EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Thursday 26th October 2024, 10:00am – 13:00pm at The Red Lion, Whittlesford

In Attendance:

Name	Role	Hospital
Lynda Menadue **LM**	RTC Chair / HTC Chair	North West Anglia – Hinchingbrooke and Peterborough
Frances Sear **FS**	PBMP	NHSBT
Dora Foukaneli **DF**	Consultant Haematologist	NHSBT / CUH
Joanne Hoyle **JH**	TP	West Suffolk
Emily Rich **ER**	TP	North West Anglia – Hinchingbrooke and Peterborough
Martin Muir **MM**	TLM	Royal Papworth
Sheila Needham **SN**	TP	Lister
Clare Neal **CN (Minutes)**	RTC Administrator	NHSBT
Danny Soltanifar **DS**	HTC Chair	Norfolk & Norwich
Craig Thomas **CT**	TP	Colchester
Rebecca Smith **RSm**	TP	Ipswich
Michaela Rackley **MRa**	TP	Royal Papworth
Julie Jackson **JJ**	TP / TP Chair	James Paget Hospital
Suzanne Docherty **SD**	Consultant Haematologist	Norfolk & Norwich
Eleanor Byworth **EB**	EPA Network Manager	Norfolk & Norwich, James Paget and Queen Elizabeth KL
Rosalinda Bouzenda **RB**	Blood Transfusion Manager	Bedfordshire Hospitals
Gilda Bass **GB**	TP	West Suffolk Hospital
Ellen Strackosch **ES**	TP	Luton & Dunstable
Jenine Yearwood **JY**	TLM	Southend
Sandra Faloye SF	TLM	Queen Elizabeth Hospital KL
Claire Sidaway **CS**	TP	Addenbrooke's Hospital
Aline Seigneur **AS**	TP	Addenbrooke's Hospital
Shinsu Kuruvilla **SK**	TP	Queen Elizabeth KL
Harriet Madiyiko **HM**	TLM	West Suffolk Hospital
Katarzyna Janse Van Rensburg **KJVR**	TP	Peterborough Hospital
Ben Balagot **BB**	Cell Salvage Lead	Watford General Hospital

Apologies: Mohammed Rashid, Donna Beckford-Smith, Stephen Cole, Katherine Philpott, Isabel Lentell, Leila Khalil, Sewa Joacquim-Runchi, Aline Seigneur, Caroline Lowe, Julie Edmonds

1. Welcome

LM welcomed everyone to the meeting.

2. RTC Meeting Minutes

Minutes from May 2024 agreed as correct. **LM** agreed for these to be uploaded to the website.

- **ML** are minutes published on website? **LM** we need to be able to speak frankly and openly. They are not published until after they are agreed at the next meeting. **CN** please advise me if there are any parts of the meeting that should not be recorded.

Actions from previous meeting:

No	Action	Responsibility	Status/due date
1	Major Haemorrhage Flowcharts – Trauma	**DF / LM**	Ongoing
2	Simulation	**IL to discuss with GB**	January RTC
3	Simulation – theme for RTC 2025	**LM**	2025

4	Education afternoon after RTC	**LM**	2025
5	Haematology Trainees Guidance	**DF to send to CN to circulate**	ASAP
6	EWG – if you would like to join please advise CN.	**Advise CN** **CN to add IL**	Ongoing
7	Raise concerns of donors - feeling valued, lack of appointments, number of attempts, alternative approach to cannulation.	**LM to raise**	Ongoing
8	WBIT paperwork	**CN to add East of England logo and circulate to region for use as a pilot.** **LM to raise at NBTC**	Ongoing
9	Platelet Audit	**FS to discuss changes with Brian** **CN to circulate to RTC for completion by 26 September. Feedback at January 2025 RTC**	Data collected and will be reviewed for recommendations

3. RTC Action Plan

- **Benchmarking and Audits**
  - **JJ** the TP Group have 4 benchmarking audits. WBIT (only two hospitals have added into this so far during 2024). If we are benchmarking against other hospitals, we need the information added. There seems to be too much information on this tool so this will be looked at during a TP meeting.
  - **LM** I have been offered broken down data of usage / wastage for the region. This was offered at the RTC Chairs meeting. **JJ** I can pull a summary of where wastage is happening. **LM** they are offering this as a report so you don't have to pull it yourself. **DF** the tools are in place to pull this data. I receive it for larger hospitals so we can see how Addenbrooke's compare to other larger hospitals. **LM** regional data is being offered and can be matched to hospitals of a similar size.
  - **JJ** QS138 insight tool, NCA are asking us for data. The region is above average for iron, TXA, consent. The region are below average for assessing after a single unit is given. SHOT benchmarking is out. **LM** can I have a show of hands how many input into QS138.
- **LM** RTC need to look at the paediatrics and trauma MH flowchart.
- **LM** RTC need to have a plan for education in 2025 and will discuss in RTT. Moving along with MH sim. West Suffolk will be updating at the January RTC what West Suffolk have in place.
- **LM** Mums, Babies and Blood will take place in February.

CN will amend action plan accordingly and upload to website.

4. PBM Update

FS provided an update to the group.

- **LM** where are the QR codes? **FS** these can be taken from the presentation which will be circulated. **ES** we have added a QR code to our consent forms. **LM** we could add it to peri-operative information. It is up to the patient to look at the information and up to the anaesthetist / surgeon to advise patients of it.
- **JJ** I am going to ask if Anwen will come to our November TP meeting to discuss QS138 for any questions.

5. Regional Group Updates

- **Education Working Group**
  The next meeting is planned for 6th November 2024.
- **TADG Group**
  KP was unable to attend the meeting.

- **TP Group**
  - **JJ** a national group is looking at the shared care form so this can be used nationally. This form originated from the East of England.

6. Customer Services Update

MR was unable to attend to provide an update.

Amber Alert and Blood Stock / Supplies

- **FS** the amber alert remains in place. Stocks have improved. There is concern about levels once London activity returns to normal following the cyber attack.
- **DF** the amber alert will stay. There is a deduction by one day in levels almost weekly. During the summer we called a lot of donors and can't call them back yet. We will be in a difficult situation if we don't remain at amber alert.
- **LM** NBTC advised if we came off amber alert too early, we could end up in a red alert. As we have used our donors, we currently don't have any to call on. There is not a lot we can do at the moment. We do currently have 7 days stock but this could drop easily.
- **JJ** Lise Escort had a meeting with us on Monday to see if there is anything we can do to relieve the pressures. We are all receiving comments about donor sessions.
- **JJ** we would like some information from NBTC to go to Medical Directors about one unit transfusion as we still have a culture about two units. **CT** I spoke to a few doctors, mainly medical who have said it is quicker to discharge if two units are given rather than one unit and review. **LM** how many have this issue?. 6 hospitals have this issue.
- **DF** in many audits 50% O negative goes to O negative patients. We need to look at where O negative is going and whether it is going to non O negative patients to avoid wastage. We need to lead the way and demonstrate what we are doing. We need to ensure we are taking two samples for patients within good time so we have their blood group.
- **DF** can we do anything around wastage? **JJ** we were looking at completing a deep dive audit, we can bring this forward if necessary. **DF** I am not sure we have too much time to do this. We need to look at blood stocks. All hospitals need to look at this and their data.
- **LM** how can we support lab managers as an RTC? **RB** what techniques do hospitals use to ensure we have blood group in a timely manner? **LM** are we giving O Neg in emergency situations? **MRa** how many hospitals have emergency O negative and not O positive? **KJVR** the experience of the BMS on the bench has an impact.
- **MRa** our haemobank will issue to O positive to a male patient. **JJ** the majority have O positive available but have to talk to lab. If they had more O positive available then we would save about 50 units. **LM** most of ours are obstetric major haemorrhage.
- **LM** do we need to push as an RTC about O positive / O negative? **DF** we need to look at bigger picture. Hospitals need to look at practices and risk assessments. Out of 16% emergencies, 5% could have been saved.
- **LM** could hospitals keep less O negative? **DF** we want to reduce hospital stocks. There is fear and that's why hospitals stock so much. **RSm** we have all reduced stocks. If we have had no issues, we need to remain stocked as we were. **CT** it shows that out stock was higher than it needed to be.
- **DF** 11% substitutions is due to special requirements. Do we have the skills within the lab to substitute? **SD** we have had increasing numbers of sickle cell patients needing O negative.
- **DF** London hospitals have pre orders. We have unexpected patients and orders.
- **FS** going back O positive in emergencies. Do you know why it is not used? **SD** it is the fear factor. We are due to become a trauma centre. We have discussed having a haemobank so it will issue O positive to a male patient. Hopefully it will give confidence to staff. **EB** the labs work hard to switch from O negative to O positive. **ER** that's what we have but it does depend on the confidence and experience of the lab staff. **LM** not everyone has electronic issues. After the first request / first issue, everyone should move to O positive if the patient is a male or a female over 50. If we as an RTC suggest this, it will give confidence to the region. It is being pushed due to amber alert but it is also safe. **DF** if blood is taken from the emergency department it is O negative but if it is given from the lab O positive is given if the blood group is confirmed. **ES** do you not keep O positive in the emergency department? **CS** there is a risk

assessment going through at the moment. **DF** Addenbrooke's is the biggest hospital with the lowest usage of O negative and the lowest wastage. There are other ways to preserve. **CS** our emergency department has confidence in the lab. **DF** the lab is based one floor up, this all plays a role. **ES** we have two units O negative / positive in the fridge in our emergency department. It is used. Males are given O positive. **LM** we have 3 units in theatres. They want us to put two units in the emergency department when we have electronic issue. **LM** if you are going to collect from the lab anyway, O positive should be given to males and females over 50.

- **DF** Addenbrooke's has 4 deliveries a day. By having frequent deliveries we are able to keep a limited stock. **ER** I think this is Peterborough's issue as we have one delivery. **DF** can we make some suggestions, we need to make targeted recommendations and improvements. **DF** we can ask **MR** to abstract substitution data.
- **SD** I am really concerned about length of amber alert and cancelling surgeries. **DF** have you cancelled procedures? **SD** patients are not anaemic but have been asked for cross match. **ES** we have a patient awaiting surgery but we keep cancelling as they would like 4 units on site. **JJ** Lise Escort said on Monday that you shouldn't be cancelling surgery but defer for correctable anaemia. **DF** the first amber alert in 2022 requested deferring surgery if there was a blood requirement. The emphasis this time is not to continue with surgery for those who need correctable anaemia. **DF** from the lab managers perspective, what would lab managers like to see, more deliveries? Sharing stocks? **RB** we started sharing between Luton and Bedford. We have used this service a few times, it is useful. **LM** do we share between Hinchingbrooke / Peterborough? Are there any trusts that aren't able to share within trusts?
- **LM** are we allowing cancellations to be made by staff who are non-clinical? **SD** the private lists are looking at blood groups and cancelling those with O blood.
- **DF** I was at BBTS. For this specific amber alert, there is no request to defer surgery unless they have correctable anaemia.

7. Presentation – Cell Salvage at Watford Hospital

BB presented to the group.

- **LM** how many episodes have not been processed? **BB** the majority of episodes have been processed.
- **LM** it is great to have 8 operators. We only have 3. We don't have vascular services. **BB** our vascular services are going to move to Lister Hospital. We will be left with trauma and obstetrics. **CT** we are using it less for vascular. We have high training levels.
- **SK** are all your operators ODPs? **BB** we have also trained day surgery nurses. **LM** do those trained just deal with cell salvage or do they do other tasks too? **BB** they just concentrate on cell salvage.
- **SK** we face staffing challenges.
- **DS** how long are you allocated for training?
- **BB** I was employed for this, the biggest issue I have is pulling out the staff to train rather than me training. **BB** my sole role is to be cell salvage lead.
- **CT** do you have an on call rota?
- **JJ** do you have a contact group with other cell salvage leads? It would be good for you to have a group to share issues. **ER** there is a Facebook / WhatsApp group. **JJ** cell salvage leads are an isolated practitioner in a specialist area. We could share lead contacts. Advise **CN** to create a contact list.
- **BB** it is a good thing to have cell salvage available especially with blood shortages. **LM** in the previous amber alert we promoted cell salvage use and increased usage. In our Trust we have to access the training from the company. How have you found it without having this support? **BB** the rep trained me as 'train the trainers' so I could train others. Other hospitals seem to use other machines.
- **CS** how are you recording all the data? **BB** we have a recording sheet which also goes into the patient notes. We have electronic notes. **CS** if you wanted to look at how many patients use cell salvage, do you have to do this manually? **BB** yes.
- **CT** from past experience, we set cell salvage up to collect as standard, we put processing set in if it goes above 300mls.

- **MM** do you add heparin to the unit? **BB** there is a reservoir where we collect the blood, that is where we add heparin. When we have a large enough collection it is processed.
- **JY** do you still need support from lab? **BB** 125mls blood is ready in 5 minutes. Anaesthetist can give back to the patient straight away. **JY** for AAA, do you still get call for blood? **BB** sometimes it is sufficient. Instead of using 4 units, we are using half when we have used cell salvage.
- **KJVR** are the machines always available? **BB** if they are booked we make sure they are available. **KJVR** how far in advance are they booked? **BB** usually two weeks in advance, sometimes one.
- **LM** we have a booking system in our hospital. They need to be booked ahead and surgeons are advised in advance. We do our best to accommodate requests. We may move a C-Section by a day if needed. It's the training we struggle with.
- **CT** with regards to training, we have moved away from JPAC workbook and use our own. We have our own competencies. **LM** would you be able to share these? The workbook is extensive.
- **CT** we also have cell salvage super users. **LM** could we have East of England RTC super users that other Trusts can use? **CT** they would need to be on same system as others.
- **JJ** our rep will come in and train staff. It is releasing staff that is an issue.
- **LM** the first thing required is to have a super user in each hospital.

8. Discussion – Infected Blood Inquiry

- **LM** shared the recommendations. They have not been accepted yet. I was asked to make sure you are aware of what the recommendations are.
- **<u>Training</u>**
  - **JH** NHS England are wanting us to use the 11 core subjects but transfusion isn't one. If transfusion is a core subject it would save time. **DF** I agree. This message went to medical schools. It went to Royal College of Anaesthetists. **JH** can we move forward on this?
  - **JJ** my issue is transfusion training isn't mandatory for doctors. **DF** major haemorrhage is mandatory. **LM** consultants have to have it for appraisals. Trainees less so. **JJ** are updates mandatory? **ER** every two years. **JJ** we are pushing that it needs to be mandatory. CS we have tried. **LM** I managed to get it through via the medical director, I said it would take 10 minutes for a doctor to complete. If you are new it may take 30-40 minutes. I said it had to be done for CAS Alert.
  - **SN** we get face to face for all doctors. **LM** ours is e-learning on ESR. **ES** do you have your own e-learning? **ER** yes local to us.
  - **GB** we are all investing so much time, we need to have a directive from higher up.
  - **JH** if a member of staff completes core training via ESR and they move on they can take it with them. **JJ** I would like to provide the information but they won't make it mandatory. **LM** do you think we should have transfusion mandatory training in East of England? **CS** they are recommendations not that you have to do it. **SN** we have some staff groups that don't do it. **LM** our staff have to put in a request if they feel it is not part of their role.
- **<u>Outcomes</u>**
  - **JJ** who is going to go to every patient to found out the outcome of transfusion. We would find out if there any issues.
  - **DF** did they give any further clarification at NBTC? **LM** no. **DF** there are several working groups in place which may provide clarity.
- **LM** there is a national working group to look at funding. I am on this group. I will report back how we can access money.
- **RSm** I am unsure why they haven't looked at giving one unit and review. **LM** these are very broad statements / recommendations. I would put one unit review under PBM.
- **Patient Representative RTC**
  - **LM** I have been advised we need a patient representative on the RTC. We really need a representative to come to virtual meetings. **ES** we were told that we couldn't have a

patient representative on HTC. **DF** each hospital / Trust have responsibility to give training and documentation to this person.
    - **LM** please can you report back any issues / concerns / blocks you have.
    - **HM** is the expectation to come to the whole meeting? **LM** this is why I suggested the virtual meeting as it is more accessible. Our HTCs are virtual so a patient representative could attend these.
    - **ES** what is the objective of having a lay person? **JJ** ours used to feed back to executive board. **DF** they are able to provide patients perspectives. We need to know the impact of decisions made on patients.
- **CS** I have looked at the use of tranexamic acid. **DS** the team brief is a good place for this to sit.

9. HTC Updates

Completed forms have been reviewed by **LM**. Actions will be taken by RTC with points raised.

10. Any Other Business

- **DF** please look at NBTC guidance about surgeries. **LM** if you are finding information that says surgeries should be cancelled please let us know.

Date of Next Meeting: 2025 dates have been circulated.

LM thank you for attending.

Actions:

No	Action	Responsibility	Status/due date
1	Review WBIT Tool	**TP Group**	Meeting during 2025
2	Paeds and Major Haemorrhage Flowchart	**RTC**	
3	RTC Action Plan	**CN**	Ongoing – update after meeting and upload to website
4	Plan for East of England Education	**RTT**	Ongoing
5	Ask Anwen to join TP Meeting in November for questions on QS138	**JJ**	ASAP for November meeting
6	Information from NBTC regarding one unit transfusion	**JJ requested**	Take to NBTC
7	Deliveries	**DF speak to MR**	
8	Advise of cell salvage leads	**ALL advise CN**	Ongoing
9	Advise LM of any issues with having a patient representative	**ALL**	
10	Review HTC reports and look at actions required	**LM / RTT**	
11	Review NBTC guidance on amber alert and surgery	**ALL**	
12	Advise LM if you find information that surgeries should be cancelled	**ALL**	