Liam Donaldson

From: Mike McGovern

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HSC 1998/224: BETTER BLOOD TRANSFUSION: FOLLOW UP ACTION

Issue:
We are proposing a follow up to the joint Chief Medical Officers led initiative in 1998 to support the better use of blood in the NHS. The aim is to hold the event in October or November this year and that you lead the work with the other three CMOs. This would involve an evaluation of progress since 1998, consideration of new priorities and outlining a plan for NHS blood services. We have not approached the other CMOs as yet, though they will possibly be aware of our intentions through officials. We would be grateful for your views and to discuss before proceeding further.

Background:
2. In July 1998 the four UK CMOs held a symposium on 'Evidence-Based Blood Transfusion' aimed at improving blood transfusion services in the NHS. The drivers at the time were the precarious blood stocks, concern about the unknown risk posed by variant CJD to patients from blood transfusion, and widespread recognition that blood was being used inappropriately. The Department issued HSC 1998/224 'Better Blood Transfusion' to NHS trusts based on the recommendations from this symposium.

What HSC 1998/224 requires:
3. The HSC required action aimed at improving hospital blood services, specifically:

From March 1999, all NHS Trusts should:

- ensure that hospital transfusion committees are in place to oversee all aspects of blood transfusion
- participate in the annual enquiry Serious Hazards of Transfusion (SHOT) enquiry.

By March 2000, all NHS Trusts should:

- have agreed and disseminated local protocols for blood transfusion, based on guidelines and best national practice, and supported by in house training.
- have explored the feasibility of autologous blood transfusion and ensured that where appropriate, patients are aware of this option. In particular they should have considered the introduction of perioperative cell salvage.

What has this achieved:
4. This was a first step in central action to improve NHS blood services and how blood is used by clinicians. In the HSC we indicated that we would audit the impact of these recommendations and a national survey of all acute trusts where blood is transfused is currently in preparation. The results will be available later in the year, in

time for the proposed initiative. However we know that participation in SHOT has more than doubled, that almost all trusts now have transfusion committees and that protocolised blood transfusion is improving. We also know that autologous blood transfusion has not increased and this has led to criticism.

Collaboration with the NAO and NBS:
5. In the meantime the National Audit Office reviewed the National Blood Service and published its report last December 2000. Though the NAO did not look at blood transfusion practice it considered that this could be improved and offered to support (financially) the Department and the NBS in setting up a further better blood transfusion initiative.

Other drivers:
6. All the work on risk assessment relating to the unknown contribution of blood transfusion to the transmission of vCJD has emphasised that the better use of blood and avoiding its use are important risk reduction measures. SEAC has agreed with this. The SHOT report in March also emphasised the importance of the judicious use of blood, and the need to improve safety even further by introducing systems that reduce the major threat to safety -human error. In addition, the recent high court ruling on hepatitis C transmission through blood transfusion underlines further the seriousness that must now be paid to this area of practice in the NHS.

Work so far:
6. We met with NAO and NBS before Easter to discuss how we might take forward the work. We have agreed that DoH will lead, working with NBS on the programme. NAO will work with DoH on the organisation -we would wish to get in a professional conference organiser on the advice of COMMS. We have a small steering group in place comprising one/two people from the three groups and a patient representative.

Outline of what is proposed:
Timing: Late October/November.
Venue: Central London
Meeting: Full day. Minister to open. CMOs to lead/participate/act as a panel/chair sessions. Overall independent reporter/chair –NHS clinician/shaker/thinker.
Participants: Invited. Experts, blood transfusion staff, clinician/blood users, NHS managers, RO staff, patient representatives. Crossover with those who came in 1998.
Programme: Results of national audit. Focus on achievable priorities for NBS blood services. Set framework for future work and a blood plan.
Format: Plenary -set out focus areas. Working groups -clarify priorities
Outcomes: Immediate priorities for NHS blood services -HSC to service. Outline blood plan. (Will also help in preparing for Spending Review).
Other: We propose setting up an 'event' website to help publicise the work, get views and buy-in from the wider NHS and public, and to inform participants.

Action required:
8. We would be grateful for your advice before proceeding any further with this work.

Dr Mike McGovern

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