See Amendments to minute attached at back

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IN CONFIDENCE

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

Minutes of Meeting of Directors held at the Protein Fractionation Centre, Liberton, Edinburgh, at 11.00 a.m. on Tuesday, 15 October, 1974.

present : Major-General H.C. Jeffrey (In the chair)
Dr. C. Cameron
Dr. J.D. Cash
Dr. I. Cook (items 1 to 5)
Dr. H.B.M. Lewis
Dr. J. Wallace
Mr. J.G. Watt
Dr. A.E. Bell
Mr. R.H. Roberts
Miss M. Corrie (Secretary)
Dr. Heather M. Dick (for item 5)

1. INTRODUCTION

An apology was tendered on behalf of Dr. Maycock who had been prevented from travelling to Edinburgh by industrial action at London Airport. General Jeffrey explained that Dr. Heather Dick had kindly agreed to attend the meeting after lunch when item 5 would be discussed.

2. MINUTES OF THE MEETING HELD ON 7 AUGUST, 1974

The following amendments were made to the Minutes of the last meeting which had been circulated :

a. Page 2, para 2b. Add full stop after "Committee" in line 3. Amend following to read:

"Dr. Maycock said that DHSS had agreed to consider the feasibility of purchasing and distributing commercial blood products solely through Regional Transfusion Centres".

Delete next sentence beginning "The start of . . . . ".

b. Page 3, para 2e(iii) Delete " . . . . once the PFC was in production".

c. Page 4, para 3b Amend to read "There was a need for this information to be more widely available and this could perhaps be achieved by General Jeffrey writing a brief paper on the subject for publication".

d. Page 5, para 5 Amend second sentence to read: "It was hoped to produce 200 doses per week of 200-250 plasma units each when the full process area was commissioned".

e. Page 6, para 11a Amend to read:

"Dr. Maycock informed the meeting that the working party on the formation of a bone marrow/

marrow donor panel was reaching the end of this work. Its report would probably recommend that:

Bone marrow donors should be recruited by Regional Transfusion Centres, preferably from among blood donors. Because of relative scarcity of antisera, tissue typing would be done, to begin with, at designated centres. The recommendation would probably be that Scotland should have a centre. Details of donors should probably be stored on the computer at the National Tissue Typing Reference Laboratory, R.T.C. Bristol. A clinician who required a bone marrow donor should apply to N.T.T.R.L. which would tell him which R.T.C. had a suitable donor in its panel. A code of practice should be adopted to protect bone marrow donors. Such a code had been drafted: the Treasury, the Life Assurance Officers' Association and the medical protection societies had been consulted".

f. Page 6, para 11b, line 5. For "fractions" read "doses".

With these amendments the Minutes were agreed to be a true record.

3. MATTERS ARISING FROM THE MINUTES

a. Stock Position at PFC (Minute 3c)

The stock position for the week ending 11 October was tabled, together with intake, production and issue figures for the quarter ended 27 September 1974. Mr. Watt explained that in addition to the stock shown he had 2256 100 ng. doses of anti-D as well as 3450 ml awaiting filling which would provide 1500 doses. The prospects of providing 5000 doses of 200 units anti-tetanus in the current year were good.

The need to have a reserve to carry the PFC over the period of its move to Liberton was discussed and the difficulties explained.

b. Purchase and distribution of human blood products (Minute 2b)

Dr. Bell explained there was no progress to report. It was noted that CCC had, at a recent meeting, accepted the principle so far as Scotland was concerned that any commercial blood products required by the NHS in Scotland should be purchased and distributed through SNBTS. It was agreed that good progress was being made in Scotland towards control at pharmacy level and towards increased production by the Transfusion Service.

c. The use of human blood for the preparation of biochemical control sera (Minute 2e)/

c. The use of human blood for the preparation of biochemical control sera (Minute 2e)

General Jeffrey reported that this subject had been discussed at the meeting of Regional Transfusion Directors from England and Wales on 9 October when Professor T.P. Whitehead of the Laboratory Development Advisory Group had been present. Professor Whitehead had said that the advice of the sub-group on quality control (biochemistry) of LDAG of which he was chairman was that human blood should be used to prepare only those control sera which could not be made from animal or inorganic material. It was envisaged that the control sera from human blood would be prepared by the NHS. In a few cases where this could not be done the NHS would contract with commercial concerns on an ad hoc basis. Professor Whitehead had suggested that a code of practice for the use of human material in the preparation of biochemical control sera should be drafted. The meeting had agreed to form a working party of three English Directors and members of LDAG to discuss details.

This report of the meeting and the changed emphasis on the source of material for control sera were welcomed. It was felt that recently published WHO views on the undesirability of the commercial exploitation of human blood may have had some influence.

d. MRC working party on factor IX concentrates

Mr. Watt reported on the latest meeting of the working party. Draft protocols had been agreed for the clinical trials of the use of factor IX concentrate in liver biopsy and in the reversal of oral anticoagulants. The factor IX would be supplied by the PFC and the Oxford Transfusion Centre who were the UK's only producers. It was acknowledged that differences in production and quality control resulted in very different products from the same raw material.

The Directors supported Mr. Watt in his request that he should supply one batch of 200 doses of factor IX for each trial. After some discussion as to who should apply for a clinical trial licence it was agreed that he should supply a production protocol to enable the MRC to apply for the licence.

The question of mounting clinical trials within the BTS was discussed. It was agreed that any proposal should be put to the Directors' meeting in the first instance. The support of the Planning Council's advisory body on blood transfusion would be valuable and it was explained that the most likely source of funds would be the SHHD Chief Scientist organisation.

e. Venepuncture (Minute 6)

As agreed at the last meeting a code of practice in respect of BTS nursing staff carrying out venepuncture had been drafted and circulated for Directors' approval. In response to a point made by Dr. Wallace the certificate of competence was amended to read " . . . . and is in my opinion competent to take venous blood without the/

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the direct supervision of a medical officer". It was agreed that the code of procedure as amended should be submitted to the CSA.

4. THE SUPPLY OF PLASMA

Discussion centred on a paper prepared by General Jeffrey and which had been circulated to Directors and to members of CCC. The following main points were made concerning BTS blood products:

a. Products giving rise to no particular problems.

(1) Albumin. The PFC can fractionate plasma to either albumin or PPF. Albumin requirements were a fraction of PPF needs and there would be no problem in meeting the target when the PFC at Ellen's Glen was operational.

(2) Dried plasma. Law were aiming at a stock of 6000, not yet reached. The future programme would be regulated to PPF demand.

(3) Platelets. Local provision presented no problems.

(4) Fibrinogen. Supply had a much greater potential than demand.

(5) Factor II, IX, X. Plasma supply exceeded demands.

(6) Normal immunoglobulin. Supply virtually unlimited.

(7) Specific immunoglobulins.

(a) Anti-vaccinial. The supply of plasma was more than adequate to meet likely needs. However the question of the possible prophylactic administration of anti-vaccinial immunoglobulin to cover primary vaccination in adults was raised and it was agreed that General Jeffrey would seek to gain information as to current policy from the Joint Committee on Vaccination and Immunisation.

(b) Anti-tetanus. With the help of the substantial contribution being made by the Inverness centre the target for next year (5000 doses) should be met.

(8) PPF. No immediate problem once the PFC was fully operational; CCC had put up proposals to tide over the interim period.

b. Problem areas

(1) Factor II, VII, IX and X. Likely requirements would necessitate an increase of 1500 donations a year into EDTA. Directors had already responded to a previous request by Mr. Watt to contribute EDTA plasma and undertook to continue to do so.

(2) Specific immunoglobulins.

(a) Anti-D. Only a marginal surplus was being produced, and PFC could not build up stocks to tide them over period of shortage or process failure. A 10% increase in input was required/

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required for this purpose. Inverness are replacing some of their immunised donors and hope to supply increased plasma in the spring of 1975. Directors, particularly of centres with low contributions of Anti-D plasma at present, undertook to review their efforts.

(b) Anti-HB Ag. Much more information was required on effective dosage and likely requirements of this product. Supplies were adequate at present, but demand might increase and a continued effort was required by regions to supply suitable plasma.

(c) Anti-rubella. The application of this product and consequent probable requirements were discussed but no definite recommendations made as yet.

(3) Intermediate Factor VIII. To effect a smooth changeover from cryoprecipitate to intermediate factor in the treatment of haemophilia an initial stockpile of about 1 million units would be required. This would need a 10% increase in supply of fresh frozen plasma to the PFC. A major difficulty was the separation and freezing of plasma within a few hours after donation to preserve the Factor VIII content. This meant staff had to be available for prolonged periods in the evening. The possibility of using plasma separated and frozen the morning after donation was raised. PFC were conducting a trial with the Inverness region, and further discussion on detailed requirements for fresh frozen plasma was postponed until results of this trial were to hand.

5. POLICY ON TISSUE TYPING

General Jeffrey welcomed Dr. Dick to the meeting. It was explained that the object of the discussion was to determine what, in the opinion of those present, should be the role of the transfusion service in tissue-typing. A paper describing the present situation and making recommendations had been circulated by General Jeffrey and discussion centred on this. Scottish Transfusion Centres were all presently engaged, or arranging to engage, in tissue-typing of healthy donors and ante-natal patients, (the provision of tissue-typing sera). The Edinburgh Centre had also been engaged since 1969 in the tissue-typing service required for organ transplantation in Edinburgh and regarded this as an integral part of its function. The expenditure incurred was recouped quarterly from the Lothian Health Board. The Aberdeen and N.E. Region had been asked to prepare to undertake tissue-typing for a projected organ transplantation unit in Aberdeen Royal Infirmary. Tissue-typing for organ transplantation in Glasgow was undertaken for the Greater Glasgow Health Board by Dr. Dick, consultant in clinical immunology at Glasgow Royal Infirmary.

Dr. Dick was asked for her views, which were as follows:

a. Histocompatibility testing in its widest sense must be understood to have implications beyond "tissue typing" by which was generally meant HL-A antigen identification on leucocytes. There were other systems of histocompatibility antigens which were now detectable by more complex tests such as mixed leucocyte culture (MLC).

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b. The applications of HL-A typing in blood transfusion practice were now clearly established, and included the use of matched platelet and leucocyte transfusions and the identification of anti-HL-A antibodies.

c. Anti-HL-A antibodies were important for several reasons

(i) They could be a cause of non-haemolytic transfusion reactions.

(ii) Their presence could reduce the efficacy of platelet (and probably leucocyte) transfusions.

(iii) They were an essential requirement for the identification of HL-A antigens in tissue typing methods.

d. Given that HL-A typing was now an essential function of Regional Transfusion Centres, it was desirable that quality control should be of as high a standard as possible. Many laboratories which were capable of simple HL-A typing would be unable to obtain supplies of the rarer typing sera to improve the antigen recognition on their routine cell panel. Those laboratories which had a major involvement in histocompatibility should be prepared to assist by acting as "reference" laboratories for other centres.

e. The collection of reagents for HL-A typing was an essential function and should be given high priority by the interested Regional Centres. It should be recognised that even if other forms of histocompatibility testing, e.g. MLC, did eventually appear to have more relevance than HL-A matching for organ transplantation, anti-HL-A reagents would still be required for tissue typing for other purposes. Such antisera might also prove to be reagents which could be utilised in serological tests currently being developed to identify non HL-A antigens.

f. The expansion of HL-A typing facilities should not be based exclusively on service commitments for kidney transplantation. This aspect of tissue typing might not continue to be of such overriding importance. The possible establishment of a "National" or European bank of HL-A typed blood donors (for matched platelet or leucocyte transfusion, or bone marrow grafts) would result in a service commitment for tissue typing laboratories, but did not necessarily require 24 hr. facilities for typing. These developments were potentially large and could be dealt with only by collaboration between centres.

g. It should be recognised that histocompatibility testing was not a static exercise: research and development were inextricably mixed with service commitment. It would be the role of a few laboratories to develop the subject in depth. Once the clinical value of each development had been resolved, and its place in patient care established, then it might be necessary to offer facilities on a wide basis. This cautious approach would be applicable not only to organ transplantation, but also in the newer study of the relationship between HL-A and other histocompatibility antigens to disease.

After further general discussion the following points were agreed :

(1) Tissue-typing for leucocyte and platelet transfusions is a natural responsibility/

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responsibility of the transfusion service.

(2) The transfusion service should screen blood donations suitable for the production of reagents.

(3) The relationship of histocompatibility antigens and disease was not as yet of vital importance to the transfusion service, but it did provide its staff with increased job satisfaction and could be of diagnostic and genetic importance in the future.

(4) Tissue-typing for organ transplantation purposes was a proper function of the transfusion service and would be eventually required in those centres where organ transplantation was performed. With present commitments in this field, tissue typing and cross-matching for Scotland could well be carried out in the two established centres (Glasgow and Edinburgh). When the Glasgow and West of Scotland centre returned to Glasgow, as was hoped, there should be an amalgamation with Dr. Dick's laboratory. It was recognised that the whole question of tissue-typing as a method of determining compatibility for organ transplantation, and the techniques to be employed, was still under discussion.

(5) It could be seen from the above that the blood transfusion service had a responsibility which had to be funded.

It was agreed that General Jeffrey should revise his paper in the light of the discussion and of comments made by Dr. Cash in a paper the latter had circulated concerning indications for tissue-typing. The revised paper would be sent to Directors for their final comments before its submission to CCC.

General Jeffrey thanked Dr. Dick for her valuable contribution to the discussion and Dr. Dick said that, for her part, she was very glad indeed to have been afforded the opportunity.

6. PROVISION OF ADVICE ON BLOOD TRANSFUSION MATTERS TO THE SCOTTISH HEALTH SERVICE PLANNING COUNCIL

General Jeffrey reminded Directors of the discussion in CCC on 10 October of a paper prepared by SHHD which contained the latter's suggestions for membership of an advisory group on blood transfusion matters to the Planning Council. The paper had been remitted by CCC to the Directors' meeting for further consideration.

Dr. Bell opened the discussion by reminding Directors that the role of the Planning Council was to offer advice to the Secretary of State on the development of the Health Service in Scotland. It had held one meeting and it was known that it proposed to conduct its business through two committees :

a. Programme Planning Committee

This would consider services comprising a wide range of specialties and services - child health and the care of the elderly were two examples - and would have a series of advisory groups reporting to it.

b. Specialist and Support Services Committee

This would concentrate on single services such as nursing, information and/

and computers and blood transfusion, each of which would be represented by an advisory group reporting to the committee.

Dr. Bell explained that the Planning Council would be essentially a lay committee since most of the Health Boards - who were all represented - had nominated their chairman.

Proposals from the Directors for major developments in blood transfusion or for changes in current policy would normally be discussed at a Directors' meeting and forwarded by the Chairman to the Secretary of the Planning Council for consideration by the Council. The latter would make its recommendations to the Secretary of State for decision and this would be transmitted to the CSA Management Committee for implementation. The Planning Council had the right to delegate authority to its committees so that proposals might well proceed from that Committee to the Secretary of State without the need for further consideration by the full Council.

Directors were then asked to consider the proposals for membership of the advisory group on blood transfusion which had been prepared on behalf of CCC by the latter's secretariat and which would be presented, together with the Directors' views, to the Planning Council for consideration. The proposals were that the advisory group should have the following membership:

Representing	No.	Suggested Representatives
Medical Specialties	7	1 haematologist 1 microbiologist 1 general surgeon 1 cardiac surgeon 1 obstetrician/gynaecologist 1 general physician 1 general practitioner
Health Boards	2	1 Secretary 1 Chief Administrative Medical Officer
CSA - Blood Transfusion	3	National Medical Director Scientific Director 1 Regional Director in rotation
Scientific interest	1	Scientist employed by SNBTS
Laboratory technology	1	Technician employed by SNBTS
SNBTA	1	Representative to cover particularly donor interests
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The chairman should, it had been suggested, be appointed by the Planning Council, not necessarily from amongst those nominated for membership of the advisory group.

It was unanimously agreed that an advisory group devoted to blood transfusion was necessary. Opinion on the above constitution was divided as follows :

(1) BTS membership./

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(1) BTS membership. 1 Director agreed with the proposal outlined above. 4 considered that all five Regional Directors should be members. One felt that the Regional Directors would best be represented by the Directors of the West & SE Regions alternately plus one representing one of the smaller Regions in rotation. Reference was made to meetings held with SHHD between 31 January and 31 March 1974 at which Directors had received the impression that their representation within the Planning Council would be no less advantageous than it had been on CCC.

(2) Scientific membership. 4 Directors agreed with the proposal in the paper. One said he would be agreeable provided all five Regional Directors were members. Another did not see the benefit of the membership of a BTS scientist under any circumstances.

(3) Representation from laboratory technology. 4 Directors were in agreement with the proposal while two were not.

(Secretary's note :- the above includes the written views of Dr. Cook, received after the meeting which he had to leave before this item was discussed).

It was agreed that General Jeffrey should convey the Directors' views to SHHD for onward transmission to the Planning Council.

7. TECHNICIAN TRAINING

In response to a question General Jeffrey confirmed that he had received from the senior chief technicians in the BTS a paper on training facilities which would be discussed with Directors at the earliest opportunity.

8. GRADUATE SCIENTISTS GROUP

It was agreed that relationships with the Graduate Scientists Group should be discussed at a future meeting.

9. DATE OF THE NEXT MEETING

The next meeting was subsequently fixed for Friday, 10 January 1975 at 11.00 at the PFC Liberton.