EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Thursday 30th January 2025, 10:00am – 13:00pm via Microsoft Teams

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
Mohammed Rashid **MR**	Customer Services Manager	NHSBT
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
Rebecca Smith **RSm**	TP	Ipswich
Michaela Rackley **MRa**	Customer Services Manager	NHSBT
Julie Jackson **JJ**	TP / TP Chair	James Paget Hospital
Suzanne Docherty **SD**	Consultant Haematologist	Norfolk & Norwich
Maria O'Connell **MOC**	TP	Basildon
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
Jane Tidman **JT**	TLM	Lister
Donna Beckford-Smith **DBS**	TP	Watford
Katarzyna Janse Van Rensburg **KJVR**	TP	Peterborough Hospital
Sebastian Ignacak **SI**	TP	Colchester
Dipika Solanki **DS**	TP	Watford
Sarah Clarke **SC**	TP	Ipswich
Helen Dakers-Black **HDB**	TP	Addenbrooke's
Isabel Lentell **IL**	Consultant Haematologist	West Suffolk
Mireille Connolly **MC**	TLM	West Suffolk
Megan Lawn **ML**	TP	Royal Papworth
Kumarani Akurugoda **AK**	TP	Luton & Dunstable
Justin Harrison **JH**	Consultant Haematologist	Watford
Caroline Lowe **CL**	TP	Milton Keynes
Shehan Palihavadana **SP**	TLM	Peterborough
Katherine Philpott **KP**	TLM / TADG Chair	Addenbrooke's
Alison Rudd **AR**	TP	Norfolk & Norwich
Dino Maw **DM**	Consultant Haematologist	James Paget
Khuram Shahzah **KS**	TLM	Luton & Dunstable
Karen Baylis **KB**	TP	Lister
Danielle Fisher **DF**	TP	Bedford
Sewa Joacquim-Runchi **SJR**	TLM	Milton Keynes

Apologies: Eleanor Byworth, Stephen Cole, Luke Groves, Emma Hall, Angelo Giubileo

1. **Welcome**
   LM welcomed everyone to the meeting.

2. **RTC Meeting Minutes**
   Minutes from September 2024 agreed as correct. Action plan will be amended by **CN** according to todays meeting. **LM** agreed for these to be uploaded to the website.

Actions from previous meeting:

No	Action	Responsibility	Status/due date
1	Review WBIT Tool	**TP Group**	February 2025 Meeting
2	Paeds and Major Haemorrhage Flowchart	**RTC**	Take to RTT
3	RTC Action Plan	**CN**	Ongoing – update after meeting and upload to website
4	Plan for East of England Education	**RTT**	Take to RTT
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 – Complete
7	Deliveries	**DF speak to MR**	Complete
8	Advise of cell salvage leads	**ALL advise CN**	Ongoing
9	Advise LM of any issues with having a patient representative	**ALL**	Ongoing
10	Review HTC reports and look at actions required	**LM / RTT**	On Agenda
11	Review NBTC guidance on amber alert and surgery	**ALL**	Complete
12	Advise LM if you find information that surgeries should be cancelled	**ALL**	Complete

3. **PBM Update**
   FS presented to the group.

RTC PBM update January 2015.pdf

- **LM** do you have a specific patient information leaflet for obstetrics and possible blood transfusion? **FS** no we don't have a specific leaflet but we have a dedicated webpage. **LM** we have a digital app that's being launched and I was asked to provide a leaflet. **CS** we have been asked for a leaflet on neonatal exchange. **FS** that's complex. I can take these comments back to the PBM team to see what is suggested. We may be able to add some information to web pages. **MR** do you think this is covered in the blood essential booklet? **CS** we are trying to develop something and have spent time seeing if any other information out there. I am happy to share this with once it's finished. **FS** I can put you in contact with the London PBMP as London region may have something.
- **TADG Group**
  - **KP** there has been an improvement in stocks over the last few weeks. A positive / A negative is on a downward trend due to focus being on other groups. A positive donors have been contacted.
  - There has been discussion at the Emergency Planning meeting about putting O positive on air ambulances. We've had discussions with MAGPAS and East Anglian Air Ambulance. They are not keen to go down that route. They would rather reduce units.
  - The O negative audit that **DF** was leading on, results are in and we are putting together mini reports for each hospital. These will be sent out to hospitals who provided enough data to give advice and support. Those who only submitted a few units will be acknowledged but won't receive a mini report. **MR** is it too late for data to be submitted? **DF** it is a bit late. Survey period was September, we closed data collection in

November. Reports show unusual utilisation of O negative. If we are observing unusual utilisation of O negative with more than 50% of all O negative going to non O negative patients nationally, there is a need following the publication of the reports to do it again. I think it would be more sensible for people to prepare to participate in the next round rather than extending this one. Interpretation of data would be difficult if we extend. **KP** highlights coming out of the this report will be where is O negative going? 45% went to O negative patients. In 2018 60 % went to O negative patients and in 2010 70% went to O negative patients. There is obviously change in practice. We are looking into why this is the case. 13% goes to emergency cases. Wastage is lower than what it was in 2018.

- **KP** the haemoglobinopathy genotyping programme. There was an email that came out about the number of rejected samples. This is due to NHS numbers not being on the sample or consent box not being ticked.
- **KP** albumin supplies have been unsteady. This will now be produced by Octapharma. 80% will be coming from them. The rest will come from smaller suppliers.
- **KP** the SABRE website is being updated.
- **KP** the National Shared Care Group have taken the East of England Shared Care Form and turned it into an electronic version. We can demonstrate this at the next TADG / TP meetings. It's not been verified but it is a nice piece of work.
- **KP** the TADG group have a couple of people interested in being Deputy Chairs. Negativity around staffing and recruitment issues. There have been freezes on recruitment and inexperienced locums are being used. UKAS was discussed, they are coming out to do inspections in parts. We discussed NHSBT pricing. There have been concerns about turn around times and reports from Colindale and have been advised to raise these with **MR**. **KP** we have a high number of new faces within the TADG group so will be doing some support work for new laboratory managers.
- **MM** our Trust have taken up the shared care form that Cambridgeshire and Peterborough area distributed so if we are developing another electronic one it may need to be called something different. **KP** please can I have a link please.

- **TP Group**
  JJ we are continuing with work already planned. We are planning our simulation day in June. We are waiting to see what audits are taking place. There are changes nationally including a project to develop a capacity plan for the TPs. **CS** is on the infected blood inquiry group. We are going to be co-ordinating audits nationally rather than regionally. **JJ** there are huge changes coming. Raising the profile of transfusion higher in Trust management eyes will bring changes. **LM** I think there will be a lot of changes with the IBI.

4. Customer Services Update

MR presented to the group.

Customer Service Updates RTC Jan 202!

- **JH** with regards to the Amber Alert, it's been going on since July 2024. We recently held a typing event at the hospital which was hugely attended. The response was still people are struggling to access appointments. Is there any idea of when this will end? **MR** decisions are made in line with the Government, when instructions come from higher up we will implement changes. **DF** it is considered an important issue. Many activities are ongoing. Moving fast with the O negative audit in the middle of a shortage was to understand the usage and give more meaningful recommendations to all parties involved to improve the situation. The position in Cambridge was to establish the Emergency Blood Management Group. With regards to typing events and then not being able to donate, we need to feed this back. How can we take advantage of this exercise? **FS** we have run some of these events and have fed this back too. I think it needs to come from the RTC. **DF** I have written before on behalf of the RTC. I think we need to escalate. If we have testing events then we need to have open appointments available to donate or mobile donation collection. **JJ** NHSBT are having fortnightly meetings with national TP / TADG meetings. Every meeting this issue is raised and I will raise again at Monday's meeting. The last time I asked about

donor sessions, the response was about the Brinxton site and another site. It doesn't help those who don't live in cities. **IL** I emailed **MR** about this, we had a request from our Chief Executive about whether a mobile unit could attend West Suffolk. It is this kind of initiative people are wanting to see happen. The next appointment near Bury St Edmunds is May 2025. **LM** I have also been asked this for Peterborough.

5. **Presentation – Simulation at West Suffolk Hospital**

IL presented to the group.

- **IL** I would like to take this opportunity to thank **GB / JH** and everyone involved in this simulation.
- **GB** the obstetric team are used to simulation. It becomes more realistic. They picked up on transferring of the patient. It was positive to see how porters and switchboard responded. Their initial code red is their emergency obstetric so they expect the obstetric team to turn up. They assess the patient and if it's a major haemorrhage, a second call goes out.
- **LM** for anyone who is not clinically on the floor, that was very realistic.
- **SD** that was terrific. We tend to do ours in a classroom environment. I am not sure we have done any in a clinical environment. **AR** the skills and drills used to be held on the unit but we don't have the space due to the number of patients. We also held drills that moved between departments including a paediatric who was moved to theatres.
- **SD** are you able to share the video?
- **IL** we need to check consent and permissions to share.
- **GB** we were able to share in this meeting but haven't got consent to share wider. We can go back to them to ask for permissions.
- **IL** this is a good video example.
- **LM** there is a way of asking for consent to share for training purposes and teaching.
- **KB** we are starting off with this. We are looking at what we are going to do. I have my first meeting set up but have no money to run these. It was really good to see how you've done this. Did you feed back to switchboard?
- **GB** yes we did and porters are also invited to the debrief. They didn't feel they needed to attend this one as all worked well.
- **JJ** our Obstetric Department are enrolled with prompt. We are unable to video as we don't have the resources. We try and involve the lab staff. I am struggling to get any other area other than maternity involved.
- **GB** the important part was getting clinical skills involved. After the CAS alert this became a must. It is finding someone in the department who is keen. We are fortunate that endoscopy, theatres and obstetrics have a joint audit day. That helps us run them as some theatres close down. In ED unless it is unsafe, the drill goes ahead as it could happen at any point in the day. In two weeks they are simulating a teenage stabbing due to the county line issues in our region. Someone is going to act as a teenager bleeding at the door. We had an obstetric case that went through ED. The more people learn, they share and want to get involved.
- **LM** hopefully we can get a regional video that can be shared.
- **JJ** there is a national video available on e-learning for health.
- **MR** how are you preparing the simulated packs? Occasionally we are asked to provide these but it is not something we do.
- **GB** we have a scribe in each area. A senior will note down the practice on the laboratory. If they say they are going to defrost FFP, its is noted but not done. I don't think we have ever run one that has gone as far as needing FFP. The packs are made by clinical skills lab using dye. Depending on the sample we are going to have available, if its cross matched labels are produced. Sometimes we test out peoples knowledge of O positive / negative. We might switch labels around.
- **CL** that was very interesting. I love that you've made a distinction between drills and simulation. We are good at doing simulation at Milton Keynes and have the support. We are attached to the Buckingham Medical School. We run yearly simulations on major haemorrhage, TACO and febrile allergic reactions with F1 /F2s. We do this over a 3 month period. We have also done some work in theatres but would like to do more drills.

- **JH** this work has evolved over a long period of time. We have tried different things. It has taken time. **LM** how long has it taken to get to where it is. **GB** about 3 years. **LM** please don't be discouraged, it takes a long time to get the buy in from other areas and staff. **GB** what we are doing is improving patient care and safety and that helps drive enthusiasm. **LM** it makes a massive difference.
- **LM** you said you were putting the call out again because you were moving the patient. Is that what you do? We are having a bit of an issue with porters and who calls. GB they put the call out once and communicate directly with the laboratory. Our numbers are on the algorithm. In this scenario they used the switchboard process to tell the laboratory. They could have rang the laboratory directly. The laboratory prioritise that line. The drill showed that the phone in theatres is on the other side of the wall. Information was being shouted so hands free phones have been purchased.
- **LM** I like your board. Can we have a photo to share?
- **LM** did you have any issues getting live calls through switchboard? **GB** the manager was happy. I always forewarn the laboratory manager, switchboard manager and consultant haematologist. The only thing we do is acknowledge if they want to call the resus team but tell them not to do it. **LM** that might be where our issue was.
- **GB** we also run them at the private hospital. I've been given an emergency number so out of hours major haemorrhage call from the private hospital comes in via our switchboard and the emergency number had moved on. When we did the drill we realised it was wrong.
- **LM** thank you so much to everyone involved for sharing this with us. If you are able to change permissions so we can share it with our teams, that would be beneficial.

6. Discussion – Stock Sharing

- **KP** I can share the national SLA.
  Blood stocks - Hospitals and Science - NHSBT
- **CN** will ask **EB** to share details on EPA stock sharing.

7. Audit – Platelet Re-Audit

LM this will be discussed at RTT and results shared at a later date.

8. Audit – FFP / Cryo

LM shared the previous documents used for comment. We would like to keep it similar so they are easier to compare.

- **IL** my feeling is that most centres now, especially with the regional pathway of care for TTP patients are not getting their plasma exchange anywhere except for example Addenbrooke's.
- **LM** would it be better doing a separate plasma exchange audit?
- **ML** if you are going to ask for primary diagnosis, it makes sense to keep the option of SDFFP on there to check its been used appropriately. I know some sites use SDFFP. I know at King's we used a lot of Octaplas for paediatrics.
- **DF** I agree and the indication includes people with clotting factor deficiencies if there is no alternative non human alternative. It depends on the focus of the audit.
- **MM** in terms of the coag screens columns, out products are based on ROTEM results rather than coag screen so we would have different parameters.
- **LM** I know other places have TEG / ROTEM. We may have to add a column.
- **LM** take out MBFFP and add a column (point of care coagulation testing, was that used?). You could leave out coagulation screen.
- **GB** we find it difficult to find out the grade of requester. **JJ** what value is knowing the grade? **LM** I would like to know who it is? **JJ** speciality rather than grade. **IL** I think that is more meaningful. You want to know the clinical team that is requesting it. **CL** could we have specialty rather than clinical area? **LM** if we kept clinical area and change grade to specialty requesting. I want to know where it is being given. Speciality will tell us where its being given outside of major haemorrhage.
- **SD** our renal patients have octaplas. **LM** lets leave it in**.**
- **LM** under coag screen we could have APTT / PT / was any point of care testing used.

- **SD** I think it should be PT APTT. INR is really strictly for warfarin treated patients.
- **JJ** f codes state INR as one of their reasons.
- **DF** the national indication codes reflect some adaptation with current practice. It is a pragmatic approach rather than scientific. If we ask coagulation screen test, it would be more sensible to ask what test. What test do you follow?
- **LM** add all 3 under pre and post screen.
- **JJ** can we add a questions whether the use was deemed appropriate or not?
- **LM** who completes these audits? **JJ** the TP for James Paget but could vary in Trusts**. GB** we have Junior Doctors involved in audit.
- **ES** if it's authorised by the Consultant Haematologist, shouldn't they make the decision that its appropriate use because at our site outside of major haemorrhage it has to go via a Consultant Haematologist on-call. We had a patient the other day who needed a needle biopsy who wasn't on any anti-coagulation, had an INR of 1.8 and they wanted before biopsy at 1.5. Haematologist authorised it.
- **IL** I think its valid to leave it in even if it is authorised by a Consultant Haematologist. Why not audit our practice also. That is a good example. We would advise its highly unlikely to lower the INR in this case but you've said the patient will miss their slot, may not get their biopsy so why do prevent that procedure going ahead.
- **LM** it may also highlight the need for training outside the transfusion / haematology teams for areas who are not as aware / up to date on current protocols.
- **MM** can I ask how many units you will be expecting to audit?
- **LM** what would be a reasonable amount?
- **JJ** suggested 40 over 3 months.
- **IL** we can discuss further at RTT.
- **LM** the cryo collection tool is pretty much the same as the FFP. We can make the same amendments.
- **LM** do we want to add peri-partum?
- **LM** I am not sure how many smaller hospitals will get.
- **MM** Royal Papworth is a high user with 770 a year.
- **JH** West Suffolk do 58 a year.
- **LM** we can discuss this at RTT. We may need to do something different for Royal Papworth, Addenbrooke's and Norfolk & Norwich.

9. HTC Updates

LM this was missed from September 2024 RTC. Points raised will be covered during 2025.

HTC Reports 26.09.2024.pdf

- If there are any combined protocols, flowcharts you would like to have, please advise **CN** and we can collate information.
- Points such as staffing will be noted at NBTC
- A presentation for discussion – major incident response (Addenbrooke's) as the trauma centre and a DGH for learning
- Trust should provide an impact report for the amber alert
- **GB** when we have huge documents are changed. Nothing is tracked and it takes a lot of time to review. It would be great in their quality control to know what has changed. **LM** do we want an executive summary? **GB** anything would be helpful.
- **LM** if you have a document that you have put together which has taken a long time, please share it. We can put information together and share. Also if you have a new project, we can put a call out for business cases.
- **JJ** Lise Estcourt is chairing most of the IBI working groups. I have asked if regular updates can sent out of what the working groups are doing. There is a lot happening nationally.

10. Any Other Business

- **CN** it was raised in HTC Chair Reports to vary the day of RTCs. 2025 meetings have been planned but we can look at this for 2026. **LM** can I have a show of hands if changing the day would make a difference? **CN** will send an email asking for suggestions.

Date of Next Meeting: 2025 dates have been circulated.

LM thank you for attending.

Actions:

No	Action	Responsibility	Status/due date
1	Publish RTC Minutes on Website	**CN**	ASAP
2	Update Action Plan and publish on Website	**CN**	ASAP
3	Discuss with PBM Team comments regarding leaflets	**FS**	ASAP
4	Share link of Cambridgeshire and Peterborough Shared Care Form	**MM to KP**	ASAP
5	Ask EB about EPA Stock sharing	**CN ask EB**	ASAP
6	Audits – take to RTT Make amendments	**RTT**	Ongoing
7	HTC Updates • Advise of any combined protocols / flowcharts wanted • Major Incident Response Presentation (Addenbrooke's and DGH) • Trust Impact Reports from Amber Alert • Executive Summary for document changes • Ask Lise Estcourt for updates from IBI working groups	**ALL** **? September RTC** **? September RTC** **LM to raise** **LM to raise**	
8	Emails RTC asking about days for meetings 2026	**CN**	Collate information before dates are booked for 2026

The link to the current patient leaflets is https://hospital.blood.co.uk/patient-services/patient-blood-management/patient-information-leaflets/ - the 'Having a Blood Transfusion' leaflet is currently under review and due out this year so I don't know what the new content will be yet, just so you are aware that main leaflet will change shortly.

Cell salvage leaflets can be found at https://www.transfusionguidelines.org/transfusion-practice/uk-cell-salvage-action-group/patient-factsheet these are also currently in a review process so the list may change regularly