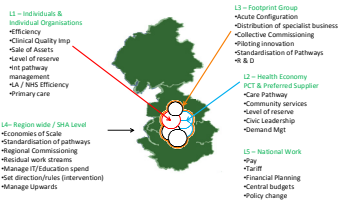


Slide 2

**Accountability Framework**  
"Each level does what only it can do"



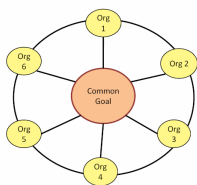
Slide 3

**Contribution to Efficiency and Productivity Gain**

Year --	1	2	3	4	5
Levels	1	1	1	1	1
↓	2	2	2	2	2
↓	3	3	3	3	3
↓	4	4	4	4	4
↓	5	5	5	5	5

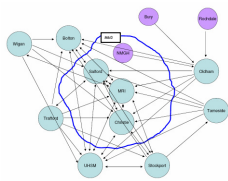
Slide 4

**Necklace Model**



Slide 5

**Pathology referrals across Greater Manchester**



Slide 6

- Slide 2 highlighted the Trends in NHS expenditure since 1948. JS explained that the green bar shows the predicted expenditure for 2011 onwards. RPy mentioned that this has been interpreted at SRFT as each NHS employee needs to save £3,000 per person per year.
- Slide 3 shows a whole system approach and demonstrates this in 5 levels.
  - 1 – Individual organisation
  - 2 – Health economy e.g. PCT and local provider
  - 3 – Footprint – the SHA is divided into 7
  - 4 – SHA
  - 5 – National
 It is estimated that the savings to be made across this footprint group is £950 million. Slide 4 shows efficiency and productivity gain over the next 5 years and level 3 (collaborative working) will give the largest increasing contribution year on year.
- Slide 5 demonstrates a necklace model which is a group of organisations working together towards a common goal. This is currently what is happening across GM with the Pathology service and the 20:20 emerging vision work.
- Slide 6 shows the current movement and activity regarding pathology referrals across GM.

- JS explained that the group now needs to focus on continuum of service provision. JS explained that a sector model could be based upon Pennine which has been road tested on a smaller scale. JS informed the group that Len Fielding, Lab Manager at Pennine gave a presentation to the Strategy group which demonstrated the significant savings achieved. JS asked the group not think in geographical terms as this immediately applies constraints. JS asked the members to look at what potential reconfiguration of services would mean for Haematology, and expressed his awareness that several PCTs are looking to remove Primary Care services altogether. JS asked the members to think about what the loss of this work would also mean.

- RPy enquired if there is a feeling within the CEs of individual ownership of their Trusts pathology services or of collective ownership. JS commented that there is probably variation in feeling regarding this but reiterated that this problem cannot be solved at level 1 or 2 and reminded the group of the need to work collaboratively at level 3.
- The group discussed that whichever models and preferred options are looked at be it centralisation to 1 site or centralisation within sectors the following will need to be investigated, discussed and agreed upon:
  - Central Services Laboratory
  - Essential Services Laboratory
  - Point of Care Laboratory
  - Point of Care Testing
- The group discussed the terminology used and felt that Central Services Lab should be Reference Lab; Essential Lab should perhaps be Local Lab and agreed that POCT for Haematology is mostly anticoagulation. The group agreed that when referring to centralising services this could refer to either the centralisation of all services to one site or equally to the centralisation of a particular service or test to a central site. The group also agreed the service should be a 24 hour service. DR asked members to try and agree essential on site services and suggested all of blood bank, all A&E and all inpatient Haematology. Services to be centralised could include outpatients, GP work, Immuno assays, A/Cs and haemoglobinopathies. MB said that some outpatient investigations required a quick TAT and should be deemed 'essential'.
- Bolton Trust has clearly stated that tests should be repatriated if it is cheaper and TAT's are quicker. UHSM send work outside GM as it is cheaper. Pennine enquired how repatriation of work can be considered cheaper when equipment needs to be procured. The group commented that surely central services should be charging marginal costs due to high volume of work and to encourage users. Pennine suggested would it not be better to know what current costs/charges are. JS confirmed that the Network is trying to collect that information. SC commented that it is hard to move forward without knowing how the savings will be apportioned across the Trusts.
- The group were concerned about deciding what services are essential or non essential as this could lead to assumptions about staffing levels being made. JS pointed out that if we only discuss benefits to individual Trusts we will never move on. Members talked about the possibility of centralising Haematinics due to the required TAT and DH commented that it is quicker to just carry out the test rather than fill out new request forms and arrange transport. DH also pointed out that if Bolton stopped Haematinics the lab's large expensive analyser would not be fully utilised. Procurement is based on potential capacity so it would not be replaced in 5 year. RPy pointed out that this is a 5 – 15 year plan. JS commented that with the breakthroughs in IT and the introduction of GP Order comms request forms will be eliminated. RPy enquired if the group felt it essential for Transfusion to be an on-site service? RPy stated it does not matter how far away the lab is as long as the TAT is achieved. DR commented that at UHSM A&E is a quarter of a mile away and there is unhappiness. RPy stressed that at SRFT maternity is also a quarter of a mile away but still in the same building.
- JS commented that there is no getting away from the fact that 20% savings may need to look at a reduction on staff. JS acknowledged this is the most unpleasant aspect of reconfiguration but reminded the group the original aim of the project was to steer our own destiny rather than have things done to us. External consultants may come in and, rightly or wrongly, we may end up with a shed on the M60 as it will be seen to be the cheapest option.
- JS explained the need to include quality metrics into the CE document. There is a need for them to be generic rather than discipline specific. DR reminded the group that the 5 key metrics need to be within the Darzi parameters of Safety, Outcomes and Patient Experience. JS suggested metrics around improvement of IT connectivity. Metrics around the clinical interface have been suggested and RPy enquired how you measure this? JS suggested looking at previous statistics and measuring the improvements, for example looking at the number of times a patient is bled. RPy confirmed Salford is investigating this currently under inappropriate testing.
- The group discussed the Pennine 4 hour rule of thumb and RPy pointed out that Andrew Foster CE of WWL had suggested 2 hours. Members mentioned that some Outpatient units are changing and becoming a one stop shop. Elective patients attend for pre ops and doctors require results ASAP for same day admission decisions to be made. DH commented that it is cheaper to do testing in-house and harder to separate out the work to be sent away. DH also stated that customers need to be consulted before services are redesigned. The customer may request a test to be carried out on site that the lab has just relinquished the capability to carry out. RPy stated that clinical services should not be redesigned without involving pathology.
- After a lot of discussion there remained great differences of opinion within the NAG.
- **Any other business –**
- Harmonisation – JS explained that there are very few Haematologists involved in the harmonisation of reference ranges and units. Andrew Will has written to JS with regard to the Paediatric reference ranges. Although the Haematology input is thin on the ground there is a fairly general consensus disagreeing with the use of litres over decilitres. This is now been put back to the Haematology community for further consultation.
- MB gave a quick presentation regarding harmonisation. The information is based upon the responses of 27 Trusts. The results show that the source of the reference ranges is 54% from literature and 27% have been in-house derived. There is

no back up as to where these ranges have been derived from. MB stated that scientifically the wobbles in the reference ranges cannot be justified as labs using the same analysers have different reference ranges but we as a group could reach a consensus. MB informed the group that NHS Wales are currently looking to procure a single LIMS system and also to adopt a single reference range across the country.

- Chair – As the new HAEM NAG Chair RPy took the opportunity to thank DR for his input as NAG Chair.
- Dabigatran – LK explained that the Cardiac Network is looking at a piece of work around the use of new anticoagulation drugs such as Dabigatran within GM. LK asked for assistance from the members present to identify Consultant Haematologists from within the GM Trusts. LK will email members for details.
- IBMS CPD – certificates were not available and LK will post out to members.

#### **Actions**

- Members to email LK with Vice Chair nominations
- LK to email members for Consultant Haematologist contact details re: Dabigatran
- LK to post IBMS CPD certificates to eligible members.

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

- None

#### **Date and Time of Next Meeting**

- Tuesday 16<sup>th</sup> March 2010, 2pm – 4pm, One Central Park, Manchester, M40 5BP