

Greater Manchester Pathology Network Board Meeting
Friday 3rd April 2009
Salford Suite, St. James' House, Salford M6 5FW
2pm - 4pm

Notes of the Meeting

1 Present

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| Dr Mohammed Al-Jafari (MA) | - Chair, RCPATH NW Regional Council, Consultant Pathologist North Cheshire Hospitals NHS Trust |
| Dr Gordon Armstrong (GA) | - Consultant Histopathologist, Salford Royal NHS Foundation Trust |
| Dr Reeta Burman (RB) | - Consultant Microbiologist/NAG Chair, Pennine Acute Hospitals NHS Trust |
| Dr Gillian Burrows (GB) | - Director of Pathology, Stockport NHS Foundation Trust |
| Dr Mike Burrows (MB) | - Joint Chair, GM Pathology Network; Chief Executive, Salford PCT |
| Dr Neha Dalal (ND) | - Clinical Director, Tameside Hospital NHS Foundation Trust |
| Mr Andrew Foster (AF) | - Joint Chair, GM Pathology Network/Chief Executive, Wrightington Wigan & Leigh NHS Foundation Trust |
| Ms Susan Gillespie (SG) | - Director of Pathology, Wrightington, Wigan and Leigh NHS Foundation Trust |
| Dr Andrew Hutchesson (AH) | - Pathology Clinical Lead, Royal Bolton Hospital NHS Foundation Trust |
| Prof Keith Hyde (KH) | - Deputy Clinical Director, Central Manchester NHS Foundation Trust/
Network Clinical Lead |
| Mr Neil Jenkinson (NJ) | - Network Director, Greater Manchester Pathology Network |
| Mrs Rachel Pearson (RP) | - Network Business Manager, Greater Manchester Pathology Network |
| Mr David Rowlands (DR) | - Acting Haematology NAG Chair/Pathology Manager, UHSM NHS Foundation Trust |
| Mr Jeff Seneviratne (JSe) | - Biochemistry NAG Chair/Network Clinical Lead |
| Dr Jonathan Shanks (JS) | - Director of Pathology, The Christie NHS Foundation Trust |
| Mr Allan Wilcox (AW) | - Pathology Manager, Wrightington, Wigan and Leigh NHS Trust |
| Ms Patricia Zukowskyj (PZ)* | - Associate Director of Diagnostics, Trafford Healthcare NHS Trust |

*representing Dr David Alderson, Director of Pathology, Trafford Healthcare NHS Trust

In Attendance

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|------------------------|--|
| Dr Richard Byers (RBy) | - GM&C HMD Lead, Central Manchester NHS Foundation Trust |
| Mr Alan Campbell (AC) | - Director of Strategic Commissioning, Salford PCT |
| Dr Andrew Dodgson (AD) | - Consultant Microbiologist, Central Manchester NHS Foundation Trust |

2 Apologies

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|-------------------------|---|
| Dr David Alderson (DA) | - Director of Pathology, Trafford Healthcare NHS Trust |
| Dr Brian Benatar (BB) | - Director of Pathology, Pennine Acute Hospitals NHS Trust |
| Prof Eric Bolton (EB) | - Clinical Director, Health Protection Agency / Central Manchester NHS Foundation Trust |
| Dr Trevor Carr (TC) | - Director of Pathology, Royal Manchester Children's Hospital |
| Dr Mina Desai (MD) | - Consultant Cytopathologist/NAG Chair, Central Manchester NHS Foundation Trust |
| Dr Matthew Helbert (MH) | - Consultant Immunologist, Central Manchester NHS Foundation Trust |
| Dr Sezgin Ismail (SI) | - Director of Pathology, UHSM NHS Foundation Trust |
| Dr Lorna McWilliam (LM) | - Consultant Histopathologist/NAG Chair, Central Manchester NHS Foundation Trust |
| Dr Andrew Turner (AT) | - Consultant Virologist, Central Manchester NHS Foundation Trust |

3 Chair's Communications

There were none.

4 Notes of the meeting held on 6th February 2009

The minutes were agreed as a correct record.

5 Matters Arising

On Action 119 - KH to pursue GM Pathology Network engagement with the CLRN via Andrew Hutchesson - KH reported that he has spoken to Andrew Hutchesson and that Dr. Hutchesson, as a member of both this Board and the CLRN Board, has agreed to ensure a link between the two. AF thanked KH for his persistence in this matter. MB suggested it would be useful to invite the CLRN

Clinical Director, Martin Gibson to the next Network Board meeting to further the Network Board's understanding of research funding.

Action 124 - MB to invite Martin Gibson to the next Board meeting

On Action 120 - NAGs to do SWOT analysis of the Carter recommendations and DH response - see below under agenda item 8: Network Advisory Groups.

On Action 121 - RP to circulate draft terms of reference for the Strategy Group - RP reported that these had been sent with the minutes of the last meeting, and again with the papers for this meeting.

On Action 122 - Terms of reference for Strategy group to be agreed at the next Board meeting - see below under agenda item 7

On Action 123 - NAG chairs to ensure Network input into SHA Clinical Pathway Groups - see below under agenda item 8 - Network Advisory Groups

No further matters were raised.

6 Presentation on Contestability Framework

AF welcomed Alan Campbell (AC), Director of Strategic Commissioning at Salford PCT, who gave a presentation on the current procurement and commissioning rules. AC explained that NHS Reforms are creating a managed market for healthcare and formalising the way in which the NHS procures services. There are now clearer rules than have ever been seen before and a formal Dispute Avoidance and Resolution Service (DARP). Oversight of the market is provided by the independent Co-operation and Competition Panel, chaired by Lord Carter of Coles. This panel can advise and intervene and is responsible for scrutiny of the system.

AC explained that PCTs are required to open the market to formal competition to encourage the development of NHS and IS providers. There is also scrutiny of public sector contract awarding and a requirement to adhere to EU law. The PCT Procurement Guide creates rules for every transaction with providers, with a role for the SHA in resolving disputes between commissioners and providers.

AC explained that World Class Commissioning (WCC) is expected to stimulate competition, and that PCTs will be tested on the WCC Competencies annually. The 11 WCC competencies are:

1. Locally lead the NHS
2. Work with community partners
3. Engage with public and patients
4. Collaborate with clinicians
5. Manage knowledge and assess needs
6. Prioritise investment
7. Simulate the market
8. Promote improvement and innovation
9. Secure procurement skills
10. Manage the local health system
11. Make sound financial investments

AC provided an overview of the Principles and Rules for Cooperation and Competition (PRCC), which govern PCTs' procurement and commissioning processes, highlighting that PCTs need to be able to demonstrate fairness and transparency, but that vertical integration of services is permissible (e.g. Foundation Trusts providing community services). AC highlighted the importance of engaging clinicians at every stage.

AC explained that the assumption now is that services will be tendered: any decisions not to tender must be approved by the PCT Board. In practice, this will mean full competition where the market preparation is advanced (e.g. general acute services), limited competition for some areas (e.g. some scarce high technology services; third sector market areas needing development and support) and some services where competition will not be sought (e.g. where services are

integrated with the local authority). AC highlighted the following reasons why services might not be contested:

- Service has a strong alliance to an existing area of provision and provider continuity is a high priority
- Where the cost of a contested approach can't be justified in light of the contract value
- Where the PCT wishes to encourage provision from a sector that might otherwise not prevail
- Where failing to award a contract might undesirably put a provider at risk

AF thanked AC for a very good presentation and for providing some clarity around the new commissioning rules. AF felt that the PRCC (e.g. Commissioners should use the providers best placed to meet patient needs) were open to a wide range of interpretation and questioned the role of the Network in this context. AC felt that the Network was a key source of clinical expertise that could inform the commissioning process by which funds are committed. MB suggested that case law will emerge on the interpretation of the PRCC.

JS felt that it was important for laboratories to think about other ways of delivering services and that there was a role for the Network in showing commissioners what models are available. KH envisaged commissioners using the Network as a sounding board.

7 Network Strategy Group - Terms of Reference

NJ explained that this sub-group of the Network Board would look at the strategic vision for the medium to long term. AF emphasised the need for the Network to use the expertise of its members to give best advice on service development.

MB was supportive of this work, but felt it was important to ensure that Acute Chief Executives are aware of it.

Action 125 - AF to ensure Acute Chief Executives are aware of the Network Strategy Group

It is proposed that the Strategy Group will meet on a quarterly basis and its recommendations will be further developed and ratified by the Network Board. The proposed membership of the Strategy Group is as follows:

- Acute Chief Executive
- PCT Chief Executive
- Network Clinical Leads
- Nominated representative from each Network Advisory Group
- SHA representative
- Process for Investment and Reform representative (Financial)
- Network Director
- Network Business Manager
- Members co-opted to support discipline specific developments
- Primary Care User

GA had discussed the terms of reference with colleagues at SRFT, where there were concerns that the listed membership may lead to an unbalanced representation of providers. MB suggested that all labs will probably be represented in some way, and NJ agreed to ensure this is looked at when drawing up membership. GA also felt it was not clear how the Strategy Group differed from the Network Board. NJ explained that the size of the Board, whilst excellent for engagement across the system, was unwieldy for strategic discussions. The Strategy Group was therefore necessary to take the Network to the next level. All recommendations from the Strategy Group will be ratified by the Network Board. It was agreed to take GA's concerns into account in the management of the Strategy Group.

NJ felt that quality will be a major driver in commissioning and that pathology services will need quality metrics and be able to prove that they are providing value for money. He argued that all labs in the Network should participate in the Keele Benchmarking scheme, to ensure that appropriate data is available for commissioners.

NJ recognised the limitations of the current scheme, but felt it was important for all labs and all disciplines across the Network to take part in Keele Benchmarking for 2009-10 and reported that the cost of this would be c.£30k. JSe agreed that participation as a Network would provide

useful information. NJ agreed to bring a paper outlining the recommendation to the next Board meeting.

Action 126 - NJ to bring paper re: Benchmarking to next Board meeting

JSe explained that he is currently working with Keele Benchmarking and that the whole of Scotland have been participating for the past 2 years. JSe reported that the Department of Health, in response to the second Carter report, have commissioned Collinson-Grant to review the scheme.

8 Network Advisory Groups

Biochemistry

JSe reported that a lot of work is in progress on standardisation and harmonising practice e.g. Gestational Diabetes reporting. Dr. Andrew Hutchesson is leading a piece of work on the implications of new NICE guidance on Familial Hypercholesterolaemia and the NAG are building a business case to put into the Process for Investment and Reform. JSe felt this was a good example of the role of the Network in identifying gaps in clinical services. JSe reported that there has been a change in providers of GP Out of Hours services which presents an opportunity to standardise reporting levels and arrangements. The NAG had an animated discussion around the SWOT analysis, which will feed into the Network Strategy Group.

Cytology

MB explained that although the work in Greater Manchester on a consensus solution towards two sites had progressed well and had broad support, a number of factors had contributed to the decision of GM PCT Chief Executives to tender the service. Firstly, the situation in the other North West health economies: the provider Trusts in Cumbria and Lancashire failed to reach agreement and a Pathology Commissioning Network has been established to pursue a formal procurement. At the other end of the spectrum, provider Trusts in Cheshire and Merseyside had proposed a networked solution which effectively maintained the status quo, with no centralisation to achieve critical mass. Secondly, the Department of Health procurement guidance means that there is now an assumption that PCTs will tender, with any decision not to tender requiring the approval of the PCT Board. Given that in Greater Manchester it would be necessary to gain the approval of ten PCT Boards, and that there is a market for cervical cytology screening, there was an appreciable risk of a legal challenge to a decision not to tender. Coupled with the knowledge that Cumbria and Lancashire, as well as South Yorkshire and Bassetlaw PCTs were tendering, the ten GM PCT Chief Executives took the decision to pursue a formal procurement.

An initial meeting has taken place to understand the issues surrounding the tender and a commissioner and independent clinician have been identified. An early issue is that there is a substantial programme of research at one of the provider sites and this has been passed to the Competition Panel for advice. MA asked what professional input there will be into the service specification. MB explained that there will be significant clinical input, via an independent clinical expert as well as a director of public health, Dr Turnbull and the Network. MB confirmed that current providers will be able to bid for the work and NJ explained that it would not be possible to submit a Network bid, as the Network is not a statutory organisation. It is hoped that the tendered service would commence from April 2010.

NJ highlighted the 'Jade Goody' effect by which cervical screening services have seen an average increase in workload of 60% which is putting pressure on turnaround times and further impacting the already low morale of staff.

JSe felt that PCTs' decision to tender raises a more general issue of the risk of services not seeking to change if it means they will be opened up to tender. AF felt that the challenge was to design a service model that commissioners will buy into.

Haematology

DR reported that the clinical workload of consultant haematologists meant that they often did not attend the NAG meetings. A key issue for the NAG at present is Anticoagulation Services, which PCTs are keen to deliver in the community. DR reported that Manchester PCT are keen to tender for a community anticoagulation service and that Network representatives from North, South and Central Manchester have been liaising with the PCT around this, given the expertise in

the Network to inform standards and influence pathways. NJ explained that commissioners have approached the Network on this issue.

The NAG, alongside colleagues in Biochemistry, are working on a Network response to the proposals for a Greater Manchester targeted screening programme for Genetic Haemochromatosis. The consensus view is that there is not enough evidence of the clinical benefits to support the proposals.

KH reported that a meeting has taken place with consultant haematologists and representatives from the National Blood Service to plan how to progress the development of a Greater Manchester service for Therapeutic Apheresis.

Histopathology

NJ reported that at their last meeting the NAG had a demonstration of the PACS system used by radiology to share learning on information governance and explore whether histopathology reports/images could be included.

Microbiology

RB introduced Dr Andrew Dodgson (AD), chair of the C. Diff subgroup of the Microbiology NAG. The subgroup have agreed guidance on the prevention and management of C. Diff which RB was keen to present to the Board. AD explained that C. Diff is a major issue for all Trusts, citing one Trust outside the Network which has exceeded its target for CDT and where the PCT is considering levying a £12m fine.

Following the publication of new DH guidance in April 2008, the Microbiology NAG convened a multi-disciplinary subgroup A group consisting of Consultant Microbiologists, Infection Control Practitioners, Antibiotic Pharmacists and Biomedical Scientist from representative Acute Trusts across Greater Manchester to develop a strategy on the prevention, diagnosis and management of Clostridium difficile infection in Acute NHS Trusts. AD explained that this group have distilled the 21-page DH document into 8 pages under 3 main headings - Prevention, Diagnosis and Management.

In terms of diagnosis, the group recommend that all in-patients with diarrhoea (sample that takes the shape of the container) should be routinely tested for CD toxin if 2 years of age or over. RB explained that this was in line with DH guidance, but was likely to have a negative impact on Trust targets for C Diff infection rates. AD felt that worrying about these targets was potentially doing a group of patients a disservice.

AF commended this work and felt that it should be formally endorsed by the Network Board and agreed with Chief Executives and Commissioners as a gold standard. NJ highlighted that the GM Directors of Commissioning now have a business manager to link with. It was agreed to circulate the recommendations and to ensure a formal presentation is on the agenda for the next Board meeting.

Action 127 - C Diff guidelines to be circulated and formally presented to the next Board meeting

Immunology

NJ reported that following Mansel Haeney's retirement, Matthew Helbert has been invited to represent Immunology on the Network Board. NJ also reported that the North West Specialised Commissioning Team have appointed a Project Manager for Immunology and Allergy, Louise Sinnott, who has been invited to attend the next Board meeting

9 Network Board SWOT analysis

KH highlighted the following services under consideration for contestability, either locally or nationally:

- Immunology
- Cytology
- IS CATS
- Primary Care Pathology (Biochemistry/Haematology/Microbiology)
- POCT

- Anticoagulant Services
- Pathology Services

KH explained that this analysis would inform the Network strategy and facilitated discussions on the Strengths, Weaknesses, Opportunities and Threats for Pathology Services and the Network in the context of the recommendations of the second Carter report. The outcome of these discussions is appended as a table at the end of the minutes.

10 Priority Action Groups

PAG 5 - IM&T

JSe reported that the Lab2Lab project is progressing very well under David Slater's project management. The iSoft interface is currently being tested and is anticipated to be delivered by the end of April 09, with the first testing between Stockport and MMMP (Telepath to Telepath) scheduled for May 09. JSe confirmed that the link between the two immunology laboratories (Telepath to Apex) is early in the project plan.

JSe explained that the focus of the project has been on getting the iSoft interface working and that the Network will approach Clinisys about their costs once this has been achieved. AW explained that the main problem with Clinisys was financial, but that the lab managers from the affected Trusts were supportive of the project approach. AW felt the Network has a great opportunity to be the first in the UK to achieve electronic lab-to-lab links.

11 HMD Update

RBy reported that an operational manager has been appointed with an expected start date of June 09 to oversee the implementation of Phase 2. Phase 2 will extend the service to haematological malignancies, will provide MDT support and will accommodate fresh samples. Planning for the workflow is proceeding and the resource implications (staff, consumables and equipment) are being detailed in conjunction with financial planning for a full service. The balance of work for liquid haemato-oncology diagnosis between Central Manchester and The Christie has been formally agreed with the Executive teams of both Trusts and will be delivered on a sector basis.

12 Any other business

A proposal to have a Pathology entry at the RHS Show at Tatton Park on 22nd to 26th July 2009

JSe tabled a paper outlining this proposal from Dr. Emma Watson, a consultant microbiologist at Stockport. The RCPATH has a strong tradition of entering the Chelsea Flower Show, and has won both gold and silver medals, winning gold again in 2008. This has been successful at increasing public awareness of pathology and bridging the gap between the public's perception of what pathologists do and the broad spectrum of what we actually do. The RHS Show at Chelsea is very popular both with the press and the public. The RHS show at Tatton is also a hugely popular event drawing thousands of visitors of all ages from across the North West.

JSe explained that Dr. Watson has been in touch with the RCPATH and Regional Council and extended an open invitation for members of the Board and their colleagues to be involved. Sponsorship will be sought from diagnostics companies. MA felt that this was a great idea and a good opportunity to raise the public perception of pathology. The Board supported the proposal.

13 Date of Next Meeting

Friday 5th June 2009, 2pm-4pm - Salford Suite, St James House, Salford, M6 5FW

Network Board SWOT Analysis

Strengths	Weaknesses
<ul style="list-style-type: none"> ➤ Essential service - 70% diagnoses rely on pathology ➤ ? Costing system ➤ Accreditation ➤ IT Connectivity ➤ Comprehensive service end-to-end ➤ Good clinical relationships e.g. MDTs ➤ Quality metrics available ➤ Adoption of new technology ➤ Collaborative Network ➤ Added value ➤ Integrated service ➤ R&D ➤ Specialist services ➤ Clinically led ➤ Teaching/training ➤ Resilience in system/robust service ➤ Expertise ➤ Increasingly responsive to users 	<ul style="list-style-type: none"> ➤ Access to capital ➤ Significant overheads ➤ Labour inflexibility ➤ Low profile/often forgotten (e.g. Darzi) ➤ Not included in service planning ➤ Logistics outside lab control ➤ No standard/robust costing methodology ➤ Inadequate marketing ➤ Customers don't understand the service - creates problems with demand management and service design ➤ Hard to prove value for money ➤ Lack of public understanding ➤ Not all services 24/7 ➤ High risk in some areas ➤ Teaching/training - not factored in ➤ Seen as secondary care service - perceived as not primary care focused ➤ Dependence on host Trust
Opportunities	Threats
<ul style="list-style-type: none"> ➤ Influence/advise commissioners and Trust management ➤ Infection control ➤ Cancer Network ➤ Commissioning ➤ Molecular technologies - if investment made ➤ OMIX ➤ POCT ➤ Automation ➤ Implementing Carter recommendations ➤ MAHSC - teaching/training/R&D ➤ Phlebotomy services in the community ➤ Working with primary care 	<ul style="list-style-type: none"> ➤ Contestability ➤ Commissioning naivety ➤ Credit crunch ➤ Age profile of workforce ➤ Workforce planning ➤ Recruitment/retention ➤ Automation ➤ Carter 2 ➤ User expectations ➤ Slow to change ➤ Procurement guidance/rules ➤ Commissioning/PBC ➤ Loss of UG training ➤ Increased unfunded workload ➤ Cherry picking ➤ CATS ➤ Dependence on other services ➤ Fragmented