

Policy for Requesting Blood Transfusion by General Practitioners and Blood Sampling for Transfusion by Health Care Professionals in the Community	
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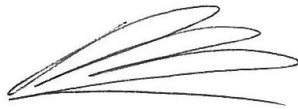
Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience	✓	Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards Regulation No.	12	Infection Control	
Note: This document has been assessed for any equality, diversity or human rights implications			

Controlled document

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Full History		Status: Draft	
Version	Date	Author	Reason
1	01/07/2015	Transfusion Doctor	New Policy, to meet Department of Health <i>Safe and Appropriate Use of Blood 2007</i>

Associated Trust Policies/ Procedural documents:	Consent for Examination or Treatment Policy Identification of Patients Policy Venepuncture Guidelines Incident Reporting, Analyzing, Investigating and Learning Policy and Procedures.
In consultation with and date: Hospital Transfusion Team 01/07/2015 Risk Management 01/07/2015 Equality and Diversity Lead 23/07/15 CCG Area Manager sent on 7/9/2015 Policy Expert Panel 3/8/15 Patient Blood Management Group 10/9/15	
Contact for Review:	Dr Barrie Ferguson
Executive Lead Signature: Adrian Harris	

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1. INTRODUCTION

- 1.1 [The Department of Health directive “A Better Blood Service”](#) (DoH, 2007) requires all NHS Trusts to have policies and guidelines on the administration of blood and blood products⁽¹⁾.
- 1.2 This document sets out the Royal Devon and Exeter Foundation Trust’s position (hereafter referred to as the Trust) with regard to:
- Safe and appropriate requesting of blood transfusions by General Practitioners
 - Safe practice in venous blood sampling for transfusion for Health Care Professionals working in a community setting
- 1.3 **Failure to comply with this policy could result in disciplinary action**

2. PURPOSE

- 2.1 Patient Blood Management (PBM) is a multidisciplinary, evidence-based approach to optimising the care of patients who might need transfusion. PBM 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.
- 2.2 PBM represents an international initiative in best practice of transfusion medicine and this policy has incorporated the key objectives of the PBM conference: ‘The Future of Blood Transfusion’, June 2012, hosted by the Department of Health (DH), the National Blood Transfusion Committee (NBTC) and the NHS Blood and Transplant (NHSBT)
- 2.3 The Trust recognises that Blood Transfusion involves a complex chain of events. Errors in this process can have serious consequences, including transfusion of ABO incompatible red cell units which can lead to the death of a patient and is listed as one of the Department of Health’s ‘Never Events’
- 2.2 The purpose of this policy is to ensure that relevant staff have access to national and local guidance regarding requesting a blood transfusion and blood sampling for transfusion.
- 2.3 This policy has been developed in order to reduce risk and improve quality of care to patients

3. DEFINITIONS

- 3.1 **Bedside** – for the purpose of this policy the bedside refers to the patient’s side, whether the patient is in a bed, on a trolley/operating table or sitting in a chair.
- 3.2 **Better Blood Transfusion** – produced in response to the [Department of Health Circular HSC 2007/001 Better Blood Transfusion – Safe and Appropriate Use of Blood](#) (DoH, 2007). Some of its aims are to improve safety, avoid unnecessary use of blood components. A part of this is an educational programme

- 3.3 **Medicines and Healthcare products Regulatory Agency (MHRA)** – the MHRA is responsible for regulating blood establishments and hospital blood banks. The MHRA is responsible for monitoring compliance with [Blood Safety and Quality Regulations 2005](#).
- 3.4 **Never Events** – “[Never Events](#)” were defined in 2008 by the National Patient Safety Agency as “serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers”. This includes ABO incompatible transfusions
- 3.5 **Positive patient identification** – wherever possible this is achieved by asking the patient to **state** their full name and date of birth. This must match **exactly** the information on the patient’s identification bands attached to the patient and the key item being checked. i.e. request form, prescription or at administration the blood component/product. For patients who are unable to identify themselves e.g. paediatric, unconscious or confused, or where there is a language barrier, verification of the patients identification should be obtained from a parent or carer (if present at patients bedside) and checked with the patient’s identification band(s).
- 3.6 **Serious Adverse Blood Reactions and Events (SABRE)/ Serious Hazards of Transfusion (SHOT)** – are UK based organisation which collects information from adverse events and transfusion reactions in order to monitor the safety of blood transfusions. SHOT produces an annual report based upon the data collected, producing recommendations.
- 3.7 **Special Requirements** – any special requirement (e.g. irradiated or CMV negative) which is a patient-specific clinical requirement (defined by the patients underlying clinical condition).

4. DUTIES AND RESPONSIBILITIES OF STAFF

- 4.1 **Trust Board**
The overall accountability for effective risk management in the Trust lies with the Trust Board. At an operational level, the Trust has designated a number of committees to manage the risks relating to blood transfusion facing the Trust.
- 4.2 **Chief Executive**
The Chief Executive is responsible for ensuring that the Trust meets all legal requirements regarding blood transfusion.
- 4.3 **Medical Director**
The Medical Director has oversight of the implementation and governance of the policy. The chair of the PBMG will report directly to the medical director via the Clinical Effectiveness Committee (CEC).
- 4.4 **Patient Blood Management Group, (PBMG)**
- This group is responsible for ensuring the safe, secure and economic use of blood transfusions and blood products and compliance with legislation and best practice.
 - This group includes clinical and medical representatives from key areas of the Trust involved in blood transfusion.

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- The Patient Blood Management Group reports to the Medical Director via the Clinical effectiveness Committee.
- 4.5 **Hospital Transfusion Team (HTT)**
- The Hospital Transfusion Team operates on behalf of the Patient Blood Management Group.
 - This team is responsible for reviewing and monitoring the Trust's compliance with Better Blood Transfusion and associated policies and guidelines, reporting to MHRA and SHOT as appropriate.
 - This group includes the Clinical Lead for Transfusion, the Transfusion Practitioner, Transfusion Manager, Quality Manager, Community Hospital Transfusion Practitioner and Blood Transfusion Doctor.
 - A member of the Hospital Transfusion Team will review all community requests for blood transfusion
- 4.6 **Chair of PBMG**
- The Chair will ensure that the PBMG minutes are accurate, that actions are completed, and will report these to the Clinical Effectiveness Committee.
- 4.7 **All staff involved in transfusion.**
- Must comply with the requirements of the Trust Transfusion Policy and associated documents.
 - Must complete transfusion training and undertake the transfusion competencies appropriate for their role, or any other relevant training/competency assessment expected by the Trust
- 4.8 **Lead Consultant for Transfusion**
- The Lead consultant for transfusion will advise the chair of the PBMG on technical aspects of blood transfusion
- 4.9 **General Practitioners requesting blood for transfusion from the Trust Blood Transfusion Laboratory**
- General Practitioners are responsible for ensuring that they request blood for transfusion according to national and local guidelines to reduce the risk of adverse events from blood transfusions and inappropriate blood transfusion.
- 4.9 **Phlebotomists and others taking blood samples are responsible for:-**
- Checking the identity of a patient before taking any blood samples
 - Checking information written on the request form is complete
 - Using safe techniques for obtaining blood
 - Correct labelling of blood sample tubes in accordance with the Blood Transfusion Policy
- 4.9 **The Blood Transfusion laboratory is responsible for:-**
- Compatibility testing and issuing of blood products
 - Managing blood stocks and liaison with the National Blood and Transplant (NHSBT)
 - Investigating adverse events and reporting them to the Serious Hazards of Transfusion scheme and the Medicines and Healthcare products Regulatory Authority where appropriate.

5 REQUESTING OF BLOOD TRANSFUSION BY GENERAL PRACTITIONERS AND BLOOD SAMPLING FOR TRANSFUSION BY HEALTH CARE PROFESSIONALS IN THE COMMUNITY

- 5.1 It is the responsibility of doctors requesting blood transfusion to ensure that they are following local and national guidelines so that blood is requested in a safe and appropriate way.
- 5.2 It is the responsibility of all health care professionals taking venous blood samples for blood transfusion to follow local and national guidelines so that blood is sampled in a safe and correct way.
- 5.3 There is a national mandatory requirement (NPSA 2006 *Right Patient Right Blood*, reviewed by NBTC 2015) that all health care professionals involved in the process of blood transfusion undergo regularly training. The current recommendations are that this training is completed every 3 years as a minimum.
- 5.4 Online training and assessment packages are provided by the RD&E Hospital Transfusion Team and are available at www.exeterlaboratory.com

6 THE DECISION TO TRANSFUSE

- 6.1 The decision to transfuse a patient should be made on an individual patient basis depending on symptoms and signs, the decision should be informed by National Indication Codes to guide practice.
- 6.2 *Indications for Blood Transfusions in Non-Bleeding Patients (NBTC 2013)*
- In chronic anaemia aim to maintain haemoglobin levels so as to prevent symptoms of anaemia, transfusing when haemoglobin levels fall below 80g/l is appropriate for many patients
 - In patients with cardiovascular disease consider transfusion at haemoglobin of less than 80 g/l or for symptoms for example chest pain, hypotension or tachycardia unresponsive to fluid restriction or cardiac failure
 - In post-operative patients, those acutely medically unwell or in ITU use a haemoglobin level of less than 70g/l as a guide
 - In patients with severe sepsis, traumatic brain injury or acute cerebral ischaemia use haemoglobin levels of less than 90g/l to guide transfusion
 - After radiotherapy, there is limited evidence for maintaining haemoglobin over 100g/l
- 6.3 If the reason for anaemia is unknown, take blood samples to investigate pre-transfusion. If a treatable cause is identified, e.g. B12, folate, iron deficiency, treat the cause, this may avoid the need for transfusion
- 6.4 It is very rare to need to transfuse a patient to a haemoglobin level over 100g/l
- 6.5 Size Matters: In a patient weighing 70 kg, a 1 unit transfusion will on average increase the haemoglobin by 10g/l, in a smaller person, for instance 50-60 kg, 1 unit may increase the haemoglobin by 15 to 20 g/l.

- 6.6 For patient safety, particularly the risk of circulatory overload during or after transfusion, the Transfusion Laboratory will only provide a maximum of 2 units per patient for transfusion within 24 hours.
- 6.7 Circulatory overload up to six hours after transfusion is known as Transfusion Associated Circulatory Overload (TACO). Patients transfused in Community Hospitals are particularly at risk of TACO as they are generally frail, elderly and often return home on the day of transfusion.
- 6.8 TACO is now the most common cause of death after blood transfusion and the British Committee for Safety in Haematology has published guidelines for prevention of TACO
- 6.9 *Pre Transfusion Guidance on Prevention of TACO (taken from BCSH 2012)*
- The decision to transfuse must be based on a thorough clinical assessment of the patient and their individual needs. The rationale for the decision to transfuse and the specific components to be transfused should be documented in the patients' clinical records.
 - This clinical assessment should include an evaluation of the patient's age, body weight and concomitant medical conditions that predispose to TACO: cardiac failure, renal impairment, hypoalbuminaemia and fluid overload. These factors should be documented in the patients' clinical notes and should be considered when prescribing the volume and rate of the transfusion, and in deciding whether diuretics should be prescribed.
 - Single unit red cell transfusions are recommended where possible in non-bleeding patients
- 6.10 Advice with regard to the decision to transfuse can be obtained from the Haematology Consultant for the patient or the on call consultant and from the Hospice or Oncology department as these are the patients most likely to be transfused in the Community.
- 6.11 All requests for blood transfusion from General Practice will be reviewed by a member of the Hospital Transfusion Team

7.0 PATIENT CONSENT FOR BLOOD TRANSFUSION

- 7.1 Staff must follow the [Consent Policy](#) The patient must be competent to take the particular decision, have received sufficient information to make that decision and not be acting under duress.
- 7.2 Written consent is not required for transfusion, however wherever possible the healthcare professional making the decision to transfuse the patient should discuss this decision with the patient and any discussion or verbal consent must be documented in the patients notes. It should also be documented if no discussion with the patient/guardian has taken place and the reasons for this⁽¹⁾.
- 7.3 The patient/guardian must be fully informed of the need for the transfusion. This includes the risks involved and any alternatives that may be available and all such discussions must be documented in the medical notes. Where possible the proposed

treatment is discussed between the medical staff and the patient/parent/guardian in advance^{(1) (3) (9)}.

- 7.4 Where adult patients lack the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no one else can give consent on their behalf. However treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance directive⁽⁵⁾.
- 7.5 Patients should also be given the appropriate patient information leaflet as soon as possible prior to the transfusion commencing. These leaflets are available in the Community Hospitals and can be ordered from the Community Transfusion Practitioner.
- 7.6 Patients may not give consent for blood transfusion for a variety of reasons; some religious groups, including Jehovah's witnesses, Rastafarians and Scientologists may not give consent, but patients may not give consent for non-religious reasons.
- 7.7 In British law the fully informed competent adult patient has an absolute right to accept or refuse medical treatment. Therefore, to administer blood in the face of an informed refusal by the patient may invoke criminal and/or civil proceedings.
- 7.8 Alternatives to transfusion may be available, advice from secondary care colleagues should be considered.

8.0 COMPLETING THE TRANSFUSION REQUEST FORM

- 8.1 Requests for cross match of red cells must be accompanied by a fully completed blood transfusion request form and sample
- 8.2 Telephone requests for red cells are acceptable where a confirmed blood group is already available, a valid sample is available and a valid reason for transfusion is given by the requestor.
- 8.3 Patient labels may be used on the request forms, however all blood samples for transfusion must be labelled by hand

Royal Devon and Exeter **NHS**
NHS Foundation Trust

**EXETER PATHOLOGY SERVICES
BLOOD TRANSFUSION DEPARTMENT
ENQUIRIES (01392 40)2467**

Use patient sticker or hand write:

- Hospital or NHS number
- Surname
- Fore name
- Date of birth

Requesting Doctor to print name
Sample taker should print/sign name/grade and date/ time sample

Doctor to complete special requirements box

Doctor to complete time and place of transfusion

Doctor to complete reason for transfusion (if possible not low Hb but symptoms etc)

Respond Deliver & Enable

8.4 Routine transport from the community to the RD&E means samples only arrive in the laboratory in the late afternoon. Therefore allow 48 hours from taking the sample to arranging the transfusion time; this enables the laboratory to cross match the blood and then send it out to the community the following afternoon for transfusion the next day.

9.0 SPECIAL REQUIREMENTS

- 9.1 The Medicines Health and Regulatory Authority (MHRA) requires the request form for blood transfusion to ask whether the patient requires either irradiated or cytomegalovirus negative blood.
- 9.2 Irradiating blood completely removes any leucocytes remaining in the red cells after leucodepleting during the processing of whole blood. This removes the risk of Transfusion Associated Graft versus Host disease, a rare but often fatal complication of transfusion.
- 9.3 Some patients, because of their diagnosis or treatment, either in the past or present, are at higher risk of developing this condition and therefore require irradiated blood.
- 9.4 There is a system for identifying these patients in the RD&E as they are diagnosed or treated and a warning regarding the need for irradiated blood is placed on the laboratory computer. The patients themselves are also informed and given a warning card to carry. The requirements are also listed on the back of the transfusion form.

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9.5 Patients who may be transfused in the community and who require irradiated blood :

Patients with Hodgkin's disease or a previous history any time in the past of Hodgkin's disease
Patients treated with purine analogue drugs either in the present or at any time in the past. (Fludarabine, Cladribine, Deoxycoformicin, Bendamustine and Clofarabine)
Patients treated with Alemtuzumab and/or Rabbit Anti Thymocyte Globulin (ATG)
Patients undergoing bone marrow or peripheral blood stem cell harvesting for future autologous reinfusion during and for 7 days before harvest
Cytomegalovirus negative blood is only required by neonates and women receiving a planned transfusion
All donations from HLA matched donors or first or second degree relatives
Severe T-Lymphocyte immunodeficiency syndromes in children and infants
Allogeneic haemopoietic stem cell transplant recipients from the time of conditioning therapy, continues while the patient is receiving GvHD prophylaxis. If chronic GvHD present or taking immunosuppressants irradiated components required indefinitely
Allogeneic stem cell donors, 7 days prior to and during the harvest
Autologous stem cell recipients from conditioning therapy until 3 months post transplant (6 months if total body irradiation is used)

9.6 The other special requirement box on the request form relates to the requirement for cytomegalovirus (CMV) negative blood. Only neonates and women who are having a planned transfusion in pregnancy require CMV negative blood.

10 SAMPLE VALIDITY TIMES FOR TRANSFUSION

10.1 Patients may develop antibodies to red cell antigens after a blood transfusion or pregnancy. There are National Guidelines (BCSH 2012) which inform us how far in advance of a planned transfusion a sample can be taken.

Patient type	Repeat Sample required
Patient transfused or pregnant within previous 3 months	72 hours before transfusion
Patient not transfused or pregnant within previous 3 months	7 days before transfusion

10.2 If the sample is taken within 72 hours of the planned transfusion then the sample will be processed automatically by the laboratory.

10.3 If the sample is taken over 72 hours but within 7 days of the planned transfusion then the laboratory will fax you a form to sign to confirm that the patient has not been pregnant nor had a blood transfusion in the previous 3 months and will then process the sample.

10.4 Some haematology patients who are transfusion dependent require frequent transfusions and the 72 hour rule could make it more difficult for you to organise

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these transfusions. If the case is discussed with a Consultant Haematologist, it may be possible to exclude the patient long term from the 72 hour rule, allowing you to use the 7 day sample validity time.

- 10.5 If you have any queries about sample timings, please phone the laboratory on 402460 before the sample is taken or email the Hospital Transfusion Team at rde-tr.HTT@nhs.net.

11 THE TWO SAMPLE POLICY

- 11.1. The Transfusion Laboratory requires evidence of a patient's ABO group from 2 separate samples before cross matching blood, this reduces the risk from mislabelled samples
- 11.2 Over 90% of patients already have an ABO group recorded on our computer system and just need 1 new sample for cross match
- 11.3 Where there is no historic blood group and two samples are required, the second sample must be taken either by another staff member or by the same member of staff using a separate venepuncture and request form with the second sample request having a different time of sampling.
- 11.4 If you are unsure of how many samples to take please ring the Transfusion Laboratory

12 TAKING THE SAMPLE FOR TRANSFUSION

- 12.1 Patient Identification errors remain the commonest error reported to Serious Hazards of Transfusion (SHOT)
- 12.2 There are 2 main reasons why the blood in the tube is not from the patient whose details are written on the sample label.
- Failure to positively identify the patient, so that the blood is taken from the wrong patient
 - Failure to complete the label on the blood sample bottle at the bed or patient side so that the blood is taken from the right patient but labelled with another patient's details
- 12.3 The risk from these 'Wrong Blood in Tube' incidents is reduced by our two sample policy
- 12.4 When taking blood samples, only one patient must be bled at a time to minimise the risk of error and open questions must always be used:
- **ask** the patient their first name, surname and date of birth. (A family member/carer may be able to confirm the patient's identify using open questioning).
 - These answers must match exactly the details on the transfusion request form

12.5 When **labelling** blood samples:

- Blood sample tubes must never be pre-labelled
- The sample tube must be labelled immediately by the bed or patient's side after the blood has been taken by the person taking the sample.
- The sample tubes must be hand written with the minimum patient identification of:
 - Patient's surname.
 - Patient's forename.
 - Date of birth.
 - Patient identification number (hospital number or NHS number)
 - Date and time sample collected
 - The sample tube and the request form must be signed, dated and timed by the person collecting the sample.

12.6 For safety reasons the laboratory has a zero tolerance policy for mislabelled samples, this is an MHRA requirement.

12.7 The patient identification on the request form and the sample (surname, forename, date of birth and hospital number/NHS number) must match exactly. Any sample which does not conform to these criteria will not be processed by the Transfusion Department.

12.8 If the request form has the NHS number on it, then the sample must also have the NHS number written on it; if the request form has the Hospital number on it, then the sample must have the Hospital number on it. If a patient sticker with both numbers is used on the form then either number can be used on the sample label.

12.9 Samples with PAS labels, overwritten patient details or two samples that appear to have been taken by the same person at the same time will also be rejected by the Transfusion Department. The sample taker will be informed by the Blood Transfusion Laboratory that the sample has been rejected.

13 ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author Transfusion Doctor, Blood Transfusion. An electronic copy will be maintained on the Trust Intranet, P – Policies – B- Blood Transfusion. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

14. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY/ STRATEGY

7.1 To monitor compliance with this policy, the auditable standards will be monitored as follows:

No	Minimum Requirements	Evidenced by
1.	Review of appropriate requesting by General Practitioners	Annual Audit of Transfusion in the Community against national and local guidelines.
2.	Review of transfusion sample mislabelling from the community	Annual Audit of the percentage of rejected samples for transfusion from the Community, comparison will be made with sample rejection numbers from the Trust.

7.2 Frequency

In each financial year, the Transfusion Doctor will audit the minimum requirements to ensure that this policy has been adhered to and a formal report will be written and presented at the Hospital Transfusion Team meeting and Patient Blood Management Group.

7.3 Undertaken by

Transfusion Doctor

7.4 Dissemination of Results

At the Patient Blood Management Group Committee/ Group, which is held quarterly.

7.5 Recommendations/ Action Plans

Implementation of the recommendations and action plan will be monitored by the Clinical Effectiveness Committee, which meets monthly

7.6 Any barriers to implementation will be risk-assessed and added to the risk register.

7.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers' cascade system.

8. REFERENCES

Department of Health (2007). *Safe and Appropriate Use of Blood*. London: Department of Health (HSC 2007/001). Available at: http://www.transfusionguidelines.org.uk/docs/pdfs/nbtc_bbt_hsc_07.pdf

The Blood Safety and Quality Regulations 2005. (SI 2005/50). London: Stationary Office. Available at: <http://www.legislation.gov.uk/uksi/2005/50/contents/made>

Patient Consent for Transfusion 2011 SaBTO
<http://www.transfusionguidelines.org.uk/document-library/documents/sabto-guidance-for-clinical-staff/download-file/SaBTO%20guidance%20for%20clinical.pdf>

NHSBT: Indication Codes for Transfusion 2013
<http://hospital.blood.co.uk/media/2995/917bce4f-ad57-43a6-9d03-3603094010b1.pdf>

BCSH: Addendum to Blood Administration 2012
http://www.bcshguidelines.com/documents/BCSH_Blood_Admin_-_addendum_August_2012.pdf

APPENDIX 1: COMMUNICATION PLAN

Royal Devon and Exeter
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COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	General Practitioners and Healthcare Professionals who request blood for transfusion from the Trust and are involved in this transfusion process
The key changes if a revised policy/strategy	Not applicable
The key objectives	The purpose of this policy is to ensure that relevant staff have access to national and local guidance to promote safe and appropriate blood transfusion and to reduce the risk of adverse events and inappropriate transfusions
How new staff will be made aware of the policy and manager action	Induction Process
Specific Issues to be raised with staff	Promote the online training and assessment packages via email and Local Medical Committee newsletter. Inform General Practitioners of maximum 2 unit transfusion in 24 hour policy and that every request for blood transfusion from the community will be reviewed by a member of the Hospital Transfusion Team (already completed, via email to all Practice Managers)
Training available to staff	Training and assessment packages available on the Exeter Clinical Laboratory website
Any other requirements	
Issues following Equality Impact Assessment (if any)	None
Location of hard / electronic copy of the document etc.	Policy Document on lan and on www.exeterlaboratory.com

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APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Policy for Requesting and Sampling Blood for Transfusion by General Practitioners and Other Healthcare Professionals in the Community
Division/Directorate and service area	Special Services Division,
Name, job title and contact details of person completing the assessment	Dr Barrie Ferguson, Speciality Doctor in Transfusion
Date completed:	6/7/2015

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**

2. **Who does it mainly affect?** *(Please insert an “x” as appropriate:)*

Carers Staff Patients Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?** (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an “x” in the appropriate box (x)

Protected characteristic	Relevant	Not relevant
Age	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sex - including: Transgender, and Pregnancy / Maternity	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Race	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Religion / belief	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sexual orientation – including: Marriage / Civil Partnership	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to...** (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Age, Religion

5. **Do you think the document meets our human rights obligations?**

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- **Fairness** – how have you made sure it treat everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

6. **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

Age – Being over 70 years old is one of the risk factors for TACO – Preclusion of treatment an age alone is dicrimatory – the policy is clear that it is the discussing of risk factors that commonly comes with age rather than age being the risk factor

Religion – Transfusion of blood components/products may be refused by some religious groups – the policy is clear that some religions have deeply held beliefs about refusal of blood or blood products, so care needs to be taken before transfusing and patients who object need to managed in line with the separate Trust policy for Patients who Refuse Blood or Blood Products.

Have consulted with:
Chaplaincy Office, Hospital Transfusion Team, Patient Blood Management Group, Policy Expert Panel and the clinical Effectiveness Committee

7. **If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.**

“Protected	None
-------------------	------

characteristic”:	
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	