

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

Histopathology / Cytology Network Advisory Group Meeting  
 Tuesday 22<sup>nd</sup> September 2009, 2pm – 4pm  
 One Central Park, Northampton Road, Newton Heath, Manchester, M40 5BP

In attendance			Apologies	
Samer Al-Habba	SA	Pennine Acute Hospitals NHS Trust	Khalid Ahmed	Pennine Acute Hospitals NHS Trust
David Bisset	DB	Royal Bolton Hospital NHS Foundation	Pam Atkinson	Central Manchester NHS Foundation T
Mina Desai	MD	Central Manchester NHS Foundation T	Brian Benatar	Pennine Acute Hospitals NHS Trust
Amanda Eckersley	AE	Pennine Acute Hospitals NHS Trust	Sadhna Bhatnagar	Pennine Acute Hospitals NHS Trust
Karen Graham	KG	The Christie NHS Foundation Trust	Nick Bullough	Tameside Hospital NHS Foundation Tr
Roger Hunt	RH	Stockport NHS Foundation Trust	Neha Dalal	Tameside Hospital NHS Foundation Tr
Keith Hyde	KH	GM Pathology Network	Sudha Desai	Salford Royal NHS Foundation Trust
Neil Jenkinson	NJ	GM Pathology Network	Najib Haboubi	Trafford Healthcare NHS Trust
Richard Lambert	RL	Pennine Acute Hospitals NHS Trust	Richard Hale	Stockport NHS Foundation Trust
David May	DM	Tameside Hospital NHS Foundation T	Cath Hall	Central Manchester NHS Foundation T
Lorna McWilliam	LM	Central Manchester NHS Foundation T	Miles Howe	UHSM NHS Foundation Trust
Rachel Pearson	RP	GM Pathology Network	Yvonne Hughes	Central Manchester NHS Foundation T
Paul Purnell	PP	UHSM NHS Foundation Trust	Laura Kidd	GM Pathology Network
Michael Scott	MS	UHSM NHS Foundation Trust	Lia Menasce	The Christie NHS Foundation Trust
Jonathan Shanks	JS	The Christie NHS Foundation Trust	Melanie Newbould	Central Manchester NHS Foundation T
Kanwal Sikand	KS	The Christie NHS Foundation Trust	Mark Pearson	Royal Bolton Hospital NHS Foundation
Daniel Smith	DS	Stockport NHS Foundation Trust	Richard Pope	Central Manchester NHS Foundation T
Denise Smith	DSm	Royal Bolton Hospital NHS Foundation	Madhu Rao	Pennine Acute Hospitals NHS Trust
Stephen Voysey	SV	Collinson Grant Healthcare	Craig Rogers	WWL NHS Foundation Trust
Godfrey Wilson	GW	Central Manchester NHS Foundation T	Rajagopal Saravana	Stockport NHS Foundation Trust
			Jeff Seneviratne	GM Pathology Network
			Ann Taylor	Royal Bolton Hospital NHS Foundation
			Malcolm Timmins	Stockport NHS Foundation Trust
			David Walsh	WWL NHS Foundation Trust
			Alan Webster	UHSM NHS Foundation Trust
			Tom Wilson	Pennine Acute Hospitals NHS Trust
			Anne Yates	Salford Royal NHS Foundation Trust

### Discussion Points

- DB welcomed the group to the meeting. All members introduced themselves for the benefit of Stephen Voysey from Collinson Grant Healthcare.
- **Network Strategy Group** - SV gave a presentation and explained that between now and December the NAG groups will be discussing options to meet the objectives posed to the Network by the CEs. SV explained that after this meeting Collinson Grant will launch the E Room. Each member of the group will receive an email invitation to join the E Room. Members can edit their details and change their passwords. Each week a new topic for discussion will be posted in the E Room. The E Room can be accessed at <https://www.collinsongrant.com/eroom/clients/GMPN>
- If any changes are made to discussions in the E Room members will receive an email alert. Any members wishing to comment on a topic/discussion anonymously must email SV directly at [svoysey@collinsongrant.com](mailto:svoysey@collinsongrant.com)
- SV explained that the E Room houses a folder for each of the NAG disciplines. Those present agreed that it would be best if all folders were open to everyone. SV explained that the NAG distribution list had been used as a starting point for the eRoom membership. If additional consultant or scientific staff would like to join the eRoom they will need to contact RP who will be able to pass on their contact details.
- MD asked when the NAGs would receive feedback from this session and the eRoom discussions. SV explained that a summary would be presented to the next meeting of the Strategy Group on 22<sup>nd</sup> October 2009. KH requested that the NAG chairs present a summary for their discipline to the Strategy Group.
- **Future Service** - SV commented on the drive towards consolidation of cervical cytology services following the recommendations of the SCHARR report that labs should screen a minimum of 35,000 samples per year. There was some discussion around the technological changes that will impact on cervical cytology e.g. ARTISTIC and MAVARIC trials. RL suggested that following semi-automation service configuration is likely to be linked to the capacity of the machines. MD highlighted the government pressure to achieve a 14-day TAT for cervical cytology and skill mix issues arising from this. DB explained that this service is currently the subject of a tendering process.
- GW felt there were three elements of quality in the service that histopathology provides to clinicians: 1) Correct diagnosis – clinicians assume this is correct; 2) Timeliness of report (TAT) and 3) Appropriate liaison between the lab and clinician. SV asked whether it was necessary or possible to improve these by 20%. LM emphasised that the 20% target was aspirational and GW felt that TAT was the only easily measurable aspect of quality. DB recognised the difficulty of

identifying potential savings but gave the example of Quest who have the contract for cervical screening for the Republic of Ireland and expect their screeners to screen 60 slides per day; in Greater Manchester the average screened by each screener is under 30.

- MD felt it was important to consider non-gynae cytology separately from cervical cytology and highlighted the existing successful model in Greater Manchester.
- DB highlighted the conflicting pressures for cellular pathology. On the one hand there is a call to move closer to the patient, whilst on the other is the drive towards a smaller number of larger laboratories. The latter has a particular impact on MDT meetings. The pressure to be close to the patient is particularly acute in non-gynae cytology, with a requirement to get the results back whilst the patient is at the clinic. DB also argued that the work of the lab reflects the clinical services at the Trust, and that there has been a large impact from the major reconfiguration of cancer services in the region.
- DB felt it is preferable to have processing and reporting carried out in the same place.
- **Technology** - DB emphasised that cellular pathology is different from other laboratory disciplines in that there is very limited automation of the key steps of the process i.e. cutting of sections, handling of specimens and microscopic examination.
- Methodological developments e.g. IHC and molecular diagnostics tend to be expensive and do not remove the need for traditional histopathology. Rather, they provide the pathologist with more information to produce a more detailed report for the clinician. DB explained that histopathology reports have become increasingly detailed over time e.g. Breast cancer receptor/HER2 status and reports for lymphomas. This additional information can help to support more targeted treatments.
- There was some discussion around immuno staining. SA highlighted the immuno staining department at UCL which offers over 400 antibodies at a reasonable cost. There was some discussion about the possibility of a similar service being established in Greater Manchester or the North West.
- MD highlighted the problems of implementing LBC technology for non-gynae cytology.
- GW felt that it would be greatly beneficial to have harmonised IT across Greater Manchester, given the constant exchange of information required across cancer patient referral pathways. LM agreed that it would be better if all labs were on the same system and could share reports and welcomed the project to develop a business case for the procurement of a single laboratory IT system for Greater Manchester. MD added that this was also an issue for cervical cytology, where the histology report is necessary for future patient management.
- Members felt that digital imaging was not appropriate for diagnosis but agreed that it was an essential tool in education and the support of MDTs. KH suggested that digital imaging technology may develop sufficiently over the next 5-10 years to be more widely used in histopathology.
- GW raised the issue of electron microscopy. The instrumentation is expensive and a major capital investment is required. Whilst EM was overtaken by IHC for most areas, it is still a requirement for renal and muscle tumours.
- **Demand** – DB suggested that there is likely to be an increase in the use of molecular diagnostics across a whole range of tumours to support targeted treatments. DB felt this would add quality, but also significant cost.
- DS highlighted changes which make savings elsewhere in the patient pathway but not in the laboratory e.g. change from urine cytology to new test.
- DB highlighted the pressure towards specialisation e.g. bowel cancer screening requirement that no more than 3 histopathologists reporting from any one lab. GW agreed that demand for sub-specialisation has been driven by the changes in cancer services and the Improving Outcomes Guidance. GW felt that sub-specialisation ensures good clinical liaison and a tailored service between the histopathologist and clinician. DB was concerned that this specialisation means each pathologist seeing less biopsies, thereby making each biopsy more expensive, highlighting the differences in the number of consultant histopathologists at labs in Greater Manchester, working on similar numbers of biopsies. However JS argued that there is some evidence to show that sub-specialisation actually increases efficiency, as the pathologist has greater knowledge. He argued that maximum efficiency could be achieved by sub specialist teams working on a mix of simple and complex cases across a larger geography. GW felt that a networking arrangement would be necessary to ensure the best service for some of the smaller sub-specialisms.
- KH asked the NAG to consider the impact of the loss of primary care work (up to 20% of workload) and the loss of work being seen through IS CATS (targeting up to 40% of outpatient activity). Members felt that this work was high volume but low in terms of cost and effort. It is not clear what this work represents in terms of laboratory income.
- **Workforce** – members identified problems with succession planning, particularly for specialist areas.
- MD commented on the difficulties of recruiting specialist consultant cytopathologists and of the introduction of advanced practitioners in cytology.
- PP commented that BMSs are beginning to take on some of the roles of consultants, especially cut up. As yet this has not saved consultant costs, but has freed up their time e.g. to attend MDTs. The problem for many sites is that they do not have the time to train BMSs to take on additional roles. KH suggested that appropriate training could be commissioned by the SHA workforce planning group if the NAG described the roles needed to support the cancer plan.
- Members felt that the consultant histopathologist should retain ultimate responsibility for cut up and that all consultant histopathologists should do enough cut up to maintain competence and be able to teach others.

- DB suggested that specialisation increases consultant staffing requirements, but others argued that it would be sensible for there to be a network of cover across a number of sites.
- LM highlighted staff as the major cost for histopathology and that there is an ongoing requirement for more staff, including to meet CPA requirements.
- **Other issues** – KH reported that he recently met Jonathan Marron (Policy Director, Monitor) who felt that 20% savings was appropriate in the economic context and that if the Network doesn't do it; someone will do it for us.
- DB argued that Trust CEOs would not wish to give up control of their pathology departments, as the departments are necessary to allow them to meet cancer targets.
- DB suggested that there may be different solutions for different disciplines. He felt that networks are most effective where all members have equal status, which he does not feel to be the case in Greater Manchester.
- PP expressed concern that the service will be forced to consolidate. KH reminded members of the economic situation and this work as an opportunity for labs to control their own destiny. If labs do not describe a model of services for the future it will be left to market forces or 'chaos theory'. DB felt members should take cervical cytology as a learning point – if an agreement could have been reached we may have avoided tendering.
- GW reported on the benefits of having a service improvement project manager, who overviewed all processes in the department and every step in these processes. These have improved, with a substantial improvement in TAT as a result of having staff at all levels (clinical/technical/admin) working closely together.
- MD reported that MRI and Pennine have been national pilot sites for Lean in cervical cytology and have seen great improvements in TAT.
- DB thanked members for their contributions and encouraged members to continue discussions via the E Room.
- **Minutes of the meeting held on 30<sup>th</sup> July 2009** – The minutes were accepted as a correct record.
- **GM Cytology Tender** – DB reported that he had written to Mike Burrows but not received a reply. He did however receive a copy of the letter from the SHA to Cheshire and Merseyside which stated that the SHA will not support C+M decision not to tender.
- NJ confirmed that the tender is going ahead and that the process will be outlined at the next meeting of the Network Board on 2<sup>nd</sup> October 2009. NJ confirmed that there is extensive Network representation on the steering group, whose members include: Elaine Whitby, Lesley Turnbull, Mark Chidgey, Rachel Pearson, Jeff Seneviratne, Neil Jenkinson, Steve Downing and Mike Burrows.
- The advert/PQQ will be published soon; there is no confirmed timeframe for this at present.
- NJ highlighted a number of issues around describing the whole pathway.
- DB emphasised the need to reach a solution as soon as possible given the current issues around staffing and particularly the end of the processing contracts. NJ agreed that transitional arrangements will be vital.
- **Trafford Histopathology Tender** – DB reported that he had written to Ron Calvert (CE, Trafford Healthcare NHS Trust) and received a lengthy reply explaining why the service had to be tendered: the Trust is in formal turnaround with the SHA and Histopathology at Trafford is a significant national outlier in terms of cost. The tender has now gone out and the advert can be viewed at the following link: <http://www.hsj.co.uk/home/tenders/expressions-of-interest-provision-of-a-full-histopathological-and-cytopathological-service/5006135.article>
- DB felt that the Network is at risk if more Trusts tender their services.
- **Any Other Business** –
- KH encouraged members to attend the Primary Care Listening Event on 7<sup>th</sup> October, or at least to submit posters on quality improvements.
- DB reported that David Walsh is leaving Wigan to take up a post at Whiston Hospital. DB expressed thanks for David Walsh's contribution to the service and the Network.
- IBMS CPD Certificates - were available

#### Actions

- Any additional eRoom members to pass their contact details to RP

#### Recommendations to the Priority Action Groups (if any)

- None

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

- None

#### Date and Time of Next Meeting

- Friday 13<sup>th</sup> November 2009, 2pm-4pm, One Central Park, Northampton Rd, Manchester M40 5BP