

Blood Matters

Quarterly information for hospitals served by the National Blood Service

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Blood components will require a NAT test for HCV before they can be released for direct clinical use. The NBS has begun to validate procedures to meet this requirement.

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SELECTION OF LEUCOCYTE DEPLETING TECHNOLOGIES TECHNOLOGIES AND QUALITY MONITORING OF LEUCOCYTE DEPLETED BLOOD COMPONENTS

Leucodepletion (LD) is a demanding technology. This article describes how the NBS has set out to choose and monitor systems so as to reliably deliver all blood components leucodepletion ("Universal LD")

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A review of the activities of the Blood User Groups by Dr Cliff Morgan, Consultant in Intensive Care and Anaesthesia at the Royal Brompton Hospital and Chairman of the London and South East Zone Blood User Group

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PROFILES - MIKE FOGDEN, CHAIRMAN; AND MARTIN GORHAM, CHIEF EXECUTIVE, OF THE NBA.

Profiles provided courtesy of Dr Frank Boulton, NBS Consultant, Southampton, and Editor of the BBTS Newsletter

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Introduction

In July last year a national Blood Matters meeting was held at the Royal College of Pathologists, jointly organised by the National Blood Service (NBS) and the National Blood User Group (NBUG). The primary aim of this meeting was to provide a forum in which to update all haematologists in charge of hospital blood banks on the challenges faced by the NBS and the impact these would have on the services provided to all its hospital users.

The title Blood Matters came originally from an initiative launched by the London & SE Zone of the NBS. The planned quarterly newsletter aimed to keep hospitals up to date with the changes taking place within the NBS, rather than receiving a multiplicity of circular letters which would otherwise have been necessary.

After the national Blood Matters meeting, it was agreed that this NBS update newsletter should be launched nationally as a means of informing all hospital users of what changes are taking place within the field of blood transfusion, and the impact these changes would have on the NBS and its blood supplies and services to hospitals.

This first issue contains articles introducing the new Chairman and Chief Executive of the National Blood Authority (the Special Health Authority responsible for managing the NBS); an update on the introduction of nucleic amplification technology (NAT) testing in the form of HCV PCR testing by a minipooling technique as a release criteria for frozen blood components; the NBS approach to achieving 100% leucodepletion of all blood components by 1 November 1999; comments on the CMO's initiative for Better Blood Transfusion and an update on the work of the National & Zonal Blood User Groups.

The Blood User Groups have now developed into mutually beneficial fora, where constructive discussions take place between NBS staff and key hospital staff and collaborative projects are being developed. It is hoped that this type of blood user network could be used and expanded to provide the liaison link with Hospital Transfusion Committees, thereby providing a mechanism to promote and respond to the Health Services Circular HSC/1998/224 on Better Blood Transfusion.

Please do not hesitate to contact my colleague Alison Murray on 01923 486800, fax 01923 486801 or email angela.robinson@nbs.nhs.uk if you have any comments or ideas about this newsletter.

Dr Angela Robinson
Medical Director, National Blood Authority

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www.bloodnet.nbs.nhs.uk**

NAT (Nucleic Amplification Technology) Testing for HCV (Hepatitis C virus) in the NBS

The NBS has been planning the introduction of Nucleic Acid Amplification Technology (NAT) testing for the detection of HCV. Originally the aim was to ensure plasma sent to BPL for fractionation was negative for HCV by NAT. The strategy adopted by the NBS has the ultimate aim of utilising NAT testing as a pre-lease requirement for labile blood components. Although the original aim is no longer relevant, as British plasma is not now used for fractionation, the aim to release labile components on a NAT HCV negative result is supported by the NHSE.

This testing and subsequent release of components is to be introduced in 2 phases 1) the release of frozen components for direct clinical use 2) the release of labile components.

Phase 1

Frozen products for direct clinical use to be tested for HCV by NAT.

Progress so far

- A separate EDTA sample for NAT testing is being taken from donations in the NBS
- The plasma from the NAT samples is made into mini pools of 96 samples using Tecan Genesis sample handlers. This process has been fully validated
- The mini pools are sent to Bio Products Laboratory Elstree for testing by automated methodology using Qiagen robots for the extraction stage and Roche Cobas/ Amplicor amplification and testing system. Validation of these systems is complete
- Validation of entry of results to Pulse, the NBS computer system, is now complete.
- Plans are being completed for the management, build up and recall of stocks of frozen products so that when the date from which patients are to be transfused with frozen products tested negative for HCV by NAT is announced, the Service will be able to respond.
- Hospitals have been and will continue to be informed of any developments.

Phase 2

Progress on the management of cellular products

- Approval has been given to establish 3 NAT testing laboratories, one in each Zone.

**NBS NAT Steering Group
April 1999**

Better Blood Transfusion

The recommendations of HSC 1998/224, that all NHS Trusts should have a hospital transfusion committee (HTC) in place to oversee all aspects of blood transfusion and participate in reporting to SHOT, are welcomed. Although the concept of an HTC is almost as old as the regular practice of transfusion therapy, there has hitherto been no mandate in the UK to create an HTC. The situation has been different in the United States, where the risks and costs of transfusion have been higher, and malpractice litigation in this area became a major industry with transfusion-transmitted HIV and HCV. As a consequence, a functional HTC in the U.S has, since 1982, been a requirement for accreditation by the College of American Pathologists and by the Joint Commission on Accreditation of Hospitals.

In the UK, recommendations for the remit of a voluntarily constituted Hospital Transfusion Committee have come from the Research Unit of the Royal College of Physicians in its 1995 publication of Audit Measures for Good Practice in Blood Transfusion Medicine. Few would challenge the published remit, but few can comply in full with the recommendations. At this point in time 65% of Trusts have HTCs and their achievements are variable, whether with respect to improving the process or the outcome of transfusion practice. Frequently, HTCs lack enthusiastic support from other Directorates and a supportive infrastructure, and have hung loosely and powerlessly within a Trust Audit framework. One would hope that the HSC, together with the introduction of Clinical Governance and escalating costs of blood components, will provide the drivers to focus on appropriate transfusion therapy.

Nevertheless, what are the implications for Trusts? Compositions and reporting lines of existing HTCs will undoubtedly change, to gain authoritative rather than tacit support from Directorates and direct access to the Trust Executive. The formation and agreement of local protocols for blood transfusion, as recommended by March 2000, is a comparatively simple task when based upon existing BCSH guidelines. A suggested checklist

is provided below. However, there is no BCSH recommendation for red cell transfusions and lessons need to be applied from the February editions of the New England Journal of Medicine with respect to haemoglobin triggers in critically ill patients and the commentaries from Dr L T Goodenough. Sensible pragmatism would provide at least a start to avoid over transfusion of red cells.

The establishment of HTCs and the creation of local protocols are not in themselves the complete solution to improving transfusion practice. To be truly effective, HTCs need to have the means to uncover local problems and the means to take corrective action. It takes time and manpower to devise and implement profitable audits and provide ongoing evidence through repeated cycles. It takes time, commitment and effort to repeatedly educate all groups of staff to achieve change in practice. It is also likely to require peer pressure from comparisons between Trusts to constructively examine variation in practice.

The role of the Transfusion' Service and local user groups in providing support and handling comparative data will also need to be defined. Resources will have to be found at Trusts, Regional and National level, if we are to effect a systematic approach to changing practice.

The UK has never before had such an impetus to improve the appropriateness of transfusion practice. What we now need is an unfolding strategy, with the necessary manpower and infrastructure to collectively make the most of the opportunities of HSC 1998/224 in the interests of patient care.

The Health Service Circular, Better Blood Transfusion, requires all NHS Trusts to have agreed and disseminated local protocols for blood transfusion by March 2000. Hospital Transfusion Committees, new and old, may find this check list of clinical transfusion protocols useful when reviewing their compliance with this requirement.

BETTER BLOOD TRANSFUSION PROTOCOLS

PROTOCOLS	GUIDELINES
Requesting blood and taking samples. Collecting cross-matched blood from blood bank fridge. Administration and monitoring of transfusion. Management of transfusion reactions	BCSH Guidelines in preparation Handbook of Transfusion Medicine, 2nd edition 1996, HMSO
Platelet transfusion	BCSH Guidelines - Transfusion Medicine 2nd edition 1992, 2, 311 - 318 Consensus Conference on Platelet Transfusion. RCPE 1997

BETTER BLOOD TRANSFUSION PROTOCOLS

PROTOCOLS	GUIDELINES
Use of fresh frozen plasma	BCSH Guidelines - Transfusion Medicine, 1992, 2, 57-63
Use of albumin	Handbook of Transfusion Medicine, 2nd edition, 1996,
Irradiation of blood components	BCSH Guidelines - Transfusion Medicine, 1996, 6, 261-271
Transfusion of neonates and infants	BCSH Guidelines - Transfusion Medicine, 1994, 4, 63-69
Massive blood loss Consider specific policies for management of: obstetric haemorrhage. ruptured aortic aneurysm. gastrointestinal bleeding.	BCSH Guidelines - Clinical Laboratory Haematology, 1988, 10, 265-273 The report of the National Confidential Enquiry into Perioperative Deaths 1993/4. NCEPOD (1996) London
Maximum Surgical Blood Order Schedule (MSBOS)	Clin.Lab. Haemat. 1990,12,321-327
Autologous red cell transfusion	BCSH Guidelines part 1 Transfusion Medicine, 1993, 3, 307-316 part 2 British Journal of Anaesthesia. 1997, 78, 6, 768-771
Management of Jehovah's Witnesses or other patients	Surgical Management of Jehovah's Witnesses. Code of Royal College of Surgeons. 1996 (Phone 0171 405 3474).

NBS Transfusion Medicine Clinical Policies Group. April 1999

Selection of Leucocyte Depleting Technologies and Quality Monitoring of Leucocyte Depleted Blood Components

The objective set for universal leucocyte depletion in the NBS is that blood components will be leucocyte depleted to $< 5 \times 10^6$ white cells per unit of red cells/therapeutic dose of platelets by the end of the second day after collection. This is in response to the presently hypothetical risk that nvCJD will transmit via leucocytes in transfused components. There is no clear evidence as to the critical number of leucocytes which have to be removed to prevent any risk of nvCJD transmission. However the 5×10^6 /unit figure is known to significantly reduce the risk of HLA alloimmunisation and CMV transmission, is in line with current UK guidelines, and importantly, can be achieved with current systems with $> 99\%$ consistency. This paper aims to give a broad outline of the approaches the NBS will be taking to quality monitoring of leucocyte depleted components to give maximum reassurance to clinicians and patients.

The overall approach

We are following the strategy outlined by the international Biomedical Excellence for the Safety of Transfusion group of the International Society of Blood Transfusion (Ref 1).

A variety of approaches are currently taken internationally (Ref 2). This outlines 3 stages of monitoring: detailed evaluation of any new process under consideration, local validation at every site where it is implemented, then a statistical approach to routine quality monitoring.

STAGE 1. NATIONAL EVALUATIONS OF LEUCOCYTE DEPLETING TECHNOLOGIES

The objective here is for NBS to have an approved list of filters/apheresis equipment to be held by the Blood Pack User Group. This approach was taken because most filters now are manufactured as an integral part of a blood bag set. We will aim to use more than 1 manufacturer for each filter type. Filters/packs currently in use were automatically approved as being suitable for our needs; this backed up by prospective collating of data nationally on their performance in routine use. For packs/filters not previously used by NBS, we are following a nationally agreed protocol for their evaluation. In this, detailed evaluation of a small number of packs (phase 0) is followed by larger field trials (phases 1 and 2) designed to demonstrate consistency of process. This can be assigned a numerical (Cpk) value by the use of the Quality Analyst software package. Ideally, we will only accept filters with a Cpk value of > 1.00 . Evaluation may be done under more than one condition eg filtration on the day of collection or on chilled blood the following day. At each stage, there is formal sign off before a filter can proceed to the next stage, with final approval leading to the filter being added to the approved

list. In addition, all manufacturers whom we plan to use will be subjected to audit visits by NBS trained auditors. We have obtained information on manufacturers' internal quality control procedures, and have emphasised to them the importance of prior discussion with us if improvements to filters are being considered.

STAGE 2. LOCAL IMPLEMENTATION

At this stage, when local SOP's are written, great care is taken to ensure that the variables which can affect filter performance are controlled as tightly as possible. Training is undertaken in conjunction with the manufacturer. During implementation, every component produced has a white cell count performed until it is clear that the process is giving consistent results, with >99% of components in the $< 5 \times 10^6$ range.

STAGE 3. ROUTINE QUALITY MONITORING

In planning for universal leucocyte depletion, we considered various options for routine quality monitoring:-

Option 1: To perform a white count on every component produced

White cell counting at very low levels cannot be done on standard blood cell counters and flow cytometry or other specialised equipment is needed. There are currently no systems which would allow sampling and counting of every component in the short time available before component issue. This option was therefore rejected.

Option 2: To count 1 % of components produced/month, as at present

This option seemed to be inadequate, in that it does not provide sufficient data rapidly enough to allow a timely response to an upwards drift in the results.

Option 3: To count 1-5% of components and subject the results to 'real time' statistical process control

This is the approach NBS will be adopting. The Cpk value obtained in the field trial determines the percentage of packs which need to be counted - the more consistent the process, the smaller the percentage can be. Statistical control charts are then established on which the results are plotted on a daily basis. Any upwards drift in the results leads to increased monitoring and a review of the filtration procedure. Fortunately, the mean WBC achieved by current filters are well below the 5×10^6 cut off, so action can be taken early to prevent unnecessary release of components with $WBC > 5 \times 10^6$. However, because not every individual component is counted, it is inevitable that, very occasionally, a component issued for use will contain $> 5 \times 10^6$ WBC. When processes are "in control", the data we have so far accumulated on a variety of filters suggest that this will occur with a frequency of 0.1-1%, and that such failures will nearly always have values close to the 5×10^6 cut off. This is in line with specifications.

Contingencies to cope with an out of control leucodepleting process

Surplus blood is not a luxury that we enjoy so we will not be in a position to divert blood components from clinical use should a particular process for leucodepletion fail to meet specification in spite of corrective action. Our own growing experience and that around the world shows that the processes we have chosen to use are robust such that risk of significant failure is very small. However, we must plan to cope with this risk prior to full implementation of leucodepletion. We are presently accumulating

the experience and hard data that is needed for these plans to be rational. Our approach will be reported once available.

Counting leucocyte depleted components - how low can you go?

Because standard blood cell analysers are not sufficiently sensitive to count leucocyte depleted components accurately, current methods involve either large volume (Nageotte) counting chambers or flow cytometry. Chamber counting is too labour intensive for large scale use, so flow cytometric methods will be adopted. NBS has also approved an alternative technology (IMAGN 2000) in which samples in a capillary tube are scanned by a moving laser.

It will be important to establish consistency of counting between different blood centres so a national quality assurance scheme has been established in which samples of filtered red cells or platelets have been prepared centrally and counted by every processing centre within NBS. We are also arranging that NEQAS run an external scheme for us involving the use of stabilised blood samples with very low leucocyte levels.

Research and development

The following areas are under active development:

1. Development of microplate methods which would eventually allow leucocyte counting of every component
2. Techniques for measuring leucocyte differential and lymphocyte subsets.
3. Measurement of cell-derived fragments and platelet microvesicles in leucocyte-depleted components.
4. Removal of cell-associated viruses by leucocyte depleting technologies.
5. Filtration of HbS (sickle trait) positive blood. There is some evidence that this may be problematical, so a formal study is being undertaken as a matter of urgency.

Conclusion

The primary remit of the leucocyte depletion project as defined by the Secretary of State for Health is to provide leucocyte depleted components as a precautionary measure, and in such a way as not to jeopardise the provision or safety of blood components. We believe that our initial approach combines maximum assurance with minimal delay to the issue of components. Undoubtedly this area will develop, with both improved filter and apheresis technology, and novel counting methods so that all the benefits of leucocyte depletion for patients can be achieved.

References

1. Dumont L.J. et al. Practical guidelines for process validation and process control of white cell-reduced blood components: report of the Biomedical Excellence for Safer Transfusion (BEST) Working Party of the International Society of Blood Transfusion (ISBT). 1996 Transfusion 36: 11-20.
2. Engelfriet C.P. Reesink H.W. The Use and Quality Control of Leucocyte-Depleted Cell Concentrates. International Forum. 1998. Vox Sang. 75: 82-9

NBS Leucodepletion Programme Implementation Board

April 1999

Blood User Groups

The reorganisation of the National Blood Service in 1995 was accompanied by the establishment of a National Blood Service User Group with a mandate from the then Secretary of State for Health to fulfil the following terms of reference:

- To monitor the service provided to hospitals by the National Blood Service, in particular the commitments given by the National Blood Authority
 - To maintain or improve current delivery times for emergency supplies of blood, with a guaranteed maximum of two hours delivery time
 - To provide each hospital with the specialist services it requires from the NBS
 - To improve clinical support services provided by Blood Centres
 - To collaborate in developing best practice in the use of blood for the benefit of patients
- To bring to the attention of the NBA at national level problems which cannot be resolved at Zonal level.

The NBSUG is chaired by Professor Ted Gordon-Smith by appointment by the Secretary of State and includes representatives from each of the three English Zones and North Wales together with representatives from the relevant Royal Colleges, senior hospital management and a patient representative. The Zonal Blood User Groups are chaired by the Zonal representative to the NBSUG and also include at least two users from the area of each Blood Centre. The representatives were selected to provide good coverage of the relevant specialities, not just haematologists but also major blood users from surgery, anaesthesia, obstetrics, paediatrics etc. (Membership of each ZBUG is attached at Appendix 1).

There have been three formal meetings of each ZBUG per year since Autumn of 1996, usually followed within a month by a meeting of the NBSUG. The timing of the meetings in this way has facilitated communication from Zone to National level and vice versa. There has been a lot to communicate in the three years. It was predictable that there would be some problems associated with the implementations of the various reforms of the service flowing from the 1995 reorganisation. The User Groups were very much involved in collecting grievances and passing them on to the relevant targets. More importantly however, the User Group structure was able to go some way to bridging the gap between the disgruntled local blood product users and hard pressed national directors and policy makers. It may be no coincidence that the Blood Centre merger between Liverpool and Manchester went a lot smoother than the Brentwood Cambridge merger, arguably because of lessons learned in the latter and applied to the former.

Less predictable was the huge impact on transfusion practice of the nVCJD issue. The fallout from nVCJD is well known and doubtless will continue for some time.

One positive outcome however, is that an unprecedented amount of interest in transfusion has resulted. The recent Chief Medical Officers' Seminar on "Better Use of Blood" was well attended and resulted in a Health Service Circular which contains sensible guidelines and real requirements. At last, the need for Hospital Transfusion Committees to exist and furthermore to engage in audits of clinical practice and ensure the adoption of good practice has some official teeth. This will undoubtedly, help those who have been struggling with the uphill battle of imposing good transfusion practice on unwilling clinicians for many years with little success. There is now real interest among all users of blood and blood products to contain costs and ensure safety. Patients are becoming more aware of potential treatments such as pre-deposit autologous transfusion. More and more surgeons are willing to evaluate intra-operative blood salvage. It is more important than ever that the ZBUGs receive support from all the relevant specialities from all over each of the Zones so that issues can be debated, taken to National Level and potentially make a real impact on the problem. The ZBUGs should not be seen as closed shops. The size of the groups was determined by practicalities. They can be enlarged to accommodate a committed and enthusiastic additional participant or three!

The Chairmen of each ZBUG are particularly keen to include additional non-haematologists so that the blood users can be more fairly represented. Anyone interested in joining the committees should contact the respective Chairmen by phone, letter, fax or e-mail.

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Appendix 1

The London and South East ZBUG is chaired by Dr Cliff Morgan who is a consultant in Intensive Care and Anaesthesia at the Royal Brompton Hospital. The other members of the group include:

- **East Anglia** - Dr Nuala Simpson, Consultant Haematologist, Ipswich Hospital and Ms Gill Pont, nursing representative, Norfolk and Norwich Hospital
- **North East Thames** - Dr Margaret Boots, Consultant Haematologist, Colchester District Hospital, and Dr Harsha Boralessa, Consultant Anaesthetist, Oldchurch Hospital

- **North West Thames** - Dr Christine Costello, Consultant Haematologist, Chelsea and Westminster Hospital and Mr John Hollingdale, Consultant Trauma and Orthopaedic Surgeon at the Central Middlesex Hospital
- **South West Thames** - Dr Megan Rowley, Consultant Haematologist, Kingston Hospital and Dr Khalid Haque, Consultant Paediatrician, St Helier's Hospital Carshalton
- **MLSO** - Mr Grant Webb, Central Middlesex Hospital
- **NBS** - Dr Susan Knowles, Professor Marcela Contreras, Mr Stuart Penny

The Northern Zone BUG is chaired by Dr Derek Norfolk, Consultant Haematologist at Leeds General Infirmary. The other members of the group include:-

- **Leeds** - Dr M Howard, Consultant Haematologist,
- **Leicester** - Awaiting replacement
- **Liverpool** - Dr B E Woodcock, Consultant Haematologist, Southport and Formby District General Hospital and Dr M Desmond, Consultant Anaesthetist, The Cadiothoracic Centre, Liverpool NHS Trust
- **Liverpool** - Dr B E Woodcock, Consultant Haematologist, Southport and Formby District General Hospital and Dr M Desmond, Consultant Anaesthetist, The Cadiothoracic Centre, Liverpool NHS Trust
- **Manchester** - Dr A T Macheta, Consultant Haematologist, Furness General Hospital and Dr M A Thomson, Consultant Neonatologist, Hope Hospital
- **Newcastle** - Dr J P Wallis, Consultant Haematologist, Freeman Hospital and Dr Alistair Gasgoine, Consultant Physician, Royal Victoria Infirmary
- **North Wales** - Dr D K Watson, Consultant Haematologist, Wrexham Maelor Hospital
- **Sheffield** - Dr E Logan, Consultant Haematologist, Kingsmill Centre
- **MLSO** - Mr Gordon Jayne, Department of Blood Transfusion, Sunderland Royal
- **NBS** - Mr Terry Male, Mr Steve Morgan, Dr Dorothy Stainsby

The Midlands & South West Zone BUG is chaired by Dr Adrian Coplestone, Consultant Haematologist at Derriford Hospital. The other members of the group include:-

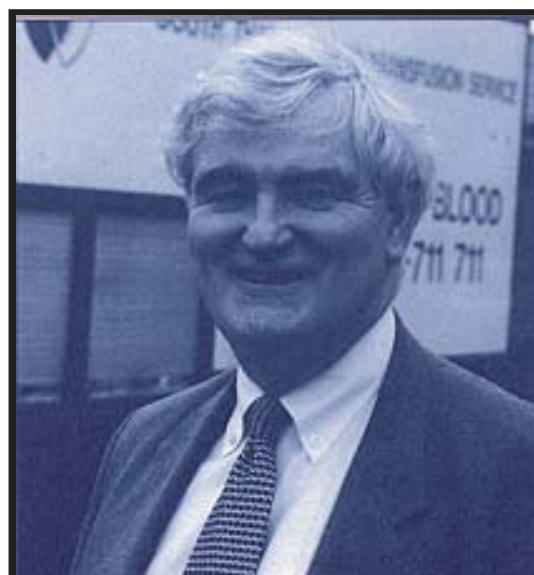
- **Birmingham** - Ms L Buist, Surgeon, Queen Elizabeth Hospital and Dr K Stockley, Haematologist, Worcester Royal Infirmary
- **Bristol** - Dr S Chown, Haematologist, Cheltenham General Hospital and Dr B Spiedel, Paediatrician, Southmead Hospital

- **Oxford** - Dr S Kelly, Haematologist, Wycombe General Hospital (non-Haematology representative to be arranged)
- **Southampton** - Dr C James, Haematologist, Royal Hampshire County Hospital and Dr P Swayne, Anaesthetist, Salisbury District Hospital
- **MLSO** - Mr S Bates, Cheltenham General Hospital
- **NBS** - Mr Gary Austin, Mr Richard Bedford, Dr Tim Wallington

PROFILES - Mike Fogden, Chairman; and Martin Gorham, Chief Executive, of the NBA.

In April last year Frank Dobson, Secretary of State for Health, appointed Mike Fogden as the new Chairman of the National Blood Authority. One of Mike's first tasks was to find a new Chief Executive and the Appointments Panel's unanimous choice was Martin Gorham who started in October. These appointments signal a new era for the NBS. In this article we take a look at their backgrounds and hear some of their first thoughts about the Service and its future.

Mike Fogden was a career civil servant who began his Civil Service career in 1958 after National Service in the RAF. He started at the Ministry of Pensions and National Insurance, later subsumed within the Department of Health and Social Security. He quickly rose through the ranks to spend three years as a private secretary to Richard Crossman and Sir Keith Joseph, Secretaries of State at the DHSS in the Labour and Conservative Governments. Following a period working on Health and Social Security policy he moved to the Department of Employment in 1984 first as an Under Secretary and then to head up the Employment Service. As Chief Executive of this Service from 1987 to 1991 he was credited with revitalising the national network of Job Centres.



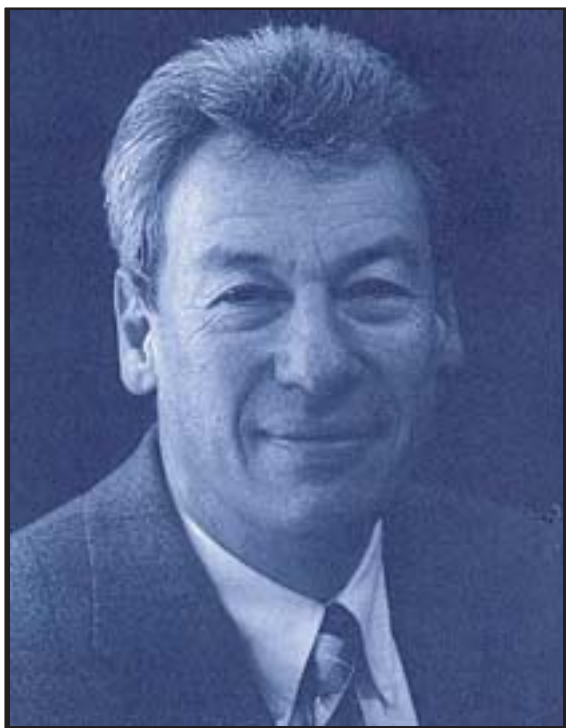
Mike Fogden

Mike is very much his own person and does not subscribe to 'change for change's sake'. He supports open and frank communication and advocates firm and clear management. He believes that sound judgement requires consideration of all the evidence and has spent much of his time in the NBA visiting various parts of the Service, listening to and exchanging views with people working in different areas and disciplines.

In his Christmas letter to everyone in the NBS he said: "I must say I have been impressed by much of what I have seen. In particular, the commitment of those people I have met in our worthy organisation has given me much cause for hope and optimism about our future. There is, of course, still much that we can do to make the running of our Service better in all sorts of ways and I have been heartened by the numerous ideas that people have given me."

Mike's one personal crusade is to introduce appointment systems for donors more widely throughout the Service. "We have to do everything possible" he says "to make giving blood easy and convenient. With people leading ever-busier lives they no longer have time to wait in queues; and why should they? Where appointments are available, the evidence shows that people are much more likely to turn up at the session and, more importantly, to return to give blood again."

Martin Gorham has spent his whole career in the NHS. He joined the NBS from the NHS Executive, South Thames, where he was Director of Projects and



Martin Gorham

Corporate Affairs. Prior to that he acted as Chief Executive of the London Ambulance Service having been given the task in 1992 of restoring and rebuilding that organisation. Over four years he successfully achieved a major turn round in the LAS culminating in its being awarded NHS Trust status. Martin has been involved in running several hospitals, notably the Norfolk and Norwich Hospital (as General Manager) and the Northern General Hospital, Sheffield (as Hospital Manager). He recognises the importance of keeping in touch with people working in the front line, in collection teams and laboratories as well as the managerial functions. He has already visited nearly all the NBS Centres and is about to start visiting the collection teams. Given his busy schedule this will take more than a year as we have over 90 teams. Nevertheless, he sees this as a priority.

Martin's main task since he joined the NBS has been to draw up a new strategic plan. This is now in draft form and he is discussing his ideas with all senior managers on a one-to-one basis so that they can contribute to and comment on the development proposals. He will present his conclusions to the NBA Board, probably in March. He has made it clear that his strategy report will contain proposals affecting the way the Service nationally and Zones would operate in the future. In a recent letter to senior managers he emphasised:

"If structural change is made, it will be made on a timescale in which it is safe and prudent to do so, without affecting the supply of blood and blood products to patients. The timescale for any change has not been determined. There is nothing in the draft strategy report to suggest that we will need fewer people at any level as a result of its proposals, either in the short or longer term. The challenges we now face mean that we need to retain experienced and enthusiastic people in jobs in which they can give of their best.

"The draft strategy report has put forward proposals for improving the outcomes we deliver to patients and hospitals. It is on those aspects that we should concentrate."

Martin has thrown his support behind the Donor 2000 project, which is taking a radical look at the way the NBS organises donor recruitment, sessions and session planning. While accepting the need to modernise this side of the Service he also recognises the importance of retaining the goodwill of our voluntary donors, emphasising the professional, caring aspects of the service we give them.

The National Blood Service has been through a gruelling time but there is now a greater recognition in the organisation that change is inevitable and, with new leadership, increased confidence that improvements can be delivered.