MEETING MINUTES

SOUTH-WEST REGIONAL TRANSFUSION COMMITTEE

Wednesday 15th MAY 2025, 10:00-12:30

Via Microsoft Teams

Attendance:

NHS HOSPITALS/ORGANISATION	
Dorset County Hospital NHSFT	No Representation
Gloucestershire Hospitals NHSFT	Tracy Clarke (TC), Laxmi Chapagain (LC), Stuart Lord (SL), Rebecca Frewin (RF), Sophie Scutt (SS)
Great Western Hospitals NHSFT	Julie Ryder (JR)
North Bristol NHS Trust	Tim Wreford-Bush (TWB), Mooi Heong Tay (MT), Karen Mead (KM), Elmarie Cairns (EC)
Royal Cornwall Hospitals NHS Trust	Olly Pietroni (OP)(Chair) , Pedro Valle Vallines (PVV), Ian Sullivan (IS)
Royal Devon University Healthcare NHSFT	Amy Heaver (AH), Sarah Wheeldon (SW),Jennifer Davies (JD), Carolyn Jones (CJ), Rob Baker (RB)
Royal United Hospitals Bath NHSFT	Nicola Wilson (NW)
Salisbury NHSFT	Anushka Natarajan (AN), Leah Pecson (LP)
Somerset NHSFT (Musgrove)	Martin Best (MB), Annette Bayon (AB), Michelle Jane Davey (MJD)
Torbay and South Devon NHSFT	Steve Mills (SM)
University Hospitals Bristol & Weston NHS FT	Lucia Elola Gutierrez (LG), Tom Latham (TL), Stephen White (SW)
University Hospitals Dorset NHS FT - Poole	Vikki Chandler- Vizard (VCV), Alison McCormick (AM)
University Hospitals Plymouth NHS FT	Caroline Lowe (CL), Samantha Reynolds (SR)
NHSBT (Filton)	Mathew Hazell (MH), Rhian Edwards (RE)
PRIVATE HOSPITALS	No Representation
NHSBT	
PBMP	Samantha Timmins (ST), Sandra Rakowsa (SR)
RTC Administrator	Sherin Monichan (SM)
Customer Services Manager	

1. Welcome and Apologies: (Speaker: OP)

- OP opened the meeting, acknowledging the administrative transition and explaining the decision to hold the meeting online due to the recent changes in chair and administrator roles.
- A special thanks was extended to SC, the outgoing RTC Chair, for his years of leadership and significant contributions to education and maternal anaemia initiatives in the region.

2. Minutes of Previous RTC Meeting:

OP highlighted the following main points of the meeting held on 20.11.24.

- **Education and Training Initiatives**
  A new regional education group has been established to oversee and coordinate educational activities across the region. A report from the group was scheduled later in the agenda, aiming to support the planning and delivery of future events and improve engagement.
- **IBI Dashboard and NICE QS138 Tool**
  - The group had resolved to begin work on developing an IBI dashboard for the South West region to improve transparency and facilitate shared learning. This topic was revisited in detail during the meeting, with JD and PK presenting the gap analysis completed at Exeter.
  - ST noted ongoing discussions regarding the future of the NICE QS138 Quality Tool, particularly concerning its integration into Model Hospital. This has been raised as a question, and ST is currently awaiting further clarification or feedback.
- **Provision of Patient Information Leaflet (PIL) for Transfusion During Severe Shortages**
  - ST agreed to follow up with Anne Davidson regarding the creation of a PIL to provide guidance during times of service disruption or blood shortages.
- **RTC Patient Representative Recruitment**
  - OP invited attendees to suggest or nominate patient representatives interested in joining the RTC. Paul Chaplin (PC) volunteered and has since taken up the role. However, one additional patient representative is still being sought to ensure full coverage.

3. NBTC/RTC Chair Update (Speaker: OP)

OP provided a summary of key updates from the National Blood Transfusion Committee (NBTC) meeting held on 24 March 2025. The following points were highlighted:

- **<u>Transfusion 2024 update</u>**:
  - The five-year forward plan was outlined, including numerous resources and workshops provided by the Transfusion Practitioner (TP) Network.
  - The 1st Anniversary of the Transformation and Training Hub was celebrated. This hub offers access to educational resources aimed at healthcare professionals involved in blood transfusion, as well as others seeking to build transfusion knowledge. These resources are available via the NBTC website.
  - Hospital Blood Data Integration Pilot: A pilot project is currently underway involving approximately 20 hospitals across the UK, with the aim of automating data collection related to hospital blood stock levels and wastage.

- Transfusion Research Network Project: A Research Manager has been appointed to increase engagement with the programme. Funding has been secured until the end of 2026, supporting the continued development of transfusion research initiatives.

- **Transfusion transformation strategy (TTS):**
  - In response to recommendations from the Infected Blood Inquiry, the Transfusion 2024 Strategy is being revised into a new framework known as the Transfusion Transformation Strategy (TTS).
  - This is a collaborative initiative involving NBTC, NHS England, NHSBT, and key stakeholders such as the Royal Colleges and specialist societies.
  - However, concerns were raised about governance and funding structures due to recent NHS reorganisations, which may affect the influence and role of the NBTC moving forward.

- **HTC Survey:**
  A national HTC survey was circulated; however, it did not reach hospitals in the Southwest due to an oversight. The results were nonetheless discussed:
  - Around 25% of HTCs are no longer formally designated as committees but rather function as "groups."
  - Approximately 84% still report directly to patient safety or clinical risk groups.
  - A significant proportion lack dedicated administrative support.
  - Only 50% have a designated clinical lead for cell salvage.

  The survey link has now been distributed across the Southwest region. The regional outcomes were reviewed later in the meeting.

- **Education Working Group:**
  - Plans are in place to **expand educational outreach to the Peninsula Deanery**, including the introduction of **transfusion training placements** starting in **August 2025**, aimed at addressing geographical disparities. Ongoing work is being carried out to assess the effectiveness of educational activities, including face-to-face and e-learning formats.
- **TLM Support:**
  - Webinars and drop-in sessions have been developed to support the new lab managers. Also, National TP network has been relaunched with more of the education days and survey in the workbook.
- **SHOT Symposium:**
  - Next one is scheduled on 11.07.25. Report will highlight the concerning with regards in transfusion related deaths with the trends going up to delay and errors which includes the lab related error increasing more than 50%.
- **NHSBT R&D:**
  - Five-year review has been completed and there has been few shortfalls which including financial constraints. Notably, the current Blood Transfusion Research Units are set to expire in 2027, prompting considerations for renewal or replacement strategies.

4. **HTC Chair's Report Highlight: (Speaker: OP)**

A brief regional HTC survey was circulated across the Southwest, and the following key themes and outcomes were shared:

- **Survey Feedback Summary:**
    - There was positive engagement with efforts to reduce platelet usage.
    - Several hospitals reported changes to emergency blood stocks, including transitioning to Group A RhD positive and reducing stock levels from 2 units to 1.
    - BSMS reports showed variation in data management—while some hospitals handle large data volumes well, others are feeling overwhelmed.
    - A wide range of audits have been undertaken, but staff shortages are significantly impacting audit capacity.
    - Main concerns highlighted included:
        - Audit burden due to workforce and financial constraints.
        - The prolonged Amber Alert has lost urgency and become normalized.

IBI Recommendations – SW RTC Survey Analysis

OP presented a **graphical overview** of the regional responses to IBI recommendations. Colour coding was used:

- **Red** = Not implemented
- **Yellow** = In progress
- **Green** = Implemented

The five major areas of discussion were:

- **Tranexamic Acid (TXA):**
    - Most hospitals have made some progress by incorporating TXA into the WHO surgical safety checklist, although debate remains over whether it's suitable for all types of surgery.
    - Many hospitals reported having TXA policies already in place.
    - Suggested improvement: Better integration of TXA discussions into pre-operative patient blood management (PBM) planning.
    - Ongoing transition to electronic patient records highlights the need for digital solutions over audit-heavy processes.
    - Progress has also been made with NHSE reporting.
- **Transfusion Laboratories:**
    - Staffing concerns remain prevalent, particularly regarding adequate cover, training, and supervision.
    - Despite this, many labs are satisfied with their skill mix, with junior staff being well integrated.
    - Common challenges include recruitment, retention, and funding, with several teams having escalated these to their Trust's risk register.
    - OP encouraged others facing similar issues to follow suit in formally documenting risks.
- **Transfusion Training:**
    - Induction training is widely implemented, and compliance is being monitored.
    - However, many hospitals commented on the limited training opportunities available in the South West region, suggesting a need for regional support.
- **SHOT Recommendations:**
    - Widespread concern that SHOT recommendations are often vague and difficult to interpret.
    - Some hospitals noted that TXA-related recommendations fall outside the scope of the transfusion team, limiting cross-departmental engagement.

- **Outcome Tracking (SQR):**
    - Blood products are not currently covered under Standardised Quantitative Reporting (SQR) in many hospitals.
    - Some institutions use presumed fate reporting instead.
    - OP mentioned that this is expected to change, with a vein-to-vein electronic tracking system being introduced Trust-wide.
    - Encouragingly, four out of seven Trusts have already implemented this system, indicating progress and potential for wider rollout.
- **Additional Discussion Points:**
    - ST proposed creating a SharePoint folder in the TP channel for shared policies, particularly on topics like TXA and capacity management.
    - PJ suggested adding a section to the next HTC Chair report regarding how labs are recording and escalating unmet capacity demands.
    - ST expressed concern over the increasing vagueness of SHOT recommendations, questioning whether the issue should be escalated to the NBTC.
    - TL noted that NHS England working groups are also grappling with similar IBI-related challenges and are under pressure to deliver meaningful progress.
    - Action: OP to send a summary of the feedback to TL, who will raise it within NHS England working groups to obtain further insights and feedback

5. Dried Plasma and Dried Cryoprecipitate: (Speaker: RE)

RE opened the session by introducing herself and outlining the clinical need underpinning the dried plasma (DP) projects.

- **Military Use of Dried Plasma:**
    - RE provided a brief overview of the military's requirement for dried plasma. Currently, the UK military sources dried plasma from Germany (LyoPlas) and the French military (FlyP). However, concerns remain regarding supply sufficiency, logistical resilience, and the practicality of glass bottle storage in field conditions.
- **Civilian Need for Dried Plasma:**
    - RE discussed the outcomes of two surveys distributed in November 2021, which highlighted the potential utility and demand for dried plasma in civilian medical settings.
- **Spray-Dried Plasma (SDP):**
    - Emphasizing the distinction, RE clarified that the product under development is *spray-dried*, not freeze-dried. It will be sourced from NHSBT plasma, manufactured in the UK, and regulated by the MHRA.
      Key benefits include:
        - Manufactured domestically
        - Stored in plastic pouches (ideal for military use)
        - Rapid reconstitution time
    - RE mentioned that a dedicated lab has been established at the Cambridge NHSBT site, with plans to acquire an additional spray-drying machine. Clinical trials are expected to commence next year in hospital settings. Further research is ongoing to determine optimal storage conditions.

- **Spray-Dried Cryoprecipitate (SDC):**
    - Still in the early stages of development, this product offers rapid reconstitution and does not require freezing for storage. It is a fibrinogen-rich resuscitation fluid, particularly suitable for obstetric haemorrhage and major trauma scenarios. RE noted its potential to significantly reduce cryoprecipitate wastage in the UK.
- **Comments and Suggestions:**
    - ST highlighted current air ambulance practices involving pre-sourced plasma and referenced the BSH guidelines.
    - OP recommended that RE reach out to air ambulance trusts across the UK,. These services may offer valuable feedback.
    - JD inquired about the types of bags suitable for emergency use. RE responded that this will be assessed during the upcoming clinical trials.
    - MH asked whether UK production can meet the potentially large-scale plasma demand for battlefield scenarios. RE confirmed that the capacity currently exists to meet those requirements.

6. **Customer Services Update:** (Speaker: CS); PPT has been shared with the RTC. Please follow the links to the surveys and feedback.

7. **PBM update (Speaker: ST)**

Key Updates

- **New Resources – "Fit to Donate"**
    - ST emphasized the importance of maintaining donor health, noting that anaemia is a major reason donors become ineligible and lose post-donation support. ST shared links to relevant YouTube resources and webpages (refer to the PPT).
- **Upcoming Resources & Patient Information Leaflets (PILs)**
    - Updated UKIBTN joint PILs are now available.
    - A new Anaemia PIL is currently in development.
- **Ongoing Projects**
    - Baby Blood Assist: A bedside app designed to support paediatric and neonatal transfusions by offering policy guidance and Q&A functionality.
    - Blood Transfusion E-Learning Modules: Development is in early stages. The module is intended to be UK-wide. Accessibility issues are under review. ALB review is delaying merchandise aspects.
    - Women's Health Content: "Blood Essentials" content has temporarily been removed from the website due to an error. ST noted it is being fixed and is the point of contact for any queries.
- **Audits, Trials, and Publications**
    - NICE Quality NCA Audit: Reports are now available. There is an ongoing discussion on managing overlap between the NCA Quality Improvement Tool and regional activities.
- **Upcoming Audits:**
    - Major Haemorrhage Audit – Planned for April 2026.
    - NCA Anti-D Audit – Also planned for 2026.

Guidelines:
    - CPOC's pre-operative anaemia pathway has been updated.
    - BSH administration guidelines are currently under review.
- **Webinars:** Relevant links are available in the PPT.
- **PBM Team Update:**
    - ST announced internal efforts to improve team efficiency, including potential practitioner recruitment and resource optimization reviews.
      ST welcomed Sandra, who will be taking over ST's role. Sandra introduced herself to the team.
- **BSMS Report:**
    - Feedback on the new BSMS report is available. Queries should be directed to ST or the BSMS team**.**
- **WHO Surgical Safety Checklist Discussion**
    - ST highlighted discussions among Royal Colleges regarding the inclusion of TXA in the WHO Surgical Safety Checklist. A list of relevant surgeries is being developed collaboratively.
- **Governance Models**
    - The team is exploring various governance models, particularly infection control, to inform the development of a new framework.
- **Medical Education Programme**
    - Plans are in place to launch a PBM education programme for undergraduate medical students. A one-year review is in progress, with outcomes expected by the end of May—potentially delayed due to NHSE restructuring.
- **Memorial for Those Affected/Infected**
    - ST noted that a memorial has been unveiled in Filton to honour individuals affected and infected by transfusion-related issues.
- **Blood Stocks Update:**
    - **Amber Alert Status**
      ST expressed concern that the Amber Alert system has lost effectiveness but noted that an exit plan must comply with NHSE requirements. A transition was initially scheduled for April but is now planned for June.
    - **Group O Donor Recruitment**
      Encouragingly, issues with Group O blood supply have improved following a successful recruitment campaign. The opening of the new Brixton Donor Centre has helped increase capacity.

Q&A and Discussion:

- JD raised the question of whether a revised transfusion grid or criteria needs to be considered by the blood supply team in light of changing norms and around reducing wastage and patient blood management.

- ST answered that its not sure where we are in the terms of stockholding and there has been work going on in the donor base as well. This will be put in as a point of discussion in the high-level meetings.

- OP acknowledged previous discussions with Bruce Daniel about integrating patient blood management data into Model Hospital dashboards. He noted the difficulty of using current datasets (e.g., wastage, multiple transfusions) to capture effective PBM and proposed a more

integrated digital output from patient records as a future solution. He committed to revisiting the conversation with Bruce Daniel.

- ST agreed and offered to follow up with Louise from the Transfusion Transformation Team for updates from their side.
- SS shared insights from the recent NATA conference in Munich, highlighting the newly released WHO PBM implementation guidelines. Although the original document has existed since 2023, the new emphasis is on implementation strategy. Sophie noted that the first 12 pages are particularly essential reading and that WHO is encouraging governments to adopt PBM more robustly.
- SS also pointed out that Europe-wide blood shortages are likely to persist due to demographic shifts—specifically, baby boomers transitioning from the largest donor to the largest recipient group. A shortfall in younger donors is now a common challenge across many countries.

Working group Updates:

8. **TLM Group (Speaker: IS)**

The SW Laboratory Managers Group met on 4th April with a new format. Rather than separate morning and afternoon sessions, a full-day joint meeting was held with both laboratory representatives and NHSBT. The agenda was described as comprehensive, featuring multiple presentations and active discussions.

Key Topics and Presentations:

- **Blood Bank and MHRA Reports**
- **NHSBT Shared Learning**
- **Inspection Reviews and Blood Compliance Reports:**
    - Compliance submissions were due by the end of April. No significant concerns were raised, although some questions were flagged as ambiguous and addressed to the best of their ability.
- **Transfusion 2024 – Research Network Presentation**
- **BSMS Data Presentation – Matt Jones (Blood Stocks Management Scheme)**
    - The event also provided valuable networking opportunities, allowing face-to-face discussions and fostering collaboration.
- **Outcomes and Actions:**
    - A total of 17 actions were raised, reflecting a highly productive session.
    - Temperature Mapping: Follow-up meeting scheduled with MH and BD.
- **Clinical Scientist Role Development:**
    - Discussions focused on supporting the development of HSST (Higher Specialist Scientific Training) roles in transfusion services and how hospitals can be assisted in implementing these roles.
- **Five-Day FFP (Fresh Frozen Plasma):**
    - Though currently recommended only for use in major haemorrhage, some hospitals are beginning to use it in other clinical scenarios, such as patients with ongoing oozing (based on WHO bleeding scores). This evolving practice may eventually reduce FFP wastage, a known issue across hospitals.
- **Acknowledgement:**

- IS thanked **Carol** (not present) for her substantial help with preparing the agenda and meeting minutes. As the lab managers group often lacks formal administrative support, her assistance was particularly appreciated.

9. **TP Group: (Speaker: SL)**

The SW TP group held its first meeting of 2024 in March, delivered virtually. It saw strong engagement with 11 trusts and NHSBT in attendance. The session combined data review, educational updates, and collaborative project planning.

- **Survey Results:**
  - Presented findings from the Major Haemorrhage and O Positive Blood Use Survey (Nov 2023), highlighting variation in practice across the region.
- **QS138 Review:**
  - Provided feedback from the 2023 cycle of the NICE PBM Quality Standard QS138 and outlined next steps.
- **Educational Segment:**
  - Delivered by David (Bristol) and James (Exeter) from the SW HLC, offering regional updates and guidance, which was well received by attendees.
- **Ongoing Projects:**
  - **Sample Acceptance Criteria Standardisation:**
    A working group, led by SL and Pedro, is developing a regional template to align understanding of "zero tolerance" labelling practices across transfusion labs. Two meetings have been held to date.
  - **Standardising Major Haemorrhage Activation:**
    Following survey findings, efforts are underway to map and align major haemorrhage activation procedures across trusts—particularly the role of switchboards and lab contact. The goal is to reduce confusion for rotational doctors and improve consistency in critical processes.
  - **PBM Standards Audit (QS138):**
    Data collection for Q4 2024–25 (January–March 2025) is currently in progress.
- **National TP Network Involvement:**
  - SL and EG are active in the National TP Network, which relaunched late last year.
  - The recent national meeting featured representation from TPs, SHOT, MHA, NHSBT, BBTS, lab managers, and patient groups.
  - The format is now project-based, encouraging actionable outcomes.
  - TPs are actively involved in multiple IBI recommendation working groups, ensuring practitioner perspectives shape future policy.

SL encouraged input from other TPs on the call and welcomed any follow-up questions.

10. **SWPBMG: (Speaker: EC)**

The virtual meeting was held in January 2024, with strong attendance from across the region. The

session included business updates, educational presentations, and updates from collaborative PBM initiatives.

Key Updates

- **PANDA Trial – Maternal Anaemia:**
    - The PANDA trial remains **open for recruitment**, focusing on managing anaemia in pregnancy. The group reviewed ongoing participation and engagement.
- **QS138 Quality Insights Report:**
    - Presentation delivered by ST.
    - The Southwest region was the second highest in report completion rates—commended for strong performance behind the pilot region.
- **UK Cell Salvage Action Group:**
    - A new chair, Craig Carroll (Salford**)**, has been appointed.
    - Focus areas include:
        - National minimal data **set** for cell salvage (initiated through the SW PBM group and supported by OP).
        - Proposed national reporting via RTC chairs — currently under discussion due to lack of administrative support.
- **Cell Salvage Patient Education Project:**
    - EC and NHSBT PBMP are leading the development of a Google Health video series.
    - Designed to explain the importance of cell salvage to patients and support the consent process.
    - Accompanied by updated PILs and newly approved fact sheets, all now available on the JPAC website.
- **Upcoming Cell Salvage Webinar:**
    - A practical, region-focused session is in planning in SW.
    - Topics will include:
        - Clinical use
        - Incident (SHOT) reporting
        - Data collection practices
        - Best practices and implementation strategies

Educational Presentations

- **Rate and Change Implications – Dr. Gupta (Gloucester):**
  Explored whether analyser changes in blood results led to over-transfusion. Well-received and clinically relevant.
- **Quality Control in Cell Salvage – Catherine (NBT):**
  Audited QC techniques used on machines, discussing the correlation between poor samples, low QC results, surgery type, and machine performance.
- **Quantifying Blood Loss – Dr Issy Gardner:**
  Addressed the challenges of estimating blood loss during cell salvage.
    - Noted as a key issue for clinicians.

- Issy is set to present further findings at a national conference, with an update expected at the next PBM group meeting.

Upcoming Meetings

- **Informal Virtual Meeting – June 2024:**
  - No fixed agenda
  - Opportunity for networking, discussing challenges, and sharing good practices
- **Face-to-Face Meeting – September 2024:**
  - Agenda already in development
  - Will feature multiple educational sessions and peer collaboration

11. Education/objectives Update

- **Launch of the Regional Education Working Group**
  - SW confirmed the launch of a new Education Working Group for the Peninsula region, following a recommendation from the NBTC. Until now, the Peninsula was one of the few regions without a dedicated subgroup.
  - She formed the group alongside ST and Angharad (clinician). A few colleagues in Bristol also expressed interest. She invited additional members from across the region, aiming to include clinicians, transfusion practitioners (TPs), and scientists to ensure broad professional representation.
- **Group Aims and Priorities**

  The group will:

  - Deliver 1–2 regional webinars annually as part of the NBTC national education programme.
  - Develop and support education and training initiatives within the region.
  - Act as a collaborative platform to address regional learning needs and share best practices.
- **Upcoming Webinar – September 10, 2024 (Provisional Date)**

  The group has selected the topic "Special Components and Special Requirements" for their 2024 webinar, based on a fixed NBTC topic list. The team is currently confirming speakers.

Planned content includes:

  - Current practice overview.
  - Review of blood component basics and special requirement scenarios.
  - A presentation from Shruthi and her team on managing unmet special requirements, especially from a SHOT (Serious Hazards of Transfusion) perspective.
- **SPR (Specialist Registrar) Transfusion Rotation:**
  - SW announced that from Spring 2025, Specialist Registrars will begin a 2-month transfusion-focused rotation at Derriford Hospital. Although funding became available in August 2024, a shortage of eligible trainees delayed the first placement.
- **Review of Educational Resources**
  - SW plans to review current online transfusion education resources to identify which are useful and relevant. She encouraged group members to suggest ways to promote and use online content more effectively across the region.

She also proposed using the RTC website to:

- Post updates from the Education Working Group.
- Share webinar links, educational materials, and recommended resources for regional training.

- **Integration with RTC Education**
  - The group will support education sessions at RTC meetings, contributing to wider knowledge-sharing and skill development.
- **Call for Participation**
  - SW encouraged anyone interested in supporting education in transfusion to join the group by contacting herself or ST.

12. IBI Gap analysis:

- **RDUH Approach to IBI:**
  JD provided an update on the ongoing work related to transfusion safety and improvement within the Trust, aligned with the Improving Blood Transfusion Initiative (IBI).

IBI Report and Recommendations

- **Aim:** To ensure transparency across the Trust regarding the IBI recommendations, identify those relevant to the organisation, assess current compliance levels, and develop a realistic and actionable compliance plan.
- **Actions Taken:**
  JD presented a spreadsheet template created by RDUH, designed to assess compliance and track progress. Key elements of the spreadsheet included:
  - Current compliance status
  - Responsible individuals or teams
  - Definitions of success and how it would be measured
  - Identified areas for improvement

  JD noted that while the Trust has robust incident reporting, there is a need to strengthen near-miss reporting. The staff survey and SHOT report highlighted gaps in safety culture, reinforcing this concern.

  An example was provided from a consultant hepatologist who took proactive steps to improve compliance with one of the recommendations.

- **Next Steps:** Once the compliance spreadsheet was completed, it was submitted to the Clinical Effectiveness Committee, which approved the accompanying action plan. Action items were then uploaded to the incident reporting system (Datix), along with designated timelines and responsible personnel. These actions were made visible across the Trust to enhance transparency and accountability.

  It was also identified that enhancements were needed within the EPIC EPR (Electronic Patient Record) system to support best practices. As a result, development tickets were raised.

- **Development Requests in EPIC:**
  - **Improvement in Blood Component Administration**
    Status: Amber – Work in progress
  - **Transfusion Registry Dashboard for Monitoring & Audit**
    Status: Good progress

- **Development of BPAM and MAR for Traceability and Safe Practice**
  Status: In progress

- **Overall Outcome:**
  JD remarked that the IBI initiative served as a valuable platform—"a soapbox"—to re-emphasise the importance of transfusion safety. It helped bring the issue back to the forefront and enabled engagement with key bodies, such as the Clinical Effectiveness Committee. As a result, blood transfusion risks gained greater visibility and priority.

However, JD acknowledged that not all issues have been resolved and that several areas of development remain pending.

Q&A:

PV: *Why use the transfusion dashboard when the Trust already uses Blood Track?*
JD Response:
While Blood Track is used primarily for safety scanning, the transfusion dashboard in EPIC offers a more comprehensive view of patient information—such as haemoglobin levels, consent documentation, and overall clinical condition. The dashboard also automatically updates, enabling monthly or quarterly reviews without manual data handling. EPIC provides a broader and more integrated data view than BloodTrack.

OP: *Who is responsible for driving the recommendations forward? Is it the lab, Clinical Effectiveness Committee, or another group?*
JD Response:
The initiative was initially led by the transfusion team, who assessed compliance from their perspective and populated the spreadsheet. It was then escalated through governance, with input from relevant teams such as Hepatology and Haemophilia. The Clinical Effectiveness Committee subsequently reviewed and approved the action plan to be taken forward.

13. Amber Alert Update (Speaker: OP)

OP provided an update on the current status and local response to the national Amber Alert related to red cell supply, following information shared at the National Blood Transfusion Committee (NBTC) meeting held in March.

- The NBTC had originally forecasted an exit from the Amber Alert status by May 2025, but this has now been pushed back to June.
- He emphasised that ongoing efforts are underway nationally to improve resilience in the red cell supply chain.
- In response to earlier discussion around whether "Amber is the new Green", he acknowledged the uncertainty but shared practical measures that Cornwall has implemented during the alert:
  - Reduction in blood stock at satellite fridge locations as a local strategy.
  - For example, in certain locations, stock of O Negative blood units was reduced from 2 to 1.
  - This measure has helped lower overall stockholding across the Trust.
- OP noted that these changes, initially introduced in response to the Amber Alert, are now being considered for permanent implementation, even after the alert status is lifted.

14. AOB: (Speaker OP)

1. **Communications from NHSBT with regards to the funding**; no longer will be able to use the external venues: preferable venues: Exeter and Taunton. RTC will seek appropriate venue for face-to-face meetings, but virtual meetings may be needed in interim
2. **Audit proposal**: OP mentioned about the TACO audit proposal and asked ST if there have been enough volunteers for the data collection for the audit tool. ST responded that the number of volunteers is not enough to move forward to understand the feedback on the HTC chairs report and audit demands. We need more medics and haematologist to come forward.
3. **RTC Budget:** OP mentioned that we have a small surplus budget to publicise educational courses and events and can submit an application for a contribution towards expenses. Resources might grow as we are not spending money on venues.

15. Next meeting date: 26th November 2025

Action Log:

S. No	Actions	Actioner(s)	Status	Notes
1	QS 138 to be uploaded in the model hospital	ST	WIP	Waiting for the feedback
2	ST to raise the query to Ann Davidson about the feedback reprovision of a PIL to cover transfusion in times of severe shortages	ST	WIP	
3	Volunteer on joining as a Patient Representative in joining RTC. One more volunteer needed	All		
4	ST to add folder in the SWTP SharePoint for sharing the policies (e.g. TXA) across the trust	ST	Done	
5	OP to revisit the conversation with BD about integrating patient blood management data into Model Hospital dashboards.	OP		
6	ST agreed and offered to follow up with Louise from the Transfusion Transformation Team for the updates from their side	ST		
6	IS to add the point of how the labs are recording escalating capacity issues and challenges in the TLM agenda & consider adding to next HTC Chairs survey.	IS/OP		
7	OP to send TL summary of the comments on the Chairs report for the NHSE working group	OP		
8	Volunteers for the audit proposal: Medic and haematologists	All		

Short Forms in this document:

Abbreviation	Full form
TXA	Tranexamic Acid
DP	Dried Plasma
SPD	Spray Dried Plasma
PIL	Patient Information Leaflet
ALB	Arms Length Review
SHOT	Serious Hazards of Transfusion