

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

Microbiology/ Virology/ Mycology NAG
 Manchester Suite, Holiday Inn, 888 Oldham Road, Newton Heath, Manchester M40 2BS
 Thursday 3rd June 2010, 2pm – 4pm

In attendance			Apologies	
Reeta Burman	RB	Pennine Acute Hospitals NHS Trust	Robert Berry	Tameside Hospital NHS Foundation Trst
Mairi Cullen	MC	UHSM NHS Foundation Trust	Eric Bolton	HPA NW/ CMFT NHS Trust
Andrew Dodgson	AD	CMFT NHS Trust	Ivor Cartmill	Pennine Acute Hospitals NHS Trust
Dave Ellis	DE	HPA NW/ CMFT NHS Trust	Kirsty Dodgson	CMFT NHS Trust
Sue Fraser	SF	Salford Royal NHS Foundation Trust	Erika Duffell	HPA/CMFT NHS Trust
Keith Hyde	KH	GMPCTs	Barzo Faris	Trafford Healthcare NHS Trust
Azhar Iqbal	AI	Royal Bolton Hospital NHS Foundation T	Camelia Faris	WWL NHS Foundation Trust
Neil Jenkinson	NJ	GMPCTs	Barbara Isalska	UHSM NHS Foundation Trust
Ed Kaczmarek	EK	HPA NW/ The Christie NHS Foundation	Naeem Khattak	Pennine Acute Hospitals NHS Trust
Laura Kidd	LK	GMPCTs	Richard Mallard	HPA/CMFT NHS Trust
Sarah Maxwell	SM	Stockport NHS Foundation Trust	Robert Nelson	WWL NHS Foundation Trust
Rachel Pearson	RP	GMPCTs	Hari Panigrahi	Pennine Acute Hospitals NHS Trust
Sue Spilsbury	SS	Stockport NHS Foundation Trust	Ahmed Qamruddin	CMFT NHS Trust
Moira Taylor	MT	Stockport NHS Foundation Trust	Debasis Sanyal	CMFT NHS Trust
Philip Unsworth	PU	Tameside Hospital NHS Foundation Trst	Jeff Seneviratne	GMPCTs
Pauline Westbrook	PW	Trafford Healthcare NHS Trust	Maurice Sidorczuk	Pennine Acute Hospitals NHS Trust
David Weston	DW	HPA NW	Chinari Subudhi	Salford Royal NHS Foundation Trust
			Tina Tennant	Royal Bolton Hospital NHS Foundation T
			Andrew Turner	CMFT NHS Trust
			Allan Wilcox	WWL NHS Foundation Trust

Discussion Points

- **Welcome and Introductions** – RB welcomed the group members and apologies were given.
- **Notes of 18th March 2010 and any matters arising** – The minutes were agreed and there were no matters arising.
- **Chair's Communications** –
- RB explained to the group that the GM Pathology Network Board had met on 14th April 2010 at which both the strategic outline cases for the GM LIMS and the 20:20 Emerging Vision projects were presented. NJ pointed out that the procurement of a GM LIMS system is a key enabler for the redesign of pathology services across GM. NJ reported that the Board & CEOs have supported the initial outline for the GM LIMS and a full business case will now go ahead. NJ also confirmed that both the Acute and PCT CEOs supported the strategic outline case for the 20:20 Emerging Vision at their respective meetings on the 16th April 2010 and support was given for work to begin on economic capacity modelling and a governance framework.
- **Network Strategy Update** – NJ updated the group that the option to stay as we are is no longer an option. After the extensive research carried out via the NAGS 3 options had emerged:-
- **Option A Collaborative Model** – which we are currently undertaking
- **Option B Consolidation Model** – consolidating services utilising a number of CSLs and ESLs
- **Option C Centralising Primary Care** – this option could affect the viability of most providers.
- NJ confirmed that the consolidation model emerged as the preferred option which fits in line with Carter's recommendation. NJ explained that the Network has been keen not to describe sectors or locations but that there are natural sectors in the North with Central and South being more difficult. NJ explained that the idea was for people to think more of a virtual organisation as pathology will be the first service to touch upon sovereignty issues amongst the CEOs it will set a precedent for the other services. The CEOs know they need to work at level 3 and the Network has asked them to liaise with staff to enable them to make correct decisions for the service. Sadly pathology is still seen as a support service by some Trusts. There is no need to wait for the reconfiguration of clinical services we just need to factor it in and be flexible. NJ explained that ultimately the CEOs want the proposed model to be independently financially assessed. The paper that went to CEOs on 16th April 2010 included options ranging from one to four clusters for **illustrative purposes**:
- **Option B1 – One Cluster** - In this model, Greater Manchester would operate with 1 CSL and 15 ESLs. Capital investment would be required to develop a CSL capable of delivering services for all work not required to turnaround in less than 4 hours.
- **Option B2 – Two Clusters** - In this model, services would be consolidated in two sectors. This could mean the development of 2 CSLs and 14 ESLs. Sector arrangements could be North (Bolton, Salford, Wigan (inc Leigh and Wrightington), Pennine and Tameside) and South (Stockport, South Manchester, Central Manchester (inc Children's), Trafford and Christie)

- **Option B3 – Three Clusters** - In this model services would be consolidated in three sectors. This would be broadly in line with current clinical reconfiguration considerations of 3 clusters in Greater Manchester. This could lead to development of 3 CSLs and 13 supporting ESLs. North West – Bolton, Salford and Wigan (inc. Leigh and Wrightington); North East – Pennine (inc. Oldham, North Manchester, Rochdale and Bury) and Tameside; Central and South – Stockport, Central Manchester (inc. Children’s), South Manchester, Christie and Trafford.
- **Option B4 – Four Clusters** - In this model services would be consolidated in four sectors. This could lead to development of 4 CSLs and 12 supporting ESLs. North West – Bolton, Salford and Wigan (inc. Leigh and Wrightington); North East – Pennine (inc. Oldham, North Manchester, Rochdale and Bury); South East – CMFT (inc. Children’s), Tameside and Stockport; South West - South Manchester, Christie and Trafford.
- The paper was revised to include a four cluster option following discussion at the Board meeting on 14th April 2010. This reflected concerns that a ‘Central and South’ sector may be too large or may be dominated by the bigger laboratories.
- NJ stressed it is up to each discipline to decide how many clusters are needed and that although the disciplines are looking at their needs on an individual basis it will all be tied together in the bigger picture, e.g. Haem and Bio may become blood sciences. NJ commented that the bigger picture needs more than collaboration to achieve the financial savings and quality needed to be successful. RB informed the members that the job in hand now is to decide what is the best way to provide a quality Microbiology service across GM.
- EK commented that the DH want plans from each SHA by June 2010 to achieve the required 20% savings out of pathology. NJ warned that we will lose control of this if we are seen to prevaricate and not move quickly enough. If as a Network we put forward a reasonable option we will be left alone to get on with it. As a community this is our last chance to own and steer our destiny. KH commented that the Carter report has been around for 5 years now and the message to the DH from the Treasury is the money is banked get on with it. NJ mentioned that cost avoidance savings could also contribute. The Network team updated members that nationally other areas have brought in external companies to carry out the same work we have completed together. KH stressed that the Network is trying to maintain the NHS as the preferred provider. NJ informed the group that KPMG has been doing some scoping work similar to our project but on a smaller scale in another part of the country. The work involves 4 PCTs and will cost £1.5 million for 6 months work. It is a warning to us that we could be overtaken by the system and the costs that would be involved.
- RB asked all members to contribute to an open discussion.
- SM expressed concerns as currently in GM we have between 10 and 16 labs and if we need to reduce the number of labs this means that around this table some people will lose their lab and some will expand. That is a big change for all of us and proof is needed of where these savings will come from. SM continued that if savings will be made in estate then fine 10 labs to 5 labs etc but is it in demand management or procurement as it was with Pennine. NJ confirmed the savings are in all areas. AI also enquired about the source of the savings and also had concerns about the one cluster option. The group discussed the more immediate situation of Wigan and the talks being held between Bolton, Wigan and Salford. NJ explained that the situation with Bolton, Wigan and Salford requires a quicker solution e.g. within 18 months and as such is being looked at from a managerial aspect more than a professional/clinical aspect and ultimately it will need to complement the bigger picture and the work undertaken by the Network.
- RB explained to the members that we can all argue and be protective but if we lose the GP work we will all be in trouble. SM enquired if all Trusts joined forces could a 20% procurement saving be achieved and then everyone can retain their labs rather than jumping into one big lab without the proof it will achieve what we need. KH stressed that the suggestion is not have one big lab; the Network needs to know from the NAGS what is the best way forward.
- SF felt the timescale was too short for a GM approach to be achievable and perhaps a phased approach would be more beneficial. AI suggested reducing to 3 to 4 labs per sector and then taking this wider. NJ explained that by adopting a managed approach and natural wastage implementation could take 5-10 years but if we lose this opportunity the measures forced upon us could be much more draconian. SF felt that the available increase in automation could lead to a reduction in the number of staff needed. SF commented that we have a very different scenario to Pennine as Pennine is one Trust with a purpose built lab. SF pointed out her comments were in no way intended to be negative as she personally is keen to progress the work.
- RB enquired about the possibility of a Pathology Trust and MT expressed concerns regarding unifying Trusts and policies and used MRSA as an example. Stockport GPs complain about differing hospital policies and are looking for a unified MRSA screening policy. A sub group was set up and a decision could not be reached within the sub group mainly due to outside influences e.g. Trusts and PCTs. How do we influence outside bodies? AD suggested that if we were a more unified voice from a pathology stand point maybe we would have more influence. Another suggestion was to centralise MRSA screening thus making access to information easier and all adopting a 1 swab policy for MRSA testing. Currently SHH take 1 swab, do not use agar and do not reswab. The same policy is used for both elective and emergency patients. MC confirmed that UHSM is looking to adopt a similar policy.
- MC explained that as the representative for UHSM she would like to state that the Microbiologists there are not in agreement about there being no need to have a Microbiology lab on site. UHSM has made it very clear it wishes to retain its lab. EK commented that a clinical presence on site is essential not a lab. NJ explained that people need to think of themselves as GM not as individual Trusts. MC commented on the need to keep things that work well, in particular

- specialist services on site as there is a requirement for an improvement in quality and the last thing wanted is a reduction in quality. UHSM have cystic fibrosis and respiratory units which in their opinion need to remain at UHSM. That is where the expertise and familiarity is but other things could be centralised. The group discussed specialist services and commented that Christie has specialist services and no Microbiology on site. UHSM could be linked via Telepath and authorised reports would be accessible. KH commented that 10 years ago there wasn't a Micro lab at UHSM and that we should be using that knowledge of the pros and cons to facilitate this exercise.
- KH commented that we need to persuade CEOs to work with us and reminded the group that Primary Care would have gone out to tender 12 months ago without the 20:20 Vision work. KH reminded the group that we have a very small window of opportunity it is summer now and then it will be November and the Government will have settled in and will want their money. We need to have plans ready by the end of summer for CEOs to sign up.
 - AD commented that we spend 66% of the pathology budget on staff indicating where the savings will fall. These reductions in staff could only be achieved by coming together and pooling staff to deliver the service. RB confirmed that in order to achieve 24/7 working the pooling of staff would be required. DW commented that as labs are being asked to stay open longer and longer hours there is a need to join up with other Trusts as one lab does not have the manpower to achieve 24/7 working. DE commented that he had already been through 2 consolidations and this proves that it can be done but we still only work 7.5 hour days and the time for change has come. DW explained the personnel issues experienced at his Trust and the difficulty with recruiting and on call. He has been supporting his service with agency staff. It would therefore be beneficial to work with another Trust but the difficulty is knowing where to start and who to approach. AI confirmed that Bolton has been helping Trafford with their on call but has now been told it cannot work with Trafford as it will be going into a different sector.
 - PW felt that Trafford is currently losing out on both staff and innovation and so this is a win/win situation for her Trust. RB commented that staff will have to move base there is no choice now. PW felt that a move of base will not affect the scientists and professionals but more the lower grade staff who choose to work near home. SF commented that staff are worried they will not retain their grades and that the skill mix and banding need to be scrutinised. KH explained that the MSC Oversight Board at the SHA chaired by Patricia Zukowskyj, Associate Director of Diagnostics, Trafford Healthcare NHS Trust had asked for nominations for a Network representative and KH has been put forward.
 - SS agreed in principle with other colleague's comments but felt that again we are just talking and not moving on. SS enquired who will make the decisions regarding sectors and KH confirmed that CEOs will make the final decision regarding number of clusters and sector locations. SM clarified that we are all in agreement bar UHSM and now is the time to get our teeth into it and surely the next stage is to continue in the footsteps of Bolton, Wigan and Salford and commence talks. KH reiterated the next stage is to decide 1, 2, 3 or 4 core labs. SM confirmed the group all agree not 1. NJ asked the group to agree how many CSLs are needed and what should be included in an ESL.
 - RB expressed a desire to keep all Microbiology together and asked what Bolton, Wigan and Salford are proposing. AI clarified that the Trusts have proposed to consolidate Micro at 1 site but that as yet there has been no decision from the CEOs. SM and PU suggested looking to move equipment as well as staff to make best use of it. SF mentioned that staff T&Cs is currently all different at the individual Trusts and suggested a unified Network policy. RB confirmed the same issues were experienced at Pennine. DE felt that as group radical decisions were needed quickly before some one makes them for us. MC enquired about the timescale to create Pennine as it will take longer for GM. DE enquired if the group felt that Kiestra was the way forward for Micro. SF commented that with all Micro on 1 site using the Kiestra system the indicated savings were £1.3 million over 3 years after capital investment.
 - DW confirmed that the CEO at UHSM has expressed his preference for the B4 cluster model and talks have begun between UHSM, SHH and Trafford. AD felt the members were being asked to make un-informed decisions based upon gut feeling and would prefer to see figures to show the differences and benefits between model B3 and B4. RB stressed we all need to put our cards and costs on the table and asked NJ if the information on current spends is available as it is not in the public domain. NJ confirmed the data has been gathered. The group agreed that they need to start somewhere and felt the best way forward was to look at staff structures and estimate costs for both the B3 and B4 models including savings on equipment, CPA, EQA and IQA and carry out a comparison.
 - DE commented that as the NW sector have already consolidated it leaves no scope for savings to be made and would mean that the other 3 sectors need to save £20 million between them. Pennine currently costs £18 million and serves 25% of the GM population. The current GM community pathology spend is £120 million so Pennine has made a significant saving. AI commented that Pennine received a large amount of investment and NJ confirmed that the need for investment and the key enablers e.g. transport and IM&T have been recognised and built into the emerging vision. SF enquired if Pennine have to make further savings, RB confirmed it does.
 - RB explained that Dr. Mike Cheshire, Medical Director at the SHA is now chairing the Pathology Modernisation Board and has asked for nominations for an Acute CEO and a PCT CEO and Clinical Leads. NJ explained that Mike Burrows and Andrew Foster have been nominated to represent the Network along with KH and JS. The first meeting will take place 21st June 2010 and this shows things are moving faster than we think.
 - RB reminded the group of a letter sent by RP on 14th May asking for the members to supply the names of potential external assessors for Microbiology. RB confirmed she has spoken with EB and asked for suggestions, the members thought of a few people to be considered and asked if required would their services need to be paid for. NJ confirmed that is highly

likely. SM felt we should make very clear that we as a discipline are not prepared to budge unless IM&T and transport are sorted. DW commented that the HPA could save £300,000 if they moved out of UHSM and back to CMFT.

- RB summarised that the group felt that 1 and 2 cluster arrangements were not do able but 3 was possible and 4 was preferable at the moment but aiming to reduce to 3. The group felt that it would be easier to be told by the CEOs which model it will be now make the decision how that will work and agree SOPs and quality control RB summarised that the project has already begun and we need to move it on.
- **New Health Protection (Notification) Regulations 2010** –RP explained the email and papers received from Erika Duffell at the HPU have been forwarded to the group and asked for any comments to be sent directly to Erika at erika.duffell@hpa.org.uk
- **Any other business** –
- IBMS CPD Certificates – Certificates were available.
- PAG 7 Communication Membership – SM explained that the PAG 7 Communications group wishes to progress its work on the GM Pathology website and as such is looking to expand its membership. Microbiology is well represented on the existing group but any members wishing to join should email LK at laura.kidd@manchester.nhs.uk
- L2L Commitment – JS had given apologies but the group discussed the imminent start of a TB route between MMMP and SHH and MMMP and Trafford. It was also confirmed that Immunology testing has begun between MRI and Pennine. NJ confirmed that DS will be staying on as the Project Manager for the foreseeable future.
- Commissioning TB Services in GM – EK explained that the draft proposal re TB have now been finalised and offered to send the final docs to LK for circulation. The TB Commissioning Board is looking for a 2 site delivery as opposed to the current 6 site. Bolton PCT is taking the lead on commissioning.

Actions

- Members to email comments on New Health Protection Regulations to Erika Duffell
- Members wishing to join PAG 7 to email LK
- LK to circulate final TB commissioning proposal

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

- None

Date and Time of Next Meeting

- Thursday 29th July 2010, 2pm – 4pm, Manchester Suite, Holiday Inn Manchester Central Park, 888 Oldham Road, Manchester, M40 2BS