Unconfirmed Minutes of the South Central RTC Education Symposium & Meeting
SHOT in the Dark
Held on 25 June 2014
Regency Park Hotel

Attendees		
Diana Agacy (DA)	TP	Southampton Hospital
Helena Beamis (HB)	BMS	Queen Alexandra Hospital
Susan Chambers (SC)	TP	Queen Alexandra Hospital
Michael Cheung (MC)	TLM	Nuffield Hospital Hampshire
Marie Cundall (MC)	Senior BMS	Royal Hampshire County Hosp
Pushkar Dadarkar (PD)	RTC Chair	Wexham Park Hospital
Kerry Dowling (KD)	BMS	Southampton Hospital
Christine Ellis (CE)	TP	Wexham Park Hospital
Edward Fraser (EF)	TP	Oxford University Hospitals
Tanya Hawkins (TH)	TP	Royal Berkshire
Kathryn Hayes (KH)	TP	Hampshire Hospitals Trust
Kay Heron (KH)	TP	Queen Alexandra Hospital
Beverly Janes (BJ)	ITU Sister	Southampton Hospital
Carolina Lahoz (CL)	Consultant Haematologist	Wexham Park Hospital
Peter McQuillan (PMc)	HTC Chair	Queen Alexandra Hospital
Christopher Marks (CM)	Patient Representative	Oxford HLC
Gwynn Mathias (GM)	Consultant Haematologist	Queen Alexandra Hospital
Jacky Nabb (JN)	RTC Administrator	NHSBT
Lyndsey Paton (LP)	BMS	Wexham Park Hospital
Terrie Perry (TP)	TP	Wycombe General Hospital
Maria Poole (MP)	BMS	Wexham Park Hospital
Wendy Qin (WQ)	Staff Nurse	John Radcliffe Hospital
Michelle Ray (MR)	CSM	NHSBT
Nigel Sargant (NS)	Consultant Haematologist	Hampshire Hospitals Trust
Louise Sherliker (LS)	PBMP	NHSBT
Dawn Smith (DS)	TLM	Southampton Hospital
Simon Stanworth (SS)	Consultant Haematologist	NHSBT
Chris Stevenson (CS)	QA Manager	NHSBT
Nicky Wilkes (NW)	BMS	Queen Alexandra Hospital

Apologies		
Lindsay Duffin	Group Transfusion Nurse Specialist	Nuffield Health
Olufemi Eniola	Chair of HTC	Wexham Park Hospital
Sharon Greasley	Director of Nursing	BMI Healthcare

1) Overview of Transfusion Reporting – presented by Tanya Hawkins

Points covered included:

- Explanation of the 2 different reporting systems for transfusion in the UK
- National trend over recent years
- Regional trend over recent years
- Trust trend over recent years
- What is reported and who it is reported to. If unsure phone MHRA & SHOT before time is spent reporting it, but it should be reported locally
- Impact of not reporting – National information is incorrect and guidelines may be misinformed
- **Recommendations**
    - Discussion of clinical incidents need regular slot at RTC meetings
    - Transfusion practitioners need to work together to standardise reporting
    - Need to increase reporting at Trust level – Not everyone needs to understand it
    - Be aware of sensitivity of reporting – use it in positive way

2) Clinical Incidents – interactive session – presented by Tanya Hawkins

Seven case studies were presented and for each incident the delegates were asked three questions:

1. Who should it be reported to?
2. What category should it be reported to SHOT?
3. What category should it be reported to MHRA?

3) Root Cause Analysis - Presented by Chris Stevenson

Points covered included:

- What is Root Cause Analysis?
- Root Cause Analysis Process – 14 steps
    - A detailed guide to ensure we follow the process consistently
    - Steps may be longer/shorter/combined depending on the nature of the event
    - Broadly broken into 3 parts
        - Finding the root cause
        - Finding the Solution
        - Implementation and follow up

Copies of the above presentations are attached

4) RTC Chair Update – Pushkar Dadarkar

Pushkar Dadarkar provided an update from the RTC Chair and NBTC meetings held on March 17th 2014, further details can be found on appendix 1. It should be noted that since the meeting in March the PBM document has been distributed.

Pushkar Dadarkar advised the meeting that due to the merger of Wexham Park Hospital and Frimley Park this would be his last meeting as RTC Chair.

5) Patient Blood Management Update

Following the PBM meeting in September three working groups were formed to take forward agreed objectives

5.1 Anaemia – update provided by Edward Fraser

- OUH are working with pre-op assessment to identify patients undergoing surgery
- OUH flow chart has been approved, other Trusts can use it to gain agreement with Commissioners
- Next steps carry out a survey of all South Central Trusts to identify where we are. Trusts share protocols etc, and identify what support can be provided to Trusts needing approval.
- Request for volunteers to join the working group

5.2 Tranexamic Acid; results of SCRTC audit of practice – update provided by Nigel Sargant

- Survey of the Trusts in the region identified that SC Trusts do not have protocols
- Action – look at adapting the protocol from Bath Hospital to be used Regionally
- Request for volunteers to join the working group

5.3 Information – update provided by Dawn Smith

- Data had been received from all but four hospitals within the region
- The initial benchmarked data was presented and has been sent to TPs and TLMs
- Data will be requested every 6 months and a benchmark report produced

6) HTC Update

Updates were provided by the following Trusts, further details can be found on Appendix 2

- Queen Alexandra Hospital Portsmouth
- Southampton University Hospital
- Hampshire Hospitals Trust
- Wexham Park Hospital
- Oxford University Hospitals
- Buckinghamshire Hospitals Trust
- Royal Berkshire Hospital

7) Update from the Hospital Transfusion Special Interest Group, Spring Meeting, May 13th, 2014

This meeting was attended by 4 people who were awarded bursaries from the South CentralRTC, Terrie Perry (TP), Ben Sheath (BMS), Lyndsey Paton (BMS) and Olufemi Eniola (HTC Chair). A combined report has been produced including summary presentation slides and is attached.

8) Blood Usage across the region

The Blood Usage data for the South Central Region was sent to all HTTs prior to the meeting and was reviewed.

9) Budget

We have sufficient sponsorship to cover the Education Days and RTC meetings, however there are fewer sponsors for the Obstetrics Education Day than has been achieved in the past so there will be less funds available for bursaries etc this year.

Appendices

1 RTC Chair Update
2 HTC Update

Attachments:

1 Overview of Transfusion Reporting Presentation
2 Clinical Incidents Presentation
3 Root Cause Analysis Presentation
4 Update from the Hospital Transfusion Special Interest Group, Spring Meeting, May 13th, 2014

Appendix 1

RTC Chair update
Meeting held on June 25th 2014
Dr Pushkar Dadarkar, Chair - South Central Region RTC

Minutes of RTC Chairs / Royal College of Pathologists - 17th March 2014

1) RTC Reports Reviewed and discussed

- East - Pathology Modernisation. Concerns over loss of key staff and skills in blood transfusion. No NHSBT customer services staff for 3 years
- N.E. - PBM day cancelled due to lack of interest from clinical staff and managers other than transfusion teams. A failure to circulate NBTC's PBM recommendations cited.
- S.E. - Surveyed Drs about consent for transfusion. Informed consent stickers to be used. Poor Attendance and unable to recruit lay member
- S.W. - Developed guidance to help Drs obtain consent for transfusion. A T.P. group developing regional competencies for transfusion.
- N.W. - Further call for PBM recommendations. Difficulties in encouraging and maintaining attendance from HTC chairs. All Trusts represented. Awaiting funding for Pre-op anaemia management pilot.
- E. Mid - Finding affordable locations for events a concern
- London - Many working groups and good attendance. No RTC administrator.
- S.Central - Chair's Trust to be taken over by hospital in another RTC. Successful ongoing PBM programme with three active workgroups (Haemorrhage, Anaemia, IT). New NBTC Customer Services rep.
- W.Mid - Good attendance, not necessarily from HTC Chairs. Seeking patient representative.
- York/Humber - high demand for forthcoming PBM event

2)Audits

- Multi-regional audits on use of blood components in liver cirrhosis, use of FFP, massive haemorrhage and platelet usage.
- Audit presented on transfer of blood between hospitals
  - Most blood units not used and wasted
  - 10% transfused in transit
  - Poor documentation
  - Different hospital numbers causing issues
  - Need for better communication between labs and teams

3) Business

- 'Guidance for Emergency Transfer of Blood & Components with pt.s between Hospitals' draft document reviewed and updated
- Website - concern about delays in updating (at time of meeting)
- Skills for Health Blood Component Transfusion Training Passport (London Group)
  - Include blood transfusion so core training may be transferred from Trust to Trust
  - Induction can focus on Trust specific issues
  - The developing group are keen to get NBTC endorsement
  - Although concept favourable it is similar to NPSA review of competencies so suggested that the groups link up.
- One Trust wants to change the name of their HTC. Acceptable as long as remit remains the same.

4) Summary

- Considerable audit activity at both RTC and Nationally
- Concerns about Pathology modernisation and Mergers of Trusts across RTC boundaries
- All finding it difficult to attract patient representatives
- Challenging to continue to engage hospitals in PBM - needs drive and direction from NHS England
- Concern about delays in updating NBTC and RTCs website on transfusionguidelines.org, and posting minutes and documents

Minutes of National Blood Transfusion Committee 17th March 2014

1) Patient involvement working group

- Patient info leaflets updated and added to
- Request dedicated patient information pages on website
- Discontinue translation into other languages due to lack of demand and cost
- Supporting the NCA on patient information and consent

2) PBM Working Group

- NHSBT had identified funding for 3 projects proposed by the Group:
- Expansion of NCA Team to support national PBM audits
- Implementation of Pre-op anaemia management in hospitals in the NW RTC
- Clinical Benchmarking to gain better understand of blood demand
- Develop 'App' to assist Drs with implementation of PBM
- NBTC Chair and Secretary met with the National Medical Director in Oct 2013. Prof Martin (NHS England director Pathology) to progress agreed items.

3) Education Working Group

- Academy of Medical Royal Colleges has submitted application to GMC for revisions to Foundation curriculum - to include patient identification to address concerns raised by SHOT.
- A competency assessment tool for Foundation Drs is being developed
- Curriculum content of all acute post grad disciplines reviewed. Recommendations for enhancing content and assessments in relation to Transfusion.
- Portfolio for haematology trainees updated.
- Proposed standard request form for Transfusion discussed. Standard terms for diagnosis and justification for blood ordering developed by PBM should help address this.

4) NPSA Working Group

- Review Groups recommendations for competency assessments circulated for comments
- Expectation of Flexibility at Trust level as to implementation.
- Further work - development of core standards for training and assessment
- Awaiting clarification as to which body is responsible for implementation of NBTC and NHS England Recommendations across Trusts

5) Transfusion Lab Managers Working Group

- Progress report
- Draft Guidance for Emergency Transfer of Blood under development presented. To be distributed when complete.
- Review and Update of NBTC red cell and platelet shortage plans, and recommendations on appropriate use of O neg

6) Royal Colleges

- Continued concern about delays in provision of blood as a consequence of BCSH guidelines of requirement of second sample. Not required if secure electronic pt id systems in place. (recommendation makes it clear that this should NOT impede provision of blood in emergency)
- Concerns about provision of patient info. and obtaining consent for transfusion (subject of NCA audit)
- Specific concerns highlighted wrt training of midwives, ODP (cell salvage), Interventional radiologists.
- Behring warning about lack of efficacy of anti-D in obese women and recommendation for iv administration discussed. Data requested.
- Lack of training of Medical Staff for Major Haemorrhage

7) PBM - Learnbloodtransfusion

- 85,000 users registered on LearnPro
- variable uptake between Trusts
- New course pending - Mx of acute transfusion reactions, good manufacturing practice, and use of anti-D

8) NCA Programme Update

- Completed - Red cells in cardiac surgery, use of Blood in neurocritical care, use of Anti-D
- In Progress - Patient info and consent, national survey on use of red cells
- Future - Mx of patients with haemoglobinopathies and lower GI haemorrhage
- AFFINITE underway - Research programme to assess potential for national audits to influence change in transfusion practice
- Use of data already held has facilitated current audit (national cardiac database). Consider using other registries to participate in NCAs

9) NHSBT

- 2013/14 - RBC demand down 4.2% (?increase in PBM activity)
- 2014/15 - expected to decrease further 2-3%
- O Neg by 0.6% to 11.1%
- Demand for platelets stabilised
- Anticipated reduction in platelets prepared by apheresis as a result of recommendations by SaBTO (80 - 60 - 40%)

10) SHOT update

- SHOT symposium in July 2014
- Sir Bruce Keogh to talk about human factors and how we can change practice
- Work to develop a combined haemovigilance reporting system with MHRA
- All ABO incompatible blood transfusions to be recorded as never events (rather than just ones that caused patient harm)

Appendix 2

SOUTH Central RTC Meeting 25 June 2014

HTC Update

1 Queen Alexandra Hospital

- Implementing 2 sample rule from July 1st
- Use of NHS numbers planned
- Concern – Acquiring an emergency phone in the laboratory for Massive Haemorrhage

2 Southampton University Hospital

- Blood on board air ambulance from March, working with OUH to look at replenishing blood used
- Planning Electronic ample labelling at the bedside, presenting to Chief Executive on July 4th
- Non medical authorisation of blood, DA attended a course and is working to introduce it
- E learning, introducing safe transfusion practice at Southampton, the learn blood transfusion was found to be too long. DA is willing to share this with other hospitals in the region on request
- Local audit – pre thawed FFP impact on wastage and usage

3 Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital

- NHS numbers have been introduced, some teething problems but by and large has worked well
- CPA inspection completed at Basingstoke and expected at Winchester
- First combined HTC meeting held
- New fridges in BMI
- Audit on orthopaedic surgery
- MSOB coming into Basingstoke – no date as yet
- Producing uniform Transfusion Policy across both sited
- Producing uniform Massive Haemorrhage Policy across both sites
- Planning Redesign Transfusion Page on ICE transfusion system
- Redesign Discharge Record
- Lab staff to go and see a transfusion and will not sign off competency until done

4 Wexham Park Hospital

- Trying to implement Electronic Labelling System, hope to achieve in July 2014, once trialled will be rolled at across the Trust including GPs
- Increase in Datex errors in Anti D, have introduced midwife sessions and information in Maternity Newsletter
- Plan to look at introducing an App for the use of FFP
- Plan to put prescription chart on ICCE
- Local Audit – Transfusions in satellite day unit. Plan to do more when Kim East returns, i.e. wristband and platelet
- HTC – cannot get representation from GP

5 Oxford University Hospitals

- Have gained agreement with Labs to agree a set of tests nurses can request in Electronic System
- Electronic prescription authorisation for blood, links to latest blood results. Warning blood management alert if outside guidelines. Piloted in Haematology Unit.
- Audit – WBIT
- EF on Editorial team for transfusion guidelines website, plan to be fully populated by Autumn 2014

6 Buckinghamshire Hospitals Trust

- Out of special measures
- Achieved two sample policy, zero tolerance policy hand writing of labels
- Consent form went in to use in June 2014 and including in patients note
- Audit consent form in three months
- Intranet has been updated and the transfusion section has been lost, plan to get it reinstated
- E learning – NLMS, has attended all meetings

7 Royal Berkshire Hospital

- Moved over to Octaplas at the beginning of the year
- Shift work from March this year is causing concern and being monitored
- Third returns audit being arranged