Radcliffe Department of Medicine
Nuffield Division of Clinical Laboratory Sciences

UNIVERSITY OF OXFORD

1st November 2023

Sir Brian Langstaff,
Chair, Infected Blood Inquiry,
Fleetbank House,
1st Floor, 2-6 Salisbury Square,
London, EC4Y 8AE

Dear Sir Brian,

Re: Measures for the Inquiry to consider for improving the safety of transfusion and measures to reduce the need for transfusion

You may remember that we wrote to you on 16th November 2022 about the use of tranexamic acid as a means for reducing bleeding and the need for transfusion in surgery. We provided data on the poor compliance with the NICE Quality Standard on the use of tranexamic acid in surgical patients which was discussed in the evidence provided to the Inquiry by Professor Roberts on 10th November 2022 and also by Professor Murphy in his evidence on 24th February 2022.

In summary, the audit of the 4 NICE Quality Standards for Blood Transfusion included 153 sites who contributed data on 4679 patients. For the section of the audit on the use of tranexamic acid in surgery, 1079/1599 (67%) patients undergoing surgery with expected moderate blood loss received tranexamic acid, meaning that a large proportion (>30%) of eligible surgery patients do not receive it. We estimated that compliance with the NICE Quality Standard would prevent over 15,000 major surgical bleeds, save 33,000 units of blood and save many millions of pounds for the NHS each year.

The actions we have taken include:-

1) The establishment of an implementation group with representation from the Royal College of Surgeons of England, the Royal College of Anaesthetists and the Royal College of Physicians. Our aim was to make sure that all surgeons and anaesthetists are aware of the benefits of tranexamic acid use in surgery and that 'consideration of tranexamic acid use' is included in the safe surgery checklist of all NHS hospitals.

2) The Royal College of Surgeons (England) and the Royal College of Anaesthetists have highlighted the use of tranexamic acid in surgery in their journals and newsletters, social media outlets, and a webinar on tranexamic acid delivered by the President of the Royal College of Surgeons and Professor Roberts.
3) We are working with NHS England and NHS Improvement so that tranexamic acid use is considered for inclusion as one of the CQUIN (Commissioning for Quality and Improvement) quality indicators. Under the CQUIN system NHS Trusts are offered a financial incentive to implement effective patient care.

We appreciate that these activities may not be sufficient to ensure full compliance with the NICE Quality Standard for the use of tranexamic acid in surgical patients, and other actions will be needed. However, we were very disappointed to find that the 2023 audit of the NICE Quality Standards for Blood Transfusion produced nearly identical results to the 2021 audit indicating no improvement despite the actions we have taken (see below).

Audit of Compliance with the NICE Quality Standards for Blood Transfusion	**2021**		**2023**	
	Number	**Compliance**	**Number**	**Compliance**
Patients with iron deficiency anaemia given treatment with iron prior to surgery	672	59%	602	59%
Surgical patients expected to have at least moderate blood loss given Tranexamic Acid	1079	67%	880	67%
Patients receiving blood transfusion clinically reassessed and have their haemoglobin levels checked after each unit of red blood cells	893	58%	772	64%
Patients likely to need a transfusion given WRITTEN AND VERBAL information about the risks and benefits of transfusion	422	26%	477	35%

The results of the national audits of the NICE Quality Standards for Blood Transfusion are provided to the transfusion teams participating in the audit. In addition, a summary of the reports for each NHS Trust are sent to the Chief Executives of each NHS Trust. The data from the audits are now also available on the Model Health System (https://www.england.nhs.uk/applications/model-hospital/). This allows NHS Trusts to compare their compliance with the NICE Quality Standards

for Blood Transfusion with other Trusts. How well the data from the national audits and the Model Health System are used and how effective they are in driving better practice is unknown. A major limitation is the indirect feedback of these data to hospitals via Chief Executives and transfusion teams, and the likely poor onward dissemination of the data to anaesthetists and surgical teams.

We would also like to draw your attention to the attached opinion piece from one of us (Professor Toh, Chair of the National Blood Transfusion Committee) published in the British Medical Journal on 23rd October 2023. It describes the recent increase in deaths related to transfusion reported by the Serious Hazards of Transfusion (SHOT) haemovigilance system, and the need for both improved processes for tracking the transfusion pathway from donor to recipient ('vein-to-vein' transfusion) and less inappropriate use of blood. It points out the challenges in their implementation in terms of funding, an overstretched workforce and inadequate IT to deliver the required standards of blood management. It highlights the important work of the Infected Blood Inquiry and the potential for its recommendations to drive improvements in the safety of hospital transfusion and better transfusion practice.

This new information is intended to be helpful to the Inquiry as it considers making recommendations about improving transfusion practice. We are very willing to provide the Inquiry with more details about these suggestions if asked to do so.

Yours sincerely,

GRO-C

Michael F Murphy
Professor of Blood Transfusion Medicine, University of Oxford
Consultant Haematologist, NHS Blood and Transplant and the Oxford University Hospitals NHS Foundation Trust
NHS Blood & Transplant,
John Radcliffe Hospital,
Oxford
OX3 9BQ
Direct line: GRO-C
mike.murphy@ GRO-C

Radcliffe Department of Medicine

UNIVERSITY OF OXFORD

GRO-C

Ian Roberts
Professor of Epidemiology
London School of Hygiene and Tropical Medicine
Clinical Trials Unit
Keppel Street, London WC1E 7HT
Tel: GRO-C
ian.roberts@ GRO-C

GRO-C

Cheng-Hock Toh
Professor of Haematology, University of Liverpool
Honorary Consultant Haematologist, University Hospitals NHS Foundation Trust
8 West Derby Street
Liverpool L69 7BE
Tel: GRO-C
toh@ GRO-C