NORTH EAST & YORKSHIRE REGIONAL TRANSFUSION COMMITTEE

North East & Yorkshire RTC Meeting Minutes

13:00 – 16:00 Wednesday 19 March 2025

Attendees		
Bushra Amin	BA	Transfusion Practitioner, Sheffield Teaching
Aimi Baird	AB	Transfusion Practitioner, Newcastle
Helen Barber	HB	Transfusion Practitioner, Leeds
Gillian Bell	GB	Transfusion Laboratory Manager, Doncaster and Bassetlaw
Lucy Bevan	LB	Transfusion Practitioner, Newcastle
Amanda Burns	ABu	Chief BMS, Hull & East Yorkshire
Carolyn Carveth-Marshall	CCM	Transfusion Practitioner, South Tees
Vicki Chalker	VC	Chief Scientific Officer, NHSE
Andrew Charlton	AC	Consultant Haematologist, Newcastle and NHSBT
Victoria Chong-Cave	VCC	Biomedical Scientist, Co Durham & Darlington
Laura Condren	LC	Transfusion Technical Lead, South of Tyne Clinical Pathology Services
Debra Cox	DC	Transfusion Practitioner, North Tees
Rachael Denham	RD	Biomedical Scientist, South Tees
Graham Donald	GD	Patient Representative, NBTC
Victoria Dowson	VD	Transfusion Practitioner, North Tees
Laura Duffy	LD	Transfusion Practitioner, Newcastle
Rohit Kumar	RK	Neonatal representative
Khaled El-Ghariani	KEG	Consultant Haematologist, Chair of HTC, Sheffield Teaching
Jay Faulkner	JF	Transfusion Practitioner, Leeds
Stephanie Ferguson	SF	Transfusion Practitioner, Leeds
Phoebe Fletcher	PF	Transfusion Practitioner, Sheffield Teaching
Jenny Fullthorpe	JF	Biomedical Scientist, York and Scarborough
Clive Graham	CG	Consultant Microbiologist, Chair of HTC, North Cumbria
Alison Hirst	AH	Transfusion Practitioner, Airedale
Bryony Hodgson	BH	Biomedical Scientist, Doncaster & Bassetlaw
George Holmes	GH	Clinical lead for Transfusion, Northumbria
Catrina Ivel	CI	Transfusion Practitioner, York and Scarborough
Jasmin Jaimon	JJ	Transfusion Practitioner, Gateshead
Magda Jakubiak	MJ	Transfusion Laboratory Manager, North Cumbria
Marina Karakantza	MK	Consultant Haematologist, NHSBT
Nicola Keeping	NK	Haematology Departmental Manager, South of Tyne Clinical Pathology Services
Sam Kershaw	SK	Transfusion Laboratory Manager, Calderdale and Huddersfield
Rohit Kumar	RKu	Neonatal Representative
Michelle Lake	ML	Transfusion Practitioner, Calderdale & Huddersfield
Joanne Lawson	JL	Blood Sciences Departmental Manager, Co Durham & Darlington
Solome Mealin	SM	Patient
Paula Mitchell	PM	Service lead for blood transfusion, Harrogate
James Naseem	JN	Scientific Training Officer, NHSBT
Karen Nesbitt	KN	Transfusion Practitioner, Gateshead
Achana Obris	AO	International Training Fellow in Transfusion Medicine
Jill Parkinson	JP	Transfusion Practitioner, Bradford
Ashley Pearson	AP	Biomedical Scientist, Co Durham & Darlington

Rachel Perkins	RPe	Transfusion Laboratory Manager, Sheffield Teaching
Ric Procter	RP	**Chair**, A&E Consultant and Chair of HTC, South Tees
Sue Rabett	SR	Transfusion Practitioner, Leeds
Jordan Reed	JRe	Transfusion Practitioner, York and Scarborough
Emma Richards	ER	Transfusion Practitioner, Doncaster & Bassetlaw
Janice Robertson	JR	**Minutes**, RTC Administrator, NHSBT
Alexandra Rosa	AR	Clinical Scientist, Hull & East Yorkshire
Faye Smith	FS	Transfusion Practitioner, Harrogate
Brian Taylor	BT	Transfusion Laboratory Manager, Sheffield Teaching
Gemma Timms	JT	Consultant Anaesthetist and Chair of HTC, Newcastle
Vicky Waddoups	VW	Transfusion Practitioner, Rotherham
Tracey Watson	TW	Head of RCI Barnsley, NHSBT
Benjamin Wetherell	BW	Consultant Anaesthetist and Chair of HTC, Bradford
Rebecca Weatherill	RW	Deputy Blood Transfusion Manager, Rotherham
Abbie White	AW	Transfusion Practitioner, Northern Lincolnshire & Goole

Apologies		
Rachel Allan	RA	
Amanda Baxter	ABa	Transfusion Practitioner, Sheffield Children's
David Bruce	DB	Head of RCI Newcastle, NHSBT
Robin Coupe	RC	Customer Service Manager, NHSBT
Allistair Dodds	AD	Consultant in anaesthesia & Pain Management and Chair of HTC, South Tyneside & Sunderland
Peter Douglas	PD	Consultant in Emergency Care, Chair of HTC, Northumbria
Fiona Hickey	FH	Consultant Haematologist, Chair of HTC, Sheffield Children's
Wasim Hussain	WH	Customer Service Manager, NHSBT
Juliet James	JJ	Transfusion Practitioner, Co Durham & Darlington
Angela Kanny	AK	Haemostasis and Thrombosis link
Carole McBride	CMc	Transfusion Practitioner, Mid Yorkshire
Alison Muir	AM	Transfusion Laboratory Manager, Newcastle
Janet Nicholson	JN	Transfusion Practitioner, North Cumbria
Annette Nicolle	AN	Consultant Haematologist, Gateshead
Michelle Scott	MS	Transfusion Laboratory Manager, Sheffield Children's
Karen Simblet	KS	QA Manager, NHSBT Newcastle
Karen Ward	KW	Transfusion Laboratory Manager, Northumbria
Helen West	HW	Transfusion Practitioner, Bradford
Jemma Yorke	JY	Consultant Obstetrician, Chair of HTC, Co Durham & Darlington

1.	**Welcome**
	RP welcomed the group.
2.	**Apologies for absence, minutes of last meetings and matters arising**
	Apologies noted. Minutes of previous meeting, 13 November 2025 confirmed. **Action**: Post confirmed minutes onto NBTC website.
	Matters arising
Closed	Confirmed minutes of previous meeting posted onto NBTC website.

Closed	Working group set up to take 'Reporting of transfusion reactions in patients that have left the Hospital' forward.
Closed	Implementing the IBI recommendation - How are people recording the outcomes of transfusion?' discussed at the RTC chairs meeting. This issue needs to be steered from the NBTC.
3.	**Education Section**
	Updates from SHOT presented by Vicky Waddoups Do I want to know dilemma? Update from SHOT - Do I want to know dile
	Updates from SHOT paper by Mark Taplin The infected blood inquiry Update from SHOT - The Infected Blood Inc
	Update from RCPath & SHOT Advances in Transfusion Symposium 20th & 21st November 2024 by Alison Muir Update from RCPath-SHOT.pdf This article has not been published yet but has been submitted to ISBT.
4.	**Discussion of the IBI checklist and PBM benchmarking document** IBI-Template-Response-Document-NBTC-J
	IBI - NHSE update presented by Vicki Chalker VC updated the group on the work ongoing at NHSE, she is focusing on recommendation 7 - Patient Safety: Blood transfusions Sub categories include Tranexamic Acid / Transfusion 2024 / Transfusion Staffing and Resource / Training, Standards and Accountability / SHOT Recommendations Implementation and Monitoring / Establishing the Outcome of Every Transfusion. Working groups have been established for each of these sub categories led by Dame Sue Hill. There has been a review of Transfusion 2024, stakeholders included patient representatives and family members of patients who have been impacted by the infected blood inquiry work. In addition, we have been developing the Transfusion Transformation Strategy, this will build on the work of Transfusion 2024 and take the work forward. The draft will be disseminated for wider strategic input. There are five key pillars where we feel we need to focus:

- Improving governance
  To ensure that patients have effective delivery of transfusion care across the system.
- Quality of transfusion care
  To improve the safety and the outcome for patients.
- Digital and data transformation
  To improve aspects of the NHS where we are delivering care.
- Workforce capacity and capability
  Ensure we have sufficient competent staff.
- Undertaking research to drive improvements in performance and care.
  To ensure that the changes we are making are evidence based. For example, the blood group genotyping program for patients with sickle cell thalassemia and rare anaemias, using extended blood matching to enable patients who require regular transfusion to get better matched blood.

VC advised that she would like feedback on The Transfusion Transformation Strategy Development. A questionnaire will be circulated for comments.
In addition, a programme has been devised and resource requested to support it, to support staff and staff training along with building a more robust system for supporting staff in training.

There is a subgroup focusing on looking at electronic blood management systems and digital tracking for samples to improve the process. We have some excellent systems already in place and need to share best practice. Digital transformation is costly but it is really needed in implementing change and it will take time.

To cover all the different aspects of patient safety, we ae looking at systems for benchmarking to help identify areas where things are going well and areas where they need some support which will help us spread best practice across the system.

NHS England longevity has been in the news recently.
VC reassured the group that this piece of work is really important and we are working with the Department of Health on the Infected Blood Inquiry and what we need to change and do as a community across the country to improve this. The work will not stop irrespective of what the organisation's name is.

We need to work together to make sure that we can impact change irrespective of organisational barriers.

The group feel that they need practical advice on how to action the requirements of the IBI recommendations. VC will take this back to Shruthi Narayan and the working group and feed back to us.

If anyone has something specific they would like to discuss, VC is happy to be contacted at victoria.chalker@nhs.net

IBI – Patient Engagement presented by Graham Donald

GD discussed points that he considers important to patients.

Tranexamic Acid: latest QS138 audit shows that usage is increasing, implemented in around 75% of patients. As a patient GD felt that this should be 100%.

Transfusion 2024 – now Transfusion Transformation: GD questioned if this would have an effect on the transfusion community and change practice.

Transfusion Laboratories: Report are increasingly alarming in regard to staffing. SHOT reports show that staff are working on their own and completing tasks that they are not competent in.
GD questioned if there are sufficient scientist being trained to fill positions.

Training in Transfusion Medicine: There is an implication that there is a deficiency in training. The recommendations do not cover refresher training for those who do not regularly participate in Blood Transfusion. Basic errors continue to happen due to lack of regular training with both junior and senior clinicians and patients not challenging them. SHOT have video of a presentation by Dr Su Brailsford's, Consultant in Epidemiology and Health Protection, at the 2024 joint RCPath and SHOT symposium, covering the learning from the Infected Blood Inquiry which is of interest.

Implementing SHOT reports: SHOT reporting is increasing but reporting should be mandatory rather than advisory along with participation in QS138 audit. Recommendations are not being implemented as they are not mandatory.

The IBI report recommended that all transfusion outcomes be recorded, this is already done in Scotland. GD noted that for recording of the outcomes to be worthwhile, it would have to be shown that outcomes were better in Scotland than elsewhere.

Delayed / unnecessary transfusions and TACO are responsible for more patient death / morbidity than WBIT so focus should be on these.
Improved I.T. systems will lead to better record keeping, monitoring, fewer errors and better patient outcomes. The IBI report does not directly refer to patient consent but GD questioned if more patient involvement would have given a different result.

Announcement that NHSE is to be abolished. What difference will this make to implementation of the recommendations. If Transfusion is not a priority for government there is a concern that things will not improve. The IBI is an opportunity for the transfusion to be heard by health professionals and the public.

The latest National Comparative Audit has added a fifth measure, restrictive thresholds for transfusion, which feature in the NICE guidelines but are not a quality standard. Reports state that over half of transfusion were above that threshold and therefore were unnecessary.

Patient experience presented by Solome Nanziri

SN is a sickle cell patient who undergoes regular transfusions and joined us to discuss points that she considers important in her patient experience.

As a patient receiving transfusion, she feels that consent is signed when she is very unwell and not it the best state to fully understand, she also feels that some patients are not empowered to ask questions. An App to share with friends and family would be beneficial to avoid duplication of discussion of the safely of blood transfusion and put patients at ease.
SR advised SN that regularly transfused patients only need to give consent on an annual basis and to ask for her when next at the hospital to clarify the process.
Young patients with sickle cell disease need to be given a voice to make teachers and peers understand the disease, its symptoms and its effect on them.
The transfusion community need to look at the right way of supporting patients after

	treatment if they are having symptoms and are concerned MK advised that the RTC is currently working 'UK&I Framework for the Provision of Blood Transfusion Out of the Acute Hospital Setting' and urged the group to submit feedback on the document sent to TPs on 19 March 25. SN feels that blood transfusion is intrinsically safe but tiredness of staff increases the chance of human error within the process.
5.	**Success and Progress** Update from Trusts inc. Trust responses and time frames
	Rotherham NHS Foundation Trust Presented by Vicky Waddoups  Rotherham update.pdf
	Hull & East Yorkshire Hospitals NHS Trust Presented by Alexandra Rosa  Hull & East Yorkshire.ppsx
	Leeds Teaching Hospitals NHS Trust Presented by Marina Karakantza  Leeds Teaching.pdf
	Rotherham NHS Foundation Trust Presented by Victoria Waddoups  Rotherham update.pdf
	Sheffield Children's NHS Foundation Trust  Sheffield Childrens.pdf
	Points made in response to the presentations: AC advised that engagement with professional societies to increase the visibility and culture is ongoing. The Medical Schools Council has asked every medical school in England to explain what their transfusion curriculum looked like. Tranexamic Acid Should we consider a regional form pooling together different surgical checklists, looking at how we should we report and capture data, use of Model Health report form to gather and share evidence and Big Data integration to help look at the outcome. For data be meaningful we should show that TXA has been considered rather that used as there are good reasons to not use TXA but this will be shown as a failure. Other alternatives such as cell salvage should also be considered. Results from the Perioperative Quality Improvement Programme (PQIP) may also

	assist. Use of TXA should not be used as a performance indicator. Business Cases Pooled Trust business cases are assisting in achieving funding. Produce a gap analysis and present to the board. This may result in the board requesting a business case be submitted rather than go through the funding route.
6.	**A.O.B.**
	None noted
7.	**Date of next meetings**
	• 11 June 2025 • 10 November 2025

RTC – Action list

Item No	Action	By Whom
2	Post minutes of previous meeting, 13 November 2025 onto NBTC website.	JR