

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
Thursday 12th March 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	Andrew Dodgson	Central Manchester NHS Foundation Tr
Peter Chadderton	PC	Royal Bolton Hospital NHS Foundation Tr	Camelia Faris	WWL NHS Foundation Trust
David Ellis	DE	HPA NW/ CMFT NHS Trust	Azhar Iqbal	Royal Bolton Hospital NHS Foundation Tr
Wayne Goddard	WG	Trafford Healthcare NHS Trust	Barbara Isalska	UHSM NHS Foundation Trust
Keith Hyde	KH	CMFT NHS Trust/GMPCTs	Neil Jenkinson	GMPCTs
Ed Kaczmariski	EK	HPA NW/ The Christie NHS Foundation T	Rizwan Khan	Royal Bolton Hospital NHS Foundation Tr
Naeem Khattak	NK	Pennine Acute Hospitals NHS Trust	Hari Panigrahi	Pennine Acute Hospitals NHS Trust
John Mace	JM	WWL NHS Foundation Trust	Maurice Sidorczuk	Pennine Acute Hospitals NHS Trust
Richard Mallard	RM	HPA/ CMFT NHS Trust	Sue Spilsbury	Stockport NHS Foundation Trust
Sarah Maxwell	SM	Stockport NHS Foundation Trust	Peter Taft	Salford Royal NHS Foundation Trust
Rachel Pearson	RP	GMPCTs	Moira Taylor	Stockport NHS Foundation Trust
Jeff Seneviratne	JS	GMPCTs	Tina Tennant	Royal Bolton Hospital NHS Foundation Tr
David Slater	DS	GMPCTs	Andrew Turner	CMMC NHS Trust
Chinari Subudhi	CS	Salford Royal NHS Foundation Trust	Emma Watson	Stockport NHS Foundation Trust
Philip Unsworth	PU	Tameside Hospital NHS Foundation Trust		

Discussion Points

- RB welcomed the group, particularly Network Clinical Leads, Jeff Seneviratne and Keith Hyde and the Project Manager for the Lab2Lab project, David Slater.
- **Chair's Communications** – RB explained that the last Network Board meeting was held on 6th February 2009 where discussions took place on the implications of the second Carter report and DH response as well as on the strategic vision for the Network in the context of the contestability framework and the aspirations of individual Trusts. RB also raised at this meeting her view that there was a need for the SHA to drive a standardised approach to universal elective screening for MRSA.
- RB reported that a good summary of the second Carter report and DH response can be found in the January 09 edition of the RCPATH Bulletin. As not all members have access to this, RB agreed to send a copy to RP for circulation.
- **Notes of 16th January 2009 Meeting** – NK highlighted that the date had been incorrectly recorded as 16th November 2009. The notes were otherwise agreed as a correct record.
- **Matters Arising** – the following matters were raised:
- C Diff presentation to the Network Board – RB explained that this would take place at the next Board meeting on 3rd April 09
- Review of priorities for weekend working – a draft questionnaire has drawn up by Peter Taft and circulated for comments. Completed questionnaires to be returned to Peter Taft by 17th April 09 so that results can be collated in time for discussion at the next meeting.
- Virology update meeting – RB reminded members that the Gerald Corbitt Memorial Meeting which will be held on Saturday 14th March, 2009 in the postgraduate centre at MRI. This meeting is taking place on a Saturday to maximise attendance. The NAG may organise a virology update meeting later in the year.
- 'How to do it' Leaflets – SM had brought a number of examples to the meeting as a starting point for a local formulary. It was agreed to circulate these by email and to discuss in more detail at the next meeting.
- **MRSA subgroup update** – since the last NAG meeting, the group have met twice on 10th February and 10th March 09.
- The subgroup discussed where responsibility for decolonisation lies and how many times a patient should be decolonised before an elective procedure, bearing in mind the 18 weeks target from referral to treatment. The subgroup felt there should be no difference in approach between DGHs and tertiary centres.
- Some Trusts (e.g. Stockport) are doing a lot of publicity around the introduction of screening including posters, patient information leaflets and local press. The subgroup felt it would be useful to share this learning across GM.
- A key area of variation in practice is with the number of swab sites for each patient, with Trusts in GM taking between one and three swabs per patient. PC highlighted that although the 'green book' specifies taking swabs from 3 sites, there is not necessarily the funding or laboratory capacity to support this. RB felt there was a need for a clear steer from the SHA/DH on this issue and agreed to raise this with Mike Burrows. RB has circulated a number of email discussions from AMM members on this issue, and it is clear that nationally opinion on the number of swabs is divided.
- The subgroup have agreed to collect data from all labs after 6 months of universal elective screening (Oct 2009) and will write a paper on the findings.

- The notes from the most recent meeting have been circulated and include a first draft of a consensus approach to MRSA screening prior to elective admission to hospital. Moira Taylor has asked members to comment on this plan by 27th April 09. SM explained that whilst members may have some comments already, more helpful views may emerge once labs have commenced universal elective screening. The subgroup will meet again on 7th May 09.
- **Lab 2 Lab Project – Microbiology Issues** – JS explained that the project is progressing well with testing due to commence between X-Lab (Lab 2 Lab middleware provider) and iSoft (Telepath), and that the project team felt it would be useful to discuss the project with microbiology colleagues because of some of the complexities of microbiology requesting and reporting.
- DS explained that this is a very ambitious project, as Lab 2 Lab requesting and reporting has not been achieved anywhere in the UK. DS showed a diagram of the proposed solution for Greater Manchester and explained that X-Lab is a spin off company from the Yorkshire Centre for Health Informatics at Leeds University, working with Rick Jones (Biochemist and lead clinician for Connecting for Health).
- Across Greater Manchester, 7 labs have an iSoft system (Salford, Stockport, Tameside, Trafford, Wythenshawe and Adult/Children's at MRI), 4 labs have a Clinisys system (Bolton, Pennine and Wigan) and The Christie use Technidata. X-Lab is the middleware solution which routes data as orders in and results out and does the necessary mapping. WG highlighted that many labs have local read codes. JS explained that the first time a test is requested, X-Lab will suggest a match for the requestor to approve.
- A work package and functional specification have been agreed with iSoft. A caveat has been inserted into the functional specification stating that 'in the light of the complexity of the project, the specification will be subject to review during the testing phase of the project'. DS explained that this will provide the flexibility to get the interfaces operational. DS explained that Alan Blackley at MMMP has been heavily involved in the development of the iSoft specification. DE felt it was important for lab users to be involved in the design of the system, as they will have to use it. JS explained that the project is lab driven and that the initial specification was drawn up with people from this Network, iSoft and YCHI. DS agreed that lab input was vital, and explained that the project team would be producing a quarterly newsletter to ensure that all levels of lab staff are aware of the project and its progress.
- DS explained that he and David Money (retired Lab Manager, Tameside) would be working with key stakeholders to produce a document describing the laboratory requirements for testing by the end of March 09 .
- DS explained that Clinisys are keen to include their own L2L solution (CDM) which would need its own server and have quoted prices well in excess of the project budget for interfaces. Therefore no order for interfaces has yet been placed with Clinisys and the focus of the project is on getting the solution operation between iSoft labs. Phase 1 testing will be taking place as follows:
 - Microbiology – Stepping Hill Hospital, Stockport linking to MMMP for Chlamydia requests and results –a relatively simple result and a high volume of tests (approx 12,000 per year). DS highlighted resource issues for the lab as these test are not currently booked into Telepath at Stockport. A pre-requisite of the L2L solution is that all send-away tests are booked into the home LIMS. DE highlighted that there is some reflexing with chlamydia testing. DS explained that the interfaces will be set up to cope with this, and this will be a key element of the testing phase.
 - Clinical Chemistry - Stepping Hill Hospital, Stockport linking to Leeds General Infirmary for Renin aldosterone and dihydrotestosterone requests and results. X-Lab has been testing with Leeds GI over recent months. DS argued that given the proximity of the X-Lab offices to Leeds GI and the fact that Stockport send samples to Leeds for the stated tests, it is appropriate that these labs are used in this phase of the project.
- DS explained that the NHS number will be used as the primary identifier for matching as district/case numbers may be duplicated across Greater Manchester. DS recognised that there are some issues to address around the use of NHS number, as several groups of patients do not have one e.g. armed forces personnel and asylum seekers.
- DE highlighted that the Lorenzo project at MRI requires services to be mapped to the National Catalogue for Pathology. DS explained that X-Lab will be using SNOMED-CT to do the mapping, and that X-Lab are also working with Connecting for Health to make the National Catalogue more useable. As not all members were aware of the National Catalogue, JS explained that it was created for Connecting for Health by System-C and is currently in the form of a very large Excel spreadsheet, detailing every test or 'orderable' in pathology. X-Lab are developing this spreadsheet into a more user-friendly database.
- **SWOT analysis on the implications of Carter/Darzi for Microbiology** – KH explained that input from each of the NAGs will inform the **Network strategy** and feed into the Network Strategy Group (a subgroup of the Network Board). He highlighted the four strands of the Network communications strategy:
 1. Acute Trusts – role for Clinical Directors and Pathology Managers as advocates of the Network within their Trust.
 2. Primary Care – links with PEC Chairs and commissioners, including practice based commissioning hubs.
 3. National – Modernisation team, especially Ian Barnes
 4. Regional – SHA, System Management Team (led by SHA Chief Economist – Kirsten Major), Specialised Commissioning Team.
- The Network, via the Communications PAG, will produce a communications brochure detailing what has been achieved already, work in progress and future plans.

- KH explained that following a meeting with PEC Chairs in November 08, the following **primary care priorities** were identified:
 1. Phlebotomy services (including transport)
 2. Anticoagulation services
 3. IT links (requesting and reporting)
 4. Point of Care support
 5. Appropriateness of testing (demand)
- KH recognised that across the Network a large number of work streams have been identified but felt that it was essential for the Network to prioritise a smaller number of deliverables.
- KH explained that as part of the DH Contestability Framework, if any service is being changed it must be tendered and highlighted current **services being tendered** as follows:
 1. Immunology (Pennine)
 2. Cytology – already tendered in Republic of Ireland - service now being provided by Quest Laboratories. Despite the Network arguing the case not to tender and offering a professionally managed solution, PCT CEs across Greater Manchester (also Cumbria and Lancashire) have agreed to tender cervical cytology screening.
 3. IS CATS – now operational in Greater Manchester, seeing >800 patients in the first three weeks. Pathology provided by TDL (private lab in Salford Quays).
 4. Primary Care Pathology – biochemistry, haematology and microbiology. TDL are advertising for primary care work and BMS staff.
 5. POCT
 6. Anticoagulation
 7. Pathology – Bedford currently tendering, also Watford. Pathology services delivered in partnership with private sector at Guys and St. Thomas’.
- KH explained that a Network Strategy Group will be set up as a subgroup of the Network Board. The Strategy Group will evaluate the implications of the Carter and Darzi reviews (based on feedback from NAG SWOT analyses) and facilitate the development of medium and long term strategic direction. The Strategy Group will also explore the set of challenges that would have to be overcome for the Network to provide a stronger model of ‘managing’ pathology services to include dispute resolution and advice on service development.
- KH highlighted the following **local key players** in terms of the Darzi review:
 - Dr Steve Ryan – Clinical Pathway Groups (Healthier Horizons) Lead, NHS Northwest
 - Dr James Kingsland – Merseyside GP and President of the National Association of Primary Care. KH explained that at the FiLM conference Dr Kingsland spoke about ‘make and buy diagnostics’ i.e. greater use of point of care testing; buying in what can’t be delivered at the point of care (possibly from the independent sector).
 - Dr Amir Hannan – Hyde GP and Primary Care Lead for NHS Northwest (also Clinical Lead for GM CATS). KH explained that Dr Hannan took over the Shipman practice in Hyde and that his innovations in real time digital medicine are therefore well observed. Dr Hannan allows patients to have electronic access to their health record, including immediate access to lab results. KH explained that whilst this is a potentially contentious issue for laboratory professionals, Dr Hannan has tested the clinical governance of the arrangements and has received no complaints since the service was established 12 months ago. More information can be found at the practice website: <http://www.htmc.co.uk>
- KH showed a short video highlighting global trends and technological developments, which Dr Hannan had used as part of his presentation to the FiLM conference.
- KH summarised **the 20 recommendations of the second Carter report/DH response**, highlighting the following:
 1. Development of quality standards
 2. Review of accreditation process
 3. Development of Networks with a clinical and commercial director. KH explained that the GM Network is already set up in this way.
 4. The role of National Clinical Director for pathology will be carried out by Ian Barnes.
 5. Clinical governance for all providers of pathology services, including point of care.
 6. IT connectivity as a matter of priority
 7. Need for services to be more responsive to users’ requirements, particularly addressing the accessibility and convenience of phlebotomy and sample collection services. National project underway for Choose and Book phlebotomy. WG felt that labs need to be much less restrictive about their opening hours and that there is a need to consider provision of phlebotomy services in non-clinical settings e.g. pharmacies and supermarkets.
 8. Quality and safety of service
 9. Consolidation of specialist services
 10. Workforce reform - MSC
 11. PCTs/Providers to work together to develop cost effective plans for implementation of Carter proposals
 12. Tariff – initially looking at community based and specialist pathology
 13. Benchmarking – Primary Care

14. Department of Health to develop commissioning guidance and model contracts
15. National formulary
16. Innovation
 - KH also highlighted the current economic climate as a further issue for consideration.
 - KH reminded members of the Network's priorities for 2009:
 1. Primary Care (see above)
 2. Wider Stakeholders
 3. Strategic Direction post Darzi/Carter
 4. Infection Control
 5. Workforce, Training and Education – including Modernising Scientific Careers and working with universities.
 6. Lean – sharing learning – the Network team will be meeting with David Hamer (Bolton) to agree how to disseminate learning around Lean, and also recognise the work that has taken place in other labs.
 7. Cytology
 8. Immunology
 9. Lab to Lab
 10. Cancer
 - KH explained that the Process for Investment and Reform is the route for the Network to approach PCTs for funding. However PCTs are keen for the process to be more commissioner-led than provider-driven.
 - Members were in agreement about that laboratory services have not traditionally been priced properly and that the lack of a common pricing/costing structure, mechanism or methodology was a weakness. SM felt that the strength of the labs was in the total quality package, which provided a service of testing and clinical advice with the appropriate quality control and clinical governance. SM also felt it was important to think about Microbiology as being part of a wider laboratory medicine package.
 - JS felt that a lot of power has now moved to PCTs, who are being driven by government to take on more responsibility, which may lead to the consolidation of laboratory services (as in Coventry and Warwick) or to tendering of elements of lab services (e.g. cervical cytology). JS felt that a strength of the Network is the ability to respond to such pressures collectively. PC felt it was important to engage more with GPs/PCTs and for labs to start thinking more radically about where pathology services are delivered. WG agreed that labs should consider making services more accessible by using locations such as 24hr supermarkets. WG felt that it was essential to ask service users what they want.
 - RB felt it was difficult to engage with commissioners, despite the many good ideas generated in the NAG (e.g. infection control, demand management for urinalysis etc.)
 - DS explained that he has done a lot of work with GPs as part of the roll out of electronic requesting in Pennine. Through this he has learned that GPs are generally very supportive of the current service, but have some issues around the logistics (transport/IT). DS explained that GPs want to receive reliable electronic test results and that IT is a critical area. Through the Lab 2 Lab project, DS has seen dramatic differences in the way that different Trusts support IT.
 - RB asked members to complete the SWOT analysis proforma and return to RP by 31st March 09, to allow time for collation and presentation to the Network Board on 3rd April 09. The collated responses are detailed in the table below.
 - **Have you seen?** – RB explained that the draft GM Hepatitis C strategy and treatment guidance had not been intended for general distribution, and should only have been sent to those labs currently offering the test (i.e. Salford, Pennine, Bolton, Stockport and Tameside). Members from those labs with any comments on the documents should send these to paul.klapper@cmft.nhs.uk
 - **PAGS** – the update report was received.
 - **Any Other Business**
 - **IS CATS** – KH gave a brief presentation on the Care UK CATS that are now operational in Greater Manchester, highlighting the following points:
 - GP referral to treatment to facilitate meeting the 18 week target. Accept rapid referrals by all methods (e.g. email).
 - 30% of NHS activity across 5 specialties - General Surgery, Urology, Gynae, ENT and Musculoskeletal (inc Orthopaedic & Rheumatology). 864 referrals since 2nd Feb 09.
 - 7 locations across the conurbation including Gala Bingo – Longsight, Cousins Furniture showrooms – Salford, West End Working Men's club – Denton and Stretford Leisure Centre. Accessible within 30 minutes for 95% of patients
 - **Chlamydia Screening Quarterly Data** – RP explained that it is the responsibility of each PCT to ensure data is submitted so that it counts towards the 17% coverage target for 2008/9. As we are fast approaching the end of the financial year and it is important that all laboratories submit non-GUM, non-NCSP chlamydia data for Quarter 4 (January – March 2009). The RU Clear Team is collating this information on behalf of the 10 PCTs in Greater Manchester and a data template has been circulated to lab managers.
 - **CPD** – IBMS CPD certificates were available.

Actions

- AD/RB - C Diff guidelines to be presented to Network Board

- RB to send a copy of the article on the second Carter report and DH response from the January 09 edition of the RCPATH Bulletin to RP for circulation
- Members to complete weekend working questionnaire and return to peter.taft@srft.nhs.uk by 17th April 09
- Members to send comments on draft plan for universal elective MRSA screening to moira.taylor@stockport.nhs.uk by 27th April 09.
- Members to return completed SWOT analysis form to RP by 31st March 09.
- Salford, Pennine, Bolton, Stockport and Tameside – any comments on HCV documents to be sent to paul.klapper@cmft.nhs.uk
- All labs to submit Q4 Chlamydia screening data to samantha.scanlon@manchester.nhs.uk by 16th April 2009

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

- None

Date and Time of Next Meeting

- Friday 8th May 2009, 2pm – 4pm, One Central Park, Manchester, M40 5BP.

*****PLEASE NOTE CHANGE OF DATE*****

Strengths	Weaknesses
<p style="text-align: center;">Benchmarking data - must be available and robust</p> <ul style="list-style-type: none"> ➤ Professional expertise ➤ Quality/Value-added ➤ Trust - willing to share best practice ➤ Part of total laboratory medicine package including clinical advice ➤ 70% of clinical decisions rely on pathology ➤ CPA Accreditation ➤ Strong links and good working relationships with GP Practices ➤ Patient-centred approach with NHS values - i.e. not commercial/money based ➤ Manchester Medical Microbiology Partnership ➤ Critical Mass ➤ Regional Strategic Influence ➤ Relationships with wider Public Health Community ➤ Providing link between hospital and community ➤ Local labs a benefit for staff recruitment and retention 	<ul style="list-style-type: none"> ➤ Lack of end-to-end IT connectivity ➤ Lack of engagement with commissioners ➤ Lack of robust costing model - no clear prices to give to commissioners/demonstrate vfm ➤ Not 24/7 ➤ Income from PCTs doesn't come to labs ➤ Slow decision making ➤ Phlebotomy services non-existent in many areas ➤ Transport can be inflexible ➤ Commissioners understanding of pathology services/quality/benchmarking data. ➤ Small labs may not have enough throughput of cases for staff to gain experience in certain tests, conditions, etc. ➤ May not have changed some things that would merit change ➤ Staffing: it may be more difficult to cross cover, with small numbers in local labs ➤ Lack of long-term cross discipline integrated strategic and financial plan
Opportunities	Threats
<p style="text-align: center;">Commissioning of services/Practice Based Commissioning</p> <ul style="list-style-type: none"> ➤ Local formulary ➤ Harmonisation ➤ Roll out of Order Communications ➤ Transport/phlebotomy - delivering customer/patient requirements ➤ Commissioning guidance and model contracts (if properly thought through) will help bidding for relevant funding to support scheme developments ➤ Near patient testing to enhance patient involvement in the provision of laboratory services - must be quality controlled ➤ Improvement of the 'pre/post analytical' aspects of pathology if CPA/UKAS merge ➤ Better communication with service users ➤ To get commissioners to understand and quantify the clinical aspects of the delivery of pathology results ➤ Centralisation of specialist services should drive up quality and research - but only if funding appropriate ➤ HPA consolidations ➤ Lead of "regional" screening strategies ➤ A chance to re-examine possible improved ways for delivering the service(s); possibly new services ➤ Possibly get rid of some old services, or methods (e.g. automated urine microscopy and screening, instead of 'manual') ➤ Market services to a broader customer base ➤ Labs from different Trusts working collaboratively 	<ul style="list-style-type: none"> ➤ ICATS/IS ➤ TDL ➤ Need to know what our (IS) competitors are doing and what our customers want ➤ Failure to invest in emerging technologies (e.g. molecular) ➤ Lack of support from Trusts ➤ Cherry picking of high volume/low cost work affecting the efficiency/cost effectiveness of what remains ➤ Funding must be in line with research needs ➤ Loss of local research will be detrimental to local innovation and job satisfaction ➤ If driven by users without support for staffing to delivery the requests for information, it will lead to tensions and dissatisfaction with apparent poor service delivery. ➤ Development of "Mega" labs ➤ Private provider(s) may promise 'the world' but then not deliver - may not provide testing or advice for difficult or unusual cases ➤ Fragmentation of service ➤ Loss of close working links with clinical staff ➤ Different levels of finance available to different providers ➤ Maintaining a high quality fully established consultant workforce
Cross-cutting issues	
<ul style="list-style-type: none"> ➤ Network-wide IT and transport ➤ Workload ➤ Demand management - education of users ➤ Staffing and recruitment ➤ Costing needs: 'Datatree' is a costing software programme, reportedly a "true cost", involved a lot of work setting up 	

