

Hospital Transfusion Committee

Haematology Consultant Transfusion Lead Toolkit



**For a Word version of this document with accessible links, please contact
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Guidance for New and Developing Transfusion
Lead Consultants

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Foreword

This toolkit has been produced to assist you in your role as Haematology Consultant Transfusion Lead.

We hope it provides you with guidance to fulfil this important role and would welcome any feedback you may have on the document or suggestions how the Regional Transfusion Committee (RTC) can support you further.

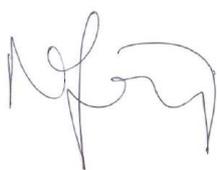
The NHSBT Patient Blood Management and Customer Service Teams welcome the opportunity to support your Hospital Transfusion Committees by aiming to attend at least one meeting per year. Although they all have different roles, their overall aim is to work collaboratively with hospitals to ensure that blood components are safe, used appropriately and available when you need them. Please do invite them and provide meeting dates as far in advance as possible.

For more details on the Customer Service Team's roles see page 18.

The function of the RTC is facilitated by the Regional Transfusion Team (RTT). There are also sub groups of the RTC for Transfusion Laboratory Managers: the EoE Transfusion Advice and Discussion Group, and Transfusion Practitioners: the EoE TP Network. Both groups meet quarterly and are actively involved in supporting the objectives of the RTC.

We would welcome your attendance at the RTC meetings which are held three times a year at St John's Innovation Centre, Cambridge. Dates and agendas are sent via email from our RTC administrator. The meetings provide an opportunity to keep up to date with transfusion news and issues both regionally and nationally, to share experiences, participate in active discussions and to network with colleagues from other hospitals.

In addition the RTC holds at least one education event every year on a wide range of transfusion related topics.



Nicola Jones
Chair, East of England Regional Transfusion Committee
Consultant in Cardiothoracic Anaesthesia and Critical Care
Papworth Hospital



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Transfusion Team Infrastructures in England

The aim of this section is to provide an overview of the different transfusion committees and teams who work collaboratively to improve transfusion practice.

National Blood Transfusion Committee (NBTC)

The NBTC was established in 2001. Its remit is to promote safe and appropriate transfusion practice. The committee provides a forum to discuss national transfusion issues and to channel information to the 10 Regional Transfusion Committees (RTCs) to share with hospitals in their regions.

The NBTC is made up of representatives from:

- NHS England
- Royal Colleges
- Specialist Societies e.g. British Society for Haematology (BSH), British Blood Transfusion Society (BBTS)
- Other organisations e.g. Serious Hazards of Transfusion (SHOT) scheme, Institute of Biomedical Sciences (IBMS), Medicines and Healthcare products Regulatory Agency (MHRA).
- NHS Blood and Transplant (NHSBT)
- Patient groups
- All Regional Transfusion Committee Chairs

The NBTC aims to meet twice a year. The minutes from each meeting are available via the NBTC website on the UK Blood Transfusion & Tissue Transplantation Services website: www.transfusionguidelines.org.uk The Executive Working Group is a subgroup of the NBTC, it ensures that the momentum of the committee's activities is maintained between full committee meetings; this group also meets up twice a year.

Regional Transfusion Committee (RTC)

The RTCs are responsible for implementing actions of the NBTC in England. They oversee the activities of the local HTC and provide a link between the HTCs and NBTC.

The RTC is usually made up of representatives from:

- Consultant Haematologists, HTC Chairs, TPs, and TLMs from all the region's hospitals (NHS and private hospitals)
- The NHSBT Customer Service Team
- Patient representative

There are three meetings of the East of England RTC per year; minutes and actions are disseminated to all members including all Consultant Haematologists with responsibility for transfusion in the region. The work of the RTC is co-ordinated by the Regional Transfusion Team (RTT). Information on RTCs can be accessed at: www.transfusionguidelines.org.uk

Hospital Transfusion Committee (HTC)

Every Trust involved in blood transfusion should have a HTC as stated by the DH in the Health Service Circular 2007/001: **Better Blood Transfusion - Safe and Appropriate Use of Blood**. The HTC should have the authority to take the necessary actions to improve transfusion practice.

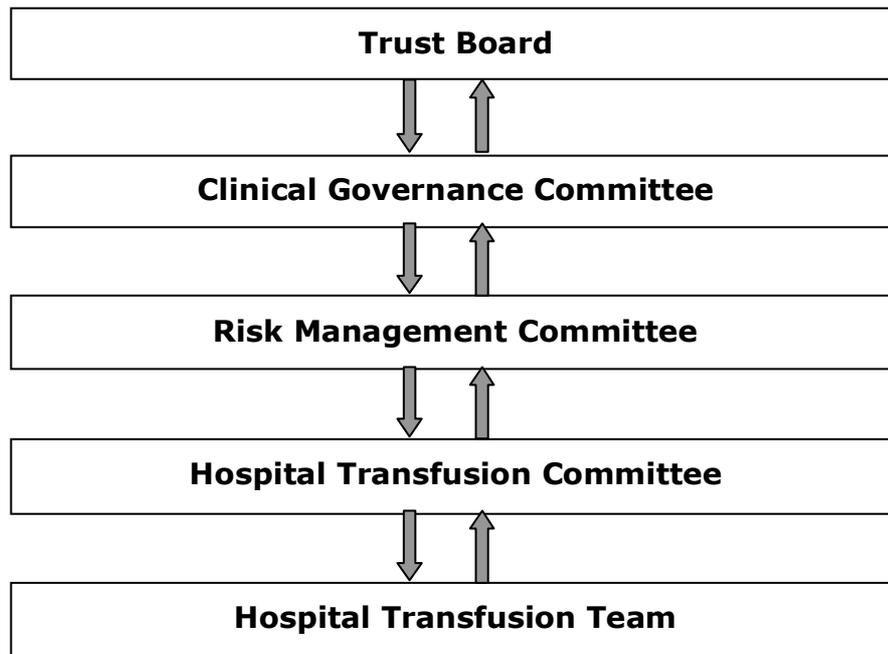
An HTC should:

- Promote safe and appropriate blood transfusion practice through local protocols based on national guidelines.
- Audit the practice of blood transfusion against the NHS Trust policy and national guidelines, focusing on critical points for patient safety and the appropriate use of blood.
- Lead multi-professional audit of the use of blood within the NHS Trust, focusing on specialities where demand is high, including medical as well as surgical specialities, and the use of platelets, plasma, and other blood components as well as red cells.
- Provide feedback on audit of transfusion practice and the use of blood to all NHS Trust staff involved in blood transfusion.
- Regularly review and take appropriate action regarding data on blood stock management, wastage and blood utilisation provided by the Blood Stocks Management Scheme (BSMS) and other sources.
- Develop and implement a strategy for the education and training for all clinical, laboratory and support staff involved in blood transfusion.
- Promote patient education and information on blood transfusion including the risks of transfusion, blood avoidance strategies and the need to be correctly identified at all stages in the transfusion process.
- Consult with local patient representative groups where appropriate.
- Modify and improve blood transfusion protocols and clinical practice based on new guidance and evidence.
- Be a focus for local contingency planning and management of blood shortages.
- Report regularly to the RTC, and through them, to the NBTC.
- Participate in the activities of the RTC.
- Contribute to the development of clinical governance.

Although no recommendation is made from the DH regarding actual HTC membership, it is suggested that the committee membership should include:

- Chair
- Transfusion Laboratory Manager (TLM)
- Transfusion Practitioner (TP)
- Haematologist with responsibility for transfusion
- Senior nursing and midwifery representation
- Representatives from clinical high users of blood components
- Anaesthetist
- Member of risk management
- Representative from finance
- Representative from the Primary Care Trust or equivalent organisation

The committee should aim to meet at least 3 times per year. The HTC should report to senior management within the Trust, usually via the Risk Management Committee. A suggested organisational structure for HTC feedback is shown as follows:



Hospital Transfusion Team (HTT)

In accordance with the recommendations from the Health Service Circular 2007/001: **Better Blood Transfusion – Safe and Appropriate Use of Blood**, Trusts should establish a HTT for promoting good transfusion practice through the development of an effective local clinical infrastructure. The team should consist of the Lead Consultant for Transfusion (with sessions dedicated to blood transfusion), Transfusion Practitioner, Transfusion Laboratory Manager and possibly other members of the HTC. There should be identified clerical, technical, managerial and IT support, the team should also have access to audit and training resources to promote and monitor safe and effective use of blood and alternatives. The HTT should aim to meet on a monthly basis.

The role of the HTT is to:

- Implement the HTC's objectives
- Promote and provide advice and support to clinical teams on the safe and appropriate use of blood
- Promote patient information and education on blood transfusion safety and use of alternatives
- Actively promote the implementation of Patient Blood Management
- Be a source for training all NHS Trust staff involved in the process of blood transfusion
- Produce an annual report including its achievements, action plan and resource requirements for consideration by senior management at Board level through the HTC and the Trust's clinical governance and risk management arrangements.

NHS Blood and Transplant (NHSBT) Regional Team

A priority for NHSBT is to '*continue to work with hospitals to ensure best use made of blood through the Patient Blood Management initiative*' (NHSBT Strategic Plan 2014-15). The Regional Team structure is one of the initiatives established to drive forward the recommendations in the National PBM Guidelines released by the NBTC in July 2014 – see p8.

A regional team is linked to every Trust and hospital in England. Each team works with the local healthcare community to ensure that the service provided by NHSBT is of the highest possible standard and to support clinical colleagues in Trusts to promote PBM. The team works in partnership with the other UK Blood Services and inputs into many national groups such as the NBTC, SHOT, National Comparative Audit (NCA) and Blood Consultative

Committee (BCC). The team contribute to the development and dissemination of evidence based transfusion guidelines and policies. A key objective for the regional team is to support the activities of the RTC.

Each team includes representatives from the Customer Services, Patient Blood Management and Patient Clinical teams.

Consultant Haematologist - The Consultant Haematologist is a member of the PBM Patient Clinical Team. The primary focus of this role is to provide clinical support and advice to hospitals. The Patient Clinical team provide 24 hour on call support across England and North Wales. Posts are often joint with a local large Trust.

Customer Service Manager (CSM) - The CSM is a member of the Customer Services Team. The CSM has a scientific background and is the primary link between the blood centre and the hospital transfusion laboratory. They ensure that hospital transfusion laboratories obtain the best quality of service from NHSBT by handling complaints and escalating requests for service improvements and developments.

Patient Blood Management Practitioner (PBMP) - The role of the Patient Blood Management Team is to support and promote Patient Blood Management initiatives to optimise the care of patients who may need transfusion. By acting as a resource and by facilitating networking, each regional PBMP works with hospital Transfusion Practitioners (TPs) to identify specific areas of support required. This support may involve 1:1 visits to the TP or attendance at HTTs or HTC's. The PBMP also facilitates regional training and educational events either as a support to TPs or as the event co-ordinator.

Regional Transfusion Committee Administrator – The RTC administrator works closely with the PBMP in maintaining good communication with HTTs and organising regional education events on transfusion related topics. She also provides monthly and annual summary reports of usage and wastage to HTTs.

Duties and responsibilities of a Transfusion Lead Consultant Haematologist

- To provide the medical leadership of clinical and laboratory aspects of transfusion complying with current regulatory frameworks.
- To work with clinical directorates to develop policies for the safe and effective use of blood products based on national guidance including evidence from audit and research.
- To take part in the teaching and training of Transfusion Medicine to medical, nursing and scientific staff and to medical students.
- To develop and maintain an active interest in patient blood management, including the use of point of care testing for haemoglobin concentration and haemostasis and alternatives to donor blood such as peri-operative cell salvage and pharmacological agents such as anti-fibrinolytics and intravenous iron and ensure that this is implemented.
- To promote patient information and education on blood transfusion safety and the use of alternatives and patient consent.
- To ensure that transfusion incidents and adverse events are investigated and reported and SHOT/SABRE as appropriate.
- To monitor usage and wastage with reference to BSMS data and lead implementation of strategies to correct any outlying practice.
- To participate actively, via the Hospital Transfusion Team (HTT) and the Hospital Transfusion Committee (HTC) in Clinical Governance via national, regional and hospital audits.
- To be prepared to act as Chair for both the HTT and HTC meetings.
- To attend regional and national transfusion meetings and take part in other activities related to continuing medical education for blood transfusion.
- To participate in clinical research in transfusion medicine.
- To ensure a funded minimum session in the job plan dedicated to the Transfusion Lead role.
- To participate actively in Continuing Professional Development.

Legislation and Regulation

Haemovigilance

The Blood Safety and Quality Regulations (2005) and SABRE

The EU Blood Safety Directive introduced a legal requirement for serious adverse reactions (SAR) and serious adverse events (SAE) occurring within EU Member States to be reported to the relevant Competent Authority. The Department of Health designated the MHRA as the UK Competent Authority. For this purpose the MHRA developed an online reporting system: Serious Adverse Blood Reactions and Events (SABRE) for the purpose of reporting these events

The Directive also requires that each reporting establishment submit to the Competent Authority an annual summary report of serious adverse reactions and serious adverse events. MHRA facilitate this process. The Competent Authority submits an annual summary report to the EU Commission.

SABRE, the on-line reporting system, can be accessed via the MHRA website: <http://www.mhra.gov.uk>

MHRA has produced two guidance documents to help to clarify what incidents are reportable and information on how to submit reports. These are:
Background and Guidance on reporting Serious Adverse Events and Serious Adverse Reactions SABRE a User Guide.
These documents are available on the website above.

Medicine and Healthcare Products Regulatory Agency,
151 Buckingham Palace Road,
Victoria,
London SW1W 9SZ
Tel: 020 3080 7336
E-mail: sabre@mhra.gsi.gov.uk
Website: <http://www.mhra.gov.uk>

SHOT

SHOT is a confidential, anonymised, UK wide scheme that aims to collect data on adverse events of transfusion of blood and blood components. Adverse events at hospital level are usually reported to SHOT by the Transfusion Practitioner or Transfusion Laboratory Manager.

SHOT produce an Annual report of findings and recommendations. Reports, resources and reporting guides can be found on the SHOT website;
<http://www.shotuk.org/>

Reporting to SHOT remains voluntary, but is required for compliance with Health Service Circular 2007/001: Better Blood Transfusion Safe and Appropriate Use of Blood, and active participation in SHOT by all hospitals was recommended by the Chief Medical Officer for England in his 2003 Annual Report.

More information can be obtained from:
The SHOT Office, Manchester Blood Centre
Plymouth Grove, Manchester
M13 9LL
Tel: 0161 423 4208, Fax: 0161 423 4395
Email: shot@nhsbt.nhs.uk Website: <http://www.shotuk.org>

Since 2015 SHOT and SABRE haemovigilance reporting have been combined and is accessed via the SABRE website.

GMP – Good Manufacturing Practice.

This is covered under the MHRA compliance report and is based on the general principles of the Medicines Control Agency – Rules and Guidance for Pharmaceutical Manufacturers and Distributors 2002. GMP for the laboratory covers:

- Quality
- Personnel
- Premises and Equipment
- Documentation
- Production/Processes
- Quality Control
- Contract Manufacture
- Complaints and product recall
- Self-inspection

United Kingdom Accreditation Service (UKAS)

This has recently encompassed the old Clinical Pathology Accreditation (CPA) assessment. This process will see all laboratories assessed to ISO 15189 (2012) standards from 2013. UKAS places more emphasis on the traceability of the result and the equipment used to obtain the result. Any biological quality control material needs to be referenced to a national standard and any calibrated equipment must be serviced and link back to the national standards for the equipment used to carry out the service.

Management of patients who refuse blood

Trusts should ensure that procedures are in place for managing patients who refuse blood. Patients who refuse a blood transfusion do so for various reasons and may not necessarily be a Jehovah's Witness. It is important that the patient understands the consequences of not having a blood transfusion and wherever possible is offered an alternative.

Refusing a blood transfusion should be documented in the medical notes and brought to the attention of all medical professionals involved in the care of the patient. The medical professionals need to clarify with the patient which blood components and products, if any, they would be willing to accept.

Jehovah's Witnesses have a network of Hospital Liaison Committees (HLC). A representative is assigned to every hospital. Representatives can be contacted 24 hours a day to advise or liaise with patients, hospital staff and relatives on concerns regarding the care of Jehovah's Witness patients.

Contact information for these committees is available from a central co-ordinating office, Hospital Information Services (020 8906 2211 or email his.gb@jw.org)

Jehovah's Witness patients who refuse blood will usually carry an Advance Decision to Refuse Specialised Medical Treatment and are encouraged to update this every 4 years

Useful resources and web links can be found below;

The Jehovah's Witness community website:
www.JW.org

This includes a section for medical professionals:
<http://www.jw.org/en/medical-library/>

Developing a conservation care plan for Jehovah's Witness patients with malignant disease
<http://www.transfusionguidelines.org/document-library/documents/developing-a-blood-conservation-care-plan-for-jehovah-s-witness-patients-with-malignant-disease-1>

Care plan for surgery in Jehovah's Witnesses
<http://www.transfusionguidelines.org/document-library/documents/care-plan-for-surgery-in-jehovahs-witnesses-leaflet-1>

Blood Stocks Management Scheme (BSMS)

BSMS was established to understand and improve blood inventory management across the blood supply chain.

The VANESA data management system is used to collect and view real time data and charts. Hospitals can use this scheme to monitor and audit their blood issues and wastage and benchmark against similar hospitals and specialities. The accuracy of the data is reliant upon input of data by hospitals.

A number of reports are available for hospitals to view on their homepage including an inventory summary report and an O D negative report. The BSMS has a large bank of data on the blood supply chain and has detailed knowledge of its various elements.

Further information can be found at: <http://www.bloodstocks.co.uk>.

In addition the East of England regional Hospital Liaison team produce and circulate to each HTT a highlight summary report of issue and wastage data over the previous 12 months and an annual report.

Anti-D

BCSH published a Guideline for the use of anti-D immunoglobulin to prevent haemolytic disease of the newborn in 2014.



Q:\Guidelines\BCSH
guideline on anti-D.pc

SHOT have produced anti-D resources:



SHOT-Bites-No2-Anti
-D-Lessons-and-Highl



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Cell-free fetal DNA (cff DNA) testing for fetal D blood group in pregnant D negative women is now available from NHSBT.



user-guide-for-fetal-
rhd-screening-service

NHSBT also offers a full range of antenatal screening. See:

<http://hospital.blood.co.uk/diagnostic-services/red-cell-immunohaematology/antenatal-reference-services/>

Patient Consent

The Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) published a report in 2011 'Patient Consent for Blood Transfusion'

<https://www.gov.uk/government/publications/patient-consent-for-blood-transfusion>

The report contains the following recommendations:

- Valid consent for blood transfusion should be obtained and documented in the patient's clinical record by the healthcare professional.
- There should be a modified form of consent for long term multi-transfused patients, details of which should be explicit in an organisation's consent policy.
- Patients who have received a blood transfusion and who were not able to give valid consent prior to the transfusion should be provided with information retrospectively.

Further resources have been developed to support with these recommendations and can be found at;

<http://www.transfusionguidelines.org/transfusion-practice/consent-for-blood-transfusion>

Change to the consent law in 2015

The law relating to informed consent changed in 2015. There is now an increased duty for a clinician to provide a patient with accurate, up to date information about the proposed medical or surgical procedure.

<http://www.bmj.com/content/350/bmj.h1481>

Resources

LearnBloodTransfusion have developed an e-learning module on consent and it can be accessed on the LearnBloodTransfusion website:

<http://www.learnbloodtransfusion.org.uk/>

Information and resources on the consent process in transfusion can be found at:

<http://hospital.blood.co.uk/patient-services/patient-blood-management/consent-for-transfusion/>

NHSBT provides a variety of patient information leaflets and factsheets for Health Care professionals. These can be accessed and downloaded at:

<http://hospital.blood.co.uk/patient-services/patient-blood-management/patient-information-leaflets/>

Also free to order from: <https://hospital.nhsbtleaflets.co.uk>

Patient information leaflets to assist Health care professionals obtain consent for H&I testing can be downloaded at:

<http://hospital.blood.co.uk/diagnostic-services/hi/patient-information-leaflets/>

Emergency planning and business continuity

There exists the ever possible risk of reduced stocks and blood shortages, although this is rare in the UK. The NBTC sub group on contingency planning released an integrated plan listing actions to be taken by NHS Blood and Transplant and hospitals in times of shortages. Documents to support hospitals in contingency planning and emergency blood shortage planning can be found on the Hospitals and Science website

<http://hospital.blood.co.uk/business-continuity/contingency-planning/>

Adverse effects of transfusion and further reporting

There are a large number of possible adverse effects that can be associated with a transfusion. Adverse effects arising from transfusion should be investigated by the HTT and reported to SHOT and serious adverse reactions to MHRA in addition.

Current blood donation testing strategies minimise the risk of viral transfusion transmitted infections in the UK but on very rare occasions infectious donations are undetected and enter the blood supply. The latest figures showing frequency of infections in blood donors is available from Public Health England at:

<https://www.gov.uk/government/publications/safe-supplies-annual-review>

To assist with the investigation and reporting of adverse effects documents and forms are available from the Hospitals & Science website for use in hospital blood transfusion laboratories. These include a "Summary of actions for hospital staff" and a form to request "Investigation of serious adverse reaction to blood and component transfusion". See: <http://hospital.blood.co.uk/diagnostic-services/reporting-adverse-events/>.

In addition all duty consultants and Patient Clinical Team consultants within NHSBT are trained to deal with all adverse events and reactions arising within hospitals or blood establishments.

A regional algorithm has been produced by the East of England RTC to aid with the identification and treatment of adverse effects to transfusion

<http://transfusionsguidelines.org.uk/uk-transfusion-committees/regional-transfusion-committees/east-of-england/policies>

Further information on the adverse effects to transfusion can be found at:

The Handbook of Transfusion Medicine

<http://transfusionsguidelines.org.uk/transfusion-handbook/5-adverse-effects-of-transfusion>

The British Committee for Standards in Haematology (BCSH) Guideline on the Investigation and Management of Acute Transfusion Reactions (Tinegate et al., 2012)

(<http://www.bcsghguidelines.com>)

SHOT

<http://www.shotuk.org/reporting/sabre/>

Training

The NHSBT Learning Delivery team provides knowledge-based training programmes in transfusion science and transfusion medicine. Programmes range from basic to advanced topics and are open to medical and scientific staff and healthcare workers. They also co-ordinate training of hospital staff in Transfusion Medicine, providing courses for trainees through to haematologists. Details can be found at:

<http://hospital.blood.co.uk/training/>

E-learning

Learnbloodtransfusion is an interactive eLearning resource covering a wide range of transfusion related topics, including safe transfusion practice, blood components and good manufacturing practice.

Further details can be found at:

<http://www.learnbloodtransfusion.org.uk/>

NHSBT processes and services

Recall.

Occasionally components have to be recalled to ensure patient safety. Processes and procedures can be found at:

<http://hospital.blood.co.uk/diagnostic-services/reporting-adverse-events/component-recall/>

Specialist product guidance / advice

NHSBT provides user guides for its specialist services such as red cell immunohaematology (RCI) and histocompatibility and immunogenetics (H & I) which can be found at:

<http://hospital.blood.co.uk/diagnostic-services/diagnostic-user-guides/>

See also:

RCI

<http://hospital.blood.co.uk/diagnostic-services/red-cell-immunohaematology/>

H & I

<http://hospital.blood.co.uk/diagnostic-services/hi/>

HEV

<http://hospital.blood.co.uk/products/hepatitis-e-screening/>

Clinical advice

The NHSBT patient clinical team are available for advice 24 hours a day. To contact one of them, phone the Hospital Services department at your NHSBT delivery centre:

Brentwood: 01277 721005

Cambridge: 01223 588021

Colindale: 02089 572700

The Update

The home page of the hospitals and science website contains The Update, a monthly communication comprised of 3 sections: Action, Information and Training and Education.

<http://hospital.blood.co.uk/>

Patient Blood Management (PBM)

Patient Blood Management is an evidence-based, multidisciplinary approach to optimising the care of patients who might need transfusion. It puts the patient at the heart of decisions made about blood transfusion to ensure they receive the best treatment and avoidable, inappropriate use of blood and blood components is reduced. It represents an international initiative in best practice for transfusion medicine.

National, regional and local audits in England consistently show inappropriate use of all blood components; 15-20% of red cells and 20-30% of platelets/plasma. Evidence shows that the implementation of *Patient Blood Management* improves patient outcomes by focussing on measures for the avoidance of transfusion and reducing the inappropriate use of blood and therefore can help reduce health-care costs.

Patient Blood Management: The Future of Blood Transfusion conference was held on 18 June 2012. The event was jointly hosted by the Department of Health, the National Blood Transfusion Committee (NBTC) and NHS Blood and Transplant (NHSBT) and supported by Professor Sir Bruce Keogh, NHS Medical Director.

The aim of the multi-disciplinary conference was to share views on how blood transfusion practice could be improved to:

- Build on the success of previous *Better Blood Transfusion* initiatives and to further promote appropriate use of blood components.
- Improve the use of routinely collected data to influence transfusion practice.
- Provide practical examples of high quality transfusion practice and measures for the avoidance of transfusion, wherever appropriate.
- Consider the resources needed to deliver better transfusion practice including support from NHSBT.
- Understand the patient perspective on transfusion practice.

PBM recommendations developed from this conference were launched in June 2014. They are supported by NHS England and the NBTC. They provide initial recommendations about how the NHS should start implementing *Patient Blood Management*.

A toolkit to assist NHS Trusts has been developed and posted on the NBTC website or see appendices p23

<http://www.transfusionguidelines.org.uk/uk-transfusion-committees/national-blood-transfusion-committee/patient-blood-management>

Some key points from the PBM Recommendations for the Transfusion lead to consider:

- All NHS Trusts should establish a multidisciplinary PBM programme through the HTC or as a subgroup of the HTC.
- Analyse case mix and clinical services to determine the main targets for PBM
- Identify PBM champions to help educate staff and patients.
- Establish a PBM committee (either stand-alone or within the Hospital Transfusion Committee) to oversee the PBM programme.
- Obtain a mandate for PBM from hospital management.
- Educate clinicians about PBM and evidence-based transfusion practice.
- Adopt a PBM scorecard to share with senior NHS Trust members to monitor adherence to guidelines for blood avoidance and the use of blood, including the use of benchmarking to identify clinicians/clinical teams who are consistently well outside of average blood use for a specific procedure.



@PBM_NHS

PATIENT BLOOD MANAGEMENT LOCATION OF RESOURCES

NHSBT Hospitals and Science website:

O D Negative toolkit:

<http://hospital.blood.co.uk/patient-services/patient-blood-management/o-d-negative-red-cell-toolkit/>

Single unit:

<http://hospital.blood.co.uk/patient-services/patient-blood-management/single-unit-blood-transfusions/>

PBM working group TOR template:

<http://hospital.blood.co.uk/patient-services/patient-blood-management/>

PBM Newsletters:

<http://hospital.blood.co.uk/patient-services/patient-blood-management/nhsbt-pbm-newsletters/>

IV iron business case template:

<http://hospital.blood.co.uk/patient-services/patient-blood-management/pre-operative-anaemia/>

Pre operative anaemia:

<http://hospital.blood.co.uk/patient-services/patient-blood-management/pre-operative-anaemia/>

Size matters poster:

<http://hospital.blood.co.uk/media/27082/140820-1-25596-patient-blood-management-size-matters-flyer-a5.pdf>

PLEASE NOTE THAT THE HOSPITALS & SCIENCE WEBSITE (<http://hospital.blood.co.uk>) IS CONSTANTLY UPDATED.

Transfusion Guidelines website:

PBM overview and recommendations:

<http://www.transfusionguidelines.org.uk/uk-transfusion-committees/national-blood-transfusion-committee/patient-blood-management>

London RTC anaemia recommendations:

<http://www.transfusionguidelines.org.uk/uk-transfusion-committees/regional-transfusion-committees/london/rtc-business/rtc-working-groups>

The National Institute for Health Care Excellence (NICE) produced Guidelines for Blood Transfusion in November 2015.

There can be accessed at: <https://www.nice.org.uk/guidance/ng24>

NHS & Independent Hospitals/Trusts within EoE RTC including name of Transfusion Lead

Below is a list of Hospitals / Trusts which fall within the East of England Regional Transfusion Committee including the Consultant Haematologists name. Only private hospitals which are direct customers of NHSBT are included in this list but all private hospitals in the region are welcome at the RTC.

Hospital	NHS Trust	Name
Addenbrooke's	Cambridge University Hospitals	Dr Dora Foukaneli
Basildon	Basildon & Thurrock University Hospitals	Dr Parag Jasani
Bedford	Bedford Hospital	Dr Muhsin Almusawy
Broomfield	Mid Essex Hospital Services	Dr Shereen Elshazly
Colchester	Colchester Hospital University	Dr Sudhakar Makkuni
Lister QE II	East & North Herts	Dr Xenofon Papanikolaou
Hinchingbrooke	Hinchingbrooke Health Care NHS Trust	
Ipswich	Ipswich Hospital	Dr Debo Ademokun
James Paget	James Paget University Hospital	Dr Cesar Gomez
Luton & Dunstable	Luton & Dunstable University Hospitals	Dr Ching-wai Cheung
Norfolk & Norwich	Norfolk & Norwich University Hospitals	Dr Hamish Lyall
Papworth	Papworth Hospital	Dr Martin Besser
Peterborough	Peterborough & Stamford Hospitals	Dr M. Sivakumaran
Princess Alexandra	Princess Alexandra Hospital	Dr Faris Al-Refaie
Queen Elizabeth	Queen Elizabeth Hospital King's Lynn	Dr Lisa Cooke
Southend	Southend University Hospital	Dr Paul Cervi
Watford	West Herts Hospitals	Dr Sue Bradley
West Suffolk	West Suffolk Hospital	Dr Sandra Young-Min
Independents		
Brentwood Nuffield		Dr Paul Cervi
Ramsay Rivers		Dr Faris Al-Refaie
Spire Hartwood		Dr Parag Jasani
Spire Cambridge Lea		Dr Parag Jasani

East of England RTC Chair & NHSBT Customer Service Team

Contact Details, Roles & Responsibilities

Dr. Nicola Jones – RTC Chair

Nicola was elected to the Chair's role in December 2015. The Chair is responsible for ensuring the RTC meets its principle objective of promoting safe and effective transfusion practices within the region. The Chair represents the region at the bi-annual RTC Chairs and NBTC meetings and facilitates the circulation of NBTC recommendations to HTCs by reporting back on National activities to RTC meetings.

Ms. Jane O'Brien – RTC Administrator

jane.o'brien@nhsbt.nhs.uk

Direct line 01223 588906

Jane provides administrative and audit support to the RTC, the NHSBT Hospital Liaison regional team and the RTC sub groups. She also produces monthly and annual reports for hospitals.

Dr. Dora Foukaneli – Consultant Haematologist, Patients Clinical Team, Patient Blood Management

dora.foukaneli@nhsbt.nhs.uk

Direct Line 01223 5888098 / PA 01223 588901

Dora works with NHSBT in a joint post with Cambridge University Hospitals NHS Foundation Trust. Dora works with the Customer Service Team at the Cambridge Blood Centre, the NHSBT Patient Blood Management Practitioner, the NHSBT Patients' Clinical Team and the Addenbrooke's Universities Hospital Trust Transfusion Team to improve transfusion practice in line with Patient Blood Management and other initiatives.

Ms. Frances Sear – PBM Practitioner – NHSBT Patient Blood Management Team

frances.sear@nhsbt.nhs.uk

Direct line 01223 588159 / Mobile 07889304606

Frances is responsible for leading activities designed to assist Patient Blood Management, including the provision of an on-going programme of support, education, audit, research and specialist transfusion advice

Mr. Mohammed Rashid – Customer Services Manager

mohammed.rashid@nhsbt.nhs.uk

Direct line 01223 588165 / Mobile 07471147917

Mohammed provides a link between NHSBT and the hospitals served by the Cambridge and Brentwood Blood Centres, managing the communication, complaints and performance monitoring processes and ensures NHSBT works towards delivering an outstanding service. Mohammed acts as an advocate ensuring their views are considered in all NHSBT activities and developments and is responsible for managing all aspects of customer care.

East of England RTC Website

For up to date RTC news and information, please visit:

<http://www.transfusionguidelines.org.uk/uk-transfusion-committees/regional-transfusion-committees/east-of-england>

Extract from the East of England RTC Welcome page:

- East of England RTC
 - Audits
 - Calendar
 - Contacts
 - Education
 - Policies
 - RTC business

If you would like to suggest any changes or additions to the East of England website pages please contact:

Jane O'Brien RTC Administrator

E-mail: jane.o'brien@nhsbt.nhs.uk

Direct line 01223 588906

The East of England website is housed on the JPAC website- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee;
<http://www.transfusionguidelines.org.uk/>

Extract from the home page of the JPAC website:

Welcome to JPAC

The Joint United Kingdom Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) was created in 1987 and saw the beginning of closer collaboration between Blood centres across the whole of the UK.

The purpose of this website when launched in 2002 was to be a vehicle of publishing the various JPAC publications. This initial core function was soon extended to other aspects of the UK transfusion and Transplantation activities.

The site is used by clinicians, scientists and other healthcare professionals across the UK and abroad both from Blood Services and hospitals.

Other useful websites

British Committee for Standards in Haematology: www.bcshguidelines.com

Serious Hazards of Transfusion: <http://www.shotuk.org/>

British Blood Transfusion Society: <https://www.bbts.org.uk/>

Transfusion evidence library: www.transfusionevidencelibrary.com

Relevant Organisations

British Society for Haematology: <http://www.b-s-h.org.uk/>

International Society of Hematology: <http://www.ishworld.org/>

European Hematology Association: <http://www.ehaweb.org/>

Network for the Advancement of Patient Blood Management, Haemostasis and Thrombosis:
<http://www.nataonline.com/>

Royal College of Pathology: <https://www.rcpath.org/specialist-area/haematology.html>

Audits

The National Comparative Audits (NCA) / Regional Audits currently in progress along with the plan for 2014:

National Comparative Audits

- Audit of the Use of Anti-D: 2013, report issued November 2014
- Patient Information and Consent audit: 2013, report issued November 2014
- Audit of Transfusion in Children & Adults with Sickle Cell Disease: January 2014
- Audit of Patient Blood Management in Surgery: April 2015
- Audit of Use of Blood In Haematology: January 2016

The NCA audit user's homepage can be found at www.nhsbtaudits.co.uk

http://hospital.blood.co.uk/safe_use/clinical_audit/National_Comparative/index.asp

Regional Audits

- In 2016 we invited all hospitals in the region to participate in audits of FFP and Cryo. These took place at a time convenient to each laboratory during May and June.
- The Transfer of Blood Components with Patients– a 6 month audit of practice. 2013
An audit of practice following the introduction of regional paperwork for transfer of blood products with patients between hospitals. The results of this audit were published in Transfusion Medicine Sept. 2015



Transfer of blood
with patients EoE auc

- East of England Audit of pre-transfusion haemoglobin levels. 2014.
A regional audit of pre-transfusion Hb levels to allow a useful and interesting overview of red cell transfusions within the region and whether hospitals follow a restrictive or liberal transfusing policy.



EoE Hb audit final
report.pdf

- East of England re-audit of platelet use. 2014
Re-audit of the use of platelets within the region. Data collection between October 2014 and March 2015 and reported to the RTC in June 2015.



Q:\Final report EoE
Platelet audit 2014 - .

East of England RTC policies and guidelines

- [Protocol for major haemorrhage in children](#) (Addenbrooke's Hospital) Adopted as a regional document by the East of England RTC.



EoE MH in children
2016.pdf

- [Major Haemorrhage Guidance](#) by the East of England RTC was recently updated following new guidelines from NICE and BCSH.



East of England RTC
Major Haemorrhage G

- [Acute Transfusion Reaction Guidelines](#) for the identification and treatment of acute transfusion reactions was produced by the East of England RTC so that hospital staff moving around the region's hospitals will find a common method of dealing with possible transfusion reactions. Updated January 2016.



East of England RTC
ATR Guidelines V2.pd

- The East of England RTC has produced [regional guidelines on the transfer of blood with patients](#) and accompanying [blood and components transfer forms, version 2](#). These were derived from the national document.



Transfer of Blood
EoE RTC V1_.pdf



Transfer of Blood
Appendices EoE RTC

- The East of England TADG has compiled a list of [Group O RhD negative Top Ten Tips](#)



Q:\Group O RhD
Negative top tips.pdf

- The East of England has developed a regional [Single Unit Guideline](#), together with an [Algorithm](#) for laboratory review of red cell requests.



Q:\EoE Single unit
policy.pdf



Single unit\Algorithm
for reviewing red cell

- The East of England has a [Shared Care](#) document to ensure that patients whose treatment is shared by 2 or more hospitals receive the correct blood components. Details of special requirements and the duration of need is included on the reverse.



Shared care form V2
EoE 02.16.doc

Forthcoming Events 2017

Regional meetings

6th June 2017

9th November 2017

EoE RTC Meeting

St Johns Innovation Centre, Cambridge

Time 10.00 – 13.00

Regional education events:

15th June 2017.

Blood Matters: transfusion education for haematology/oncology staff

Granta Centre, Granta Park, Great Abington, Cambridge.

Time 9.30 am to 4.00 pm

National meetings and education events:

12th July 2017.

SHOT Symposium

Harpenden, Herts

12th – 15th September 2017

BBTS Annual conference

Glasgow

International meetings:

20th -21st April 2017

NATA Symposium

Florence, Italy

Appendices

I. Person Specification for Lay/Patient Representative on Hospital Transfusion Committee (HTC)*



HTC Lay
Representative (appe

II. Strategies to improve clinician attendance at, and engagement with, Hospital Transfusion Committee (HTC) meetings**



HTC Attendance
(appendix 2).pdf

III. Patient Blood Management and Recommendations and Action Plan



National PBM
recommendations Jun



PBM action plan.xls



PBM resources.doc

Thank-you to:

- The Midlands and South West BBT Team for providing these documents* **
- Acknowledgment: The North West RTC Toolkit for HTC Chairs.

All information in this toolkit is correct to date.