EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Thursday 13th October 2022 via Microsoft Teams, 10:00am – 13:00pm

In Attendance:

Name	Role	Hospital
Dora Foukaneli **DF**	Consultant Haematologist	NHSBT / Addenbrooke's
Frances Sear **FS**	PBMP	NHSBT
Joanne Bark **JB**	PBMP	NHSBT
Anwen Davies **AD**	PBMP	NHSBT
Mohammed Rashid **MR**	Customer Services Manager	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
Martin Muir **MM**	TLM	Royal Papworth
Michaela Lewin **ML**	TP	Royal Papworth
Emily Rich **ER**	TP	North West Anglia – Hinchingbrooke and Peterborough
Lynda Menadue **LM**	HTC Chair	North West Anglia – Hinchingbrooke and Peterborough
Te-Ahna Hans **TH**	Senior	West Suffolk
Stephen Wilson **SW**	HTC Chair	Norfolk & Norwich
Laura Wilmott **LW**	TLM	Peterborough
Allan Morrison **AM**	Blood Transfusion Quality Manager	West Suffolk
Gregorie Pankhurst **GP**	TP	Norfolk & Norwich
Karen Baylis **KB**	TP	Lister
Jasmine Beharry **JBe**	TLM	Milton Keynes
Sarah Parsons **SP**	TLM	James Paget
Teresa Nicholas **TN**	TLM	Broomfield
Charlotte Alford **CA**	TLM	Luton & Dunstable
Krupa Amin **KA**		West Herts
Georgie Kamaras **GK**	HTC Chair	Luton & Dunstable
Frank Baiden **FB**	TLM	Queen Elizabeth Hospital KL
Julie Edmonds **JE**	TP	Lister
Michelle King **MK**	TLM	Nuffield
Swati Pradhan **SPr**	HTC Chair	Bedford
Kaye Bowen **KBo**	TP	Peterborough
Mireille Connolly **MC**	Senior	West Suffolk
Danielle Fisher **DF**	TP	Luton & Dunstable
Roberto Consuegra **RC**	Consultant Haematologist	James Paget
Justin Harrison **JHa**		West Herts
Loraine Fitzgerald **LF**	TP	Bedford
Shalinee Wickramasinghe	Customer Services Manager	NHSBT
Claire Sidaway **CS**	TLM	Hinchingbrooke
Janet Shalini **JS**	TP	Princess Alexandra
Jane Tidman **JT**	TLM	Lister
Sophie Staples **SS**	Blood Stocks	NHSBT
Jill Caulfield **JC**	Blood Stocks	NHSBT
Louise Meaney **LME**	TLM	Southend
Trisha McClure **TMcC**		Nuffield Health

Clare Neal **CN (Minutes)**	RTC Administrator	NHSBT – Not in attendance

Apologies: Donna Beckford-Smith, Claire Atterbury, Ellen Strakosch, Stephen Cole, Florian Falter, M Sivakumaran, Andrew Dunn, Gilda Bass, Michelle Reece, Dharini Chitre, Sandie Jardine

1. **Welcome: DF** welcomed everyone to the meeting. The last meeting was held in June. Lynda Menadue is our new chair. Suzanne Docherty is our Deputy Chair. Lynda Menadue will commence as Chair in January 2023. Introductions were made. Minutes were agreed as correct. If there are any changes to these, please forward them to **CN**. We have amended the agenda according to the amber alert. I propose an extraordinary RTC for 5-6 weeks' time. **LM** I would like to have a discussion now and have a plan for a meeting for before Christmas would be a good idea.

2. **Update on Key Messages from Amber Stock Alert and Regional Support**
   - **TADG Group – KP** I was informed on Friday about the potential of an amber alert. We discussed as a group. We called an extraordinary TLM meeting on Tuesday. We discussed stock sharing.
   - **FS** presentation attached. **LM** why are we not giving tranexamic acid in GI bleeds? **FS** there was a recent trial. **DF** the massive haemorrhage guideline published by BSH in June has the references as well as the exclusion and reasons. Some people argued that the trial utilised significantly high doses of tranexamic acid and this is where toxicity and neurotoxicity was identified. It will be important to share this with everyone.
   - **DF** we meet as a Hospital Liaison Team weekly on Thursday at 10:30am. If you would like to join this as a drop-in session, please let **CN / FS** who will send you a Teams Link.

3. **Blood Stocks Management Team**
   Presentation attached. **DF** do we have any questions.

4. **Amber Alert Hospital Updates**
   - **LM** We have held an emergency blood management group meeting. We have sent out communications via the Medical Director. We are using screen savers. We have targeted anaesthetists and orthopaedics. We have identified in our theatres most of what takes the blood is major paediatric orthopaedics. We do pelvic and femoral osteotomies for congenital dysplasia of the hip. We do quite a lot in young patients. There is 30% chance of them needing blood so these will wait 4 weeks. We have discussed redo major joints such as hips, knees and shoulders. So far with discussions with orthopaedics, we have said that normal joints such as knees are done under tourniquet anyway and with tranexamic acid, I can't remember the last time we transfused and knee ops. Hips can't be done under tourniquet but it is rare for non-traumas to get blood. Should we be saying that hips should have a minimum before they start. As a Trust we made the HB 120. We don't stick to that like glue.
   - **ML** we are currently liaising with NHSBT. If we cancel our elective cardiac surgery and only do urgent work, the impact on our blood use will go through the roof. Our urgent cases use a lot more blood. Elective cardiac surgery accounts for 2/3 of our work so that would be a lot of cancellations. **DF** cardiac surgery have not been requested to be cancelled. **ML** we have had the debate as the plan says, 'cancel elective surgery'. **DF** colleagues across the country are looking for standardisation that everyone does something similar. I believe the amber alter has hit the BSH website and they expect the information to go to the Royal College of Surgeons and appear on the website. Surgeons will be alerted from their own bodies. There is escalation to NHSBT whether charges for adhoc delivery can be modified. This is under discussion to enable hospitals to keep less stocks if there is a confidence delivery can be made without additional charges. This is under discussion.
   - **DF** Do you have difficulties to escalate to your Medical Director or to discuss with your colleagues the current situation? There are areas in the country that are struggling with communication. **JHa** we don't have issue with escalating messages.
   - **JHa** the issue is the types of surgery that is going to be affected as a lot of our orthopaedic surgery is done at a satellite hospital and therefore we ordinarily we cross match blood even

though it may not be used. It is a ½ hour journey to get blood across in an emergency. We want to be doing the same as other hospitals. We are all trying to catch up from COVID so I think there needs to be a uniform view. We have a schedule where we crossmatch 2 units of blood for various procedures. As a first filter I have suggested these are the first cases that need to be reviewed. If other places are going to carry on doing cardiac and other procedures then it affects out patients who are not having dramatic surgery but still potentially might bleed and need blood available. We need some kind of guidance so that everybody is doing the same thing. **LM** I completely agree. Speaking to the orthopaedic surgeons, for us the elective surgery is the redo large joints and major paediatric. We didn't find anything else in a district general hospital. Outside of elective surgery there is loads but inside elective surgery there isn't. **DF** people are asking if we can give an estimate of cases likely to be cancelled. Do you have any feeling of the number of surgical cases you will cancel? **LM** ours in one a week for major paediatric and 2 a week for redo joints. **LW** it is hard to get that data from our system on who is having what blood for what procedure.

- **LW** we mentioned the advice for elective surgery. Does NHSBT have any idea what percentage of blood is used for the procedures we are looking at cancelling. If it is less than 1% is that a big enough dent to pull this back. We have asked our clinicians to review medical patients for optimisation instead of going straight to red cell transfusion and we've really tried to empower the lab more so with this one unit and review. We have said for any non-bleeding patient only one unit is issued and you phone them to explain why. **FS** from the information that we've been given they expect to see 1-2% savings on blood use across the country. Although it's small, it will all help. **LW** do they feel that will be enough? DF we have to conserve stocks in a safe way. In Addenbrooke's we reduced the threshold for transfusion for haematology patients. We made this change 10 days ago. We have 70 now for everyone. There are publications supporting this change. They are aiming for HB 120. The publication suggests this is no longer a necessity. You know your environment and where savings can be made. **LW** if we are all making changes, NHSBT need to know what we are doing so they don't think it is just elective surgery making the savings. **FS** it is important to keep a record of the changes made and the impact of those changes. Feedback is very welcome. LM we have got a two-pronged plan, firstly to limit elective cases and secondly I am meeting with clinical leads for surgery and obstetrics to talk to them about TXA use. We will audit this. The IV iron pathways are falling apart as we have no space in clinics. We need someone to open slots so we can give IV iron infusion. **DF** is this an activity to create a spreadsheet with the hospitals to record the activities they are doing. We could include new activities and failing activities due to no space. **LM** can we also have an email out to HTC Chairs to create a list of what they have cancelled or put a limit on. It will be good to know everyone is doing the same and is a good platform to use to be able to go back to colleagues to advise them.
- **SW** I don't think there is much to say at the moment. We are just ensuring our surgeons and clinicians all play ball. We haven't got anything new to add. We have a HTC meeting on Monday. The pre-alert went out to the Trust and today's meeting is an escalation of that.
- **JH** we are looking at meeting every 48 hours but there is probably not a lot of surgery that is being cancelled. We have reiterated that we will only issue one unit to non-bleeding patients. It would be good to have clarity on what surgeries we should be cancelling as I don't think it will have a huge impact. **MC** from the meeting yesterday it was all areas, not just surgical. We have another meeting tomorrow. Issuing one unit will be irrespective of their HB. If we have any issues we can refer to our consultant. We reduced stock and have looked at whether we can do further. **DF** what are you using as measure to reduce? MC we have reduced as a percentage. We are asking staff to check stock levels more regularly and will try and use SERV to bring blood over more regularly. **LW** have we spoken to SERV that we may use them more. Does NHSBT liaise with them at all? **SP** I have had a phone call this morning asking if it will impact the service. I have said we may use overnight. **DF** there is discussions within NHSBT about providing more adhoc deliveries.
- **TN** we have been doing all the same things. We have another meeting later. I don't think there are many surgeries we will cancel.

- **LME** we are having pressure to transfer blood between sites. We have reduced our stock significantly but we've got a holding site at Basildon. We are getting reports daily from IT so I can meet with seniors on both sites regarding what stock is in order.
- **JT** we have had our emergency meeting. With regards to surgeries, a lot of day cases are being put on lists instead. We are having meeting with our satellite fridge remote hospitals today to advise them we are reducing the amount of o negatives they hold on site. They are mainly private hospitals. We are making sure clinical areas are aware. We are doing everything else like PBM, making sure clinical areas are aware and implementing cell salvage.
- **CA** we are doing similar actions to everyone else. One of things discussed at our meeting was looking at the grades of doctors that can order blood. We are looking at Consultant / registrar level. We are trying to introduce one unit and checking haemoglobin. It is in our policies but it is not always well followed. We are releasing one unit and then we encourage to do checks before a second unit is issued. **DF** so for consultant led transfusions for all patients, not just surgical? **CA** anyone that meets category one or two we are allowing through. Anyone that is an elective transfusion that is haemodynamically stable are the ones that we are encouraging the consultant / registrar to be ordering. DF that is a very good initiative.
- **TMcC** I would like to reassure you all that Nuffield are taking part in this initiative. We are aware that some of our elective surgeries may need to be cancelled. Some of our surgeries are NHS. Wea re looking at 120 as a trigger for orthopaedics, 100 for gynae and then maybe some scoliosis surgeries that we may need to look at. We are looking at reducing our usage.
- **DF** the message to everyone in term of O negative / positive is not only about wastage but about being used properly.
- **JHa** West Herts has reduced its stock holding. Our one-unit transfusion figures are pretty good. There is a National CEO / COO meeting taking place today which our COO is at. We have another hospital meeting tomorrow to feedback from all the meetings that have taken place. It sounds like we won't have to postpone many surgeries. I think it is really important we look forward at planned admissions for surgery so we can look at each case rather than having a blanket ban. What is the view on vascular surgery? **DF** at the moment vascular and cardiac can continue. The examples we were given of surgeries most likely to be postponed were orthopaedic. It is unlikely to have a huge impact on the situation.

DF is it fair to say that all hospitals in the region and transfusion teams have escalated the message, the blood management plans are in place and introducing additional measures. Hospitals are introducing additional measures to what has been requested because they felt the impact will come from other activities. Measures include optimisation, reduction of thresholds, consultant led decisions for transfusion for ambiguous cases and aiming for ideal optimisation for general surgeries. People have expressed concerns some of the pathways for optimisation cannot work due to capacity, the challenge of cross matching blood and moving blood if surgery is done remotely. Do you have any comments or questions? **KP** I will add that the things we are putting in place we probably should have put in place a long time ago. The reduction that we have had at Addenbrooke's in our usage and issues has been about 40% compared to last week. There is a suggestion that this is down to surgeries being cancelled due to bed availability but there has been a significant reduction in our workload in the last few days. When we are getting 60-70 orders a day for red cells we can't scrutinise every case. When we have 30-40 sessions then we can. **DF** the Medical Directors Office has created virtual drop-in sessions twice a day for surgeons. One of the associate medical directors and the resilience lead is there and it gives opportunity for clarifications. There is tremendous intensification of activities in terms of optimisation. We were having battles with a lot of people for appropriate response and quick control of bleeding. There is more engagement. There are specific recommendations for sickle cell patients. These will go directly to those treating these patients. We do not have a huge population in this region. **LW** in terms of support Hospital Services may need, for the past two days I have rung them early to reassess stock to cancel orders due to circumstances changing such as patients being discharged etc. Yesterday it was 8 units and today it was 4. It may be something for hospitals to consider but Hospital Services may need support if everyone starts changing their orders. **JJ** I would like to have more national guidance on what surgeries should be postponed. The EBM plan says cancel

elective operations; the screen saver says consider cancelling elective operations so they don't go together. I've got surgeons arguing they don't lose a lot of blood. If you can avoid using any blood by not putting a patient's life at risk then you should be cancelling that elective operation. Hospitals will continue as normal if we don't get national guidance. We will need an escalation pathway if we can't get engagement from the Trust. **DF t**he Addenbrooke's Associate Medical Director expects clinical staff to start cancelling the ones they can make decisions for easily. The ones who are waiting for a long time, the impact may cause significant damage so escalation will be for discussion at an MDT and if the decision cannot be made at that level it will go to a silver command. Discussions at a silver level need to consider **KP** input. **JJ** it seems like we are all doing something slightly different, we all need to be following the same guidance. They are also looking at if they cancel operations and breaching the 18 weeks wait, they are going to get fined. They are looking at all the consequences not just the consequences to the patient. **DF** I have just received a message from NHSBT, one is a call for donors and the other is a call for volunteers for even simple jobs such as welcoming donors.

LM plan to meet in December. A lot of the discussions are very clinical, I may send out an extra email to HTC Chairs to try and encourage a larger clinical attendance assuming that the amber alert is still running. **DF** I hope that this meeting will not be needed as with hospital activities, NHSBT movements and support from the wider NHS we will come out of this situation. As you know if we have we have to go to red alert, many activities will have to be cancelled. One activity which needs some reflection is supporting critically ill patients undergoing massive haemorrhage. On JPAC under the emergency planning, there is a guideline published in 2020 of how patients have to be triaged if they need massive haemorrhage support during blood shortages. It is difficult to ask people to make that decision at that difficult time so it is better that people a preview of this document. **LM** asked **LW** if that is the flowchart they have in their policy. **LM** we have seen that and discussed that as we were concerned it may go to a red alert.

GP we are down a TLM at the moment, so please advise if there is anything we need to be aware of. **FS** if you would like any other contacts / deputies contacts added to our distribution lists, please let us know.

5. Date of Next Meeting and Close:

- **Extraordinary RTC December 2022 via Microsoft Teams – Date to be Confirmed**
- **2023 meeting invites will be circulated**

Actions:

No	Action	Responsibility	Status/due date
1	Email re Hospital Liaison Meeting Drop-in Session	**CN to Circulate Details**	ASAP
2	Arrange Extraordinary RTC Meeting for December	**CN**	ASAP
3	Spreadsheet – record activity for hospitals – New and failing activities	**FS / CN set up spreadsheet** **ALL to complete**	ASAP
4	Email to HTC Chairs – what is cancelled or put a limit on	**FS**	ASAP
5	Escalation - Transport - Amending orders - Guidance on operations to be postponed - Pathway for escalation if we can't get engagement from Trusts		
6	Questions - Should we insist for effective and perfect optimisation prior to surgery?		