

COMMENTS FROM BSH PRESIDENT – Dr Archie Prentice

On behalf of the BSH I thank Drs Dorothy Stansby and Hannah Cohen for the opportunity to congratulate the entire SHOT team on their excellent work. Once again they have produced a comprehensive report of hazardous clinical incidents which contains some powerful messages and joins the series of their annual reports which have been driving change in clinical transfusion practice. There is an increasing sense of ownership and involvement in the production of these reviews amongst the biomedical scientists, clinical scientists, doctors and specialist nurses who deliver the transfusion service in hospitals. The willingness of colleagues to be so freely and openly critical of their own work is a heartening reminder of their professional commitment to the highest quality of care, a commitment which is entirely independent of any politically driven demand to achieve crude numerical targets.

It is important to say why BSH takes this exercise so seriously, what these reports tell one about the nature and the scope of the risk inherent in blood transfusion for patients and practitioners, and why these reports are symptomatic of wider problems in the NHS and medical education.

BSH is an independent learned society operating as a charity. So it can speak, hopefully objectively, openly and critically, about the state of all aspects of Haematology. In recent years BSH has offered membership not only to doctors but increasingly to Clinical Scientists, Nurses and Biomedical Scientists, recognising that this is a multi-professional specialty in which we need increasing dialogue and mutual understanding of each others roles. It is

now the only society which can offer such over-arching representation of all those interested in the practice of Haematology. In addition the Society has had a longstanding interest in the definition of standards of practice and has published many guidelines through the activities of its sub-committee, the British Committee for Standards in Haematology (viz: the first and earliest reference in this SHOT report and a third of all its references). Colleagues' contribution to the process of producing BCSH guidelines is voluntary and independent of commercial and political influence. This process is steadily becoming more multi-disciplinary and multi-professional. In a culture of increasing aversion to any risk, the work of BCSH is increasingly important. There are signs that the courts may in future accept failure of adherence to such guidelines as evidence of incompetence and negligence. The SHOT exercise is a natural extension of guideline production. We need to know to what extent these are followed, where and, if not, why not.

A bag of blood is a biological time bomb and its transfusion is potentially seriously hazardous. But if guidelines are to be useful, then the level of such risk must be assessed realistically. The spectrum of risk of death stretches from birth itself to becoming seriously ill and then increases with medical and surgical interventions. In other words blood transfusion is always given against a background of co-morbidity and, if we are to ask for resources to minimise risks associated with it, then we need accurate data showing incidence rates of unacceptable and unsafe events compared to the overall use of blood transfusions. Hopefully such denominator data will be collected and included in future annual reviews by SHOT. The death rates in all SHOT

reports to date would suggest that serious or life-threatening risk is low, certainly when compared to deaths due to anticoagulants. At the hospital level the provision of safe transfusion may be working well overall in the UK. But there is no room for complacency. The process of provision of safe blood is long, fast and complex and therefore vulnerable to undetectable and irretrievable error. There is a worrying increase in the reports of potentially and actually damaging incidents which could be real and not just a reflection of increasing confidence in the SHOT reporting system. There is no doubt that, not only BMS in the hospital transfusion lab, but also junior Doctors and Nurses are being driven harder by political pressures without sufficient support. It is therefore not surprising to see an increased frequency of non-lab errors at the blood sampling and labelling stage as well as at the stage of the pre-transfusion bedside check.

Detailed analysis of the process of care delivered by the NHS, such as that contained in SHOT reports, should make its Executives take note of the failings in the performance of the Trusts for which they are legally responsible. It may be more difficult for us to help politicians to understand the significance of these details because of their obsession with crude numerical targets. These symptoms of a service under stress need to be measured accurately, just as for the level of risk of transfusion itself as described above. The role of the Consultant Haematologist is widely accepted in controlling use and abuse of blood products. There are now over thirty Consultant posts vacant in the UK and this number is increasing at an alarming rate as more and more take early retirement. The rate of expansion of funded SpR posts is inadequate to cope with this growing gap in staffing. Recruitment, retention and morale of BMS staff are at an all time low. Providing safe on-call transfusion services has never been

more difficult and increasing numbers of Trusts are forced to use non-transfusion and even non-Haematology staff to maintain them. In many Trusts the nurse:patient ratio in “non-intensive” wards is dangerously low and the skill-mix reviews currently being undertaken to cope with the *Agenda for Change* and financial constraints simultaneously may well reduce and de-skill that ratio further.

It is difficult to see how we can protect this long, fast, multi-step, multi-professional and therefore vulnerable transfusion pathway in the face of all these pressures.

Increasing rates of error should not come us an unexpected shock. However well motivated professional staff may be, they are human and there is a limit to their ability to avoid transfusion errors. We would all wish this practice to be completely free of mistakes and negligence but there is much loose talk of compulsion to meet fixed and stringent standards which does not allow for consideration of inadequate staffing. Any attempt to impose compulsory standards on any under-resourced system by inspection and accreditation will fail. There is plentiful evidence to support this view. We should use SHOT data to impress on NHS Executives the urgent need to establish a system which identifies Trusts in which transfusion risks and rates of adverse events are unacceptably high. Re-organisation of existing resources may be sufficient to reduce the risks and events in some Trusts but it is more likely that additional resources will be required in most. Many colleagues feel that CPA cannot deliver this level of inspection. But an inspection and accreditation process which includes performance of the non-lab steps in the transfusion process is needed urgently. We have only until 2006 before EU and UK law makes it unavoidable.

So we have a tough educational task to achieve this. Medical school curricula have been notoriously inconsistent in the extent to which Transfusion Medicine is taught but now the curricula of some new schools are severely hypoplastic. New junior medical staff need further training before they enter the transfusion pathway as a step which can fail and harm through lack of understanding. Our Executives and Politicians also need to be brought to an understanding of the consequences of any decline in the safety of hospital transfusion services. It is difficult to see how we can break into their cycle of short-term, outcome target-based and cash-limited thinking to achieve that understanding. Perhaps their own crude limitations are the key as surgical targets must be at risk if blood cannot be safely transfused. Furthermore re-election would perhaps be less likely by a public who had lost trust in a party which allowed one of the State's prized possessions, the transfusion gift relationship, to be wasted or worse to be made dangerous. It is perhaps timely to start a dialogue with our national news media to give the risks of transfusion and the risks to the hospital transfusion service a higher public profile.

BSH continues to support SHOT and encourages it to expand on its efforts. We offer our help and we should be able to work together to capitalise on the foresight which led to this exercise in defining how well a service is delivered, how vulnerable it is to neglect and how we might protect and develop it.

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President BSH