

South East Coast
Regional Transfusion Committee Meeting

Post Graduate Education Centre, East Surrey Hospital

Wednesday 21 February 2018

(1545 – 1645)

Unconfirmed Minutes

Present:	Howard Wakeling Fatts Chowdhury Anwen Davies Leslie Delieu Keith Kolsteren Lisa March Frances Moll Jeyanithy Nicholas Emma O'Donovan Rashmi Rook Richard Whitmore	SEC RTC Chair & Consultant Anaesthetist Consultant Haematologist Patient Blood Management Practitioner Transfusion Practitioner Transfusion Practitioner Transfusion Practitioner SEC RTC Administrator Laboratory Manager Consultant Haematologist Lead Biomedical Scientist Customer Services Manager
Apologies:	Ralph Ezekwesili Gemma Fawke Robert Goddard Nicola McVeagh Ruth O'Donnell Malcolm Robinson	Consultant Haematologist Assistant Transfusion Practitioner Chief BMS Blood Transfusion Lead Transfusion Practitioner Transfusion Practitioner Laboratory Manager

Howard Wakeling (HW) welcomed everyone to the meeting.
He thanked everyone for their contribution to the Education Symposium, which had preceded the committee meeting.

Regional Audit Feedback: OD Neg Audit

Richard Whitmore (RW) gave a presentation (see attached).

RW referred to the results from the SEC Hospitals, gathered between 1 – 14 April 2017. The audit was specifically designed to be simple, just using the Blood Transfusion LIMS system, no patient notes etc. were required.

He explained that the results included NHS (P119 – P375) and non-NHS hospitals (P150 – P904).

The audit gathered information where wastage was due to a variety of factors for example temperature control failure. The audit did not identify the fate of units sent from one hospital to another.

ACTION – Future audit template to capture the final fate of units sent to another hospital (RW)

Members discussed the stocks held at their hospitals. Stock fluctuations could be caused simply by someone looking in **just** their stock fridge, and not considering potential stock returns. This could increase stock significantly, it was agreed a balance was needed and improved communication. There was also an example where red cells orders had not been

updated to take into account changes in practice and changing demand. A simple review of stocks and the ordering process had led to a significant monetary saving.

Highlight reports, provided each month, indicate where wastage or demand appears high, and RW and Anwen Davies (AD) discuss this with the hospitals concerned.

New software is being trialled - VMI Project. This is a joint project between specific hospitals and NHSBT. This NHSBT software compares an hospitals current stock with agreed stock levels; VMI creates orders to replenish used stock to these targets, without staff having to order blood manually.

Members discussed the conclusions drawn from the presentations made at the Education Event (held earlier in the day), and the need for good preparation of the patient before theatre. With the right checking systems in place the result should lead to a reduction in the stock requirements. A suggestion for stock delivery on a Saturday, to prevent the "Friday panic", was being considered but all the associated implications had to be taken into account.

RW encouraged stock sharing between adjacent hospitals. Members noted the hospitals that were already sharing stock, and while stocks were reduced, it did not always lead to cost savings. RW and AD plan to visit hospitals to discuss SLAs. It was noted that it is important that agreements are properly defined.

QS 138 Toolkit Anwen Davies (AD) gave a presentation (see attached)

AD outlined the four statements from the NICE Guidelines – QS138.

This had been published a year ago, and a trial audit to measure compliance was being rolled out.

Members agreed that it was very difficult to define and measure for some of the standards and concern was expressed that the figures didn't give any indication of the number of patients seen overall during this pilot.

It was difficult to get data, however, while patient and surgery details could be accessed, for complete data each patient would then have to be individually checked.

ACTION: It was agreed that QS1 needed to be revised and a better solution considered.

Hospital Updates:

East Surrey Hospital Rashmi Rook noted a template for staffing issues and the capacity of plans for the Laboratories had been issued.

Medway and Darent Valley Hospital Leslie Delieu noted that the pathology services at Medway and Darent Valley Hospitals are merging to become North Kent Pathology Services.

Kent & Canterbury Hospital Keith Kolsteren noted a first for the Chemotherapy Bus with a successful transfusion taking place on board.

The following reports had been submitted by email:

Harvey's Gang (Malcolm Robinson)

We continue to grow and be recognised: Harvey's Gang has gone live with tours in 31 Trusts, with an additional 29 Trusts working on to start. We have a live site in all countries

making up the United Kingdom. We are working with Eire and hope to go live by Easter. Shortlisted for a Chief Scientific Officers 2018 award for Healthcare Sciences, to be announced in March 2018.

Harvey's Gang will be at BGS Reading attending with a stand; Applied for Poster Presentation to Brisbane Healthcare 2018.

As NHS is 70 would like help and support to encourage Harvey's gang to reach at least 70 sites by year end.

Last year presented at ScotBlood in June and at IBMS Congress, and the inaugural BGS Dublin in December 2017. Working to make eg a reality and 360° Virtual laboratory views for youngsters unable to attend. Would like BBTS to ask to present or allow a Harvey' Gang stand.

The Harvey's Gang Film is available: <https://m.youtube.com/watch?v=qSiglllVqmg>. There had been recent publications in: The Biomedical Scientist, The Guardian, IBMS Letter to Harvey: Sarah May; Deputy CEO, IBMS, Harvey's Gang Lab Tour

Ashford & St Peters, Frimley Park and Royal Surrey County Hospital: (submitted by Nicky McVeagh)

- Fetal RhD testing was implemented in July 2017.
- 3 yearly competency assessments have now been changed to a single knowledge assessment. There is no pass or fail mark; rather there are pass or fail questions.
- We have moved to using O Rh D positive blood as emergency blood for men only at this stage at all sites. Component usage is down at all three sites for RC and platelets due to a mix of proactive Consultants, BMS empowerment and TP activity.
- A new Blood Transfusion Policy for Neonates and children has been produced. This has been really welcomed especially at ASPH which has a NICU and has improved liaison and communication.

Iatrogenic Anaemia: (submitted by Ruth O'Donnell)

A poster on ITU blood sampling practice was presented at the education day (21/02/18) A guidance document with recommended maximum discard volumes has been developed, with the aim to minimise or avoid iatrogenic anaemia. This resource is available on request.

London and South East Coast Trauma Group: (submitted by Julie Coles)

The last trauma group meeting discussed the experiences of St. Mary's Hospital in the recent major incidents. Major incident action cards were also discussed; staff communications, remembering staff ID, ensuring suitable cover for the following shifts, plus an awareness of how these scenarios affect staff. Lots of interesting discussions around this currently topical subject.

Consent (ICAG): (submitted by Liz Tatam)

Two members of the SEC TP working group attended the NBTC 'Consent Event'. It was a very positive experience for us to present the progress we have made on achieving consent for transfusion within the SEC region. The development of the ICAG pad into a national resource available via the NHSBT distribution hub is almost complete, a move welcomed by all the SEC TP group. It is considered that the profile of consent is high within the region, with a consent session featuring as part of the February SEC RTC study day. Consent will continue to be monitored via the use of the QS138 toolkit.

Regional Transfusion Committee Budget

The 2017/18 budget had now been spent.

Future RTC Meetings

Members discussed the value of the education events, but it was acknowledged that to release people for the same event was not always easy. Cross regional events provided greater opportunities and should be considered.

Suggestions for future events:

- Mitigating Risks;
- Worthing Toolkit;
- Risk Management

Any Other Business: No other matters were raised

Date of Next Meeting: tba

Unconfirmed