NHS
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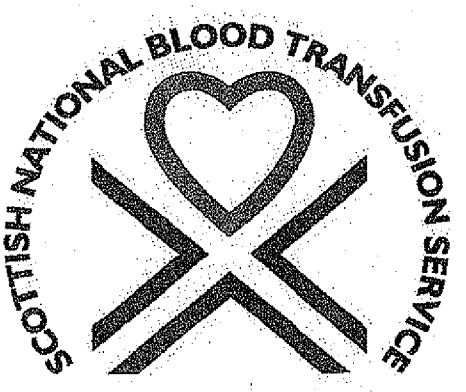

PENROSE INQUIRY

Scottish National Blood Transfusion Service

Donor Selection Policies and Procedures

SNBTS DOCUMENT REQUEST No:

2010/00056

September 2010

APPENDIX 2

GLOSSARY

AIDS	Acquired immunodeficiency syndrome - a disease which damages the ability of humans to fight off other infections. Originally know as Gay Related Immunodeficiency (GRID) and first reported in the USA in 1981. The disease is caused by a blood-borne virus, the Human Immunodeficiency Virus (HIV).
Autologous blood donation	The collection and reinfusion of the patient's own blood or blood components
HTLV-III - human T-cell lymphotropic virus	This was the original designation of the virus responsible for AIDS, later named human immunodeficiency virus (HIV) by international consensus.
NANBH - non-A, non-B hepatitis (term first used by Lancet editorial 12 July 1975)	Hepatitis that is not due to either the hepatitis A virus or the hepatitis B virus. Prior to the discovery of the hepatitis C virus, this group would have included infection with the hepatitis C virus as well as hepatitis due to other viruses (e.g. cytomegalovirus, Epstein-Barr virus) and non-viral causes of hepatitis (e.g. obesity, alcohol, certain medications).
SARS - severe acute respiratory syndrome	A new respiratory virus infection which arose in the Far East in 2003 and spread within weeks to over 30 countries.
Seroconversion	A response to an infection, usually occurring early in an infection, which denotes the point where an individual goes from having no antibody, to the formation of antibodies against the agent causing infection.
vCJD - new variant Creutzfeldt-Jacob disease	A disease which destroys the brain. The human form of BSE (mad cow disease). Associated with the consumption of food contaminated with BSE. Known to have been spread from human to human via transfusion of red blood cells in 4 cases. vCJD has been the main driver of blood safety initiatives in the past decade.
West Nile Virus	The virus is transmitted to humans by a mosquito bite. It can cause encephalitis (inflammation of the brain) or meningitis (inflammation of the lining of the brain and spinal cord). Proven to be capable of transmission by blood transfusion.

Contents

1. Introduction

There is no mention of AIDS in the 7th edition of Mollison's classic textbook *Blood Transfusion in Clinical Practice,* published in 1983[1]. This was the year when, following a preliminary report in 1982, the relationship between AIDS and blood transfusion was established beyond doubt[2,3,4] and the year in which the virus responsible was isolated[5]. Over the course of the following two years the hitherto obscure art of assessing potential blood donors' fitness and suitability to donate was transformed. Blood donor sessions were in the frontline of the battle against this worldwide epidemic.

Though the emergence of AIDS was to have a massive impact on transfusion services throughout the world, transfusion transmitted infection was far from unknown, and research in this field had been dominated by the search for the causative agents of hepatitis.

Post-transfusion hepatitis (PTH) had been a major concern since World War II, particularly in the USA, where by the late 1960s PTH rates of around 30% were being recorded[6]. It was known that there was a strong association between PTH and paid, as opposed to voluntary, unremunerated blood donors. As blood donor centres in the USA moved to eliminate paid donors of whole blood in the late 1960s, the incidence of PTH gradually fell from a high of around 30% of transfused patients. It was to fall further with the introduction of a test for hepatitis B in 1970, but the problem was not to disappear entirely, and in the late 1970s post-transfusion non-A, non-B hepatitis (PT NANBH) was a major concern, with an incidence in the USA of up to 10% of transfused patients[6]. Added to this was the accumulating evidence of PT NANBH and clinically evident chronic liver disease in haemophilia patients. The epidemiology of this form of hepatitis, which was thought to be caused by at least 2 as yet unidentified viruses, was poorly understood. The evolution of this area of research, in which SNBTS played an active part through the work of its scientific staff in Glasgow[7] and Edinburgh, and which is covered in detail in other Scottish National Blood Transfusion Service (SNBTS) papers, was to raise difficult issues in the formulation of donor selection policies and procedures as transfusion services grappled with the problem of AIDS.

2. Donor Selection 1975 – 1982

Before World War II some Scottish regions had paid blood donors, but the service established in Edinburgh by John Copland never did. Copland was the prime mover in establishing a national service, and he insisted that his policy of voluntary, unremunerated donation be applied throughout Scotland[8]. A question about a history of jaundice or hepatitis had been standard in donor session forms for many years, with any episode of jaundice that suggested viral hepatitis leading to permanent exclusion of the donor. However concern about the problem of NANBH began to become apparent in documents relating to donor selection in the late 1970s, with references appearing to both intravenous (IV) drug use and the advisability or otherwise of accepting prisoners as blood donors. In a letter from the Chief Medical Officer (CMO) to all Regional Medical Officers, dated 1 May 1975, the CMO acknowledged that there was a relatively high risk of hepatitis B being transmitted by the blood of prisoners, but "... probably an equally high risk in other groups of the population, e.g. drug addicts." He concluded thus: "The advice I have received is that it is not necessary to discontinue the collection of blood at prisons and similar institutions."[9].

This was, of course, before the NANBH problem was fully appreciated, and the CMO's remarks are to be seen largely in relation to hepatitis B. This was in line with a World Health Organisation (WHO) document published in 1971, which made specific mention of the need for donors to be unpaid volunteers, but made no reference to drug misuse or imprisonment in the context of donor selection[10]. In the first guidelines drawn up by the International Society for Blood Transfusion (ISBT) appeared in 1976, under the heading "Hepatitis" it was stated that "Prospective donors should be excluded if they are suspected to be parenteral drug users". Donors were also to be excluded if they were "inmates of a correctional institution"[11].

No information is held on how widely these ISBT recommendations were disseminated, but the most relevant document from that time, the Memorandum on the Selection, Medical Examination and Care of Blood Donors, declares that "Illicit drug taking if admitted or suspected should debar"[12], and similar advice appeared in the DHSS guide issued in 1979[13]. Neither document makes reference to prisoners or the use of prisons as donor session venues, and occasional prison sessions were held in Scotland until March 1984. There is an absence of evidence that prisoners had a higher incidence of NANBH than the general population. However, studies by Wallace, Barr, and Dow, from Glasgow, had shown some evidence that there was

more hepatitis in prison donors[14]. One study from the USA in the 1960s had shown that rates of PTH in recipients of prisoners' blood were no different from those in recipients of non-prisoner volunteer donor blood[15]. However, the relevance of this work to the situation in UK prisons more than a decade later is open to question.

The Memorandum and 1979 Guidelines, for the first time, permitted the acceptance of donors with a history of jaundice or hepatitis provided complete recovery had occurred more than 12 months previously, following the endorsement by the Standing Advisory Council (SMAC) on 11 November 1975 of the recommendations in the second report of the Advisory Group on testing for the presence of Hepatitis B Surface Antigen and its Antibody, which had been approved by the Minister of State in October 1975. No documentary evidence has been found to indicate precisely when this policy was implemented by SNBTS, but by 1982/3 it was incorporated in all existing examples of donor selection documents used in donor sessions in all SNBTS regions, and was detailed in the "Guidance on the Selection, Medical Examination and Care of Blood Donors" produced by the joint NBTS/SNBTS Working Party in 1983.

Little or no documentation exists to show how these top level policy issues were converted into practical procedures at the blood donor session. There is evidence that as late as Spring 1983 donor session forms in some Scottish National Blood Transfusion Service (SNBTS) regions did not mention intravenous drug use as a reason for deferral. In June 1983, however, the first SNBTS leaflet for donors describing the groups at high risk of AIDS (including IV drug abusers) was issued, and donor selection questionnaires were amended to refer donors to the leaflet as a necessary preliminary to donation. The evolution of donor deferral procedures from that time on is described in section 3 below.

It is important to appreciate that although National Transfusion Services with defined administrative structures had evolved in the NHS re-organisation of 1974, the Regional Transfusion Centres (RTCs) were largely autonomous entities as far as professional matters were concerned. The Regional Transfusion Director (RTD) and his/her consultant colleagues determined their own local policies and issued guidance to medical and nursing staff, and documents, for example information for donors, session records, publicity materials etc, were designed and printed locally, albeit with a national logo. Discussions between RTDs at national level were just that, and consensus was not always achieved. Moreover, the concept of clinical freedom was sacrosanct, and

every donor session was overseen by a doctor who had the final say on all matters of donor selection.

The blood donor service in the pre-AIDS era was possibly more concerned with donor welfare than patient safety. Admittedly there was little in the way of an "evidence base" for excluding donors who might harbour transfusion transmitted infections (TTIs), but minutes of committee discussions and correspondence from that time suggest that, as well as concerns about the blood supply sometimes outweighing tentative safety concerns, there was an attitude of deference to donors' sense of propriety (presumed), and a fear that embarrassing intrusions into the donors' private lives could lead to a mass exodus. An example of this can be found in the minutes of the National Blood Transfusion Service (England & Wales) Regional Transfusion Directors (NBTS RTD) meeting of 18 May 1983, when AIDS is mentioned in these minutes for the first time. A leaflet with proposals for excluding high risk donors had been drafted in Edinburgh and circulated, and in discussion it is minuted that the RTDs rejected the option of questioning donors. In a subsequent draft leaflet this appeared in a "question and answer" section as follows:

"Will donors be questioned on sexual matters when they attend to give blood? DEFINITELY NOT (sic)"

This question and answer did not appear in the final version of the NBS leaflet, but the attitude to which it bears witness, born as it was of a deep respect for the altruism and dedication of donors, was widespread in transfusion services, and indeed fears about the impact of intrusive questioning on donor attendances was not without foundation. A fall in the number of donations of 5 – 6% was recorded in the UK in the first quarter of 1985, prompting the UK government to spend £250K on an advertising campaign[16]. Nevertheless, AIDS ushered in a new age of awareness of risk and frankness in addressing the behaviour and lifestyle of potential donors.

3. Identifying donors at risk of HIV/AIDS

The change of tempo in all aspects of the work of the UK transfusion services from mid-1983 was dramatic. However, a more robust approach to eliciting information from donors did not come immediately. In the first guidelines issued to staff in the Edinburgh centre a definition of "high risk groups" appeared for the first time in the UK

transfusion services. These were taken directly from the first US guidelines detailing the risk groups, which were published by the US Public Health Service in March 1983[17], and were as follows:

1. men who have multiple partners of the same sex
2. intravenous drug abusers
3. Haitian immigrants to the USA
4. haemophiliacs
5. recipients of blood transfusion
6. sexual contacts of people at risk to AIDS

Potential donors in these groups were to be asked "to avoid giving blood until we have a suitable screening test". In a covering letter to Sessional Medical Officers, the consultant for donor care commented that, "We are not in a position to defer anyone from donating blood if they are in good health and fulfil the normal blood donor criteria."

The reason for this seemingly timid approach was twofold. On the one hand, the local correspondence suggests that donor session staff, knowing that gay men were considered to be the main risk group in the USA, were using subjective and unsubstantiated criteria to identify donors who were potentially at risk. On the other hand, the Scottish Homosexual Rights Group (SHRG) had issued a statement on 21 May 1983 rejecting "any proposal for a voluntary or compulsory ban on British gays giving blood". The SHRG was highly influential, boasting an array of professors, doctors, MPs and MEPs on its advisory council. As well as attempting to calm the atmosphere at donor sessions, the Edinburgh and South East Regional Transfusion Centre (SERTC) donor care consultant, and the SERTC Director, engaged the SHRG representatives in dialogue. This was extremely productive in securing the co-operation of the Scottish homosexual community, and gave rise to formal collaboration in the establishment of the Scottish AIDS Monitor Group (SAMG), an information sharing group consisting of representatives of SHRG, SNBTS and a consultant in genito-urinary medicine (GUM) physician, on 22 June 1983.

The leaflet that resulted from this first round of communication was issued in Edinburgh in June 1983. The SERTC Director sought the views of Dr A E Bell, Medical Officer in the Scottish Home & Health Department (SHHD), and while it was not to be regarded as official SHHD policy, the proposal to issue the leaflet and enter

discussions with the homosexual community with a view to having them disseminate it within their organisations, while making no changes in the current donor selection procedure, was endorsed as "a sensible course of action".

This first leaflet was widely circulated within the UK transfusion services, but there is little surviving information on how it was used either North or South of the border. The National Blood Transfusion Service (NBTS) Directors decided to produce their own leaflet, "AIDS and how it concerns blood donors" [SGH0026676 in PPR]; this was issued in December 1983 and used UK-wide, thus superseding the SNBTS leaflet. The high risk groups were reduced to three: homosexual men; drug addicts, male and female, using injections; and sexual contacts of people suffering from AIDS. A history of blood transfusion was not included as a risk factor, as it was considered that "... there is only the most remote chance of this happening with ordinary blood transfusions given in hospital."

Activity in transfusion centres was by now frenetic, with a remarkable increase in volume of internal memos, discussions, staff training sessions etc. Morbidity and Mortality Weekly Reports (MMWR), the official bulletin of the Centers for Disease Control in Atlanta, and the American Association of Blood Banks (AABB) Weekly Reports, as well as reports from UK infection surveillance agencies (Communicable Disease Surveillance Centre (CDSC) in Colindale and Communicable Diseases (Scotland) (CD(S)) at Ruchill Hospital, Glasgow) were scanned for the latest information on the epidemic, and the definitions of the high risk groups evolved rapidly. Early advice to ministers was given by the Advisory Committee on the Viral Safety of Blood (ACVSB), comprising experts in all disciplines relevant to the problems being posed by the emerging epidemic, and this included SNBTS representation. It was advice from this and other national committees, notably the UK Government's Expert Advisory Group on AIDS (EAGA), which first met in early 1985, that determined how the definition of high risk groups would change over the coming years, taking into account the epidemiological, virological and clinical evidence appearing in published materials in the UK and in other countries. The USA was to remain at the epicentre of this process, and as a general rule the UK and other developed countries followed their lead, with account being taken of local factors as they became known. Also, just as dialogue with the Scottish homosexual community had proved vitally important, so links were established with UK organisations such as the Terence Higgins Trust.

The SNBTS leaflet was revised and issued on 16 August 1984 as an "Important Message to Blood Donors". For the first time Africa was included as a risk factor, and Haiti was reinstated, as in "residents of or visitors to certain areas such as Chad, Haiti and Zaire." As before, donors regarding themselves as belonging to any of the high risk groups were asked not to donate, but already there was concern that this approach might be inadequate, and in November 1984 the SERTC issued redesigned donor questionnaires which required the donor to sign a declaration that they did not belong to one of the high risk groups.

Discussions with SAMG continued, and in spite of the above measures the SHRG representatives advised in a meeting in January 1985 that there was evidence that some high risk donors could still be giving blood. The questionnaire for regular donors was amended and issued in March 1985. By May 1985 all registered donors in South East Scotland had received at least one copy of the leaflet (no record has so far been found of the timing of its dissemination in other parts of Scotland).

4. Donor selection in the context of the test for antibodies to HIV

The first test for anti-HTLV III, as the causative agent was then designated, was introduced in the USA in March 1985, and preparations were ongoing for its implementation in the UK on 15 October 1985. Paradoxically, this was perceived to present a potential for increased risk of infected individuals presenting themselves at donor sessions, in order to obtain testing. This threat was felt to be very real in Edinburgh, where experimental use of the prototype tests had revealed an unexpectedly high prevalence in local intravenous drug users who shared needles. Discussions with local consultants in infectious diseases led to the establishment of a self-referral clinic for AIDS testing at the City Hospital, Edinburgh. Initially funded by a grant from the Chief Scientist's Office (CSO) of the Scottish Home and Health Department (SHHD) to evaluate its effectiveness, this approach was entirely vindicated by a survey of those attending for testing, a high proportion of them declaring that they would otherwise have attended to donate blood[18].

The risk of transmission of HIV by transfusion was greatly reduced by the introduction of testing, but the possibility of a donor recently exposed to the virus and testing negative because antibodies to the virus had yet to develop, but nevertheless being infective, was fully appreciated. The term "window period" was coined to describe this

possibility. The first occurrence of such an event was described in the USA in early 1986[19], and at around the same time two transfusion recipients in the West of Scotland were infected by a window period donation from a regular donor who seroconverted[20].

In reporting on the first window period transmission the AABB "emphatically" recommended that "blood collecting establishments analyze and review every facet of their donor screening and history procedures to determine if they are providing maximum opportunity for the donor to be truthful about his/her medical history." They went on to recommend that "...establishments should conduct personal and private interviews with each donor." This reflected a shift away from the focus on the risk groups as defined by epidemiological knowledge, the facts of which were now well established, to the methodology of obtaining accurate information from donors about their personal behaviour. Building on experience with the donor declaration, and alarmed by the discovery of a high prevalence of HIV in Edinburgh, the SERTC introduced in 1986 a system whereby donors were asked to reflect on their status *after* donating, and to inform the Service if the blood should be withheld. This is a variant of a procedure known as CUE (confidential unit exclusion), which was widely used in the USA and elsewhere, including the North London Centre. In the CUE system, donors were asked to tick a box if they wanted to designate their blood as "not for transfusion". Reports on the effectiveness of this intervention were mixed, but in the final reckoning most reviewers regarded it as largely ineffectual, and many uninfected donations were lost in the process[21].

One area of contention had been the wording of the high risk exclusion criteria. It became clear that many people at risk of exposure did not regard themselves as being part of a group. The terms "risk activity" or "risky behaviour" therefore were introduced, and questioning donors about specific behaviours became the norm. Thus the wording of the exclusion relating to Africa became much more explicit about sexual contact with someone living in Africa south of the Sahara, or with someone from one of those countries. Continued experimentation in the SERTC led to the introduction of personal interviews for new and "lapsed" (i.e. had not attended for more than 2 years) donors, and from 1 January 1992 this was to include direct oral questioning (DOQ) about risk activity, rather than asking if they had read and understood the information provided. The SERTC experience with this method confirmed the results of studies published in the USA showing that DOQ effectively increased the proportion of donors admitting to risky behaviours[22,23,24]. After extensive debate this method was adopted throughout the UK transfusion services during the 1990s.

Even more effective than DOQ interviews is an entirely impersonal interview using computer software. In 1989, in collaboration with the Psychology Department of the University of Edinburgh, the SERTC conducted a pilot study of a computerised donor selection algorithm using the then novel touch-screen technology. The results were encouraging, but a bid for grant funding was unsuccessful and the project abandoned. Researchers in the USA took up this challenge in the late 1990s, and have reported successful outcomes, leading to the introduction of this methodology into routine practice in some transfusion centres, though the logistical difficulties have thus far prevented widespread use[25,26].

5. Standardisation of Donor Selection Policies within the SNBTS and across the UK

It had become clear, as the response to the challenge of keeping the blood supply as safe as possible from the threat of HIV developed, that the differences in approach between regions and across borders were difficult to justify. At the request of the SNBTS National Medical Director (NMD), Dr Gillon was asked to prepare a paper[27] comparing donor selection policies in the five Scottish regions. This paper, dated 11 November 1985, was discussed by the Co-ordinating Group on 30 April 1986. It was minuted that the directors agreed that a standard set of criteria should be produced, based on the "A-Z Guidelines" then in use in Edinburgh. The first such guidelines were finally agreed and issued in 1988. A formal comparison of how information about AIDS was provided to prospective donors was carried out at the request of the NMD in November 1987.

In 1988 the SNBTS Directors recommended that all donors should receive information about AIDS with the call-up letter, i.e. before attending the session. In 1989 the SERTC Director wrote to the NMD about the need for a standardised SNBTS donor health enquiry process (as opposed to guidelines on donor acceptance or deferral), mentioning the requests that had been made for extra staff to conduct clinical interviews. A Donor Consultants Group was set up in order to address these matters in close collaboration with the Regional Donor Services Managers, resulting in centrally approved and published donor selection criteria and associated materials for use in donor sessions by 1992.

At around the same time two UK national developments were to have major impact on the service: The introduction of "General Management" to the NHS, and the publication of the first *Guidelines for the Blood Transfusion Services in the United Kingdom*, to become known as The Red Book, in 1990. This joint initiative of the Regional Transfusion Centres and the National Institute for Biological Standards and Controls (NIBSC) had been set in motion in 1987, with a view to complying with an imminent EU directive which would bind member states to introduce strict product liability by July 1988. Since then 7 editions of the Red Book have appeared, and the expert group devising the Guidelines, which cover all materials produced by the UK Blood Transfusion Services, evolved into the Joint UKBTS/NIBSC Professional Advisory Committee (JPAC). A system of Standing Advisory Committees (SACs) was established, including the SAC on the Care and Selection of Blood and Tissue Donors. It was some years before the systems for producing common policies were fully in place; and the Medical Directors of the four UK services retain the right to implement policies as local circumstances demand, but the days of widely varying practice across the country are long gone. More than that, the EU Directive that gave rise in the UK to the Blood Safety and Quality Regulations 2005 (the BSQR), ensures that similar standards of blood safety are in place throughout the European Union.

6. Summary and Conclusions

From the relatively unstructured and professionally led service developments of the 1980s in response to AIDS and PTH, great strides have been made in ensuring that a system is in place for rapid response to emerging threats to the blood supply. A key part of this is the process of assessing the eligibility of donors to provide blood for transfusion. The selection of a safe donor population has been described to be the single most important contributor to a safe blood supply[28].

The effectiveness of the measures taken at donor sessions in response to AIDS was demonstrated when an antibody test for hepatitis C was introduced. Studies from different parts of the world confirmed that the prevalence of this and other virus markers in the donor population are much lower than in the general population, mainly as a result of donor selection procedures[29,30]. In most developed countries these procedures are required by regulatory agencies, and blood establishments are regularly inspected against these standards.

The intense and rapid response of the donor services of the disparate UK Blood Transfusion Services to AIDS was key to minimising the impact on patients of this dreaded complication of transfusion therapy, as demonstrated by the outcome of the lookback procedures documented elsewhere. The elimination of so many potential donors at risk of AIDS also had the fortuitous effect of reducing the threat of hepatitis C until a test was available, as seen in the much lower than expected prevalence of antibodies to HCV in UK donors, described elsewhere in SNBTS papers.

Effective donor selection remains a vital part of blood safety precautions, and concerted and rapid interventions in response to recent emergent threats such as SARS, West Nile Virus and vCJD are due in no small measure to the events described in this paper.

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APPENDIX A	Chronology of Developments in Donor Selection		
DATE	**GUIDELINES, POLICIES, LEGAL REQUIREMENTS**	**DONOR SELECTION METHODOLOGY / VENUES**	**CONTEXT / COMMENTS**
Pre – 1980	Blood Transfusion: A Guide to the Formation and Operation of a Transfusion Service, WHO 1971. ISBT Guide to Selection of Donors. 1976 (1.A.1.) (questionnaire with Y/N tick boxes) Memorandum on the Selection, Medical Examination and Care of Blood Donors (December 1977: 1A1.2-E)	Memorandum distributed to all RTCs. Donor session procedures, forms and documents produced locally. Doctor in attendance at all sessions.	Letter from CMO to all RMOs 1 May 1975 – relatively high risk of hepatitis B being transmitted by the blood of prisoners, but probably equally high risk in other population groups, e.g. drug addicts ..."The advice I have received is that it is not necessary to discontinue the collection of blood at prisons and similar institutions." (1A3.1) ISBT: Prospective donors should be ruled out "... if suspected to be parenteral drug users .... or .... are inmates of a correctional institution." Memorandum : "Illicit drug taking if admitted or suspected should debar"
1981			First reports of new disease, later named AIDS
1982			First report of AIDS in transfusion recipient
1983	Leaflet "AIDS and Blood Transfusion: Some Background to the Recent Publicity" issued in June 1983, Edinburgh BTS.	Leaflet made available at donor sessions, "with no high profile publicity". Also distributed through "Gay Community". SHHD agreed to this as official	Outbreak of hepatitis B in IVDA in Edinburgh, 1983/4 March 198 : virus responsible for AIDS isolated in France.

		policy (BMcC memo, 11 May 1983)	Scottish AIDS Monitor Group established June 1983.
1983 (continued)	DHSS leaflet "AIDS and how it concerns blood donors". Approved by DHSS 4 August 1983 (Memo from JDC to M Corrie), issued September 1983	Edinburgh leaflet distributed to Scottish RTCs; discussed by English RTDs, who commission own leaflet. Prospective donors in risk groups asked "to avoid giving blood". Correspondence with Gay Medical Association, November 1983. 21 November 1983: AIDS information printed on donor call-up letter. Scottish leaflet withdrawn, December 1983, DHSS leaflet available at all sessions.	Risk groups identified as: • Men who have multiple partners of the same sex • IVDA • Haitian immigrants to USA • Haemophiliacs • Recipients of blood transfusion • Sexual contacts of people at risk of AIDS September 1983 "Haemofact No 2" released by the Haemophilia Society to members:- "the advantages of treatment far outweigh any possible risk".
1984	Leaflet "AIDS – Important Message to Blood Donors" (SNBTS) issued August 1984	25 March 1984: last SNBTS prison donor session. Donors asked to sign health check questionnaire: that they have read and understood the leaflet and are not in risk group – November 1984. A – Z list of donor exclusion criteria in use in Edinburgh BTS during 1984.	First mention of Africa in risk group definitions. December 1984: Haemofact No 5:- "... many transfusion Centres are not yet maintaining a satisfactory level of precaution against high risk donors giving blood." Response from RTDs, 23 January 1985: "... disquiet expressed that the Transfusion Service was being monitored ... not necessary or helpful". CDSC report: "No cases of AIDS or HTLV III (Ab) in drug users in the UK as at November 1984".

1985	Revised donor health check questionnaire, April. Autumn: new leaflet, "AIDS: new information for blood donors"		March: anti-HTLV III (HIV) test introduced in USA Report for NMD on regional differences in donor selection (author J Gillon) EAGA and Lothian Aids Advisory Group established October : anti-HTLV III test introduced in UK Lookback implemented immediately. Self-referral clinic for AIDS testing in Edinburgh SHHD issue "Information for doctors concerning the introduction of the HTLV III antibody test.
1986	Criteria re Africa revised New NBTS leaflet September 1986	Post-donation slip distributed to all donors in Edinburgh Centre, asking them to let staff know if any reason not to use blood for transfusion.	High prevalence of anti-HTLV III in Edinburgh recognised, relation to IVDA established. MMWR July 1986 : first report of window period transmission of HIV
1987	May – revision 5 of "AIDS: Important message for blood donors"	Edinburgh post-donation slip discontinued in regular donors	Correspondence between B McClelland and P Hewitt (N London) re CUE. Paper comparing methods for disseminating AIDS information in the 5 Scottish regions, November 1987. First UK autologous pre-deposit blood donation programme established in Edinburgh

1988	"Guidance for the Selection of blood donors" issued November – the first SNBTS national guidelines for donor staff. Revised health check for new donors November 1988.		
1989	Guidelines for the Transfusion Services of the UK (the "Red Book") – the first UK-wide donor selection guideline.		Hepatitis C virus discovered. Prototype anti-HCV test. Letter from SERTC director to NMD on need for a standard SNBTS donor health enquiry process, and additional staffing. Computerised donor screening piloted in Edinburgh.
1990			1st generation anti-HCV test available. 1st edition of Guidelines for the UK Blood Transfusion Services
1991	Direct oral questioning of new donors in Edinburgh BTS. "Guidance for the selection of blood donors" revised.		Anti-HCV test introduced in UK on 1 September 1991
1992		SNBTS paper, "Procedures for management and updating of SNBTS Medical Selection Guidelines and associated literature." – the first formal national standardisation of procedures.	UK Government agreed to no-fault compensation scheme for patients infected with HIV by transfusion. Paper by NMD: "Donor selection guidelines: did they work and what more?"