Feedback workshop on EU directives

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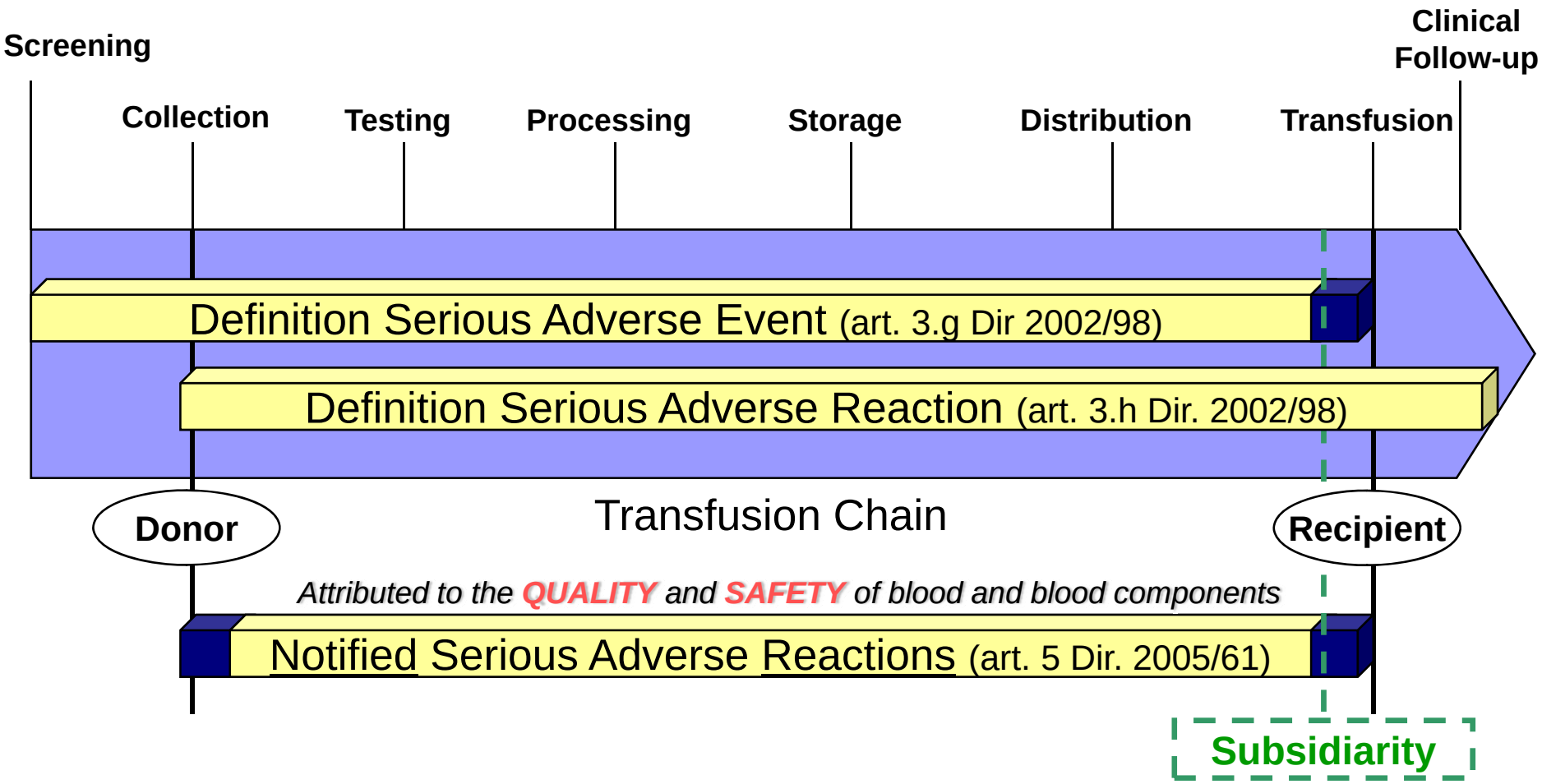
Session on EU directives

- What to report to EC
- EU funded project: EU-Q-SOP manual
- Blood SAE / SAR: BE, FR, UK
- Tissue and cells: SAE / SAR
  - EU funded project: EUSTITE
  - NL

What to report to the EC

- Need to clear up as much as possible questions IN ADVANCE to the first collection (learning exercise during the coming years).
- MS agreed with the Commission's proposal for a common approach (scope and definitions) regarding the information to report.
- During the last meeting of competent authorities a working group on SAR and SAE was created.
- Finalisation of the common approach by the Commission June 2008.

SAR and SAE
Scope of the Blood Directive



SAR and SAE definitions

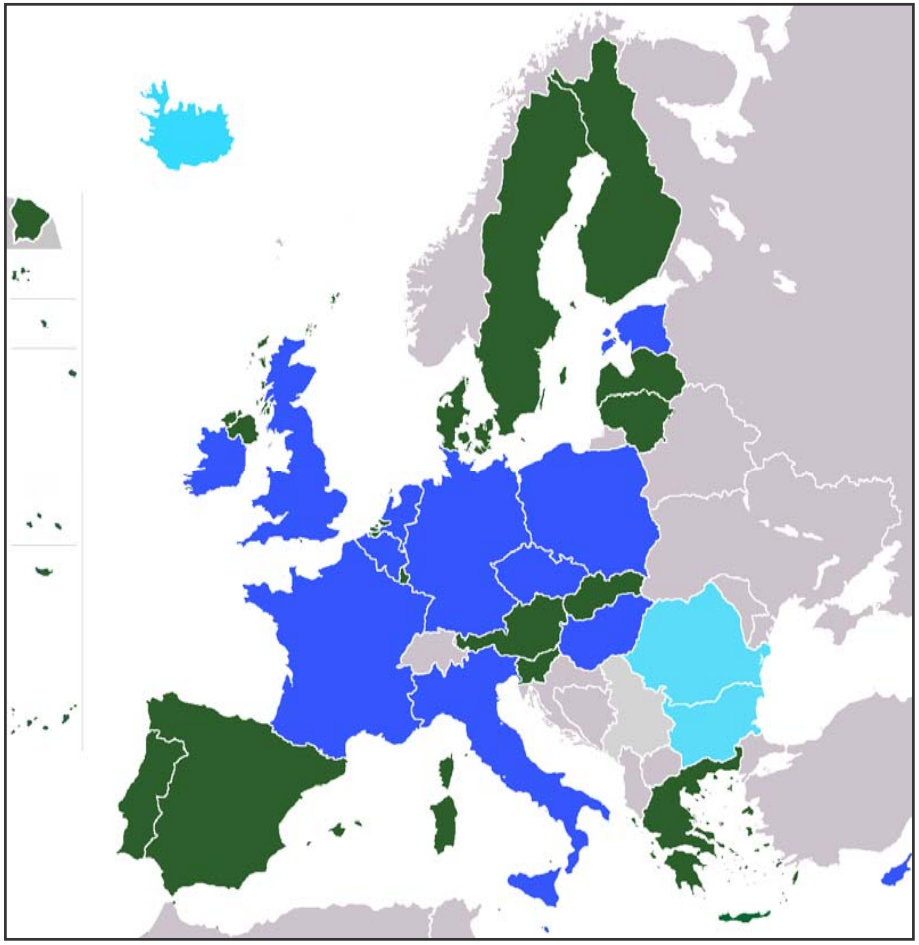
SAR definitions:

- As a starting point: available ISBT definitions should be used as references. These definitions may be subject o further refinement in 2008.
- For TTI: SHOT definitions (ISBT definitions not available).

SAE definitions

- Table according to the proposed format with examples of events and how they should be classified

EU-Q-Blood-SOP Project



16 Participants from

EU member states:
BE, CZ, DE, EE, FR, IE, IT, CY, HU, MT, NL, PL, UK

(acceding) new member states
BG, RO

EFTA states:
IS

EBA European Blood Alliance

Project objectives

Develop a Manual describing a methodology based on good practice that will

(1) **assist blood establishments to implement or expand their standard operating procedures (SOPs).**

(2) contribute to the understanding and management of quality processes in blood services.

(3) **assist blood establishments in preparing for the inspection of their services** related to the implementation of quality relevant elements required by the EU directive 2002/98/EC.

EU-Q-Blood-SOP Manual

1 - Background and Objectives

2 - Quality principles
linked to the Directive 2002/98/EC and 2005/62/EC

3 – Development and Implementation of an SOP
Divided into 6 steps (Chapters 3.1-3.6):

1 Identify the objective and scope of the SOP and draft a title
2 Identify the competent user and assign responsibility for writing the SOP
3 Use the Master SOP to write an SOP
4 Design a process flow chart and describe each step of the work process in this flow-chart
5 Initiate document change control
6 Conduct training in the use of the SOP

4 - SOP Master and Examples (WG1-4)
covering critical quality activities

Annex – Terminology , References and Participants

http://www.eu-q-blood-sop.de

EuBIS
European Blood Inspection System
Co-funded by the EC – GA No. 2006202

The general objective of the Project is to address the scope define in Area 2.2.4 of the work plan 2006 of the Public Health Programme ensuring
Equivalent recognition of inspections of blood establishments among all Member States through the development and implementation of commonly accepted criteria and standards leading to comparable quality systems and inspection procedures.

EuBIS - General Objectives

(1) define requirements for quality management systems of blood establishments based on the Directive 2005/62/EC.

(2) develop pan European standards and criteria for the inspection of blood establishments based on GMP guidelines to assist national inspections in implementing the Directive 2002/98/EC and its technical annexes.

(3) establish a common benchmark system for continual improvement. This benchmark system should develop practical assistance and advice to optimise processes based on good practice among blood establishments.

(4) develop a training programme for inspectors

EuBIS Inspection Manual

Chapter 1: Quality system (standards-cross reference)

Chapter 2: Organisational requirements of a CA / BE

- Qualification and training of inspectors
- Inspection Master Plan (Schedule)
- Number of inspectors (staff) to cover the task

Chapter 3: Inspection process of BE (external by CA)

- Type of inspection
- Inspection team
- Information provided by the BE to CA before inspection
- Documents/Lists of SOP (optional)
- Information available on site during the inspection by CA
- Inspection report

Chapter 4: Self-Inspection process (internal by BE)

- Quality policy (Management)
- Type of inspections
- Responsiabilities
- Inspection team (e.g Peer-inspection process)
- Internal inspection report
- Evaluation system for deviations and continuous improvements

Chapter 5: Inspection checklists

http://www-eubis-europe.eu

Some possible definitions of a reportable SAE in blood establishments

1. Any untoward occurrence (error, quality deviation or accident) from collection to distribution, that may lead to harm of the patient?
2. The release of a blood component, that did not fulfill the Q and S requirements?
3. The distribution of a blood component, that did not fulfill the Q and S requirements?
4. The use of a blood component, that did not fulfill the Q and S requirements?
5. An event that could have (had) implications for other patients due to a procedural or a technical problem?
6. An event that might put the live of a donor in danger?
7. An event that could have (had) implications for other donors due to a procedural or a technical problem?
8. Or combinations of these?

Reportable SAE

- Reportable SAE should be:
  - clearly defined.
  - limited to the ones that slip through the barriers.
  - standardised.

- Results of two year reporting in Belgium using a limited defiition indicate that standardised definitions of reportable SAE:
  - make possible stable reporting.
  - provide an estimation of non-conformity of distributed BC.
  - allow comparison of data.
  - help to evaluate effect of modified procedures/training.

Reporting of SAE and SAR in France

Reporting of: - post donation information (PDI) started in 2002
- SAE and SAR in donors started in 2006

Notification of SAE according to a decicion-making algorithm (in BE before release: notification of repititive adverse events and special adverse events required thrugh annual reporting)

Notification of SAR in donors: definition of serious AR

- Medical intervention of the donor (in 200: 186 cases)
- Hospitalisation of the donor (in 2007: 74 cases)
- Death of the donor

Reporting of SAE and SAR: the UK experience

Existing HV scheme - SHOT

- Professionally led scheme (on voluntary basis) providing analysis of anonymised data by experts in each area of reporting.

New role of MHRA: 'Competent Authority':

- Implementation of new legislation and regulator
- Annual report on SAEs and SARs to EC.
- May impose sanctions and demand corrective actions on individual sites

New

- Mandatory reporting
- Data available to blood inspectors
- SARs – collected by both SHOT and MHRA
- SAEs include those where blood not transfused
- BE reports required to go to MHRA

How SAE and SAR reporting is done in UK

- Online reporting system: SABRE (serious adverse blood reactions & events)
- Single portal for reporting to MHRA and SHOT
- Accessible via MHRA, SHOT, JPAC and blood services websites
- User friendly home page, welcome, explanatory pages
- Improvement for SHOT, now has online database
- Benefit to MHRA of tapping into existing reporting culture

Working together

- Collaboration and co-operation between SHOT and MHRA
  - Strengthening of UK haemovigilance
  - Improved data collection for SHOT via SABRE
  - Potential for new developments in data analysis
  - Professional laboratory and clinical experience and expertise available to MHRA
  - Clear different remits for SHOT and MHRA but symbiotic, mutually enhancing relationship

The EUSTITE Project
Objectives

- **Standardisation of principles and practices in the inspection and certification of tisse banks in the EU.**
- **Development of a model for the rreporting and investigating of adverse events and reactions associated with the quality and safety of tissues and cells in the EU.**

Key concepts for an EU Proposal

- Criteria for reporting SAEs to CA
- Severity grading system for SARs with guidance on which level to report to CA (based on ISBT system for blood)
- Imputability grading system for SARs
- Impact grading system (risk matrix including wider system implications) for SAEs and SARs
- Guidance on applying these tools
- Guidance on management of SAEs and SARS that have cross-border implications

Proposed criteria for SAE reporting to Competent Authorities

Deviations should not be reported as SAEs to CAs unless:

1. **Inappropriate tissues or cells have been released for clinical use (even if not used)**
2. **The event could have implications for other patients or donors because of shared practices, services, supplies or donors**
3. **The event resulted in loss of any irreplaceable autologous tissues or cells or any highly matched (i.e. recipient specific) allogeneic tissues or cells**
4. **The event resulted in the loss of a significant quantity of unmatched allogeneic tissues or cells**

Adverse REACTION Evaluation and Reporting to the Competent Authority

Each report of a suspected AR received by a TE should be evaluated using the following tools:

- Severity
- Imputability
- Impact

Proposed Impact Assessment Tool

Step 1: Probability of Recurrence

Step 2: Consequences

Step 3: Risk Matrix

Step 4: Response

The Impact Assessment Tool is essentially a tool for the risk assessment of an event or reaction.

Step 3: Apply Risk Matrix

Probability of recurrence → / Consequences ↓	Almost certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Severe 5	25	20	15	10	5
Major 4	20	16	12	8	4
Moderate 3	15	12	9	6	3
Minor 2	10	8	6	4	2
Insignificant 1	5	4	3	2	1

Step 4: Response

The response of a TE or CA to a specific SAR/SAE should be proportionate to the risk indicated by the incident as assessed by the risk matrix

EUSTITE Vigilance and Surveillance Pilot

- The approved EUSTITE ‘tool kit’ and reporting system will be piloted in partner countries and in any other MS that wish to participate for 1 year from July 2008
- All SAEs and SARs will be collated and their management and outcome reviewed and reported
- The project will make recommendations to SANCO on future management of V&S of tissues and cells in the EU
- WHO will publish global recommendations on management of V&S in transplantation

Cells and tissues: reporting of SAE and SAR in The Netherlands

- TRIP asked to set up compliant tissue vigilance system
- Pilot launched in August 2006
- First results
- Dificulties and questions:
  - Difficult to find central point of contact in the hospitals (need for tissue vigilance officer)!
  - Known side effects?
  - Reporting to tissue-specific organisation (e.g. JACIE)

    does not obviate the need to report under the Directive!
  - Which adverse events?
  - Need for imputability assessment.
  - Side effect which is not unexpected?
  - Late reporting (‘cold’ vigilance)
  - Need for list of tissue specific side effects

Thank you