

**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 15<sup>th</sup> January 2010, 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	Barzo Faris	Trafford Healthcare NHS Trust
Peter Chadderton	PC	Royal Bolton Hospital NHS Foundation T	Camelia Faris	WWL NHS Foundation Trust
Andrew Dodgson	AD	CMFT NHS Trust	Wayne Goddard	Trafford Healthcare NHS Trust
Dave Ellis	DE	HPA NW/ CMFT NHS Trust	Ibrahim Hassan	UHSM NHS Foundation Trust
Keith Hyde	KH	GMPCTs	Azhar Iqbal	Royal Bolton Hospital NHS Foundation Tr
Barbara Isalska	BI	UHSM NHS Foundation Trust	Neil Jenkinson	GMPCTs
Ed Kaczmariski	EK	HPA NW/ The Christie NHS Foundation	Naeem Khattak	Pennine Acute Hospitals NHS Trust
Rizwan Khan	RK	Royal Bolton Hospital NHS Foundation T	Hari Panigrahi	Pennine Acute Hospitals NHS Trust
Laura Kidd	LK	GMPCTs	Maurice Sidorczuk	Pennine Acute Hospitals NHS Trust
Richard Mallard	RM	HPA/CMHC NHS Trust	Moira Taylor	Stockport NHS Foundation Trust
Sarah Maxwell	SM	Stockport NHS Foundation Trust	Andrew Turner	CMFT NHS Trust
Ken Mutton	KM	CMFT NYHS Trust	Philip Unsworth	Tameside Hospital NHS Foundation Trst
Robert Nelson	RN	WWL NHS Foundation Trust	Pauline Westbrook	Trafford Healthcare NHS Trust
Rachel Pearson	RP	GMPCTs	Alan Wills	East Cheshire NHS Trust
Jeff Seneviratne	JS	GMPCTs		
Sue Spilsbury	SS	Stockport NHS Foundation Trust		
Chinari Subudhi	CS	Salford Royal NHS Foundation Trust		
David Weston	DW	HPA NW		
Allan Wilcox	AW	WWL NHS Foundation Trust		

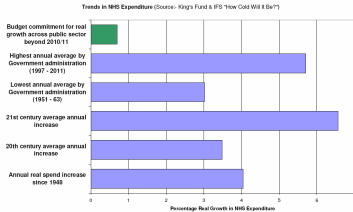
**Discussion Points**

- **Welcome and Introductions** – RB welcomed members and gave best wishes for the New Year. RB took the opportunity to thank group members for the large attendance figures achieved in 2009 and continued support through 2010. RB commented that this will be an interesting year for Pathology and stressed the need to steer our own destiny.
- **Notes of 12<sup>th</sup> November 2009 and any matters arising** – The minutes were agreed and there were no matters arising.
- **Chair's Communications** – RB explained to the group that a National update had been given to the GM Network Board on 18<sup>th</sup> December 2009 by Dr Ian Barnes (IB), National Clinical Director of Pathology, Department of Health and stressed that his message was loud and clear. RB asked both KH and JS to give the group a brief overview of IB's update and also a status report on the current 20:20 vision work.
- **Network Strategy Update** – KH explained that IB stated that the message from the DH is about the transformation of pathology services, including the reduction of waste. IB felt that pathology services need to be better at measuring performance and need to establish a baseline on this. Pathology services need to improve quality outside of the lab i.e. at the clinical interface. IB also highlighted the need for pathology services to demonstrate continuous quality improvement, and felt that the pass/fail nature of accreditation is unlikely to deliver this. IB explained that QIPP (Quality, Innovation, Productivity and Prevention) has now been rebranded as 'The Quality and Productivity Challenge'. IB explained that he has been asked to lead on the QIPP work stream for Pathology as it is seen as one of the top 10 priorities nationally. Jim Easton sees pathology as of higher importance due to the already large evidence base that has been gathered (Carter). KH explained that IB had stated that the GM Pathology Newsletter for autumn 2009 all looks glossy and the joined up approach from the 10 Trusts within GM is exactly what is needed, but it is now essential to deliver.
- JS explained to the group that benchmarking data is still being collected and will include information to help validate the £500 million. There has been an additional request for information for the SHA, primarily information around spend and workload over the last 3 years. There have been developments since Christmas and JS informed the group he has been working in conjunction with Les Martin (Cumbria & Lancs.) and Ken Barr (Cheshire & Merseyside) to ensure a co-ordinated response. JS also confirmed that the information will be fed into the Medical Directors Office. JS explained that a meeting with the SHA will take place next week.
- KH gave the group a Strategy update using a series of slides to highlight particular areas:-

## Timeline

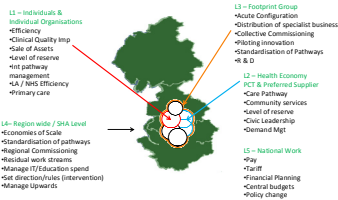
Date	15-Dec	15-Dec	15-Jan	15-Jan	15-Jan	25-Jan	11-Feb	18-Feb	25-Feb	14-Mar	19-Mar	16-Mar	19-Mar
All		Writing Group				Writing Group							CEO
PM	Strategy Board		Micro NAG	Plan NAG	Writing Group	Diags TBA	Path NAGs	Strategy Board		Path NAG	Plan NAG	Micro NAG	

### Slide 1



### Slide 2

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



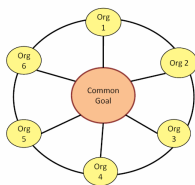
### Slide 3

#### 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

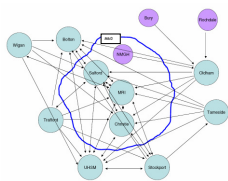
### Slide 4

#### Necklace Model



### Slide 5

#### Pathology referrals across Greater Manchester



### Slide 6

- Slide 1 was used to bring the group up to speed on the status of the project. KH circulated an index format that the Writing group have used as the skeleton of the paper that will be presented to the CE's on 19/03/10. The Writing group will meet next on Friday 29<sup>th</sup> Jan 2010.
- Slide 2 highlighted the finances of the NHS since 1948. KH predicted that this slide will be the significant slide of 2010. KH explained that the green bar shows the predicted expenditure for 2011 onwards. KH reminded the group that competition is key for an expanding NHS but collaboration is the way forward for a contracting NHS.
- 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 the 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.

- KH continued to talk to the members about the Writing group and showed a series of slides to be used as pointers for discussion. KH asked the group to think about and discuss 'the provision of service along the following continuum:-
  - 1 Central Services Laboratory
  - 2 Essential Services Laboratory
  - 3 Point of Care Laboratory (could be for A&E, Neo natal or in a community setting – Pathology would be in charge)
  - 4 Point of Care Testing
- EB mentioned the Pennine 4 hour rule of thumb (all tests requiring a 4 hour turnaround are performed on site) and stressed this is a subject that needs to be discussed. JS stressed at this point that the group needs to think more theoretically than geographically as this will immediately constrain thinking and it will not be a decision that that the Network can make. KH also mentioned that Neil Jenkinson (NJ) Network Director has been seconded as Acting Director of Commissioning for NHS Manchester for a three month period and is currently being pressed for a PCT model where all Primary Care work will come out of all 10 Trusts and be centralised. The Commissioners are insisting on this being an option for consideration. This could potentially de-stabilise Acute pathology provision.
- JS clarified that the use of the term centralise does not mean 1 site only and also does not mean geographically. Centralise could mean management and stressed the need to look at clinical requirements for patients.
- SM expressed fears as the Pennine model is to centralise as much as possible and shut everything else down. EB explained that the idea could be to centralise services within the sectors and went on to explain that a single site is not sustainable and has no business continuity. EB pressed the group to ignore geographical boundaries and focus on what services we need to provide in GM. EB went on to explain that potentially this could be an opportunity for investment as a whole. We could look at automation with Kiestra, Trusts could not do this individually but together collaboratively we could have a solid business case.
- RB commented that although she takes colleagues comments on board, Pennine has generated savings through superb IT and transport links and have managed to repatriate tests from Central Manchester and could generate still more savings by looking at unnecessary testing. KH stated a very clear message regarding IT that the GM LIMS project and other IT projects have to be in place before reconfiguration can begin. JS took the opportunity to remind the group that we need a plan that goes at an achievable pace and does not need to be complete within 12 months.
- **R Mallard Questionnaire** – RM gave a presentation regarding what has come out of the questionnaire circulated to Microbiology members. RM stated his awareness of deficiencies within the questionnaire and thanked the 7 out of 10 labs that responded. The survey demonstrated the following:-
  - There are 2 lab IT systems currently in use Clinisys and Telepath with the latter having the slight majority of users.
  - GP Order Comms and Ward ordering are well established
  - Most sites have remote user enquiry with the LIMS
  - 7 blood culture systems are interfaced to the LIMS which could be a possible area for procurement savings.
  - 6 labs providing blood cultures on call 2 are not (RM pointed out that there are 8 responses as CMFT has 2 labs)
  - 1 lab still uses glass bottles and so this is a safety consideration – members of the group pointed out that these can be monitored remotely now, glass carriers are now available and there is the alternative to switch to plastic
  - 1 site is piloting the use of PCR testing and the remaining sites carry out conventional testing. BI commented that a decision will be made on the use of PCR at UHSM at the end of Jan 2010. Current thinking is that UHSM will go back to conventional testing at that time.
  - Urine Microbiology – could this be centralised? It equates to 50% of the work load and there is the possibility of the work being lost if Primary Care is taken out of Trusts.
  - Automated Susceptibility testing – 2 sites have no automation at all.
  - Therapeutic drug monitoring appeared to be a good example of how Microbiology could work with other disciplines
  - Pregnancy testing – 4 labs offer this service 3 do not it is a urine test and is it really a Microbiology test?
  - Andrology – this is Non-Microbiology why are our labs carrying out these tests?
  - Mycology – is a definite centralisation candidate.
  - Arguments both ways for on call
  - Serology –another obvious centralisation candidate
  - Chlamydia – another potential test to centralise

- **Common Themes –**
- Inequity of service provision
- Need for capital investment in automation and interfaces
- LIMS are not used to full extent possible
- Potential cost savings if procurement is joined up
- Cost savings may be made by devolving and/or centralising some tests
- SM remarked that this goes back to the sectors and making cost savings through centralisation and closing down sites not needed. Smaller labs feel threatened.
- RB suggested Len Fielding Lab Manager at Pennine should be invited to the next meeting to give a presentation showing the savings achieved by the reconfiguration of services at Pennine. KH stated that if we took the savings from Pennine and scaled them up across GM they would be very significant. EB commented that Pennine has only in effect centralised 2 services. RB confirmed that at Pennine Microbiology and Histology are centralized at Oldham Laboratory. Essential services laboratories for Blood Sciences and Blood Transfusion are at North Manchester and Fairfield. Haematology and Blood Transfusion services only are presently sited at Rochdale Infirmary Hospital. The GP blood sciences work load is processed at the central lab at Oldham with the only exception being that the FGH work load which will also be transferred to Oldham. JS picked up on SM's fears and explained that we should not be looking at 'winners and losers' and if productivity and efficiency cannot be increased and we cannot deliver improved quality by the potential changes then we should not go forward with them.
- RB commented on the cost variations in Carter's 2<sup>nd</sup> review regarding cost per test varying from £4 - £9.50. Variation implies inefficiency and Commissioners will look at this variation. EB stated that we need to retain direct access work within NHS provision. The group decided on the need to agree on the following:-
  - What services are essential on site? With Microbiology it may be none.
  - What core services need to be readily available in an Acute setting?
  - What are the essential elements of a Microbiology service?
  - Define speed of service e.g. differing levels of service:-
    - Urgent
    - Routine
    - Primary Care
  - Define TAT:- User definition from request to result and Lab definition from receipt of specimen
- **Quality Metrics** – need to be generic rather than discipline specific and need to include a clear definition of TAT, IT connectivity and clinical interface
- KH pointed out that Andrew Foster is the Chair of the GM Pathology Network Board and is very keen for quality metrics to be measured under the Darzi parameters of Safety, Outcomes and Patient Experience.
- RB enquired if in light of the amount of information to be gathered RP could produce a questionnaire for the group to be circulated thus giving other members not in attendance the opportunity to contribute. RB asked if the questionnaire could afford members the opportunity to state exactly which tests they feel are essential to remain on site. EK commented that The Christie has no Microbiology on site but this is not detrimental to the patient. RB clarified that essential means clinical.
- SM commented that it is not essential for the Microbiology lab to be onsite but it is essential for the IT and transport links to be able to ensure that a sample is processed within 2 hours. EB felt it is important that clinical interaction with the patient is not lost. RB agreed and confirmed that Consultant Microbiologists need to carry out ward rounds and visit labs. The need for clinical input is essential. The group agreed that questionnaire needs to pick out what tests are done on site, what clinical input is needed on site and how clinical advice is delivered. SM commented that currently we work on 1 foot in the lab and 1 foot in the hospital but this is likely to change, labs will close and hospitals will be without labs. It is already happening. JS confirmed that due to the economic and financial challenge facing the NHS will mean change is inevitable we have no choice. SM looked for reassurance that all the pain will be worth it and the savings will be achieved.
- AD commented that a new way of working is needed. AD enquired about RB's daily routine and RB confirmed she has a weekly routine and time slots including a general meeting on Monday morning and ward rounds on Tuesdays and Fridays. AD commented that in 10 years time the students of today will be the consultants and they may not be as lab orientated as we are, this is not necessarily a good thing but it is out of our control.
- RK commented that infection control requires a frontline presence in hospitals and the importance of this cannot be underestimated. KM (Virologist) stated that he could not think of anything that is essential on site providing there is access to clinical advice.
- RB asked RP/LK to organise another meeting prior to the March NAG meeting to concentrate on the outcomes of the questionnaire. The group agreed that the following members would aid RP and LK in the creation of the questionnaire, BI, SM, AD and RM. All responses will be sent to RP and LK for collation. EB stressed to the members that the message

from Dr Ian Barnes National Lead for Pathology, DoH is the Treasury has already banked the £500 million and that Pathology has been identified very high up on the QIPP agenda. The message is do not think of yourselves think of your patient.

- JS reminded the group to look at how we engage with hospital users and GPs they value that they can ring someone and talk to them we need to make sure we do not lose this.

#### **Actions**

- LK/RP to contact Len Fielding re: presentation
- RP/LK to produce and circulate a questionnaire for the members (BI, AD, SM and RM to aid with this)
- All members to email questionnaire responses to RP/LK for collation
- RP/LK to organise meeting to discuss questionnaire responses prior to March NAG meeting

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

- None

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

- Friday 19<sup>th</sup> March 2010, 2pm – 4pm, One Central Park, Manchester, M40 5BP.