Regional Transfusion Team Meeting

Tuesday 28th January 2025 – CX Hospital

Chair: Phil Kelly (PK)

Attendance:

Name	Role	Organisation
Catherine Booth (CB)	Consultant Haematologist	Barts Health & NHSBT
Danny Bolton (DB)	Customer Service Manager	NHSBT
Emily Carpenter (EC)	Transfusion Practitioner	King's College Hospital
James Davies (JD)	Transfusion Practitioner	King's College Hospital
Michaela Rackley (MR)	Customer Service Manager	NHSBT
Nella Pignatelli (NP)	London's Regional Transfusion Committee Administrator	NHSBT
Phil Kelly (PK)	London's Regional Transfusion Committee Chair	King's College Hospital
Selma Turkovic (ST)	Patient Blood Management Practitioner	NHSBT
Wendy McSporran (WM)	Transfusion Practitioner	Royal Marsden
Ursula Wood (UW)	Transfusion Practitioner	Guy's & St Thomas' NHS Trust

Apologies: Jey Visuvanathan (JV)

Special mentions: Rachel Moss (RM), Tim Williams (TW), Tracy Johnston (TJ), Aimi Baird (AB), Jen Rock (JR) and Sachin Ramoo (SR)

-- Meeting starts --

1. Introductions & Apologies

PK asks the group to introduce themselves as this was MR and NP's first RTT meeting.

2. Minutes & Actions of Last Meeting

The group confirms the draft minutes from the last meeting on the 26th of September 2024

3. NBTC Meeting Update

No NBTC Meeting since the last RTT meeting so no update available.

4. RTC Education events- Plasma and Platelets

NP told the group that the RTC education event on Plasma and Platelets which happened on the 22nd of January went well. There were 231 attendees, and the evaluation survey of the event revealed a top box score of 96.7%, which surpasses the 95% goal. NP added that there was high attendance from all over the UK not just London. NP also mentioned that a lot of attendees were interested in learning more about current studies and they would like to hear more from researchers or individuals currently doing research. The attendees seemed keen on obtaining data to keep on top of current research.

PK praised the event for allowing a good channel of communication between speakers and attendees due to the use of the Q&A function. PK added that many attendees requested future education events to be on major haemorrhage. ST mentioned that in the Blood Transfusion Education and Discussion Group (BTEDG) the attendees are also asking for more case studies on major haemorrhage and to hear more from the laboratory's perspective. PK tells the group that he will take these comments from attendees to the next NBTC Chairs meeting.

WM stated that there were a number of specialities contributing to the discussions which is a strength of an online meeting as opposed to face to face. PK agreed and explained that before Microsoft Teams these events were mainly regional. The group agreed that the time slots for the education event were well spaced out and that the break between was good as it prevented loss of concentration and engagement. ST emphasised that it may have been a bit difficult for all attendees to engage with debates via Teams as their cameras and microphones were turned off. WM added that she was surprised with the level of engagement from attendees and that people wanted to engage as much as they did. NP agreed and added that the Q&A function was utilised well as other attendees could respond to each other and foster up more conversation around certain topics as opposed to the chat function.

5. Laboratory Manager Update

JV sent his apologies and could not provide an update.

DB provided a general update telling the group that the last Transfusion Advisory Discussion Group (TADG) meeting was at the end of October and then there was an education session in November. DB added that during the last TADG meeting, JV wanted to talk about the cyber-attacks and people's experiences but there was not much engagement of this topic by the attendees.

6. Transfusion Practitioner (TP) Update

JD led the update on the TP group (Appendix 1).

TP Group

- Chair of the TP group has changed jobs and now JD and PW are co-chairs of the group.
- TP meetings continue every fortnight online.
- Meetings are productive and allows TPs to ask or share anything amongst peers.
- Lots of focus on blood shortages now in their meetings.
- National Transfusion Practitioner Network (NTPN) are meeting with NHSBT every fortnight to discuss projections of blood shortages, and this is being fed back to their TP meetings. Any ideas from TP meetings are also fed back up to the NTPN also. This allows for a good line of communication and ensures everyone is informed of the shortages at the moment.
- Discussions around IT systems is common in TP meetings – EPIC, EPRs and blood tracking.
- This year, there will be 2 face-to-face and two virtual TP meetings with topics yet to be decided.

National TP Network (NTPN)

- AB is back as chair of the NTPN and has relaunched it with a real push to support the professional framework and Transfusion Transformation as well as to implement some of the recommendations of the IBI.
- JR has been working with a framework consultant who has done frameworks for other professionals in the past.
- Draft timelines suggest the framework will be released finally in March 2026.

Wrong Blood in Tube (WBIT) Working Group

- The chair of WBIT has left so SR is interim chair for the time being.
- The group is using the reporting tool which has allowed for useful data to be collected.
- Uncertainty on what actions this group can do other than collecting and reporting data on WBITs.
- The reporting tool is good because it provides a more local breakdown of reasons.
- A lot of London hospitals are using the tool but there are still some that are not.

EPIC Working Group

- WM added that there are no guidelines for configuration of major EPR providers.
- JD told the group that a colleague from Royal Cornwall has written an article with assistance from JD that will be published by the BBTS Bloodlines magazine about specification for electronic sampling labelling.

- JD agrees that although it is s a start on some sort of guideline, it does not hold much weight as a BSH guideline.
- JD told the group that RM was very keen on getting some sort of guideline overall for EPR suppliers around sample labelling and blood administration using an EPR system – mainly looking at EPIC and Cerner.
- WM told the group that it is well documented that errors vary amongst systems. She continued to explain that some systems allow for a fully labelled label without ever going near the patient and that it took a year of work to ensure that the patient is scanned now and if not, the label produced is blank.
- EC added that for non-transfusion samples, although it is supposed to do that in the same way, it is commonly circumvented.
- JD told the group that every hospital must start from scratch with an EPR install and all hospitals will eventually need to go through this process. Furthermore, data shows since his hospital (King's College) had EPIC they saw a massive increase in wrong blood in tube incidents (WBITs) and a decrease in the quality of sampling practice.
- PK asked if there was enough data on this issue to create an abstract and added that numerous hospitals and trusts are experiencing similar issues with EPIC. WM agreed and added that Manchester had so many problems that when they went live for sampling, they had to stop within 24 hours afterwards due to errors – especially due to printing labels away from patients.
- CB shared that in her hospital they had some teething problems but not a massive number of WBITs and added that it would be hard to do a high-quality research study on this as data would need to be collected in certain ways which would be difficult – such as interrupted time series.
- JD stated that a problem with only looking at WBITs and tube errors is that it is quite a blunt measure of sampling practice because that is only when it has gone really wrong. Even with a reduction in WBITs, sampling practice has not improved, and people are still printing away from bedsides and carrying wristbands in their pockets.
- MR added that EPR systems like EPIC are hard for customers to say no to because they provide so many other benefits with other issues that are outside of transfusion such as managing medication.
- JD agreed and said that the transfusion side is a small part of the overall EPR.
- WM added that EPIC has helped the lab as they can see what staff are up to electronically and can reject samples if they see the time between printing a label and receiving it at the lab was too long.
- MR suggested that more patients should write up formal complaints, so this issue is taken more seriously.

7. London Platelet Action Group (LoPAG)

UW joined the meeting via Teams to provide an update.

- UW admits that more could have been done with LoPAG in 2024, and they have yet to organise a meeting in 2025. There was however an educational event on the 10th of September 2024 which was well attended, and feedback was positive. A newsletter also went out in Spring 2024.

- In response to the NHS, who are supporting focus groups, LoPAG has introduced TW as deputy chair.
- UW believes having a deputy chair will provide the group with a more robust governance structure and that more can be achieved this year than last.
- Material was made available on the NBTC website during the first platelet shortage. UW wants to make more accessible packs for trusts to use so that there is guidance and advice on triaging and making the best use of stock.
- EC stated that in a previous TP meeting it was mentioned that BMS are hesitant in issuing platelets across groups even though they know it is technically right. EC asked UW if there was any educational material on this specifically. UW explained that it is difficult as although they have the backing of consultants at the NHSBT who provide information all the time, laboratory policies do not seem to follow suit fast enough. UW further explained that a lot of Laboratory Information Management Systems (LIMS) are set up to make BMS more wary of doing it, and that they do not have plans to update those parts of their system.
- UW added that if there is no blood group, the emergency groups are hardwired in and you cannot avoid this until you put a blood group in, which defeats the purpose of it being an emergency. There is a way to manually issue it, but this does not help with the confidence of staff.
- EC responded informing the group that currently biomedical scientists must overrule an alert that states you might kill a patient if you use an alternative platelet group.
- UW concluded that it is important to have an educated and confident workforce, but if computer systems tell staff a different gold standard in keeping patients safe, this is going to create confusion.
- JD suggested bringing this to the TADG (Transfusion Advisory Discussion Group) to feed through to the CliniSys user group.

8. RTC Activity Log

The RTC Activity Log was reviewed and accepted by the group (Appendix 2).

Actions:

The group agreed to close Twitter/X account for the London RTC and tasked NP to save all the data into a folder before doing so. The group wanted to focus on LinkedIn and BlueSky. NP tasked in handling the London RTC LinkedIn account.

PSIRF education event North West RTC Video still waiting to be produced. ST informed the group that she spoke to TJ, and they had not heard anything back yet from the region and that she will chase it up and get back to the group.

The action to consider setting up O Positive Working Group with input from TPG and TADG will be reviewed by JD and he will update the group regarding any updates.

9. Customer Service/ PBM update

ST, MR and DB agreed to present to the group together (Appendix 3).

JD asked if there is anything at the RTC or RTT level that can be done to help with blood shortages. WM and JD agree that hospitals are doing the most they can. WM added that a report showed they are still down 30% donors compared to pre-Covid and that there are reports of people struggling to get a blood donation appointment. MR added that lots of people are frustrated that their appointments are being cancelled after making arrangements with work, childcare and travel.

10. Any other business

The team agreed on pushing for 'IBI and its implications' for the next RTC education event topic. NP to make arrangements for this. The team agreed to have the event in November this year on Teams.

The next RTT meeting will be on the 29th of April 2025 on Teams.

11. Actions:

Action	By whom	Status
Share comments from attendees of the recent RTC education event to the next NBTC Chairs meeting.	PK	
Decide on topics for two face to face and two virtual TP meetings .	JD/PW	
Organise dates and venues for TP meetings.	NP/JD	
Organise a LoPAG meeting.	NP/UW/TW	
Produce more accessible packs for trusts to use so that there is guidance and advice on triaging and making the best use of stock.	UW	
Bring up emergency platelets issue to the TADG (Transfusion Advisory Discussion Group) to feed through to the CliniSys user group.	JD	
Close London RTC Twitter/X account and download data.	NP	
Start to use London RTC LinkedIn and build up a following.	NP	

PSIRF education event North West RTC Video needs to be chased up.	ST	
Setting up O Positive Working Group with input from TPG and TADG.	JD	
Request ‘IBI and its implications’ as the next RTC Education Event topic.	NP	

--meeting ends --