

Biochemistry Network Advisory Group Meeting
 Tuesday 20th January 2009, 2-4pm
 Room 323, One Central Park, Northampton Road, Manchester, M40 5BP

In attendance			Apologies	
Gwen Ayers	GA	Central Manchester NHS Foundation Trst	Malcolm Blower	The Christie NHS Foundation Trust
Mags Dewsnap	MD	GMPCTs	Chris Chaloner	Central Manchester NHS Foundation Tr
George Fielding	GF	Stockport NHS Foundation Trust	Denise Derby	The Christie NHS Foundation Trust
Susan Gillespie	SG	WWL NHS Foundation Trust	Neil Jenkinson	GMPCTs
Christine Hill	CH	Trafford Healthcare NHS Trust	Steven McCann	Stockport NHS Foundation Trust
Rod Hinchliffe	RH	Central Manchester NHS Foundation Trst	Lance Sandle	Trafford Healthcare NHS Trust
Andrew Hutchesson	AH	Royal Bolton Hospital NHS Foundation T	Stephen Scarisbrick	Salford Royal NHS Foundation Trust
Rachel Pearson	RP	GMPCTs	Gilbert Wieringa	Royal Bolton Hospital NHS Foundation
Jeff Seneviratne	JS	GMPCTs		
Felicity Stewart	FS	Salford Royal NHS Foundation Trust		
Keith Wiener	KW	Pennine Acute Hospitals NHS Trust		

Discussion Points

- JS welcomed the group to the new meeting venue
- **Chair's Communications** – JS reported that the last Network Board Meeting was held on 12th December 2008, prior to the publication of the second Carter Report and attended by Dr Ian Barnes (National Clinical Lead for Pathology). SG reported that Ian Barnes suggested that the DH response to Carter may be more significant. Both documents are available from www.dh.gov.uk/en/Healthcare/Secondarycare/Pathology/DH_075531
- Also discussed at the Network Board were priorities for 2009 which include POCT and demand management, and are very much in line with Carter and Darzi.
- JS reminded members that the BNP Workshop was taking place at the Village Hotel in Bury on 26th January 2009, and thanked Gill Burrows for engaging with the Cardiac Network to make this happen. There are currently 2 labs in Greater Manchester (WWL and Stockport) offering BNP, whilst other labs have found it difficult to get funding. FS reported that costing showed it was cheaper to do echocardiographs. SG discussed the difficulty in costing the service along with QC, particularly if real time turnaround (as opposed to batching) was required. KW wanted to know if point of care was included. JS felt it was easy to justify the use of BNP in Primary Care, especially for suspected heart failure where echocardiography is not already in use. Uses in secondary care, either emergency or monitoring, may require further debate. JS hoped the event would be a success and felt that there may be potential for a follow up workshop.
- **Minutes of last meeting held on 10th November 2008** - were accepted as a correct record.
- **Matters Arising –**
- **Changes to HbA1c Reporting** – Diabetes UK/ACB have produced 2 documents on the changes for Laboratory Professionals and Clinical Healthcare Professionals. JS agreed to circulate to all members. From the 1st June 2009, HbA1c will be reported in mmol per mol (IFCC units) with dual reporting to be phased out over 2 years. KW not clear whether manufacturers were changing instruments to read new units soon as it will affect the way computer data is managed. RH advised that Biorod have no plans to do this until 2010 and that each lab would have to do their own conversion. KW thought this would also be an issue for point of care testing (DCAS). CH highlighted that the lab doesn't necessarily have control over all DCA's in use and suggested that the changes to reporting information be circulated widely. Members felt that a coordinated approach would be useful to reflect patient flows. It was agreed to set up a subgroup to collect information on instruments, reference ranges and challenges and to involve haematology colleagues, (HbA1c is done in Haematology in some labs) as well as POCT colleagues. It was felt that it would also be useful to liaise with Diabetologists. KW, CH and GF volunteered and RP agreed to call for interest via email. FS highlighted that Diabetologists had expressed some concern about any discontinuity in long term monitoring data. KW explained that Diabetologists at Pennine use the Diamond System database and explained that they were already aware of the changes. CH suggested coordinated info sheets, similar to that drawn up for eGFR reporting, and others agreed.
- **Gestational Diabetes** – SG informed the group that the survey had been sent again but there had been few replies. SG explained that there was some concern about the financial implications of the new NICE guidance (July 08 – see www.nice.org.uk/nicemedia/pdf/DiabetesFullGuidelineRevisedJULY2008.pdf). SG further explained that most labs were following WHO guidance and that a Consultant at WWL was reluctant to move from the SIGN guidance.
- **Updates on Workstreams:**
- **Familial Hypercholesterolaemia** – Draft recommendations have been developed by a group chaired by AH and including GB, LS, CS and FS, with a recommendation that Labs should diagnose FH using the Simon Broome criteria and attach standard comments to reports. Where total cholesterol is >7.5 and/or LDL-cholesterol is >4.9 mmol/l (adults) or >6.7 and/or 4.0 mmol/l (children up to the age of 16), the recommended comment is 'suggest consider familial hypercholesterolemia or secondary causes'. The comment should not be attached if serum triglyceride concentration is

increased (>1.8 mmol/l): the recommended comment for this situation is 'significant mixed hyperlipidaemia; suggest consider familial or secondary causes'. JS and AH proposed to adopt this system and those standard comments, which should trigger a referral to a lipid clinic. JS wondered if the laboratory computer systems could cope with the comments as there is a limit on the number of characters that can be used and comments may need to be reduced accordingly. KW asked if the report was trying to convey the exclusion of secondary causes first. FS felt that FH and other genetic disorders were not being sufficiently considered or identified in Primary Care. JS suggested that could be an argument to leave it as it is. FS commented that promotion should be given more thought. KW suggested one should only consider FH after excluding secondary causes. FS suggested that the wording of point 1.1.5 in the report should be modified to avoid confusion i.e. *This comment should be used irrespective of the serum triglyceride concentration*

- AH highlighted that as there are currently only 2 sites offering a genetic diagnostic service for FH – London and Belfast. AH felt that the workload would merit a service in the North West and suggested approaching commissioners about this. AH explained that Professor Paul Durrington and lipid clinic physicians are discussing this with Rob Elles. RP noted that we would need to identify costs to build a business case. AH explained that these are currently £200-300 in London and £50 in Belfast. FS highlighted the difference in cost is because the services test for different things and suggested that there was a piece of work to be done on what would be the most appropriate for the region. Written patient consent should be obtained before analysis for genetic testing is performed. FS suggested that there was a pro-forma available for genetic testing which is quite detailed and included storage and other permissions. This could be the model for a consent form. AH agreed to discuss genetic testing with Mike France/Paul Durrington, and to discuss consent issues with Rob Elles.
- AH noted the need to know demand for the service and suggested that requests should be limited to lipid clinic specialists only, and only for confirming clinical diagnosis and cascade family screening. The discussion moved to clinical capacity and it was agreed that though some was known others had been estimated in the 9 centres across Gtr Manchester. AH suggested an under provision given that there is currently under-recognition of FH. Whilst this may increase with Primary Care Initiatives to screen for those at risk of Coronary Heart Disease, GP's may not recognise 'FH' and give patients statins. AH suggested that it might take 2-3 nurses to assist with counselling, dietary assessment etc. and screening should be across Manchester involving a Pan Manchester database. AH suggested that it would be useful to firm up info on clinical capacity, especially new patient slots, to support business case for support nurses.
- Lance Sandle had started discussions with a pharmaceutical company about the database, though AH recognised the potential conflict of interest in this. FS noted that a database system was used in the FH Cascade study and felt it was worth exploring whether this could be adapted as a clinical tool. It was not clear whether this system was available for purchase, though FS highlighted that it includes pedigree drawing. JS agreed that this was worth exploring but recognised the potential information governance issues that would need to be addressed. JS summarised by stating that decisions be left to the group, that the first recommendations (1.1.3 and 1.15) be implemented and that the computer systems should be explored. Whatever happened, it was desirable for it to be standardised and consistent. GF suggested that labs try the recommended standard comments in their LIMS and report back to the network. This would provide further useful information. JS suggested all labs measuring lipids try to implement these recommendations, and asked all members to comment on the overall recommendations before the next meeting.
- **GP Out of Hours Communications** - JS reported that he had written to Danielle Freedman on the discrepancies between local SOP's and RCPATH guidance on the action/concern level. Danielle Freedman had responded, recognising the need for review and KW had forwarded a copy of the GM document. The issue will be discussed at the next RCPATH SAC in February 2009.
- **Paraprotein Investigations** – Paper sent out including cryoglobulins. It was hoped that Gilbert Wieringa would be here today in order to take this forward. JS to speak to Gilbert about it and invited any comments. FS suggested involving Haematology colleagues and JS explained that this was covered by including Jim Cavet (Clinical Lead for Myeloma at Christie) in the group.
- **Harmony Project** – JS was away for the last meeting but this is progressing well as a national project. A letter was due to be sent out by Ian Barnes/Jonathan Berg. JS reported that Scotland, Ireland and Wales are now involved and the project is looking at immunology, haematology and paediatric reference ranges. JS also reported that he had received an email from Chris Chaloner asking which labs used age related references, and for which analytes. RP agreed to circulate a request for this information. KW highlighted that most paediatric reference ranges in use in the network were originally taken from Pendlebury. SG asked whether the Harmony Project was looking at standardising profiles and whether members felt there was any value in having an emergency admission profile. SG also asked whether members felt calcium should be included in a U&E profile, as this was frequently requested as an add on. It was felt that a separate request should be completed for any 'add ons'. SG suggested identifying the top ten add ons and adding them to the profile. KW felt that clinicians ought to know what to request and SG felt that labs needed more clinical details. FS noted that more consultant led ward rounds on A&E generate more requests, but also ensure earlier patient discharge or admission. Members had previously shared A&E protocols and KW suggested revisiting these. JS felt it was important to address the whole area of appropriate testing and that this should include alerting clinicians to what they should be requesting as well as managing demand for inappropriate requesting. SG recognised that emergency units are under huge pressure and are working differently, and suggested that labs may also need to work differently. FS explained that SRFT had demand management software that was piloted for CRP and FBC. There are agreed rules on appropriate repeat intervals: 72 hours for CRP and 48 hours for FBC. This has now been extended to other analytes. FS expressed some reservations about

the system, particularly about how to deal with people who wanted to override the software. There were concerns that it leads to lots of telephone calls requesting emergency bloods, and that generates different work. SG reported that she had trialled setting the repeat interval for TSH at 7 days, but that this too generated additional work.

- **Referred tests** – It was agreed to develop part of the network website with this information and RP agreed to follow this up with GW.
- **Priorities for 2009** - The NAG agreed on the following priorities:
 1. FH
 2. HbA1C
 3. Appropriateness of Testing – JS suggested using the next meeting as a workshop session on this issue, and asked members to bring requesting protocols etc. with them next time.
 4. OOH reporting
 5. Paraproteins
- **Haemochromatosis** – JS raised the issue of the Genetic Haemochromatosis (GH) screening project, which is looking at whether the targeted screening currently in place in Wigan should be extended across Greater Manchester. The process of targeted screening at Wigan is that patients who have routine LFT's and are identified as having raised ALT, are then assessed for transferrin saturation. JS felt that there were a number of problems with the proposal and Dr Kate Ryan (Consultant Haematologist) has expressed several concerns. GA suggested that a research project should be set up to properly evaluate GH targeted screening. AH explained that Peter Elton (Director of Public Health, Bury PCT) is now leading the project and has convened a meeting for 10th February 2009, which AH and Kate Pendry are attending. JS agreed to follow this up with NJ.
- **4.3 Network Response to Modernising Scientific Careers consultation**
- RP explained that the Network is keen to formulate a response to the consultation and asked any members with comments to contact her. The consultation documents are available from: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_091137. The Consultation has been extended by one week and will now close on the 6th March 2009.
- **Carter** – JS emphasised that the DH response was of key significance. Members also highlighted professional body responses e.g RCPATH and ACB.
- **PAGs** – Update on progress
- **IM&T** - JS asked if anybody had noticed the benefits with GP Order Comms. CH responded that there were two pilot sites at Trafford, but that there had been some problems with the interface affecting haematology requests. GF informed group that there are 12 sites live across Stockport with a roll out programme in place. KW informed that the paperless system at Pennine is working well.
- JS reported that there had been a meeting yesterday re Lab to Lab. The first versions of software will be available from iSoft in the next few weeks. No agreement has yet been reached on interface costs for Clinisys.
- **Any other business**
- SG explained that she had had a request from Pharmacy to put Albumin results on reports with Phenytoin and adjusted for Phenytoin Albumin results. Following an incident with a pharmacist error in calculation of the equation, all Phenytoin results also add on Albumin so that pharmacists can calculate it if they want to. This was not an issue for any other Labs
- The group agreed that not having a joint meeting had enabled more in-depth discussion of Biochemistry issues. RP suggested it may be useful to collaborate with colleagues from haematology in the work stream sub groups, outside of the main NAG meetings.
- IBMS CPD Certificates were available

Actions

- AH to discuss genetic testing consent issues with Rob Elles
- AH to discuss options of genetic testing for FH with Mike Frayne and Paul Durrington.
- All labs to implement initial FH recommendations 1.1.3 and 1.1.5.
- Explore use of existing computer systems – GF/GB for Telepath and AH/SG for Masterlab
- All to collate information on number of lipid clinic sessions with new patient slots to be reported
- JS to circulate changes to HbA1C reporting documents
- Changes to HbA1C reporting to be put on POCT PAG and Haematology NAG Agendas
- RP to call for interest for sub group on changes to HbA1C reporting
- RP to follow up with GW re: referred test and developing local assay finder
- Members to bring requesting protocols with them to facilitate workshop discussion at the next meeting

Recommendations to the Greater Manchester Pathology Network Board (if any)

- None

Date and Time of Next Meeting

Monday 23rd March, 2009, One Central Park, Manchester. M40 5BP