

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

Microbiology/ Virology/ Mycology NAG
Ken Barnes Suite, Holiday Inn, 888 Oldham Road, Newton Heath, Manchester M40 2BS
Thursday 18th March 2010, 2pm – 4pm

In attendance		Apologies		
Robert Berry	RB	Tameside Hospital NHS Foundation Trst	Louise Bell	Salford Royal NHS Foundation Trust
Eric Bolton	EB	HPA NW/ CMFT NHS Trust	Peter Chadderton	Royal Bolton Hospital NHS Foundation T
Reeta Burman	RB	Pennine Acute Hospitals NHS Trust	Andrew Dodgson	CMFT NHS Trust
Ivor Cartmill	IC	Pennine Acute Hospitals NHS Trust	Kirsty Dodgson	CMFT NHS Trust
Barzo Faris	BF	Trafford Healthcare NHS Trust	Erika Duffell	HPA/CMFT NHS Trust
Wayne Goddard	WG	Trafford Healthcare NHS Trust	Dave Ellis	HPA NW/ CMFT NHS Trust
Keith Hyde	KH	GMPCTs	Camelia Faris	WWL NHS Foundation Trust
Azhar Iqbal	AI	Royal Bolton Hospital NHS Foundation T	Neil Jenkinson	GMPCTs
Barbara Isalska	BI	UHSM NHS Foundation Trust	Ed Kaczmarek	HPA NW/ The Christie NHS Foundation
Laura Kidd	LK	GMPCTs	Naeem Khattak	Pennine Acute Hospitals NHS Trust
Richard Mallard	RM	HPA/CMFT NHS Trust	Sarah Maxwell	Stockport NHS Foundation Trust
Ken Mutton	KM	CMFT NHS Trust	Robert Nelson	WWL NHS Foundation Trust
Maurice Sidorczuk	MS	Pennine Acute Hospitals NHS Trust	Rachel Pearson	GMPCTs
Sue Spilsbury	SS	Stockport NHS Foundation Trust	Hari Panigrahi	Pennine Acute Hospitals NHS Trust
Andrew Turner	AT	CMFT NHS Trust	Debasis Sanyal	CMFT NHS Trust
Allan Wilcox	AW	WWL NHS Foundation Trust	Jeff Seneviratne	GMPCTs
			Chinari Subudhi	Salford Royal NHS Foundation Trust
			Moira Taylor	Stockport NHS Foundation Trust
			Tina Tennant	Royal Bolton Hospital NHS Foundation T
			Philip Unsworth	Tameside Hospital NHS Foundation Trst
			David Weston	HPA NW

Discussion Points

- **Welcome and Introductions** – RB welcomed the group and explained that after KH has presented he will leave the meeting so an open discussion can place. RB stressed to everyone attending that this will probably be the last opportunity to influence the 20:20 Emerging Vision for GM.
- **Notes of 15th January 2010 and any matters arising** – The minutes were agreed and there were no matters arising.
- **Chair's Communications** –
- **Writing Group** – RB explained to the group that the Writing Group had met on Wednesday 17th March 2010 to look at the strategy and plans for the Emerging Vision. RB also explained that KH would demonstrate the basis of this today and the group will have the opportunity to fill the document out and put their views forward.
- **Network Board** – RB informed the members that the minutes of the last GM Pathology Network Board on 18th December 2009 make for an interesting read and encouraged the members to find the time to view them.
- **Network Strategy Update** – KH explained that today he would circulate a draft of the 20:20 Emerging Vision SOC and ask the group to debate the options for service redesign. KH began by referring to the situation with Cytology and how 18 months ago it was agreed that the current 6 sites for Cytology should be reduced to 2 for GM (Pennine and CMFT) to make efficiencies and now events have overtaken us and we have 1 site in GM for Cumbria & Lancs. and GM. This was not the preferred option and the lesson to be learned from this is we must stand up for ourselves take the opportunity to steer our own destiny and have our say rather than let someone make changes for us.
- **Quality Metrics** – KH explained that the 20:20 Emerging Vision SOC will be presented to the Strategy Group on Friday 26th March followed by the GM Pathology Network Board on Wednesday 14th April 2010. The document will now be presented to the CE's in June/July to give the Network a consultation period. Through the NAGs approx 10-15 quality metrics have been produced some common across all the disciplines. KH explained to the group about the Pathology Futures Group which is led by Dr Ian Barnes and Gifford Batstone. The aim of the group is to produce a set of national quality metrics. Jeff Seneviratne, Joint Clinical Lead for the GM Pathology Network is a member of the group and rather than reinvent the wheel it was suggested that we use the draft national metrics and add regional/local metrics we agree. The national metrics are measured in three categories:-
 - outcome measures
 - process measures (such as waiting times)
 - structure measures (the presence or prevalence of specific capability)
- There will need to be scoring of each key indicator to decide if it is outcome, process or structure. The other suggested method of evaluation is the 7 tests listed below to evaluate a measure of quality:
- Utility – why would you want to measure this?
- Feasibility – how would you measure it?

- Comparability – are results from different services comparable?
- Differentiation – is the measure likely to show up differences between services?
- Diagnosis - do you know what to do with your result
- Authority – who decides what's good?
- Credibility – is the measure accurate? Is it credible? Can it be gamed?
- KH recapped on the economic climate showing a slide which demonstrates the 0.5% predicted growth in the NHS for 2011 onwards this is the lowest ever increase since the NHS began in 1948. KH also showed a selection of slides from the Chief Executives Forum on 26th February 2010 led by the Acute CEs, Commissioners and SHA. The view from the DH is that the QIPP agenda will resolve the problems. KH explained that NHS Northwest has recently appointed Dr Mike Cheshire as their new Medical Director and that Mike is the nominated executive lead at NHS NW for the QIPP Pathology workstream. KH demonstrated the 5 levels of action. Level 1 being individual organisation up to level 5 national. Level 3 is whole health economies (reconfiguration). KH explained to the group that from the £500,000,000 savings mentioned in Carter would come half from lean and efficiencies and the other half from reconfiguration. Pathology has been an easy target due to the DH and Treasury felling that the Carter methodology is robust. KH highlighted one of Jim Easton's slides to show that the language has changed recently from collaboration to rationalisation.
- Questionnaire Feedback – KH explained that the figures taken from the mini Keele benchmarking show a total non-pay and pay figure of £26.2 million for Microbiology. The data is very raw and needs clarification and ratification but shows a total GM Pathology spend of £125,000,000. The Carter review and mini Keele information gives GM Pathology services a figure of £20-25 million to save. The worst case scenario if we do nothing could be that each individual Trust takes a hit of between £1-5 million each.
- KH continued that the SHA are pushing for a necklace model where a group of organisations work together towards a common goal. KH explained to the group about the 3C's, our proposed options for the future:-
- Continue collaborating as we are – the group felt that the definition of this model should be changed as it does not represent a collaborative model
- Consolidation of services
- Consolidation of Primary Care services – e.g. all Primary Care Services into one factory.
- This is the option that PCTs and Commissioners are leaning towards as they wish to tender services and would have last year if the 20:20 work had not slowed the process.
- KH explained that sites with a Centralised Services Laboratory will need to include the facility of an Essential Services Laboratory. EB pointed out that the same can be said regarding POCT. EB suggested that the Network could centralise all Primary Care work at 2 – 3 labs.
- The group talked about a sector model with perhaps 3 or 4 sectors, Central/Pennine/South and West but agreed this is ultimately the decision of the CE's. IC mentioned the possible reconfiguration of clinical services and pointed out that this makes reconfiguration harder for us. KH reiterated that we need to be flexible and be able to move pathology services wherever and whenever clinical services move and that the sectors should reflect this. The group discussed their varying experiences with reconfiguration and the group agreed it is harder for some members than others to envisage a CSL as they have no prior knowledge or experience. KH pointed out to the group that the sector model is not just based upon Pennine although the evidence does back up the savings achieved and continued to give details of various medical services internationally that run successfully with the use of remote labs. EB issued a word of warning to Trusts wishing to remain as they currently are as the retention of GP work is not their decision and if it is taken away the Trust will collapse. We need to safeguard against this possibility and make sure that both Acute and PCT CEs will agree to keep their services within the NHS.
- RB stressed that if all GP work goes to the private sector all Acute Trust labs will lose a large portion of Primary Care Microbiology work, which is a significant amount of work. The future of NHS labs has to be 24/7 or a private company will take the work. It is no secret that 3 Trusts with GM are currently negotiating to create their own little mini network (Wigan/Bolton & Salford). AW commented that Wigan has brought in an external consultant as the lab there is to be demolished next year. The report is due at the end of April 2010 and will assess if laboratory facilities will be kept at all at Wigan. The plan is to map out single cell pathology for Microbiology for all 3 Trusts but there is no indication as to where it will be based. MS commented that the option to do nothing is missing from the 3C's because it is not an option. This sentiment was reiterated by AW who explained the external consultant at Wigan has been told to specifically ignore the do nothing option. EB applauded the 3 Trusts for collaborating and for the 3 CEs for working together and steering their own destiny. Questions were asked regarding proposed management structures and who will be the host Trust. AW confirmed that currently there is no further information. The group briefly discussed the merger of Microbiology at Ashford and Kent and the result leading to no reduction in quality. KH mentioned the newly refurbished TDL lab at Salford. The lab is not better than an NHS lab but the protocols and IT show how joined up we could be and how we could benefit. WG enquired whether TDL provide a result only service or result and interpretation service? RB explained that they employ the services of a doctor in London who may be providing an interpretation service based upon the one sample but no patient information. The group discussed BMI taking work apart from Histo away from Pennine at the end of April 2010. There is no Microbiology on site at Salford at all they have a van that leaves at 11pm and returns at 5am. BI expressed concerns

with regards to the potential chasing of samples and longer TATs. EB urged the group to think about what needs to remain on site being dependent upon which clinical services are provided at a particular site. The Christie has had no Microbiology on site for years and has managed. The group agreed that each lab with GM has provided a quality service which everyone was happy with this is in no way a criticism but the changes in climate now mean there has to be changes but as a group can set the standards.

- **Discussion** – RB asked the group if they are happy with the definition of an ESL in regard to the 4 hour TAT. The group agreed that this was really more of a concern for blood sciences as Microbiology results cannot be given in 4 hours. BI suggested that this could be slightly amended and used as a protocol for how long a sample should take to process. The group agreed that first a decision should be made on whether the 4 hours is to result and report or just to process. BI went on to suggest the group should agree which specimens should be reported next day. The group felt that as the 4 hour TAT is more to do with A&E, Microbiology could agree the 4 hours to process from receipt of sample as a person could have been in A&E for 2 hours before a sample is even taken. The group discussed the centralization of some tests including Meningitis screening on PCR. RB reminded the group that currently PCR samples are being sent to Newcastle when there are sites within GM that could facilitate this service, collaboration could change this and produce savings. The group felt that for this to be successful standardization across the service would be needed and both KM and EB felt that this could be a quality driver and we could equip labs to turn around quicker and improve quality.
- The group went on to discuss how a CSL would work for Microbiology. BI enquired if the group felt that there should be some clinician input into this decision. RB confirmed that the Writing Group is enlisting both a GP and Clinician user to get their perspective on the proposed strategy. RB felt that clinicians just want the result they do not usually have strong views on how they get it. The group discussed the centralisation of all Primary Care work and agreed there is not 1 lab in GM that could take all the TB work let alone all the GP work. BI had reservations about the centralisation of everything as UHSM are already receiving criticism from clinicians regarding long TAT where critically ill patients are concerned. The group discussed the potential to centralise TB, MRSA screening and Mycology. RM pointed out that technology could supply the solution to all the problems if not immediately then in time. Members of the group felt that technology solutions would need to be in place or an assurance of availability given. AW informed the group that the Trusts currently involved in talks with his Trust are non compatible regarding IT and the consultant has been told that whatever the costs involved will be to make IT work the funding will be forthcoming. Lab2Lab is not an option to remedy this issue as bacterial labs and cultures were not included in the project. MS commented the group need to investigate whether these concerns are a show stopper.
- RM explained to the group that from a predicted saving of £25 million the portion Microbiology will be responsible for achieving is approx £6 million, this means realistically the service needs to lose 100 staff. It is unpalatable but anything else is tinkering around the edge of the problem. EB urged the group to engage with proposals or we run the risk of not being able to influence quality and standards of services further down the line. MS commented that the idea is to gain a collective view from this group which is not possible as we cannot agree. The group asked for clarification that the reconfiguration of services at Pennine achieved a 20% saving. Representatives from Pennine explained that Micro and Histo are centralised at 1 site with Haem at 3 sites (ESLs). All GP work is done at Oldham and there is currently a lab at Rochdale. The Rochdale lab is due to close and this will reduce the number of ESLs to 2. Pennine confirmed that through the reconfiguration there was a reduction of 10 staff from 100 but although significant savings were achieved it did not equate to 20%. EB commented that this shows if 4 Trusts down to 1 cannot achieve a 20% saving our situation is more drastic than we thought.
- **Any other business** –
- **IBMS CPD Certificates** – LK apologised as certificates were not available and agreed to post them to members.
- **Micro NAG Meeting 18th November 2010** – LK explained that the planned November NAG Meeting clashes with the Tuberculosis Conference in Manchester on Thursday 18th November. It was agreed to move the meeting to Tuesday 23rd November 2010.

Actions

- LK to post IBMS CPD certificates to AW, RM, WG and SS
- LK to alter dates for November Micro NAG meeting
- RB to provide A4 sheet to NJ re: group view on the proposed strategy

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

- None

Date and Time of Next Meeting

- Friday 21st May 2010, 2pm – 4pm, Venue TBC