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Dr. M CONTRERAS
Director

MC/mm

31st May 1990

Dr Hilary Pickles
Principal Medical Officer
Department of Health
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Dear Hilary

Further to our meeting with Mr. Malone-Lee in Sheila Adam's office, I am writing to give you some information on what we have been doing at the North London Blood Transfusion Centre to improve knowledge of blood transfusion and promote sensible usage of blood and blood derivatives. I hope that from this letter, it will transpire that cross-charging for blood and blood products will not automatically lead to a "better" use of resources and that in the long run it might even be detrimental to patient care.

We in the Transfusion Service are being encouraged to believe that the devolution of our budgets to Districts will promote greater efficiency in the use of blood and blood components and increased collaboration between supplier and user. However, the North London Blood Transfusion Centre (NLBTC) supplies blood to some Special Health Authorities and has been 'cross-charging' for non-red cell components for several years. Our experience strongly suggests that the putative advantages of 'cross-charging' will not be realised.

Over the last three years, we have seen a 14-21% annual increase in the use of F.F.P. and platelets in institutions being cross-charged. This escalation in demand greatly exceeds the increase in usage in other hospitals, for during this period, NLBTC has increased overall production of these two components by just 5% annually. We accept that the "cross-charged" hospitals have been building specialist units, treating patients who generally require more blood and component support than the average, and would hope that their increase in usage could be readily accounted for as a result of increased clinical activity or justifiable changes in patient management. However, an audit recently conducted by us in five major hospitals (see below), revealed no justification for the

use of more than 50% of fresh frozen plasma (FFP) irrespective of whether the hospital was being cross-charged or not.

In our dealings with 'cross-charged' hospitals, we have also experienced several instances where the clinicians have used payment as an argument for their right to receive whatever they demand, rather than what can reasonably be provided or would constitute the most appropriate therapy for a specific patient. There is no indication that cost is a restraining factor.

The consultants at this Centre firmly believe that it is only through continuous contact with, and education of our user hospitals that we will be able to improve the practice of clinical blood transfusion and make the best use of blood derivatives. NLBTC supplies over 50 hospitals in the NHS, SHAs and in the private sector. These hospitals have each been allocated one consultant, who pays regular visits and is available for help and advice. During visits we discuss transfusion practices within the hospital and give clinical and technical advice when required. We monitor blood transfusion laboratory stocks and returns on a monthly basis and discuss the introduction of new forms of therapy (e.g. liver transplantation) which might increase demands on the transfusion service. We encourage blood donation in hospitals by staff and patients' relatives and are now starting to see much greater cooperation from hospital authorities, since our Regional Chairman has been very active in this field and has written to all DGMs and UGMs asking for their support.

The five consultants at NLBTC are actively involved in undergraduate and postgraduate teaching. We teach clinical blood transfusion and immunohaematology in all the medical schools within the Region as well as at UCH/Middlesex. Annual general meetings are held for consultant haematologists in order to provide an update on managerial and scientific matters related to blood transfusion. We also hold regular meetings of chief MLSOs in technical charge for blood transfusion laboratories.

We believe that the way forward in clinical blood transfusion is the establishment of Hospital Transfusion Committees with representatives from those clinical specialties most concerned with blood usage, including a nursing representative. Such committees should meet on a quarterly basis and should deal with matters such as transfusion practice within the hospital, use and abuse of blood and blood components, audit of the use of blood etc. As a first step we recently conducted a retrospective audit in five major hospitals supplied by NLBTC, looking at the practice of transfusion of platelets and fresh frozen plasma. It was necessary to search for a total of 600 case notes in order to provide 200 cases for the audit. Review included an assessment as to whether the transfusions were indicated. Results of this analysis were disappointing particularly for FFP, where only 21% of transfusions were indicated, and 60% were definitely not indicated. With respect to platelets, only 53% of transfusions were indicated while 19% were definitely not indicated. From this retrospective audit, we concluded that improvement in all aspects of transfusion practice is necessary. Education regarding the value of blood

components and areas in which their use cannot be justified is particularly needed. Hospital transfusion committees are now being established in the five audited hospitals and we intend to encourage a further five hospitals to move in this direction in the very near future. We view the audits as a means of education and not as a reason for reprimanding users.

With the aid of a firm of external financial consultants, our treasurer and support services manager have conducted a detailed costing of all the blood components and services provided by this Centre. This exercise has been a real eye opener for all of us since we were not always aware of the real cost of some of our products and/or practices. The costing exercise helped us to introduce notional charging as from 1st April 1990. Notional invoices are sent to all NHS hospitals (managers and consultant haematologists) to make them aware that blood derivatives are an expensive commodity.

It is very sad that the Department of Health has decided not to support the principle of self-sufficiency in blood and blood products wholeheartedly. The Department of Health is leaving BPL and RTCs to fend for themselves when we all know that self-sufficiency can only work if it is heavily subsidized. Why shouldn't the blood freely donated by British donors go back to British patients or to themselves? Have we not learnt our lesson with HIV and haemophilia?

We are worried about the 30% of business that BPL plans to do directly with Districts. This is particularly dangerous in those Regions where the blood transfusion budget has already been devolved to Districts, since the price offered to hospitals might be lower than the price offered to the Regional Transfusion Centre who is buying much larger quantities; this does not make financial sense! I am also concerned that this is a one year agreement because the situation next year will be totally different. However, we are setting a precedent and we might be vulnerable as Regional Transfusion Centres when budgets are devolved to hospitals and commercial suppliers cut prices of albumin and Factor VIII. Surely, hospitals would choose to go elsewhere! We might be able to balance the books so long as we produce enough plasma on a cost-efficient basis. However, it is extremely difficult to be cost efficient if you care about your donors and you follow good manufacturing practice and BPL specifications.

From all the above, we are concerned that charging for BPL products and devolving budgets to hospitals will necessarily increase the cost of the service and will be to no avail. We will have armies of financial clerks checking that the monies go round in circles.

We believe that education, audit, peer review and an increased awareness of product liability will provide far more effective tools in rationalising the use of blood components.

With kind regards

Yours sincerely

GRO-C

Marcela Contreras
Director

cc Dr Sheila Adam
Dr H H Gunson