London Transfusion Practitioner Group Meeting

Monday 9 September 2024 - Virtual Meeting
Confirmed Minutes

Chair:
Dipika Solanki **(DS)** (Imperial)

Deputy Chairs:
Pascal Winter **(PW)** (Barking, Havering & Redbridge)
James Davies **(JD)** (Kings)

Attendance:

Sarah Lennox **(SL)** (Royal National Orthopaedic)	Charlene Furtado **(CF) (**Guys & St. Thomas)
Charlie Little **(CL)** (HCA Laboratories)	Ann Minogue **(AM)** (Queens)
Rebecca Patel **(RP) (**Northwick Park)	Rachel Moss **(RM)** (GOSH)
Emily Carpenter **(EC)** (Kings College)	Abiola Adeniyi **(AA)** (Homerton)
Sarah Hammond **(SH) (**Barts Health)	Jamilla Koshoni **(JK)** (Whittington)
Nathalie Muller **(NM)** (Royal London)	Zsofia Takats **(ZT)** (Hillington)
Lipa Islam **(LI)** (UCLH)	Tim Williams **(TW)** (Kings College)
Tracy Johnston **(TJ)** (PBMP London)	Estelle-Maria Chambourd-Smith **(EMCS)**

Apologies: Selma Turkovic **(ST),** Sharon Harding **(SH)**, Wendy McSporran **(WM)** and Katie Pritchard (KP)

Minute Secretary: Nella Pignatelli (NHSBT).
Please contact nella.pignatelli@nhsbt.nhs.uk for any amendments.

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Meeting starts

1. Welcome and Introductions

DS welcomed everyone to the meeting. Introductions were made.

2. Minutes of the Last Meeting and Action Log

The minutes from last meeting on the 11th of June 2024 were accepted as a true record.

Outstanding actions:

		Responsibility	Status
1	BBTS TP Session	RM D/W JS	BBTS programme changed - closed
2	Venue for Meeting in June	ALL	Completed
3	Circulate PSIRF YouTube Video when available	TJ	Still pending
4	EPIC EPR Working Group	RM	There was a hospital Epic group, but the lead is currently off for a while. RM is co-chairing BBTS session on IT systems in transfusion she will suggest establishing a UK working group with oversight of all IT systems related to BT (LIMS, tracking and EPR). Pick up after BBTS
5	Risk Matrix Detectability	RM	RM forwarded the matrix that she was referring to, to WM has raised the matter at the meeting. - completed
6	Upload WBITs from 01.01.2024 using the following link: - WBIT RTC Regional Reporting Tool (snapsurveys.com) Last question (free text) tell us if you use electronic / paper based / hybrid system, what the issue is and what system you use.	All	

DS referred to actions above and asked the group for any updates.

- (3) **TJ** confirmed that the Patient Safety Incident Response Framework (PSIRF) video is still unavailable. **TJ** will be informed when it is available. **DS** asked if this action should be put on hold and **TJ** agreed.

- (5) **RM** brought up the need for a more cohesive IT systems approach to transfusion at a meeting with SHOT which was well received. An individual at the meeting stated to **RM** that the BSH guidelines on IT systems should be as much about the clinical side as it is about LIMS, to which everyone agreed. **RM** will be co-chairing the IT systems session at BBTS in a couple of weeks and will bring up this issue again. **RM** is hoping that the meeting with colleagues from Exeter will lead to some movement in this area, with aims to make it a national working group eventually. **RM** will keep TPs in the loop.

- (6) **DS**: emails were sent out to the WBIT Working Group but there was a low response rate. **DS** will elaborate further during the WBIT Working Group update later on in the meeting.

DS concluded that the actions have been covered and asked if there were any corrections. Condolences were also given for Angela, the NHSBT Administrator for London, who had sadly passed away. **DS** thanked Frances for temporarily covering the admin work for the group.

3. London TP Updates

3.1 London Platelet Action Group (LoPAG)

DS told the group that there are no updates from LoPAG, but there is a meeting tomorrow and DS will share any updates retrospectively to the group. **TW** informed the group that he is now deputy chair of LoPAG.

3.2 WBIT Working Group

DS reiterated that current members of WBIT Working Group were emailed but the response rate was low. **DS** asked the group if anyone would like to get involved with the WBIT Working Group. **DS** explained that the chair has stepped down and there were other issues and concerns which meant the work involving the IT server regarding WBIT had ended.
DS wants to restart the work, with tools such as the WBIT Audit Tool being examples of why such work is needed. The group have been happy with the use of the tool, with data kindly supplied by **TJ**. Members can make changes and amendments to the tool as they see fit. **TJ** told the group that an in-depth report from the June meeting had been produced. **DS** asked the group to email their interest in joining the WBIT Working Group and a date will be scheduled to review the data from the WBIT Audit Tool in depth. **DS** summarised by stating that there needs to be a greater understanding of what is going wrong at a base level when WBIT occurs.

3.3 British Blood Transfusion Society (BBTS)

RM informed the group of the upcoming BBTS event from the 17th till the 22nd of September 2024. The agenda for the event included a TP session, Margaret Kenwright awards and an IT session (chaired by **RM**). The event was not streamed online. **RM** mentioned that the BBTS TP group are looking for more people to join them.

3.4 Shared Care Working Group (SCWG)

TJ informed the group that there was a national meeting which gathered a lot of attention towards the group, including engagement from SPICE team and RCI. A business case was brought forward to make the Shared Care Working Group national, which was agreed.
The big Working Group will consist of two people per region – preferably one nurse and one person from a laboratory. The SCWG need to wait for the National Blood Transfusion Committee (NBTC) to agree, for the allocation of a Regional Transfusion Committee (RTC) admin, and which national group it would fit in. **TJ** stated it will fit in nicely with SCRIPT or the Transfusion 2024 Working Group and that it will also be under the heading of the National TP Network (NTPN) and the National Lab Manager (NLM) so there will be representatives from both. **TJ** reiterated that until the group hears back from NBTC, they are at a stalemate.

4. NHS Blood & Transplant (NHSBT) Updates

TJ referred to blood stock levels and informed the group that O positive and negative blood are in amber alert. Additionally, B negative, A positive and A negative blood groups are pre-amber alert until around late September 2024. Early October 2024 will be the next update on blood stock because although the rest of the stock levels look good, activity will restart around September. LIMS systems will be in place hopefully for those that were a part of the cyber-attack which must include time for training. A lot of background work is happening to encourage donations which are opening up more appointments too.

TJ stated that the NHSBT recommendations are to continue with the orders of the O groups, keep taking in substitutions and make sure EMBA protocols are up to date and in place.

TJ announces a few updates:

- Since the 1st of September, the Rad-sure labels have gone back to the old ones and tells the group to make sure all relevant signage within training is updated.
- There is a fire-risk in Basildon, so the centre is temporarily closed. **TJ** asks if this had affected anyone in the meeting as Basildon supplies the London region. **TJ** advised if this has caused any issues to contact your customer service team.
- Due to the amber alert, a quick reference guide was launched with PBM toolkits and advice available via QR codes.
- Irradiated Blood Components and Receiving Anti-D immunoglobulin in pregnancy booklets updated
- QS138 Nice Quality Standard Audit is due in October 2024 and Major Haemorrhage Audit due in Spring 2025.
- TJ suggests aligning NCA data collection so that it can be used for the QS138 Quality insights tool too.

JD stated that the group needed more support with using the QS138 Audit Tool. **TJ** suggests that the group should attend a face-to-face tutorial that her colleague will run.

4.1 QS138 Quality Insights Audit Tool

TJ led the discussion about QS138 by comparing the NHS Quality Insights Audit Tool that was created by the NHSBT to the National Comparative Audit of Blood Transfusion NICE 2024. **TJ** states that the National Audit looks through a national lens, categorising hospitals into Trusts whereas the Quality Insights Audit Tool provides insights into individual hospitals. **TJ** suggests that if you are doing the National Audit to collect additional information at the same time so there is an option to use the Quality Insights Audit Tool later. The NHS Quality Insights Audit Tool is NICE endorsed, a part of HQIG? and part of Transfusion Transformation 2024. All the hospitals in Wales and 18 in London have joined.

JD shares feedback gathered from a fort-nightly meeting and expresses that members are struggling in using the Quality Insights Audit Tool. **JD, DS** and **PW** decided the best course of action is to host a tutorial at the next fort-nightly meeting on how to use the tool, hosted by a colleague from the NHSBT.

CL shares that a colleague was interested in making Audits more real-time for HCA as appose to retrospective.

SL shares concerns that there is not enough time to do more than one audit especially for TPs that are part-time. **SL** concluded with **TJ** that it would be more manageable to do the Quality Insight Tool on years when the National Comparative Audit does not focus on QS138.

4.2 Rad-sure labels

DS shares that she was on the working group for the change to the new labels and it was not well received by many colleagues.
RM who was one of the stakeholders in the NHSBT working group for bringing back Rad-sure labels tells the group that an evaluation was done, and they felt that from a clinical point of view Rad-sure labels were superior.

5. National Transfusion Practitioner Network (NTPN) updates

5.1 Transfusion Transformation

DS had fed back to the NTPN in a face-to-face meeting in June about the success of TP2024 "A Day in a life as an International TP". A lot of feedback was received and overall was a success. **DS** and other London TPs took part in the working group that led to the revamp of Transfusion 2024 to Transfusion Transformation.

6. International Society of Blood Transfusion (ISBT) updates

RM informed the group that she is now temporarily chair of the TP group for the ISBT until November 2024 when there will be a vote for chair. **RM** intends on staying on as chair.
The ISBT wanted to increase membership and had its first ever ISBT TP group supported by ISBT members in Barcelona. The group had a fantastic turn out and they hope to do something similar in Milan around the start of June 2025. RM lets the group know that if they are interested - or know someone who would be interested - in seeing the outside of the UK and working at an international level, to join the ISBT and the Clinical Transfusion Working Party. RM prefaced that travel costs would not be paid for and offered an alternative to help without out-of-pocket expenses, which included helping with work streams and just being a part of the process.

ISBT's 'Transfusion Practitioners across the world Podcast' also available via the following link: https://www.isbtweb.org/communities/transfusion-practitioners/transfusion-practitioners-podcast.html

7. Sharing and Caring

7.1 Recruitment events

JD introduced **EMCS** from NHSBT who has joined to answer some queries the TP group had about donations. **EMCS** introduced herself as the Senior Community Engagement Coordinator, with her designated areas being the London Borough of Newham, Hackney and Waltham Forest. **EMCS** hosts 'What's your blood type' events or general recruitment events, sensitising the public to the importance of blood donation. **EMCS** wants to host more of these events in different trusts, with an emphasis on the North East area such as Barts and Whipps Cross Hospital. **SH** told **EMCS** that she will be in contact as this is her area. **EMCS** asked if anyone else in the group would like to introduce these events in different areas and a few other TPs offered their contact information.

RP told the group that Blood Donation and Organ Donation are going to team up for Organ Donation Week. This involves volunteers having their finger pricked by staff, informing the individual of their blood group and telling them how important it is to sign up to both organ donation and to donating blood. At times, **EMCS** can also book volunteers directly on the day for a blood donation appointment. **EMCS** stated that as well as registration, it allows for appointments to be booked that are convenient in terms of location. The mobile session unit has limited appointments available so main donor centers are used and the nearest location to the individual's work or home is prioritised.

JD told the group that various sites within the King's College Hospital NHS Foundation Trust have seen a lot of engagement with the recruitment events, with 250 people registering as a blood donor at the Denmark Hill Campus and 70 at the Princess Royal University Hospital (PRUH) Site. **RP** asked if it is possible for **EMCS** to organise recruitment events in areas with a low footfall and **EMCS** stated that it is welcomed, as even 1 more individual signing up is a success. **EMCS** continued to explain that as well as recruitment, this is an opportunity to educate the public and challenge some misconceptions surrounding who can and cannot donate.

7.2 Infected Blood Inquiry (IBI)

SL asked the group if they had any recommendations on handling IBI as a trust wide issue. **RM** let the group know that there is a chance this will trigger a national response as there is a lack of direction on implementing IBI recommendations, and that Tranexamic Acid is the only recommendation with measurable progress. **SL** highlighted that as they are only recommendations, they will not apply to all hospitals in the same way and continued to explain that monitoring tranexamic acid is not new, but they are now asking for onwards compliance reporting without defining where that reporting will be. **RM** mentioned that there was a change in Government shortly after the report came out and that hopefully someone from NHS England will provide some direction soon. **RM** stated that there are pressures for the Central Alerting System (CAS Alert) to be completed as it has a deadline even though out of the two, IBI should be prioritised. **EC** added that transfusion transformation groups are going to try and support the IBI, but it will most likely not be fast enough to fully support what our trusts need. **EC** will bring up this issue at the next National Transfusion Practitioners Network meeting.

7.3 Paediatric TACO Checklist

RM told the group that although there is no TACO Checklist for Paediatrics and Neonatal and that her colleague who is leading on the BSH guidelines will most likely be responsible for creating a national TACO Checklist for Paediatrics. **RM** stated that they are looking at a way for EPIC to pick up TACO at risk children at the point of prescribing rather than add an entirely new step involving the TACO Checklist and that the checklist for Paediatrics will be adapted from the adult TACO checklist to exclude sections such as co-morbidities – which most children do not experience.

KM expressed that in her trust it was a concern that many patients were flagged as high risk to the point where people stopped relying on it fully and so her trust introduced 'moderate risk' for patients who have just had fluid who usually flag as high risk. **KM** stated that this in turn has made the TACO checklist more usable and people pay more attention to it. **TJ** reminded the group that there is a shared point folder for TACO and that it would be great to share ideas and information there that could benefit other hospitals and Trusts.

8. Business Continuity Planning

Presentation delivered by **JD**.

Q&A followed shortly after with lots of questions and examples given from various TPs about Business Continuity.

9. Actions

	Action	Responsibility	Status
1	Discuss the need for a more cohesive IT systems approach to transfusion at BBTS	RM	Pending
2	Organise a meeting to review the data from the WBIT Audit Tool in depth	DS/TJ	Pending
3	Reach out to Estelle and organise 'What's your blood type' events in North-West London / reach out to Estelle's colleagues to organise these events around London	SH/ALL	Pending
4	Make sure all relevant rad-sure signage within training is updated	ALL	Pending
5	Group should organise and attend a face-to-face tutorial or online tutorial on using the QS138 Audit Tool	ALL	Pending
6	Upload WBITs from 01.01.2024 using the following link: - WBIT RTC Regional Reporting Tool (snapsurveys.com) Last question (free text) tell us if you use electronic / paper based / hybrid system, what the issue is and what system you use.	ALL	Pending
	Circulate PSIRF YouTube Video when available	TJ	On Hold

Date of Next Meeting: 5th December 2024