5 The Infected Blood Inquiry and Haemovigilance

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Abbreviations used in this chapter

AOMRC	Academy of Medical Royal Colleges
IBI	Infected Blood Inquiry
MHRA	Medicines and Healthcare products Regulatory Agency
NHS	National Health Service
NHSBT	NHS Blood and Transplant
NICE	National Institute for Health and Care Excellence
TTI	Transfusion-transmitted infection
UK	United Kingdom

Recommendation

- Complete implementation of the IBI report recommendations to improve healthcare systems and optimise safety. The effectiveness of the implementation should be monitored regularly

Action: All professional organisations related to healthcare in the UK and all relevant bodies responsible for various recommendations as detailed in the report

Introduction

The IBI was an independent, public, statutory inquiry established to examine the circumstances in which men, women and children treated in the NHS were given infected blood and infected blood products, particularly in the 1970s and 1980s. Sir Brian Langstaff chaired the Inquiry, and the final report was published on 20 May 2024 (IBI, 2024). SHOT released a statement following the release of the IBI Report (See 'Recommended resources').

It has been humbling, upsetting, and moving to hear and read the report's findings, evidence and lived experiences of the Infected and Affected. The SHOT Steering Group and Working Expert Group members would like to acknowledge the scale of the tragedy and extend their heartfelt compassion. We are considering the findings and recommendations from this comprehensive report. We are committed to working with the MHRA as the regulator and other key stakeholders, including patients, and pledge to assist and support effective implementation of all recommendations related to haemovigilance.

Recommendations relating to haemovigilance and transfusion safety

It is encouraging to see several recommendations in the IBI Report supporting haemovigilance, patient blood management, transfusion education, laboratory support and digital transformation within transfusion. Many of these recommendations align closely with the philosophy of SHOT, and priorities we have identified over recent years. There were several themes that emerged from the final report of the IBI. Sir Brian Langstaff identified the first theme as the failure to make patient safety the paramount focus of decision making and action. The report contains several wide-ranging recommendations that addresses the wider healthcare system and practices, not just transfusion medicine (IBI, 2024). The following infographic summarises the main themes from the safety messages and recommendations from the report. Recommendation 7 focusses on 'Patient Safety: Blood Transfusions'.

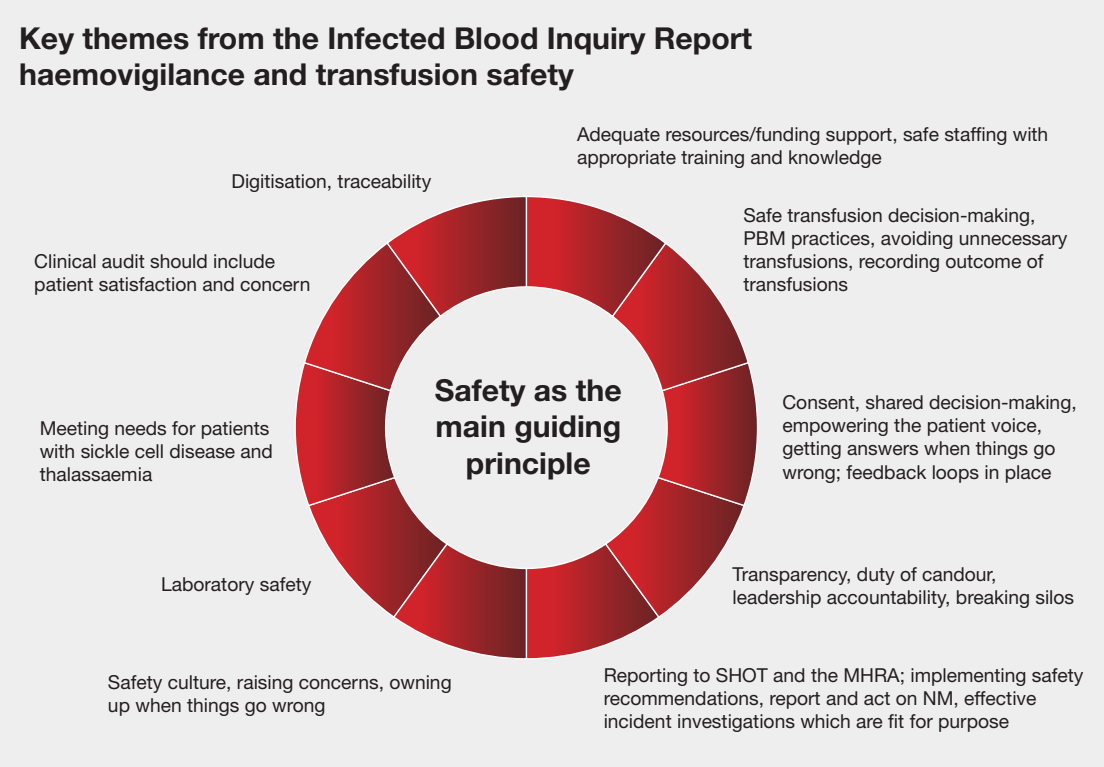


Figure 5.1: Key themes from the IBI Report related to haemovigilance and transfusion safety (IBI, 2024)

MHRA=Medicines and Healthcare products Regulatory Agency; NM=near miss; PBM=patient blood management

The Inquiry report has put the spotlight on haemovigilance, acknowledging the importance and value of reporting and learning from incidents and implementing SHOT recommendations to improve transfusion safety. Recommendation 7e states:

7 (e) That all NHS organisations across the UK have a mechanism in place for implementing recommendations of SHOT reports, which should be professionally mandated, and for monitoring such implementation.

Partnering with patients to enhance safety

Giving patients a voice is one of the main messages from the IBI Report (IBI, 2024). Recommendation 10 focuses this and lists several measures for action.

Engaging patients, their families, and carers as 'safety partners' to co-create safer systems, identify, and rectify preventable adverse events was one of the main recommendations in the 2021 Annual SHOT Report (Narayan, et al., 2022). It is time to transform healthcare by elevating the patient's voice to its rightful place of importance – their voices hold the key to creating a healthcare system that is not only effective but also compassionate and truly patient-centred. Shared decision-making should become the norm and patients must be active partners in their care and in improving organisational safety. This begins with a commitment to listen and to learn from those who experience care firsthand. Transparent and open communication is the foundation of trust. Healthcare providers must embrace this recommendation, enhance communication skills, understand the diverse backgrounds of their patients, and build stronger, meaningful relationships with patients, carers and families with appropriate use of technology. Feedback mechanisms must be in place to ensure the healthcare system evolves with the needs and insights of those it serves. By giving patients a voice, we honour their experiences and insights, creating a healthcare system that is safer, more effective, and profoundly more compassionate.

Several resources have been developed to support consent and shared decision-making for transfusion (See 'Recommended resources'). However, a recent 2023 national comparative audit of NICE Quality Standard QS138 showed that only 475/1356 (35.0%) transfused patients had evidence of receiving both written and verbal information about the risks, benefits, and alternatives to transfusion (compared to 26% in the 2021 audit) (NHSBT, 2024; NICE, 2016). This highlights the need to urgently improve and implement systems to ensure appropriate informed consent for transfusions and promote shared decision-making.

A new mobile application called 'MyTransfusion' is in development. This has been co-created with input from patient representatives and transfusion experts and is expected to be released later this year and aims to support the shared decision-making process.

TTI risk-reduction measures

The UK Blood Services are among the safest in in the world and several measures have been implemented to minimise the risk of TTI. Improvements in the transfusion pathway including stringent donor selection, arm cleaning, diversion of initial part of the donation, microbiological screening tests, optimal storage and transport, quality-control processes and safe management of any suspected TTI cases have helped minimise the risk of TTI in the UK blood supply. Several resources have been released recently capturing the safety measures to ensure microbiological safety and trends in infections reported (See 'Recommended resources').

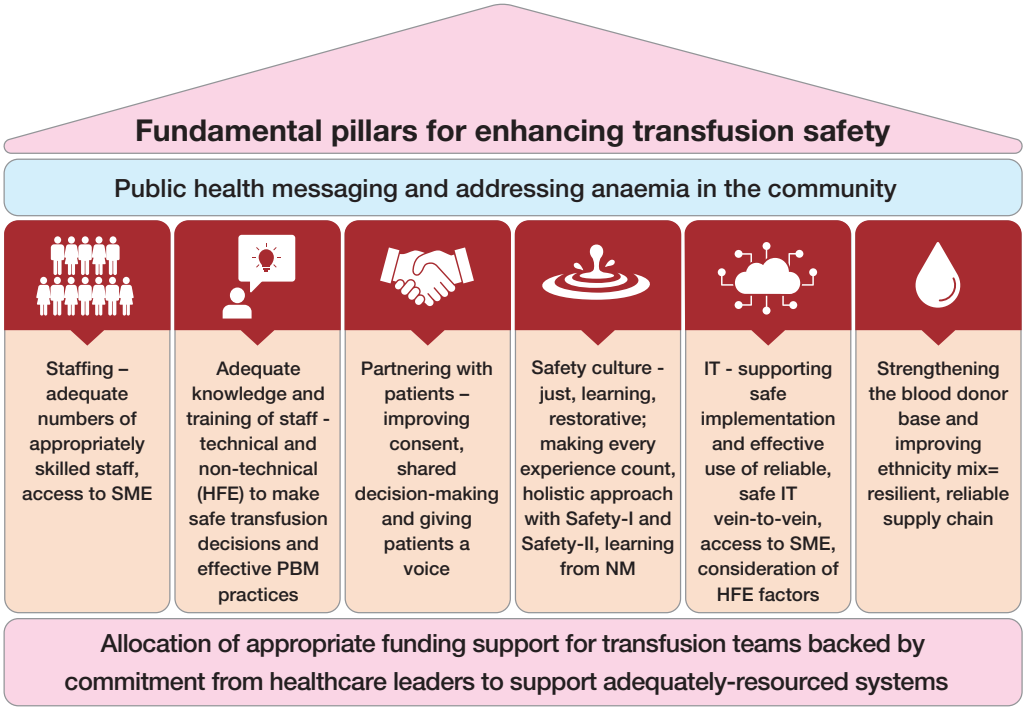
Conclusion

The recommendations from the IBI report are crucial for addressing the failures of the past and significantly enhancing the safety and trustworthiness of healthcare systems. We must ensure effective implementation of the recommendations to prevent similar incidents in the future. This begins with meaningful engagement and partnering with patients, and ensuring that the healthcare system is transparent, accountable, and provides high-quality care. The Report is not just a document but a call to action, urging all of us to reinforce our commitment to safety which should be the main guiding principle for decision-making in healthcare. It provides us with a clear roadmap for achieving excellence in transfusion safety and we should use the insights from this report to drive impactful changes, promote innovation and foster a culture where safety is paramount.

Several safety initiatives across the UK in the last couple of decades have helped improve transfusion safety (See 'Recommended resources'). There, however, cannot be any complacency and the real work lies ahead to address the increasing challenges we are facing in an NHS that is in crisis. A recent AOMRC report states, 'If we do not act with urgency, we risk permanently normalising the unacceptable standards we now witness daily, to the detriment of us all' (AOMRC, 2022). We must take action to prevent further avoidable harm and make meaningful strides towards building a system that protects and promotes health for everyone with engagement, collaboration with patients and rebuilding trust with continued vigilance.

Based on the emerging themes from serial Annual SHOT Reports and aligned with the IBI Report, tangible actions are needed in all areas captured in the illustration below to truly improve transfusion safety in the UK.

Figure 5.2: Fundamental pillars enhance transfusion safety in the UK



Applicable to both clinical and laboratory transfusion teams

HFE=Human factors and ergonomics; IT=information technology; NM=near miss; PBM=patient blood management; SME=subject matter expert

The Thirlwall inquiry recently published a damning summary of progress made by the NHS and government across 30 inquiries, including Mid-Staffordshire NHS Foundation Trust – dating back to 1967 (Thirlwall Inquiry, 2024). The analysis found that just 302 of more than 1,400 recommendations had been adopted. We stand at a critical juncture, one where words must transform into actions and promises must become reality. It is our collective responsibility to ensure the recommendations from the Inquiry do not gather dust but are actively pursued and implemented. Let us honour the voice of all the Infected and the Affected, their experiences should be catalysts for change.

Recommended resources

Statement from SHOT in response to the Infected Blood Inquiry Report
Statement from SHOT in response to the IBI report - Serious Hazards of Transfusion (shotuk.org)

Transfusion safety initiatives across the UK
Current Resources - Serious Hazards of Transfusion (shotuk.org)

Patient information page on the SHOT website
https://www.shotuk.org/patients/

Consent for transfusion – information for patients
Transfusion Information for Patients (transfusionguidelines.org)

Support available through the Inquiry from the British Red Cross
Psychological support provided by the Inquiry | Infected Blood Inquiry.

Managing the safety of the blood supply video
SHOT Videos - Serious Hazards of Transfusion (shotuk.org)

Infected Blood Inquiry website
Homepage | Infected Blood Inquiry

Transfusion-Transmitted Infections (TTI) Cumulative Data
Cumulative SHOT Data by Category - Serious Hazards of Transfusion (shotuk.org)

References

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