SERIOUS HAZARDS OF TRANSFUSION WORKING PARTY - FUNDING PROPOSAL.

Background.

In contrast to the USA, there is no voluntary or mandatory system in the UK for reporting of transfusion-related fatalities or serious complications. Such a system would cover rare but important events such as transmission of hepatitis B and C, HIV and other viruses, bacterial contamination, ABO incompatibility and other 'blood-into-wrong-patient' episodes, transfusion-related graft-versus-host disease (TA-GVHD) etc. The Medical Directors of the National Blood Service and the Scottish National Blood Transfusion Service have recognised the important role which such a reporting system can have. Firstly, it can provide information critical to policy-making eg need to test for additional markers of hepatitis B. Secondly, it can monitor the application of current guidelines eg irradiation of blood components. Finally, it can highlight areas where enhanced training is required eg in transfusion procedures.

In 1994, an *ad hoc* group of transfusion specialists, hospital haematologists and virologists was convened to consider the problem and devise a solution. A number of important issues emerged :-

1. There would be a need for absolute anonymity and confidentiality, particularly where errors of practice were involved eg blood given to wrong patient. A system would therefore be required that did not necessarily involve reporting via Transfusion Centres.

2. Diagnosis and investigation of some complications was specalised and would require close liaison with Transfusion Centres or other laboratories. In the area of infection reporting, it was essential that well established local practices to ensure product withdrawal were not bypassed or replaced.

3. Some form of 'screening' of notifications would be required to prevent the database becoming cluttered with minor reactions of no serious consequence.

4. Hospital staff should perceive this as an extension of professional audit and not as a policing exercise by the Transfusion Services.

Proposed solution.

1. Infectious hazards (bacterial, viral and protozoal) will be dealt with by a new liaison post between the NBS and the PHLS Communicable Disease Surveillance Centre. This person would receive reports from blood centres and PHLS laboratories, ensure that investigations were complete and collate statistics for an Annual Report. This part of the process is being overseen by Dr John Barbara, and is already fully funded.

2. A central database will be established to cover all serious non-infectious hazards as defined by the group. The hospital haematologist responsible for transfusion, who in any case will be aware of most serious events, will report cases would be reported to a national co-ordinator. These would be either a hospital haematologist or a transfusion consultant chosen to cover the whole of the UK (Dr Elizabeth Love, Consultant, Manchester Blood Centre has been nominated). The co-ordinator would be provided with appropriate local support, along the lines of NEQAS. This could be a nurse/MLSO to screen initial reports, plus secretarial time. Assuming not more than 200 notifications/year, 0.5 day/week consultant time should be sufficient.
All serious incidents will be followed up with a detailed questionnaire. Once investigations are complete the data will be anonymised and entered on the database. **The destruction of paper records will then ensure that no link can be made between individual reports and those held on computer file.**
Draft initial report forms and follow-up questionnaires are attached.

3. The involvement of Royal Colleges and professional organisations is seen as essential to give the activity a professional focus, as with National CEPOD (Confidential Enquiry into Perioperative Deaths).

An informal link has been established with the Chief Executive of CEPOD, which should be maintained. A Steering Group representing appropriate bodies has being formed, which will require terms of reference, and probably a small executive group to manage the running of the scheme. The following organisations have so far indicated their wish to be represented (nominated rep listed):-

IBMS - Mr Tim Booth, Cardiff Blood Centre
BBTS - Dr John Barbara, North London Transfusion Centre
BSH - Dr Hannah Cohen, St Mary's Hospital
Royal College of Anaesthetists - Professor Graham Smith
Royal College of Nursing - Mrs Susan Scott
Royal College of Obstetricians - name to follow
Royal College of Pathologists - Professor John Lilleyman, St Bartholomew's (Chair of SAC in Haematology)
Royal Colllege of Physicians - Dr W Wagstaff
Royal College of Surgeons - name to follow
UK Blood Transfusion Services - name to follow

British Paediatric Association - no reply yet
Royal College of Midwives - no reply yet.

The first meeting of the Steering Group is planned for December 12th.

LAUNCHING THE SCHEME.

Wide publicity within the NHS will be required to raise awareness and promote reporting. PR advice is being sought from within the NBS, but the following should be considered:-
- editorials in BMJ and Lancet, Transfusion Medicine and British Journal of Haematology, plus medical magazines eg Hospital Doctor
- articles in professional newsletters - RC Nursing, NEQAS
- individual targetting of membership of BSH, BBTS, hospital Chief Executives, anaesthetists.

A press release for national media would be advisable to minimise adverse responses.
If funding can be found, the scheme will probably be ready for launch in April 1996.

FUNDING.

To fully recover the costs of the scheme will require approximately £36k/year (outline budget below). This is highly cost-effective considering the potential long-term benefits. Initial approaches to the Department of Health and the Royal College of Pathologists have been unsuccessful. The Scottish National Blood Transfusion Service has indicated that in principle they would fund an appropriate share of costs to allow the scheme to be established. It is hoped that the other UK transfusion services will feel able to contribute *pro rata*, at least for the first 2 years, after which time the scheme and its funding will be reviewed.

GRO-C: Lorna Williamson

Lorna Williamson

23rd November 1995.