REGIONAL TRANSFUSION COMMITTEE

APPROVED Minutes of the meeting held on Thursday 20th March 2014
9.50 am to 1.00 pm at St John's Innovation Centre, Cambridge

Attendance:

Name	Role	Hospital
Donella Arnett **DAr**	Transfusion Practitioner	Watford
James Bamber **JB** *Chair*	Consultant Anaesthetist HTC Chair	Addenbrooke's
Cynthia Beatty **CB**	Consultant Haematologist	WSH
Kaye Bowen **KB**	Transfusion Practitioner	Peterborough
Lesley Denham **LD**	Biomedical Scientist	Spire Hartswood
Aman Dhesi **AD**	Regional Lead, PBM	NHSBT
Haifa Eden **HE**	Consultant Haematologist	Broomfield
Carol Harvey **CH**	Transfusion Laboratory Manager	Southend
Jennifer Heyes **JH**	PBM Practitioner, London	NHSBT
Loraine Holland **LH**	Transfusion Practitioner	Bedford
Al Hunter **AH**	Service Improvement Manager	NHSBT
Julie Jackson **JJ**	Transfusion Practitioner	James Paget
Sharon Kaznica **SK**	Transfusion Practitioner	Ipswich
Andy King-Venables **AKV**	Transfusion Practitioner	Hinchingbrooke
Fadzai Marange **FM**	Pathology Manager	Nuffield Health
Lorraine Mounsey **LM**	TP/BMS	Papworth/Addenbrooke's
Sheila Needham **SN**	Transfusion Practitioner	East & North Herts
Tina Parker **TPa**	Transfusion Practitioner	Broomfield
Graham Philpott **GP**	Consultant Anaesthetist HTC Chair	Broomfield
Martin Pooley **MP**	Transfusion Laboratory Manager	Addenbrooke's/Papworth
Alison Rudd **AR**	Transfusion Practitioner	Norfolk & Norwich
Frances Sear **FS**	Transfusion Practitioner	Hinchingbrooke
Claire Sidaway **CS**	Transfusion Practitioner	Addenbrooke's
Ellen Strakosch **ES**	Transfusion Practitioner	Luton & Dunstable
Sue Turner **ST**	Transfusion Practitioner	Colchester
Richard Whitmore **RW**	Customer Service Manager	NHSBT
Jane O'Brien **JO'B** *Minutes*	RTC Administrator	NHSBT

Apologies:

Debo Ademokun CH Ipswich
Bal Appadu CA Peterborough
Claire Atterbury TP Queen Elizabeth
Alex Boyle TP Norfolk & Norwich
Joe Burford BMS West Suffolk
Sarah Cork TLM James Paget
Dora Foukaneli CH Addenbrooke's/NHSBT
Clare Hay TLM Hinchingbrooke
Caroline Hough TP Addenbrooke's
Cathryn McGuiness TLM Princess Alexandra
Karen Mowbray TDL Ramsay Rivers
Nick Sheppard TLM Broomfield
Steve Tucker TLM Colchester
David Green TLM Basildon
Charlotte Alford TLM Luton & Dunstable
Debbie Asher TLM Norfolk & Norwich
Gilda Bass TP West Suffolk
Sue Bradley CH Watford
Ann Marie Chell Pinehill Hitchin
Adrian Ebbs TLM Queen Elizabeth
Henrietta Hill CA Luton & Dunstable
Joanne Hoyle TP West Suffolk
Rajamani Sethuraman CA Princess Alexandra
Sarah Snape CA Bedford
Velchuru Vamsi CS James Paget

1. **Welcome and introduction:** JB welcomed all present to the meeting and round table introductions were made.

2. **Minutes of last meeting:** Agreed as accurate.

Matters arising: The letter to Trusts requesting permission to de-anonymise regional SHOT data has been put on hold while attempting to establish if SHOT have plans for de-anonymisation.

3. Education events:

Mums, Babies and Blood: to be held on 19th June at St John's. Because of space restrictions, initially we are limiting applications to 4 per Trust and qualified midwives who have not attended the event in the past. Booking is open and relevant paperwork has been distributed to the RTC. Topics will include groups and antibodies, feto-maternal haemorrhage and anti-D, haemolytic disease of the newborn, anaemia in pregnancy, venous thrombo-embolism, massive obstetric haemorrhage and a patient's story.

Blood Transfusion in Surgical Practice: to be held on 18th September at Wyboston Lakes Conference Centre. Sessions will cover pre-operative, peri operative, post-operative and outside hospital. Topics will include: antibodies explained, anti-coagulants, anaemia, bloodless surgery, treating bleeding, use of tranexamic acid, cell salvage, surgical strategies to stop bleeding, the unexpected transfusion and trauma bleeding. The programme is in draft, but should be finalised shortly. JB asked that, when it becomes available, RTC members circulate conference paperwork to a wide audience and encourage attendance.

4. RTT update:

MBL survey:

- Dr Foukaneli was asked by the EoE Trauma Network to discover how many of the region's hospitals use the Massive Blood Loss protocol as agreed by the RTC and the Trauma Network, so a Survey Monkey questionnaire was devised.
- Not including Papworth (which does not take trauma cases) 9 of the regions hospitals follow the agreed MBL protocol. However, 2 of these, Southend and Watford, are in the London Trauma Network not EoE.
- 9 hospitals call their policy MBL or Massive Blood Loss. With the exception of Colchester who use Code Red and Code Blue, all the others use Massive or Major Haemorrhage.
- 7 hospitals do not perform any skills and drills in relation to massive haemorrhage; another 3 just do them in obstetrics. Other sites mentioned are A & E and theatres.
- A summary of this survey will be distributed.

As the MBL policy has now been in use for almost 2 years, JB asked how it is working in practice. CH said Southend waste more FFP since its implementation and sometimes the second pack is ordered before the first because the clinician wants platelets. JB said there is no evidence to support the use of platelets earlier. CS said activation of the protocol is being reviewed internally at Addenbrooke's because it is felt that FFP may be under utilised in clinical areas.

JB said that implementation of the protocol depends on each hospital and it is the responsibility of the clinical area to ensure products are collected. He also said that the take home message from the NBTC meeting is that all hospitals should practice Skills and Drills and not just in the clinical areas where frequent bleeds occur. CB said West Suffolk hospital had recently performed a drill with the BMI hospital to which they supply blood and it was a very useful exercise.

RW said that an estimation of blood loss exercise at a London education event had highlighted that a considerable majority of people underestimate. Our education day in September will include an audience participation session on the estimation of blood loss. JB said that as part of his presentation on massive obstetric haemorrhage he suggests doubling one's initial estimate. DAr has a quiz on blood loss estimation

which she agreed to share. JB noted that in cases of placenta accreta use of FFP has risen and RBCs use decreased.

Pre- transfusion Hb audit:

- 15 trusts took part in this audit. Raw data (actual data will be less because of duplicates) indicates there were between 48 and 240 cases per hospital, with a total of 1197 cases of transfusion and 87 (7.3%) of those were to patients with an Hb >100g/L.
- Full analysis of this audit will take some time. Results will be presented at the June RTC meeting.

Turning Point:

We have purchased Turning Point technology, which allows for audience participation during meetings and education events, from the RTC budget. So far we have 30 handsets but will purchase more when the budget is replenished in April.

Regional transfer of blood audit documents:

The recent audit highlighted a deficiency in appendix 2, which did not allow for recording of the time of transfusion should this take place en route or on arrival at the receiving hospital. This has been amended together with some layout changes. These amendments have been approved by the EoE TADG and the RTT and have been distributed for use. *Full appendices attached with minutes.* As this region's representative, Adrian Ebbs took the document to the National Laboratory Managers group and the RTT agreed that it can be adapted for national use.

Monthly and annual report survey:

A survey concerning monthly and annual reports from hospital liaison and CUSUM reports from BSMS was sent to all TLMs and TPs in the region. If you haven't already done so, please take a few minutes to complete this survey as it will help us establish whether or not the hospital liaison team are providing you with the correct amount of useful information.

5. Transfer of blood audit: Discussion at RTC and TADG meetings about the logistics and appropriate method of transferring blood products with patients revealed concern about the practice and included a SUI report about a patient transferred with a transfusion underway and no clinical supervision in the ambulance. Therefore it was agreed to audit this practice and a real time audit was carried out from 1st July to 31st December using the RTC agreed regional transfer documentation. Labs were requested to fax all transfer documentation to JO'B and regular reminders were issued. The NBTC had expressed an interest in this audit and so JB gave a presentation at the meeting on 17th March which was repeated here.

Results:

Trusts participating: 17/18

Total incidents of transfer: 45. Transfer incidents involving RBC: 44

Transfer **to** regional hospitals: 37 Transfer **to** hospitals outside region: 8

Transfer **from** regional hospitals: 44 Transfer **from** hospitals outside region: 1

No. units RBC transferred with patient	No. occasions
1	1
2	14
3	9
4	12
5	1
6	7

	RBC only	RBC & FFP	FFP only
Patients transferred with	36	8	1
Number of Patients transfused in transit	4 *1 x 1 unit* *3 x 2 units*	1 *2 units RBC,* *1 unit FFP*	2 *1 X 1 unit* *1 x 2 units*

	Total units transferred	% transfused en route	% transfused on arrival	% into stock	% wasted	% fate unestablished
RBC	148	6.1	2.7	38.5	34.5	18.2
FFP	24	16.7	8.3	12.5	45.8	16.7

- 81% of transfers within region were to Addenbrooke's and 16% to Papworth
- Most 'wasted' blood was due to unsealed boxes or OTC
- 56% of 'fate unknown' incidents were transfers to London hospitals
- Many hospitals did not use agreed regional transfer documents or used the documents inconsistently
- 3 audited transfer incidents occurred without knowledge of sending hospital's transfusion laboratory
- 19 transfer forms gave details of special requirements – only 1 recorded 'irradiated blood', none recorded antibodies
- 1 baby transfused in transit with MB FFP
- One patient was transferred between 2 hospitals less than 60 miles apart with 6 units of RBC and 4 units of FFP.

Limitations:

- Transfer documents were not received from all hospitals in all cases – in several cases documents only came from the receiving hospital.
- There may other cases in which blood was transferred without laboratory knowledge and transfer documentation.
- Because this audit utilised transfer of blood documents, which are for laboratory use, there was no method for capturing the clinical scenarios which led to the transfer of the patients.

Conclusions:

- There is still variation in laboratory practice for 'out of hospital' transfer of blood products
- There is evidence of lack of knowledge about transfer practice by 'out of hours' lab staff
- The agreed EoE transfer documentation not being used by several hospitals
- Better use of EoE documentation would help communication between labs and may help reduce 'fate unknown' incidents
- Many labs appear to be 'unable' to override clinician request to transfer multiple units.

JB expressed his thanks to all laboratory staff and TPs who took part in this audit, in particular the staff at Addenbrooke's for their vital contribution and JO'B for administering the audit and providing the results.

There was discussion as to whether anaesthetists would be aware that blood in theatre had been sent from another hospital and if so, would they have an aversion to using it. CS said that Addenbrooke's often have trauma packs awaiting the arrival of a patient and clinicians would prefer to use that blood, rather than products from a potentially unknown source. CS also said that boxes received unsealed are often opened by people checking to confirm what is inside.
AR spoke of an incident where a child was transferred by the CATS (Children's Acute Transport Services) and the staff took a unit of blood saying they had a fridge on board. JH queried whether this would satisfy cold chain validation. JO'B said this had been mentioned at both TP and TADG meetings and very few present had heard of CATS. They are an NHS organisation which has been operating for 10 years mainly in

the London and South East. We have been in touch with them and have invited them to an RTC meeting in order to facilitate communication and exchange of information.
JB said there is reference to 2 other audits of transfer of blood but there is limited data available on one and none on the other. He said the data we have at present does not support the continuation of the practice of transferring blood with patients.
He asked why some hospitals are not using the regionally agreed transfer documents. JO'B said there was a variety of paperwork in use in some hospitals. Transfers are not a very common occurrence and often occur at night when staff on duty might not be aware of the correct documentation.
MP said there was anecdotal evidence that a member of staff at Papworth refuses to accept transferred patients unless they are accompanied by blood products.
JB said there is a need to engage with clinical colleagues plus laboratories should encourage the use of the regional documentation.

6. NBTC and RTC Chairs meetings: JB attended these meetings on Monday 17th March and his presentation on the main points is attached with these minutes.

- The lack of CSM support for Brentwood and Cambridge was highlighted but the NBTC were informed that the post has now been filled.
- BBTS are inviting presentations on PBM: please contact JB or JO'B if interested.
- The Education Working Group is working on the inclusion of transfusion issues but there are difficulties with nursing and midwifery curricula as each school has its own programme.
- The issue of CSL Behring's guidance that pregnant patients with a high BMI should be given anti-D IV was discussed. It is agreed that this would cause logistic problems particularly with ante-natal clinics.
- NBTC have not dissented from any recommendations from the NPSA SPN 14 review group. The issue as to who has ownership of this now that NPSA has been disbanded is still unclear. It should be noted that the recommendations are the minimum required.

7. Group O Rh D negative:
AD discussed the BSMS recommendations "Red cells for emergency use – best practice from BSMS regional road shows" (sent in hard copy to labs and available at: http://www.bloodstocks.co.uk/pdf/red_cells_for_emergency_use.pdf).
Ideally O negative blood should go to O negative patients but giving it to O positive patients is acceptable if units are near time expiry. RW said that hospitals supplied by the Cambridge centre in particular regularly ask for additional requirements for emergency and flying squad blood which are unnecessary.
HE asked if leucodepletion removes the need for CMV negative components. SaBTO recommendations state it should still be used for pregnant patients. Some hospitals do not follow the SaBTO guidelines. It was also noted that clinicians may not be aware of the guidelines and so are requesting CMV negative units against hospital policy.

MP gave a presentation on Group O RhD negative issues and waste in our region (attached with minutes). The reasons for changes in issue were discussed. JJ said that O negative issue dropped at James Paget in 2013 because in 2012 there were 3 haematology patients being transfused every other day which resulted in an artificial rise in use.
It was noted that Peterborough Hospital, which had the highest O negative issues in the region for many years, has had a steady and sustained decrease. KB said that moving to the new hospital helped because previously the hospital was over several

sites. However, they still cover Stamford hospital and supply a private hospital. Issuing blood on demand has also helped reduce use.
Most hospitals in the region have low Group O negative wastage but some are high. SN said that because there are no transfusion staff on duty at night at Queen Elizabeth II hospital O negative is stored there but sent back to the Lister when it becomes short dated. QE II is due to close later this year, so this will cease to be an issue. AD said it would be useful to be able to compare regional and national WAPI data as we have with issue data.

8. How social media can benefit transfusion: Jen Heyes, PBM Practitioner in London gave a presentation on the use of a Twitter account for the London RTC (attached with minutes).
AH asked what happens when negative comments are posted; JH replied that they are responded to on a private feed but not removed. It was noted that NHSBT have their own Twitter and Facebook accounts and have guidance as to appropriate content, language etc. AR asked if our RTC set up a Twitter account, would permission have to be gained from each Trust. AD replied that individual hospitals are never mentioned. The possibility of a Twitter account for our region will be further discussed by the RTT.

9. NHSBT update: RW gave a presentation on news from NHSBT (attached with minutes, together with the results of the latest Customer Satisfaction Survey). He said that NHSBT requests that hospital staff to read The Update available monthly on the Hospitals and Science website.
AH gave an update on the situation regarding Brentwood. The initial proposal to close Brentwood completely was taken to consultation at all affected hospitals which led to a revised proposal retaining smaller stock holding unit in the Brentwood area. Department of Health approval is required because property is to be disposed of and this has been delayed. Therefore the NHSBT Board made the decision to proceed with items not requiring DoH approval. Therefore hospitals which are changing delivery centre (e.g. Ipswich will receive blood from Cambridge not Brentwood) will do so within a few months.
JB thanked AH for continuing to communicate with the region.

10. Pathology Transformation:

- TPa reported that Broomfield have withdrawn from TPP
- CH reported that Southend and Basildon and a private partner have joined forces to become Integrated Pathology Partnership.
- JJ reported that the Eastern Pathology Partnership went live in January and all 3 hospitals had some loss of staff, particularly amongst the more experienced. AR said there are issues relating to what constitutes “training” and there is concern that inexperienced staff may have problems coping with, for example, massive blood loss.

JB said the RTC should continue to be a forum for concerns.

11. Unified drug charts: JJ was asked to be involved in the project to provide a unified drug chart and wanted to canvas the opinion of members of the RTC. Presentation attached with minutes. Following discussion it was clear that hospitals in the region have a variety of methods; some use the prescription chart for blood, others use a fluid chart and some use one specifically for blood. JB said Addenbrooke’s are moving on to a paperless system. Several present felt that a standardised regional document would not be a workable document for all. However

AD suggested we could look at mandatory and optional fields that might be incorporated. It was noted that blood components are authorised, not prescribed. JJ will circulate the proposed transfusion page for the unified drug chart when it is available

12. A.O.B:

- CH said that one of the hospitals with whom Southend share patient care had not signed up to sharing RCI results entered onto SpICE. She said that once hard copies are stopped she won't be able to see results for these patients. JH suggested this be raised as a concern with the SpICE project group.
- Debbie Asher asked AR to inform the RTC that Norfolk & Norwich will soon be providing blood to the East Anglia Air Ambulance based in Norwich. They will be using tag traceability and a unique identifier for patients. It is hoped that this will operational by July and staff should be aware that they may receive blood with NNUH tags.

13. Close: JB closed the meeting at 1 pm and thanked everyone for attending and in particular AH, RW and JH.

Next meeting: To be held on 26th June 10 am to 1 pm at St John's Innovation Centre.

Actions:

Action	Responsibility	Status/due date
Complete survey on annual and monthly reports	TPs and TLMs who have not already done so	ASAP
Send blood loss estimation quiz to JO'B for circulation	DAr	
Raise concern about sharing RCI results once hard copy reports cease	RW	
Send transfusion section of unified drug chart to JO'B for circulation	JJ	Once complete

Attachments:

Transfer of blood appendices version 2
RTC Chairs and NBTC meetings summary – PowerPoint Jim Bamber
Regional O negative issues and wastage – PowerPoint
Twitter – PowerPoint Jen Heyes
NHSBT Update – PowerPoint Richard Whitmore
Customer Satisfaction Survey – PowerPoint Richard Whitmore
Unified drug charts – PowerPoint Julie Jackson