

Hospital Transfusion Committee

Haematology Consultant Transfusion Lead Toolkit



Guidance for New and Developing Transfusion Lead
Consultants

Contents

Item	Page number
<u>Foreword</u>	3
<u>Transfusion Team Infrastructures in England And North Wales</u>	4 - 6
<u>Duties and Responsibilities of a Transfusion Lead Consultant Haematologist</u>	7
<u>Blood Stocks Management Scheme</u>	7
<u>Legislation and Regulation</u>	8 - 9
<u>Management of Patients Who Refuse Blood</u>	9
<u>Antenatal Transfusion</u>	10
<u>Emergency Planning and Business Continuity</u>	10
<u>Training</u>	10
<u>Patient Consent for Transfusion</u>	11
<u>Adverse Effects of Transfusion and Further Reporting</u>	12
<u>NHSBT Processes and Services</u>	12
<u>Patient Blood Management</u>	13 - 14
<u>NHS & Independent Trusts within NE RTC including current haematology consultant names</u>	15
<u>North East RTC Chair, NHSBT Hospital Liaison Team and Blood Conservation Lead</u> <u>Contact Details, Roles & Responsibilities</u>	16
<u>Website</u>	17
<u>Audits</u>	18
<u>RTC Policies and Guidelines</u>	18
<u>Appendices</u>	19

Foreword

Acknowledgement: East of England RTC for the original document

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 Hospital Liaison Team 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 Hospital Liaison Team's roles see page 16.

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 Transfusion Practitioners and the O D Neg Laboratory Champions. The groups 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 Newcastle Blood Centre. 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.

On behalf of North East Regional Transfusion Committee



Dr Andrew Charlton



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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 section on the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) website: <https://www.transfusionguidelines.org/uk-transfusion-committees/national-blood-transfusion-committee> 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 Hospital Transfusion Committees (HTCs) and provide a link between the HTCs and NBTC.

The RTC is usually made up of representatives from:

- HTC Chairs, Consultant Haematologists, Transfusion Practitioners, and Transfusion Laboratory Managers from all the region's hospitals (NHS and private hospitals)
- The NHSBT Hospital Liaison Team
- Patient representative

There are three meetings of the North East 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: <https://www.transfusionguidelines.org/uk-transfusion-committees/regional-transfusion-committees/north-east>

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.

A HTC should:

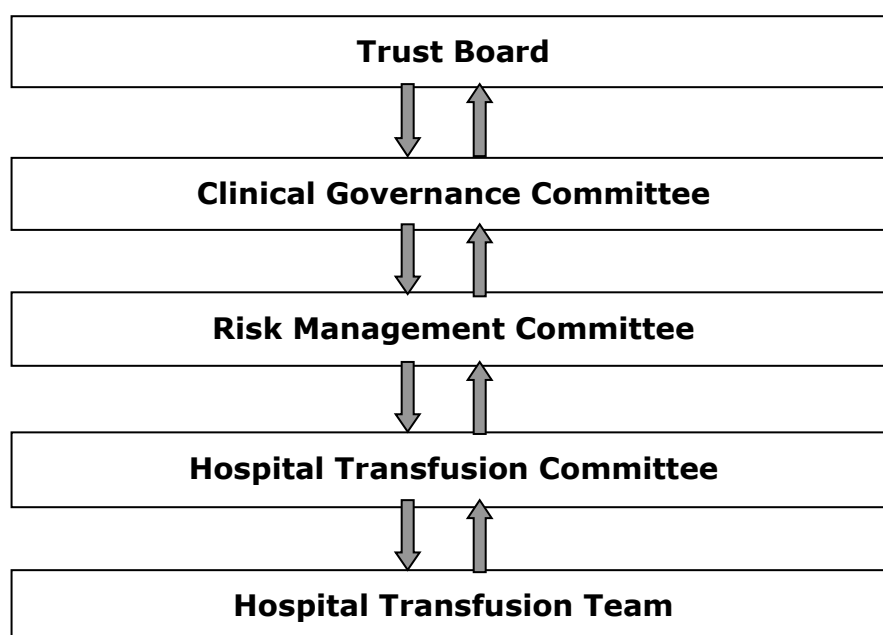
- Promote safe and appropriate blood transfusion practice through local protocols based on national guidelines.
- Audit the practice of blood transfusion against the NHS Trust policy and national guidelines, focusing on critical points for patient safety and the appropriate use of blood.
- Lead multi-professional 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 cryoprecipitate 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, consent 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 (PBM)
- 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) Hospital Liaison Team

The Hospital Liaison 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.

A hospital liaison 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 hospital liaison team is to support the activities of the RTC.

Each team includes representatives from the Customer Services, PBM Practitioner and PBM Consultant teams:

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

Customer Service Manager (CSM) - The CSM is a member of the Customer Service 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 PBM Practitioner Team is to support and promote PBM 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 TPs to identify specific areas of support required. This support may involve 1:1 visits to the TP or attendance at HTTs or HTCs. 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 components 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 PBM, including the use of:
 - a) Point of care testing for haemoglobin concentration and haemostasis
 - b) Alternatives to donor blood such as peri-operative cell salvage
 - c) Pharmacological agents such as anti-fibrinolytics and intravenous iron
 - d) Ensure that these are 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 to SHOT/ Serious Adverse Blood Reactions and Events (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 HTT and the 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.

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: <https://www.bloodstocks.co.uk/>

In addition, the North East 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.

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 SARs and SAEs. The MHRA facilitate this process and submit 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 TP or TLM.

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 professionally mandated and required for compliance with Health Service Circular 2007/001: Better Blood Transfusion Safe and Appropriate Use of Blood; 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 and all laboratories have been 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:

<http://www.JW.org>

A section for medical professionals on the Jehovah's Witness website:

<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>

Antenatal Transfusion

British Society for Haematology (BSH) published a Guideline for the use of anti-D immunoglobulin to prevent haemolytic disease of the newborn in 2014.

<http://www.b-s-h.org.uk/guidelines/guidelines/use-of-anti-d-immunoglobulin-for-the-prevention-of-haemolytic-disease-of-the-fetus-and-newborn/>

SHOT have produced anti-D resources:

<https://www.shotuk.org/resources/current-resources/>

Cell-free fetal DNA (cff DNA) testing for fetal D blood group in pregnant D negative women is now available from NHSBT <https://ibgri.blood.co.uk/services/molecular-diagnostics/fetal-genotyping-diagnostic/>

NHSBT also offers a full range of antenatal screening. See: <http://hospital.blood.co.uk/diagnostic-services/red-cell-immunohaematology/antenatal-reference-services/>

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 NHSBT 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/>

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/>

Patient Consent for Transfusion

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 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/>

E-learning for Health at www.e-lfh.org.uk/programmes/blood-transfusion

The National Learning Management System at <http://www.esrsupport.co.uk/catalogue.php5>

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/>

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. In addition, serious adverse events and reactions that are reportable to the MHRA (See MHRA section for details) should also be reported via SABRE.

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

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

Further information on the adverse effects to transfusion can be found at:
The Handbook of Transfusion Medicine

<http://transfusionguidelines.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://onlinelibrary.wiley.com/doi/10.1111/bjh.12017/full>

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

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/>

Clinical advice

The NHSBT PBM Consultant Team are available for advice 24 hours a day. To contact one of them, phone the Hospital Services department at your NHSBT delivery centre: Newcastle: 0191 202 4500

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 DH, the NBTC and NHSBT, 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 HTC) 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:

Patient Blood Management

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

O D Negative Red Cell Toolkit:

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

Platelet Resources

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

Education

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

Patient Information Leaflets

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

Pre-operative anaemia: (including an IV Iron business case template)

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

Single Unit Blood Transfusions:

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

Campaign Resources

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

Consent for transfusion

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

Transfusion Team Resources

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

Patient Blood Management Newsletters

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

Please note, 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>

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

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

NHS & Independent Trusts within NE RTC including name of Transfusion Lead

Below is a list of Trusts which fall within the North East Regional Transfusion Committee

NHS Trust	
City Hospitals Sunderland NHS Foundation Trust	Dr Susanna Mathew Susanna.Mathew@chsft.nhs.uk
County Durham & Darlington NHS Foundation Trust	Dr Adil Iqbal adil.iqbal@nhs.net
Gateshead NHS Foundation Trust	Dr Annette Nicolle annette.nicolle@nhs.net
North Cumbria University Hospitals NHS Trust	Roderick Oakes Roderick.Oakes@ncuh.nhs.uk
North Tees and Hartlepool NHS Foundation Trust	Dr Nini Aung nini.aung@nhs.net
Northumbria Healthcare NHS Foundation Trust	Dr Simon Lyons Simon.Lyons@northumbria-healthcare.nhs.uk
South Tees Hospitals NHS Foundation Trust	Dr Dianne Plews dplews@nhs.net
South Tyneside NHS Foundation Trust	Dr Susanna Mathew Susanna.Mathew@chsft.nhs.uk
The Newcastle upon Tyne Hospitals NHS Foundation Trust	Dr Andrew Charlton andrew.charlton1@nhs.net
Independents	
Nuffield Health Newcastle upon Tyne and Nuffield Health Tees	Dr Chris Tiplady chris.tiplady@northumbria-healthcare.nhs.uk
SPIRE Washington Hospital	Dr Annette Nicolle annette.nicolle@nhs.net

North East RTC Chair, NHSBT Hospital Liaison Team and Blood Conservation Lead

Contact Details, Roles & Responsibilities

RTC Chair – under review

The chair is responsible for ensuring the RTC meets its principle objective of promoting safe and effective transfusion practices within the region.

Janice Robertson – RTC Administrator

janice.robertson@nhsbt.nhs.uk

Direct line 0191 202 6604

Janice provides administrative support to the RTC, the NHSBT Hospital Liaison team and Chairs of the RTC subgroups.

Andrew Charlton – Consultant Haematologist, PBM Consultant Team

Andrew.charlton@nhsbt.nhs.uk

Direct Line 0191 202 4548 / 0191 202 4542 PA, Sue Henderson

Working with the Hospital Liaison Team at the Newcastle Blood Centre and the NHSBT PBM Consultants team to improve transfusion practice in line with Patient Blood Management and other initiatives.

Charlotte Longhorn – Patient Blood Management Practitioner Team

charlotte.longhorn@nhsbt.nhs.uk

Mobile 07385387429

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

Robin Coupe – Customer Service Manager

robin.coupe@nhsbt.nhs.uk

Direct line 0191 202 4553 / Mobile 07711447558

Robin provides a link between NHSBT and the hospitals served by the Newcastle and Leeds Blood Centres, managing the communication, complaints and performance monitoring processes and ensures NHSBT works towards delivering an outstanding service. Robin 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.

Aimi Baird – Blood Conservation Lead

aimi.baird@nuth.nhs.uk

Direct line 0191 244 8852

Aimi's main role is to promote blood conservation by liaising with colleagues in the region and with the conservation leads in other RTC regions. This will encourage sharing of best practice within the region and nationally.

North East RTC Website

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

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

Extract from the NE RTC Welcome page:

- Audits
- Calendar
- Contacts
- Education – Presentations
- Education - Resources
- Policies
- RTC business

If you would like to suggest any changes or additions to the North East RTC website pages please contact: janice.robertson@nhsbt.nhs.uk Direct line 0191 202 6604

The North East RTC 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 Society for Haematology: <http://www.b-s-h.org.uk/>

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

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

Transfusion evidence library: <http://www.transfusionevidencelibrary.com>

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

European Haematology 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

National

For details of National Comparative Audits (NCA) currently in progress or planned, please visit <https://hospital.blood.co.uk/audits/national-comparative-audit/>

Regional

Please visit the North East RTC audit page for information on regional audits / surveys
<https://www.transfusionguidelines.org/uk-transfusion-committees/regional-transfusion-committees/north-east/audits>

North East RTC policies and guidelines

- The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) **Major Haemorrhage Protocol** and **Prescription Charts**
- **Guideline for the authorisation of blood components by non-medical authorisers**
Clinical practice assessment document for the guideline above is available on the [education page](#).
- Procedure for the transfer of blood components between hospitals
- Warfarin reversal protocol
- DOAC - management of bleeding and major surgery

The above are available via the [North East RTC policies page](#)

[Pre-transfusion blood sampling process](#) video available via YouTube

Haematology [Cancer Clinical Guidelines](#) are available on the resources page of the Northern Cancer Alliance website.

The North East RTC supports the principle that trusts can accept transfer of clinical staff transfusion competencies from other trusts within the region.

Appendices

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



HTC Lay
Representative (appx

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



HTC Attendance
(appendix 2).pdf

III. Patient Blood Management Recommendations and Action Plan



National PBM
recommendations Jun



PBM action plan.xls

Thank-you to:

- The Midlands and South West PBMP Team for providing documents I and II.
- Acknowledgment: The North West RTC Toolkit for HTC Chairs.