National Blood Transfusion Committee

Minutes of the Meeting of
National Transfusion Practitioner Network Working Group
of the NBTC

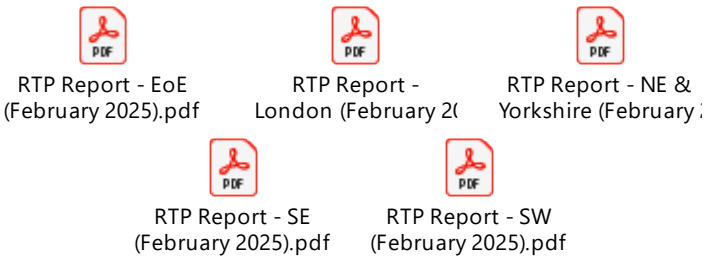
Thursday 13th February 2025
10:00am – 11:30am
via MS Teams

Present (32)		
Aimi Baird	AB	Chair - Advanced Transfusion Practitioner, Integrated Laboratory Medicine, The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Emily Carpenter	EC	Transfusion Practitioner, Kings College Hospital NHS Foundation Trust
Samantha Carrington	SC	Transfusion Practitioner, University Hospitals Southampton NHS Foundation Trust
James Davies	JD	Transfusion Practitioner, Kings College Hospital NHS Foundation Trust
Egle Gallo	EG	Transfusion Practitioner, University Hospitals Bristol & Weston
Ant Jackson	AJ	Transfusion Practitioner, United Lincolnshire Hospitals NHS Trust
Julie Jackson	JJ	Transfusion Practitioner, James Paget University Hospital Foundation Trust, Norfolk
Stuart Lord	SL	Lead Transfusion Practitioner, Gloucestershire Hospitals NHS Foundation Trust
Rachel Moss	RM	Senior Transfusion Practitioner, Great Ormond Street Hospital for Children NHS Foundation Trust
Jordan Reed	JR	Transfusion Practitioner, York and Scarborough Teaching Hospitals NHS Foundation Trust
Emily Rich	ER	Transfusion Practitioner, North West Anglia – Hinchingbrooke and Peterborough
Jonathan Ricks	JR	Lead Transfusion Practitioner, University Hospitals Southampton NHS Foundation Trust
Dipika Solanki	DS	Trust Transfusion Practitioner Team, Imperial College Healthcare NHS Trust
Rebecca Spiers	RS	Transfusion Practitioner, Warrington & Halton Teaching Hospitals, NHS Foundation Trust
Pascal Winter	PW	Transfusion Practitioner, Barking, Havering and Redbridge University Hospitals NHS Trust
Wendy McSporran	WM	Advanced Transfusion Practitioner, The Royal Marsden NHS Trust
Jennifer Rock	JRo	T2024 Education Lead, NHSBT
Jane Murphy	JM	NTPN Administrator, NHSBT (Minutes)
Nella Pignatelli	NP	NTPN Administrator, NHSBT
Lorraine Boylan	LB	Pre-Assessment Lead, Buckinghamshire Healthcare NHS Trust
Mike Dawe	MD	Haemovigilance Unit Manager, MHRA

Anwen Davies	AD	Patient Blood Management Practitioner South East, NHS Blood and Transplant
Paul Davies	PD	Senior Clinical Audit Facilitator, National Comparative Audit of Blood Transfusion, NHS Blood and Transplant
John Grant-Casey	JGC	Programme Manager, National Comparative Audit of Blood Transfusion, NHS Blood and Transplant
Caryn Hughes	CH	SHOT Operations Manager
Louise Jeffries	LJ	Peninsula Pathology Workforce Lead, University Hospitals Plymouth NHS Trust
Zona Kelly	ZK	Senior Haemovigilance Practitioner, Belfast Health and Social Care Trust
Anna Mamwell	AM	Patient & Public Involvement Lead, NHS Blood and Transplant
Katherine Maynard	KMa	Transfusion Practitioner, Croydon Health Services NHS Trust
Karen Mead	KM	Chair BBTS TP SIG, Specialist Practitioner of Transfusion, North Bristol NHS Trust
Chris Robbie	CR	Senior Haemovigilance Specialist, MHRA
Julie Staves	JS	Chair TLM group, Transfusion Laboratory Manager, John Radcliffe Hospital
Apologies (4)		
Mike Desborough	MDe	Transfusion Research Network Lead, Consultant Haematologist, Oxford University Hospitals NHS Foundation Trust
Tracy Johnston	TJ	Patient Blood Management Practitioner, Patient Blood Management NHSBT
Denise McKeown	DM	Regional Haemovigilance Co-ordinator/ Manager of BHSCT Haemovigilance Team
Pedro Valle Vallines	PV	Deputy Chair BBTS TP SIG, Lead Transfusion Practitioner, Royal Cornwall Hospitals NHS Trust

Actions				
Item no	**Meeting Date**	**Action**	**Owner**	**Status**
2	13/02/2025	Send biographies to either Nella Pignatelli or Jane Murphy, NTPN Administrators	Core Members	Ongoing
2	13/02/2025	AM to send round draft ToR to group for comment/feedback	AB	Completed
2	13/02/2025	Agree ToR at next meeting, 19th June 2025	ALL	New
3	13/02/2025	To get feedback from each region via the RTC Administrators to see what platform for communications is currently being used	NP / JM	Completed

Minutes		
1	**Welcome & Apologies – Aimi Baird**	**Actions**
	AB welcomed the group along and all the new members, thanking everyone for their support so far with the NTPN. Apologies are listed above. Group members gave a brief introduction. This meeting is the first of the new structure.	
2	**Minutes and Actions from previous meeting, 3rd December 2024**	
	Minutes These were circulated in advance of today's meeting. AB gave a brief overview to the group. Minutes agreed as a true and accurate record. **Actions** <u>Biographies of Core Group</u> Thank you to those members of the core group who have sent their biographies for the website. Having this information available on the website is useful for people who wish to get in touch or who are working on similar projects. **Action: Please send any other biographies to either Nella Pignatelli or Jane Murphy, NTPN Administrators.** <u>Terms of Reference</u> AB currently working on and will send draft copy around to group for comment / feedback. Plan to agree at next meeting. **Action: AB to send round draft ToR to group for comment/feedback.** **Action: Agree ToR at next meeting, 19th June 2025.** All other actions completed or part of the agenda.	**Core Members** **AB** **ALL**
3	**RTP Matters**	
	AB reviewed all reports received. Key outcomes: • Usual issues: staffing / workload. Work going on at national levels in response to both Transfusion Transformation and IBI in terms of workforce and capacity planning. • Audits / benchmarking: Request for national audits to have more TP involvement around design and planning. • QS138 Insight Tool: Request if this tool be expanded / have potential to be used for other audits. • Blood Stocks: Concern for amber alert fatigue. Laboratories are reducing stock holdings. However, stock holdings are coming with shorter dates which does not help with wastage. Have received recent confirmation that stock levels are improving. • SHOT Recommendations: Some regions highlighted the barriers in implementing the recommendations. This has been raised with the SHOT rep on the group. • IBI Recommendations: Coming up to anniversary of report and concern not received any communications. A lot of work is happening at a national level and assured feedback will come.	

	• Communications: Some regions feel disjointed with communications across their region. Different types of platforms used for direct access i.e. WhatsApp, SharePoint, Future NHS. **Action: NP / JM to get feedback from each region via the RTC Administrators to see what is currently being used.** More information to be provided on the above within the agenda items.	**NP / JM**
	Please see the following submitted RTP reports for full updates:  RTP Report - EoE (February 2025).pdf RTP Report - London (February 2(RTP Report - NE & Yorkshire (February RTP Report - SE (February 2025).pdf RTP Report - SW (February 2025).pdf	
4	**Education**	
	Education leads are Jordan Reed and Emily Rich. JR provided an update. <u>TP Study Day</u> Meeting 14/02/2025 to start the planning of the event. Anyone who wishes to join the meeting or become part of this working group, please get in touch with JR / ER. <u>TP New Starter Induction Workbook</u> Working with Jen Rock and Jill Caulfield at NHSBT to establish a workbook for new starter TPs to provide support, knowledge, competencies and signposting for the first 2 years in the role. In discussion with professional bodies for their endorsement and to ensure that the workbook meets the required standard for TPs of all backgrounds and experience. Using the platform Future NHS to collaborate ideas / examples. Received examples of Trust new starter competencies and workbooks. Looking at developing a standard set of competencies / guides that can be implemented locally as required. Anyone wishing to be involved, please get in touch with either JR / ER.	
5	**Audit / Survey**	
	Leads are Stuart Lord and Julie Jackson. Stuart Lord provided an update. Plan is to do an audit benchmarking survey. Purpose of the survey is to get a baseline about the audit activity in each region. Survey comprises of four questions and will be sent to the lead TP for each region to complete. The data will be used to collaborate with the NCA Team and used as a guide where the gaps are. Also, data will be presented at the next NTPN meeting and summary posted on the NTPN webpage. Group agreed for survey to be sent out.	
6	**BSQR**	
	Rebecca Spiers is the lead and provided an update.	

	Most recent is the SHOT anti-D safety alert which came out in December. RS is currently halfway through the gap analysis and wanted to highlight it is taking more time than expected to complete.	
7	**IT Vein-to-Vein Systems**	
	Leads are James Davies and Pascal Winters. James Davies provided an update. Discussion amongst TPs has highlighted that when hospitals have large EPR systems installed, they have to start from scratch with the clinical build for transfusion modules even though all hospitals will want/need the same basic requirements from the EPR in terms of sample labelling and administration. This burden often falls on the TP who is then faced with a huge workload designing an unknown system from scratch. Suppliers are often not very forthcoming with information about what their system can/cannot do for transfusion workflows – often two hospitals with the same system may have different features/options available and not be aware of alternative options. There are existing guidelines for LIMS suppliers and order comms (BSH, SCRIPT etc), but similar guidelines do not exist for the clinical processes. We want to create such guidelines and get them ratified and published by a recognised body (e.g. BSH, SHOT/SCRIPT etc).	
8	**Transfusion 2024 – Transfusion Transformation**	
	Jen Rock provided update. <u>Transfusion Transformation</u> Strategy document has been written by NHSBT and has been sent to NHSE for review. Release is going to be delayed due to IBI and what it going to be recommended going forward. <u>Framework</u> JRo thanked the group along with the working / steering groups for being so supportive. Framework consultant is now in post. Plan for the next 2 months: • Use of Padlet to start looking at what framework and resources people are using as we are moving away from ma competency framework to a professional development framework. • Engagement workshops to be held. Four, 1-hour sessions. Each session will be the same with a bit of variance with who is presenting. Once all the information has been gathered, the writing group will start to produce the first draft of the framework. The plan is to send out snapshots for review rather than sending the whole document so gradually building up the document. In talks with IBMS and Royal College of Nursing for their support and endorsement. Currently on plan for the framework to be launched this time next year. <u>Workstream Feedback</u> There is representation from this group on all of the workstreams. Following updates were given: • Appropriate Use (Wendy McSporran) Last meeting was held in October 2024. The group looked at the final draft focusing and reinforcing the IBI recommendations on alternative use.	

	Highlighted from the draft, the section regarding pre-op anaemia and patient consent. Hoping the paper will be published early Spring. • Digital Capacity and Integration (Emily Carpenter / Dipika Solanki) Also waiting to hear from NHSE, once this has ben received looking to work on mapping out the digital transfusion pathway. Thanks for the group for completing the shared care survey, results of which were able to feed into the scoping document prior to the strategy being completed. DS fed back on the digital interoperability survey completed. Lots of different systems all with different aspects. Results of survey will be shared with this group once they have been reviewed with Louise Sherliker. • Workforce (Aimi Baird) Currently at draft recommendation stage which includes the need to stabilise and strengthen the workforce through leadership and governance. Looking at requirements of strong consultant scientific leadership within transfusion along with organisation, culture and well-being. Outside of transfusion laboratories, ensuring there is an adequate mix of scientific and clinical knowledge. Training / education is also a big part making sure it is fit for purpose, accessible and there is career development and progression.	
9	**Transfusion Research Network**	
	Wendy McSporran provided an update. This is part of the Transfusion 2024 workstream with the purpose to increase research and transformation in both laboratories and clinical areas. Research Manager has just started in post and the first meeting of the network will be held in March. Following this, WMc will feedback the kind of research projects that are being planned. Network will be looking for TPs to contribute ideas of where they would like to see research and where there is a possibility of making service improvements.	
10	**Infected Blood Inquiry**	
	There is representation from the NTPN on all the NHSE Working Groups. Following updates were given: • IBI recommendation 7aiii (Julie Jackson / Stuart Lord) This recommendation is on auditing and benchmarking. Looking at having a benchmarking tool like the QS138 Quality Insights tool. Also, a CQC Standard for Transfusion which will raise the profile as will have to provide evidence that standards are being meet. This will be monitoring practices and processes such as bedside checks and will not encroach on the MHRA's regulatory function. JJ / SL have been asked to put together a TP capacity plan. Request has been made for an official summary update so this can be feedback to Trust Management. • IBI recommendation 7c (Aimi Baird) This recommendation is looking at workforce and capacity planning and what is needed to strengthen and improve the workforce along with improving the overall safety standards for transfusion. In the very early stages. The group have identified what is needed and are trying to find out what is happening up and down the country. Have the buy in from NHS England and putting in requests for funding to develop the workforce. This covers TPs, labs, medical consultants and clinical support for transfusion teams. Have a Task and Finish	

	group that have been assigned to get some of this project pushed forward as quickly as possible and waiting to hear what funding is available. • IBI recommendation 7d & 3 (Angela Houston / Aimi Baird) This group are reviewing the eLearning across England, Wales, Scotland and Northern Ireland. Looking at the benefits and how it could be used as a passport sort of training if people move to different Trusts. Also, reviewing what transfusion resources are available and looking at the undergraduate / postgraduate training provisions across all nations. Started off by sending out surveys to medical schools across the four nations for input as to what is currently in place and what needs to be in place. Very much in the early stages. • IBI recommendation 7e (Claire Sidaway/Aimi Baird) Unfortunately, have no update for this meeting but will hopefully have for next meeting. It was suggested with all the work this group is doing in relating to the above recommendations that it would be useful for a response to be put forward from the NTPN. If anyone would like to be involved in looking how to do this, please let AB know. Jonathan Ricks raised a query regarding a letter from the Medical Director of NHS and others in the IBI compensation authority about the retention of records dated 9th December 2024. The compensation scheme to open for applications till 2031 and it says this window is being extended for individuals who are diagnosed at a later date. They request that any original documentation relating to infected blood that your organization has in its possession is not destroyed. It goes on to say, it is imperative that relevant documents are not destroyed that would impact an individual's application to the infected blood compensation scheme. JR asked the group if any action is needed and if needed to change the retention of documents as letter was a bit vague. JR mentioned that as a region in the South East, they would like to make a joint decision. RS advised at the Trust they did a quick audit of what they had on their off-site storage as it changed from 30 years. They realised that some documents had already been destroyed because they were in keeping with the current guidance. So, they saved the document in their quality management system and wrote that they have done a quick audit. They have looked at what documentation they have, where it is stored, how of it is and will keep it indefinitely now, but at the time, they were sticking to the rules of retention that they were supposed to. Electronic records would not have been destroyed after 30 years. Julie Staves mentioned the need to keep access to Trust legacy systems and check that people with log ons, actually log on. Otherwise, they are not going to remember how to do it.	
11	**Affiliated Groups - Updates**	
	Northern Ireland ~ Zona Kelly NI Belfast Overview (NTPN 13.02.2025).p	

BBTS TP SIG ~ Karen Mead

BBTS TP SIG Update (NTPN 13.02.2025).p

NHSBT PBM / QS138 Quality Insights ~ Anwen Davies

NHSBT PBM and QS138 Quality Insigh

NCA ~ Paul Davies

National Comparative Audit programme:

- 2022 Comparative Audit of Acute Upper Gastrointestinal Bleeding – national report recently published, all sites have access to a copy.
- 2022 Audit of Patient Blood Management in Elective Paediatric Surgery – national report recently published, all sites have access to a copy.
- 2024 Audit of NICE Quality Standard QS138 – national report due at the end of the month
- 2025 Major Haemorrhage Protocol audit – due to start Spring 2025
- 2025 Anti-D Immunoglobulin Prophylaxis audit – due to start Autumn 2025

Collaboration between NCA and TPs when developing audits:

- Future audits – the NCA would welcome input from NTPN on potential audits, particularly any highlighted by survey of the network.
- Ongoing audits – A TP representative is always included on the team for any national comparative audit.

Post-audit collaboration:

- TP volunteers have been helping to trial a “quick audit” tool to allow local repeat of the bedside transfusion audit. These tools will be a single file containing all the documentation required to audit from data collection to reporting on the same day. We hope to develop more of these in the future to go alongside other NCAs and similar audit topics.
- The NCA plan to identify sites with potential for improvement post-audit and work with TPs at those to facilitate that improvement. Similarly, sites with high levels of compliance will be approached to identify potential learning points.
- We hope to record action plans, interventions and examples of best practice to develop a library of potential interventions and facilitate the sharing of knowledge and best practice.

MHRA ~ Mike Dawe

In response to the IBI recommendation 10a (v) which was:

Steps to be taken to give greater prominence to the online Yellow Card system to those receiving drugs or biological products, or who are being transfused with blood components.

We have two streams of work:

1. We have arranged for Blood Workshops to be delivered.

The first IBI Blood workshop was delivered on the 24th January 2025, for the SW and Wales Blood Transfusion Community,

The agenda that was delivered was as follows:

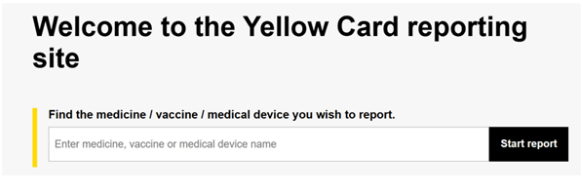
- Patient powered transfusion safety- how can we make this happen? focusing on how to give patients a voice (including YC reporting)
- Infected Blood Inquiry (IBI) report, recommendations, and impact on haemovigilance (Including YC changes)
- IBI recommendations implementation plans – progress and challenges
- Application of human factors and ergonomics in transfusion – Regarding incident investigation with regards to systems and processes and what affects outcomes
- Haemovigilance reporting including participation benchmarking – To include tools for investigation and tracking and trending by cause.
- Discuss key clinical and laboratory issues from recent Annual SHOT Report (Open Forum)
- Transfusion IT updates – SCRIPT surveys and IT resources
- Round up and close.

A short survey has been initiated to get feedback however in the round up section the delegates provided some very positive feedback not only on the topics covered but also gave their ideas on how to improve their own processes and systems employed within their organisations. The feedback survey results will be collated and feedback to us by the end of February 2025. A further 4 Blood Workshops are planned (London, Midlands, Scotland, and Northern Ireland (TBC)) throughout the next 12 months.

2. We are in the initial development stages of changing the Yellow Card reporting format making more prominent reporting Blood Products and providing a message board providing guidance for HCP's and Patients where to report issues with Blood Transfusion and Blood Donation. This includes the following:

We have modified the YC landing page:

Old



Blood Products are already accommodated for, so reporters just enter the blood product and then they will be directed to the ADR Form to complete.

New

HCP and Patients can click on the blood transfusion or blood donation link. This will direct them to the following message board.

	Blood Transfusion/Blood Donation Message Board (Draft) Thank you for reporting this incident to the Yellow Card System. Incidents involving the transfusion of blood and blood components and issues regarding blood donations are regulated to be reported under the Blood Safety and Quality Regulations (BSQR) and not the Yellow Card system. A blood product is any therapeutic substance derived from human blood and plasma-derived medicinal products (PDMPs). These are regulated under the Human Medicines Regulation 2012. Incidents involving Blood Products are reported through the YC system. Blood and blood components are defined as transfusable components that can be derived from donated blood and include red cell concentrates, Platelets, plasma, cryoprecipitate, and granulocytes and are regulated under the Blood Safety and Quality Regulations (BSQR) (2005 as amended)/. Blood, blood components and blood products are therefore regulated under completely different regulations. For Health Care Professionals please contact your local Blood Transfusion Laboratory or Blood Donation Centre to report your incident. For patients, please follow the guidelines below. As part of this regulated process NHS Trusts and Health Boards are mandated to report transfusion related incidents to the Medicines and Healthcare products Regulatory Authority (MHRA). To ensure that the Trusts and Health Boards follow their regulatory responsibility please raise this incident through the Trust or Health Board complaints process. If your incident occurred during a blood donation, please raise a complaint through the local blood services complaints process. For blood, blood component transfusions please raise a complaint with your local Trust or Health Board. Information on how to do this is on the local hospital's website. For blood donation incidents in England please use the link https://www.blood.co.uk/compliments-and-complaints/ For blood donation incidents in Scotland please use the link https://www.scotblood.co.uk/contact-us/compliments-suggestions-and-complaints/ For blood donation incidents in Wales please use the link https://www.welsh-blood.org.uk/complaints/ For blood donation incidents in Northern Ireland please use the link https://nibts.hscni.net/about-us/ From an inspection perspective, there is no change at this point but any changes to Blood Transfusion Processes employed by the Hospital Blood Banks and Blood Establishments will be looked at inspection if they fall within the Blood safety and Quality Regulations.	
	ISBT ~ Rachel Moss • Podcast 13 has now been published; *"Talking transfusion in neonates & paediatrics"* - Transfusion Practitioners across the world Podcast | The International Society of Blood Transfusion (ISBT) • The TP group in conjunction with the ISBT transfusion education group have produced *Essentials in Transfusion* to support colleagues in low to middle income countries that don't have a structured transfusion education programme for doctors & nurses – Essentials of Blood Transfusion Teaching for Nurses | The International Society of Blood Transfusion (ISBT) & Essentials of Blood Transfusion Teaching for Resident Doctors | The International Society of Blood Transfusion (ISBT) • ISBT (Europe) will be in Milan 31st May – 4th June ISBT Milan 2025 | The International Society of Blood Transfusion (ISBT) The TP session is on Tuesday 3rd with the theme being "*Educating the educators"* • The ISBT TP group membership is increasing so anyone who is interested in developing resources that benefit TPs around the world then join ISBT, apply to the Clinical Transfusion Working Party and join the TP sub-group	
	SHOT ~ Caryn Hughes Due to timings; AB requested update to be sent for inclusion in the minutes.	
	NTLM ~ Julie Staves Due to timings; AB requested update to be sent for inclusion in the minutes.	
	Pathology Network ~ Louise Jeffries Due to timings; AB requested update to be sent for inclusion in the minutes.	
12	**Blood Stocks**	
	Due to timings; AB requested update to be sent for inclusion in the minutes.	

13	**NTPN Webpage / Socials**	
	Attached update provided by Ant Jackson Webpage and Social Media Updat	
14	**AOB**	
	National Shared Care Working Group ~ Katharine Maynard The National Shared Care group was set up in 2024, following the success of a London regional group and we have now met three times. The main outputs have been: • A national survey reviewing current shared care practices and possible solutions to support this. • Based on this survey, developed a scoping document used as part of evidence portfolio for Transfusion Transformation. • A new editable PDF shared care form. Currently under review, ideally would like to be reviewed and badged by NBTC. • Request sent to all regions will examples of good, shared care practices, particularly focussed on internal practices within trusts, with a plan to develop a toolkit. **New TP Pack ~ Tracy Johnson** AB to feed information provided by TJ to the Education / Webpage groups who can then link directly with TJ moving forward. **Future Meetings ~ Aimi Baird** Future meetings will be extended to 2 hours with the aim of finishing early rather than overrunning.	
15	**Date of Next Meeting**	
	Thursday 19th June 2025, 10am – 12pm MS Teams	