SYD – Kim Stewart

It's my great pleasure now to introduce Miss Kim Stewart, Director of the Office of the Chief Medical Officer of New South Wales Ministry of Health. Kim is the, has had a long career in the Ministry. She's worked in Health as a nurse. She's also had policy positions in Aboriginal Health Information Management and Health Protection. She tells me though that blood is her greatest passion. Kim.

Thank you Leigh. Thank you. Thank you for inviting me to speak here today. I am going to talk about the action plan that we're trying to implement in New South Wales in response to the national wastage reduction strategy. Here we go.

So the context for New South Wales, we've got mixed performance across our public and private sector, ranging from best practice we've got some of the 1% wastage sites but we've also got some very high wastage sites. We've had to (1.00) budgets for the public sector for the last eight years or so as we heard earlier today but we have central payment system for products that are used in the private sector. This comes along with the opportunity for transparency and understanding of wastage. That has accompanied the implementation of BloodNet and particularly the Fate module. And also we've had very enthusiastic engagement from the CEC, Clinical Excellence Commission, our local health districts, private providers and also the Blood Service who is a key partner with us in trying to address our wastage problem here.

So just talking about money. Based on the incomplete data that we have for 2012/13, you can see we've got in excess of six million dollars out of an approximate $130m, that was spent in New South Wales on blood in that financial year. So 3.3 million red cells, 1.8 million platelets and 1.1 million FFP. I was very pleased to see that we're less than a third of the national wastage, given that we're approximately a third of the national population.

So just some of the data, some of the final plots that we've been using to talk to our facilities about our data. So this is just for the principle referral hospitals. You can see that there's quite a bit of variability there in practice, regardless of the volume of usage. So we've got some significant outlier sites. We've got some that, the red line by the way is the shadow target that we're working with at the moment that's the likely target that will be introduced into our budgeting arrangements from next financial year. So we've got some very good performers, which are better than three standard deviations outside average use, as well as some significant outliers and that pattern is repeated for platelets, which has even more variability as you can see. So generally, below the shadow wastage target but one that's right on it and all over the place in terms of performance. And the same goes for FFP, so quite a lot of work to do there.

So in terms of our action plan, cross-sectoral engagement, so we've got a working group. It's lead by the Clinical Excellence Commission, chaired by Amanda Thomson, whose here today, who is the medical advisor to the Blood Watch program. We've got scientists and haematologists from the public sector, the private sector and the Blood Service, as well as the Blood Service Operations Manager, participating in that group. We've been looking at the data together

and looking at contributing factors and we surveyed all of our facilities, presented them with their wastage data and then asked them to come back to us with what they believe were the contributing factors for wastage and what they thought some of the solutions might be.

In terms of the issues that have been identified out of that process, we're always looking for more data, I think everybody is in this sector. One of the things that has been identified is there's almost too many opportunities to explain wastage in BloodNet and perhaps it's not necessarily as meaningful as we would like it to be, the data that we get from the Fate Module.

Integration of BloodNet and the Laboratory Information Systems is a very important determinant of the quality of the data. And it's also an issue in terms of data entry burden. So if clinicians have to enter the data twice, there's perhaps more of an incentive to just pick the first reason on the list or not necessarily to enter the data.

In terms of the things that we've been thinking about in relation to strategies to reduce blood. Looking at the size of the facilities and therefore their case mix. Their distance from the Blood Service. In terms of what they have to have in inventory but also what the delivery schedule might be like. Policy and the extent to which it's standardised and the technologies that are available to us to assist in that process.

In terms of what we got out of the survey of our AHPs, I'd like to acknowledge the work that Trevor Cobain from New South Wales Health Pathology has done in pulling all of these things together. So I'm really presenting Trevor's work to you here today.

Existing strategies which are probably familiar to many of you and which we've heard a little bit about this morning already, that we'll be looking to extend or expand are about hub and spoke ordering models and using those hub and spoke arrangements to look at how we can rotate stock and how the larger facilities can support smaller facilities.

Active transfusion committees. We've heard quite a bit about that this morning and about the value of those committees in reviewing data. Also cold chain and fridge policies. There have been a lot of issues identified with the performance of fridges and cold chain maintenance in our smaller facilities but also with the end units in the hospital. So in the theatres and in some of the units that are remote from the blood bank to which the blood's distributed.

Policies. So issues policies. One unit has a time issue except if there's an emergency. Also something that Peter just talked about, visible stock expiry schedules and scientist review of issues. And then delivery schedule, so inventory levels or frequency of delivery and the capacity to reduce stock levels.

Some additional existing strategies. Patient specific orders. Using product for another patient after an agreed time. Looking at how the platelets are used. So first in, first out. And also reviewing the locations where platelets are stored.

FFP. Using thawed product for another patient. There's recently been a new policy guidance from one of the professional societies on that, of thawing two

units only at a time. Storage and packing to minimise breakage that we've heard about.

Warfarin reversal guidelines, so some of the clinical guidelines as well. So I guess nothing particularly new but trying to look at how we can do things more systematically.

In terms of some of the solutions that are under consideration. Trying to look at much more proactive inventory management and policy across the state and we'll be working closely with Pathology North, the Blood Service and our colleagues in the private sector in that regard. Strengthening the clinical and blood bank governance arrangements. And also using the data as best we can and looking at enhancing our data linking capacity as well.

Thank you.