

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

Microbiology/ Virology/ Mycology NAG  
G54, One Central Park, Northampton Road, Newton Heath, Manchester M40 5BP  
Friday 16<sup>th</sup> January 2009, 2pm – 4pm

In attendance			Apologies	
Reeta Burman	RB	Pennine Acute Hospitals NHS Trust	Eric Bolton	HPA NW/ CMMC NHS Trust
Ivor Cartmill	IC	Pennine Acute Hospitals NHS Trust	Peter Chadderton	Royal Bolton Hospital NHS Foundation Tr
Andrew Dodgson	AD	CMMC NHS Trust	David Ellis	HPA NW/ CMMC NHS Trust
Ed Kaczmarek	EK	HPA NW/ The Christie NHS Foundation T	Wayne Goddard	Trafford Healthcare NHS Trust
Camelia Faris	CF	WWL NHS Foundation Trust	Keith Hyde	CMMC NHS Trust
Barzo Faris	BF	Trafford Healthcare NHS Trust	Azhar Iqbal	Royal Bolton Hospital NHS Foundation Tr
Rizwan Khan	RK	Royal Bolton Hospital NHS Foundation Tr	Barbara Isalska	UHSM NHS Foundation Trust
Richard Mallard	RM	HPA/ CMMC NHS Trust	Neil Jenkinson	GMPCTs
Sarah Maxwell	SM	Stockport NHS Foundation Trust	Naeem Khattak	Pennine Acute Hospitals NHS Trust
Rachel Pearson	RP	GMPCTs	Hari Panigrahi	Pennine Acute Hospitals NHS Trust
Maurice Sidorczuk	MS	Pennine Acute Hospitals NHS Trust	Tina Tennant	Royal Bolton Hospital NHS Foundation Tr
Sue Spilsbury	SS	Stockport NHS Foundation Trust	Andrew Turner	CMMC NHS Trust
Chinari Subudhi	CS	Salford Royal NHS Foundation Trust	Emma Watson	Stockport NHS Foundation Trust
Peter Taft	PT	Salford Royal NHS Foundation Trust		
Moira Taylor	MT	Stockport NHS Foundation Trust		
Philip Unsworth	PU	Tameside Hospital NHS Foundation Trust		

### Discussion Points

- RB welcomed the group, particularly Dr Subudhi who would now be representing SRFT in place of Paul Chadwick.
- **Chair's Communications** – RB explained that the last Network Board meeting was held on 12<sup>th</sup> December 2008, prior to the publication of the second Carter report, and attended by Dr Ian Barnes (National Clinical Lead for Pathology). Ian Barnes had explained that within the Department of Health a Diagnostic Programme Board has been established. As part of this there is a Pathology Delivery Plan and a wide range of projects/working groups including:
  - Pathology Programme Board
  - Pathology Partnership Group
  - Action Learning
  - Service Improvement
  - Clinical Leadership
  - Accreditation
- There was some discussion at the Board about a potential loss of local responsiveness arising from consolidation. Ian Barnes explained that the Carter recommendations are not a mandate and that any consolidation would be by local determination. Keith Hyde felt that the Network was in a strong position to pilot some of the Carter recommendations.
- SM reported that the economies of scale mentioned in the second Carter report had been a major talking point at the recent ACP council. In particular there could be a tension between a move towards larger labs alongside a shift to more pathology in the community. The feeling at the ACP council was that without local labs there could not be the same relationship with the community and this may have an impact on the quality of pathology in the community.
- One of the proposals in Carter is for a formulary of tests so that GPs know what tests are available and when and how they should be used. RP explained that this is not the same as the National Catalogue for Pathology which is an NPFIT project to map pathology tests to SNOMED codes and standardise test names. RB felt that the NAG should develop a Greater Manchester test formulary as a key project for 2009. It was recognised that this would be a major piece of work but agreed that it would be useful to have common pathways. As a first step it was agreed to share 'How to do it' documents and SM agreed to lead on this.
- **Notes of 28<sup>th</sup> November 08 Meeting** – Agreed as a correct record.
- **Matters Arising** – the following matters were raised:
- Meetings in 2009 – RB explained that the meeting scheduled for 15<sup>th</sup> May 2009 may need to be rearranged.
- **Red Cells Reporting/Reference Ranges for Urine** – BF explained that the reference ranges on the UF100 were based on the local population and that there were variations in the 'normal' range e.g. Trafford 0-26 is normal; Pennine 0-35, whilst the view of urologists is that if the red cells in urine value is more than 5 to look for a haemorrhage. PT highlighted that reference range could be significantly affected by the use of boric acid. Members agreed that it was essential to involve urologists in the interpretation of results. MS explained that the lab at Pennine had sent a translation table to all GPs and wards and agreed to send this to RP for circulation
- RB explained that there are NICE and SIGN guidelines which give a clear indication of when GPs and paediatricians should refer patients to a urologist. She agreed to look up this paper and send it to RP for circulation.
- BF had seen a good presentation by haematologists and agreed to send this to RP for circulation.

- **TB Service Specification** – this was agreed by members and could now be submitted into the PIR process. This is the Association of GMPCTs 3-5yr plan for all spending on GM-wide projects, including work identified by Networks as well as Chief Executives and Directors of Public Health, Commissioning and Finance. All proposals for investment must go through this process. PIR is looking at major investments and strategic direction. There are over 140 projects under consideration and hundreds of millions of pounds worth of investment with the top 40 projects receiving funding.
- RB thanked members for completing the original audit and for their comments on the service specification.
- **C Diff testing guidelines** – RB had reported to the Network Board that these were in development.
- AD thanked all who have contributed to the development of the guidelines, particularly Mairi Cullen who started the work before going on sabbatical. AD thanked members for their comments on the draft guidelines, which were now intended to be aspirational, rather than a minimum standard.
- RB informed members of a recent DH publication: 'Clostridium Difficile infection: How to Deal with the Problem' – this qualifies the definition of a recurrence. The major headings in this DH document are covered in the testing guidelines developed locally and AD agreed to cross reference both documents. The DH document is available to download from: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093220](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093220)
- A number of Trusts use the Waterlow score and capture over 75% CDT patients in this way. It was agreed that the risk factor 'high Waterlow score' needed to be qualified and CS agreed to send information on this to RP.
- The use of a chlorine containing agent for routine cleaning is not in the new DH document and BF highlighted complaints from his local estates department that chlorine containing agent should not be used in areas that are not well ventilated. It was agreed that the use of a chlorine containing agent should be considered for routine cleaning.
- Antibiotic stewardship - BI had made some comments which had been incorporated: 'If safe to do so, either avoid the use of antibiotics or give a short course of a narrow spectrum/low CDI risk agent'. PU highlighted that his colleague Howard Sacho was pressing for a reduction in the use of antibiotics across the board. A number of Trusts are using stickers in patient notes to prompt antibiotic review.
- There was some discussion on defined daily doses (DDD). This is not generally available on a ward level. MT explained that at Stockport they get the costs of antibiotics and pharmacy audit points of prevalence on a quarterly basis.
- Education and Training - RK explained that at Countess of Chester CDT 'Roadshows' were set up, initially for hospital staff but later extended to GPs. These would take half a day, involve gastroenterologist colleagues and cover CDT infection, antibiotic stewardship and infection control culminating in a quiz to test learning. RB liked this idea.
- Also at Countess of Chester there were a number of awareness programmes using an ACTION card (c.f. Board to Ward SIGHT), where ACTION stands for: antibiotics, clean, treat, isolate, observe and nutrition. RK agreed to send a copy of this to RP for circulation
- Visitors – AD explained that recommendation on children not visiting patients with CDI was a recognition of the fact that children may have less effective hand hygiene than adults, rather than that they are at greater risk of infection.
- Laboratory testing methods/QC – it was agreed to remove 'QC' as it is not mentioned; though it was recognised that QC does need to be addressed. PT highlighted the challenges of QC given that levels of CDT are not consistent within a sample. SM highlighted that a report on internal QA is due from Prof. Mark Wilcox (Leeds).
- It was agreed that laboratories should carry out CDT testing 7 days a week and report results within 24hrs of receipt (not collection) of the sample.
- Identification of severe disease – AD explained that the guidelines identify a number of clinical markers and whilst Trusts have the discretion to choose their scoring system, they must have one in place. RB suggested that it would be useful to get gastroenterologist colleagues involved earlier and BF explained that at Trafford they are trying to develop a team including microbiologists, pharmacists and gastroenterologists to review severe cases.
- Treatment of CDI – AD explained that this was one suggested algorithm and was not definitive. Treatment algorithms are given on p33 of the new DH document.
- RB referred members to an article in the Journal of Antimicrobial Chemotherapy 2007 59 (4) Musher, D.M. et. al on the response to nitazoxanide where conventional metronidazole therapy has failed see: <http://jac.oxfordjournals.org/cgi/content/full/59/4/705>
- RB felt that it may be useful to collate data on who is using intravenous immunoglobulin for severe/recurrent CDI
- RK asked members if they had any experience of using faecal catheters/flexiseal which can help contain spores. AD felt that they can improve dignity and CS and BF reported giving intracolonic vancomycin (500ml clamp and lock for 30mins three times a day) through a bowel management system with some success. BF highlighted some challenges with monitoring.
- EK asked members about the use of faecal transplants, which would usually come from a family donor and be screened for blood borne viruses. EK suggested that Prof. Mark Wilcox felt that faecal transplants should be used over IVIG.
- Outbreak definition – AD explained that it was up to individual Trusts to define this.
- Reporting of deaths from CDI – AD highlighted the importance of this as it is mentioned in the new DH document. Members agreed that they should emphasise to junior medical staff who are unsure as to whether C. Difficile contributed to the death of patient to seek the advice of senior colleagues. IC explained that some coroners think that C. Difficile should always be mentioned even where it did not contribute to the death of a patient, which he felt was wrong.

- RB agreed to present these guidelines to the next meeting of the Network Board on 6<sup>th</sup> Feb 09
- **MRSA subgroup update** – a meeting will take place on 10<sup>th</sup> February 09. The membership has been confirmed as follows: Moira Taylor, Emma Watson, Ed Kaczmarek, Richard Mallard, Barbara Isalska, Rob Nelson and Diane Dean. RB suggested it may also be useful to invite Steve Downing to the meeting.
- RB explained that the economic modelling for universal screening carried out by Steve Downing has identified costs in the region of £20m for Greater Manchester
- RB referred members to a DH letter of 21<sup>st</sup> December 2008 which stated that all Trusts should have in place an action plan for universal elective screening by February 2009.
- MT felt it would be useful for the NAG to develop a coordinated approach to screening as this would be better for GPs. There is currently some variation in the number of swabs to be taken.
- RB informed members of an email from AMM that she had received this morning and agreed to forward to RP for circulation.
- **Review of priorities for weekend working** – PT explained that whilst there is increasing pressure to offer a much wider range of services on a 6 or 7 day basis (e.g. MRSA, C.diff, TB) many labs have limited resources for providing a weekend service. IC felt that Saturday should be a normal working day. RB asked PT to devise a questionnaire to audit this issue.
- **NAG priorities for 2009** – RB was very pleased with the progress made on TB and C. Diff. In addition to MRSA and the Local test booklet, members felt it would be useful to receive an update on issues from virology colleagues (e.g. respiratory virology). RB agreed to contact Andrew Turner/Ken Mutton/Paul Klapper to arrange something.
- **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](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_091137)
- **New Products – tried and tested** – PT reported that Binax legionella and pneumococcal kits for rapid test from blood culture are about to be launched.
- MS reported that 3M have withdrawn their BacLite rapid MRSA test
- **PAGS** – the following updates were given:
  - Workforce – A consultation on Modernising Scientific Careers will run until 6<sup>th</sup> March 2009. The PAG are keen to formulate a Network response to the proposals. The PAG are also evaluating a tool to support workforce planning in pathology.
  - IM&T – The PAG are keen to participate in national work to develop an IT strategy for NHS Pathology. GP Order Comms is being rolled out across Greater Manchester and has been very well received, with noticeable improvements in data quality. On the Lab 2 Lab project, all iSoft interface orders have now been placed and negotiations with Clinisys are ongoing.
  - Communications – The website design has now been approved and the site is currently being built. This will include a local assay finder, initially for Biochemistry where the data has already been collected.
- **Any Other Business**
- CPD – IBMS CPD certificates were available. The meetings are not accredited for RCPATH CPD, however RCPATH members can write a reflective note on their learning from the meeting for their CPD portfolio

#### Actions

- Members to bring their 'How to do it' documents to the next meeting
- RB to send paper on NICE/SIGN guidance re: red cells to RP for circulation
- MS to send Pennine red cells translation table to RP for circulation
- BF to send haematologists' presentation on red cells to RP for circulation
- AD to cross reference local C Diff guidelines with new DH document
- CS to send information qualifying 'high Waterlow score' to RP
- RK to send ACTION card re: C. Diff to RP for circulation
- AD/RB - C Diff guidelines to be presented to Network Board
- RB to send AMM email re: MRSA to RP for circulation
- PT to devise questionnaire to audit priorities for weekend working
- RB to contact virology colleagues to arrange a meeting on virology issues.
- Members to send any agenda items for the next meeting to RP

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

- To endorse TB and C Diff guidance

#### Date and Time of Next Meeting

- Thursday 12<sup>th</sup> March 2009, 2pm – 4pm, One Central Park, Manchester, M40 5BP.