EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Thursday 1st December 2022 via Microsoft Teams, 15:30pm – 16:30pm

In Attendance:

Name	Role	Hospital
Lynda Menadue **LM**	RTC Chair / HTC Chair	North West Anglia – Hinchingbrooke and Peterborough
Dora Foukaneli **DF**	Consultant Haematologist	NHSBT / Addenbrooke's
Frances Sear **FS**	PBMP	NHSBT
Katherine Philpott **KP**	TLM / TADG Group Chair	Addenbrooke's
Joanne Hoyle **JH**	TP / TP Group Chair	West Suffolk
Julie Jackson **JJ**	TP / TP Group Chair	James Paget
Suzanne Docherty **SD**	Consultant Haematologist	Norfolk and Norwich
Ruth Smith **RS**	TP	Addenbrooke's
Aline Seigneur **AS**	TP	Addenbrooke's
Isabel Lentell **IL**	Consultant Haematologist	West Suffolk
Stephen Cole **SC**	HTC Chair	Colchester
Emily Rich **ER**	TP	North West Anglia – Hinchingbrooke and Peterborough
Alison Rudd **AR**	TP	Norfolk & Norwich
Te-Ahna Hans **TH**	Senior	West Suffolk
Stephen Wilson **SW**	HTC Chair	Norfolk & Norwich
Maria O'Connell **MOC**	TP	Basildon
Allan Morrison **AM**	Blood Transfusion Quality Manager	West Suffolk
Rebecca Smith **RSm**	TP	Ipswich
Donna Beckford Smith **DBS**	TP	Watford
Sheila Needham **SN**	TP	Lister
Ellen Strakosch **ES**	TP	Luton & Dunstable
Jasmine Beharry **JBe**	TLM	Milton Keynes
Georgie Kamaras **GK**	HTC Chair	Luton & Dunstable
Kaye Bowen **KBo**	TP	North West Anglia – Hinchingbrooke and Peterborough
Claire Sidaway **CS**	TLM	Hinchingbrooke
Janet Shalini **JS**	TP	Princess Alexandra
Louise Meaney **LME**	TLM	Southend
Trisha McClure **TMcC**		Nuffield Health
Clare Neal **CN (Minutes)**	RTC Administrator	NHSBT

Apologies: Michaela Lewin, Martin Muir, Gilda Bass, Terrie Perry,

1. **Welcome – Introductions and Apologies: LM** welcomed everyone to the meeting. Introductions were made.

2. **Update on Key Messages from the Pre-Amber Alert and Regional Support**
   FS presentation attached. There is a lot of information in the spreadsheet that was put together during the amber alert. Some of the key points that I noticed are that most of the activities that actually happened apart from surgery being cancelled which wasn't a lot were not things that were included in the EBMAs. They were things that the hospitals were doing themselves. They were drumming down onto their PBM activities. There is lots of small detail going on with HTC's trying to fill loopholes in pathways and trying to get training in cell salvage. Some issues that came up locally was a number of hospitals struggled to get cell salvage in place. They hadn't got enough staff trained and couldn't get staff trained in time. The same with iron services. They have policies in place, they use iron, but they hadn't got the capacity or they hadn't got the capacity for a anaemia service. These are things people

had been working on for a long time but when it came down to it they were struggling with capacity. On a regional level these may be areas we need to look at. How do we help hospitals fill these gaps? With regards to tranexamic acid, there are a few hospitals nationwide that were saying that it was obvious they weren't using this in the way this should be despite the guidance and NICE guidance being there for quite a long time. **DF** I think it is a good starting point. This is a situation where we need to become familiar and improve over the coming months. We are out of the amber alert but there is no guarantee that it will not become unstable. It was a good opportunity for us as a hospital to realise that we have missed a lot of guidelines and opportunities in the past to implement PBM. **FS** this is a common theme across the country. The hospitals are now realising.

3. Discussion on Amber Alert / Pre Amber Alert Practice

- **LM** it all sounds very familiar. We didn't cancel much surgery. We stuck like glue to one unit and review. We tried to implement cell salvage and would like to collaborate with others who have struggled with this. **FS** I will try to put together a summary report particularly on PBM initiatives.
- **SW** at Norfolk & Norwich we did cancel some surgery but not very much, mainly elective, adult scoliosis surgery. We do have cell salvage reasonably well established in maternity and some of our major orthopaedic and other blood loss theatres. With regards to tranexamic, we need to be sure that we put out a more subtle message, I had to deal with one patient who ended up with a massive clot in their bladder. It took a long time to sort out. I have had people say they have stopped donating as they are fed up with being hurt by the needles. We shouldn't be hurting our donors. **LM** I think that is a very valid point, as a Paediatric Anaesthetist we do not stick a needle in anyone without cream on. **FS** I know there was a study at one point on it. **SW** if you look back about 10 years there was an extremely big study that showed that not only were cannulas above a 20 guage less painful on insertion, the cannula was actually better tolerated.
- **DF** we had a significant reduction in blood use. We cancelled 8 or 9 procedures, it was very much in haematology, oncology and people receiving chemo/radiotherapy. We have reduced the triggers for transfusion for haematology to 70 strictly for haematology, 80 for day unit, oncology 70 and for chemo/radiotherapy we moved from 120 to 100. That helped tremendously, it is in line with the APP. There are publications to support this decision. We saved roughly 200 units. **LM** our haematologists did change some of the thresholds. It may be useful for everyone to see your changes. **DF** this practice has also been translated into practice at private hospitals. We had very good support from lab managers. You have to be realistic with the decisions you make. **KP** numbers were significant. The lab staff took on board the changes. It was a lot of work for them, they were checking every unit. It will be interesting to see what the numbers for November are as we didn't have any major traumas during October. **DF** we had engagement from the beginning of October. Through regional meetings we can encourage this practice. **IL** we were already working to these thresholds. 70 is our standard. **LM** does anyone have any numbers from a District General Hospital. **JH** we know ours went down in September. **LM** this is just our statistics, we around 700 per month so we are a higher district general hospital user. **KB** shared some statistics. They used 646 units in October and 598 in November. Last October it was 788 units and last November it was 747 units so a significant reduction. The number of requests went down, people were thinking before they requested blood. **LME** our sample group requests went down dramatically by about 300 at Basildon. I don't know if anyone else saw that. I haven't looked into it in any detail. **JBe** we were down 61 units from October to November. We have started the conversation about cell salvage.
- **TMcC** our usage is tiny but our ordering and usage reduced by 15-20%. We only cancelled a couple of surgeries.
- **FS ML** sent through some feedback. There was a lot about communication which I will feedback. Communications seemed to be received by different staff groups at different times. The alert was a good opportunity for them internally as they completed drills on the emergency blood management plan but it is very different in real life. Having a BMS as their CEO is very

useful. They have written up the alert as a document so they have lessons learnt. Has anyone else done the same?

- **DF** in Addenbrooke's we are going to make a few tweaks to the emergency blood management plan in response to what we learnt. Our new HTC Chair has converted areas we had difficulty into quality improvement projects. We will start from tomorrow meeting regularly. One of those is the implementation and expansion of tranexamic acid. The other one is pre-assessment in line with the recent publications for pre-assessment and iron clinics. The other one is blood usage in blood haemorrhage. **FS** HTC's will now have more evidence to show areas they have struggled and achievements. **LM** we have got a meeting planned to review audit and we have a couple of things to show our data to the Chief Nurse. We have also sent out a couple of thank you / encouragement emails to the people who did manage a little bit of cell salvage. We have a total of 3 ODA's who can run cell salvage. We will try and get some more. Each time it did save at least a unit of blood each time. We will have a statement of lesson learnt. **LM** maybe we can feedback our lessons learnt at a face to face RTC. We can put them up as posters around the room.
- **DF** is there a specific area regionally where we need to improve so we can include into education. Can we put a section on the June RTC which covers Amber Alert Lessons Learnt? We can ask people to present and have posters. Then we can look from that what education is needed by the region. **FS** two of the main areas that came up apart from communication were cell salvage and anaemia and iron. It wasn't the fact that they hadn't got it, it was that there was no capacity. I don't know how that is resolved. **LM** it is definitely worth looking at further.

4. AOB

- **LME** just for the 1 unit transfusions, in the laboratory I would like to collate something about what was good and what was bad, what the BMS needed as backup. Every hospital is different with their transfusion teams. Was it led by clinicians behind you or were the lab able to deal with it. I don't know if we can do a survey as I would like to know what the good and bad points were about the lab being involved as we were the police for it. What helped. **FS** there is the TADG next week. **LM** January RTC may be too early but we can give you a slot on the June RTC. **LME** we can briefly discuss next week as every Trust is different where they get their support from and this was a big factor in the amber alert. **LM** I think that is a really good idea. If we looked at the clinical side and lab side and presented in June.
- **DF** if we go back to an Amber Alert or a Red Alert, how can we support each other? I know the TP and TADG Groups will be supported by their chairs in having appropriate meetings. **FS / CN** we can re-introduce the drop in to the Hospital Liaison Meetings on Thursday mornings. Would we have an extraordinary RTC or should we rely on the TADG / TP / Hospital Liaison Meetings? **LM** we accidentally had the RTC as we already had it in place. Now that we have had an amber alert, would we need an extraordinary RTC within a week or could it wait a couple of weeks? **JH** not unless we went to red. **DF** I think if the sub groups meet as required and we have the drop in sessions, we could re-assess if an RTC is needed if an alert continues for more than two weeks. If it is a red alert, we should have an extraordinary RTC. **LM** I agree as a lot of people would be involved in a red alert.

5. Date of Next Meeting and Close:

LM thank you for attending.

- 26 January 2023 – Virtual, 15 June 2023 – Face to Face, 05 October 2023 – TBC

Actions:

No	Action	Responsibility	Status/due date
1	Amber Alert Lessons Learnt	**Add to June RTC Agenda** **ALL – provide information to display around the room**	
2	RTC Agenda Items • One Unit Transfusion – Lab • One Unit Transfusion – Clinical	 **LME** **??**	 June 2023 June 2023