





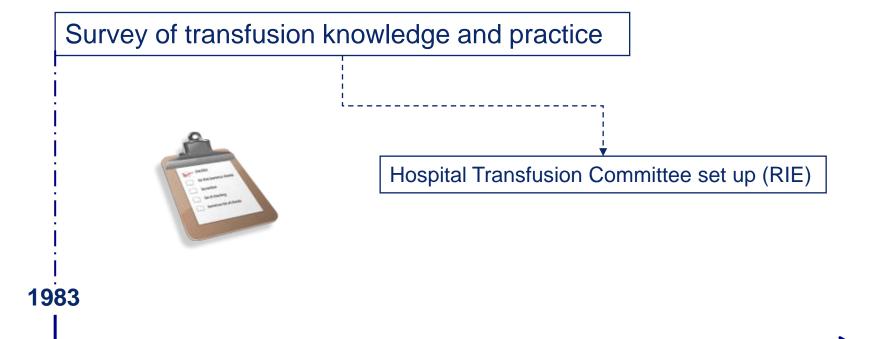
A Decade of Better Blood Transfusion in Scotland

Susan Cottrell, Transfusion Practitioner
NHS National Services Scotland



On Your Marks...

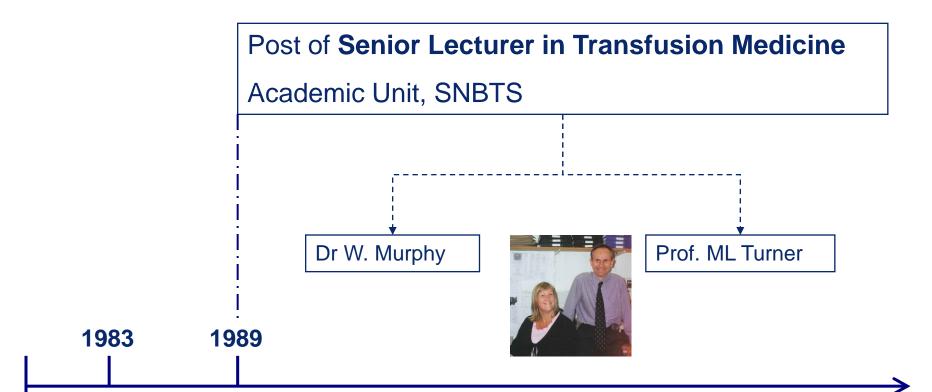






On Your Marks...

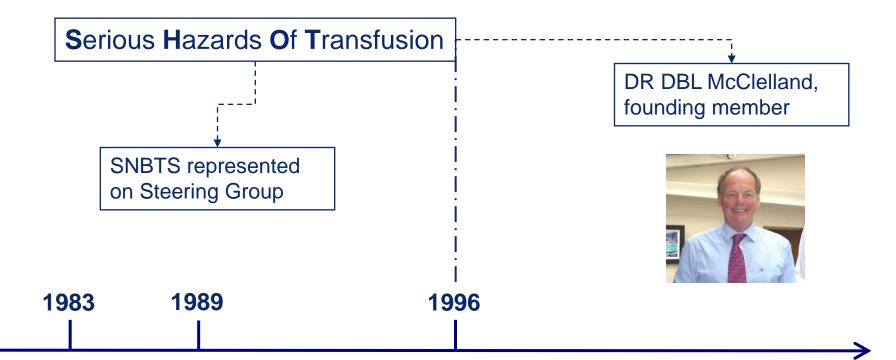






On Your Marks...







Get Set...



Effective Use of Blood Group



Better Blood Transfusion Continuing Education Programme

1983

1989

1996

1998



Get Set...



NHS MEL 1999 (9) Better Blood Transfusion

Key Recommendations:

- HTCs in each Health Board
- Participation in SHOT
- Local Transfusion Policies
- In-house training in Transfusion
- Explore Cell Salvage

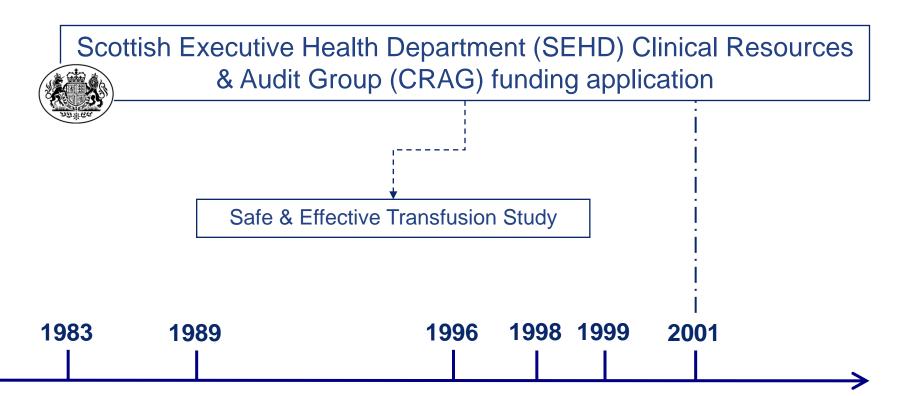
1983 1989 1996 1998 1999





Get Set...



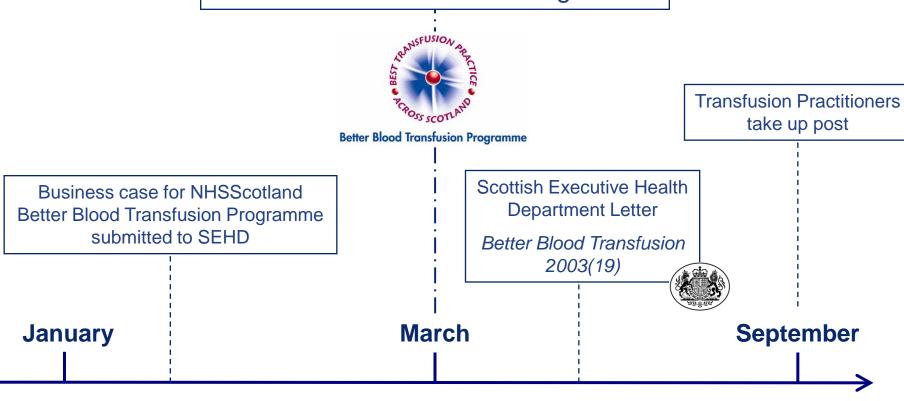




GO!



Better Blood Transfusion Programme





BBTP Objectives



'Establish a programme which will promote appropriate use and reduce risk to patients'

(NHS HDL 2003 (19))

SAFE

Right blood, right patient, right time

EFFECTIVE

Doing the right thing

EFFICIENT

Doing things right



BBT Programme Launch



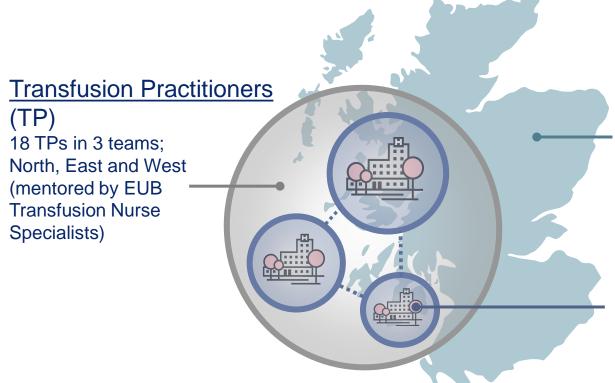


Crieff, 2003



BBT Programme Structure - 2003





Central Programme Team (CPT)

Programme Director 2 Programme Analysts Office Administrator (based in Edinburgh)

Hospital Transfusion Teams

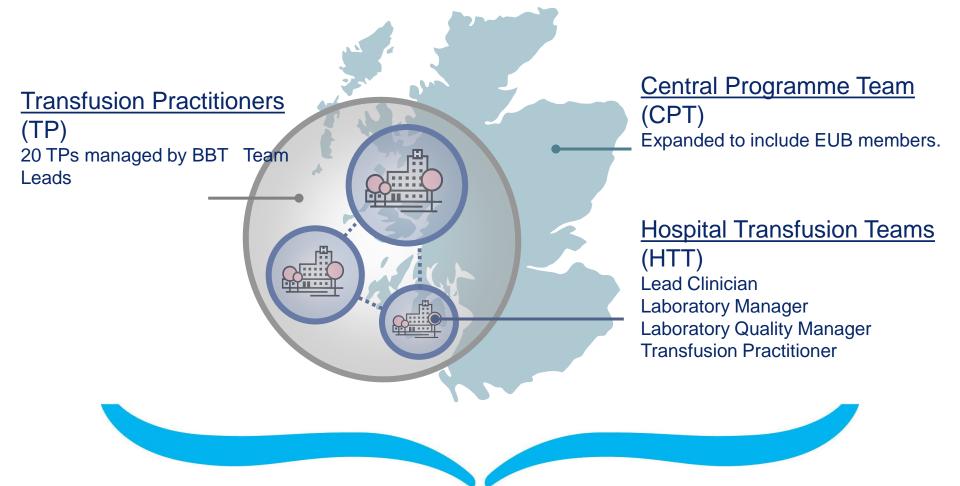
(HTT)

Lead Clinician
Laboratory Manager
Laboratory Quality Manager
Transfusion Practitioner



BBT Structure – 2008 EUB & BBTP Merge





Scottish Clinical Transfusion Advisory Committee



Safe



Education and Training

In the beginning...

- Which members of staff require education?
 - No Training Needs Analysis
 - Variation of staff groups involved
- How do we manage training records?
- Difficulty accessing staff / venues / equipment
- eLearning introduced late 2004





Safe



Learnbloodtransfusion (LBT)

And now...

- - 3 Core modules & 6 Specialist modules
 - More in development
- ♦ 80% of staff complete training online







Did You Know?



 Since 2004 over 78,000 NHSS staff have completed the LBT module: Safe Transfusion Practice



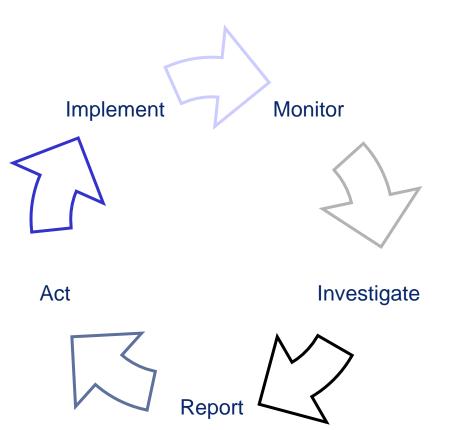
Placed end to end, they would stretch from the foot of Ben Nevis to the summit 100 times!



Safe



Haemovigilance



BBT promote active participation in the UK haemovigilance system

- 10% SHOT reports from NHSS
- Since 2001 the total number of SHOT reports has doubled
- ABO Incompatible transfusions have gone down from 7% to 2%
- A sign of an effective haemovigilance system

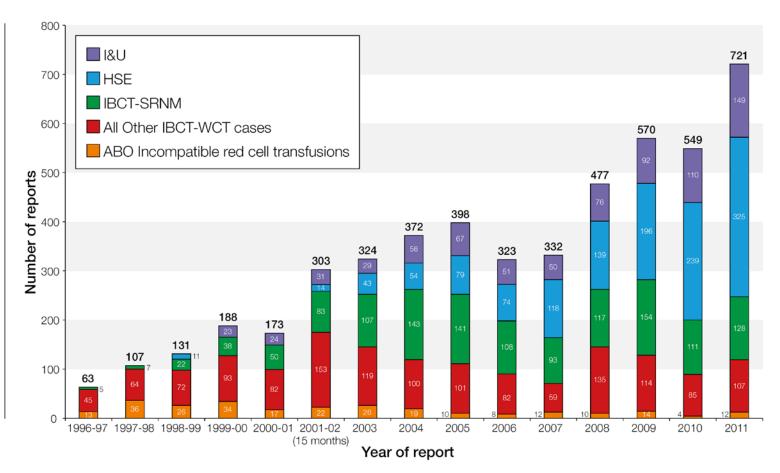


Safe



Haemovigilance

Figure 4.3
Incorrect blood
components
transfused (IBCT)
either due to wrong
component (WCT)
or where special
requirements were
not met (SRNM),
handling and
storage errors (HSE),
showing the number
that resulted in
ABO-incompatible
transfusions





Effective







Efficient



Maximum Surgical Blood

Ordering Schedule -

helping clinical teams to use blood appropriately Doing things right

Blood Conservation
Practitioner - dedicated
to promoting alternatives
to transfusion

Supporting clinical and laboratory teams to make best use of the donor's gift

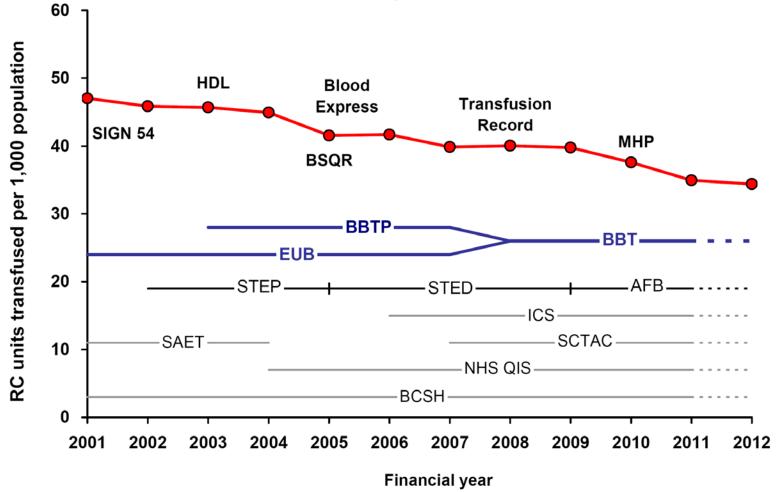
Account for Blood -

providing national data to support clinical practice and stock management











Did You Know?



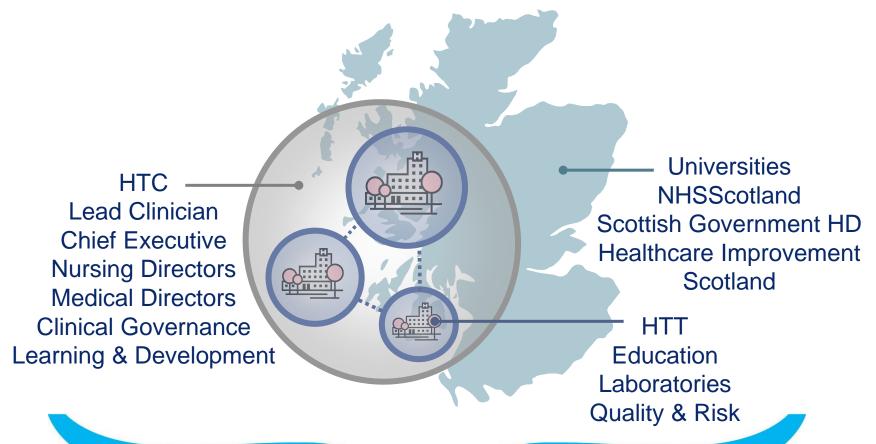
- Since 2003 we have saved 105,000 litres of blood through reduced use
- Equivalent in volume to 4.2 million drams of whisky – one for every adult in Scotland!





Relationships – Local







Relationships – National



UK Transfusion Networks

Medicines & Healthcare Regulatory Agency

National Audits & Clinical Trials

British Committee for Standards in Haematology

Serious Hazards of Transfusion

UK Blood
Transfusion Services



Relationships – International







Better Blood Transfusion The Future







Better Blood Transfusion The Future



- Ensure that NHSScotland has enough blood to meet the transfusion needs of patients in Scotland by focusing on:
 - Gaining insight into the clinical context in which blood components are used
 - Optimising blood component stock management
 - Continuing to support safe, effective and appropriate transfusion

