EAST OF ENGLAND REGIONAL TRANSFUSION TEAM

Minutes of the meeting held on 23 June 2021, via Microsoft Teams Meetings
10:30am – 12:00Noon

Attendance:

Name	Organisation	Name	Organisation
Dora Foukaneli **DF**	Consultant Haematologist, CUH / NHSBT	Isabell Lentell **IL**	Consultant Haematologist, West Suffolk
Frances Sear **FS**	PBMP, NHSBT	Claire Sidaway **CS**	TLM, Hinchingbrooke Hospital
Tracy Nevin **TN**	TP Network Chair, Princess Alexandra Hospital	Julie Jackson **JJ**	TP, James Paget Hospital
Clare Neal **CN** *Minutes*	RTC Administrator, NHSBT		

Apologies: Nicola Jones **NJ**, Mohammed Rashid **MR**, Gilda Bass **GB**, Lynda Menadue **LM**, Lisa Cooke **LC**, Katherine Philpott **KP**, Michaela Lewin **ML**, Suzanne Docherty **SD**

1. **Welcome** **DF** welcomed everyone to the meeting. Introductions were made.

2. **Minutes agreed:** Previous minutes were agreed. Please advise **CN** of any amendments.
   Actions from previous meeting
   1. Discussions Regarding Simulation – **FS** We might be able to access funds for this but will need to put together a business case to access potential funds. Once a plan is in place as to how this is going to happen, then we can put this business case together. Are we able to move forward with this in the current situation? **DF** it would be good to bring to the next meeting. **FS** is it worth putting plans in place ready for when we can proceed with simulation. **TN** spoke to their simulation team; the Trust is only allowing 3 people in a simulation session so this would prove difficult. **JJ** obstetrics may already have a simulation video https://www.promptmaternity.org/contact-us. **JJ** will ask their Obstetrics Clinical Educator to see if there is anything that can be shared. **FS** I think Jim Bamber was involved in a video. **DF** it is not exactly simulation but a very good quality video. Maybe this link can be sent to delegates on Mums, Babies and Blood. **FS** we plan to give delegates links and resources so they can access them.
   2. Education Working Group - **DF** it would be good to arrange a first meeting to move forward with this. **DF** continues to teach registrars; this is open to all registrars in the region. **DF** would like to invite members of the RTT to participate with this. Can you teach on 7th July **IL**? **JJ, TN, CS** and **FS** it would be good to include you too. **DF** we had bad feedback nationally for training for registrars so **DF** started this training at the start of the pandemic. This training can be used as a model. Can a similar model for other groups such as paediatrics, anaesthetists? **FS** advised that **KP** was very keen at RTC to start a programme for BMS's. **DF** advised that many join the education sessions from home so zoom is working well. **FS** we are still ongoing with trying to set up a zoom account for the region. **TN** Princess Alexandra do not have access to zoom. Could there be a template of subjects to cover to take to working groups to ask for their input. **DF** has utilised the registrar groups for many purposes such as training the trainer. **DF** is asking a small group first to ensure experiences staff are delivering sessions. **DF** firstly an Education Working Group Meeting needs to set up. Separate programmes can be planned for different staff groups such as TP, BMS, Haematology Trainees. Once all the information is gathered, a programme of presenters can be put together. **CN** to set up a meeting and circulate.
   3. Mums, Babies and Blood Study Day – this is planned for 5th July 2021.
   4. Terms of Reference - **FS** we are waiting for the RTC terms of reference from the NBTC in order to merge into the RTT terms of reference. **DF** it needs to be specific and relevant to East of England RTT. **FS** details of the working groups and what is happening in each group can be added. Working groups, projects and audits can all be included. **FS** will wait to hear from NBTC for their guidelines and then they can be added in. These will be circulated and ratified by email.

CS how many people to other regions have in their RTT's. **FS** it is completely different per region. A lot of other regions have a lot of working groups set up whereas the East of England region feedback to RTT, TP and TADG groups. It may be worth setting up more working groups in order to involve more hospitals within the region. **TN** if the regions are disproportionate then can we have a number or people attending the meeting according to the size of the region. **DF** I don't think the number of attendees is an issue, representation from each group is more important.

3. RTC Business

DF it is really good to hear from each hospital so I tried to engage everyone, even if it was a couple of lines. **FS** it was a really good meeting. **DF** observing other RTC's, we need more voice from each hospital. I was very much motivated by your initiative to recognise good practice **JJ**. Rather than always looking at negatives and near misses, it was great to see that you are highlighting achievements and good practice. **IL** I think that is a very good idea. If every hospital is contributing and sharing good practice / initiatives, it is also an opportunity to also highlight any challenges the hospital is facing that quarter too. Others may be able to offer guidance. **FS** when we did the wastage campaign, everyone was so engaged, everyone wanted to win the box of chocolates. **DF** we need to endorse this idea into the hospitals so we can recognise achievement. It needs effort and education. **IL** if there is an expectation at every RTC to contribute, then before every meeting the HTC will need to have a discussion to take and share. This is also good sharing practice and discussions within the HTC. **FS** maybe we need to change the wording on the agenda. **DF** everyone needs to feel it is open and able to share, they should be able to share positives and challenges. If they have had a challenging few months, you wouldn't want them to feel excluded from discussions. **JJ** we got one of those awards and it came at the right time for us which gave a great boost to morale for staff. **TN** I replicate this, you should be praising the work hospitals have done as a result of an incident. It engages people. **DF** for the RTC we should have an expectation for hospitals to report. The HTC should discuss near the next meeting what they would like to discuss at next RTC. This could include achievements, questions, shared initiatives and challenges. This is what everyone wants to hear. **ML** uses this transfusion link which is a leaflet / magazine that she shares. **FS** we did share ideas in the TP group. **DF** do we need a template of something similar? **FS** we started putting something together per quarter after all meetings had taken place so that we could summarise what was happening across the region. **DF** it could be one page after all meetings with a summary and national highlights. **FS** we started it with TP and TADG groups. **DF** we need to look at different ways to encourage engagement. **FS** and **CN** will re-look at this. **JJ** I put together an RTC report as I am trying to engage more staff from James Paget.

DF any there any more matters from the RTC? **FS** the main thing is the Deputy Chair position; we need to liaise with **NJ**. If the RTT have no objections then maybe we need to put a Deputy in place if **NJ** is unable to attend a meeting to approve. **DF** I think it would be a good idea to have more than one deputy. **DF / FS** to discuss with **NJ**.

DF I discussed at the RTC that there are patients who present with low haemoglobin and need extensive investigations before receiving transfusion. Samples go to Colindale for investigation and if haemoglobin is below 60, sometimes below 50, Colindale ask the Consultant on call to ensure that a plan is place if the patient deteriorates or requires transfusion. My observation is, not necessarily from the East of England, when I speak to hospitals, there are BMSs that are reluctant to administer anything if they have the fear that cross match may be incompatible. NHSBT ask the Consultant's to call the hospitals as there have been deaths in the past implicated from these situations and we need to try and avoid this. It will help if the BMSs understand why we are calling them and the next obstacle is when I try and talk to the haematologist covering the blood bank, they normally know nothing about the deteriorating patient and therefore cannot support the BMS in this situation. What is the correct approach and how can we make BMS ready to receive the phone call from NHSBT and motivate Consultants to help? **CS** it sounds like a good topic for the BMS education platform. It is such a rare occurrence for our hospital as those patients are not seen by us but we have some very inexperienced Band 5s on our out of hours rota who are not confident with the information that they are receiving. They are not exposed to these issues regularly enough. They know the theory but if you ask them to issue blood on it, they don't have the confidence. **DF** we need to education them and also the hierarchy. They need to know the ideal situation but also be

aware that time does not always permit, the patient's condition and also limitations, availability. You need to know the next best available. **DF** last night it was a 1 year old, haemoglobin of 47 and they couldn't determine blood group so they didn't know what to give. **CS** because they can't establish the group on the samples we have got, LIMS systems won't allow you to issue because there is no group available and they are also reluctant to feed in information without confirmation. **DF** in this situation**,** this is why you have emergency blood. I would prefer them to look for emergency blood in this case rather than doing something hesitantly. **CS** sometimes it does need to be clearer to them what they are being instructed to do. **DF** if the laboratory managers group develop guidance, the guidance needs to reflect the appropriate laboratory SOP. The hospital needs to define different scenarios and conditions. **CS** we might be falling foul of is the SOP cover specific scenarios. I am not sure that people have the experience to follow several at the same time. I will speak with **KP** and we can have a chat with the TLM's to see if anyone has an overarching flowchart. **DF** the flowchart needs to include information about the Consultant covering the blood bank. **DF / IL** could then develop something for the Consultant covering the blood bank of how they need to support labs in this scenario. **CS** we need to consider that Consultants might be covering across sites and may not know the patient. The first contact may be from the BMS. **DF** if they are covering blood bank they need to fulfil the responsibility. **TN** it is down to the clinical team. Clinical staff should also have a flow chart. We have a maternity lady who has got a rare antibody so there has been lots of discussions and the Consultant's response was ' we can give O Neg'. We have got time as she is only in the early stages. We have had the same with elective surgery. We have time to plan for these patients. **CS** that is not new and has happened for many years. DF is highlighting the haematology trainees not having as much transfusion training as she would like so also having medical trainees, surgical trainees and also their seniors educated is tricky. **DF** we had a unit given in the emergency department to an elderly patient and this last had antibodies. This unit was completely unnecessary. It would have been ok if she was bleeding catastrophic and administering blood was necessary. **TN** if you are talking BMSs, you also need to talk clinically. **DF** if we develop toolkit then this can be shared nationally. You cannot teach and education people in the middle of the night. **TN** working on the national steering group, I have asked for anything implemented to go on Blood App. Is this something we can include for clinical staff around antibodies. Otherwise you are replicating something else. **DF** personally I think this is important. We need to education staff. Let's start the standard approach with an algorithm and toolkit, possibly different ones for each professional group. Then we discuss whether it can go to an App. **JJ** it is a brilliant idea but it also needs to come from the various Royal Colleges such as the Royal College of Anaesthetists as if they are telling them this is what they should be doing, they won't ignore it. **DF** this piece of work affects our BMSs and Consultant Haematologists. **TN** I think positive reinforcement may come into force here too so you can share something that someone else has implemented. If they know others have implemented something then they are more likely to. **DF** if they have an algorithm then they can refer to this. **TN** this is a good subject for the groups training. **DF** there is no such thing as perfect blood, we need to keep the patient alive to receive the perfect blood. **DF** it is the most frequent phone call we receive so it needs to be addressed somehow. **FS** if there is any information you would like to put into toolkits then we can include this.

4. Any Other Business

FS we are looking at guidelines and toolkits.

FS do we want to think about any audits. Is there anything regionally that we need to think about? Some regions have started doing something. **CS** I wouldn't suggest putting anything in at the moment. **FS** we will keep that as whenever we can we will resume. **DF** we need to revisit effective communication for special requirements. **FS** we are re-launching the shared care form so maybe you've got an opportunity there. **IL** we had an incident overnight, we didn't know a patient needed irradiated blood. We did not receive a form. We will look into this event further. It reminded me again that looking at that will be really good.

JJ thank you for letting me join the meeting today as it has been really interesting.

TN at the National Group we are looking at O D Positive, it may be worth seeing what everyone is doing in this region. We are looking at a toolkit which can be shared to the App. **FS** I know that the TADG often talks about it too so maybe worth speaking to **KP** to bring the two groups together for that one. **TN**

it would be nice to know what people are doing regionally to see if there is good practice. **DF** it would be good to work with **KP**. **FS** this can be done as a regional snap survey. **DF** remember we are one of the best regions for use of O Negative blood and we are really proud. **TN** it is more how they are implementing it and processes. **DF** we have to be sensible, if people are using O Negative at a lower level, I don't mind if they use OD Negative for male patients in certain instances. There are places out of East of England that use a lot of O Negative. **JJ** as well as looking at how hospitals have implemented good practice, we need to look at why people haven't implemented it too. We have a very good reason at James Paget and it is important to listen to that. **DF** if we want to look carefully at O Negative, we need to bring it back to the RTC agenda. Whatever survey we circulate, it needs to be conjunction with the 2018 audit. **DF** it may be difficult for some hospitals to implement.

TN the national group for O Positive have asked why some hospitals are good at it, not everyone can implement it and not everyone is in agreement with it because of their cohorts of patients. We have said we were not happy to do it unless we've done a baseline order as to who, why, what are the obstacles. DF it is not necessary for everyone to implement. If we know that 8% of the population is O D Negative, you have to have adequate blood to cover these patients. On top of this you need additional percentages for transplants, anomalies and emergencies. If each hospital has a reasonable level they keep as stock, if you are below that or within that range continuously, how can you keep less? **IL** I think that is really useful guidance. There is the feeling that every site should be doing that. How do you put safe protocols in place? We know it's an option, particularly people using lots of units, we should be switching them to O Positive but do we have to for every single patient, no. **DF** you have the NBTC guidance suggesting you keep below 12% but you could be consistently below this. We have 8% of the population are O D Negative but Newcastle have a different population so they need to have more blood to cover their population. You need to know your population, your patients, your hospital data and services. All this adds up. We will not achieve anything by having a blanket percentage.

JJ I have been attending Queen Elizabeth HTT meetings. I have been there to see what they do and support them. We picked up that our usage was very minimal compared to them even though we are of similar sort of area. We had a look at it and our endoscopists have developed a pathway so patients who come in with a GI bleed are minimally stabilised in A&E. They are taken straight to theatre where the endoscopy team meets them, the surgeons are there, they scope them and if the endoscopy team can't stop the bleeding then the surgeons are there. We hardly ever use more than 1 or 2 units on these patients whereas Kings Lynn use maybe 5+ units. It is important to look at what others are putting in place. **FS** it would be great to share that. **DF** could any TP's attend other HTT's. Can we clarify the governance around that? **FS** the difference between them all is vast. I have heard of it being done. **JJ** I found it really useful and the 3 hospitals are trying to standardise across the entire portfolios. I have learnt things from them and they have learnt from me. We all have different skills, knowledge and backgrounds etc. **FS** a lot of those that are merging are attending each other's but is probably not happening so much across the networks. **DF** it is good to compare like to like.

TN has been invited to the London TP Group because of the WBIT audit so it will be good to see what they do. Something that was discussed at RTC a long time ago was that we normally have a template for HTC to show what we are doing. Ids this something that can be discussed at RTC so you bring your template and share what each hospital is doing as part of HTC's. **FS** we tried to engage and encourage but we didn't get anyone sending information back. **DF** we need to allow them to participate in a way they feel comfortable and they may be put off by filling in a form. I left it open at RTC and it encouraged more open discussion. DF we can keep it on hold, allow free discussion. In time a more standardised form may need to be implemented.

Date and Time of Next Meeting: Wednesday 20th October 2021, 10:30am – 12:00 via Microsoft Teams

Actions:

	Detail	Responsibility	Due
1	Discussions regarding simulation		**Ongoing**
2	Set up Education Working Group	CN to liaise with DF	**Ongoing**

3	Terms of Reference	FS / CN	**Ongoing – awaiting NBTC ToR**
4	Summary Report for RTC Members Each Quarter	FS / CN	**Each Quarter**
5	RTC Deputy Chair	DF / FS to liaise with NJ	**October RTC**
6	O Negative – add to RTC agenda	CN	
7	O Negative – combine what is being discussed at various groups	TN / KP	**Ongoing**