FOR DECISION
ARE YOU CONTENT FOR THE ATTACHED CIRCULAR TO BE PUBLISHED?
IF SO YOU NEED TO SIGN AND DATE THE IMPACT ASSESSMENT (FLAGGED)

1. Robert Parsons APS/CMO

2. Ian Bishop PR-OFF-MS(H)

From: Dr Denise O'Shaughnessy GRO-C: Ian

Date: 31 October 2007 31/10

GRO-C: DP ✓ 6/11/07

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Mr John Henderson
Ms Julie O'Connell
Mr William Connon HPIH&SD/HP
Ms Vicky Spellacy GATEWAY

Revised Health Services Circular (HSC) – Better Blood Transfusion: Safe and Appropriate Use of Blood

1. On 6 June, I wrote to CMO, asking for approval of the Better Blood Transfusion Health Services Circular (HSC) (attached Annex A). After revision it was sent to GATEWAY for approval.

2. GATEWAY advised that as, this was a HSC and DH have significantly reduced the number of HSCs published, we would need Secretary of State's approval to proceed. We contacted SofS's office and they have designated the appropriate Minister, MS(H), to sign this HSC.

TIMING

3. As soon as practicable.

BACKGROUND

4. The better blood transfusion initiative was proposed in 1998 by CMO in response to reduced availability of donors, and hence supply of blood, as well as the potential risks posed to the general public of mistakes made in the transfusion process and the threat of secondary vCJD transmission.

5. CMO met with the National Blood Service last year to discuss Better Blood Transfusion (BBT) and the way forward. It was agreed that a further event (BBT3) should take place and an HSC would be published.

6. BBT3, attended by CMO, took place on 16th March 2007 and was a huge success. A DVD of the day's event was distributed to everyone who attended this important event. The actions agreed by the stakeholders at BBT3 included those to make transfusions even

safer, to promote the appropriate use of blood and the alternatives to blood transfusion and to increase public and patient involvement.

7. BBT1 in 1998 and BBT2 in 2001 were each followed by a HSC to inform the service of the appropriate good practice agreed at each event. Combined they led to a 15% reduction of red cell use in surgery and avoided a potential blood shortage. As previously agreed, this BBT3 HSC will build on and consolidate previous work and will help to underline important issues of blood safety and appropriate use to Trust management.

8. We have completed, and cleared with the Better Regulation and Simplification branch, the required Impact Assessment form (Annex B), which clearly shows the value of implementing the recommendations of BBT3 at minor cost to the NHS. The cost estimates are conservative figures and we expect that a 4.6% fall in red cell use will actually lead to savings to the service. We have agreed to monitor this closely. More information regarding this initiative is in the annexes of the Impact Assessment form.

CONCLUSION

9. Before sending to GATEWAY for publication we would be grateful if:
   i. both CMO and MS(H) would endorse the attached HSC, and
   ii. if MS(H) could then sign the relevant section of the Impact Assessment form (page one of Annex B).

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Consultant Haematologist
Area 531, WEL
Ext GRO-C

Better Blood Transfusion

Appropriate Use of Blood

For action by:

Strategic Health Authorities (England) – Chief Executive
Strategic 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
Professional Associations and Royal Colleges
Strategic Health Authority Directors of Public Health
Strategic Health Authority Directors of Performance Management
Strategic Health Authority Nurse Directors
Postgraduate Medical Deans
Monitor
Foundation Trusts

Further details from:

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Additional copies of this document can be obtained from:
Department of Health

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London SE1 6XH

Better Blood Transfusion

Appropriate Use of Blood

Summary

This Health Service Circular 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 previous *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
- As part of clinical governance responsibilities, make blood transfusion safer
- Avoid the unnecessary use of blood and blood components (fresh frozen plasma and platelets) in medical and surgical practice
- Avoid unnecessary blood transfusion in obstetric practice and minimise the risk of haemolytic disease of the newborn (HDN)
- Increase patient and public involvement in blood transfusion

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 Trusts in the implementation of *Better Blood Transfusion* was developed on the www.transfusionguidelines.org.uk website in 2003. It provides access to national guidance, examples of good practice and patient leaflets, and it will now be updated.

Rationale

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 an essential support to many medical 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 future 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 continue to occur. The incidence of ABO-incompatible red cell transfusions appears to be reducing, possibly due to greater attention to detail

during the pre-transfusion bedside check, but there are still too many "incorrect blood component transfused" errors and further measures need to be taken by Trusts, including the implementation of the recommendations in the National Patient Safety Agency (NPSA) Safer Practice Notice *Right Patient – Right Blood* - www.npsa.nhs.uk/site/media/documents/2009_0316FEB06_V20_WEB.pdf. This emphasises the importance of the final pre-transfusion bedside check, and the need for Trusts to consider the use of information technology (IT) to improve transfusion safety and ensure that all relevant staff are trained and undergo competency assessment.

- There is continued wide variation in the use of blood, even with the existence of national and local clinical guidelines developed by clinical professionals on the appropriate use of donor blood. 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. Reductions have not been seen in fresh frozen plasma or platelet transfusions, and efforts are needed to avoid inappropriate usage of these blood components.
- Attention should also be focussed on reducing avoidable transfusion for iron deficiency anaemia in pregnancy and reducing errors in relation to anti-D prophylaxis.
- 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.

ACTION

- This guidance is addressed to all Trusts providing blood transfusion and managing patients who may need transfusion
- Primary Care Trusts (PCTs) and acute Trusts should work together to implement the attached action programme
- NHS acute Trust Boards should formally review arrangements for *Better Blood Transfusion* and the appropriate use of blood at least annually;
- Strategic Health Authorities have an important role to play in ensuring arrangements are in place for delivery.

Progress is expected in all areas (except those mentioned in the text) by Nov 2008, when the first national audit of compliance will commence. Annual audits will continue until full implementation to a maximum of 5 years.

GUIDANCE

- Foundation Trusts are advised to take note of the contents of this HSC

Action

- **Ensure that *Better Blood Transfusion* is an integral part of NHS care**

Objective	Action	By whom
Secure appropriate arrangements for *Better Blood Transfusion* and the appropriate use of blood	• Ensure senior management and Board level commitment	Chief Executives of NHS Trusts.
	• Secure appropriate membership and functioning of the Hospital Transfusion Committee and Team including staffing and resources (see Annex A)	Chief Executive of NHS Trusts.
	• Ensure the Hospital Transfusion Team develops appropriate action plans based on local need and national initiatives e.g. from the National Patient Safety Agency and regulations e.g. the UK Blood Safety and Quality Regulations (2005)	Chief Executives of NHS Trusts with Hospital Transfusion Committees and Teams.
	• Ensure the Hospital Transfusion Team produces 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	Chief Executives of NHS Trusts working with clinical governance and risk management leads, Hospital Transfusion Committees and Teams.
	• Ensure that appropriate blood transfusion policies are in place, implemented and monitored	Chief Executives of NHS Trusts with Hospital Transfusion Committees and Teams
	• Ensure that education	

	and annual training are given to all health care staff involved in the process of blood transfusion and is included in the induction programmes for new staff	Chief Executives of NHS Trusts with Hospital Transfusion Committees and Teams
	• Ensure that procedures are in place for managing Jehovah's Witness and other patients refusing blood	Chief Executives of NHS Trusts working with clinical governance leads, Hospital Transfusion Committees and Teams
Improve the quality of service provision through clinical audit and continuing professional development	• Review the blood transfusion content of clinical multi-disciplinary audit and CPD programmes for NHS Trust staff, including the Hospital Transfusion Team	Chief Executives of NHS Trusts working with clinical governance leads and Hospital Transfusion Committee and Teams
	• Ensure participation in the Blood Stocks Management Scheme	Chief Executives of the NHS Trusts with blood transfusion laboratories
	• Ensure participation in the national comparative audit programme for bood transfusion organised by the Royal College of Physicians and NHSBT	Chief Executives of the NHS Trusts working with clinical governance leads and Hospital Transfusion Committee and Teams

- **Make blood transfusion safer**

Objective	**Action**	**By whom**
Continuously improve the safety of the blood transfusion process, taking advantage of developments in technology	• Ensure that policies and technologies to secure patient identification throughout the transfusion process are risk assessed,	Chief Executives of NHS Trusts working with clinical governance and risk management leads, clinicians, hospital staff, blood transfusion

	implemented and monitored to comply with the UK Blood Safety and Quality Regulations (2005) and National Patient Safety Agency (NPSA) recommendations	laboratories, Hospital Transfusion Committees, Hospital Transfusion Teams
	• Ensure that all relevant staff are assessed for their competency in safe transfusion practice in line with NPSA recommendations	Chief Executives of NHS Trusts, pathology managers, blood transfusion laboratories, Hospital Transfusion Committees and Teams By November 2009
	• Ensure good and safe hospital transfusion laboratory practice including participation in national laboratory accreditation schemes	Chief Executives of NHS Trusts, pathology managers, Hospital Transfusion Committees and Teams
	• Ensure adequate staffing of hospital transfusion laboratories including out of hours	Chief Executives of NHS Trusts, pathology managers, Hospital Transfusion Committees and Teams
	• Ensure that staff in blood transfusion laboratories are trained and assessed for competency in safe laboratory transfusion practice based on knowledge and technical skills	Chief Executives of NHS Trusts, risk management leads, pathology managers, Hospital Transfusion Committees and Teams
	• Carry out regular (at least annual) local audits of key steps in the transfusion process, including sample labelling and the pre-transfusion bedside check, and participate in national audits of the transfusion process	Hospital Transfusion Teams
Ensure that reporting of serious adverse events to	• Ensure that adverse events to transfusion and near	Chief Executives of NHS &F Trusts working with

blood transfusion and near misses is being undertaken	misses are reported appropriately to local risk management, SHOT and the MHRA via the Serious Adverse Blood Reactions and Events (SABRE) system	clinical governance and risk management leads, clinicians, hospital staff, blood transfusion laboratories, Hospital Transfusion Committees, Hospital Transfusion Teams
	• Ensure timely feedback to users on lessons learnt and preventive measures	Hospital Transfusion Teams

- **Avoid the unnecessary use of blood and blood components in medical and surgical practice**

Objective	Action	By whom
Ensure the appropriate use of blood and the use of effective alternatives in every clinical practice where blood is transfused	• Implement existing national guidance (see Annex A) on the appropriate use of blood and alternatives	Chief Executives of NHS Trusts working with clinicians and Hospital Transfusion Committee and Teams
	• Ensure that guidance is in place for the medical and surgical use of red cells, and other blood components such as platelets and fresh frozen plasma	Chief Executives of NHS Trusts working with clinicians and Hospital Transfusion Committee and Teams
	• Ensure regular monitoring and audit of usage of red cells, platelets and fresh frozen plasma in all clinical specialities	Hospital Transfusion Committees and Teams working with clinicians
	• Empower blood transfusion laboratory staff to ensure that appropriate clinical information is provided with requests for blood transfusion	Chief Executives of NHS Trusts working with clinicians and Hospital Transfusion Committee and Teams
	• Empower blood transfusion	Chief Executives of NHS Trusts working with

	laboratory staff to query clinicians about the appropriateness of requests for transfusion (following agreed Trust policies)	clinicians and Hospital Transfusion Committee and Teams
Secure appropriate and cost-effective provision of blood transfusion and alternatives in surgical care	• Ensure that mechanisms are in place for the pre-operative assessment of patients for planned surgical procedures to allow the identification, investigation and treatment of anaemia and the optimisation of haemostasis	Chief Executives of NHS Trusts working with clinicians and Hospital Transfusion Teams
	• Ensure that indications for transfusion are in place, implemented and monitored	Hospital Transfusion Committees and Teams
	• Review and explore the use of effective alternatives to donor blood including the appropriate use of peri-operative and post-operative cell salvage	Chief Executives of NHS Trusts working with clinicians and Hospital Transfusion Committees and Teams

- **Improve the Safety of Blood Transfusion in Obstetrics**

Objective	**Action**	**By whom**
Improve the safety and effectiveness of blood transfusion in obstetric practice, including the prescription and administration of anti-D immunoglobulin	• Ensure procedures for the prescription and administration of anti-D immunoglobulin in hospitals and primary care are risk assessed and monitored	Chief Executives of acute &F Trusts and PCTs, Royal Colleges of Obstetricians and Midwives, risk management leads, hospital and primary care clinicians (Obstetricians, GPs, Midwives and Nurses), hospital transfusion laboratories, pharmacies, Hospital Transfusion Committees and Teams
	• Ensure that clinicians in hospitals and primary care	Hospital Transfusion Teams

	are trained to understand the results of antenatal blood group serology reports and prescribe prophylactic anti-D immunoglobulin (antenatal and postnatal) appropriately	
	• Ensure that staff in blood transfusion laboratories are trained and assessed for competency in the prevention and management of HDN based on knowledge and technical skills	Chief Executives of NHS Trusts, risk management leads, pathology managers, Hospital Transfusion Committees and Teams
	• Ensure that national guidance from NICE is followed regarding prophylactic anti-D administration	Chief Executives of acute Trusts and PCTs, risk management leads, hospital and primary care clinicians (Obstetricians, GPs, Midwives and Nurses), hospital transfusion laboratories, pharmacies, Hospital Transfusion Committees and Teams
	• Ensure the use of anti-D immunoglobulin follows the same rigorous patient identification, recording and traceability requirements as all other blood products and components	Chief Executives of NHS Trusts, risk management leads, pathology managers, Hospital Transfusion Committees and Teams
	• Ensure the establishment of procedures for the identification and management of maternal anaemia in particular with correction of iron deficiency in the antenatal and postnatal period.	Chief Executives of acute Trusts and PCTs, Royal Colleges of Obstetricians and Midwives, risk management leads, hospital and primary care clinicians (Obstetricians, GPs, Midwives and Nurses), hospital transfusion laboratories, pharmacies, Hospital Transfusion Committees and Teams

- **Increase Patient and the Public Involvement in Better Blood Transfusion**

Objective	Action	By whom
Ensure patients who are likely to receive a blood transfusion are informed of their choices	• Ensure that timely information is made available to patients informing them of the indication for transfusion any alternatives available and the risks (both infectious and non-infectious) are discussed.	Hospital Transfusion Committees working with clinicians, patients groups and Primary Care Trusts
Increase patient involvement in transfusion safety	• Ensure that patients are aware of the risks of transfusion, and the need to wear an identity name band and to be correctly identified at all stages of the transfusion process.	Hospital Transfusion Committees and Teams working with clinicians
Increase patient and public awareness in blood transfusion	• Ensure that Trusts participate in Transfusion Awareness initiatives to increase patient and public involvement in blood transfusion	Chief Executives of NHS Trusts working with Hospital Transfusion Committees and Teams

- **Monitoring of the arrangements for *Better Blood Transfusion* and their effectiveness**

Objective	Action	By whom
Promote the safe and appropriate use of blood and cost-effective alternatives in Trusts	• Ensure that services for *Better Blood Transfusion* being provided are operating effectively and are part of local performance management arrangements	Strategic Health Authorities working with NHS Trusts
	• Participate in national comparative audits of transfusion practice	Hospital Transfusion Teams
	• Participate in the Blood Stocks Management Scheme	Hospital Transfusion Teams
	• Participate in national and	Hospital Transfusion Teams

	regional surveys of the implementation of the action plan in *Better Blood Transfusion*	

- **External support required to ensure the delivery of *Better Blood Transfusion***

Objective	Action	By Whom
Blood Services to provide support for Hospital Transfusion Teams	• Blood Services to maintain and further develop a support network for Hospital Transfusion Teams for the provision of clinical advice and information	Blood Services working with national and regional transfusion committees and Hospital Transfusion Teams
	• Blood Services to support clinical research on the safe and appropriate use of blood	Blood Services working with national and regional transfusion committees and relevant funding bodies for clinical research
National and regional transfusion committees to support Hospital Transfusion Teams	• National and/or regional transfusion committees should support Hospital Transfusion Teams by providing information and advice on the implementation of national recommendations and regulations, blood conservation, contingency and emergency planning, new developments and clinical research	National and regional transfusion committees working with Hospital Transfusion Teams and Blood Services
	• National and/or regional transfusion committees should support Hospital Transfusion Teams by supporting comparative audit and the sharing of data	National and regional transfusion committees working with Hospital Transfusion Teams and Blood Services, national audit programmes and the Blood Stocks Management Scheme

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 National Blood Service and chaired by the four UK Chief Medical Officers. The aim of this multidisciplinary conference was to share views on how clinical blood transfusion practice could be improved with the following aims:

- Build on the success of previous *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
- As part of clinical governance responsibilities, make blood transfusion safer
- Avoid the unnecessary use of blood components (fresh frozen plasma and platelets as well as red cells) in medical and surgical practice
- Provide better information to patients and the public about blood transfusion

A survey of acute NHS Trusts in England of progress that had been made in blood transfusion practice since the second *Better Blood Transfusion* Seminar in 2001 was presented at the conference.

It highlighted that in some areas of blood transfusion practice, there was very good progress with an increase in the following:

- Hospital Transfusion Committees
- Transfusion Practitioners
- The number of staff who have received transfusion training
- The development of protocols for the appropriate use of blood
- Transfusion audit activity
- Clinical Pathology Accreditation of hospital transfusion laboratories
- The number 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 staff
- The development of Hospital Transfusion Teams, including a transfusion practitioner and lead consultant for Transfusion
- The development of protocols for the appropriate use of blood
- The provision of information to patients
- Intra-operative cell salvage

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

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:

Sir Liam Donaldson
Chief Medical Officer