative patients in the hospital population is very important when looking at data.
   - CH said she had recently reduced the stockholding of group O and A D positive units from 7 to 5 days and had seen a considerable reduction in the blood budget. However, it has to be noted that it was a month of quiet transfusion activity and so no definite conclusions can be made at this stage.
   - For total RBC waste, we focused on Q1 2018 -19. Even allowing for the fact of the non-reporting hospital, there was a considerable drop in red cell waste. A graph showing waste against issues (for reporting hospitals only) showed the decrease clearly and for Q1, just 2 regional hospitals had a RBC WAPI higher than the National target. In addition to consolidate the picture, 13 out of the 16 reporting hospitals achieved a Q1 RBC WAPI less than their previous 12 month average.

8. **Audit of the use of ICE results:** LF gave a presentation on the audit of the review of ICE results on group and screen samples.
   - There was discussion on who has the responsibility for checking results; this varies between Trusts. DAs said that her lab staff used to look through theatre lists and flag up those requiring action but this task has not been performed since the formation of EPA due to insufficient staff. CH said that request forms often have no clinical details on them; ES said Luton & Dunstable reject samples if there are no patient details on request forms.
   - It was noted that clicking on ICE results doesn't mean that they are actually read or acted upon. HL commented also that those reading results might not necessarily understand the significance of antibodies. LW said they use a generic comment that there may be a delay in issuing blood if a patient has antibodies. It was also noted that confusion sometimes arises when staff may think that the presence of antibodies indicates a special requirement.
   - LF said that she is going to report her findings to the Trust and will feed back on future developments.

9. **NHSBT Update:** MR gave this presentation. **Attachment 6**

10. **A.O.B:**
    - CA asked what other hospitals do about competency assessments of agency nurses. AR said NNUH only allows involvement in transfusion if they are specifically trained and ES said she contacts agencies to determine the level of competency achieved. DAr said she had approached the issue of agency staff and competencies with her Chief Nurse who is addressing this on her behalf.

11. **Close:** The meeting closed at 12.55pm. NJ thanked everyone for attending.

Next meeting: Wednesday 6th February 2019 Hallmark Hotel

At the coffee break, JO'B was presented with flowers, cards and gifts to mark her retirement as EoE RTC Administrator. NJ and DF thanked her very much for her hard work and she replied that she had enjoyed the last 10 years and would miss working with RTC colleagues.

Attachments:

1	TP, TADG & RTT updates *Presentation (anonymised)*	Frances Sear, Jane O'Brien
2	EoE Snapshot Staffing Survey *Presentation*	Carol Harvey, Jane O'Brien
3	Case study: anti Ata in pregnancy *Presentation*	Carol Harvey
4	Wastage campaign *Presentation*	Frances Sear, Jane O'Brien
6	NHSBT update *Presentation*	Mohammed Rashid

Actions:

No	Action	Responsibility	Status
1	Send WBIT incident pathway to JO'B for sharing	CMG	
2	Discuss further actions with regard to WBIT benchmarking at RTT	RTT	Complete, actions agreed*
3	Send EoE Survey forms to Paula Bolton-Maggs for UKTLC reference		

- NHSBT audit officer, Brian Hockley, has been consulted about the formulation of a WBIT reporting scheme based on the current parameters using SNAP. If data for the second half of 2018 can be collated, data on 3 full years will be written up for inclusion in a professional journal.