Notes of NBS Clinical Directors Meeting
12th July 1995

1 **HCV Look Back**

1.1 Copy of the letter from Dr Metters regarding HCV recipients already under the care of hepatologists to be circulated to the Zonal Clinical Directors. Dr Hewiit in association with Stephen Janisch (Tickle & Brasseur) will be devising a draft letter for the notification of hepatologists. This will require DoH approval before general circulation for use.

Action AR

1.2 AR has had 2 meetings with representatives from the PHLS, Julia Heptonstall, Mary Ramsey and Kate Soldan. These meetings were to discuss how best to centrally collate: -

(i) information obtained from the LBF3

(ii) centrally monitor the progress of the HCV Lookback programme.

AR pre-circulated a flow chart indicating the data that needs to be collected centrally for NBA/DoH monitoring purposes, and to ensure comparability of data collection between zones.

It was proposed that AR should produce a template format based on this flow chart and taking into consideration the format already being provided from some of the zones. The arm being to keep it as simple and straightforward as possible to ease the administrative burden on centres and ensure comparability of essential monitoring data.

Action AR

For (ii) it was proposed that PF should arrange a meeting between the Clinical Directors and Mary Ramsey and Kate Soldan in the near future to discuss the data base format for the HCV-Lookback central Registry to ensure that the central collation of data is comprehensive enough and compatible with local and Zonal data collection systems.

Action PF

1.3 AR is awaiting response from Dr Metters re how to deal with potentially HCV infected transfusion recipients who were overseas nationals treated as private patients in the UK, where the overseas clinician now in charge of the patient is known. Dr Metters response to this query will be circulated to the clinical directors on receipt.

Action AR

1.4 R Tedders letter re the identification of significant RIBA indeterminants that should be included in the HCV Lookback programme was discussed. It became apparent from the discussion that some TC's - e.g. Birmingham, had already included "significant" HCV RIBA indeterminants which accounts for some of the discrepancies already noted between TC's in the number of donors and donations identified in the HCV Lookback programme. Some centres,

particularly those where "in house" confirmatory testing is done, do not do an alternative HCV EIA test. R Tedder has been set the task of producing a means of defining alternative confirmatory algorithms such that "significant" RIBA indeterminants can be identified. PF will follow this up to determine whether or not a more consistent and practically feasible system can be devised for all centres to include highly suspect RIBA indeterminate donors into the HCV Lookback programme. AR needs to report back on this topic at the next MSBT Ad Hoc HCV Lookback Advisory Committee in October. (possibly 13th October)

Action AR & PF

2 **SWAG (Specialist Workforce Advisory Group)**

This is a subgroup of AGMETS (Advisory Group on Medical and Dental Education) one of whose tasks is to plan the number of trainees required in the new unified training grade, called Specialist Registrar grade (SpR). SWAG was set up to specifically carry forward the day to day work of reviewing specialties and formulating views on the appropriate numbers needed. PF flagged up the fact that the Royal College of Pathologists report on Higher Specialist Training (assessment of the numbers of specialist trainees in Pathology 1995 - 2005) had failed to separate Transfusion Medicine as a discrete specialty and presumably lumped it together with the report on haematology trainees. AR was asked to address this issue and bring the plight of Transfusion Medicine and it's urgent need for dedicated specialist trainee registrars to the attention of SWAG before the end of July.

Dr Winyard, current chairman of SWAG had indicated in his circular letter of 27th March 1995 that views from Trusts and others not so far included in this consultation process would be welcome, but that a meeting in July would be trying to finalise the numbers of specialty SpR posts required. PF and SK had already provided AR with their zonal manpower planning predictions for consultant posts. TW promised to submit his asap. PF promised to send AR copies of the Higher Specialised training programme devised for Transfusion Medicine. Armed with this information and based on the College of Pathologists calculation for the assessment of trainee numbers required, AR to write to Graham Winyard to request urgent attention given to the specialty trainee requirements of Transfusion Medicine.

Preliminary calculations indicate that even to meet our present requirements to replace consultants already lost and those due for retirement, and to fill identified new posts, 9 Consultants need to be specifically recruited asap.

Within the next 5 years the requirements overall will be: -
5 for the Midlands and South West Zone
5 for the Northern Zone
4 for the London and SE Zone
to replace posts already available.

The current situation is unsatisfactory, with the shortage of consultant staff meaning that existing staff are being required to work harder and to change their roles within a

transitional "reorganisational" environment they do not yet fully support.

It was agreed that a minimum of 10 dedicated SpR posts are needed asap to redress the imbalance whereas at present there are only four JPAC approved SR posts. It is also recognised that these new SpR posts need to be centrally and flexibly managed - i.e. placements to be made where needed around the country and not rigidly constrained to specific sites. All four SR posts are currently filled but only one SR is likely to be ready for a consultant appointment within 12 months. This consultant and trainee manpower problem is seen as the most pressing problem facing the NBS which needs addressing asap.

Actions AR. PF, TW

Copies of the letter written by AR to G Winyard, with copies to Ken Calman, together with copies of the training programme are enclosed with these minutes.

3 **NBS policy re payment for waste/surplus materials from blood collection.**

3.1 There is a need to have clear definitions of what is genuine waste and what is genuine surplus material within the NBS.

3.2 It is deemed acceptable to devise a means of cost recovery between NHS organisations and universities and to provide "waste/surplus" materials at cost to hospitals and universities to support R&D work.

3.3 Commercial requests for material: -

This is a much more difficult issue and the first task is to collate centrally what commercial relationships are already in place.

It was felt important that guidelines should be drawn up as to how to handle commercial requests for NBS "surplus" or "waste" material, including whether a statistical analysis of donor responses to questionnaires regarding the use of this material should be done before proceeding. It was also felt to be important to clarify what use would be made of NBS waste/surplus material within the commercial sector and whether or not this was "ethically" acceptable to the NBS and justifiable to the voluntary based donor community.

The first action is to centrally collate what is happening now zone by zone. this will then lead to further discussion and recommended actions.

Action TW, PF and SK

4 **Use of G-CSF in unrelated donors**

CD provided Amgen literature on the use of G-CSF for PBSC collections, for circulation to the Clinical Directors. This confirmed the previously held view that there is very little follow up data in G-CSF treated unrelated PBSC donors. AR reported that she had received a response from K Calman re the formation of a Central

Ethical Committee to serve the needs of the NBS. The response from Dr Metters on behalf of Dr Calman was circulated. The needs of the NBS have been recognised both from the donor point of view and the multicentre nature of most of our R&D work. This working party with appropriate recommendations should be reporting in the near future.

Action AR to follow up.

5 **MB/light inactivation of Clinical FFP**

CD attended a Baxter workshop in Venice on behalf of AR and the NBS, on their development of MB/light inactivation methodology for clinical FFP. CD will circulate a report on this workshop to Clinical Directors before the next meeting. CD reported that there will be no prototypes for trial in TC's until July 1996. A CTX licence will be required and it appears that a minimum of 3 years to a maximum of 5 years trial period will be required before MB/light inactivation of clinical FFP can be put into routine use.

AR and CD to attend the next workshop to keep abreast of developments and to provide the necessary NBS input to this field of development.

Action CD

6 **Date of next meeting**

At this point time ran out so it was decided that Clinical Directors meetings needed to be more frequent. PF and SK suggested monthly meetings were essential. Agreed by CD and TW. Due to holidays however, next meeting planned for September 28th at 2pm. Subsequent meetings were arranged for October 24th at 9am, November 22nd at 9am and December 19th at 9am.