South West Transfusion Practitioners (SWTP) Business Meeting
Oake Manor, nr Taunton
21st February 2023

Attendance:	Trust
Stuart Lord (SL) (Chair)	Gloucestershire Hospitals NHS FT
Mooi Heong Tay (MT)	North Bristol NHS Trust
Julie Ryder (JR)	Great Western Hospitals NHS FT
Pedro Valle-Vallines (PV)	Royal Cornwall Hospitals NHS Trust
Nesa Kelmendi (NK)	Royal Cornwall Hospitals NHS Trust
Lorraine Mounsey (LM)	University Hospitals Dorset NHS FT – Bournemouth
Faye Jordan (FJ)	University Hospitals Dorset NHS FT - Bournemouth
Vikki Chandler-Vizard (VCV)	University Hospitals Dorset NHS FT – Poole
Soo Cooke (SC)	University Hospitals Bristol & Weston NHS FT - BRI
Lucia Elola Gutierrez (LG)	University Hospitals Bristol & Weston NHS FT – Weston
Lorraine Poole (LP)	Dorset County Hospital NHS FT
Nicola Dewland (ND)	Dorset County Hospital NHS FTFT
Michelle Davey (MD)	Somerset Hospitals NHS FT
Alison Hill (AH) (part)	Yeovil District Hospitals NHS FT
Miriam White (MW)	Nuffield South West
Clare Cook (CC)	NHSBT
Jackie McMahon (JM)	NHSBT
Simon Carter-Graham (SCG)	SHOT

Welcome:
SL welcomed all present and outlined the agenda.

Previous Meeting Minutes:
The minutes of the meeting held in October were agreed as a true record.

Review of Outstanding Actions (not covered in main agenda):
Check UHP and RD&E involvement with medical schools training re transfusion (ST):
This action will be carried over pending recruitment to the joint SW NHSBT consultant post.

Consider regional project to support trusts that are struggling with retrieving data: Following previous agreement that this is not suitable as a regional project due to the different LIMs and Blood Track systems in use, SharePoint discussion boards were set up to support any queries around data retrieval. Close as action.

Review TP ToRs re document control and contact details sharing:
SL/JM to review at next SharePoint review meeting.

LBT query re. Trusts adding local links to training modules:
CC checked with the PBM education team and this is not currently part of the functionality.

Feedback to SL on any interesting activities to include in next report to National TP Network:
This is an ongoing ask to share good practice nationally and SL has set up a folder on SharePoint (Documents > National TP Network) with a template to capture regional work, successes, challenges, which he will use to feedback to the national group. Anyone can use it to provide updates and SL will also continue to update with feedback from the regional TP meetings.
Provide lab. contact details to ST (re Retrieve Policy)
MT to check this requirement with Karen Mead. Carry action over to next meeting.
Blood Donor Tools/Point of Contact:
CC to liaise with Comms Dept to see what virtual tools are available.
Component Recall

The two actions with regard to the component recall to be closed as individual trust will liaise with NHSBT directly regarding further learning/information.

RTC Update (CC)

- The O+ in bleeding males objective has largely been met and will continue as a rolling piece of work with support available to hospitals still to implement.
- The obstetric anaemia survey will launch in March to the anaesthetic leads for the regional obstetric anaesthesia groups and will be presented at the regional maternity leadership meeting so that midwives and obstetricians are also aware.
- TXA was suggested as the next regional objective but this is under review as it came into focus with the Amber Alert. If anyone has any alternative suggestions for the next regional objective, please feedback to CC or JM.
- The Transfusion Survey deadline was extended to the end of February. Copies of previous responses were sent to all trusts when the link to the survey went out in early January. The results will be presented and used to update the Benchmarking summaries.
- The next national education event will be held virtually on either the 7th or 14th June, pending speaker agreement. The theme will be Bleeding in the Medical Patient –flyer to follow.
- BSMSEDG education programme continues.
- Please keep feeding back to the RTC via the HTC Chair's Reports anything you would like to see raised regionally or nationally.
- Continue to feedback to NHSBT to help with forecasting – the DoH is looking really closely at hospital's blood stocks reporting, specifically those that are not submitting reports. There is 100% compliance in the south west – please keep it up.
- NHSBT continues to try and increase the amount of O- donors.

PBM Update (CC)

- Quite a lot of activity around the stock shortages and documents have been uploaded to the H&S website. This includes information and access to the webinar about reduced dose apheresis platelets in the event of a severe shortage which can be found on the Blood Stocks page, together with barcodes for hospitals to use to update their LIMS
- Next concern is the RCN strike scheduled for 1-3 March. We don't know yet if this will affect NHSBT but there will be no derogations.
- Education and training – Tx Still Matters 26 April, three hour session for BMSs with 2 years of training. JM to send details to TPs.
- The QS138 quality insights audit tool developed by the PBMP team will be launched soon. It will enable trusts to measure compliance against the four quality standards and allow regional and national benchmarking.

National TP Network Update (SL)

- No update on national TP competencies.
- TP2023 – there were some volunteers from around the regions to help with this event, which has been confirmed for 17/18 May. Details have been circulated.

Highlights from the Annual SHOT Report 2021 (SCG)

Following comments at the last TP meeting about being unable to attend last year's SHOT Symposium due to the cost, it was agreed they would come and present at this meeting.

SCG's presentation covered errors, reactions and near misses – including common errors, and key messages and recommendations.

A foldable report summary is available to order from the NHSBT leaflet hub.

During the questions that followed, SC queried if Education would ever be included as a Key Message, particularly as a result of the impact of Tx education not having returned to pre-COVID levels. SCG said that there had been references to transfusion education in past reports but that if SC had any particular points she would like to see raised, send some feedback to him and he would raise it at the next SHOT group meeting. All feedback, both positive and negative is always welcome.

There was a discussion around the lack of attendance at last year's symposium, mainly due to the location and fees, SCG will feedback comments and outlined some of the criteria/considerations that SHOT have to take into account when planning events. There are plans to attend future RTCs to give everyone the opportunity to ask questions and give feedback.

Following some feedback about some of the content of last year's symposium 'going over peoples' heads', this year's will be going back to basics.

Feedback on Collaborative Working – MH SIMS Toolkit

- Following the workshop session at the October TP meeting, the MH working group has produced a toolkit of major haemorrhage resources which are hosted on the TP SharePoint and were circulated to the group prior to this meeting. These are designed to enable TPs to facilitate the delivery of simulation training and education. PVV outlined the content and if anyone has any comments, these should be fed back to JM. 2 weeks given (post meeting) for comments deadline, they can then be ratified.

Round-table Discussion:

VCV canvassed for any shared learning, either from an incident or something that went well, to be presented at the May RTC meeting. It was done for the first time at last November's meeting and both topics prompted a lot of useful discussion. The session isn't minuted but the presenters are acknowledged in the minutes. Please let JM know if you would like to contribute. SL commented that this is also mirrored at a national level as sharing practice is so valuable.
LM – seeing a lot more incidents happen, presumably due to staffing issues – seem to spend a lot of time doing SHOT reports at the moment and SL agreed this had been a bit of a theme for him of the past 6 months.
LP – asked if anyone had made any progress regarding nurse associates, associate practitioners and the administration of blood components. The view of her trust is that they should be (a) registered, (b) do the transfusion training and (c) have iv and administration competencies. SL and PVV outlined what is happening/happens in their trusts and SC reiterated the need to have robust education in place.
JR – GWH has implemented the use of PCC without haematology authorisation for ED (following CAS Alert). Trying to implement a new transfusion pathway which is an authorisation booklet looking at risks, special requirements, consent all in one place. Piloting at the moment and have an initiative called 'Improving Together' in the trust which is helping to push it through. Wrong blood to wrong patient – first one in over 20 years – electronic blood tracking and bedside administration system were not used and no bedside check was done. Thankfully it was ABO compatible. A lot of work has been done since with clinical risk department and have had to produce a poster for the safety huddles on the wards and will do something for the learning zone on the intranet. JR will ask SC if she is interested in presenting at the RTC. Were approached to train junior doctors to administer blood to help with the RCN strikes but said no.
PVV – consultants at RCHT asked for sample taking training in preparation for a possible junior doctors strike.
JP - GWH will have a team of ODPs that can go to wards to transfuse if required on those days.
PVV – first year of being able to measure the usage of O+ for bleeding men and have saved about 40+ units of O-. Would be useful to compare data regionally.
Challenges – also had incorrect blood transfused to a patient but they had a compatible blood group. Reported on DATIX and escalated to patient safety review group but because it was not a Never Event it was closed it down. Now have a screen saver about positive patient id.

AOB

None
The formal meeting was followed by an education session, presented by Chris Robbie, MHRA – Incident Investigation & Root Cause Analysis

SW TP Group Meeting, 21.02.23

Action Log:

Action	Actioner	Completed
Carried over from Oct 2021 meeting: Check UHP and RD&E involvement with medical schools training re transfusion	 ST	 WIP/review next year alongside progress with potential new SW /NHSBT joint consultant post
Actions from 11.10.22		
Review ToRs to include wording around SharePoint and sharing of TP's professional details	SL/JM	Part of SharePoint Review
Provide lab. contact details to ST (re. Retrieve policy)	All	MT to check with KM
Feedback comments re tools for trusts to assist with recruiting donors and get point of contact for general blood donation queries	CC	To find out if any virtual tools available
Actions from 21.02.23		
Use SharePoint template for feedback to National TP Group	All	
Feedback suggestions to CC/JM for next regional RTC Objective	All	
Circulate details for Transfusion Still Matters	JM	Complete
Feedback any comments on the MH SIMS Tool Kit to JM	All	
Contact JM with any shared learning for presentation at the May RTC meeting	All	