

Greater Manchester Pathology Network Board Meeting
Wednesday 14th April 2010
The Manchester Suite, The Place Apartment Hotel,
Ducie Street, Manchester, M1 2TP
3pm - 6pm

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 Brian Benatar (BB)	- Director of Pathology, Pennine Acute Hospitals NHS Trust
Mr David Brayshaw (DB)*	- Directorate Manager, Central Manchester NHS Foundation Trust
Dr Mike Burrows (MB)	- Joint Chair, GM Pathology Network; Chief Executive, NHS Salford
Dr Reeta Burman (RB)	- Consultant Microbiologist/NAG Chair, Pennine Acute Hospitals NHS Trust
Dr Gillian Burrows (GB)	- Director of Pathology, Stockport NHS Foundation Trust/Biochemistry NAG Chair
Mr Trevor Carr (TC)	- Clinical Director/Consultant Clinical Scientist, Central Manchester NHS Foundation Trust
Dr Neha Dalal (ND)	- Clinical Director of Pathology, 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 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
Dr Sezgin Ismail (SI)	- Director of Pathology, UHSM 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
Mr Allan Wilcox (AW)	- Pathology Manager, Wrightington, Wigan & Leigh NHS Foundation Trust

*representing Prof Eric Bolton, Clinical Director, Health Protection Agency/Central Manchester NHS Foundation Trust

In Attendance

Ms Bernie Foley (BF)	- Strategic Procurement, Commissioning Business Service
Ms Susan Pritchard (SP)	- Acting Programme Manager, NHS Northwest
Mr David Slater (DS)	- GM LIMS Project Manager, Greater Manchester Pathology Network

2 Apologies

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
Prof Eric Bolton (EB)	- Clinical Director, Health Protection Agency/Central Manchester NHS Foundation Trust
Dr Matthew Helbert (MH)	- Consultant Immunologist, Central Manchester NHS Foundation Trust
Prof Keith Hyde (KH)	- Network Clinical Lead/Deputy Clinical Director, Central Manchester NHS Foundation Trust
Mr Roman Pylypczuk (RPy)	- Haematology NAG Chair, Salford Royal NHS Foundation Trust
Dr Andrew Turner (AT)	- Consultant Virologist, Central Manchester NHS Foundation Trust

3 Chair's Communications

AF informed the group that although the agenda states the meeting will run from 3pm - 6pm it would be finished by 5pm.

AF thanked the main people who have worked tirelessly at the heart of the 2 main projects for discussion today: GM LIMS and Emerging Vision

4 Notes of the meeting held on 18th December 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 - MB will chase MG regarding meeting attendance. Action carried forward

On Action 147 - LK to schedule Writing Group dates to mid-Feb 2010 - This action has been completed.

On Action 148 - NJ to find out who is the lead commissioner for NHSBT via AGMPCTs - DA explained that Apheresis is not a diagnostic issue and therefore probably outside the scope of the Network. He confirmed he has sent a letter regarding a Regional Therapeutic Apheresis service to Dr Mike Cheshire, Medical Director at NHS NW, and is awaiting a response.

6 Cervical Cytology Service Redesign

BF began by informing the group that a selection of slides (including the project timeline) has been included in today's papers. BF went through the timeline (which is on schedule) in detail beginning with the issue of the Invitation to Tender on the 31st March 2010. The deadline for bidder responses is midnight on the 5th May 2010.

BF explained that the evaluation will continue through May including IMT and Finance. A recommended bidder will be selected by the end of May.

BF explained the governance process so far as illustrated in the slides. All documentation has been to the following bodies and has been agreed:-

- Stakeholder Group
- Directors of Finance (AGMPCTs)
- Directors of Commissioning (AGMPCTs)
- Commissioning Programme Board
- Project Board - AGM PCT CEOs

Similarly BF explained the engagement process and that a briefing paper has been to each of the following groups and is available via the AGM PCT website at the following link <http://www.agmpcts.nhs.uk/documents/index/cPath/31>

- Health Overview & Scrutiny Committees
- North West Social Partnership Forum
- NHS North West
- National Office-Cancer Screening Services
- GM Pathology Network
- HR via Local & AGMPCT Web

MD enquired if the provision will include Cervical Cytology screening samples from Colposcopy. BF believed that it has been included but preferred to check and encouraged MD to use the bidders' messaging platform so that all bidders would get the same message.

Below is a further written response to the verbal response given at the meeting:

Question: Will the provision include Cervical Cytology Screening Samples from Colposcopy?

Response: As Colposcopy screening samples are part of a separate pathway & not classed as population derived screening samples they remain outside of the scope of our provision. However, the Stakeholder Group have identified as part of our mobilization effort our responsibility to inform the referring trusts of GMs new contracted arrangements in order to allow referring trusts to make the necessary provider to provider arrangements with regard to all diagnostic referrals.

Furthermore - the Stakeholder Group have plotted a specific business requirement within the ITT which reads as follows:

[ITT.5.4]	Bidders must describe the systems and processes they will have in place to: <ul style="list-style-type: none"> • Wherever possible, provide direct referral to all colposcopy units with which they are associated • Ensure monitoring of referrals in terms of clinical appropriateness; • Ensure monitoring of delays in referral • Ensure all referrals have been received by the colposcopy units. • Identify and manage any referrer training and development needs;
Notes:	Short Listed Bidders responses must be entered in the space below. Additional documents, if provided, must be attached in accordance with the instructions in ITT Volume 1

7 GM LIMS Strategic Outline Case

AF explained that the full Strategic Outline document regarding the feasibility of the procurement of a single LIMS system for GM has been circulated to the group and so today the group will be asked to concentrate on the Executive Summary which has been prepared to go to the CEs meeting on 16th April 2010.

DS explained that currently in GM we have 12 live systems of which 1 serves 4 labs. Each Trust is responsible for the replacement and maintenance of their LIMS system and under the terms of replacement equipment has a 10 year life. Procuring a new system seems to be low priority within Trusts although some of these systems were installed in the early 1990s and do not reflect the needs of pathology today. DS pointed out that if we want to reconfigure pathology services across GM we will need a single IT system to make this possible.

DS confirmed that he has worked closely with an Acute Trust Director of Finance to enable the costings quoted to be as realistic as possible. It appears that the main cost savings will be around patient transfers and the reduction of duplicate testing which it is estimated will save £1.8 million per annum. A further annual IT saving of £0.5 million means a realistic saving of £2.3 million.

DS confirmed that the total procurement cost will be £7.065 million. This figure is based on the cost of the All-Wales LIMS procurement as well as quotes from two suppliers. MB confirmed that numerically the population of Wales is comparable to GM and that Wales has 14 labs in total and GM has 12.

BB showed support for the project but expressed concerns around information governance and data security. DS agreed this was a legitimate concern which will be addressed in the detailed specification. MB confirmed that the new system will need to comply with the latest NHS patient information security standards and any unauthorised staff accessing the system will be dealt with accordingly as that is a disciplinary issue. JS reiterated that an appropriate Information Governance Structure will be put in place for example GPs will only be able to access their own patients not the whole database. JE commented that the EPR system at SRFT asks staff to fill in why they are looking at a patient record. JS agreed that there are serious issues to be addressed around security and pointed to learning from similar large projects spanning Trust boundaries e.g. PACS.

GA enquired about the experience of the 2 companies approached to provide costings for the system. DS explained that both are existing suppliers, one of which is the preferred supplier of pathology systems through CSC (NPfIT) and DS is personally confident they can provide what we want. MB emphasised the capability to deliver would be assessed through formal procurement. GA commented that one of the quotes did not cover professional services and so an estimate had to be used. As we are unsure of the costs this could potentially push the cost up by £0.5 million. GA also enquired if the companies are aware that the reconfiguration of services could mean a reduction in the number of labs and could this potentially affect the cost to procure. DS confirmed that this had been discussed. GA also enquired who will fund the £7.065 million to procure the system? JE informed the group at a recent meeting Dr Mike Cheshire, Medical Director at the SHA had confirmed the awareness of the need to invest in IT for reconfiguration to be successful. NJ reminded the group that the DH is pushing consolidation across the system and this makes a good case invest to save case.

BB enquired if the introduction of a single LIMS system could make larger savings if rolled out across the North West. AF, NJ and DS confirmed that this had already been discussed and could provide potential further down the line.

AF enquired if the group support the procurement of a single LIMS system for GM and the group agreed. It was concluded that the GM LIMS Executive Summary will be presented to the CEs on the 16th April 2010.

Action 149 - MB and AF to present GM LIMS case to respective CEO colleagues on 16th April 2010

8 Emerging Vision Strategic Outline Case

As with the GM LIMS Strategic Outline document, AF explained that the full 20:20 Emerging Vision Strategic Outline document for the feasibility study of the redesign of pathology services in GM has been circulated to the group. Today the group will be asked to concentrate on the Executive Summary which has been prepared to go to the CE's meeting on 16th April 2010. Today the Board will decide whether to present the document as it stands, tweak it or not send it at all.

NJ took the group through the Summary beginning with the launch of the Pathology Modernisation programme in 1999. An independent review of Pathology Services followed in 2005. The GM Pathology Network was challenged by the CE community in May 2009 to undertake a professionally led feasibility study for the future of Pathology Services in GM. The four main objectives laid out were:-

- The achievement of efficiency savings of 20%
- Measurement and improvement of quality by 20%
- Sustaining on-site presence of necessary personnel and services in GM
- Ensuring sustainability of future pathology service in GM

NJ continued that all information gathered has been via the NAG and PAG groups and that a total of 250 members and stakeholders have been consulted. There has been every opportunity to contribute including E-Room discussions and newsletters. NJ explained that the SHA is encouraging all organisations to work at Level 3 - whole systems approach and that the drivers for change are national, regional and sub-regional. The work has led to the emergence of 3 options for the future:-

- Option A - Collaborative Model
- Option B - Consolidated Model
- Option C - Centralised Primary Care Model

Each option has been appraised and Option B scored significantly higher than Options A and C. It was felt that Option A would not meet the challenge and Option C may destabilise on-site hospital pathology services. The Strategy group felt that more detail was needed regarding Option B and so Options B1, B2 and B3 have been produced.

It was concluded that the consolidation of services is the only way to achieve the four objectives set by the CE community and therefore the recommendation to the CE's will be that the consolidation model is the best way forward for pathology services in GM. CE's will be asked to endorse the 5 points in the conclusions and agree to the second phase of the project which will be to produce both economic and capacity modelling.

DA commented that as his Trust is a very small and vulnerable Trust he had looked at the report in depth and supports a lot of the document. DA felt that although some Trusts fall into natural clusters some do not and that potentially it would be better to have 4 clusters. SI and JE commented that they had also been asked by colleagues to point out the potential for a fourth cluster. JS answered that the 3 clusters are only for illustrative purposes and no one has ruled out a fourth cluster the point is regardless of number of clusters we all need to work together. Members raised concerns about the size of the Central and South sector and DB commented that CMFT is not predatory in any way and supports a lot of regional activities including tertiary services which are expensive. DA and other members of the group commented that the HPA tariff is very high and AW commented that the recent outbreaks of measles has seen an increase in in-house testing as it is cheaper than sending it to HPA.

JE commented that the Strategic Outline document is very good but argued that no one currently has the capacity to take all work if it is centralised and so reconfiguration by discipline could be a better direction. JE also mentioned that on Monday 12th April 2010 at the National and Regional Pathology Modernisation Programmes meeting held by NHS North West it was agreed to reduce the NW footprint groups from 7 to 3 (Greater Manchester, Cumbria & Lancashire and Cheshire and Merseyside). It emerged from this meeting that GM is ahead of the game. NJ reiterated that the concept is to share resources. AF asked if a sentence could be inserted after the cluster options to state these are only for illustrative purposes and other clusters and distributed models are possible. JS reminded the group that the next phase of the project will be economic modelling and MB commented that this is the function phase and next will be the form phase.

LM commented that not all Specialist Services are acknowledged in the paper and felt there should be mention of histopathology second opinion referrals. LM also suggested the need to consider the relationship between pathology and genetics/cyto-genetics.

GB commented as Clinical Director for Stockport the inclusion of a fourth cluster is needed but that as Chair of the Bio NAG the group feels that the document does not support their comments and feelings. GB commented that when the Bio NAG carried out their option appraisal option A was do nothing after which the definition was tweaked. The Biochemistry community are unhappy as they would prefer Option A but do more with it. They feel they have seen no evidence that Option B will work. AF commented that it has worked for Pennine and GB replied that the Bio NAG group do not feel Pennine is a good model for GM. AF enquired if the group do not feel Pennine achieved savings in Biochemistry. GB stressed that no financial evidence has been forthcoming despite requesting it. JE stated that at the presentation given to the Strategy Group by Len Fielding, Pathology Manager at Pennine Acute Hospitals NHS Trust the only discipline that needed investment was Haematology and the other disciplines all realised savings. GA enquired about the savings made at Pennine and NJ confirmed that the savings Pennine have achieved are comparable and would achieve the 20% needed for GM. SI enquired if there is any evidence of quality improvement at Pennine and how has it been measured. BB stated that Pennine are paying for an expensive new build which has dampened the savings made. DA commented on his enthusiasm for the impending changes and the potential for what can be achieved if we join up and work together but stressed the importance of maintaining the clinical connection. Members felt that the rotation of staff could aid retention and recruitment and be good for career progression.

RB felt that the presence of a clinical microbiologist is essential on site and asked if the views of clinicians outside pathology had been considered. AW assured RB that all results can be accessed by telephone or remotely. NJ stressed that during the implementation phase the best configuration for each discipline will be determined based upon the needs for GM services and will be guided by professionals. JE commented that as soon as a decision is made by the CE's this document will circulate wider for comment by other clinical colleagues.

JS remarked that the original exam question was how can we provide pathology services for GM for 20% less than we currently do and that the evidence gathered shows this can only be achieved through consolidation. Macclesfield and Crewe have recently merged labs successfully improving quality and making savings. DB commented that further down the line we could look to consolidate On Call and make further savings and quality improvements.

AF summarised that fears and concerns could be allayed by the inclusion of a fourth cluster and that many of the other worries are in the reconfiguration detail and are not pertinent to this stage of the project. Some people want to effectively continue as we have for the last 2-3 years whilst others feel that this approach will not wash. As a CE AF feels that carrying on as before is not a credible option and most people in the Network have agreed with Option B. JE confirmed that the Pathology Managers are in support of Option B with a 4th cluster. GB stressed that the Bio community feels we have progressed in the last 6 months with the introduction of harmonisation and joint/central procurement and could go further with Option A. TC enquired if we need the cluster options in the Executive Summary at this point at all? AF confirmed that as a CE yes the clusters are needed as CE's are very interested in natural sectors the resolution of which will be in the next stage. AF asked again does the group broadly support the paper with the additions discussed. DA and GA pointed out some inaccuracies within the full document and members were asked to email RP, NJ and LK with any comments pertaining to errors of information and typing so they can be rectified.

Action 150 - NJ to add Option B4 (4 clusters) to paper

Action 151 - All members to email comments and errors to RP, NJ and LK

AH commented that the specialist ante natal screening service should be mentioned as it is already centralised and it would be a shame to make changes to a service that works so well. AH also felt it was regrettable that at Monday's SHA meeting the conclusions and recommendations had been put forward before being presented to this Board. JS commented that at the last minute three sub regions of the SHA were asked to give a presentation to show their current direction and that it would have been an injustice to the GM Pathology Network not to give an insight into what we have achieved. JS also remarked that the presentation was heavily caveated and it was stated that no decision has yet been reached by the Board.

MB recognised that the next stage of the project will be very labour intensive and will need additional resources. He agreed to discuss this in more detail with AF. AF felt that the issue of funding needs to be addressed and should be included in the paper.

Action 152 - MB and AF to discuss generation of resource for next stage of 20:20 project

It was agreed that there is broad general support for the paper to be presented to CE's on 16th April 2010.

Action 153 - MB and AF to present Emerging Vision case to respective CEO colleagues on 16th April 2010

9 NHS North West Pathology Transformation

SP from NHS NW explained that there was an indication from Monday's meeting was that the meeting of Networks was welcomed and should continue on a more formal and regular basis. Minutes from the meeting will be circulated by Friday 16th April 2010.

SP explained the need for good governance and nominations for a NW Pathology Transformation Board are being sought for a PCT CEO, Acute Trust CEO and Clinician from each of the three Network areas in the North West. Once nominations are received and the TOR is pulled together a board meeting will be held in May prior to the Regional meeting on 25th May 2010. SP reiterated that all feedback is welcomed. The Network Board felt it would be sensible for MB and AF to provide CEO representation for Greater Manchester. MB and AF agreed to do this.

SP confirmed that the message from Mike Cheshire, Medical Director at NHS NW on Monday was not about the SHA telling everyone what the answer is but how we must pull together. SP suggested that some resource may be available from the SHA for the next stage of the 20:20 project.

Members briefly discussed Monday's meeting and DA stated that clearly GM is ahead of the other Networks. MB commented that he is not sure what benefit regular meetings could afford GM due to our current position but that we could share lessons learned and best practice.

10 Any other business

There was no other business.

8 Date of Next Meeting

The next meeting will take place at 2pm - 4pm on **Friday 4th June 2010** at Holiday Inn Central Park, 888 Oldham Road, Manchester, M40 2BS