South East Regional Transfusion Committee

2022 Activity Summary Report

CELEBRATING SUCCESS

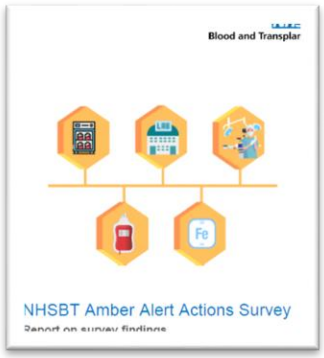
Welcome to the South East Regional Transfusion Committee's summary for 2022.
It's good to celebrate, in a year where we consolidated the hard work achieved in 2021 following our amalgamation. We have continued to share best practice and support each other across all transfusion disciplines despite the many challenges within each hospital, not least the first ever Amber Alert red cell shortage. This saw transfusion teams across the region work alongside colleagues to manage blood use, reduce stock holding and orders – thank you for your very positive response.

Howard Wakeling, SE RTC Chair

Regional Meetings

The **Regional Transfusion Team** (RTT) met four times this year – January 25, April 4, July 27 and December 14. Meetings facilitated the sharing of updates from regional teams and working groups and the opportunity to highlight learning or concerns. This enabled the 2022 workplan to remain on track, with the flexibility to re-focus where needed. In December, the Terms of Reference were reviewed and ratified.

Following the red cell **Amber Alert**, issued on October 12 and lasting four weeks, Hospital Transfusion Teams were invited to regional support meetings to discuss how they might manage the situation and what practices were being put in place. Three drop-in sessions took place (October 19/ November 2 and November 16), providing a necessary opportunity for sharing information and learning, outlining what was happening at the different hospitals and at NHS Blood and Transplant (NHSBT) to address the shortage. Many hospitals used this opportunity to review stockholding, which has shown they can safely manage with lower stock levels, keeping these levels as their new 'normal'. In East Kent, three Transfusion Laboratories reduced stock holding, which two sites have kept. Laboratory staff felt empowered to question requests in line with guidance.



NHSBT asked hospitals to complete a survey following the alert, which sought to capture feedback on laboratory and clinical measures taken to reduce demand and to gain feedback on communications. Thirteen hospitals responded from the region. Lessons learned will be very useful and important, and good practices adopted during the alert could continue. A positive outcome to the Amber Alert, was a raised profile of Blood Transfusion and Patient Blood Managment initiatives, particularly with Trust Chief Executives and Medical Directors. Oxford University Trust held a webinar to provide insights on their working arrangements during this time. The year ended with red blood cell and platelet stocks at Pre-Amber status. With ongoing fragility of supply, hospitals were reminded to continue their good practice.

Transfusion Laboratory Manager (TLM) User Groups (UG)

There continue to be two groups within the region, TADG UG for Tooting and Colindale met twice, and Oxford and Southampton UG met three times. 2022 continued to challenge staff working in Blood Transfusion laboratories in further unprecedented ways. The year started with a SHOT-CAS Alert '*Preventing transfusion delays in bleeding and critically anaemic patients'* which urged all laboratories to examine and update protocols for rapid release of blood components and products with an emphasis on training and drills to ensure 'no patient should die or suffer harm from avoidable delays in transfusion'.

Workload increases continued to pressurise services, with emergency departments experiencing high demand this year combined with teams working overtime to address the delays in elective surgery caused by covid. This often meant activity higher than pre-covid levels, adding to the ongoing burden of demand on national blood stocks. Laboratory staffing recruitment remained problematic. East Kent Trust is using creative solutions by developing support staff with accredited degrees to complete their registration portfolio and appointing these staff into vacant Biomedical Scientist (BMS) posts.

Moving into Autumn, many hospitals saw a surge in covid cases alongside Respiratory Syncytial Virus. Blood stocks fell to concerning levels with NHSBT issuing an Amber alert. Laboratory staff and clinicians worked together to manage the limited supply and reduce the impact on elective surgery. *Particular thanks go to Julie Staves and Kerry Dowling (Chair and Deputy Chair of the National Blood Transfusion Committee National Laboratory Managers Group) for their vital communications to laboratories, providing advice and support during stock shortages.*

Transfusion Practitioner (TP) Group

Meeting on three occasions in 2022, many of the group were happy to share interesting cases and incidents and any associated learning. With such a large geographical area covered, it is very likely that another Trust has experienced similar challenges and the opportunity to share and shape best practice is vital. Items discussed in 2022 included the updated BSH Major Haemorrhage guidelines and the introduction of the Centre for Perioperative Care Anaemia Pathway. Most recently, the TPs have shared information on the shortage of transfusion giving sets to better inform their Trust equipment leads.

TP Ruth O'Donnell has become the SE representative on the British Blood Transfusion Society Transfusion Practitioners Group and many from the region have recently signed up for the discussion group where TPs across the UK come together to share challenges, ideas, resources, and experiences.

British Blood Transfusion Society

A Daunting Task, but ultimately a secure readily available information service…

2022 was a year that a significant number of Trusts within our region planned, commenced, or completed the transition to electronic clinical documentation. Most have included, or are planning to include, Transfusion into their Electronic Patient Record (EPR) system. EPR implementation is certainly daunting. There are numerous EPR systems available, with different ones in use even within the Pathology Networks within the region, let alone the region as a whole. Luckily as a friendly bunch of TPs, Laboratory and Clinical staff, all of us have found a counterpart to ask questions and share ideas.

The short-term risks of staff using a new system have been discussed during our forums. Even with adequate provision of teaching, there are risks to specimen labelling, traceability, for omission or duplication of issuing and/or administering blood and incorrectly recording actions – never mind the decrease in efficiency - as staff familiarise themselves with the new way of working. Most Trusts have opted for local customisation which takes time, effort, money, and expertise. However, in the long run EPRs provide a secure readily available information service, reducing the need for patients to repeat their history and for staff (us) to have to plough through reams of paper searching for a detail. Within South East, EPRs in use include Sunrise, Cerner, EPIC, and CareFlow EPR/Electronic prescribing and medicines administration (EPMA), so please feel to contact a peer via the SE RTC Administrator, if you would like to discuss any issues.

London & South East Trauma and Haematology Group

This group, uniting key representatives from Major Trauma Centres (MTCs) and Air Ambulances to discuss current issues expanded further and now includes Oxford, Southampton, Royal Sussex, Plymouth and Cambridge, plus the four MTCs in London. The group met four times in 2022, items covered included results of the *Reversal of Direct Anticoagulant (DOAC) and Vitamin K Antagonists in Trauma Related Bleeding* pilot and audit results, shortages in freeze-dried plasma supply, component issues and wastage trends, and an update on the whole blood (SWIFT) trial.

Working Groups

Regional Blood Components Key Performance Indicators – representatives from Southampton, Brighton, Buckinghamshire and Berkshire joined a working group in March to review a new monthly report devised by the Blood Stocks Management Team (BSMT) highlighting useful blood component metrics to include in monthly hospital reports to facilitate stock management and local/cluster benchmarking. The new reports were rolled out across the country in April.

Following a 2021 National audit, volunteers from Southampton, Frimley, Oxford, Maidstone and Royal Sussex formed an **O Pos in Bleeding Males** * working group to consider regional actions. Meetings were held in April and June, where a regional survey was devised and circulated. Only three sites responded that they did not routinely supply O Pos red cells to males* in a haemorrhage situation. The results, discussed at the TP/TLM meeting, led to further support being offered, and agreement that the working group would continue. (*adult patients assigned male at birth.)

2023 South East RTC Workplan

Following the success of the first **South East joint TP/TLM meeting** in 2021, this year's meeting took place in November, and it was agreed it would become an annual fixture. Thirty six TPs & TLMs attended, with four presentations given: exploring Massive Haemorrhage pack contents; a presentation by the BSMT on regional issues and wastage trends; a Universal Plasma/Cryoprecipitate project update and the results of the O Pos in Bleeding Males Survey. The group also discussed project ideas for 2023. The RTT met in February 2023 to agree regional plans for 2023 which will continue to support the Transfusion 2024 agenda (BMS training, QS138 audit, EPR implementation), optimising the use of O positive blood and learning from blood component shortages.

National and Regional Audits

Development of the **QS138 Quality Insights** Audit tool (previously called the QS138 audit tool) continued in 2022, undergoing validation, followed by a successful pilot in December with six hospital sites from three different RTC regions. A huge thanks to Royal Berkshire and East Surrey Hospitals for taking part. Quality Insights is due to be launched in March (2023) and will enable hospitals to enter into a transfusion quality improvement cycle against the four high priority quality statements. The live tool has automated reporting available to create bespoke hospital and regional compliance reports. The SE TP group will enter a bi-annual audit of QS138, auditing every April and October. This year's first audit in April (2023) will coincide with the National Comparative Audit (NCA) Re-audit of QS138 which will allow the same set of data to be used. The tool will be rolled out across England in the first instance, followed by Wales and Northern Ireland.

The **Audit on Reversal of DOACs and Vitamin K Antagonists in Trauma Related Bleeding**, originally planned for the beginning of the year was extended due to covid-related pressures on hospitals and concluded in June. Hospitals from London and the South East took part and whilst provisional results have been shared, a formal report is due in early 2023.

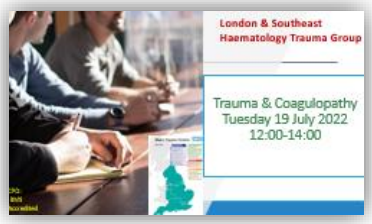
The region took part in a number of **NCA** audits in 2022: Upper GI Bleeds; PBM in Paediatrics peri-op; and Sample Labelling, reports due in 2023. Upcoming 2023 NCA audits are NICE QS138 in April, Bedside Transfusion (Autumn).

Education and Training

The Patient Experience

Regional Transfusion Committee (RTC) Education & Business Meeting held virtually on May 4 received excellent feedback from the 82 attendees, who heard the lived-experience from an exchange transfusion patient – the highs and lows of care within the NHS; the journey of a patient following a road accident; the results of a PhD student's project which the former South Central members contributed to: Building optimised outpatient servies in Tranfusion, looking at patient care. The event attracted interest from across the country and was followed by an RTC business meeting.

Trauma & Coagulopathy education event webinar was held by the London & South East Trauma and Haematology Group on July 19, open to Anaesthetists, Haematologists, Emergency Department Medics & Nurses, BMSs and TPs. The day included sessions on haemostasis in trauma and managing coagulopathy in unusual circumstances. 153 participants attended, with very positive feedback received.



A virtual ***Transfusion Bites*** was held on October 11. 147 delegates attended this popular RTC education event. Presentations included: Military Impact on blood transfusion and trauma - the Blood Far Forward project and implications for civilian practice; Challenges and benefits of implementing an EPR for Blood Transfusion; Obstetric cases, highlighting the role of Major Haemorrhage (MH) Protocols in the clinical setting and how multidisciplinary teams work together to manage such cases; and Selection criteria for different Major Haemorrhage Packs for different patient groups and the importance of checking patient identifiers. A quiz rounded up the event to consolidate learning. Presentations available here.

Goodbyes

This year we said goodbye to Richard Whitmore, NHSBT Customer Services Manager (CSM) for Tooting, as he retired after 31 years in post. We also said farewell to TP Co-Chair Jo Lawrence, who is moving to Cornwall after 32 years' service to the NHS.

We wish Richard and Jo all the best and thank them for their contributions to the South East and former South East Coast RTC over the years.

Dates for your 2023 Diary:
TP Meeting - 23 March
New SE JPAC pages – due April
BMS Study Day – 25 April
RTC Education & Business meeting – 3 May

Annual Summary Contributors:
Liz Tatam, Emily White, Jonathan Ricks, Ruth O'Donnell, Susan Mitchell, Frances Moll & Anwen Davies