

**Greater Manchester Pathology Network – Network Advisory Group – Meeting Notes/Report**

**Haematology NAG**  
**Douglas Suite, Bredbury Hall, Osborne Street, Bredbury, Stockport, SK6 2DH**  
**Tuesday 17<sup>th</sup> November 2009 11.00am - 1.00pm**

In attendance		Apologies		
Michelle Brereton	MB	Central Manchester NHS Foundation Trust	David Alderson	Trafford Healthcare NHS Trust Royal
Susan Clark	SC	The Christie NHS Foundation Trust	Tony Cumming	Central Manchester NHS Foundation Trust
David Hamer	DH	Royal Bolton Hospital NHS Foundation Trst	Mike Dennis	The Christie NHS Foundation Trust
Keith Hyde	KH	Central Manchester NHS Foundation Trust	Michael Heaton	Pennine Acute Hospitals NHS Trust
Neil Jenkinson	NJ	GM PCTs	Roy Kettle	Central Manchester NHS Foundation Trust
Laura Kidd	LK	GM PCTs	Neil Laurie	Trafford Healthcare NHS Trust Royal
Peter Kinsella	PK	Royal Bolton Hospital NHS Foundation Trst	Gwynne Lloyd	Stockport NHS Foundation Trust
Lynn O'Connor	LO	Tameside Hospital NHS Foundation	Andrew Will	Central Manchester NHS Foundation Trust
Rachel Pearson	RP	GM PCTs		
Roman Pylypczuk	RPy	Salford Royal NHS Foundation Trust		
David Rowlands	DR	UHSM NHS Foundation Trust		
Jeff Seneviratne	JS	GM PCTs		
Nick Telford	NT	The Christie NHS Foundation Trust		
Stephen Voysey	SV	Collinson Grant Healthcare		
Colin Wallbank	CW	WWL NHS Foundation Trust		

**Discussion Points**

- **Welcome and Introductions** – DR welcomed everyone to the meeting and the group members introduced themselves for the benefit of Stephen Voysey from Collinson Grant Healthcare.
- SV thanked DR for his attempts to keep the eRoom thriving and explained the idea of today is to explore in detail the main challenges set to the Network including describing what an appropriate model of service may look like, describing a hub and spoke service and 5 key quality metrics.
- **National Context** – SV explained the economic challenge of 15-20% cost and efficiency savings set to the NHS. Lord Carters report indicated that between £250- £500 million can be saved within pathology services nationally. The Treasury have taken Carter's methodology to be robust and have already banked the savings. Carter stresses that £250 million in cost savings can be attributed to cost reduction alone. The other £250 million will come from reconfiguration. Cost savings in the care pathway will be welcomed and considered but the actual savings must come from pathology. SV stressed that the invest to save argument will be listened to sympathetically but a solid case will be required. There are 10 SHA's so in theory that's a saving per SHA of £50 million. DR asked why pathology has been picked. SV explained that pathology has been picked as Carter has already done his homework on pathology services and it can be used as a test bed.
- Other options include tendering and if this is distasteful then we need to complete this exercise and give an option appraisal to CE's. KH commented that it is no secret that Serco have shown an interest in GM and also informed the group that at the Harmony meeting last week Ian Barnes had opened the meeting and gave his clearest message regarding the centralisation of pathology services. Jim Easton had also quoted "centralisation of pathology services a virtual certainty." KH stated that we as a Network can keep the NHS as the preferred provider if we give CE's a list of cost savings and potential reconfiguration models. If the CE's do not wish to pursue this then at least we tried.
- Some members of the group asked for clarity around the mention of Serco. KH and SV explained that Serco is a public sector service company employed to make changes within public sector companies. They have been successful within the prison service. Serco are currently involved in a joint venture with St Guys and St Thomas's and a partnership with Bedford running pathology services.
- KH stressed that TDL are looking to break into the public sector and stressed that the amount of remodelling currently underway at the lab in Salford is not purely for the benefit of CATS.
- DH enquired why the private sector will be cheaper and SV explained that someone will undercut everyone else to break into the market. They will make a loss to get in the door. DH enquired if Serco or TDL could deliver the service without taking over the current NHS manpower. JS commented that it will be seen as a joint venture not a take over.
- The group revisited the reason for the feasibility study and NJ confirmed the need to come up with a palatable solution to both sets of CE's so we can implement a 3-5 year plan. RPy asked for clarification concerning the savings made further down the patient care pathway. SV reiterated that although the Treasury welcomes these savings they will not be seen as part of pathology's savings. KH will argue this case later in the day.
- **Network Strategy - 20:20 Vision – Facilitated Workshop** – SV asked the members to split into 2 groups and discuss two different service models. He asked one group to look at a central lab (hub & spoke) and the other to look at sectorisation.

- **Group 1 Feedback** – The group discussed sectorisation and suggested what to centralise, e.g. some or all the work, training, management, which services, disciplines i.e. blood sciences. How will savings be apportioned across all labs? There is a need to look at demand management, Lean, IT, transport and direct to patient resulting. The group suggested that 40 – 60% of OPD/GP work is sent to the central lab direct from GPs. This is do-able but on the negative side there is the effect on staffing at the edges and the effect on TAT's. Where would the saving be as staff and equipment would still be needed at the edges? The group also raised the issue of sample quality if this model was applied across GM. Moving specialist cold work to several centres would mean moving staff around but could also mean the loss of expertise at the edges. Quality metrics to measure could be TAT, costs/productivity, user satisfaction, staff satisfaction and accreditation/compliance. The group agreed that the implication of centralised management scares most people.
- **Group 2 Feedback** – The group explored the idea of a hub and spoke model and suggested that the non urgent and primary care work could be carried out at the hub and the spokes would retain the urgent work. POCT could be used by GP's for anticoagulant and A & E. The group discussed the hub housing all or some of the specialisms. Harmonisation of protocols, equipment and procurement would be a prerequisite as would comparability of results and this could result in less testing. Staff would need to be flexible and the risks could be morale and training as staff could feel isolated. The group also discussed if the spokes would be financially viable. The group suggested TAT's, user/customer satisfaction, cost per test, quality EQA and appropriateness of testing as quality metrics. The group felt the pros and cons were similar to the sectorisation/centralisation model. JS enquired what clinical services on site determine the need for transfusion e.g. maternity and A&E. The group agreed it is do able to not have transfusion on site but SC explained you are constrained by the TAT expected on various tests from your individual trust. SV commented that off all the disciplines Microbiology feels they have the biggest opportunity to centralise as samples can be incubating whilst travelling. DH commented that sometimes standardisation of pathways and protocols can be a negative thing as sometimes one size does not fit all where labs are concerned. Patient population can suffer at a particular site as a result of a network deciding which tests should be done where.
- **Next steps & Timescale** – NJ explained that the September and November NAG meetings have generated a range of options. These options will go to CE's in January 2010 when the Network will be given the agreement/non-agreement to go ahead with economic modelling. If successful January – April 2010 will be the period to best decide the model for future service delivery. The options need to be palatable to both sets of CE's and the CE's will provide the resources for the economic modelling.
- **Any other business -**
- **3.1 Notes of meeting held on 8<sup>th</sup> September 2009** – The minutes were agreed as a correct record and there were no matters arising.
- **3.2 Chair's communications** – There were no communications
- **For Information:**
- **PAG 4** – DR explained that the PAG 4 group decided to carry out a workforce questionnaire to determine what the current workforce issues are within pathology. DR asked for everyones co operation in completing the questionnaire. RPY enquired if anyone with the group is using the DoH workforce tool? The group had mixed feelings.
- DH brought up Keele benchmarking and stated his unhappiness at being coerced into taking part despite reservations about the relevance of the information gained. DH pointed out that Bolton including the CE never agreed to take part in the benchmarking and the Network is shooting itself in the foot by forcing CE's into benchmarking. KH reiterated that it is nearly Christmas now and still need metrics. No one has had a better idea and NJ stressed that due to tight timescales the Network did not have time to produce its own survey. KH reminded the group that everyone spent 6 months arguing and discussing benchmarking. NJ stated that the use of Keele is simply to collect something then the relevant information can be extracted. KH accepted the unrest and dissatisfaction of the Network members over this issue but again reiterated no other solutions had been forthcoming. JS reminded the group for the need to collect workforce, finance and activity data, and argued that there would be disagreement about how activity is counted whatever data collection tool was used. DR stressed the difficulties of getting collaboration with GM. DH stressed he would like the previous minutes amended to show that members of this group specified they did not want to take part in Keele benchmarking and the group felt sure the Network could produce their own data collection survey.
- **Chair & Vice Chair** – DR reminded the group that volunteers are needed to take over from DR when he retires in January 2010. LK will email asking for volunteers again.
- **IBMS CPD** – certificates were available.

#### Actions

- All members to complete workforce questionnaire
- LK to email the group for chair and vice chair nominations

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

- None

**Date and Time of Next Meeting**

- Monday 18<sup>th</sup> January 2010, 2pm – 4pm, One Central Park, Manchester, M40 5BP

**Option Appraisals -  
Haematology**



<b>Benefits</b>	<b>Risks &amp; Disadvantages</b>
<ul style="list-style-type: none"> <li>➤ Training</li> <li>➤ Management</li> <li>➤ Better opportunities for staff to specialise due to relocation</li> <li>➤ Harmonisation</li> <li>➤ Single procurement</li> <li>➤ Less testing</li> </ul>	<ul style="list-style-type: none"> <li>➤ Recruitment/retention and staff morale</li> <li>➤ TAT's</li> <li>➤ Staff and equipment needed at spoke labs</li> <li>➤ Sample quality</li> <li>➤ Loss of expertise at spoke labs</li> <li>➤ Training</li> <li>➤ Financial viability of spoke labs</li> </ul>
<b>Constraints</b>	<b>Prerequisites</b>
	<ul style="list-style-type: none"> <li>➤ Harmonisation of protocols</li> <li>➤ Comparability of results</li> </ul>
<b>Key metrics</b>	
<ul style="list-style-type: none"> <li>➤ Customer/user satisfaction</li> <li>➤ Turn-around time</li> <li>➤ Costs/productivity</li> <li>➤ Staff satisfaction</li> <li>➤ Accreditation/compliance</li> <li>➤ Appropriateness of testing</li> </ul>	