

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

**Network Strategy Group
G56, One Central Park, Northampton Road, Newton Heath, Manchester, M40 5BP
Tuesday 15th December 2009 2:00pm-4:00pm**

In attendance		Apologies		
David Bisset	DB	Royal Bolton Hospital NHS Foundation T	Brian Benatar	Pennine Acute Hospitals NHS Trust
Reeta Burman	RB	Pennine Acute Hospitals NHS Trust	Eric Bolton	NHS North West
Mina Desai	MD	CMFT NHS Trust	Mike Burrows	Salford PCT
Steve Downing	SD	GMPCTs	Chris Chaloner	CMFT NHS Trust
Jackie Elliott	JE	Salford Royal NHS Foundation Trust	Amanda Doyle	NHS North West
Len Fielding	LF	Pennine Acute Hospitals NHS Trust	Richard Hale	Stockport NHS Foundation Trust
Andrew Foster	AF	WWL NHS Foundation Trust	Matthew Helbert	CMFT NHS Trust
Keith Hyde	KH	GMPN	Neil Jenkinson	GMPN
Laura Kidd	LK	GMPN	Gina Lawrence	NHS Trafford
Rachel Pearson	RP	GMPN	Toni Mathie	GM & Cheshire Cancer Network
Roman Pylypczuk	RPy	Salford Royal NHS Foundation Trust	Dave Rowlands	UHSM NHS Foundation Trust
Jeff Seneviratne	JS	GMPN	Lance Sandle	Trafford Healthcare NHS Trust
			Gilbert Wieringa	Royal Bolton Hospital NHS Foundation T

Discussion Points

- **Welcome and Introductions** – AF welcomed the members and asked for introductions around the table.
- **Notes of the 22nd October Meeting and Any Matters Arising** – The minutes of the previous meeting were agreed as a correct record.
- **Reconfiguration at Pennine** – LF gave a presentation on the “Pennine Way.” LF explained the original situation, the move from 4 Trusts to 1 and the services on the remodelled sites. All Histopathology, Microbiology primary care work is now carried out at the Central Service Laboratory at Oldham, with Essential Service Laboratories on the other hospital sites, carrying out tests where a result is required within 4 hours. DB commented that he had recently visited the Histology lab at Pennine and is now very envious of the technology and conditions. DB enquired if Pennine have blood gas analysers on site as there is no Biochemistry department onsite at Rochdale Infirmary? LF explained there are 3 including one in critical care. The analysers in question are able to perform other tests but staff on site seem unaware of the machines’ functionality.
- LF gave an overview of the pay and non-pay benefits of the reconfiguration, which after the costs of transport and capital charges had resulted in a net flat cash saving of 4.2% over 4 years.
- LF commented that not all benefits realised have been financial. There are now more tests carried out in-house meaning a reduction in TAT’s and increased marketability when tendering. There has been a positive impact on recruitment and retention as previously Histopathology had struggled to recruit but pathologists are now attracted by the large modern laboratory.
- AF commented that the 4.2% saving between 04/05 and 08/09, when adjusted for inflation actually equates to a saving nearer 16%. JE enquired if staff rotate from site to site? LF explained the staff work on a 12 week rotation incorporating 1 core week of days and nights on the Oldham site to keep skills up to date.
- **Keele Survey 2009** – LF went on to explain that according to the Keele benchmarking report 2009 Pennine are consistently in the top 10 busiest labs for all disciplines and have a cheaper cost per test than the national average.
- **Areas to be Improved** – LF talked about areas to be improved one of which is the current situation with Haematology and BT. This service is available on all 4 sites but the lab Directorate staff want to pilot the removal of Haematology and BT from 1 site and control it remotely. The staff are confident this can be achieved safely but cannot get high level approval. LF explained that Rochdale Infirmary will become a Community Health Campus in the next 12 months. This means there will no longer be A&E and Maternity services on site and at that time approval may be given to pull Haem and BT out of Rochdale.
- LF referred to the tsunami of work the lab receives at 4pm from GPs and outpatients and the reliance on support workers. This led LF to ask questions about skill mix. Currently there is a Directorate Lab Manager, a Discipline Lead for each discipline, 3 Technical Managers per discipline (IT/Quality/HR), a number of advanced BMS’s, BMS’s, Associate Practitioners and Support Workers. LF felt that the current workforce is top-heavy in management and that this will be reviewed overtime as posts become vacant.
- LF informed the group that currently there are a number of Band 7’s that work OOH but not always as an advanced BMS. Should advanced staff be paid an advanced wage for their advanced work only and an ordinary rate when carrying out lesser duties? BMS’s in Microbiology are paid 8am – 8pm flexible working including OOH and weekends. They are paid

Agenda for Change rates and there is no issue. LF asked should the number of Advanced BMS's be reduced and the number of support workers increased and perhaps the working day be a standard 8am – 8pm in all disciplines? This would remove the need for late shifts and only nights and weekends would be required, this would equate to 9 shifts instead of the current 14.

- **Lessons Learned** – LF explained that communication both internal and external has been a big lesson learned. The Andrology service moved sites and although the Trust informed the PCT they did not pass information onto the GPs and this resulted in issues. Pennine now employ a Marketing Manager for the Diagnostic Division to ensure robust internal and external communications.
- Transport played a key role as it is provided by the transport department. Issues can be caused due to lack of customer service skills within the workforce and the fact that it is not purely a pathology service.
- The ESL staffing levels are fixed. If the ESL is hit by sickness, cover is provided from the CSL.
- As a result of the merger recruitment and retention is good in some areas, e.g. Histopathology and Microbiology but poor in others, e.g. Blood Sciences where it is perceived as a 'factory lab'.
- Can you go too far? LF explained that there are now calls to reinstate a Histo presence at North Manchester due to the introduction of a 1 stop breast shop. Consultants are willing to work on site 1 day per week but a Cyto screener will also be needed for 1 session per week and there is the potential need for frozen sections to be carried out on site also. A business case is currently ongoing. JE pointed out that Salford consultants carry out their own frozen sections. LF explained that the request will be listened to and investigated and if North Manchester is prepared to provide the relevant equipment he will provide the consultant and the Cyto screener. LF informed the group that thanks to recent developments in IT consultants can now successfully view results on all sites and from home.
- RB and LF explained that there is now a need at Pennine to employ a consultant Virologist and maybe more Microbiologists, this move would save money.
- AF thanked LF for a very interesting and enlightening presentation. DB enquired if LF felt that Pennine is now big enough to become a stand alone Pathology Trust? LF asked for clarification around the number of sites involved as he felt there is currently capacity to support other sites within reason.
- **Discussion** – KH explained to the group that an autumn newsletter has been produced re: the 20:20 vision work. RP circulated the newsletter to the group and KH went onto to explain that in terms of process we are now in December and starting to pull together the NAG ideas. A Writing Group has been scheduled for 7th January 2010 to create the document that will go to the CE's. KH circulated a "Table of Contents" to show the group the outline for the document to be produced by the Writing Group in January 2010 via NAG meetings and asked any members wishing to attend please inform the Network team.
- Dr Ian Barnes will be attending the GM Pathology Network Board Meeting on Friday 18th December 2009 to give a National update to the group. JS explained that pathology now has a high profile in the DH and has been identified as a priority workstream for QIPP nationally. JS felt that the emerging vision work is in line with the national messages around improved cooperation, professional engagement and leadership, and pathology transformation being increasingly commissioner and patient driven. KH reiterated that if the CE's give the Network the green light with our proposals then economic modelling will begin.
- AF explained that as economic downturn comes closer messages from on high are becoming more stark. It is not just Pathology services that need to carry out this exercise but all services within the NHS. The end of February 2010 signals the end of phase 1 for the feasibility study. The NAG groups have considered a number of models with consensus emerging around a sector model. DB stressed there are things that have not been discussed e.g. the need to save 20% by continuing to achieve the same output of work with 4 people instead of 5. The group agreed that in terms of moving to a sector model Trusts need to be assured it is not a take over but a joint venture. Trusts still need an individual sense of pride but also to integrate and be part of the bigger picture.
- DB pointed out that CE's have a responsibility to meet access targets such as Cancer and posed the question to AF "How would the CE of WWL feel if dependent upon another Trust to meet his targets?" DB stressed that the key is to get buy in from CE's and their agreement that this is the way forward. AF felt that a 3 sector model with 1 prime trust in each sector on which work is centralised would be unlikely to get buy-in from Acute CE's. AF went on to state that the model needs to be a sector model that retains sovereignty and equity but also a large amount of reconfiguration. AF pointed out that as CE of WWL he already has to rely on others where targets are concerned, i.e. 18 week targets and cancer. The preferred sector model would be one where a service is centralised at each site this is plausible and agreeable. As the representative for AGMPCT's SD commented that AF's vision of working in sectors and sharing work is a perfect example of sector modelling as a single site is not sustainable, there is no nothing to fall back on.
- KH reiterated that as a group we are on track and ahead of the game. AF warned the group this is correct for now but it could slip at any time due to a potential emergency budget following a general election and publication of the Operating Framework due out this week. Either could pull the ground from under us. AF reminded the group that the summary document being created in January 2010 needs to be inclusive of figures as this current financial climate gives a "needs

must" to share financial budgets and info to enable Trusts to work together and be successful. KH commented that the message from the SHA is that a competitive route is not the way forward we need collaborative working. JS expressed his concern that discussions revolve around winners and losers and we need to concentrate on a win win situation achieved through collaboration.

- AF turned the discussion to agreeing what is deemed essential regarding the retention of an on site presence. LF quoted during his presentation all tests requiring a 4 hour TAT are kept on site. JE commented that sites with A&E require a 4 hour TAT and a reliable transport system is not currently in place to enable off site testing. RPy explained that it is not uncommon for the lab to receive phone calls asking for results after only 1 hour! AF asked why not have a threshold of 2 hours instead of 4? JS felt a more realistic threshold was needed.
- JE wanted to make the point that LF did not stress enough during his presentation the importance of a single IT system such as Pennine's – that is why it works! RB agreed that transport and IT are paramount to the succession of Pennine but pointed that all 4 sites have an essential service on site. JE continued to stress that without electronic reporting you will not meet a 4 hour TAT. JS and KH agreed that a single IT system is a prerequisite to reconfiguration. AF stressed that he felt a 3 hour threshold could be set. AF also stressed that the time had come to be definitive regarding what is needed on site, the 10 high impact changes, the 5 quality metrics and associated figures.
- RB asked how keen AF's CE colleagues are to drive this forward based upon the amount of work undertaken and that at every meeting the agreement of the CE's is deemed as of paramount importance. AF answered that when this project began the CE's agreed reluctantly as they had fears but were comforted to know the work would be carried out by experts within their own Trusts. Since then the economic downturn means AF could not envisage any CE would go against this due to the "needs must" situation providing the feasibility study is backed up with evidence to support what is being proposed.
- **Any Other Business –**
- IBMS CPD – Certificates were available.

Actions

- Members wishing to be involved in the Writing group to email LK/RP.

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

Date and Time of Next Meeting

- Friday 19th February 2010, 2pm – 4pm, One Central Park, Northampton Road, Newton Heath, Manchester, M40 5BP