

Shared Care Working Group

Tuesday 13th May | 14:00 – 15:30 | Teams Meeting

Chair: Kate Maynard (KM)



Attendance: 19 members

Name	Role	Organisation
Emily Carpenter (EC)	Transfusion Practitioner	King's College Hospital
Kate Maynard (KM)	Senior Transfusion Practitioner	Croydon Health Services
Luke Dowey (LD)	Transfusion Practitioner	Clatterbridge Hospital
Mihaela Gaspar (MG)	Transfusion Nurse	Royal Brompton Hospital
Julie Jackson (JJ)	Transfusion Practitioner	James Paget University Hospitals
Julie Staves (JS)	Transfusion Laboratory Manager	Oxford University Hospital
Jane Iatrou (JI)	Transfusion Practitioner	Whiston Hospital
Matt Hazell (MH)	Consultant Clinical Scientist	NHSBT
Nella Pignatelli (NP)	London's RTC Administrator	NHSBT
Nikki Swarbrick (NS)	Laboratory Incident Specialist	SHOT Team
Peter Baker (PB)	Transfusion Service Manager	University Hospitals of Liverpool Group
Sam Alimam (SA)	Haematologist	UCLH and NHSBT
Sandra Rakowska (SR)	Patient Blood Management Practitioner (PBMP)	NHSBT
Stephanie Cairns (SC)	Clinical Systems Developer	NHSBT
Stephen White (SW)	Transfusion Laboratory Manager	University Hospitals Bristol and Weston
Vathsala Juhan (VJ)	Transfusion Practitioner	Queen Elizabeth The Queen Mother Hospital
Victoria Tuckley (VT)	Laboratory Specialist	SHOT
Victoria Waddoups (VW)	Transfusion Practitioner	Rotherham
Zeynab Jeewa (ZJ)	Senior Transfusion Practitioner	University College London

Apologies: Laura Baglow-Micic, Selma Turkovic and Kath Philpott

Special Mentions: Alder Hey (AH), Kerry (K), Chen Hock (CH)

Minute Secretary: Nella Pignatelli (NHSBT).

Please contact nella.pignatelli@nhsbt.nhs.uk for any amendments.

-- Meeting Starts --

1. Welcomes & Introductions:

KM started the meeting by asking the group to introduce themselves.

2. Review of minutes from last meeting – 12th February 2025

The group read through last meeting's minutes. No amendments needed and the draft was accepted.

3. Review of Actions from last meeting – 12th February 2025

No.	Action	By Whom	Status update
1	Establish if an information governance specialist can join the group, suggested that NHSBT rep would be helpful as knowledgeable about national processes.	ST	
2	To present the shared care form at the Lab Managers Group Meeting in February, hoping they will introduce it at the next NBTC meeting for review.	KM	
3	To share form with clinical colleagues to ascertain usability.	ALL	
4	Find a patient or Clinical Nurse Specialist representative.	ALL	
5	Briefing RTC leads in advance of their meetings on the shared care form so they can review it and comment on it.	ST	
6	Send out a poll to determine the date for the next meeting.	NP	

Action 1: JS suggested that everyone should reach out to their Information Governance Team at their hospital and see if they are interested in joining the group.

Action 2: Discussed later in the meeting

Action 3: KM reported that the feedback was mainly positive.

Action 4: NP has agreed to be the group's patient representative. No Clinical Nurse Specialist found yet.

Action 5: KM confirmed it had been reviewed a lot.

Action 6: no comments

4. National Transfusion Transformation Update

JJ reported that while discussions had been progressing and changes were being implemented, there was an unexpected shift in direction, likened to the rug being pulled out from under them.

Although the transfusion recommendations were fully agreed upon — which would typically secure funding — it now appears unlikely that funding will be provided. As a result, the team will need to proceed with implementing changes using existing resources.

One of the key developments is the review of TXA (Tranexamic Acid), which may become a national requirement. This would shift responsibility from the transfusion team to anaesthetists.

Additionally, SHOT guidelines are being developed, and it is anticipated that the CQC will enforce these standards. JJ noted that Nikki and Vicki may have more detailed information on this.

There are several smaller changes underway, including the involvement of Model Health, which will now include transfusion.

JJ confirmed that there are no new recommendations expected from the transfusion side; the current recommendations are likely to remain in place. However, there may be further developments from the quality side.

JJ expressed some frustration, noting that the recent changes have made it feel as though efforts are being undermined, with responsibilities being taken away. Despite this, useful initiatives like the integration with Model Health are still moving forward.

NS agreed with JJ's comments and confirmed that SHOT is producing standards this year, which are intended to be static and enduring. The goal is for these standards to be recognised and supported at the highest levels of the hospital, rather than relying solely on Transfusion Practitioners (TPs) and Transfusion Laboratory Managers (TLMs) to advocate for them.

NS highlighted that the standards include a reference to shared care, specifically addressing the needs of particular patient groups and the importance of standardising handover and communication templates. NS reiterated that this point is explicitly included in the SHOT standards and supports the direction JJ outlined.

VT added to the discussion on the standards, expressing hopefulness about their development and implementation. She confirmed that, as NS and JS mentioned, the MHRA has indicated they will endorse the standards where they align with the SQR (Statutory Quality Requirements), and those areas will be subject to inspection. Efforts are ongoing to secure input from the CQC as well.

VT clarified that these standards are intended to replace the current system of frequent new recommendations. Instead of receiving numerous new recommendations each year, the standards will serve as a stable framework. Only in the case of a major emergency or significant shift would a new recommendation be issued. The standards are scheduled to go out for stakeholder feedback imminently, having already been reviewed once internally.

VT highlighted this as a positive change, reducing the annual workload and providing a more consistent approach.

EC raised a question about whether the upcoming consent review from SaBTO would have any implications for shared care.

JS responded, noting that they are part of the SaBTO group and clarified that the review is more focused on the decision-making process around transfusion. While shared care was mentioned during discussions, nothing specific was added about it in the review. This was because the topic is already being addressed within the Transfusion Transformation work and acknowledged by the SaBTO group, and duplicating efforts was seen as unnecessarily complicating the process.

KM thanked EC for the good question and asked for any other comments.

5. Shared Care Form Update

KM mentioned the form that has been circulated for consultation and feedback, noting that it has gone through multiple rounds of comments. Unfortunately, Heli was not present to provide an update, but a brief meeting with JS took place a couple of months ago. JS confirmed that minor cosmetic tweaks were made to the form, with input from K.

JS took the form to the National Blood Transfusion Committee (NBTC) as an agenda item at the last meeting in March. No comments were received, and the form was

approved to be badged as an NBTC document by CH, the current chair. This was seen as a positive development.

KM asked if the NBTC would host the form on their website, and JS confirmed that it could be placed in either the TP or lab section, with links between the two. Celina, the lead PA, and Jane Murphy, the lab manager, were identified as contacts for this task.

KM agreed to catch up with Heli to confirm her approval and proceed with adding the NBTC badge to the form. VT mentioned that Shruthi from the SHOT team offered to add SHOT's endorsement to the form and host it on their website, which KM agreed would be helpful.

→ Action: KM to catch up with Heli and finalise the next steps for making the form available.

The meeting then proceeded to the next agenda item, with VT taking over.

6. Safer transfusions for patients with shared care

Presented by NS and VT

VT and NS provided an update on the current data related to shared care. They explained that the 2024 data is embargoed until July, so the most recent shareable information comes from a presentation given at BBTS last year. They noted that specific shared care questions were only added to the data collection process from January 2025, meaning more targeted data will be available in the following year.

SA raised an important point about the need for a clear definition of “shared care” to ensure accurate data collection and interpretation.

VT responded by explaining that the system allows users to specify the type of shared care (e.g. between sites, departments, or labs) and that tooltips will be added to clarify definitions.

NS and VT shared a case study illustrating the risks of poor communication in shared care, which led to a patient being admitted to ICU. They highlighted that transplant and hemoglobinopathy patients are most affected by shared care issues. While errors have slightly decreased, near misses have increased, suggesting better detection but ongoing risks.

The group agreed on the importance of clarity in definitions and consistent data collection to improve patient safety and reporting accuracy.

VT and NS provided an update on shared care cases, highlighting different categories of errors. They mentioned that avoidable, delayed, and under-transfused cases often

result from a lack of clear treatment plans between shared care departments or organisations, leading to delays in patient treatment. Wrong component transfused cases were most common among transplant patients, often due to ABO and D mismatches. Specific requirements not met were frequently seen in hemoglobinopathy and cancer patients, where necessary information was not relayed to the laboratory.

NS discussed issues with right blood right patient, particularly when patients are transferred between hospitals, leading to communication and ID issues. Anti-D errors were also noted, especially in pregnant women receiving shared care across multiple hospitals.

The primary causes of errors were identified as communication breakdowns, lack of interoperability within and between organisations, and lack of knowledge about patient needs. Single points of failure, where information is only communicated to one person, were also highlighted as a significant risk.

VT shared some case studies to the group.

KM raised a question regarding the documentation of sex at birth versus current gender in transfusion records, noting the recent rulings and the complexity of the issue. KM highlighted the difficulty in knowing a patient's history, especially when they receive a new NHS number.

VT responded that there have been no SHOT reports resulting in an error related to this issue. However, some reports have been noted for learning purposes, even though they did not meet SHOT criteria.

VT mentioned that there is a national group looking at gender and transfusion, but it has not met for a while. They are awaiting official guidance from BSH on the matter. VT suggested that PB, who is also part of the group, might provide further insights.

VT raised a question about the documentation of sex at birth versus current gender, considering recent rulings.

KM mentioned the difficulty in documenting this information, especially when individuals receive a new NHS number, making it hard to track their history.

VT noted that there have been no SHOT reports resulting in errors due to this issue, but some reports have been noted for learning purposes.

PB highlighted the importance of relaying the right information from the clinical area to the laboratory sensitively, as there are legal implications for incorrect documentation without explicit patient consent.

PB also mentioned the broader implications for other clinical disciplines, such as radiology, where missing information could lead to missed screenings.

JS confirmed that the Royal College of Pathologists is expected to provide advice on this matter, which is why the working group has not met recently.

MH suggested that the responsibility for accurate documentation should be shared with patients, especially when there are legal risks for healthcare professionals.

JJ emphasised that this issue boils down to consent, and patients have the right to make decisions about their own health, even if it means not being fully protected by the healthcare system.

MH raised a question about the documentation of gender identity and sex at birth in healthcare systems, noting the recent rulings and the difficulty in knowing a patient's history due to new NHS numbers.

KM asked if there had been any SHOT reports related to this issue.

VT responded that while there have been reports noting the issue, none have resulted in an error. She mentioned that a national group is looking at gender and transfusion, awaiting BSH official guidance.

VT inquired about the status of the gender in transfusion working group.

PB confirmed that the group hasn't met recently due to the focus on the SHOT publication. He emphasised the importance of relaying the right information from the clinical area to the laboratory sensitively, noting the legal implications of recording gender information without explicit consent.

MH suggested that the responsibility for documenting gender information should be placed on the individual, especially given the risk of fines for healthcare personnel.

JJ agreed, stating that consent should include the understanding of the health implications of their gender identity. She emphasised that patients have the right to make decisions about their own health, and healthcare professionals must ensure they understand the repercussions.

PB highlighted the need for educating clinicians about the health implications of gender identity, noting that many clinicians lack understanding of transfusion and other disciplines. He stressed the importance of making healthcare settings safe for trans individuals to share their information.

SA echoed the sentiment that this issue is much broader than the group and requires national guidance. She emphasised that consent is not the solution, as it involves various healthcare experiences and misinformation.

EC added that electronic health records now have options to enter data for current gender and gender assigned at birth, and shared care systems need to be set up to receive and enter this information correctly.

PB reiterated the legal implications under the Gender Recognition Act, noting that information may be shared without explicit consent, which could be illegal.

The group agreed on the need for national guidance and education to address the documentation of gender identity and sex at birth in healthcare systems.

7. Shared Care Toolkit

7.1 Toolkit Development for Shared Care and Transfusion Management

Following previous discussions, the group revisited the idea of developing a toolkit to support shared care processes, particularly around transfusion management.

Examples Shared:

- LD's work in the Northwest.
- AH's approach, including transfusion management plans on EPR linked to labs with review dates.
- Mandated requirements on request forms.
- Paper/manual notifications and shared care examples for specific patients.

Purpose: To support internal and external shared care communication, especially in the absence of full interoperability across NHS IT systems.

Toolkit Contents (Proposed):

- Shared care form templates
- Good practice examples
- Top tips and guidance

VT offered to host the toolkit on the NBTC or NBC website, pending approval.

7.2. Formation of a Mini Working Group

Proposal: KM suggested forming a smaller working group to develop the toolkit.

Volunteers: VT and NS expressed interest, with the caveat that their availability may be limited until after July.

Action:

- Interested members are encouraged to email KM. Target to have a draft toolkit by early autumn.

3. National Shared Care and Digital Systems

Discussion: KM highlighted the importance of understanding broader shared care challenges beyond transfusion, particularly around digital interoperability.

Reference: A national subgroup under Digital Transformation is exploring shared care records and IG challenges.

KM has contacted the national group but is awaiting a response.

Members are asked to explore their local ICB websites to identify relevant contacts or teams working on shared care.

Actions:

- Members to express interest in the toolkit working group via email.
- All to review their local ICB's shared care initiatives and report back.
- KM to follow up with national digital transformation contacts.

-- Meeting ends --

No.	Action	By Whom	Status update
1	KM to catch up with Heli and finalise the next steps for making the form available.	KM/HM	
2	Interested members are encouraged to email KM. Target to have a draft toolkit by early autumn.	All	
3	Members to express interest in the toolkit working group via email.	All	
4	All to review their local ICB's shared care initiatives and report back.	All	
5	KM to follow up with national digital transformation contacts.	KM	