

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 November 2009, 2pm – 4pm

In attendance		Apologies		
Eric Bolton	EB	HPA NW/ CMFT NHS Trust	Louise Bell	Salford Royal NHS Foundation Trust
Reeta Burman	RB	Pennine Acute Hospitals NHS Trust	Robert Berry	Tameside Hospital NHS Foundation Trst
Ivor Cartmill	IC	Pennine Acute Hospitals NHS Trust	Paul Connor	CMFT NHS Trust
Peter Chadderton	PC	Royal Bolton Hospital NHS Foundation T	Diane Dean	Pennine Acute Hospitals NHS Trust
Andrew Dodgson	AD	CMFT NHS Trust	Steve Downing	AGMPCTs
Dave Ellis	DE	HPA NW/ CMFT NHS Trust	Barzo Faris	Trafford Healthcare NHS Trust
Keith Hyde	KH	GMPCTs	Camelia Faris	WWL NHS Foundation Trust
Barbara Isalska	BI	UHSM NHS Foundation Trust	Wayne Goddard	Trafford Healthcare NHS Trust
Neil Jenkinson	NJ	GMPCTs	Azhar Iqbal	Royal Bolton Hospital NHS Foundation Tr
Rizwan Khan	RK	Royal Bolton Hospital NHS Foundation T	Ed Kaczmariski	HPA NW/ The Christie NHS Foundation
Laura Kidd	LK	GMPCTs	Maeve Keaney	Salford Royal NHS Foundation Trust
Richard Mallard	RM	HPA/CMMC NHS Trust	Sarah Maxwell	Stockport NHS Foundation Trust
Robert Nelson	RN	WWL NHS Foundation Trust	Hari Panigrahi	GMPCTs
Rachel Pearson	RP	GMPCTs	Jeff Seneviratne	Pennine Acute Hospitals NHS Trust
Maurice	MS	Pennine Acute Hospitals NHS Trust	Chinari Subudhi	Salford Royal NHS Foundation Trust
Sidorczuk			Moira Taylor	Stockport NHS Foundation Trust
Sue Spilsbury	SS	Stockport NHS Foundation Trust	Allan Wilcox	WWL NHS Foundation Trust
Philip Unsworth	PU	Tameside Hospital NHS Foundation Trst	Alan Wills	East Cheshire NHS Trust
Stephen Voysey	SV	Collinson Grant Healthcare		
Pauline	PW	Trafford Healthcare NHS Trust		
Westbrook				
David Weston	DW	HPA NW		

Discussion Points

- **Welcome and Introductions** – RB welcomed the group and asked if the members present have read the 20:20 emerging vision briefing paper. RB stressed that the current situation will not go away. RB introduced SV of Collinson Grant Healthcare who 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.
- PU commented on the negative side to reconfiguration i.e. transport, workforce, IT etc. RB explained that at Pennine the priority was to unify all 4 sites. IT and transport were the major issues but once these were organised there was also the issue of staff being reluctant to relocate. After an initial period of adjustment once staff had accepted the forthcoming changes everyone was onboard and things changed. Now Microbiology has better technology in the lab than before and the opportunity to have it would not have been possible before the merger. There is a fundamental need to get the infra structure correct including car parking, portering, transport, etc.
- BI suggested the centralisation of specific tests where transport and TAT's are not as crucial e.g. elective MRSA testing. This could be automated and lower staff bands used. RM enquired if the group could establish what needs to be kept on site and asked if each site knows what the other sites do? SV enquired how achievable it would be to have a formulary of tests to be centralised? EB stated that clarity is needed as the group is trying to develop and devise a stand alone Microbiology service for the future. The outcome has to be better quality of service for patients and the support of CE's is needed. The point was made by several members that the solution for Pennine may not necessarily be the correct answer for pathology (much bigger picture.) IC reiterated that the question is how can we deliver a 20% better service for 20% less? NJ stated that if pathology can demonstrate as a service it is embarking on an implementation programme to reduce costs and increase quality we maybe able to stave off some of the more draconian measures that will inevitably put into place. MS stated that people are hedging around and do not want to talk about the unpalatable issue of closing labs. The group stressed that the option appraisals of leave everything as it is, 1 big central lab for GM, a sectorised approach, consolidation of some services can be discussed without scaring anyone. EB stressed that we need to talk about all the options and map info which is very hard as no one will share info! EB agreed that if the pathology service does nothing it will be done to us. SS commented how difficult it is to know where clinical services will be due to the SHA strategy.

Everyone is striving to be Lean and looking at skill mix. MS and IC commented that you do not necessarily need to keep essential services on site as we have the technology to centralise. PC agreed with EB that we should look at the outcome and timescales and plan accordingly. RB stressed the need to look at what can be changed not concentrate on the things we cannot. AD suggested that as a speciality Microbiology may be more open to some of the more radical solutions. Microbiology has been very slow to automate where as Biochemistry has the use of much more up to date technology.

- RM suggested a data collecting exercise. Not numeric purely qualitative to find out which lab does what tests. RM and MS to put together a proforma and forward to LK and RP for circulation and collation.
- DW commented that Virology and TB are done centrally already and that centralisation is their strength as it means centralisation of expertise, reduction on waste and patient continuity. PW expressed the risk of centralisation for a small hospital and urged the group not to make a decision too quickly and work through the structure carefully.
- The Warrington lab model has re-emerged and KH stressed to the group to produce a sensible professional view and asked members to think who they would buddy with naturally. IC stated that sectorisation is a natural winner. MS and RB commented that the consolidation at Pennine has achieved a reduction in costs and improved quality and working conditions. NJ stressed we may not achieve 20% if we show we have moved on and are moving in the right direction we will be left alone. Unfortunately pathology is still seen by some as a support service so it is more palatable to attack than some of the other clinical services. EB stated that this will be progressive and this will be the beginning of an ongoing journey. In 20 years time things maybe completely different due to technology and evolution. There could be 3 sites in 5 years and 1 site in 10 years. We will not be here in 20 years but we need to leave a legacy. The group agreed that if Microbiology services are put out to tender the private sector will move in and do the things being talked about. The group also agreed that a mandatory system is in place for infection prevention within PCT's and this must be part of the solution.
- BI stated that the specialty of Microbiology will not go away but will change. Communication is a worry with centralisation/sectorisation for labs off site. An extended working day could help to alleviate this issue but a clear communication strategy for clinicians is essential as is education on the respectful way to use our service.
- IC commented that the private sector is major player and the PCT's will ultimately make the call to change things. KH asked the group if they would prefer the SHA to tell you what the sector model is or you tell them. PU asked the group if the private sector is the best thing for patients and stated the need to justify prejudices.
- Next Steps – members split into 4 groups and discussed:-
 - An appropriate model of service provision
 - What a hub and spoke arrangement would look like
 - 5 key quality metrics for this discipline taking into account the Darzi parameters of Safety, Outcomes and Patient experience.
- **Network Strategy 20:20 Vision Facilitated Workshop** – Please see attached sheet.
- **Any other Business**
- **Notes of 18th September 2009 and any matters arising** – The minutes were agreed and there were no matters arising.
- **Chair's Communications** – RB asked the group to read the Network Board minutes from October 2009. The group worked through the actions from the previous meeting. LK to chase Siobhan Fahey regarding draft algorithms and MT regarding the MRSA questionnaire. AD was reminded to produce the C Difficile questionnaire.
- **eRoom** – BI enquired if anyone else in the group was experiencing problems accessing the eRoom? SV explained that there have been a few issues but assured the group these have been resolved now. RK stated he had not had an invitation to join the eRoom. LK agreed to email SV with RK's details to rectify this.
- **On call arrangements** – RK brought to the group's attention an email received asking for information on his Trusts current on call arrangements. RK enquired if any other group members had received the same email and knew from whom it has come. KH explained that as part of the 20:20 emerging vision work there is a potential cost saving initiative from the Pathology Managers and this could be part of the scoping work. MS stated that some labs have been contacted but not all.
- **IBMS CPD** - Certificates were available
- **Directory of Microbiology Laboratories in England** – RB explained to the group that this has just been published and urged members to go in and check their own details as entries have been found to be incorrect. www.dh.gov.uk/en/PublicHealth/Patientsafety/Microbiologyandinfectioncontrol/DH_4135669
- **HIV Maternity Testing** – RB explained that Paul Klapper has produced a draft document on performing HIV tests in maternity. RB urged the labs that perform this test to look at the documents.
- **Strategy Group Representative** – Further to a call for nominations 3 members of the group volunteered. LK has emailed RB to check if all 3 are to attend the meetings or if a vote will be cast within the group.
- **HIV POCT** – The Sexual Health Network had been in touch with the GM Pathology Network to ask for information on HIV POCT. The group felt that this was a good idea in the right setting and with the correct supervision. RB asked the labs that carry out HIV POCT to please respond to RP and give details.

- Training Representative – The group discussed during the course of the meeting potential training needs for reconfiguration and the next generation, but the group noted that a training representative is not present at this group. LK and RP to look into.

Actions

- RM/MS to produce data collecting proforma and forward to LK/RP for circulation and collation
- LK to chase Siobhan Fahey regarding draft algorithms
- LK to chase MT re MRSA questionnaire
- AD to produce C Difficile questionnaire
- LK to email SV with details of RK re eRoom
- All labs performing HIV POCT to respond to RP
- LK/RP to look into the presence of a training representative

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

- None

Date and Time of Next Meeting

- Friday 15th January 2010, 2pm – 4pm, One Central Park, Manchester, M40 5BP.

**Option Appraisals -
 Microbiology**

<p style="text-align: center;">Benefits</p> <ul style="list-style-type: none"> ➤ More cost-effective - procurement, unit costs ➤ Common reporting system ➤ Improved reporting and notification ➤ Single management structure ➤ Budgetary control ➤ Build on existing alliances and collaborations ➤ Clear separation of urgent and non-urgent activity ➤ Extended working day ➤ Better use of capacity ➤ Standardisation and harmonisation ➤ Better skill mix 	<p style="text-align: center;">Risks & Disadvantages</p> <ul style="list-style-type: none"> ➤ Problems with relocation ➤ The morale of the staff (including travel time & child care) ➤ Business continuity ➤ Training divorced from the patient ➤ Slippage on targets and trajectories ➤ Communication ➤ Accreditation, governance and safety (if the model is a stand-alone trust) ➤ Loss of local ownership and control
<p style="text-align: center;">Constraints</p> <ul style="list-style-type: none"> ➤ Transportation of samples ➤ IT ➤ Communication between medical and technical staffs 	<p style="text-align: center;">Prerequisites</p> <ul style="list-style-type: none"> ➤ Critical mass must be achieved to realise improvements in cost ➤ The service should operate 24/7 ➤ Infection control and public health functions must be integral components ➤ Flexibility of the workforce
<p style="text-align: center;">Key metrics</p> <ul style="list-style-type: none"> ➤ Turn-around time ➤ Accreditation (IQA and EQA) ➤ Customer/user satisfaction ➤ Cost per test ➤ Research and development, and training ➤ Reduction in adverse incidents ➤ Better compliance with the use of antibiotics ➤ Improved control of infection ➤ Appropriateness of testing 	<p style="text-align: center;">Threats</p> <ul style="list-style-type: none"> ➤ Market testing ➤ CATS/IS (potential overseas threat) ➤ Workforce (MSC) ➤ Economy