

Greater Manchester Pathology Network Board Meeting
Friday 2nd October 2009
Swinton 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 Warrington & Halton Hospitals NHS Foundation Trust |
| Dr David Bisset (DB) | - Consultant Histopathologist/NAG Chair, Royal Bolton Hospital NHS Foundation 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 |
| Dr Mina Desai (MD) | - Consultant Cytopathologist/NAG Chair, Central Manchester NHS Foundation Trust |
| Ms Jackie Elliott (JE) | - Directorate Manager, Salford Royal NHS Foundation Trust |
| Mr Len Fielding (LF)* | - Pathology Manager, Pennine Acute Hospitals NHS Trust |
| Mr Andrew Foster (AF) (Chair) | - Joint Chair, GM Pathology Network/Chief Executive, Wrightington Wigan & Leigh NHS Foundation Trust |
| Ms Susan Gillespie (SG) | - Director of Pathology, Wrightington, Wigan & Leigh NHS Foundation Trust |
| Dr Matthew Helbert (MH) | - Consultant Immunologist, Central Manchester 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 |
| Dr Lia Menasce (LM) | - Clinical Director, The Christie NHS Foundation Trust |
| Ms Fiona Noden (FN)** | - Divisional Director, Salford Royal NHS Foundation Trust |
| Mrs Rachel Pearson (RP) | - Network Business Manager, Greater Manchester Pathology Network |
| Mr David Rowlands (DR) | - Haematology NAG Chair, UHSM NHS Foundation Trust |
| Mr Jeff Seneviratne (JS) | - Biochemistry NAG Chair/Network Clinical Lead |
| Mr Allan Wilcox (AW) | - Pathology Manager, Wrightington, Wigan & Leigh NHS Foundation Trust |
| Ms Patricia Zukowskyj (PZ)*** | - Associate Director of Diagnostics, Trafford Healthcare NHS Trust |

*representing Dr Brian Benatar, Director of Pathology, Pennine Acute Hospitals NHS Trust

**representing Dr Gordon Armstrong, Consultant Histopathologist, Salford Royal NHS Foundation 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 |
| Ms Bernie Foley (BF) | - Strategic Procurement, Commissioning Business Service |
| Mr Anthony Rowbottom (AR) | - Consultant Clinical Scientist - Immunology, Lancashire Teaching Hospitals NHS Foundation Trust |
| Ms Samantha Ryan (SR) | - Manchester Academic Health Science Centre |

2 Apologies

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|--------------------------|--|
| Dr David Alderson (DA) | - Director of Pathology, Trafford Healthcare NHS Trust |
| Dr Gordon Armstrong (GA) | - Consultant Histopathologist, Salford Royal NHS Foundation 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 Reeta Burman (RB) | - Consultant Microbiologist/NAG Chair, Pennine Acute Hospitals NHS Trust |
| Mr Trevor Carr (TC) | - Clinical Director/Consultant Clinical Scientist, Central Manchester NHS Foundation Trust |
| Dr Sezgin Ismail (SI) | - Director of Pathology, UHSM NHS Foundation Trust |
| Ms Louise Sinnott (LS) | - Immunology and Allergy Services Project Manager, North West Specialised Commissioning Team |
| Dr Andrew Turner (AT) | - Consultant Virologist, Central Manchester NHS Foundation Trust |

3 Chair's Communications

AF reported on the changing political landscape with politicians now talking about cuts for the NHS and the Secretary of State for Health saying the NHS must prepare to make savings of 15-

20%. Greater Manchester Chief Executives have agreed that the various networks can provide them with expert advice on how to address the economic challenge. AF felt that it is to the Network's advantage that we have anticipated and started work on this and that it is good to be ahead of the game. DB commented that his Trust is facing savings of 4% next year, then 6.5% for the following three years (i.e. >20%).

AF also commented on the Secretary of State for Health's recent statement that the NHS is the preferred provider of health services. Whilst recognising that this may not yet be fully fledged policy, the statement goes directly against what has been said in the past. The full speech can be viewed at the following link:

http://www.dh.gov.uk/en/News/Speeches/DH_105366

4 Notes of the meeting held on 7th August 2009

On pp5-6 regarding the Trafford Histopathology Tender, PZ felt that the situation had not been accurately reflected and suggested some amendments. RP agreed to amend the minutes from 7th August 09 accordingly. The minutes were otherwise agreed as a correct record.

5 Matters Arising

On Action 136 - Board to send comments on 20:20 vision letter by 14th August 2009 - NJ confirmed that after taking comments from some members on board the letter to all staff was circulated on 3rd September 2009.

On Action 137 - LK to circulate Presentation on C. Diff Guidelines electronically - action completed

On Action 138 - MB to approach DoCs/CBS for Project Management support in developing the business case for a Greater Manchester service for Therapeutic Apheresis - NJ reported that the Network has applied to the Process for Investment and Reform (PIR) for support. The next PIR meeting will take place on 13th October 2009. NJ explained that PCTs are more likely to support 'invest-to-save' initiatives given the current financial climate but felt that some project management time was needed to scope existing arrangements and future requirements.

On Action 139 - Place Cervical Cytology issues on next agenda - see below under Agenda item 8 - Cervical Cytology - GM Tender

On Actions 140 and 141 - DB and PZ to meet to discuss content of letter to Ron Calvert (CE, Trafford Healthcare NHS Trust) and DB to draft letter and send to AF - DB confirmed that he wrote to Ron Calvert asking him to consider not tendering the service and suggesting a Network solution that would still meet the cost/efficiency targets on 19th August 2009. He had received a lengthy reply detailing the reasons why the service had to be tendered. DB reported that the tender has since gone out, with a closing date for expressions of interest of 30th September 2009.

DB reported that he had written to MB asking whether it would be possible to avoid the tendering of cervical cytology services. Though he had not received a reply, the letter from Mike Farrar (Chief Executive, NHS North West) to the Cheshire and Merseyside region, stating that the SHA would not support that region's networking plan suggested that any request not to tender was outwith current policy. MD reiterated the consistent view of the NAG in favour of a professional solution. AF reported that that Cheshire and Merseyside had written back to the SHA and were standing their ground. He suggested that Andy Burnham's statement that the NHS is the preferred provider may change the situation.

6 Immunology Diagnostic Service Provision Project

AF welcomed AR to the meeting. A presentation was given on the NW Immunology Diagnostic Service Provision Project with the following key points:

- £2m pump prime funding secured from SHA which has supported the creation of clinical posts and the establishment of a network for communications and dialogue in the North West. This network has been beneficial for clinical practice as well as in determining where future funding will go. The service will eventually be funded by tariff.

- The majority of allergy services are delivered by immunologists, so the two are being looked at together in this project.
- National shortage of clinical immunologists. In the North West it has not been possible to appoint to three consultant posts and joint solutions are being considered.
- The vision is for linked paediatric and adult services, delivered from a number of locations across the region with consultant-led 'hubs' leading a managed clinical network. Work is underway to establish outcome measures that monitor the impact on access, equality, clinical effectiveness and patient experience of the services.
- In terms of laboratory immunology the aims are to:
 - Support specialist allergy and clinical immunology services across the region. Clinical immunologists will act as a base from where diagnosis will be provided
 - Retain centres of excellence - clinical leadership, interaction and support with other local and regional specialities
 - Develop Clinical Governance (accreditation, quality control, audit and assessment)
 - Monitor the impact of POCT on clinical referrals to specialist allergy services and additional laboratory activity. There are particular governance issues around over the counter allergy tests from pharmacies.
- At present there are four regional centres of similar size and offering a similar repertoire at Royal Liverpool, Central Manchester, Salford and Preston. Some immunology testing is provided at other locations (e.g. DGHs) by other pathology disciplines and with some consultant immunologist support from one of the regional centres. This may not be sustainable given the shortage of consultant immunologists and current CPA requirements.

MA asked whether it would be possible to provide clinical support to DGHs with a full workforce in place. MH felt it that hub and spoke work was not appropriate and that any interpretation should be provided centrally. AR reported that Preston are now able to offer remote validation of results at Blackburn and Blackpool with electronic lab links. AW was keen to understand what work DGH labs can legitimately continue to do to control costs and reduce delays in turnaround time.

JS suggested that there is scope for improvement in the pre-analytical aspects of laboratory immunology, with a need for consistent guidance across the patch to guide requesting patterns from GPs. JS added that local labs already have good links with GPs and could support this agenda. JE explained that GP education was to be the remit of the additional medical staff that it has proved difficult to appoint.

DB suggested using the money for vacant consultant posts in other ways e.g. to train someone already qualified in another laboratory discipline. MH explained that the biggest growth area is clinical allergy and investment is being made with Tier 2 nurses and GPs with special interest. JE reported that Salford have recently appointed a clinical nurse specialist who will be able to deliver nurse led clinics.

AF thanked AR for the update on the project.

7 Presentation re: Manchester Academic Health Science Centre

AF welcomed SR to the meeting. A presentation was given on the Manchester Academic Health Science Centre (MAHSC) with the following key points:

- Federated partnership between:
 - The University of Manchester
 - Central Manchester University Hospitals NHS Foundation Trust
 - Manchester Mental Health and Social Care Trust
 - Salford Primary Care Trust (NHS Salford)
 - Salford Royal NHS Foundation Trust
 - The Christie NHS Foundation Trust
 - University Hospital of South Manchester NHS Foundation Trust
- The only AHSC which covers the full spectrum of health care (acute, specialist, mental health, primary Care)
- Formed in June 2008 prior to Lord Darzi's recommendation on AHSCs. One of 5 AHSCs designated by DH in March 2009.

- A virtuous circle of excellence in research and education leading to improved patient care, with unmet clinical need driving research and the diffusion of innovation at the heart.
- Working in partnership with NHS North West and GM Comprehensive Local Research Network (Director Martin Gibson) as well as other AHSCs internationally. Keen to develop external partnerships with industry and local NHS organisations.
- Vision is to be a leading centre nationally and internationally for the uptake of innovation health research and education into health care and to empower the workforce to be innovative.
- MAHSC has the following goals:
 1. **Improve** the health and wellbeing of the population through the development and application of innovative healthcare and research
 2. **Disseminate** innovation in technology and care nationally and internationally.
 3. **Educate** effectively in all aspects of healthcare, healthcare management, and biomedicine in support of workforce development.
 4. **Lead** on quality of care and public engagement.
 5. **Partner** more widely and more beneficially with the commercial sector.
 6. **Contribute** significantly to innovation, enterprise and economic development in the city region and the North West of England.
 7. **Attract** and retain the best national and international health researchers and healthcare workers.
- 5 Clinical Academic sections - cancer, cardio-vascular, human development (includes genomics and biomedical research centre), inflammation & repair (includes tissue engineering and repair, dermatology and musculoskeletal) and mental health
- 4 Enabling Academic sections - infrastructure & technology (including the development of bio repositories), innovation (including increasing clinical trials capability), implementation & health of the public and education and training (including linking with Health and Innovation Education Centres)
- Section leads and overall director to be appointed
- Aim to address the translational gaps between science and clinical research and between clinical research and clinical practice.
- 10-year vision:
 - More than 10 demonstrable health benefits
 - More than 100 new senior national/international health researchers
 - More than 1,000 research-enabled healthcare workers trained
 - Trebled commercial partnerships in drugs and devices
 - Health-conscious population of "citizen scientists" created
- Opportunities for engagement via:
 - CSO Healthcare Scientists Research Fellowship Competition
<http://www.nihrtcc.nhs.uk/hcs/>
 - GM CLRN Priority Groups
 - Enabling and Clinical Academic Section Leads and Deputy Director
- Further information available from www.mahsc.ac.uk and on other UK AHSCs from www.ournhs.nhs.uk/?p=1105

MA explained that there is a Research and Development group at each hospital and asked what engagement there was with these. SR explained that the MAHSC had been inwardly focused at present but was keen to engage more widely and suggested that the best areas of collaboration will be identified by the enabling section head (once appointed) and Martin Gibson (CLRN). KH explained that the research output of Greater Manchester is more than anywhere else in the UK outside Imperial College and emphasised the need for collaboration and engagement with local hospitals. AH explained that representation on CLRN is via Trust R&D departments. SR suggested that MB could discuss with Martin Gibson.

Action 142 - MB to discuss with Martin Gibson how to take forward links with CLRN and MAHSC and find areas of synergy.

AH asked about research enabled workers, highlighting that CLRNs don't support training below PhD level. SR explained that MAHSC are awaiting the development of the Health and Innovation Education Centres, which the SHA is leading, but that they are keen to develop people at all levels.

AF thanked SR for her presentation.

AF welcomed BF (Strategic Procurement, Commissioning Business Service) to the meeting. BF explained that she was representing the stakeholder group. A presentation was given on the tender process for cervical cytology services in Greater Manchester with the following key points:

- A case for the reconfiguration of Cervical Cytology Services in Greater Manchester was presented with options for Commissioner consideration. Following appraisal of the varying options; the consensus was to pursue a formal procurement of the service via the Official Journal of the European Union. Commissioners Consensus Agreement Document - Signed off - the GM PCT CEO Community - MB is project lead.
- It was agreed that changes to the reconfiguration of Cervical Cytology Services is required to ensure a high quality, clinically sustainable and cost effective service in accordance with the Cancer Reform Strategy 2007.
- Project approach:
 - Transparent, non discriminatory, robust - to treat all bidders equally; to be consistent and meet timelines issued; to develop selection criteria that stands up to challenge.
 - Achieve national & local quality standards - including 14 day TAT and appropriate workload thresholds to maintain competence. Also understanding the impacts of new technology e.g. semi-automation and falling workloads.
 - Test market for best solution - using SCIQAS framework - Service, Cost, Innovation, Quality and Assurance of Supply. Each aspect will be weighted and bidders will be asked to provide evidence.
 - Achieve best vfm / affordability - whilst cost is not the key driver in this procurement, it is necessary to reflect the NHS ethos of providing best value for money.
 - Meet specific healthcare needs of respective populations
- Project considerations - will be able to provide more detail later in the process:
 - Communication - a top priority including stakeholder mapping. Support from NHS Salford HR Director and Head of Communications & Marketing. Communications plan to be signed off by steering group and project board.
 - Pathway mapping - to identify where improvements can be made and to best inform potential bidders.
 - Timeline
 - Business continuity - very important to consider to avoid disruption to existing services.

MA asked whether the training element will be incorporated in the tender. BF explained that this has been identified and placed on a risk register along with R&D. These requirements will inform the Invitation to Tender (ITT) considerations and will be mapped as a business requirement. BF explained that the stakeholder group is made up of key individuals including clinicians, the Network, finance, commissioning, HR and communications.

DB did not question the need to reconfigure cervical cytology services but felt that the tender has created another delay in achieving this. As an existing provider DB was keen to understand the timescales for moving to the new service. He again highlighted the fact that the LBC processing contract is up at the end of March 2010 and expressed concern that Bolton may not be able to continue providing a service after this time, having already lost some staff and being unable to recruit more in the current climate of uncertainty. DB felt thus far that the impact on service of the tendering process had been very negative.

BF explained that it is a priority to sign off the communications plan at the earliest opportunity. In addition she is having a meeting with the contract manager and national buyer regarding the processing contracts and hopes this will enable a plan to be put in place.

DB reiterated the very real risk that some aspects of the service will fall before new providers are identified. DB also expressed his personal view that it would be a major tragedy and gross catastrophe if Central Manchester ceased to be a provider, given its status as the largest R&D cytology lab in the UK. MB explained that one of the issues the steering group is wrestling with is how the tender process can support the R&D at Central Manchester and added that this is the first tender he is aware of where R&D has been considered. MD welcomed the tender's

acknowledgement of the national significance of the research work carried out at Central Manchester and felt it was important to safeguard future R&D as well as existing projects.

MD noted that other existing providers were also struggling to sustain services and again reminded the Board that the NAG's preferred option was always a professionally led solution. DB suggested that implementation of this solution could have been underway by now.

MB reminded the Board that the original Arup report commissioned by Lesley Turnbull suggested a two-site solution for Greater Manchester, but this was rejected by the provider organisations at the time. The Network then set about reaching a consensus on a two-site solution, but the time this took brought us into the tendering era and commissioners had no choice but to tender the service. This could have been avoided if providers had cooperated at the time of the publication of the Arup report. MB now strongly believes that tendering can deliver service improvements that would not have been achieved with an in-house solution.

MD expressed concerns about the value for money aspect of the tender. Having sat on the national committee that has just revised the code of practice, MD explained that it is very hard to define the maximum workload for safety. MD explained that independent sector providers may have a workforce delivering a workload that is so high as to compromise quality, but that appears on paper to offer best value for money.

MD also expressed concern that there was no NAG representation on the steering group and, whilst recognising the potential conflict of interest, asked whether the NAG would be able to provide professional advice on the specification before it is issued. BF explained that there are two clinical representatives on the steering group: Lesley Turnbull and David Nuttall (scientific lead for cytology in Wales) and that she had to be mindful of due diligence in the process. MB agreed to consider how the project can manage professional input from the NAG without contaminating the tendering process.

Action 143 - MB and BF to consider how the cytology tender project can manage professional input from the NAG without contaminating the tendering process.

JE referred to the letter to Acute and PCT Chief Executives informing them of the emerging vision work and asking PCTs to suspend tendering whilst this work is carried out. She asked why cytology services were not included in this. MB explained that it was not possible to cease tendering processes that were already in motion, particularly given the position of the SHA as evidenced by their letter to the Cheshire and Merseyside region. AF again referred to the recent comments by the Secretary of State for Health about the NHS as the preferred provider and suggested this may present some room for manoeuvre. MB argued that this has not yet been translated into a policy document and that these mixed messages were not helpful. He emphasised that choice and contestability are a key feature of how the SHA intends the NHS in the North West to respond to the economic context and argued that choosing another route now would more than likely be subject to legal challenge.

DB conceded that the tendering must go ahead but argued for it to do so as quickly as possible so as not to negatively impact any further on existing services. He also suggested the need for interim arrangements to be put in place if existing providers are unable to sustain services.

BF agreed to keep the Board informed and emphasised that she is very focused on the successful outcome of the project. AF thanked BF for attending the meeting.

9 Network Strategy Group

NJ reminded members of the economic context which will affect the whole of the NHS and of the objectives set by Chief Executives to:

- Measure and improve quality by 20%
- Achieve efficiency savings of 20%
- Sustain an onsite presence of necessary personnel
- Ensure sustainability of future pathology services

NJ highlighted four key stages of the project:

1. Generation and evaluation of options for future services (Sept 09-Jan 10)
2. Determination of preferred option/s and assessment/approval by CEOs (Jan 10-Mar 10)

3. Determination of best delivery model/s for preferred option/s (-Apr 10)
4. Implementation programme (-FY 2010/11 onwards)

NJ explained that the Network has made a request for £67k from the Process for Investment and Reform to support the first phase of the project. This is to secure facilitation skills (including E-Room facility and the costs of the benchmarking exercise across Greater Manchester.

NJ explained that the DH improvement and modernisation teams were approached to provide support on facilitation, however due to timescales and capacity this was not forthcoming. The Network also approached the NW Quality Alliance. Although the latter did not have the capacity to support facilitation, they have offered support on the development of quality metrics.

NJ explained that Collinson-Grant Healthcare will support the facilitation and have already begun with the most recent meetings of the NAGs and Pathology Managers. Collinson-Grant have significant experience of pathology services, having worked with Lord Carter and his team on the recent independent reviews. The programme of work until the end of 2009 has commenced with the initial meetings of the NAGs and the launch of the E-Rooms. Online discussions will be taking place over the next 6 weeks, as well as the discussion of cross-cutting themes throughout October. Early findings will be reported by NAG Chairs to the Strategy Group Meeting on 22nd October 2009. These findings will be consolidated and briefings prepared for the next NAG meetings in November.

DB felt it was important to remind people to use the E-Rooms and NJ asked anyone who has had problems logging on to the E-Room to contact svoysey@collinsongrant.com

Action 144 - RP to contact Network members to encourage them to use the E-Room

Benchmarking

AF felt it was essential to have this information and provided reassurance that the data would be anonymised. JE explained that Pathology Managers were not opposed to sharing information, but did not feel that Keele Benchmarking (or an abridged version thereof) was the best way of getting the information. JE reported that the Pathology Managers are considering projects that will deliver significant demonstrable savings and are due to meet to discuss these on 21st October 2009. JE argued that Keele Benchmarking requires a considerable amount of time and effort from Pathology Managers and was sceptical that it would deliver useable information. PZ echoed JE's views that the results of Benchmarking would not be used. AW expressed concern about who will see the information and what they will do with it. SG agreed that it would be useful to have a clear statement about how the information will be used.

LM felt that it was inappropriate to benchmark different types of providers (e.g. teaching hospital, tertiary centre, DGH) as it is not comparing like with like. There are additional difficulties around the way data is extracted. JE agreed that comparisons across Greater Manchester are meaningless and argued that Pathology Managers already know their own costs and can demonstrate savings.

AF felt that the views on Benchmarking were defensive and protectionist.

JS felt that Pathology Managers have a very narrow view of benchmarking, which he argued is not about creating league tables but about getting measurements about what is going on at a particular moment in time (i.e. a baseline). JS argued that it can never be a waste of time to collect data on activity, staffing and costs and that it is worth putting in the effort to do this. JS reminded members that the emerging vision is not about each lab making a 20% saving locally, but about savings in the health economy of Greater Manchester. Given the efficiencies that individual labs have already achieved over a number of years, there is a need now to look more broadly.

DB argued that the need to save 20% calls for bigger things than savings on reagent costs, ultimately, where labs now have 4 they will need to deliver the service with 3.

LF argued that labs will make savings by first managing demand. Labs need to tell their users what they should be requesting and considering how best to communicate with our users to tell them what tests are/aren't useful. Whilst in the past labs may have looked to increase their repertoire and do more work to increase their income, there is no longer the money in the health

economy to do this and managing demand is therefore essential. LF conceded that there is a lot of work involved in Keele Benchmarking, but argued that it was worthwhile and had been very useful for Pennine in their process of laboratory reconfiguration.

It was clear that the benchmarking issue would not be resolved in this meeting and AF suggested a meeting be arranged between the Clinical Leads, Network Director and Pathology Managers to reach some agreement. AF also agreed to discuss this matter with his CE colleagues.

Action 145 - Meeting re: Benchmarking between the Clinical Leads, Network Director and Pathology Managers to be arranged

Action 146 - AF to discuss Benchmarking with CE colleagues

10 Priority Action Groups

PAG 5 - IM&T

Lab 2 Lab Project

JS informed the Board that the first test (Chlamydia - from Stockport to MMMP) has now gone live and the project is now moving into a roll-out phase for the Telepath laboratories. GB reported that this is looking very promising. Significant progress has also been made for the Clinisys labs who have now placed orders for an interface. A quotation has been received for an interface to the Technidata system used by The Christie, but the order has not yet been placed.

Developing the business case for a single GM LIMS

JS reported that a project manager (David Slater) has been appointed and that the first meeting of the project board (Chaired by AF) has been arranged for 20th October 2009. The project board includes director level representation from Acute and Primary Care. A stakeholder project team will be established including all lab disciplines and clinical, scientific and managerial staff to look at all aspects. JS explained that whilst a single system is not a given there is a strong drive that it will deliver quality and financial benefits.

11 For Information

HMD Update

Paper tabled.

Guidelines for Point of Care Testing in the Community Setting

JS explained that these have been developed by the POCT PAG and will be launched for consultation with primary care at the Listening Event on 7th October 2009. He felt this was an excellent example of what the Network can do and encouraged the Board to give their feedback.

12 Any other business

KH reminded members of the Listening Event: Meeting the Needs of Primary Care taking place at Bredbury Hall Hotel on 7th October 2009.

13 Date of Next Meeting

The next meeting will take place at 2pm - 4pm on Friday 18th December 2009 in the Salford Suite, St James House, Pendleton Way, Salford, Manchester, M6 5FW.