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Date: 2 July 2001

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Better Blood Transfusion: Note of meeting with UK CMOs, 21 June

We met with you last week to discuss and plan the arrangements for the second Better Blood Transfusion conference now set for 29 October 2001. The aims of the meeting were to clarify with you the overall purpose of the conference, to agree the big issues that need to be tackled, and to discuss the media profile of the event

Discussion

2. There was agreement that the day would focus on the use of unlicensed blood products, the unprocessed labile blood components –red cells, fresh frozen plasma, and platelet concentrates. Despite work over the last three years, local audits still suggest that the use of blood components remains highly variable between clinicians and hospitals, and needed to be explored as a marker of surgical/clinical practice. Most importantly, and in the aftermath of the recent HCV ruling, the risk of blood transfusion would need to be recognised up front, and put in clear perspective for the public, patients and clinicians.

3. The main issue therefore was about risk –scoping the risk of receiving blood components risk against effectiveness, communicating this to patients and the service in the context of the benefits, and reducing the risk through best clinical practice. This approach would require a full and honest partnership between the blood services and the public. It would need to be based on an agreed recognition of the risks, a policy that did not promote blood transfusion as safe, and fully governed by informed consent.

4. The overall purpose of the day would be to publicise a new open up-front partnership between the UK NHS blood services and the public. This will be based on the recognition that the safety of blood cannot be guaranteed and that the avoiding transfusion wherever possible must be an aim of clinical care. The partnership will only have an impact by ensuring blood services is on the primary agendas driving healthcare in the UK –patient safety, clinical governance, performance and risk management, comparative audit, and modernisation –embedded within and not peripheral to top level NHS management.

Profile of the Conference and media involvement

5. You indicated that the profile of the CMO conference needed to be high and to include the general and professional media. The medical press, like the BMJ and Lancet as well as Nursing Journals Hospital Doctor and Pulse should certainly be invited and we will investigate the possibility of special editions with them. You were very clear that the general media, press and TV, should also be invited, but that this would need to carefully managed. They could be present for the plenary sessions in the morning and afternoon, though not for the working sessions. A CMOs press conference might be a useful way of focussing constructive attention on the

continuing need for blood donation, the value of blood to patients, the risks of transfusion, and informed consent.

The programme, agenda and format

6. We presented a wide range of areas for consideration and you were clear that we needed to focus on the purpose of the day and 4or 5 key areas where we would be pushing for action in health impact terms over the following 18 to 36 months. The morning plenary needed to

a) set out the purpose of the day –Minister, views of 4 CMOs', or perhaps an independent commentator like Niall Dickson (?)
b) introduce the 4/5 main issues –selected speakers.

7. You suggested that it might be powerful to begin the plenary presentations with evidence from a patient about the experience of blood transfusion, capturing perhaps knowledge, attitudes and behaviours of the public and minority groups eg Jehovas Witnesses. You also suggested that the introductory plenary session might be more made more lively with alternative types of presentation eg a video or role play woven in with standard stand-up formats. The areas addressed should include patient and risk management/reduction, service redesign and good practice, implementation of guidelines/protocols, strengthening of hospital systems for ensuring the better blood transfusion, and underpinning this with multidisciplinary working involving the nurse practitioner in blood transfusion. Research would also need to be considered.

8. The plain message here must be that we've come a long way since 1998 and we now need to set out the future. It will be important that this recognises the NHS in which we now work and exploits the new systems we have or are putting in place like NICE, CHI, PALS, the Patient Safety Agency and Local Modernisation Groups. To ensure that there is public and professional buy-in a conference website would be useful. This would also help reduce the work required for the introductory plenary and canvass views from people who might otherwise not get a chance to have a say. Also a white board on the day might be used to capture the objectives, wishes and aspirations of participants.

Participants

8. We agreed that 100 invited participants was about manageable especially if there were to be 5 working groups. We could consider up to 150. There was a suggestion the morning plenary might be larger, though excluding people from the working groups might be divisive. You were broadly satisfied with the representation plan as set out and emphasised the critical need to ensure top-level NHS management and RO participation. We should flag the meeting up with Chief Executives and Medical Directors well in advance. You also indicated that that minority groups like the Jehovah's Witnesses should be invited.

Venue:

9. There was some concern about the suitability of the New Connaught Rooms especially in terms of access and flexibility, and we agreed tom check the arrangements out. We also agreed to ask the organisers to explore the possibility of other venues including the Royal College of Physicians, Regents College, The Design Centre, the Commonwealth institute, Church House and QEII.

Outcomes

10. This would be a clear policy statement or Health Services Circular outlining action aimed at

a) raising the profile of blood transfusion in the context of risks as well as benefits to patients and
b) strengthening blood services in hospitals –HTCs, clinical protocols and trained transfusion nurses, and IT prescribing systems -to ensure measurable risk reduction for patients at risk of blood transfusion
c) developing a plan for blood.

Action points

a) Set out purpose of day/define issues to be addressed: As in this note.
b) Refine programme: DoH, NBS, and NAO
c) Speakers: DoH to define with UK Health Departments, NBSs, NAO and PA.
d) Participants: 100 participants with cross over from 1998 for continuity. DoH, NBS, ROs, PA and UK Health Departments
e) Media: DoH to discuss with COMMS, NBS and NAO –professional and general press. DoH to discuss special edition of BMJ with Richard Smith
f) Venue: We have asked NAO and COMMs to spec additional venues
g) Steering group meetings: Monthly with progress reports to the CMOs.

Mike McGovern
Health Services Directorate

Copy list:
Rachel Dickson
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Aileen Keel
Gail Williams
Noel McCann
Charles Lister
Jill Taylor
Angela Robinson
Mike Murphy
Brian Gunson
John Step
Carol Lyons
Andrew Millward
Pam Binji
Rachel Hawkes