Annex A

Better Blood Transfusion

Safe and Appropriate Use of Blood

For action by:

Health Authorities (England) – Chief Executive
Health Authorities (England) – Directors of Public Health
NHS Trusts – Chief Executives
Primary Care Trusts – Chief Executives and Main Contacts

For information to:

Chief Medical Officers Wales/Scotland/Northern Ireland
Chief Executive: NHS Blood & Transplant
Medical Director: NHS Blood & Transplant
Nursing Statutory Bodies – Chief Executives
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Safe and Appropriate Use of Blood

Summary

This Health Service Circular (HSC) replaces HSC 2002/009 *Better Blood Transfusion – Appropriate Use of Blood* and sets out a new programme of action for the NHS to:

- Build on the success of existing *Better Blood Transfusion* initiatives to further improve the safety and effectiveness of transfusion
- Ensure that *Better Blood Transfusion* is an integral part of NHS care
- Make blood transfusion safer
- Avoid the unnecessary use of blood and blood components (fresh frozen plasma and platelets)
- Minimise the risk of haemolytic disease of the newborn (HDN)
- Engage patients and the public in blood transfusion safety

The programme of action should be considered in conjunction with Annex A of this circular that provides further detail on its implementation.

A toolkit to assist NHS Trusts in the implementation of the actions outlined in *Better Blood Transfusion* HSCs is available on the www.transfusionguidelines.org.uk website. It provides access to national guidance, examples of good practice and patient leaflets, and will be regularly updated.

There is an expectation that compliance with this HSC will be subject to inspection by the Healthcare Commission (HC) and Monitor.

Background

The Chief Medical Officer's third *Better Blood Transfusion* conference was held on 16th March 2007 jointly organised by the Department of Health and the NHS Blood & Transplant (NHSBT) and supported by the four UK Chief Medical Officers (CMOs). The aim of this multidisciplinary conference was to share views on how clinical blood transfusion practice could be improved and develop a new programme of action for the NHS.

The results of surveys in 2003, 2004 and 2006 of acute NHS Trusts in England on the progress that had been made in blood transfusion practice since the second *Better Blood Transfusion* Seminar in 2001 were presented. They highlighted that in some areas of blood transfusion practice, there was very good progress with an increase in the following:

- The proportion of NHS Trusts with Hospital Transfusion Committees (HTCs)
- The proportion of NHS Trusts with transfusion practitioners
- The number of nursing staff who have received transfusion training

- The development of protocols for the appropriate use of blood
- Transfusion audit activity
- The proportion of hospital transfusion laboratories with Clinical Pathology Accreditation (CPA)
- The proportion of NHS Trusts indicating that patient information is provided to patients attending pre-assessment clinics

The survey indicated the need for further progress in the following areas:-

- Training of medical staff
- The development of Hospital Transfusion Teams (HTTs), including a transfusion practitioner and lead consultant for transfusion
- The development of protocols for the appropriate use of blood
- The provision of timely information to patients
- Implementation of intra-operative cell salvage

The results of the survey, presentations and conclusions from the conference workshops can be found on the *Better Blood Transfusion Toolkit* section of the www.transfusionguidelines.org.uk website.

Rationale for the programme of action

The safe and appropriate use of donor blood and alternatives to donor blood are important public health and clinical governance issues:

- Appropriate blood transfusion is integral to many clinical treatments and may be life-saving.
- Donated blood is a limited resource. Blood supplies may be reduced as a result of further measures that may have to be taken to reduce the risk of transmission of vCJD by blood transfusion, such as the introduction of a screening test and further restrictions on the eligibility of blood donors.
- The safety of blood transfusion is highlighted yearly through the Serious Hazards of Transfusion (SHOT) scheme (a confidential enquiry for the reporting of serious complications of blood transfusion and near miss events in the UK). This scheme has shown that avoidable, serious hazards of blood transfusion, although decreasing, continue to occur. The incidence of ABO-incompatible red cell transfusions appears to be reducing, most likely due to greater attention to detail during the transfusion process including the pre-transfusion bedside check, but there are still too many "incorrect blood component transfused" errors and further measures need to be taken by NHS Trusts, including the implementation of the recommendations in the National Patient Safety Agency (NPSA) Safer Practice Notice (SPN) *Right Patient – Right Blood* - www.npsa.nhs.uk/site/media/documents/2009_0316FEB06_V20_WEB.pdf. This SPN emphasises the importance of the final pre-transfusion bedside check, and the need for NHS Trusts to consider the use of information technology to improve transfusion safety and ensure that all relevant staff are trained and undergo regular competency assessment.
- There is continued wide variation in the use of blood despite the existence of national and local clinical guidelines on its appropriate use. There has been

good progress in reducing the use of red cell transfusions (around 16% in the last 5 years). This is mainly due to a reduction in blood use in surgery, and similar efforts are now needed in other clinical specialties, in particular medicine which now accounts for over 60% of red cell usage. Similar reductions in usage have not been seen with fresh frozen plasma or platelet transfusions, and efforts are needed to avoid inappropriate usage of these blood components.

- Attention should also be focussed on the identification and treatment of iron deficiency anaemia in pregnancy and reducing errors in relation to anti-D prophylaxis.
- The Blood Safety and Quality Regulations (2005) put additional requirements on transfusion services for transfusion safety and quality, and these are currently monitored by the Medicines and Healthcare products Regulatory Agency (MHRA).
- An evidence-base for appropriate transfusion is starting to emerge, but there is a need for more and better clinical research to underpin best clinical practice guidelines.

Associated Documentation

ANNEX A – Information for Implementation of Better Blood Transfusion: updated from the Health Service Circular *Better Blood Transfusion – Appropriate Use of Blood* (HSC 2002/009)

This Circular has been issued by:

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