REGIONAL TRANSFUSION DIRECTORS' MEETING

Minutes of a meeting held on Wednesday 16 December 1970 at 12 o'clock in Room D104, Department of Health and Social Security, Alexander Fleming House, Elephant and Castle, London, SE1

PRESENT

Dr W d'A Maycock	- in the Chair
Dr W B Obank Mr L H Brandes (part-time) Mr B O B Gidden (" ") Mr G M Bebb Mr R H Hanson Mrs R A Tunnard	- Department of Health and Social Security
Dr S Murray Dr L A D Tovey Dr C C Bowley Dr J Darnborough Dr T E Cleghorn Dr W J Jenkins Dr K L Rogers Dr J Grant Dr G H Tovey Dr R J Drummond Dr G W G Bird Dr F Stratton Dr D Lehane Dr D S Smith	- Regional Transfusion Directors
Dr K L G Goldsmith	- Blood Group Reference Laboratory
Dr I S Macdonald	- Scottish Home and Health Department
Dr C Cameron	- Scottish National Blood Transfusion Association
Dr A E Wilkinson	- VD Reference Laboratory, London Hospital, Whitechapel, E1

The Chairman welcomed Dr Wilkinson.

1. CONFIRMATION OF MINUTES

The minutes of the meeting held on 21 October were confirmed, subject to the following amendments:

Page 3	Para.2(c)(i)	Alter heading to read "Testing done on behalf of RTCs in other Laboratories and Plans for Testing Donations (information received since meeting on 22 July 1970)."
" 4	" 2(e)	3rd and 4th paras - substitute "Rattee" for "Rattay"
" 8	" 5(c)	3rd para. alter to read "..... from various other countries".
" 8	" 5(c)	5th para. alter penultimate sentence to read "The following Centres stated their intention of completing the six months follow-up of mothers treated up to 31 December 1970: RTCs Newcastle .... Birmingham".

2. MATTERS ARISING

a. SCREENING FOR HL-A ANTIBODIES

Mr Bebb said that financial assistance would be an item charged against Special Medical Developments. He required more details and would be writing to the directors concerned.

b. COUNCIL OF EUROPE BANK OF FROZEN BLOOD, AMSTERDAM

Dr Maycock said he had distributed an up-to-date list of blood groups required by the Amsterdam bank. Dr Jenkins considered that group ii blood was not suitable for transfusion purposes and that it should not be sent to Amsterdam. Dr Bowley asked whether rare bloods should be sent to RTC Brentwood or to Amsterdam.

It was explained that, since UK had received practical help from Amsterdam, it was only reasonable that replacement bloods, preferably of one or other of the groups on the list recently circulated, should be sent back to Amsterdam. Four to six donations would discharge our debt. The blood should be collected using the equipment supplied by the Council of Europe Bank of Frozen Blood and in the manner recommended. Equipment and instructions could be obtained from Amsterdam.

It was suggested and agreed that Dr Goldsmith should be informed of the bloods RTCs had available and that he would advise which of the bloods should be sent.

c. SYPHILIS TESTING

The meeting considered the papers prepared by Drs Bowley and G H Tovey which had been distributed before the meeting.

Dr Bowley reported that RTC Sheffield was using an automated reagin test (ART) based upon a VDRL carbon particle method. The most satisfactory reagent so far used was Burroughs Welcome CDRL antigen coupled with Norit "Activated Carbon 'A' Special" from Holland. He suspected that the method gave fewer false positives than other methods. The sensitivity and specificity of the method however was difficult to assess because positive specimens were seldom encountered. He asked if RTDs would assist by sending him any positive plasmas discovered.

Dr Tovey reported that they had recently given up using a Kahn antigen coupled with scarlet/R for testing citrated plasma samples, in the Technicon machine, because of the variability between batches of antigen. They were now using an ART employing a VDRL-carbon antigen supplied by Messrs Burroughs Wellcome. This antigen seemed to give results exactly comparable with those given by the Norins VDRL-carbon antigen obtainable from Hynson, Westcott & Dunning of Baltimore but was much cheaper. He would prefer to use a centrally produced antigen.

Dr Wilkinson said his laboratory had been using ART, the BW antigen being combined with activated charcoal in his laboratory. So far the results obtained using ART and other techniques employing a cardiolipin antigen were identical.

Dr Wilkinson said he considered ART a suitable technique for testing ante-natal specimens. He said he would like Burroughs Wellcome to prepare a carbon-VDRL antigen, providing it was shown to be of consistent quality and at least as good as the Norins antigen. If BW could be persuaded to prepare such an antigen, VD Reference Laboratory would test batches before it was released. He thought it most important that all RTCs should use an antigen from one source so that all donors were tested at the same level of sensitivity.

Dr Bowley said that as the carbon antigen was easily prepared, it could be made in each RTC. Dr Jenkins suggested that one RTC should prepare supplies of antigen for NBTS.

After further discussion it was arranged that Mr Hanson should discuss with Burroughs Wellcome the possibility of their producing a carbon-VDRL antigen for use in an automated reagin test, but that before he did this, Dr Wilkinson would test some of the Norit carbon from Holland. He kindly undertook to inform Dr Maycock of his results.

d. HEALTH TRENDS

i. Dr Maycock said that Dr Hunt, the editor of this publication, had asked if any Directors wished to contribute articles, in order to inform general practitioners about NBTS and blood transfusion and related subjects. The meeting undertook to bear this in mind although this publication had only a limited use as a channel of information for NBTS. The Chairman agreed to inform Dr Hunt accordingly.

ii. LIFE BLOOD SERIES OF LEAFLETS

Dr Bowley and Dr Cleghorn again reported that the texts they were preparing on plasmapheresis and on the use of anti-D immunoglobulin respectively, were nearly ready. Dr Cleghorn said he could complete his text when he obtained a copy of the leaflet "Safeguards for Plasma Donors in Plasmapheresis Programs". (Mr Bebb distributed copies to all present at the meeting).

e. SIGNING OF LABORATORY REPORTS

Dr Obank reported that the Central Pathology Committee had adopted the amendment to the text proposed at RTD meeting on 21 October (Minutes p 11, para 7). He understood that the Medical Defence Union were also considering recommendations on this matter, and it would be preferable to await their views before considering further action by DHSS in the matter.

f. LEAFLET "HOSPITAL EQUIPMENT INFORMATION"

Mrs Tunnard said she had confirmed that one copy of each issue of HEI was sent to each RTD and agreed to ask for this to be increased to three. If Directors would like more than three copies, they should inform Miss M A Hall, DHSS, Hospital Supply Branch, 14 Russell Square, WC1.

At this point Dr Maycock introduced Mr Brandes and Mr Gidden who joined the meeting for items Nos 3 and 4.

3. GREEN PAPER

The Chairman recapitulated earlier discussions. The second Green Paper had been discussed at a special RTD meeting in April 1970 at which it became clear that the Regional Transfusion Directors thought that in order to achieve a uniformly efficient BTS, strong central organisation and administration were essential. The conclusions of this meeting were confirmed at RTD meeting, May 1970, at which the recommendations were made, one concerning the chairmanship of the RTD meeting and the other concerning the qualifications needed by the director of a centrally organised service. At that meeting Dr Bowley agreed to prepare a paper setting out in detail the reasons for having a centralised service. The Chairman said that this paper, which covered rather more than this term of reference, had been distributed but not yet discussed and that it would form the basis of discussion at this meeting. He said several Directors had asked for the subject of the second Green Paper to be discussed again without further delay, although the Department had suggested that further discussion should be postponed until it was known whether the second Green Paper was to be adopted or that something else was to replace it.

Mr Brandes said that the second Green Paper was dead. The present thinking of the Department was that the NHS should have a 3-tier structure - DHSS, some form of Regional Authority and some form of area authority, akin perhaps to HMC's. The intention was to unify the administration of NHS but no part of it would be under the control of Local Authorities. He thought it might be helpful in any discussion of NBTS to assume that there would be a regional authority with executive powers. He agreed that the paper prepared by Dr Bowley would be a useful starting point for discussion.

Dr Bowley explained that all but one of the RTDs to whom he had written had sent him their opinions and that the one who did not reply was on leave at the time. He had included in his paper <u>all</u> the views expressed, even though some had been expressed, perhaps in a lukewarm manner, by only one RTD. If the reader were unaware of this background he might misinterpret the document. Dr Bowley said he thought it should now be rewritten and that many of the paragraphs could be omitted. The most important paragraphs - and these points came out strongly in the original letters - were:- paras. 2.1, 2.2, 2.2.3, 2.2.4, 3.1, 3.2.2, 3.2.4, 4.1, 4.1.1 to 4.2.3. In general the correspondence with Directors made it abundantly clear that they wished to see a strong central control and that the present arrangements were unsatisfactory.

In the discussion the following points were made:-

DHSS might think that NBTS worked efficiently and smoothly under the present system. This was, in fact, not so. There were in reality 14 quasi-independent regional centres and 2 central laboratories trying to provide a uniformly efficient service of high standard without

any central co-ordinating body apart from the Regional Transfusion Directors' Meeting which had no formal authority.

NBTS was a complex service which had grown unevenly because of its fragmented administration and the different responses of regional hospital boards to the needs of the service. One effect of this was uneven provision of capital works over the years.

The Directors of RTCs tried to operate NBTS as a service but were frustrated by the lack of appropriate administrative and financial machinery. In order to provide a uniformly effective service, it was essential that there was a uniform financial policy. This did not at present exist.

Although the various categories of staff in RTCs were, in general, doing the same duties, grading and treatment in such matters as allowances were not uniform. These differences were a cause of dissatisfaction and were disruptive from the point of view of the service as a whole. An RHB could (and did) make local decisions regarding the administration and staffing of a centre which might fundamentally change the character of that RTC with respect to other RTCs and the NBTS.

Regional administration of the RTCs exposed them to the effects of personalities. A change of staff in an RHB headquarters might be accompanied by a change of attitude toward the RTC. An efficient service could not be run in such an atmosphere.

Some activities of NBTS were necessarily the sequel to decisions taken centrally, others were influenced by centrally decided policy. Yet although the policy and the reasons for it were explained to RHBs an RHB was under no obligation to carry it out if it did not wish to or if a regional committee decided otherwise. When such differences arose an RTC might find itself unable to carry out a specific task in pursuance of central policy and thus in an invidious position. For these reasons a strong central body was essential to prevent abuse of the service.

The unique position of the NBTS in the NHS should be taken into account. The main reason being that the existence of the service depends solely upon the continuing goodwill of a large body of volunteers and that the successful running of the service requires an informed and sympathetic understanding of the professional, scientific, administrative and public relations problems which are inseparable from such a service.

Although there was a clear need for a strong and effective central body and a uniform basic structure for the service, professional freedom and scope for local variation and development must be preserved.

The meeting formed a group - Drs Bowley, Darnborough, Cleghorn and Stratton and Dr Maycock

(convenor) to prepare a report setting out the reasons why a centrally controlled and administered service was necessary, and to suggest the professional and administrative structure of such a service.

Mr Gidden assured the meeting that the implications of the discussion would be fully considered by the Department in the light of the group's report and that the meeting would be informed of the Department's decisions.

4. ZUCKERMAN REPORT

Dr Darnborough asked for information regarding the position and functions of the proposed "regional scientific officer". If his duties were to be those in the draft hospital memorandum (he understood that the text distributed was being revised) there was a danger that NBTS might suffer additional fragmentation to that which had occurred over the years since 1948. He was concerned about the effect this appointment would have regionally and asked what type of person was envisaged as suitable to hold such an appointment.

Mr Gidden said the Department was aware of the difficulties associated with the post. The post, he said, would be essentially a scientific administrative post, its title had not yet been decided. The holder would be responsible to the SAMO and it was intended that he would be the servant of the proposed Regional Scientific Committee.

5. ORGANISATION OF PATHOLOGY SERVICES (HM(70)5)

Dr Stratton drew attention to a possible effect of the intended reorganisation of pathology services - that a hospital from which the pathology laboratory is removed may still expect to have the use on the premises of a blood bank supplying compatibility tested blood. After discussion, the meeting confirmed the principle followed since 1948 that blood banks (with the exceptions mentioned below) would be maintained only in pathology laboratories in charge of a pathologist. It was pointed out that there might be a need for laboratory transport in the re-organised pathology services, so that requests for cross-matched homologous group blood could be dealt with expeditiously. The exceptions were a small number of specially authorised stores of group O Rh-negative blood in isolated hospitals in Newcastle and SW Regions; this blood was not cross-matched before use.

6. PROVISION OF PREPARATIONS OF CRYOPRECIPITATE AND OF PLATELETS

CRYOPRECIPITATE: Dr Obank reported that in October DHSS had met the Directors of the London Haemophilia Centres to discuss the nature of these centres and the role they should play in treating haemophiliacs. The Directors of the Haemophilia Centres, among other things, had pointed out that application of the modern concepts of treatment necessitated freely available supplies of cryoprecipitate in larger quantities than at present.

Dr Cleghorn said it was regrettable that none of the Directors of the metropolitan transfusion centres, which were responsible for these supplies, had been invited to the meeting, to which it was replied that the meeting had been arranged to discuss the organisation of Haemophilia Centres in London and discussion on the supply of therapeutic materials had not been expected.

In the ensuing discussion several directors pointed out that supplies of cryoprecipitate could not be unlimited and it was suggested that cryoprecipitate should only be released by regional transfusion centres after evidence of a patient's antihaemophilic globulin level had been given. This, however, was feasible only in certain circumstances. There was clear evidence of a need for much closer collaboration between the haemophilia centres and the regional transfusion centres. Centres could not provide unlimited supplies and, in particular, they must be warned in advance whenever treatment facilities were to be re-organised or extended. Such consultation and warning were usually lacking. Patients were mentioned for whose treatment 1,000 cryoprecipitates had been used. Also mentioned was the case of a patient transferred from one of the metropolitan regions to Oxford for treatment; the patient's mother reported to the RTD that she had a store of frozen cryoprecipitate received from another region.

The amounts of cryoprecipitate provided differed considerably between regions. It was not clear whether this, for example, was due to undertreatment in certain regions or to wasteful use in others. It was known that in some regions many operations were now being done to remove loose bodies from joints; these operations might "consume" large amounts of cryoprecipitate.

PLATELETS: Requests for platelets were increasing in all regions. Here again, closer collaboration between the users and the RTCs was essential. Some centres supplied platelets only when they were necessary to control bleeding actually occurring. On the other hand transfusions of platelets were used to prevent the occurrence of bleeding, eg in patients with leukaemia who were undergoing intensive treatment with cytotoxic drugs which destroyed bone-marrow.

The tissue typing of platelets before transfusion was discussed. One view was that this only became necessary once a patient failed to respond to platelet transfusion. Another view, widely held in USA, was that tissue typing should be done from the outset of platelet therapy; a state of unresponsiveness could then be avoided.

Dr Maycock informed the meeting that it was intended to increase the amount of HAHG concentrate available when the extension to the BPL was brought into operation.

The meeting agreed that: (a) some means of controlling the use of cryoprecipitate and platelet preparations and a uniform policy regarding their issue against agreed indications seemed desirable, (b) RTDs would send Dr Maycock the number of donations used to prepare platelets in the last 3 months of 1970, (c) similar information regarding cryoprecipitates would be extracted from the monthly reports, (d) this subject should be discussed in greater detail at the next meeting, (e) Dr Maycock would distribute a list of centres (not exhaustive) undertaking cytotoxic treatment of leukaemia.

7. ANTI-D IMMUNOGLOBULIN

a. SUPPLIES OF PLASMA

Dr Maycock reported that the average number of donations received montly from January to November 1970(inclusive) was 505. The amount of plasma was thus still increasing but Dr Hughes-Jones' assays of plasma pools suggested that the average amount of antibody since August was still less than 20 µg/ml. The effect of excluding donations with albumin titres of 1/64 and below was not yet apparent.

b. BOOSTING AND DELIBERATE IMMUNISATION

Increases in the numbers of volunteers were reported. Dr Stratton stated that he had found in Canada and USA that by far the greatest part of the anti-D plasma was obtained from naturally sensitized individuals whose antibody level was raised by boosting.

c. DISTRIBUTION AND USE: NORMAL DELIVERIES

Dr Maycock informed the meeting that the Standing Medical Advisory Committee's Joint Sub-committee on the Prevention of Haemolytic Disease of the Newborn at its meeting on 8 December had decided to recommend to its parent committeesthat the normal dose of anti-D immunoglobulin should be 100 µg anti-D antibody in place of the dose of 200 µg used hitherto. The decision was based on evidence received by the Sub-committee from the MRC Working Party on the Use of Anti-D Immunoglobulin.

The effect of this change would be that there would be enough immunoglobulin to treat all Rh-negative mothers delivered of Rh-positive infants, irrespective of parity and mother-child ABO compatibility.

Exclusive use of the lower dose might increase, by possibly 0.3 per cent, the number of failures. The Sub-Committee had, therefore, also recommended that mothers in whom the foetal cell count indicated a transplacental haemorrhage of 5 ml or more, should be given 200 µg or more if thought necessary.

A Kleihauer test would, therefore, have to be done on all Rh-negative mothers. It was proposed that the count in 50 LPF should be replaced by a test in which the appearance of five fields in a stained smear would be compared with a stained control smear of a mixture of adult and foetal red cells, representing a TPH of 5 ml. (ie. a foetal cell count of 100 cells/50 LPF).

The preparation of reference smears is still under discussion.

ABORTIONS: The Joint Sub-Committee had also decided to recommend that women known to be Rh-negative who underwent abortion up to and including the 20th week of pregnancy should be given 50 µg anti-D antibody. Such women, in whom an Rh-positive pregnancy was terminated after 20 weeks, should receive a dose of 100 ug.

FOLLOW-UP OF MOTHERS TREATED WITH 100 µg: The Sub-committee had also recommended that a number of mothers given 100 µg should be followed up in selected regions in order to assess the results. The Directors of the following regions provisionally agreed to undertake the follow-up:-

Newcastle, Leeds, Cambridge, Brentwood, Bristol

This survey would be considered in detail at the next meeting.

PACKING OF 100 µg and 50 µg DOSES. The meeting agreed that (a) vials containing 100 ug antibody should be packed in boxes containing 10 vials without cartons. (b) Vials containing 50 µg antibody should be packed singly in cartons.

d. DISCONTINUATION OF REPORTING AFTER TREATMENT WITH 200 µg DOSE AND FUTURE USE OF NBTS 49

It was agreed that mothers treated up to the end of December in the regions, Newcastle, Leeds, Sheffield, Brentwood, Oxford, Cardiff and Birmingham should be followed up six months after treatment. This survey would, therefore, end about 30 June 1971.

It was agreed that information regarding the outcome of second pregnancies in mothers given 200 µg after the first pregnancy should be collected, because this information was the best index of the success of treatment. Directors of the following regions tentatively agreed to consider whether this information could be collected in their regions:-

Leeds, Cambridge, Bristol, Cardiff

and to report at the next meeting.

It was agreed that NBTS 49 should continue in use and that the form should be modified at the first opportunity to include the question "Number of previous pregnancies".

SUPPLY MATTERS

a. BAXTER GIVING SET USED WITH TUTA CONTAINERS

Mr Hanson said he had discussed with Baxters the difficulties reported when the BR2 set is used with Tuta containers. Baxters had agreed to look into the matter further and as an interim measure to make the BR1 set available in cases of particular difficulty. Its price will be slightly raised. The manufacturers of the Tuta bag have also agreed to modify the parts: such bags will be available in 1971.

b. LONG-TERM ARRANGEMENTS

The meeting briefly considered the problems arising from the increasing number of makers and patterns of plastic transfusion equipment and agreed to form a sub-committee with the following terms of reference to consider the matter: "In view of the increasing use of plastics containers for blood and intravenous fluids and the growing variety of containers and sets, to consider what patterns of giving sets are needed." The following were nominated to serve: Dr Jenkins, Dr Bird, a Director of a Scottish RTC, Mrs Tunnard, Mr Hanson and Dr Maycock.

The suggestion was made that the sub-committee should consider whether two types of sets should be approved - one to be used with glass containers and one to be used with plastics containers.

c. TRIAL OF PLASTICS CONTAINERS FOR BLOOD: AVON MEDICAL AND ABBOTT LABORATORIES

It was reported that the following numbers of sets made by Avon Medical and Abbott Laboratories were available for trial:

Avon Medical	single packs	- 400	Abbott	single packs	- 4,500
	pigtail "	- 400		double "	- 700
	double "	- 400		triple "	- 50

The following centres undertook to test containers. Their preferences were:-

Edgware	double and triple packs
Leeds	pigtail and double packs
Sheffield	double pack
Oxford	pigtail and double packs
Southampton	double pack
Tooting	double pack

Scottish Home & Health Department - to notify requirements.

Mr Hanson agreed to arrange distribution of packs when available.

9. ISSUE OF BLOOD TO NURSING HOMES

A document entitled "The responsibilities of the NHS pathologist when blood is supplied to a private nursing home" was put on the table. Mr Bebb explained that the document would be submitted to the Royal College of Pathologists in due course, but before this was done, RTDs were invited to send Dr Maycock any comments they wished to make.

10. LEAFLET ON RH FACTOR FOR MIDWIVES, NURSES AND HEALTH VISITORS

Mr Bebb reported that this was now in the press. The meeting agreed that RTCs would distribute the new edition in the same way as previous editions, ie Local Health Authorities would obtain copies from RTCs.

11. The next meeting was arranged for 24 February 1971.