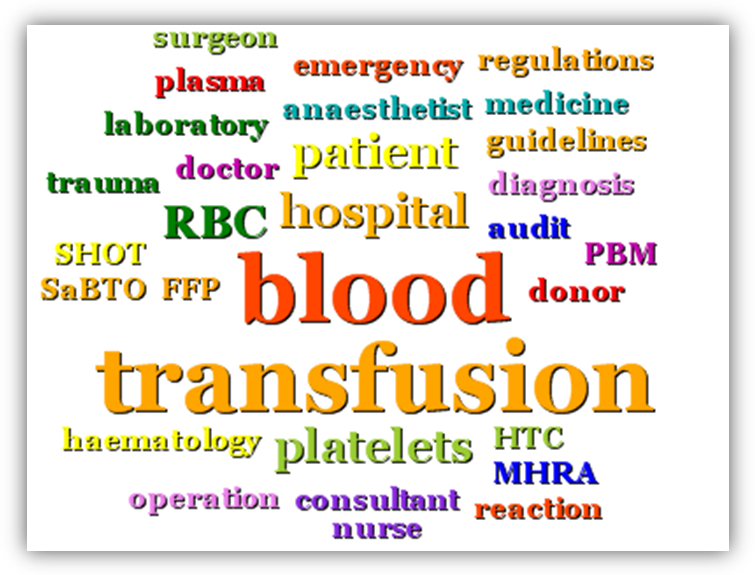


**East of England Regional Transfusion Committee**

Hospital Transfusion Committee

Chair’s Toolkit



Guidance for New and Developing HTC ChairsCONTENTS

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Foreword

This toolkit has been produced to assist you in your role as Hospital Transfusion Committee Chair.

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 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 11.

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

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 and North Wales. They oversee the activities of the local HTCs 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 Chairs of all HTCs 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:

**Trust Board**

**Clinical Governance Committee**

**Risk Management Committee**

**Hospital Transfusion Committee**

**Hospital Transfusion Team**

## 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 and North Wales. 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 hospital Trust.

**Customer Service Manager (CSM)** -TheCSM 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 HTCs. The PBMP also facilitates regional training and educational events either as a support to TPs or as the event co-ordinator.

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 Patient Blood Management team produce and circulate to each HTT a highlight summary report of issue and wastage data each month. All the data is extracted from BSMS.

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 p14

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

**Some key points from the PBM Recommendations for the HTC Chair 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:**

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/>

Size matters poster:

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

**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-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>

In December 2016, NICE produced QS138 Quality Standards for blood transfusion which can be found at: <https://www.nice.org.uk/guidance/qs138>.

In statement form, these standards are:

[Statement 1](https://www.nice.org.uk/guidance/QS138/chapter/quality-statement-1-iron-supplementation#quality-statement-1-iron-supplementation) People with iron-deficiency anaemia who are having surgery are offered iron supplementation before and after surgery.

[Statement 2](https://www.nice.org.uk/guidance/QS138/chapter/quality-statement-2-tranexamic-acid-for-adults#quality-statement-2-tranexamic-acid-for-adults) Adults who are having surgery and expected to have moderate blood loss are offered tranexamic acid.

[Statement 3](https://www.nice.org.uk/guidance/QS138/chapter/quality-statement-3-reassessment-after-red-blood-cell-transfusions#quality-statement-3-reassessment-after-red-blood-cell-transfusions) People are clinically reassessed and have their haemoglobin levels checked after each unit of red blood cells they receive, unless they are bleeding or are on a chronic transfusion programme.

[Statement 4](https://www.nice.org.uk/guidance/QS138/chapter/quality-statement-4-patient-information#quality-statement-4-patient-information) People who may need or who have had a transfusion are given verbal and written information about blood transfusion.

NHS & Independent Hospitals/Trusts within EoE RTC

including HTC Chair’s Name

Below is a list of Hospitals / Trusts which fall within the East of England Regional Transfusion Committee incorporating the HTC Chair’s 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** | **Role** |
| **Addenbrooke’s** | Cambridge University Hospitals | Dr Kourosh Saeb-Parsy | Consultant Transplant Surgeon |
| **Basildon** | Basildon & Thurrock University Hospitals | Dr Judith Whitehead | Consultant Anaesthetist |
| **Bedford** | Bedford Hospital | Dr Swati Pradhan | Consultant Paediatrician |
| **Broomfield** | Mid Essex Hospital Services | Dr Graham Philpott | Consultant Anaesthetist |
| **Colchester** | Colchester Hospital University | Dr Simon Dixon | Consultant Anaesthetist |
| **Lister**  **QE II** | East & North Herts | Dr Steven Bates | Consultant Anaesthetist |
| **Hinchingbrooke** | Hinchingbrooke Health Care NHS Trust | Dr George Koshy | Consultant Anaesthetist |
| **Ipswich** | Ipswich Hospital | Dr Gerald Glancey | Consultant Nephrologist |
| **James Paget** | James Paget University Hospital | Dr Vamsi Velchuru | Consultant Surgeon |
| **Luton & Dunstable** | Luton & Dunstable University Hospitals | Dr Georgie Kamaras | Consultant Anaesthetist |
| **Norfolk & Norwich** | Norfolk & Norwich University Hospitals | Dr Debbie O’Hare | Consultant Anaesthetist |
| **Papworth** | Papworth Hospital | Dr Nicola Jones | Consultant Anaesthetist |
| **Peterborough** | Peterborough & Stamford Hospitals | Dr Bal Appadu | Consultant Anaesthetist |
| **Princess Alexandra** | Princess Alexandra Hospital | Dr Mahmoud Wagih | Consultant Anaesthetist |
| **Southend** | Southend University Hospital | Dr Mohammed Islam | Consultant Haematologist |
| **Queen Elizabeth** | Queen Elizabeth Hospital King’s Lynn | Dr Angelo Giubileo | Clinical Specialist A & E |
| **Watford** | West Herts Hospitals | Dr Beena Parker | Consultant Anaesthetist |
| **West Suffolk** | West Suffolk Hospital | Dr Alain Sauvage | Consultant Accident & Emergency |
| **Independents** |  |  |  |
| **Brentwood Nuffield** |  | Dr Paul Cervi | Consultant Haematologist |
| **Ramsay Rivers** |  | Dr Faris Al-Refaie | Consultant Haematologist |
| **Spire Hartswood** |  | Dr Parag Jasani | Consultant Haematologist |
| **Spire Cambridge Lea** |  | Dr Parag Jasani | Consultant Haematologist |

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. She can be contacted via the RTC Administrator (below)

**Ms. Jane O’Brien – RTC Administrator**

[jane.o’brien@nhsbt.nhs.uk](mailto:jane.murphy@nhsbt.nhs.uk)

Direct line 01223 588906

Jane provides administrative and audit support to the RTC, the NHS Blood and Transplant (NHSBT) Hospital Liaison regional team and Chairs of the RTC sub groups. She also provides monthly reports for hospitals.

**Dr. Dora Foukaneli – Consultant Haematologist, Patients Clinical Team,**

**Patient Blood Management**

[dora.foukaneli@nhsbt.nhs.uk](mailto:dora.foukaneli@nhsbt.nhs.uk)

Direct Line 01223 5888098 / 07764280093 PA,

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](mailto: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](mailto:rukhsana.hashmat@nhsbt.nhs.uk)

Direct line 01223 588165 / Mobile 074711477917

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](mailto:jane.murphy@nhsbt.nhs.uk)

Direct line 01223 588906

The East of England website is housed on the [JPAC](http://www.transfusionguidelines.org.uk/) 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/>

Audits

**National Comparative Audits** [Audit of lower gastrointestinal bleeding and the use of blood 2015](http://hospital.blood.co.uk/media/28411/national-comparative-audit-of-lower-gastrointestinal-bleeding-and-the-use-of-blood-light.pdf). Report published May 2016

* Audit of Red Cell & Platelet transfusion in adult haematology patients - Audit completed.
* Re-audit of Patient Blood Management in adults undergoing elective, scheduled surgery - Re-audit September 2016
* Audit of Red Cell transfusion in Palliative care - Data collection starts in September 2016
* Audit of Red Cell & Platelet transfusion in adult haematology patients - re-audit Spring 2017

The NCA audit user’s homepage can be found at [www.nhsbtaudits.co.uk](http://www.nhsbtaudits.co.uk)

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

**Regional Audits**

* In 2016 we conducted a regional audit of plasma products.



* 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



* 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.



* 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.



East of England RTC policies and guidelines

* [Protocol for major haemorrhage in children](http://www.transfusionguidelines.org.uk/document-library/documents/protocol-for-massive-blood-loss-in-children/download-file/rtc-eeng_2014_10_N_massive_blood_loss.pdf) (Addenbrooke's Hospital) Adopted as a regional document by the East of England RTC and revised in December 2016.



* [Major Haemorrhage Guidance](http://www.transfusionguidelines.org/document-library/documents/rtc_eeng_major_haemorrhage_guidance/download-file/East%20of%20England%20RTC%20Major%20Haemorrhage%20Guidance.pdf) by the East of England RTC was updated in March 2016 following new guidelines from NICE and BCSH.



* [Acute Transfusion Reaction Guidelines](file:///C:\Users\Jane\Downloads\East%20of%20England%20RTC%20ATR%20Guidelines%20V2.pdf) 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.



* The East of England RTC has produced [regional guidelines on the transfer of blood with patients](http://www.transfusionguidelines.org.uk/document-library/documents/regional-guidelines-on-the-transfer-of-blood-with-patients/download-file/rtc-eeng_blood_transfer.pdf) and accompanying [blood and components transfer forms, version 2](http://www.transfusionguidelines.org.uk/document-library/documents/rtc-eeng_2015_05_n_blood_transfer_form_v2/download-file/rtc-eeng_2015_05_N_blood_transfer_form_v2.doc). These were derived from the national document.

* The East of England TADG has compiled a list of [Group O RhD negative Top Ten Tips](http://www.transfusionguidelines.org/document-library/documents/group-o-rhd-neg-top-tips-1/download-file/Group%20O%20RhD%20neg%20top%20tips.pdf)



* The East of England has developed a regional [Single Unit Guideline](http://www.transfusionguidelines.org/document-library/documents/single-unit-policy-1/download-file/Single%20unit%20policy.pdf), together with an [Algorithm](http://www.transfusionguidelines.org/document-library/documents/algorithm-for-reviewing-red-cell-requests/download-file/Algorithm%20for%20reviewing%20red%20cell%20requests.pdf) for laboratory review of red cell requests.

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* + The East of England has a [Shared Care](http://www.transfusionguidelines.org/document-library/documents/shared-care-form-v2/download-file/Shared%20care%20form%20V2%20a%20EoE%2002%2016.doc) 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 in included on the reverse.



Forthcoming Events 2017

Regional meetings

6th June 2017

**EoE RTC Meeting**

St Johns Innovation Centre, Cambridge

Time 10.00 – 13.00

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”**

A regional education event

Granta Centre, Cambridge CB21 6AL

Time: 9.30 am to 4.00 pm

4th October 2017

Our main education event for 2017 will be based on **Human Factors** and will include presentations and workshops.

Hallmark Hotel, Bar Hill, Cambridge CB23 8EU

National meetings:

7th, 8th & 21st June 2017

**BSMS Roadshows**

Birmingham, Sheffield & London respectively

12th July 2017.

**SHOT Symposium**

Harpenden, Herts

13th – 15th September 2017

**BBTS Annual conference**

Glasgow

Appendices

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



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



1. Duties of a Trust wide Transfusion Lead \*\*\*



1. Patient Blood Management Recommendations and Action Plan



Thank-you to:

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