

Greater Manchester Pathology Network Board Meeting
Friday 18th December 2009
G54, One Central Park, Northampton Road, Newton Heath
Manchester, M40 5BP
2pm - 4pm

Notes of the Meeting

1 Present

Dr David Alderson (DA)	- Director of Pathology, Trafford Healthcare NHS Trust
Dr Gordon Armstrong (GA)	- Consultant Histopathologist, Salford Royal NHS Foundation Trust
Dr David Bisset (DB)	- Consultant Histopathologist/NAG Chair, Royal Bolton Hospital NHS Foundation 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
Dr Gillian Burrows (GB)	- Director of Pathology, Stockport 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 Andrew Hutchesson (AH)	- Pathology Clinical Lead, Royal Bolton Hospital NHS Foundation Trust
Mr Nigel Humble (NH)**	- Pathology Manager, Tameside NHS Hospital Foundation Trust
Prof Keith Hyde (KH)	- Network Clinical Lead/Deputy Clinical Director, Central Manchester NHS Foundation Trust
Mr Neil Jenkinson (NJ)	- Network Director, Greater Manchester Pathology Network
Mrs Laura Kidd (LK)	- Network Administrator, Greater Manchester Pathology Network
Dr Lia Menasce (LM)	- Clinical Director, The Christie NHS Foundation Trust
Mrs Rachel Pearson (RP)	- Network Business Manager, Greater Manchester Pathology Network
Mr Jeff Seneviratne (JS)	- Network Clinical Lead/Biochemistry NAG Chair

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

**representing Dr Neha Dalal, Clinical Director of Pathology, Tameside Hospital NHS Foundation Trust

In Attendance

Dr Ian Barnes (IB) - National Clinical Director of Pathology, Department of Health

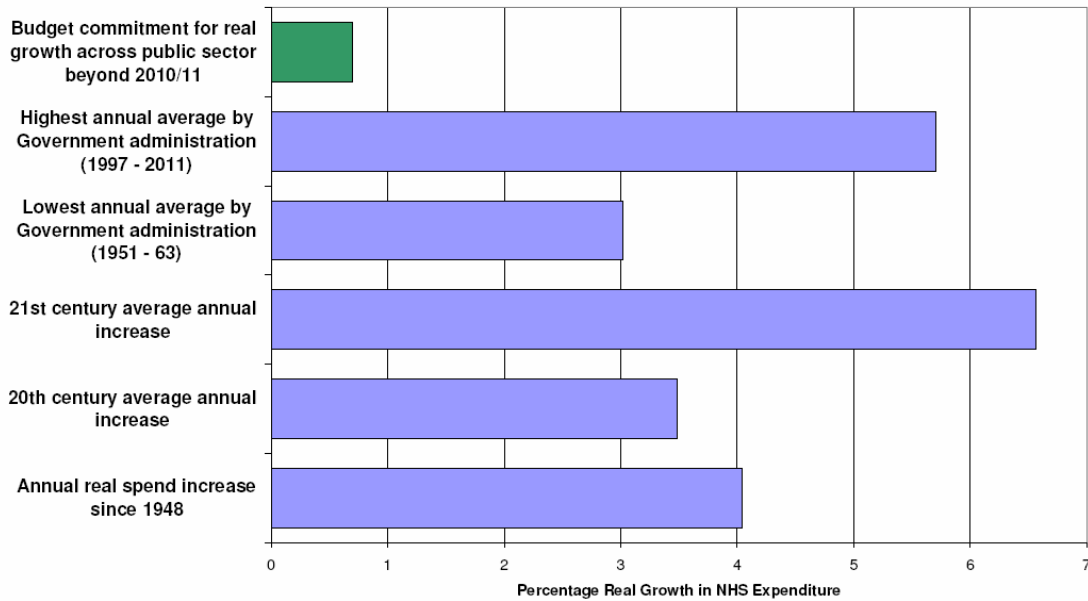
2 Apologies

Dr Mohammed Al-Jafari (MA)	- Chair, RCPATH NW Regional Council, Consultant Pathologist Warrington & Halton Hospitals NHS Foundation Trust
Dr Brian Benatar (BB)	- Director of Pathology, Pennine Acute Hospitals NHS Trust
Dr Mike Burrows (MB)	- Joint Chair, GM Pathology Network; Chief Executive, Salford PCT
Dr Matthew Helbert (MH)	- Consultant Immunologist, Central Manchester NHS Foundation Trust
Dr Sezgin Ismail (SI)	- Director of Pathology, UHSM NHS Foundation Trust
Mr David Rowlands (DR)	- Haematology NAG Chair, UHSM NHS Foundation Trust
Dr Andrew Turner (AT)	- Consultant Virologist, Central Manchester NHS Foundation Trust
Mr Allan Wilcox (AW)	- Pathology Manager, Wrightington, Wigan & Leigh NHS Foundation Trust

3 Chair's Communications

AF gave some political background and summarised that over the last 10 days there has been the Pre Budget Report, which confirmed the £15-20bn savings required and the publication of [NHS 2010-2015](#) and the [NHS Operating Framework for 2010-11](#). The latter document outlines a 3.5% reduction in tariff, as well as the mechanisms by which PCTs will be able to withhold funds from providers. AF felt it was therefore important to ensure sufficient substance to the Network's proposals around the feasibility study. The current economic context is best highlighted by the following graph:

Trends in NHS Expenditure (Source:- King's Fund & IFS "How Cold Will It Be?")



EB commented that the savings needed will require big changes and asked whether Trust or PCT mergers would be likely, noting that such organisational restructuring could significantly change the landscape in which the Network is operating. AF stated that the Operating Framework suggests a 30% cut in management costs for SHAs and PCTs and this could be interpreted as a move towards fewer PCTs. In London, for example, the 30+ PCTs have come together in 7 clusters. The Operating Framework also states that any NHS Trust that is not a Foundation Trust will have to have an agreed destiny in place by the end of 2010 and this must be implemented by 2013. This may mean mergers with existing FTs. Organisations in Greater Manchester are considering horizontal integration of clinical specialties. AF explained that whilst GM Acute Trust CEs are keen to explore vertical integration (i.e. community services being delivered by Acute Trusts), this is not widely supported by PCTs, who are concerned about the impact on community services. DA confirmed that Trafford Healthcare Trust and Trafford PCT are moving towards becoming an Integrated Care Organisation. NJ confirmed that discussions around vertical integration are underway in both Salford and Bolton and explained that other PCTs are keen to move towards Community Foundation Trust status.

4 Notes of the meeting held on 2nd October 2009

The minutes of the previous meeting were agreed.

5 Matters Arising

On Action 142 - MB to discuss with Martin Gibson links with CLRN and MAHSC - This action has been carried forward as MB had given apologies.

On Action 143 - MB and BF to consider how the cytology tender project can manage professional input from the NAG without contaminating the tendering process - JS explained that as the NAG is constituted of potential providers it was inappropriate for them to comment on the specification prior to publication. He confirmed that both himself and NJ are now members on the Stakeholder group working with the CBS to give professional input into the cytology tender.

On Action 144 - RP to contact Network members to encourage them to use the E-Room - RP confirmed that although another email about the eRoom had been circulated it has to date had little impact.

On Action 145 - Meeting re: Benchmarking between the Clinical Leads, Network Director and Pathology Managers to be arranged - RP confirmed that there have been a number of meetings with Pathology Managers.

On Action 146- AF to discuss Benchmarking with CE colleagues - AF confirmed he has spoken with all his CE colleagues and that there is now commitment from 9 of the 10 Trusts to provide the benchmarking data requested.

6 Emerging Vision for Greater Manchester Pathology Services

National Update from Dr Ian Barnes

AF welcomed IB to the meeting and thanked IB for providing this opportunity to connect what we are doing locally to the main messages nationally.

IB explained that in the previous financial crisis in the mid-1990s there was a shortfall of £1bn, which underlines the extent of the current economic problem. IB felt that this issue is financial, not political. Consequently the agenda will not change with a change of government. IB explained that pathology services are regarded as having an independent evidence base for savings and service redesign in the Carter report. There is some work currently underway via SHAs to refresh the data collected by Carter, which is now 4 years old. This will provide services with an opportunity to demonstrate what savings have been made since the original data was collected, but may also highlight further possible savings.

IB explained that QIPP (Quality, Innovation, Productivity and Prevention) has now been rebranded as 'The Quality and Productivity Challenge'. The traditional response to the need to make savings has been to allow waiting lists to grow, but the DH has been explicit about not losing the significant progress that has been made on waiting times and access over recent years of investment. There is now a need for a new approach on a system wide basis (e.g. via Networks), but this is not facilitated by the current system which is based on competition and empowering autonomous FTs. IB felt that it will be to the advantage of services and patients for pathology to take an integrated approach and work across organisational boundaries.

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. The pass/fail nature of accreditation is unlikely to deliver this.

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. IB confirmed he must produce a report on how pathology services can support the QIPP programme by the 3rd week of January 2010. IB explained that a solution must be clinically and professionally led across the wider health community, but will be driven nationally.

IB explained that the £500m savings outlined by Lord Cater have been split equally across the 10 SHAs, with each SHA being asked to save £50m. An SHA Analytical Group has been established to collect data. This will provide a snapshot to see if the Carter target is still relevant. The DH has also set up an SHA Pathology Forum, with representatives from all SHAs. Regular meetings are scheduled for 2010, with the first of these due to take place on 12th January 2010. SHAs will review all pathology services across their patch. Most SHAs have signed up to the programme which has been badged as the Carter recommendations. IB stressed he wants to see the long term sustainability of a professional service that is critical to patient care and urged the professionals to place patient care ahead of territory, power and organisations. IB also warned the group not to underestimate the private sector as the position we find ourselves in now is different than ever before. Serco are expanding and have a model of delivery.

IB argued that if we 'grasp the nettle' we can deliver what's needed: collaboration is essential but there is no 'one size fits all' solution. There are many drivers here, the NHS provides good pathology but the variability is now becoming a health risk to patients. The use of different reference ranges is a major issue due to the increase in patient self management. IB felt that it is unacceptable for the amount of variation in pathology to continue and that this is a professional issue to be addressed with some urgency.

AF thanked IB for taking the time to attend the meeting and update the Board members. AF commented that Greater Manchester's share of the Carter £500m equates to £35 million. AF felt that if the SHA is convinced by the Network's proposals they will leave us alone to get on with it.

AF asked IB if he felt that the DH will be able to offer any help on generic issues such as IT and demand management. IB explained that there have been a DH-funded projects to start to provide some of the tools, especially around IT (via Gifford Batstone) and also primary care benchmarking. IB explained that it is not always easy to roll these out nationally. IB stated his disappointment that the professional bodies within the service have not done more to standardise working practices and ranges and to manage demand.

LF commented that he has spent weeks talking to colleagues at Pennine about demand management but there is no buy in at grass roots level. Hospitals are still carrying out defensive medicine rather than taking an evidence based approach. IB suggested the need for an iterative, educational process and for more skilled pathology professionals at the clinical interface. There are also often perverse financial incentives which have hindered effective demand management in primary care pathology.

AF commented that the NHS is facing a period of economic doom and that the agenda can only be delivered by fundamental changes to clinical behaviour. IB agreed that pathology professionals need to make a better case to clinical teams about the role of pathology in helping to deliver their clinical agenda (e.g. cancer, renal, diabetes, infection control etc.).

LF asked what would be appropriate performance measures. IB felt that this should encompass clinical measures including TATs and that laboratories should think about what they provide that is of use to commissioners and clinicians. This includes a need for in transparency around performance and prices. IB suggested that performance should be related to clinical need and patient benefit.

LM mentioned that it is difficult to work collaboratively due to the constraints of being within individual, often Foundation, Trusts. LM asked if it is possible to have a single management structure and be almost a single Trust where our current lab set up would not change and the labs are seen as branches. There would be standardisation and no competition. IB answered that he has always envisaged Pathology should be a stand alone Trust with central organisation and standardised working practices. AF commented that the idea of a stand alone Trust would not be palatable to Acute Trust CEs.

EB commented that there should be different delivery models for the different disciplines. If the solution is sought professionally by discipline rather than pathology as a whole it will be more successful. Within the Microbiology NAG, for example, it was agreed that no samples need to be processed on site, which opens up all sorts of new possibilities. Each discipline is different and should be treated as such. IB agreed and reiterated that one size will not fit all. DB enquired when we will get a chance to see all the national and central plans as this could have a bearing on our direction. IB confirmed that there will be a series of communications from the DH in the New Year. DA mentioned that Alistair Darling's budget speech had been very specific about a cut in IT spends within the NHS. IB replied that much has been publicised since the speech stating that this was misrepresented and confirmed that the DH are looking at an IT programme.

Network 20:20 Vision

AF asked NJ to give a process update regarding the feasibility study. NJ explained that when the Network was established the *raison d'être* was to raise the profile of pathology sufficiently so that it could control its own destiny, with any changes being professionally led.

NJ gave an overview of the process so far, starting with the SWOT analyses in the first half of 2009, followed by the NAG meetings in July, NAG facilitated sessions in September, which considered how future services may look in terms of technology, demand and workforce and finally the November NAG meetings, which focused on potential models of service delivery along a continuum from 'do nothing' to 'fully centralise'.

NJ informed the Board that the Strategy Group have now tasked the Network with writing up and producing the document to go to CEs in the New Year. A writing group has been scheduled for 7th January 2010, a framework is already in place and it will be crosschecked across the NAG meetings in January 2010. NJ explained that the Writing group will meet until February 2010 and

then the document will go to the Strategy Group on 19th February and the Network Board on 26th February for approval before submission to CEs on 19th March 2010.

Action 147 - LK to schedule Writing Group dates to mid-Feb 2010

JS confirmed that the document will focus on a number of options from ‘do nothing’ onwards but reminded the Board that the document needs figures which have not yet been finalised due to delays in receiving the benchmarking data. KH highlighted that consensus is emerging around a 3 sector model, recognising that more discussions need to be had on the details around this. KH also alluded to the 10 high impact changes including standardisation of protocols and reference ranges, phlebotomy, IT and transport. AF was encouraged by the collaborative approach emerging towards a 3 sector model where all organisations will be treated equally, fairly and retain sovereignty but share the work and the savings.

AF informed the Board about a presentation given to the Strategy group by LF on the “Pennine Way” and explained that the rule of thumb is anything requiring a 4 hour TAT stays on site. AF went on to inform the Board that Pennine had kindly shared their financial information and had shown that over a 4 year period Pennine has achieved a 4% cash saving, taking into account current inflation that equates to a 16% saving. At this point it was stressed that much of Pennine’s success can be attributed to the single IT put into place upon the merger and the fact that the redesigned laboratories were part of a single Trust. RB confirmed that Pennine is now working on electronic GP access to reduce repeat testing and make more cost savings. JS stressed that any proposals are dependent upon the correct IT system and that this is a prerequisite. JS confirmed that GP Order Comms is currently being rolled out across GM and will help eliminate some issues.

AF took the group back to the beginning of this project and reminded the members of the original anxiety felt. He expressed his pleasure to see the emergence of the feeling of this can be achieved and how encouraged he is. AF mentioned that Phase 1 - produce a broad set of costings to CEs for agreement for economic modelling to begin is about to be completed. Based on this AF felt it would be helpful to understand any concerns that members still had. DB mentioned the Emerging Vision which is sometimes referred to as the “Emerging MRI Vision” it could be seen as a take over rather than a joint venture. KH stated very clearly that MRI wishes to collaborate. EB also confirmed that the MRI has no hidden agenda and is committed to working as a network. The MRI provides specialist services throughout GM and the NW and would want to continue to do so for the benefit of patients.

DB felt it may be difficult to define the sectors and AF suggested that it would be up to them to define. DA commented that Trafford is a small and vulnerable Trust and previous attempts to collaborate have started well and then hit a brick wall because of the nature of FTs.

AF stated that sharing information across FTs is a common issue as has been seen by the request for benchmarking data. DA confirmed his CE has been in touch regarding benchmarking and he is happy to share information as long as everyone is releasing the same. There are unfounded rumours that some Trusts are prepared to only release certain information. NJ confirmed that the mini Keele exercise was used simply as an equitable collation exercise. EB emphasised the need for data for the whole patch and suggested a role for the CBS in independently reviewing the data, as has been the case for TB services.

JE stated that the Bolton, Wigan and Salford are currently sitting down and sharing their budget information. AF stated it is far better to do this voluntarily. DB mentioned the “what we can do with 5 people we need to do with 4 argument” and how we get around this. AF explained that there is a degree of getting around this as 10% of the workforce leaves annually and skill mix can be reviewed. AF reminded the group that every service will have to do this.

7 Any other business

Therapeutic Apheresis

NJ explained that the Network has applied to the Process for Investment and Reform for project management time to support the development of a business case for a GM Therapeutic Apheresis service, but that this has not been forthcoming as PCTs regard this as a provider issue. DA felt that this was an inappropriate response as the service is ultimately funded by PCTs and GM is the

biggest conurbation not providing this service. NJ agreed to find out who is the lead commissioner for NHSBT via AGMPCTs.

Action 148 - NJ to find out who is the lead commissioner for NHSBT via AGMPCTs.

Commissioning Cover

AF explained that NJ will be Acting Director of Commissioning for NHS Manchester for 3 months from 1st December 2009. NJ will continue as Network Director for this time.

Christmas Thanks

AF took the opportunity to thank the Network support staff for their hard work this year and also all the members of the Network.

8 Date of Next Meeting

The next meeting will take place at 2pm - 4pm on **Friday 26th February 2010** at One Central Park, Northampton Road, Manchester, M40 5BP

N.B. All meetings in 2010 will be held at One Central Park