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RTDM/194

Not for Publication 23/1/85

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REGIONAL TRANSFUSION DIRECTORS' MEETING

Minutes of the 194th Regional Transfusion Directors' Meeting held at the Regional Transfusion Centre, Manchester, on 23rd January 1985

Present:	Dr J Cash	Dr R S Lane
	Dr A K Collins	Dr D Lee
	Dr M Contreras	Dr W M McClelland
	Col R C Deacon	Dr R Mitchell
	Dr J Darnborough	Dr J A F Napier
	Dr C C Entwistle	Dr F M Roberts
	Dr I D Fraser	Dr K Ll Rogers
	Dr J F Harrison	Dr D S Smith
	Dr A M Holburn	Dr L A D Tovey
	Dr H H Gunson	Dr W Wagstaff

1. On behalf of the Meeting the Chairman thanked Dr Gunson for his hospitality and said how much everyone had enjoyed looking round the new Transfusion Centre. He also welcomed back Dr Cash after his illness and congratulated Dr L A D Tovey on his appointment as Vice President of the Association of Clinical Pathologists.

2. An apology for absence was received from Dr F A Ala

3. Minutes of the last meeting

Dr Entwistle had been omitted from the list of those present.

Item 5. Dr Contreras said that one third of donors had been screened for sickle cell trait.

Item 10. It was agreed that we are correctly named as the RTD meeting.

4. Matters arising from the Minutes

The Chairman raised some points:

a) Update on Notes on Transfusion.

Dr Fraser, Dr Gunson, Dr Tovey and Dr Rogers had had informal discussions with Dr Smithies over this document. It was felt a re-write would be required because of the errors in both original and corrigenda and the delay which had occurred. This task could be taken up later in the year after divisional meetings.

b) Administrators' Meeting.

No minutes have been sent and the Chairman has had no response to his letter.

c) The Cell Separator Working Party has met.

d) The AIDS Working Party met in November. Dr Harris , Dr Lane, Dr Gunson, Dr Contreras, Professor Thom, Dr W B McClelland, Professor Weiss, Dr R Tedder, Dr Riddell, Dr I D Fraser.

It was felt by RTDs in attendance that this was an unproductive meeting, there being as yet no new leaflet, no finance and no positive move towards full donor screening.

Another AIDS Working Party has been set up by DHSS to consider Public Health Aspects. Dr Gunson and Dr Contreras are members.

e) Care and Selection of Donors.

The document was said to be in the hands of the publishers but some delay has been caused by the addition of information on AIDS.

RTDs felt that further delays were unacceptable and one primary copy should be circulated for each Centre to copy and adapt as required for its own staff.

f) Medical Staffing at Donor Sessions.

Dr Harrrison reported. While no minutes were available from the Advisory Committee Dr E Harris had written expressing the concerns already discussed by RTDs but stating that the CMO would welcome a pilot study. N E Thames RTC have this in hand - probably to start in February with the support of various Regional Committees.

g) Sickle Cell Trait Donors.

Dr Weatherall had replied to the effect that with the exception of neonates and cardiac surgery blood from sickle cell trait donors should be used freely and the black population encouraged to give blood. Dr Contreras added that sickle cell patients should be added to the list excluding use of such donor blood. It was agreed that Hb AS blood stores normally, and that all Regions have differing procedures depending on the size of the problem.

h) Anthony Nolan Panel.

Some meetings have been held on BTS involvement in bone marrow transplant patients and there is a separate agenda item. Dr Bradley has provided some details which will be distributed with regard to the donor panel.

i) MLSO Gradings.

The Chairman had been advised to discuss this with Mr Armour with regard to the Whitley Council and he had been very helpful. A reasoned document must be prepared to submit before a visit of the panel was requested. Information will be required as to full staffing of each RTC and Dr Fraser will write so that a composite document can be prepared. Dr Wagstaff reported thatno progress has been made at Sheffield.

Dr Tovey highlighted the problems of the PT 'A' and 'B' scales and the contrasting opinions of ASTMS, the ACP, the College of Pathologists and other bodies. A College Working Party is to be set up to look into the single scale proposal and requested that feeling should be expressed to the appropriate body .

Dr Cash pointed out that Whitley Council is related to the Service and other grades almost exclusively to scientific and research input.

There is very strong feeling within RTCs and the scientific community on this matter and a problem in deciding the balance between graduate scientists, MLSOs and laboratory assistants (the latter do not count towards the "head count" required for senior gradings). All felt that this was a subject of major importance but thatprogress wouldbe difficult and slow.

j) NEQAS in Serology.

Dr Fraser reported that Dr McIver had expressed the RTD's views at the subsequent meeting of the National Advisory Panel and our great reservations were accepted.

There were no changes to report but there is agreement that the system is not working. Dr Holburn was not present so no information was available from BCRL which runs the scheme and provides many of the reagents.

It was reported that Dr McIver is to be replaced.

It was agreed that this is a professional concern of the Blood Transfusion

Service which is being made very difficult for us under the present arrangements. We are regarded as the experts but have no control and little information. Perhaps Regional Medical Officers should be informed of these problems.

The professional attitude on our behalf has achieved nothing - a voluntary system is not acceptable and will not provide acceptable standards.

There is in this country no reporting system for reactions and incompatible transfusions. Dr Fraser will raise this issue with the BSH.

5 Medical Specialist Training

Dr Tovey presented a summary reflecting the many attitudes aired at the meeting of the working party. There was an agreement that however diverse the discipline involved and the interests of the candidates most would have a strong interest and background training in haematology.

Most official bodies concerned have drawn up a paper. It would seem prudent to offer our own opinions through perhaps the BBTS.

Dr Cash reviewed the recommendations of the Council of Europe for the speciality of Blood Transfusion Medicine.

The Royal College of Physicians of Edinburgh is considering a series of Diplomas in special fields including one in Transfusion Medicine and Dr Cash has recruited a Committee to examine this proposal.

The JCHMT, however, is the body which approves Training in the UK and a paper must be put to them.

Before people will take up specialist training there must be jobs for them. A commitment to Blood Transfusion Medicine would require an early career decision. There was also agreement that flexibility was required as well as a dedicated programme of training. Transfusion is not a popular specialty for recruitment.

Dr Cash agreed to report to this meeting on progress after his further discussions.

The recruitment of Senior Registrars to Blood Transfusion posts is proving difficult. In Scotland there is a careful balance between likely vacancies and training posts. Further discussions on medical manpower and roles of Consultants in Transfusion Centres are required. It was agreed that a document could be sent directly to the DHSS Central Advisory Committee.

6. National Bone Marrow Donor Panel

The registry is held at UK Transplant (paper circulated by Dr Rogers). There was much discussion as to whether we need a national panel and the success rate of unrelated transplants. There must be a clear difference between tissue typed blood donors & bone marrow donor volunteers. A very large and expensive project would be required to have the number needed. Would the money be forthcoming ? There is little co-operation from the Anthony Nolan panel. This could be regarded as a waste of public resources.

The Chairman undertook to write to London Transplant units requesting fuller information on the requirements and organisation of volunteers..

7. Organisation of NBTS England and Wales

The Paper prepared by Dr Gunson was discussed at Divisions. There was feeling from Consultants that some Central organisation would have benefits for the Service.

Divisional Chairmen had met and suggest this meeting should directly approach the NBTS Advisory Committee. A small Group should meet (including RTDs, Dr Lane, Dr Holburn and a non-RTD Consultant) to prepare a paper for consultation with all RTDs.

Dr Cash requested that contact be maintained with Scottish NBTS.

All groups felt that it was essential to maintain strong links with their Regional Health Authorities and Regional Hospitals.

7. AIDS

All RTDs have been involved in problems and are angered that no information has been given to us.

Dr Gunson was requested to update the meeting on the DHSS situation. The new leaflet will be available on 1st February and instructions will be issued to Regional Administrators with a copy to RTDs. This is expected to insist on a positive approach to its distribution. Dr Gunson stressed the efforts made by Dr Smithies and Mr Williams and the regrettable delays are in no way attributable to them.

Dr Contreras was asked to report on the correct status of HTLV 3 testing. Dr Tedder, Dr Barbara and Dr Smithies have met. As yet there is no date for availability of tests for pilot study. The anti core test is to be evaluated at Edgware on stored samples.

Most companies are approaching RTDs (these are ELISA tests). The preference within the NBTS is for an RIA technique. Dr Gunson is to pass this information to the DHSS. The suggested cost is in the region of £2.00 per test. The meeting felt strongly that we should not be pressurised by commercial sources to accept a test which i not ideal for our purposes and that we should act together. The DHSS should be pressed to make any test available to the community before its use in blood donor screening, otherwise unsuitable donors will be attracted.

Heat treatment of Factor VIII . Dr Lane said that high purity Fac tor VIII which is resistant to heat treatment will be available in the spring. There would appear to be a loss of 15% in activity after heat treatment.

It was agreed to be essential that a meeting on AIDS be held shortly. Dr Fraser will contact Dr Smithies and express our deep concern on all these matters and especially on testing.

Dr W B McClelland is understood to be attending a meeting in the USA on the significance of HTLV3 positivity and will report on this to us.

All also agreed to resist pressure from families to take blood for individual named recipients.

Some discussion took place regarding a poster about AIDS for use on donor sessions. Dr Smithies was proceeding with this.

Dr Lane stressed that the anxiety from the Haemophilia Society was not for testing but for effective heat treatment of Fac tor VIII.

It was agreed that information should be drawn from a number of meetings of special groups and an emergency meeting of RTDs arranged to keep us informed and allow discussion of this most emotive subject.

8. High Risk Patients at Special Clinics

Dr Entwistle reported that Special Clinics approached would not divulge identity of high risk blood donors. If Transfusion Centres are not informed then high risk donors will continue to be invited to sessions. It was reported that the Data Protection Act exempts such patients from confidentiality on Public Health grounds. Dr Fraser undertook to approach Dr Smithies on this matter.

9. Haemofact AIDS 5

Displeasure was expressed by some at these comments. After discussion it was agreed to record that this had been discussed and disquiet expressed that the Transfusion Service was being monitored and we feel that this is not necessary or helpful.

10. Chairmen and Members of Working Parties

Chairmen are requested to write to Dr Fraser with lists of members for circulation.

Dr Tovey raised a problem of the Anti-D Working Party. A large batch of anti-D immunoglobulin has been discarded so there is a deficit of material for processing at Elstree (300Kg a year short). An urgent request is made for an increase in supply of 30% and for the strength to be maintained.

Dr Holburn made a plea for supply of good quality anti D for grouping reagent. He suggested 2 donors at each Centre could supply an adequate amount. It was asked if it is ethical to boost donors for production of plasma for reagents?

Blood grouping with rapid anti D is well established using commercial material. Efforts will be made where possible to improve supplies.

While this shortage exists there can be no expansion of ante natal prophylaxis. It was noted that there is at present no licence for importation of anti D immunoglobulin (although this is occasionally used on a named patient basis).

Dr Wagstaff reported that the discarded material was set aside and that further processing might allow its use as i.v. anti D.

11. Data Protection Act

Are donors to be equated with patients under this Act ? If this is so donors do not know that medical information is held in this way. Both Act and Code have enormous implications for us. All micros are to be licensed by a Registrar for defined functions and personal liability lies with RTD and RHA according to a Scottish enquiry. Comments on the Code are invited.

12. Practical Examinations in Transfusion MRCPath

There is a plea for attention to layout of candidates' working data. Those involved in training are requested to stress this problem.

13. Glandular Fever

This a widespread condition and causes problems with loss of young donors. The "Care and Selection of Donors" group was informed that recurrences beyond 2 years are very rare and therefore this was adopted.

14. Coeliac Disease and Blood Donation

Approaches have been made to some Centres stating that these patients are normal when on a gluten free diet. Since the background is one of auto-immunity is it acceptable to take blood even with approval of their physician?

The definition of a blood donor is a healthy person on no medical treatment and under no medical supervision. We need clear simple rules to be applied at sessions. Donors often want to give blood for intensely personal reasons and giving blood might be detrimental to their health.

Dr Fraser will write to Professor Lorowsky.

15. British Standards Institution Technical Committee SAC II

Dr Rogers has served for many years and wishes to resign. Dr Smith and Dr Roberts

Dr Rogers (resigned)

Are members. It was decided not to replace Dr Rogers.

It was agreed that the next RTD meeting would be held on 17th April 1985 but an additional meeting was to be arranged at the DHSS to conclude the agenda and then receive a DHSS update on AIDS in about four weeks time.

Dr Rogers brought up the ILEA project in hand to introduce young people to the Transfusion Service. This group has drawn in others and RTCs may have approaches.

Similarly Dr Fraser said that the South West RHA has prepared a video on plasma collection which has now been circulated and other RTDs may be approached.

RTD Meeting reconvened 18th February 1985. Hannibal House.

Present:	Dr F A Ala	Dr R S Lane
	Dr J Cash	Dr D B L McClelland
	Dr A K Collins	Dr W M McClelland
	Dr M Contreras	Dr R Mitchell
	Col R C Deacon	Dr J A F Napier
	Dr C C Entwistle	Dr F M Roberts
	Dr I D Fraser	Dr K Ll Rogers
	Dr J F Harrison	Dr D S Smith
	Dr A M Holburn	Dr L A D Tovey
	Dr H H Gunson	Dr W Wagstaff
		Dr Gibson

Dr J Darnborough offered apologies; Dr Gibson was attending in his place.

Dr W B McClelland was welcomed.

Dr Harris now has the document re reorganisation of the NBTS. Mr Page as NHS General Manager would probably need to examine the document.

Regarding the Agenda, there are a number of additions:

1.	Heat treated Factor VIII	Dr M Contreras
2.	Tear Down Packs	Dr M Contreras
3.	Computerisation of Ante Natal Records	Dr C C Entwistle

RETURN TO AGENDA

16. Dr Holburn informed the meeting that the BGRL is happy to provide hospitals via RTCs with a variety of reagents. A list is to be circulated since the uptake is very variable and many are buying from commercial sources. RTCs are requested to circulate the list of reagents which would be available through RTDs.

17. Anti A and anti B

Dr Holburn reported. The problem is the lack of immune plasma. BGRL are now obliged to adhere to BP standards. He now required immune plasma to maintain the standard (60%). There is a lack of volume and a lack of strength and there has been a fall-off in supply of both anti A and Anti B.

Unless money is available to buy monoclonal reagents much more human material will be needed.

Is there a case now to immunise volunteers and is the material of less quality since the response has declined ?

Ovarian cyst fluid is available.

The majority feeling was for support for monoclonal antibodies.

There is at present no charge for reagents supplied and some discussion on costing took place. Dr Gunson suggested that a letter should be sent to the secretary of the CBLA.

Dr Fraser agreed to write to Dr Smithies.

18. Colour Coding for anti A and anti B

Dr Holburn said that such coding was abandoned since so many differences were in use. Coding can apply to Reagents, Packaging and Labels. A survey shows support for all 3 or none. There remains a majority support or least disagreement on label coding.

We have received the DHSS document on acceptability of coding from Scientific and Technical Division. Too many people would appear to be involved. Our working group supports colour coding and it was apointed out that there was no evidence that such coding had caused any problems.

There was support for colour coding of labels. Dr Holburn undertook to send out a letter andinformation to users, in advance of change.

19. Source Plasma for BGRL

There is an overall shortage of anti D plasma. Are we to support the provision ofanti D for preparation of grouping reagents? Are other Centres not so far involved to begin immunisation and boosting or do those already involved increase their production?

The average required is 15 Kg per Centre annually with over 100 iu of anti D.

It is obviously a user's choice - if theNHS is to keep pace with the commercial sector we have to produce equal or better material ie a rapid saline reagent as aopposed to the present albumin material. A panel of accredited donors is required for production of immunising cells. Who will accredit these donors? Some are concerned about AIDS. A meeting of the working party is needed, as there is obviously a considerable shortfall of high potency anti D for blood grouping and of anti D for immunoglobulin production. Ante natal prophylaxis nationally would require 60% more. A small number of donations could provide all the cells required throughout the country for immunisation and boosting. One donation could last for years with improving "credibility".

20. Training Needs for Staff in Blood Transfusion Units

General support was expressed for a training film for all staff involved in the team to care for donors. Dr Shepherd and Dr Webb had been proposed to help with this project. The paper had been circulated.

21. Donor Awards Scheme

Comments were invited and there was discussion over the award of Parchment Scrolls. Most RTCs awarded one at 50. Some gave an award on retirement.

22. NBTS Advisory Committee

The last meeting was in October. Dr Gunson reported. The major topic was on self-sufficiency in plasma supply. Only 6 RHAs agreed a plan with this timescale. 3 Regions agreed but no timescale was approved, 2 Regions opposed the estimate of plasma required and one Region had not replied.

This amount was too little for self-sufficiency and too little for optimum working of BPL. The Department were to consider this whole issue.

Heat treatment of Factor VIII, of course, had led to review of fresh plasma requirements.

A plea was made for those regions which had committed themselves to 'pro-rata' to be supported.

Dr Lane referred to the trial from 1st March on charging between 2 regions and BPL.

Concern was expressed that donors are recruited on a voluntary basis and we are seen to be virtually "selling" their plasma.

The Regions would have the option to buy back what they had supplied and only if they did not would others be able to purchase the product.

Charging would appear to be a little way away at present.

23. Working Parties

Cell Separators - A new committee has been convened to review platelet collection in addition to plasma and more meetings are required.

Anti D - Dr Tovey stressed the requirement for more anti D plasma. The handling charge for immunoglobulin is still under discussion.

There was little support for an anti $\bar{c}$ working standard.

Reagent Committee - This had met but topics had been already brought up at this meeting.

24. No Divisional meetings had been held.

25. Additional Items

a) Computerisation of Ante Natal Records.

Dr Entwistle reported. 44,000 annual samples would lead to a requirement of 200,000 patient records and he lacked Regional support for computerisation of this workload. They are looking into developing a core package locally which might be applicable to other regions and therefore generate Central funding.

There was support and Dr Entwistle will collect information and inform RTDs further.

b) Tear down Packs - Plasmapheresis.

A plea was made for information to be distributed when format or procedures are changed both from manufacturers and BPL.

c) Heat treated Factor VIII.

Most RTDs are unhappy at the situation existing in relations between BPL and RTDs.

Dr Lane explained the plans to produce a high purity concentrate. Mr Snape is in charge of quality control, Mr Pettet deals with product supply and 'pro-rata' is suspended.

Named patient status is required and direct care by a physician at the time of the first injection. A trial is being undertaken to assess HTLV3 status.

There being no other business it was agreed to hold the next meeting on 17th April 1985.

The afternoon was spent with Dr alison Smithies and Mr A Williams informing RTDs on the DHSS policy on HTLV3 testing and counselling.

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