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REGIONAL TRANSFUSION DIRECTORS' MEETING

Minutes of the 196th Regional Transfusion Directors' Meeting held at the Department of Health and Social Security (Hannibal House) on Wednesday 10th July 1985.

PRESENT:

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

Dr A Smithies (DHSS)
Mr A Williams (DHSS)
Mr W Armour (CBLA)

The Chairman welcomed Dr Smithies, Mr Williams and Mr Armour to the Meeting and said we appreciated their acceptance of the invitation to participate in the Meeting.

Dr Fraser also expressed our welcome to Col Robson from the Army Blood Transfusion Service who had joined the meeting in the morning. The Chairman had written to Col Deacon on behalf of the Directors thanking him for the 2½ years he had spent representing the Army Blood Supply Depot. Col Deacon had replied that he had enjoyed his association with the Transfusion Service.

There were no apologies for absence.

The Chairman introduced Mr Noble who had been involved in the transport survey at the Blood Products Laboratory. It had been felt that a short talk would be of value and Mr Noble was invited to speak.

He outlined the main points of the study. The objective was to review current methods of plasma and products transport and to see whether changes in transport and storage would be worthwhile from a cost and service level point of view. It was obviously essential to consider the many interfaces of the Service.

They had noted that Regions are autonomous with varying facilities and procedures. Costs are very different between Regions and reflect many different ways of operating and are not simply a function of distance and volume of material. The study had attempted to allocate costs when systems had allowed this.

Figures are not altogether comparable and depreciation of vehicles is not normally included in BTS costings. The simplest approach is to reduce frequency of vehicle movement but it is necessary to review the size and temperature of available cold stores and to consider the optimum use of specialised vehicles. Many RTCs have limited storage space. BPL require a more or less constant flow of plasma for processing.

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The major considerations were:

a) The facilities at each site. The possibilities of extension and where necessary further reduction of temperature.

b) Vehicles. The largest volume of frozen material to be carried within a particular vehicle size, keeping capital cost as low as possible and bearing in mind ease of handling.

c) Frequency of movement. The study ignored regular movements since this leads to some journeys being undertaken under capacity.

d) Utilisation of vehicles. Specialised vehicles dedicated to this use are expensive.

Options examined:

1) Elstree owned or hired vehicles.

(i) Large vehicles would have difficulty gaining access to some sites.

(ii) Cold storage capacities on some sites would not be adequate for longer term storage.

(iii) Transfer of frozen material from store to vehicles. Few RTCs have suitable mechanical facilities eg fork lift trucks.

The cost of this option was prohibitive. Another factor was that of the drivers already employed in this duty. Larger vehicles would require HGV licensed drivers and involvement of another Trades Union.

2) Local collection to "Hub Centres".

Eg Centres would feed to a nominated Regional Centre, then dedicated vehicles would make delivery to Elstree.

3) Use of insulated boxes carried by Express Carriers.

The storage problems would still exist and this is an expensive service. It would not be possible to use food containers for blood products.

4) Use of Trailers.

This option was finally selected because of many advantages.

The capacity was balanced with use of standard pallets dictated by BPL and varying frequency of delivery - also trying to minimise vehicle depreciation and driver time and "turn round". The trailer offers the opportunity of reducing the storage problem since plugged in on site it provides additional storage either for routine use or emergency "back-up". It is suggested that Elstree maintain two trailers in addition to RTCs. Access would be possible to all RTCs. Fitting of pallets and thermal curtains has been the subject of study and ease of handling and improved efficiency at BPL are advantageous. Temperature control could be maintained by plugging in the trailer immediately on arrival at Elstree. A 'cold' trailer on arrival would be immediately replaced by a pre-loaded trailer for a designated RTC to carry returned products.

This scheme would allow each RTC to change its practices as seemed most suitable.

Oxford and Cardiff were understood to have received trailers recently and the Directors were asked to comment. Dr Entwistle reported that the fibreglass door could be subject to damage by fork lift trucks and that the additional refrigeration equipment required space so that two different pallet sizes were now needed. Dr Napier pointed out that the trailer is heavier than anticipated and a larger vehicle would be necessary for its transport (3 Litre)

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Variation of temperature during transit was a matter for concern. The ability to maintain -40°C is above that normally required and a change in the size of the evaporator has been necessary. The manufacturers regard the two trailers under evaluation as prototypes.

Although not every RTD was in favour of such change there was agreement that uniformity of practice is desirable.

The problem of handling at Elstree should a number of vehicles arrive on one day was raised but Dr Lane felt that the trailers could be plugged in and no deterioration would occur. This is an administrative matter and could be planned and handled by BPL. Some Centres felt that regular planned journeys would be essential. Mr Noble reported that on mains 3 hours would be required to reduce the temperature to -40°C. No figures were available for a "holding temperature" in case of breakdown.

Dr Lane emphasised that mechanical handling was essential for operations at the new BPL. He also stressed the importance of this storage temperature.

Maintenance of trailers was also a concern since most Centres have their own contract for refrigeration equipment.

Dr Lane assured the Meeting that such handling would ensure that no deterioration of the product would occur during unloading at BPL.

A further discussion will take place at the next meeting in the light of experiences gained with the trailers in operation at Cardiff and Oxford.

The Chairman thanked Mr Noble for his presentation.

2. MINUTES OF 195th MEETING

10) Dr Darnborough felt that the minutes understated the problem. Although the preparation of 30 units of blood was standard it was essential to have at least 100 units available as blood loss could be severe. The minuted requirement of Fresh Frozen Plasma was also the minimum immediately available and further stocks were necessary. All agreed with this provision.

12) Dr Tovey reported that Dr Contreras would hold the list of cells.

The Anti A and Anti B problem is not solved since it is clear that finance is not available. Mr Armour reported that the last CBLA meeting discussed a Central purchasing arrangement and this matter is still being pursued covering a number of reagents.

7) Dr Contreras is also a member of the Working Group (HTLVII testing and Counselling)

The minutes were otherwise accepted.
Items 5 and 12 required input from DHSS colleagues who had to leave by 4 pm.

5. AIDS

The Chairman reported on a number of meetings. One group involving 2 RTDs from each Division and Dr W B McClelland from Edinburgh had met with Dr A Smithies (DHSS) and notes from this meeting had been circulated to all BTS Consultants. It was stressed that a UK approach to the problem is essential. It was felt not essential to have the GP's name in all instances but that all donors must be informed that testing will be carried out. A leaflet would be helpful for donors and should be distributed by all means necessary.

The NBTS 110 should be updated.

Obviously HTLVIII positive donations would be destroyed. The initial approach to such a donor would be from the NBTS and afterwards counselling would be essential. We look to the Expert Advisory Group for guidelines but GPs should be involved, with the donor's consent.

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It was agreed that follow up of previous donations of plasma should be for 3 - 5 years.

The Chairman requested the approval of the Meeting to let the Group draft a flow diagram for AIDS testing and following up of donations. The meeting tomorrow will, if given approval, pass on recommendations to the Expert Advisory Committee and save considerable time.

Dr Gunson reported on the situation so far:

a) It is hoped shortly to begin the NBTS testing and evaluate the results rapidly since there is much media pressure.

b) Professor Glynn from Colindale had requested formally a BTS representative for the PHLS Working Party and Dr Fraser was nominated.

c) Dr Taylor and Colindale have prepared a Quality Control panel of heat treated sera which are available on request. If any RTC has any weak confirmed positives they are requested to send them.

Dr Tedder has requested reporting of post-transfusion illnesses which are possibly infective.

The Reports of the evaluation will be reviewed and distributed through Regional General Managers and in journals.

Concern was expressed that high risk members of the general public might be attracted to Blood Donor Sessions in order to obtain testing, and strong feelings were expressed that publicity should be used positively to deter this happening. Dr Smithies reassured the Meeting that concern was felt centrally on this matter and the message would be reinforced on testing and counselling. Dr Smithies requested nomination of two representatives from each RTC to attend a Special Counselling Course.

Directors felt that two types of course are needed. One approach is needed for a voluntary donor and advice and a suitable introduction into a specialised counselling service can be arranged. This is quite different from the present situation where the facts are concentrated on sexually transmitted diseases and known patients.

Stress was placed on the fact that Regions have been instructed to make provisions for undertaking testing although at present techniques are not yet decided. It was pointed out that time will be required for recruitment and training of staff and for obtaining equipment. The PHLS report will indicate the preferred tests and will trigger the full evaluation in the NBTS on donor samples.

The results will be presented and RTDs will be able to decide on testing procedures. Firms have been asked for details of charges, equipment and availability. Regions have been asked to make provision but RTDs agreed that time would be required to establish routine testing since accommodation, equipment and staff training would be necessary once it was known which test would be in use. A definite date had not yet been given but some time in October was the objective.

Dr Gunson offered the continuation of Miss Rawlinson's work for a few months collating information on performance of kits, batch variation and reporting to RTDs. This was appreciated.

12. BLOOD SUPPLIES TO THE ARMED FORCES

Mr Williams reported that there is not now a clear understanding and that new discussions will take place with the Ministry of Defence. Mr Williams will then come back to Directors. It would appear that demands would be less than those discussed some years ago.

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4. BONE MARROW REGISTRY

Directors had been asked by UK Transplant Service to enrol blood donors to be Bone Marrow Donors. This topic had been raised previously and also discussed at Divisions.

The Western and Northern Groups will carry on in a small way but the Eastern Group is in favour of development of this service. It has become clear that Edgware is facing enormous problems in maintaining supplies, particularly of platelets, to bone marrow transplant centres.

When liver transplantation was discussed it was felt that other Centres could contribute to cover the extra demands faced by Cambridge. In view of the load borne by the NW Thames RTC could aid be provided also in this instance from other Regions ?

The Chairman asked for comments from DHSS colleagues on the proposal to set up a National Service and asked whether any progress had been made. Mr Williams reported that although no progress had been made the proposal was being examined. Any proposals for change to Supra-Regional Services are presented through NHS administration structures ie the Advisory Committee. The present climate does not support centralisation unless a reorganisation can be clearly seen to be more effective and efficient.

Dr Gunson emphasised that the paper was one of principle and not of a detailed structure.

The Advisory Committee has not met since this paper was presented to the DHSS and it will be discussed at the next meeting.

Dr Contreras pointed out that the Department are making decisions which involve RTCs without any consultation eg establishment of Transplant Centres.

13. FACTOR VIII

Dr Lane was asked to update the meeting on Factor VIII supply.

The Factor VIII supply position in 1985 falls into three areas. Up to April non heat-treated material was issued; then between April and August material was heat-treated. In September the issue of the new product (8Y) will begin. Clinical trials appear satisfactory and a provisional licence is likely to be granted in late summer. There is limited capacity at Elstree at present.

The Chairman asked Mr Williams whether targets would be achieved in the light of reports from RTCs. Not all Regions have committed resources to plasma collection. Stockpiles are adequate to start production but a 10% deficiency is apparent by 1987.

Dr Lane reported that un-heat-treated Factor IX is still in use. A new heat-treated product is in hand and a licence is hoped for in the late summer.

6. COMPUTER WORKING PARTY

It was felt that increasingly computer matters were being raised at the meeting of the Barcode Working Party. Divisions had discussed this matter. There is no uniformly acceptable system and there is a need for exchange of information. The subject will be kept under review.

7. CHAIRMAN OF USER GROUP IN AUTOMATED BLOOD GROUPING

The role of the Group was examined and the necessity for continuing it. There is a working group on reagents and an increasing input on microtitre systems (Dr Contreras). Dr Ala agreed to chair the meeting and to liaise with associated working groups.

8. AMENDMENT OF NBTS 110. This will be discussed tomorrow.

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10. HEPATITIS SCREENING - QUALITY CONTROL

There is a panel (PHLS) for quality control in Elisa testing for HBsAg. This is more appropriate for hospital use and does not contain weakly reacting samples more suitable for donor screening. The PHLS may be able to prepare another panel and Dr Fraser will write to Dr Taylor.

BPL material is standardised against an International Preparation, and users of those reagents have regular quality control.

11. RTCs COMMITMENT TO BGRL

Dr Contreras stressed the need for support especially during this period when monoclonal antibodies are either not yet available or not funded. Dr Contreras feels that RTDs must decide whether or not they are going to provide adequate raw material for reagents. Some RTCs supply very little - Dr Holburn circulated a print out. This matter had been discussed at Divisonal meetings.

Problems had arisen over the availability of antigen for boosting. There was conflict between supply of anti D for either clinical or laboratory use. High titre donor plasma had been supplied until Dr Holburn requested immunised material. Is screening no good ? Titres are assessed by reference - would it be possible to send out a reference panel ?

It had been agreed that not all Centres would develop immunisation and boosting programmes. It was suggested that RTCs could prepare reagents for machine use and keep BGRL reagents for issue to hospitals. There is evidence that up to 80% of hospital used reagents (reference antisera) are commercial.

All agreed that communications from BGRL to RTCs could be improved and the Reagent Working Party will consider this problem. Dr Holburn reported that a pro-rata system could not be implemented.

RTDs would attempt to improve their input but would appreciate clear specifications and targets from BGRL.

14. GRADINGS OF NURSES AT RTCs

Dr Darnborough had prepared the details collected from RTDs. The situation is more uniform than had been expected. Seniority depends to some extent on lines of responsibility either to RNO or to Director. Dr Fraser felt this information would be valuable to Centres dealing with re-gradings.

15. CHARGING FOR BLOOD AND BLOOD PRODUCTS

The report had been discussed at the Birmingham meeting.

Mr Armour reported that further considerations would take place.

16. REPORTS OF WORKING PARTIES

Anti-D Working Party - has not met.

Dr Tovey reported on accreditation of red cells and their distribution and donor boosting.

Dr Urbaniak was proposed as a Scottish member of the Working Party.

Cell Separator Working Party

The guidelines are now complete and will be circulated.

Reagent Working Party

A paper has been distributed.

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ANY OTHER BUSINESS

Dr Crawford had written to the Chairman regarding reference samples for CMV testing. Dr Fraser will copy and distribute this.

DATE OF NEXT MEETING

Dr Lane suggested that it was important to have a further meeting at BPL and it was agreed that this could be associated with the next RTD meeting, which will therefore be held at Elstree on Wednesday 9th October following a meeting at Elstree on Tuesday 8th October at 2 pm.

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