

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

Network Strategy Group
John Bray Suite, Holiday Inn, 888 Oldham Road, Newton Heath, Manchester, M40 2BS
Friday 26th March 2010 2:00pm-4:00pm

In attendance		Apologies	
David Bisset	DB	Royal Bolton Hospital NHS Foundation T	Brian Benatar
Eric Bolton	EB	HPA North West	Mike Burrows
Reeta Burman	RB	Pennine Acute Hospitals NHS Trust	Steve Downing
Gillian Burrows	GB	Stockport NHS Foundation Trust	Amanda Doyle
Mina Desai	MD	CMFT NHS Trust	Jackie Elliott
Len Fielding	LF	Pennine Acute Hospitals NHS Trust	
Andrew Foster	AF	WWL NHS Foundation Trust	
Keith Hyde	KH	GMPN	
Laura Kidd	LK	GMPN	
Neil Jenkinson	NJ	GMPN	
Rachel Pearson	RP	GMPN	
Roman Pylypczuk	RPy	Salford Royal NHS Foundation Trust	
Lance Sandle	LS	Trafford Healthcare NHS Trust	
Jeff Seneviratne	JS	GMPN	
Gilbert Wieringa	GW	Royal Bolton Hospital NHS Foundation T	
Pat Zukowskyj	PZ	Trafford Healthcare NHS Trust	
			Pennine Acute Hospitals NHS Trust
			Salford PCT
			GMPCTs
			NHS North West
			Salford Royal NHS Foundation Trust

Discussion Points

- **Welcome and Introductions** – KH welcomed the members.
- **Apologies** – Please see above.
- **Notes of the 15th December Meeting and Any Matters Arising** – The minutes of the previous meeting were agreed as a correct record and all actions have been completed. There were no matters arising.
- **Emerging Vision for Greater Manchester Pathology Services** –
- **Update on National & Regional Position** – KH brought all members of the group up to speed with the current economic climate and the challenge faced by the NHS. KH explained that through information gained via the NAGS the Writing group have drafted a Strategic Outline Document to be ratified by this group and then presented to the GM Pathology Network Board on 14th April 2010.
- AF reiterated that as KH has shown we are currently operating at level 3 but that things have moved on since we began this feasibility study last year. Things have changed and the DH is keen to move forward with the Carter recommendations and is eager to know what is happening in pathology. AF explained that CE colleagues are less sceptical than at the beginning of this project and the signs are if we give an indication that we can deliver we will be given the green light to begin the second phase of our strategy. AF highlighted the potential uncertainty given the forthcoming general election. AF remarked that although through the NAG groups we have made headway in answering the initial exam questions we need to move forward. After agreeing to keep onsite all tests needed within 4 hours we now need to look at what staff we need to keep on site (scientists, doctors etc). The group talked about the scope of laboratories and agreed that any CSL would need to have an ESL built into it.
- RPy enquired if the eagerness from the DH to move on with Carter is all of Carter or selected recommendations? NJ explained that the DH is expecting the SHA to have robust plans in place by June 2010. The group had felt that it would perhaps be better to delay the presentation to the CEs on the 16th April 2010 as the 20:20 Emerging Vision SOC will only be presented to the GM Pathology Network Board on 14th April thus not leaving an appropriate consultation period but AF explained the CEs are teed up for the presentation as originally planned on the 16th April. AF explained he has already flagged the headlines to colleagues and suggested a 1 page summary be presented on the 16th April. The group asked if clarification had been sought regarding the Carter data as it is 3 years old now and some Trusts (Pennine & Bolton) are claiming they have already delivered savings. AF confirmed that these Trusts will still need to produce the 20% savings. JS explained that SHAs have been re-basing the Carter data, but the need to make savings will remain. NJ explained that Mike Cheshire is now Medical Director at the SHA and a meeting has been called for the 12th April to develop The NHS NW Pathology Transformation Plans.
- NJ took the group through the draft document beginning with the background and history, some regional and national context and stated that in July 09 we in GM were ahead of the game. The document continues by detailing the membership of both the Strategy Group and GM Network Board. Section 2.4 details the challenge set by the CEs and section 3 is the project description. NJ pointed out that the initial request to AGM PCTs for £67,000 to support this first stage of the process has resulted in the sum of £30,000 being forthcoming which enabled the collection and completion of

the benchmarking data. NJ explained that in the document enablers have been highlighted IM&T, Benchmarking, Mapping, Transport, Procurement, Workforce and Communications. Section 4 is strategic alignment which AF felt was perhaps in the wrong position within the document. AF asked for members to email RP with any similar comments. Section 5 is the options appraisal and NJ and KH both stressed there is a strong warning and caveat on the data in its current "raw" form. At this point NJ asked for the document to remain private and confidential to this group due to the unchecked data it is still a work in progress until April. Next the group looked at the options for service redesign and sub specialties on page 29 and model descriptions of the 3Cs on page 31:-

- Option A – COLLABORATIVE MODEL
- Option B – CONSOLIDATED MODEL
- Option C – CENTRALISED PRIMARY CARE MODEL
- NJ explained that if the group agreed the models at this meeting we could discuss the options appraisal and benefits. Page 34 onwards details the project risk assessment and moves onto section 8 which is the cost and benefit analysis. Section 8.1 starts to develop the quality metrics using the draft national metrics and 8.2 details Capital such as estate and collaborative procurement, IM&T (including GM LIMS project investment) and transport which it is felt could be improved through funding from improved commissioning and reinvestment. Section 8.3 is the 10 high impact changes which could be achieved relatively quickly. Conclusions and recommendations comes next in section 9 and the final section is the timeline and the way forward. NJ further explained the objective of today's meeting is to agree the core content, models and options appraisals. NJ accepted that there are gaps around costs and informed the group he will be meeting with KPMG next week to gain advice on the best way to progress economic modelling.
- Discussion re: 20:20 Emerging Vision – AF commended the Network on the document in its current form and felt it was excellent in structure, content and flow. AF felt there was nothing that had been ignored or missed. AF confessed that he had slightly mis-sold the project to his CE colleagues as he had hinted at a consolidation model involving the consolidation of each discipline. AF gave a particular mention to the detail in the 20% quality saving section but felt the ticks in the 20% cost saving section needed to be expanded. NJ confirmed that this section needs firming up and figures included. GW enquired about the proposed meeting with KPMG and NJ explained that the original agreement with Mike Burrows had been to get help with economic modelling from the CBS but the general consensus is that the NHS does not have the required capacity. The meeting with KPMG will be to discuss approaches to economic modelling. The group discussed the contribution from the Pathology Managers as listed in the 10 high impact changes. Little detail has been given due to the sensitivity of the subject but the cost saving has been listed as £1.4 million which is a substantial. Members commented that this has been in the offing for a while but other members felt although there have been rumours the realisation it is actually happening may be a shock for staff and needs to be handled appropriately.
- JS updated the group about the Pathology Futures Group led by Gifford Batstone (CFH National Clinical Lead for Pathology) of which he is a member. The group is aiming to produce an informatics strategy for pathology nationally and develop quality metrics. JS had hoped to attend a meeting yesterday but could not. JS agreed to circulate an update to the group.
- RB stated that the Micro NAG had difficulty understanding the definitions of the models and the 4 hour TAT does not work for Microbiology as no result can be given in that timescale. Clinical Microbiologists are concerned about their role in the future but people are coming around to and understanding that there has to be change.
- RPy submitted a report from the Haem NAG which shows there is still debate around the models and the fact that the Writing group concentrated only on these 3 models. There are concerns that some sites have already reconfigured and delivered savings and therefore could do no more, but there is a general consensus and agreement in the NAG.
- GB stated that the Bio NAG wanted to add a 4th model for consideration based around the collaborative model. There are concerns around the ESL and CSL models running 24/7 and therefore not being cost effective. The 4th model would centre around retaining more services on site and collaborative procurement. RPy commented that the Haem NAG also discussed this model but felt that it would not gain acceptance.
- DB commented that the Histo/Cyto NAG have experienced difficulties in coming to a conclusion and events in Wigan (where the pathology offering is being reviewed in the context of a planned new laboratory building) will precipitate things. DB's personal view is that Wigan, Bolton and Salford should merge and become one Trust.
- Model Discussion – KH felt that the 4th model referred to is the Hamilton, Ontario model which KH and JS visited 10 years ago. This entailed retaining 4 labs overall with one discipline centralised at each lab. KH suggested checking to see what the outcome has been and what progress has been made. EB felt that the consolidation model was unclear as it could mean centralise everything to 1 site or disciplines to one site. EB also felt that we needed to include longer working hours and focus on the clinical needs of each site and possibly define a minimum data set for each discipline. JS pointed out to the group that the consolidation model doesn't specify how consolidation should take place that is the delivery aspect of the model. AF felt that the definition on the collaborative model should be expanded and that model C is just a version of model B. Model C is the nuclear model. This would potentially meltdown pathology services and as many people within PCTs do not have a clear understanding of pathology and feel misguidedly that tendering is the easy answer. NJ

explained that model C is about splitting the source of the work and model B is more focussed on the discipline, control and management. The group concluded it would be beneficial to expand the definitions.

- The group felt that the major difference between the GM reconfiguration and the Pennine reconfiguration is funding. Pennine were able to build a large new lab to take Histo, Micro and Blood Sciences. This funding will not be available and there is no lab big enough to take the work for all 10 Trusts, therefore centralising disciplines is a more realistic option. JS felt that the group needed to focus more on the principle not the delivery aspects.
- KH enquired if AF thought the decision on sectors should be left to the CEs. AF suggested that the natural sectors should be listed and included in the report for the CEs to tweak. AF felt it was important to show that the consolidation model will work best on a sector basis. The group continued to discuss a separate lab to deal with all GP work, this could entail 1 IT link to all GPs and 1 set of transport. There is a need to keep this competitive as we cannot afford to lose this important core work. JS pointed out to the group that we have to take for granted the introduction of a single LIMS system so it will not matter where the work is done. It was agreed to refine the page on models and circulate to the group for comment and ratification by this group.
- MD mentioned that Cumbria & Lancs, have gone for the option of centralisation for Cervical Cytology. The utilization of skill mix has helped to reduce costs but there is no mention of skill mix within the report. PZ confirmed it is easier to understand the consolidated model when it is based upon sectors and GM already has natural sectors. GW wanted to reiterate that option C is the nuclear option and if chosen by the CEs we need to make it very clear we wish to argue against this. We need to give clear economic evidence to show this is not a viable option.
- The group took a period of time to score the option appraisal based upon:-
 - 3 – Good chance will achieve intended benefit
 - 2 – Will possibly achieve intended benefit
 - 1 – Wont meet intended benefit
- Members of the group felt that some of points/suggestions in the option appraisal are equally weighted therefore making the choice of 1,2 or 3 more difficult.
- **Any Other Business –**
- IBMS CPD – Certificates were available.

Actions

- NJ to produce 1 page summary for presentation to CEs on 16/04/10
- Members to email RP with comments
- JS to provide Pathology Futures update and circulate to the group
- Refine and expand page on models for recirculation and ratification

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

Date and Time of Next Meeting

- Friday 28th May 2010, 2pm – 4pm, Venue TBC