UNCONFIRMED MINUTES OF THE SOUTH WEST REGIONAL TRANSFUSION COMMITTEE
Tuesday 17 November 2020, 10.00 – 12.30
Via Microsoft Teams

Attendance:

NHS HOSPITALS/ORGANISATIONS	
Derriford Hospital	Wayne Thomas (WT), Caroline Lowe (CL)
Dorset General Hospital	David Quick (DQ), Lorraine Poole (LP)
Gloucestershire Hospitals	Sally Chown (SC), Stuart Lord (SL), Tracy Clarke (TC)
Great Western Hospital	Sally Charlton (SCh), Ed Bick (EB), Jassy Uppal (JU)
North Bristol Trust	Tim Wreford-Bush (TWB), Karen Mead (KM), Mooi Tay (MT), Elmarie Cairns (EC)
North Devon District Hospital	No representative
Poole General Hospital	Vikki Chandler-Vizard (VCV), Rebecca Maddams (RM), Alison McCormick (AM)
Royal Bournemouth Hospital	Lorraine Mounsey (LM), Ian Mowatt (IM)
Royal Cornwall Hospital	Pedro Valle-Vallines (PVV), Oliver Pietroni (OP), Ian Sullivan (IS), David Tucker (DT)
Royal Devon & Exeter Hospital	Barrie Ferguson (BF)
Royal United Hospital Bath	Helen Maria-Osborn (HM), Jenny Page (JP), Thomas Scorer (TS), Adele Wardle (AW)
Salisbury District Hospital	Caroline Mathews (CM)
Somerset NHSFT	Nic Wennike (NW), Michelle Davey (MD)
Somerset NHSFT/Yeovil	Sarah Allford (SA)
Torbay Hospital	Patrick Roberts (PR)
University Hospitals Bristol	Steve White (SW)
University Hospitals Bristol/NHSBT	Tom Latham (TL)
Weston General Hospital	Sam Lewis (SL)
Yeovil District Hospital	Alison Hill (AH)
PRIVATE HOSPITALS	
Nuffield Health Cheltenham Hub	No representative
Nuffield Health Exeter Hub	Bryant Cornish
Spire Hospital, Bristol	No representative
Patient Representatives	Helen Witham
NHSBT	
Patient Blood Management Practitioner	Sam Timmins (ST)
Customer Service Manager	Emma Taylor (ET)
Clinical Consultant	Mike Murphy
Bloods Stocks Mgmt Scheme Manager	Matthew Bend
Consultant Clinical Scientist Trainee	Sara Wright (SWr)
RTC Administrator	Jackie McMahon (JM)

1. Welcome and Apologies:

All welcomed by ST, deputising for RTC Chair, Stuart Cleland (SCl). Format for the meeting explained, apologies noted and the main points of the last face to face meeting were summarised.

2. NBTC Meeting Update (ST on behalf of SCl)*

(*copies of all presentations will be available with the minutes)

- Proposal for education to be delivered on a national rather than regional level with each RTC being allocated a topic. The sessions will be live but also recorded for retrospective access and to create an educational library. Survey currently underway to ascertain most suitable platform and then a list of topics and a timetable will be confirmed.
- Proposal to change RTCs from 10 to 7 to align more with the NHS framework has been approved but there are no changes for the SW RTC.
- The expected publication date for Transfusion 2024 is 30.11.20 and this will be made available to interested parties.
- Convalescent Plasma Trials update webinar on 23 November - 11 SW trusts participating in either one or both of the trials.
- Presentation given on component development and future plans aiming to reduce complexity of supply, moving to more universal components and increasing the shelf life of some components. Three major groups – major haemorrhage, transfusion dependant population and neonates. Will invite project leads to join a regional meeting when relevant.
- SHOT Report Update - key recommendation focussing on accurate patient identification and recommendations for different ways of ensuring this, patient and staff empowerment, human factors training for lab staff. Big focus on moving towards Safety II approach to patient care and safety. Errors account for the biggest percentage of reports.
- Block contract arrangements will continue to be reviewed every financial quarter.
- Demand dropped quite significantly during first COVID-19 wave and lockdown alleviating pressure on supply but planning and forecasting for recovery was a major challenge. O neg demand has been fairly consistent all the way through and we are now slightly above demand then we were pre-COVID. After an initial drop there was a steady increase in platelet demand and SAGE has provided some data to try and help with predicting platelet demand during a second wave. RO is still a challenge and has a knock-on impact on O neg and B neg.

Hospitals were thanked for providing information to help NHSBT better understand their needs. This information is still needed to enable NHSBT to continue to plan ahead and accommodate requirements. Stock levels are sufficient but a little behind what they normally are. Work is ongoing to build supplies but increasing challenges in collecting the required number of red cells may result in supply issues in coming months.

3. Customer Services Update (ET)

- Barnsley Centre now open – update LIMS with site code.
- New H&I request forms and user guide – destroy old versions.
- Hospitals thanked for their support of the O neg, K pos initiative, which has made a huge difference on wastage, and asked for continued support going forward.
- A Neg subs – Derriford, Southmead and Musgrove Park were thanked for agreeing to order A D pos units to help preserve A Neg stock.
- TLMs working group of the NBTC has published guidance for emergency red cells:
    - Use O Positive red cells for males
    - Use O Negative, K Negative red cells for women and children (CMV- to be considered in the maternity setting)
    - Use O Positive red cells for women >51 years of age

MM asked what the picture is in the SW RTC following SHOT's recommendation that hospitals explore and implement IT outside of the lab to improve transfusion safety and reduce errors. ST responded that the results of the annual regional survey of transfusion practice will give us that data and it will be discussed at the next RTC meeting.

4. Blood Issues and Wastage (ET)

Wastage increased nationally during April and lockdown as services were halted. Rbc wastage in the south west was significantly greater than average before settling back down to below average over the summer - is there anything we could have done differently?
The impact on issues varied between the groups. O neg issues peaked at the national average in March and sustained at around 14% for the summer but are now settling down to our normal regional average of around 12%

ST pointed out that the data was presented slightly differently with issues and wastage side by side to provide insight into trends over the lockdown period.

5. Blood Stock Management through a Pandemic

Torbay (presented by ST in Julia Pinder's absence)
JP's presentation highlighted the actions taken at Torbay.
PR added that the Haem/Onc service, which accounts for 40% of blood usage, was moved to a community hospital. This caused major problems getting samples back to main hospital so set up a mini lab in the community hospital with a near patient testing, full blood count machine and member of staff to man it as well setting up a new fridge. This was biggest issue and then moving back again, along with the ongoing movement of departments around the hospital which is still causing problems.
Short dated stock received from NHSBT. ST commented that as demand from hospitals fell, NHSBT's inventory went up and stock is issued on a first in first out basis, so this was an unseen side-effect.

On the plus side, it provided extra admin time – blood policies and procedures and trust intranet updated.
Not so good was an increase in non-compliance with blood track and sample rejection due to poor labelling, transfusion team lost a member of staff, generic e-learning so new starters not familiar with local policies and paperwork.

Derriford (CL)
CL's presentation took the perspective of a much larger hospital - 1000 in-patient beds, 1800 outpatient clinics and 336 community clinics each week – Major trauma and cardiothoracic centre supported by three community hospitals so a lot of activity.
Also highlighted issues with short dated stock.
Found the NHSBT daily stock updates really useful.
Highlighted reliance on being informed of changes to planned elective surgery activities to plan stock orders.

IS commented that it was probably a similar picture across the south west with most hospitals following the same process, regardless of the number of cases they ended up with.

It will also be interesting to see how many of these changes are maintained and will be worth reviewing at the next RTC meeting.

- Derriford has managed to stop the practice of ordering platelets before a count is obtained.
- In general, there has been a lot more engagement with people joining meetings via Teams.
- NBT won't be reinstating face to face training

ST commented that the virtual medium is something that the RTC/RTT will be taking forward when considering the way education is delivered.

Picking up on some of the other issues highlighted in the presentations around clinical activity and the impact on stock, it is now easier to appreciate from an NHSBT viewpoint that when trying to understand hospital ordering practices, it can be quite challenging to provide the information to us as it is not always about numbers but more about understanding what is driving demand.

6. RTC Objectives

Use of O pos in Emergency and Major Haemorrhage
Since being set as a regional objective, this is now a national objective led by the NBTC national O neg task group. The national PBM team will be involved in implementing and promoting regionally. The initial focus from the national group is on O pos for men as it will be more straightforward to implement and they are in the process of developing a survey,toolkit and other supporting resources.

A regional survey showed that six trusts do not have a policy for O pos for emergency transfusion, with two working to implement. To take this forward, we would like to work with these trusts by providing a forum in the New Year for experience, information and data sharing with input from trusts that have already implemented a strategy.

SCh raised concerns about what the impact would be on O neg patients that are regular visitors to ED. ST acknowledged that there isn't a huge amount of published evidence but is aware that other trusts have done pieces of work around their patient population and asked VCV to contribute.

VCV – not the same issue but Poole did a look back at emergency group O issues over 11 years and approximately 16% of patients were female, with 2% being female of childbearing age and O neg. Although the policy doesn't negate the risk of creating anti-D in a male patient who is O neg, in reality the chances of it happening are very low and changing emergency O provision has a positive impact on stock holding in terms of saving units and wastage. The policy has been in place for c. 4 years with no issues. As more hospitals implement it will provide more data and in the coming years we will either see evidence that we are seeing male patients who are making anti-D and we review our practice or there will be a lack of evidence and all we have done is improve our O policies and saved O neg.

ST – this concern is common amongst a lot of trusts and has been fed-back to the working group, so hopefully they will provide the tools to help you risk assess your own patient populations. Will also take back to MM to see what information and evidence we can find.

VCV suggested that if they are known patients, they could be excluded from the emergency policy or a flag put on their electronic record. SCh voiced concern that this could be missed and also no blood fridge in ED so rely on porter to collect blood. Poole also do this and if their porters turn up and the lab hasn't been informed otherwise or had the alert, they can only take the O neg. If their lab has been informed the patient is male, they will take the O pos outside the door for the porter to collect. Porters are encouraged to liaise with the BMS to speed up the process and to make sure the lab staff are aware the O is being taken and if the patient details are available the right O can be used.

PR – Torbay have a similar policy. They have O neg grab bags but when the emergency transfusion is triggered get the BMSs involved very quickly as they are much more confident about making the selection and checking transfusion histories.

SC suggested the second Covid wave might present a good opportunity for any trusts struggling with getting an O+ policy as there could be stock issues.

ST acknowledged it is a big undertaking for some trusts but the idea of having it as a regional project is to work collaboratively and share good practice to help alleviate some of the challenges and workload faced in implementation

Maternal Anaemia (WT on behalf of SCI)
The original objective was to work in line with 2019 BSH guideline and the annual regional survey of transfusion practice was updated to try and capture this information. However, the transfusion trigger points didn't change and are quite outdated. The WHO is looking at revising these but has always recommended that the definition of anaemia should reflect the local population. Derriford decided to set up a pathway for taking a more aggressive approach to maternal anaemia by treating orally at booking rather than waiting for the 2nd or 3rd trimester:
(Unfortunately, the audio quality of the presentation was poor and the below are bullet points are taken from a previous meeting):

- An audit of the prevalence of anaemia in the local population established a significant amount were anaemic and that the normal Hb at booking was not what the guidelines say (110g/l). The average was 120g/l and this was used as the baseline. Anyone below that would be referred back to their GP to be prescribed oral iron
- The GP community wasn't engaged as much as it could have been, so a lot of GPs were not happy with this approach.
- CCG very enthusiastic to implement Devon-wide but then decided it would be too difficult for all trusts in the region to agree to do it in the same way.
- Now looking to have iron issued by the midwives and then audit and get GPs on our side by presenting data to support it.
- Have started seeing less patients presenting at term anaemic and are hoping to get some data soon to support this. We have also got a reduction in the levels of iv iron being used but don't have data to support yet.
- Going forward hope to be able to generate a report showing Hb at booking, Hb at term, hopefully ferritin, how much blood they received during their admission for delivery and post-delivery Hb and from that link with the number of patients who have had iv iron to be able to show a change over time. The intervention is very low risk and the benefits could be great.
- Next step is to present this protocol to the region and get thoughts on whether other trusts are keen to implement something similar relevant to their own population.

The Derriford team is happy to share audit tools with any trusts that are interested in reviewing their anaemia management policy and taking it on as a project. ST happy to support and facilitate It could be

an interesting piece of regional work and could provide some really interesting data.

HaemSTAR
No progress made yet in identifying suitable regional topics or interested haematology registrars but will try and pursue via the regional HaemSTAR lead.

7. Setting up of a Nightingale Hospital (TWB)
TWB presented on NBT's experience in setting up a blood supply to a Nightingale Hospital.

- Having no national model to follow and initially no named contact on site, and no engagement from the infection control lead were major constraints. There was also a lack of connectivity to NBT's blood track system as although NBT were providing the pathology, the decision was taken to use UHB's ITU system for patient id and electronic notes.
- Getting different staff to be able to follow a written process without training was probably the single most important part of the process.

In the discussion that followed, it was suggested that this could be a really useful additional tool for staff that have already been trained and assessed as trust policies can be hard to find.

MM thanked TWB for an excellent presentation and commented that the NBT experience had been replicated around the country and suggested that sharing the presentation with the NBTC and others working with Nightingale Hospitals around the country to highlight the problems could help resolve some of the issues on a national level. MM also suggested another avenue was to reactivate a national group that had been discussing issues with the Nightingale hospitals and provision of transfusion during the first wave. TWB confirmed that he was happy for his presentation to be shared.

8. **Patient Blood Management in a Lockdown – Oliver Pietroni**
OP thanked John Faulds, who has now left the trust, for the huge contribution he had made in setting up the PBM service and the ongoing collection of data.
The presentation gave some background to the service and highlighted the pre-op and intra-operative cell salvage provision and changes and challenges during the pandemic.

Overall, there was decreased caseload because of reduction in theatre activity and elective throughput but managed to maintain a good service with PBM, admin of iv iron and provision of ICS.

MM was interested to know the make-up of the team and how the service was delivered. OP explained that RCH has a full time cell salvage co-ordinator, Carol McGovern, who is responsible for cell salvage governance, collecting data and staff training. ODPs are

trained to deliver cell salvage in addition to their ODP role and have about 30 people who are trained.
AH – commented that Yeovil maintained their anaemia service, although referrals were down but they have just experienced their busiest month ever, particularly with GP referrals and have noted that the patient cohort is much sicker and questioned if this has been exacerbated by the impact on GP activity during the pandemic.
EC. Very keen to share the presentation with her NBT colleagues. Had very similar challenges with iv iron clinic and cell salvage but also saw a massive increase in regional referrals so patients from other areas coming to NBT for surgery but having their iv iron done in their local area. It is very positive for patients in this situation to have their iv iron where they live and is hopefully something that can continue.

OP confirmed that his is happy to share the slides and ST confirmed the slide deck containing all the presentations will be circulated with the minutes.

9. PREVENTT (OP on behalf of SCI)

ST summarised the background, methods and results for the trial and the conclusion that iv iron was not superior to the placebo when administered to patients with anaemia 10-42 days before elective abdominal surgery, with respect to blood transfusion or death in the perioperative period.
OP reported the results of the survey circulated prior to the meeting to ascertain to people's thoughts and if any actions were being taken following the trial -12/17 trusts responded.

ED Bick, HTC Chair, GWH joined to give some background to their scoring system for patients to meet the criteria for IDA:
Following the study results, decided to reduce the amount of iron given and analyse available data. Generally felt we were giving too much and aiming for normal levels of Hb was probably unnecessary for a lot of people. Data confirmed those benefitting the most and getting the biggest increment rises were the ones with the lowest Hb and those with a ferritin of less than 10 so arbitrarily decided that no-one over 120 should get iv iron and that the lower it was the more points you got. The chances of people who are having major GI surgery and have a pro-longed recovery ahead of them building up their Hb with oral iron are probably low, whereas those having orthopaedic surgery, as long as they do not end up needing a blood transfusion, can probably manage with a lower Hb. System currently out for comment and will go live soon if no objections. Interested to hear any comments.
OP queried if the GI surgery was laparoscopic cancer surgery or more major open surgery and EB said it was mainly resection of a cancer either, laparoscopic or open. The reason for the iron is not so much because they are at a high risk of blood transfusion but they are at risk of having a harder time getting back to normal post-operatively.
OP commented that the RCH GI surgeons are going to start looking at right sided vs left sided cancers as they are of the opinion that left-

sided cancers are more likely to bleed and have a lower Hb whereas right sided cancers are much more iron deficient so will be comparing the two to see if one is getting more benefit and will be reviewing other patient groups to see who are the responders so that the iron can be rationalised to the right patients.

ST queried if this would lead to a rise in transfusions in the orthopaedic setting and OP responded that RCH's transfusion rate for major joint surgery is less than 5% so the number needed to treat for iv iron, especially for those only slightly anaemic is phenomenal and would probably equate to 100/200 doses of iv iron to save one unit of blood which is not really economically justifiable. The impact of any changes to existing processes will have to be considered very carefully.

In conclusion OP's main criticism of the trial is the exclusion of severely anaemic patients and the rationale they usually did not progress to surgery as this is not his experience and treatment efficacy was very low – only a 5g/l increase in Hb between the two groups so not entirely sure they got the treatment right.

ST – perception from the study perhaps not that iron is not useful or is bad but more about tailoring how we use it and its really interesting to see that on the whole this is how it has been interpreted and perceived.

10. AOB

In response to PR's query regarding a Peninsula-based anaemia study, DT confirmed that the intention is to take the project forward and is currently waiting for a funding decision to see if it is going to get badged and status within the NIHR.
Barrie Ferguson has stepped down as Chair of the TP Group and was thanked for her hard work. Stuart Lord, TP at Glos Hospitals, is the new Chair and hopes to convene a formal meeting early in the New Year.
Education – the RTT has discussed producing short, pre-recorded 10-minute audio sessions covering topics like haematology, obstetrics, Tx 2024. Suggestions for other topics and volunteers to take part in sessions welcome.
SCI is reviewing the way we look at hospital activity at the RTC and introducing a new report for HTCs to submit prior to each RTC meeting.

ST thanked everyone for attending and encouraged them to fill in the feedback form either via the chat or email link.

11. Date of Next Meeting

TBC