28 SEP 1984

AGENDA - 193rd RTD MEETING

Wednesday 10th October 1984 at 11.00am

at Hannibal House (Room 30)

Dr John McIver, Chairman of the National Advisory Panel in Haematology will attend at 2.30pm to discuss NEQAS in Serology

1. Apologies for absence

2. Minutes of 192nd Meeting

3. Matters arising from the minutes:
   (a) Update on Notes on Transfusion
   (b) Administrators Meeting

4. NEQAS in Serology

5. Sickle Cell Trait Donors (L.A.D.T.)

6. DR Typing on Bone Marrow Transplant Cases (M.C.)
   (Unsatisfactory service from Anthony Nolan Panel)

7. Routine Determination of Rh Group in blood donors
   To discuss labelling of Cde/cde or cdE/cde blood as Rh positive (M.C.)

8. M.L.S.O. Gradings in R.T.C.s (W.W.)

9. Multilingual Labels on Blood Packs (W.W.)

10. Membership of R.T.D. Committee

11. Report from Advisory Committee

12. Reports from Chairmen of Working Parties

13. Reports from Divisional Chairmen

14. Any other business

15. Date and place of next meeting

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Not for Publication

REGIONAL TRANSFUSION DIRECTORS' MEETING

Minutes of the 193rd meeting held on Wednesday 10th October 1984 at Hannibal House.

Present:

Dr F A Ala
Dr M Contreras (part of meeting)
Dr J Darnborough
Col R C Deacon
Dr I D Fraser
Dr H H Gunson (a.m.)
Dr J F Harrison
Dr A Holburn
Dr D Lee (joined after item 10)
Dr J McIver attended for item 4
Dr R Mitchell
Dr J A F Napier
Dr F M Roberts
Dr K Ll Rogers
Dr L A D Tovey
Dr W Wagstaff
Dr A K Collins

1. APOLOGIES

Apologies for absence were received from Dr J D Cash, Dr D Smith and Dr R S Lane.

The meeting supported the Chairman's proposal to send good wishes to Dr Cash and Dr Contreras and hoped they would both soon be fully recovered (Dr Contreras joined the meeting later).

2. MINUTES OF THE LAST MEETING

The minutes of the 192nd meeting were accepted subject to the following amendment:

9. The document on Care and Selection of Donors required clarification not review of recommendations on Malaria.

Some discussion took place regarding content of minutes and their distribution. It was decided that once the minutes are approved a copy would be sent to Dr Smithies, DHSS. If considered necessary any contentious points would be edited.

Item 10 was brought forward.

Dr Gunson proposed that Dr D Lee should become a member of the RTD Committee on a personal basis.

Lancaster has a measure of independence but is part of the North West Regional Transfusion Service. The longstanding problem of Lewisham was discussed - it being funded by its Region through District and the Region not being directly involved. Concern was felt that Dr Lee's appointment must effect no change in the situation at Lewisham.

The Committee agreed to welcome Dr Lee on a personal basis. It is stressed that this does not set a precedent for other regions and should Dr Lee leave his successor would not automatically become a member of this committee.

The Chairman introduced some general comments which he felt relevant to the Agenda and the day's discussions.

The Blood Transfusion Service is not a National service. It consists of fourteen individual Blood Transfusion Centres in independent regions with the Blood Group Reference Laboratory and the Blood Products Laboratory. These two, while separate, being run by the CBLA, must work within the whole, since they are considerably dependent on input from RTCs.

Implementation of the Griffiths report is now in hand with the appointment of general managers and concern is felt that further fragmentation of the Blood Transfusion Service may occur.

After discussion it was decided that Dr Gunson would arrange a meeting with RTD representatives and prepare a paper which could be considered by Divisions before the next RTD meeting, on the future of the NBTS.

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3. MATTERS ARISING FROM THE MINUTES

(a) Update on Notes on Transfusion

Corrections have been produced by DHSS on adhesive paper but they are difficult to stick in and still contain typographical errors. No guarantee can be given that the Corrigenda will be used since many copies of the booklet were distributed through Regions before the corrections were available.

It was felt strongly that this document was unacceptable and reflected very badly on the Transfusion Service. Unanimous support was given to the proposal that printing of a revised edition should be undertaken and the opportunity taken for a re-examination of the document.

(b) Administrators' Meeting

Discussion took place about lines of responsibility within Centres and Regions and whether the Administrators' meeting should be responsible to this meeting.

At present 9 administrators are directly responsible to their Director, 3 have joint responsibility to the RTD and RHA and some centres have a management group. There are some grey areas.

It was felt appropriate that the MLSO's meeting should also be discussed since both had refused the terms of reference suggested by RTDs. Some felt strongly that they should relate to the RTD meeting but there was general agreement that relationships within each RTC were most important.

An analogy was drawn between this situation and a Regional Medical Committee with its advisory sub committees. The RTDs are the line of approach to Regions and DHSS and any decisions reached by the groups affecting the running of a Centre would have to be discussed with the Director.

New terms of reference have been drawn up by Mr Eddy (Oxford) to be presented to the next Administrators' meeting - the minutes of which will be sent to RTDs.

The correspondence and previous minutes were discussed and it was decided to respond to both groups that the topic had been considered and would be furthe examined. The breathing space would allow further meetings and discussion at Divisions.

(c) Cell Separator Working Party

A meeting will take place shortly and will report to the next RTD meeting.

(d) Dr Fraser had written to Dr Smithies stressing the strong feeling among RTDs that a working party on AIDS should be set up. Dr Harris has arranged this.

(e) Distribution of Rare Cells

The form had been distributed and RTDs supported the provision of comprehensive information.

(f) Care and Selection of Donors (revised edition)

The document is apparently being printed by the DHSS and the proofs are awaited. A pocket sized version has been requested.

Re BTS 110 Consent of donors. Dr Entwistle reported on correspondence with the Medical Protection Society and theirs with the Joint Protection Scheme. The opinion was returned that consent to the taking of blood is implied by signing of the document and from the circumstances surrounding the event. Dr Entwistle agreed to circulate the letter.

(g) Training in Haematology and Blood Transfusion

Dr Tovey had convened a meeting of representatives and had prepared a paper in summary which would be presented for discussion at the next RTD meeting.

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(h) Medical Staffing of Donor Sessions

Dr Harrison reported that some nurses are in training and the BMA is preparing a paper jointly with the Region to put to the Joint Consultative Committee.

Again the comment was made that we are independent regions although in many matters there is agreement and a "national policy". Most felt that the attitude of the Defence Unions was a deciding factor. Dr Harrison has discussed this problem in depth with the N E Thames RHA and their legal advisors and while the Defence Union would not recommend it a nurse could be in sole charge at a session if it is considered that this is an appropriate job for a nurse and that he or she is properly trained. If this is so then the Nurse takes responsibility for the performance of the job and not the Consultant. If there is litigation the RHA bears the responsibility. The training and assessment of the nurse are the responsibility of the Transfusion Director and obviously high standards must be met.

To meet the requirements of the B.P. and other statutory bodies a doctor must judge the fitness or otherwise of the donor. It may be that we are not currently using the medical officer fully on sessions. It is accepted that a nurse could, with comprehensive training and experience, perform venepunctures and first aid on a session perfectly well. Almost all members felt that it would still be essential to have a doctor present for donor screening and legal cover. Litigation is difficult and most RTDs felt the support of the Defence Unions to be essential. The doctor at the session is legally responsible for the blood collection.

Much of the screening at present is done by the clerical officers and donor attendants according to the set Guidelines before the donor sees the doctor, whose time is amost entirely occupied in performing venepunctures. There was some concern that without a doctor donor queries would be deferred more often to await a decision at the RTC, with consequent loss of donors. This might undermine the cost saving aspect of the scheme.

The majority of RTDs were sympathetic to the extended role of the trained nurse in carrying out venepunctures within the Transfusion Service but insisted that a physician must be present at a donor session.

This item is on the agenda of the next Advisory Committee and it is likely that RTD representatives would be asked for views.

The Chairman asked how many RTDs would feel happy at SRNs performing venepunctures and running donor sessions without a medical officer being present. The majority agreed that a medical officer must be present. The concept of nurses in sole charge was supported by only two RTDs and one other gave qualified support.

5. SICKLE CELL TRAIT DONORS (Copy of Dr Tovey's letter attached)

Although this matter was raised at the last meeting there is still no clear policy and clarification is required ie should such donors be accepted and what use should be made of the donation ?

The size of the problem varies greatly between regions. NW Thames have screened almost all their donors and introduce affected donors to the Sickle Cell Society of which Dr Brozovic is Medical Adviser. Where a small number only are involved donations may be used only for plasma. At risk donors can be identified and donations screened. If red cells are issued it is agreed that they should be clearly marked "Not for use in neonates or cardio-thoracic by-pass" but otherwise

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are acceptable for normal use. Some centres screen all blood before use in neonates. Dr Mitchell reported a case where a neonatal transfusion was performed using blood from an overseas student and sickling occurred. The donor was then given advice.

The Chairman undertook to write to Professor Weatherall to obtain his expert opinion on this subject.

The film "Black on Black" had had little effect on most centres.

Some reported it had caused upset, since donors had been given the impression they could give blood specially for Sickle Cell patients. A number of complaints had been received (largely at London centres) because of this misunderstanding.

6. DR TYPING ON BONE MARROW TRANSPLANT CASES - ANTHONY NOLAN PANEL

Concern was expressed at the poor service from this panel and the considerable charges some patients were paying eg £80 per search.

The National Panel which Dr Bradley is working to set up has not received a great deal of support from some regions.

There are a number of meetings planned on this subject and the item is postponed to allow distribution of further information and discussion.

7. ROUTINE DETERMINATION OF RH GROUP IN BLOOD DONORS

In many countries 'D' negative blood is labelled 'Rhesus negative' and used for routine transfusion to rhesus (d) negative recipients irrespective of the remaining rhesus groups with no complications. As reagents and techniques are much improved weakly reacting 'D' antigens are rarely missed.

Perhaps time could be better devoted to preventing immunisation to $\bar{c}$, Kell etc.

However, our labels state that the blood has been tested using anti-C, anti-D and anti-E and the B.P. and European Pharmacopoea state that Rh negative blood must be $\bar{c}\bar{d}\bar{e}$.

Dr Contreras will circulate a paper prepared for the Munich meeting for discussion

8. MLSO GRADINGS IN RTCs

Dr Wagstaff circulated a table of staffing levels in RTCs listing MLSOs, scientific staff and laboratory ancillary staff. It was noted that there are some inaccuracies in the document.

Although Dr Wagstaff is pursuing this matter at Sheffield it is felt that the Whitley Council PTB rules do not really apply to Transfusion Centres and all staff are conscious of wide discrepancies between gradings in hospital laboratories and in their own centres. There are numbers of departments in the Transfusion Centre and heads of departments carry responsibility for various disciplines and for clerical and ancillary grades.

With automation and computerisation staff are now more experienced and perceptive. The field is now so specialised that a staff structure exists largely unrelated to that of general hospital haematology.

RTDs as a whole wish to press for a change in the regulations to ensure fair gradings.

Dr Fraser will discuss this matter and write to the Whitley Council on behalf of the RTD Committee.

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4. NEQAS IN SEROLOGY

Revised arrangements were presented in a letter to the British Society of Haematology by Dr McIver.

Dr McIver reviewed the development of quality assessment schemes since the 1960s with Biochemistry, then Haematology and Coagulation. These initially private schemes obtained DHSS funding. Meanwhile in Blood Transfusion some excellent regional schemes had been set up but it was decided a National Blood Group Serology scheme was required and a voluntary scheme was developed with all laboratories invited to participate. Confidentiality was maintained.

Regional advisers in blood transfusion have been appointed but it is felt their role is not clear. Since the recoding in 1982 they have not been able to identify laboratories. Leaders of other schemes have pressed for this confidentiality.

Local advisers in blood transfusion feel that they must have identification of laboratories in order to be effective. The permission of Haematologists is now required before the codes may be released. The Local adviser is democratically elected and would have access to codes by virtue of the appointment and not necessarily because he or she is the RTD. However, most RTDs would like to have access to laboratory codes for a number of reasons. RTCs supply reagents and in many cases produce them. Laboratories refer to RTCs for advice or to hand on problems. The RTD is usually expected by the RHA to have some responsibility for standards within the Region.

There was some discussion on how widely MLSOs and Scientific Officers should be involved and there was some support for regional meetings with participation of wider groups of staff. A major problem is the lack of interest of many haematologists in crossmatching. Regional meetings would stimulate participation and discussion of the whole problem, although some were afraid that Consultants might opt out of the situation even more.

The points system was discussed and some dissatisfaction expressed that good laboratories were penalised for occasional false positive results and this is demoralising.

The subject of laboratory management was raised and certainly the local adviser is elected in most regions at a meeting only of Consultants. It may be that Scientific Officers and MLSOs should be more involved and would have much to contribute on a regional level.

The letter under consideration names "the Consultant or his deputy " and "the local adviser or deputy". The deputy might well be the MLSO most involved in serology. However the Consultant role in NEQAS must be reinforced to ensure they fulfil their role.

Dr McIver will report that RTDs agree with the principles laid down. It is agreed that regionalisation is the way to proceed with proper consultation with Consultants however appropriate that may be within the Region. There will be confidentiality with the local adviser who may be but is not necessarily the RTD. It is hoped that the scheme may become more 'open' in the future. There will be a review procedure after three years.

The Chairman thanked Dr McIver on behalf of all present for his attendance which was very much appreciated.

9. MULTILINGUAL LABELS ON BLOOD PACKS

The Working Party had discussed this at the appropriate meeting and decided they were not acceptable. They will be used in Europe by Travenol laboratories. It is not expected that imports into this country will be required.

These labels do not comply with the Medicines Inspectorate regulations eg anticoagulants. 47/214

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Dr Wagstaff has already written to Travenol on behalf of the Working Party.

11. The Advisory Committee meets in two weeks time.

12. REPORTS OF WORKING PARTIES

a) Machine Readable Labels.

A list was circulated of Codes for additional phenotypes.

Random numbers have been produced for use as an interim measure until the ISBT prepares a report

b) Record Keeping in BTS

Dr Entwistle reported that he is still awaiting information and one further meeting is required

c) Training - already discussed

d) Anti-D

A further meeting is to be arranged to discuss increased procurement.

13. DIVISIONAL MEETINGS

Western (by telephone). They had discussed the question of blood supply to other regions and the placing of an economic price on blood packs used. In view of cross-charging considerations should the cost be that of packs or private hospital rate ? Some regions have a more or less regular commitment to London, others will occasionally exchange blood as it is available. At present replacement of blood packs would appear to be standard practice. Centres at the moment are collecting blood for their own regional use but if there was an agreement to collect extra blood for positive transmission elsewhere the situation would perhaps be different.

Dr Entwistle raised the Council for Professions Supplementary to Medicine ruling that MLSOs in training should be seconded to haematology laboratories. It had been minuted incorrectly that Oxford had no secondment.

There is a general problem of accommodation in hospitals.

Eastern. Topics already covered.

Support of Agenda items with letters or papers was requested.

14. No other business

15. Proposed dates for RTD meetings in 1985:

23rd January	Manchester
24th April	London
10th July	Cardiff
9th October	London

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