MINUTES OF SERIOUS HAZARDS OF TRANSFUSION WORKING GROUP

FIFTH MEETING - WEST END DONOR CENTRE 6 SEPTEMBER 1995

Present: Dr Lorna Williamson - (Chair)
Dr Elizabeth Love
Dr Brian McClelland
Dr Derek Norfolk

In attendance: Mrs E A Campling, Chief Executive CEPOD

1) Apologies:

Apologies were received from Dr John Barbara, Dr Philip Mortimer, Dr Tony Napier, Dr Angela Robinson, Dr Pat Skacel, Kate Soldan, Dr Audrey Todd, Professor Alan Waters.

2) MINUTES OF THE FOURTH MEETING - 12 JULY 1995:

With reference to item 3.2 Mrs Campling explained that not all hospitals are visited in person annually.

3) MATTERS ARISING:

3.1 Review of CEPOD:

Mrs Campling gave an extremely comprehensive review of the activities of CEPOD and the salient points are recorded below:-

i) CEPOD began originally with a pilot study of three districts and this was followed by a three region study funded from the King Fund and the Nuffield Provincial Hospitals Trust. This led to the National CEPOD which comprises England, Wales and Northern Ireland. Scotland has a separate Scottish Mortality Study Group.

ii) CEPOD includes independent hospitals and each of the independent hospitals' groups contributes to funding. Mrs Campling wrote to Chief Executives of each of the private groups and these individuals took the initiative to join the scheme. The following groups are involved; BUPA, AMI, Nuffield, St Martin's, Wellington and Benendon. None of these has representation on CEPOD and they have never asked for it. Jersey, Guernsey and the Isle of Man are also included and also provide some funding.

iii) Some difficulty was experienced when College Representatives were asked to act as reporters for the scheme. Many of these were not Histopathologists and were not keen to take on this role. The trend is now to involve more Clinical Audit people although it was originally stipulated that medical personnel should be responsible for reporting.

iv) The database of Surgeons and Anaesthetists is extremely large and it proved difficult to make this comprehensive. College Tutors were asked to provide lists. CEPOD then introduced the scheme by sending personal letters to all individuals.

Note: It should be far easier to compile a comprehensive list of Haematologists and Blood Bank Heads as it is likely that Blood Centres will be in close touch with all these individuals in their catchment area.

v) Mrs Campling indicated that it proved most valuable to involve the following Associations in National CEPOD:-

The Association of Anaesthetists - Mel Morgan is the representative on National CEPOD
Anaesthetists in Training - this group represents junior Anaesthetists
The Institute of Risk Management. The journal "Clinical Risk Management" proved a useful vehicle for communication. The contact person is David Bowdon of Merritt Risk Management.

vi) **Communication** - Mrs Campling emphasized the importance of good communication and suggested that it might be valuable to utilise commercial experience in this field. News letters/journals of the various societies and professional organisations could be utilised and it was most important to include Health Services Management Groups. In particular NARHAT have produced excellent National CEPOD briefing notes within three weeks of receiving CEPOD reports.

vii) **Media Management** - Mrs Campling pointed out that this could be a problem and it might be advisable to involve a PR Agency. Dr Williamson mentioned that a full-time PR person has been appointed in the South East Zone and she will discuss the matter in principle with that person.

viii) **"Ownership" of CEPOD** - In order to illustrate this difficult area Mrs Campling gave an overview of the structure of CEPOD. Advisory groups comprising individuals nominated from various professional organisations meet to review all data prior to constructing the annual report.
ACTION - TO DISCUSS TERMS OF REFERENCE AT NEXT MEETING

There is more than one advisory group dependent on the specialities involved and the particular questions which are being investigated in that year. The groups are chaired by Clinical Co-ordinators who are nominated by the Colleges and assistant Clinical Co-ordinators who are selected by advertisement and interviews. The advisory groups comment on the data and these comments are collated by the Clinical Co-ordinators who produce draft chapters for the report. Mrs Campling then provides aggregated data (no statistics) which are incorporated into the report and vignettes may or may not be included to illustrate particular aspects. The advisory groups had felt that they had "ownership" but it was pointed out this properly belongs to the **Steering Group.**

National CEPOD is now a Public Liability Company mainly in order to solve contractual difficulties for employees. CEPOD is completely independent of the Royal College of Surgeons and pays fees to the College in order to use the facilities.

Charity status for National CEPOD is under consideration.

The chair of the CEPOD Steering Group is selected by the Steering Group itself. Co-ordinators and the Chairman present information to the Steering Group which meets approximately four times annually. The Steering Group which comprises approximately 12 individuals examines each report meticulously.

It was emphasized that the Steering Group for SHOT will require terms of reference.

viv) CEPOD - SIZE

CEPOD is based on the Study group for Maternal Deaths and all other groups (Suicides, Homicides, Stillbirth and Sudden Death in Infants) are based on CEPOD. It has a budget of approximately £450,000 per annum and ten full-time staff. The largest sample studied was approximately 6,000 but the usual sample size is 3,000. Mrs Campling explained that for the particular sample to be studied questionnaires would be sent to Consultants Surgeons and Anaesthetists, structured slightly differently to obtain different information about each incident. Mrs Campling will supply sample questionnaires and standard notification forms for examination.

x) DATA PROTECTION/ANONYMITY

The requirements of the Data Protection Act (DPA) must be remembered although it does not apply to dead patients.

With reference to anonymity information is not anonymous to administrative staff but is anonymous to clinical staff. The minimum data consistent with the sample being studied will be entered. It must not be possible to link paper information to data in the computer to clinical decisions and strict password control is in operation. The patient's name has to be available in order to return a questionnaire. Questionnaires will be numbered and the name will be erased when the questionnaire is returned to CEPOD.

xi) TERMS OF OFFICE

Mrs Campling recommended limited terms of office. The cycle of deciding on the sample to be studied, reviewing and reporting takes about three years and CEPOD representatives serve for four years.

xii) CEPOD INVOLVEMENT WITH TRANSFUSION MATTERS

CEPOD does from time to time ask about transfusion particularly with regard to the availability of blood or the wrong blood given. Mrs Campling will examine the data to ascertain whether it will provide valuable information for the SHOT group.

xiii) RETENTION OF DATA

CEPOD's data is not retained after the report has been produced. Every item of paper relating to that report is shredded and the computer data erased.

ACTION ARISING FROM MRS CAMPLING'S PRESENTATION:

a) LW to write to Chief Executives of Independent Hospital Groups
b) LW to contact the Association of Anaesthetists via Mel Morgan.
c) BMc to target group of Junior Anaesthetists
d) LW to contact David Bowdon of Merit Risk Management
e) BMc to investigate the feasibility of circulating a copy of the new handbook when launching the SHOT system
f) LW to obtain list of contacts from Mrs Campling
g) LW to contact South East Zone PR person
h) LW to obtain copy of statement of liability and articles of CEPOD plc.
i) LW to obtain sample questionnaires and standard notification forms from Mrs Campling
j) LW to obtain any information about transfusion incidents reported to CEPOD

3.2 RCPath Involvement (see note circulated with the agenda)

At the meeting between Professor Bellingham, Professor Roberts and Dr Williamson it had been pointed out that a structure with several co-ordinators may inhibit a rapid response in the case of linked events. The College would prefer a single co-ordinator, hospital based with local support. The College would be the professional overseer but is unable to fund the scheme and does not wish it to be based at the College. It was recommended that there should be a three or four person executive.

Much discussion followed about the role of the College. If the College of Pathologists is not able to fund the scheme or provide accommodation it is hard to see that it has a role over and above membership of the Steering Group
ACTION - LW to write to Professor Bellingham again.

The question of who should act as co-ordinator was discussed in detail. The pros and cons of a hospital based co-ordinator -v- a transfusion centre based co-ordinator were considered. The original concern about selecting a transfusion centre consultant co-ordinator was not felt to be well founded.

A favoured approach would be to appoint a Registered General Nurse (grade F) with appropriate background to deal with data handling. Cover arrangements would have to be considered. The consultant co-ordinator would provide an advisory role for the reporting system but it was emphasized that this is not intended to be a clinical advisory role and must not usurp the function of the transfusion centre in this respect.

Dr Williamson will write to all members of the SHOT group with general recommendations as follows:-

1) Grade F RGN to be appointed to undertake data handling.

2) Co-ordinator to be appointed from the group membership by volunteering or recommendation to run for three years in the first place. This person could be a hospital or Transfusion Centre based Consultant.

3) Four possible venues for the Co-ordinating Centre site were discussed. These are: The Hammersmith Hospital, Manchester Blood Centre, Cambridge and Edinburgh.
ACTION - LW to write to all members of the group.

Finally the Royal College of Pathologists required a revised submission with terms of reference. There may be no point in doing this if the College's role is only that of membership of the Steering Group.
? ACTION - LW

3.3 STEERING GROUP

LW wrote to 11 organisations and received replies from 9. Replies have not yet been received from The British Paediatric Association and The Royal College of Midwives. The following organisations have replied:

IBMS - Representative: Mr Tim Booth, Cardiff Blood Centre
BBTS - Representative: John Barbara
BSH - Eric Preston replied. The group discussed possible suggestions for a representative as follows:
Dr Bhavnani, Dr Mike Murphy, Dr Summerfield, Dr Wallis
Royal College of Anaesthetists - Professor Preece Roberts has nominated Professor Graham Smith as representative.
RCN - Christine Hancock has nominated Mrs Susan Scott.
RCObst - Will write again with the name of a representative.
RCPath - Have recommended the Chair of the SAC in Haematology, Professor John Lillyman.
RCPhysicians - Nominated - Dr W Wagstaff
RCSurgeons - Will write again with a nomination.

In addition it was agreed to write to the IHSM
ACTION - LW to follow up outstanding replies

3.4 FUNDING:

As previously recorded the Royal College of Pathologists is unable to fund this venture. The initial reply from Dr Jeremy Metters indicated that there would be no central funding but has asked Dr Williamson to put together a detailed proposal with funding assessment. Dr McClelland suggested that the initial figure of £10,000 per annum was not sufficient and the sum should be raised (? £20,000 - £40,000). Funding should include one session of Consultant's time, one grade F RGN, a part-time Secretary, IT equipment and disposables.

Professor Bellingham's comment re a possible audit function of the scheme was noted. Dr Williamson had pointed out that this was not the prime function of the reporting system and indeed Professor Waters already has a major interest in transfusion audit.
ACTION - LW to write again to Dr Metters and as a courtesy to inform CMOs of Wales, Scotland and Northern Ireland.

BMc to discuss this letter with Aileen Keel of the Scottish Health Department.

3.5 REPORTING SYSTEM FOR VIRAL INFECTIONS (see letter from Kate Soldan circulated with agenda)

It was felt that Kate Soldan's concerns re item 4 of her letter were unfounded. It had been agreed that the possibility of post transfusion infection should be highlighted on the general report form in order to increase awareness but it would be strongly emphasized that the general report form was not a means of reporting the incident.

Whilst on this subject the reporting system for Scotland was discussed Dr Williamson agreed to write to Professor Cash.
ACTION - LW

3.6 REPORTING SYSTEM FOR BACTERIAL INFECTIONS (see item 5 of Kate Soldan's letter circulated with agenda).

Again, there were not felt to be any problems. As for viral infections, the possibility of bacterial infections would be highlighted on the general forms and again it would be emphasized that reporting must be via the Blood Centres.

With reference to Kate Soldan's forms replies have been received from several Scottish Consultants and comments passed on.

3.7 REPORTING SYSTEM FOR NON -INFECTION HAZARDS - FOLLOW-UP QUESTIONNAIRES

Dr Williamson had received some suggestions. Dr McClelland felt that PTP should not be included as a separate category but should be catered for under "OTHER". Dr McClelland and Dr Todd will modify the general report form and send it back to SHOT group members for consideration.
ACTION - AT/BMc.

It was agreed that the purpose of follow-up questionnaires was to obtain an idea of how an incident had occurred and how recurrence might be prevented. The ultimate role of the scheme as a whole is to improve transfusion practice.

The structure of the questionnaire forms was discussed in detail. The possibility of a single form with sections applicable to different types of reaction was felt to be rather difficult. An alternative is to devise a general form which could be sent to the co-ordinator who would then ascertain details by telephone and follow this up with a more specialised form relevant to the report.

It was agreed that LW will await forms from Mrs Campling and then devise SHOT group forms based on the suggestions already made. She will then circulate these to the rest of the group.
ACTION - LW

4) LAUNCHING THE SCHEME:

A briefing leaflet had been included in BBTS AGM literature and this could be modified as a newsletter article.
ACTION - LW

Dr McClelland had some concerns about the flow-chart and will modify this to incorporate his suggestions.
ACTION - BMc

It is important to keep up the impetus of the group at this stage and an early meeting of the Steering Group was suggested for 12 December 1995 at the Royal College of Pathologists.
ACTION - LW

Dr Lorna Williamson felt it would be useful to aim for a possible start date for launch which was suggested might be April 1996.
ACTION - LW

5) ANY OTHER BUSINESS

None

8) DATE OF NEXT MEETING:

Tuesday, 17 October 1995 - West End Donor Centre, at 1.00 pm

EML/MB
18.9.95