SUMMARY OF ACTION POINTS due by the next meeting				
Item No.	**Subject**	**Details**	**Action**	**Deadline**
2.	Future Meetings	Meetings to be arranged in Nov/Dec and 2012	DK	**ASAP**
4.1.	Blood Transfusion	To consider what good practice could be implemented locally across South Central	All	**Next meeting**
4.2.	GP Demand Management		All	
4.7.	Letter to Sonia Mills	To be finalised. To check whether Anne Eden will send it	SM	**ASAP**
6.	Benchmarking and Dashboards	Comparative ESR Workforce Data to be sent out end March 2010 & end March 2011	DK	**ASAP**
		Clinical Leads/Pathology Managers to send savings data for 2009/2010 and earlier to DK where relevant	All	**ASAP**
		Heat Map to be populated from figures already available	DK	**ASAP**
		The gaps in the heat map would be discussed by e-mail before and at the next meeting	ALL	**Next Meeting**
		DK would explore how to add a quality-related measure to the heat map	DK	**Next Meeting**
		Further consideration would be given to how the GP demand management achievements are presented	ALL	**Next Meeting**
		Costs for the most common tests should be shared	ALL	**Next Meeting**
		Use of Sun quest ICE systems for demand management should be further explored.	ALL	**Next Meeting**

8.	South Central wide Projects	An interim report to be sent out	DK	**ASAP**
9.	Good Practice Events	Reports of workshops to be discussed	ALL	**Next Meeting**
10.	Items for the agenda for the next meeting	Any items which would benefit from discussion across the patch to be passed to DK	ALL	**One week before the next meeting**

Minutes of the Pathology Clinical Reference Group held on 27th September 2011

1.	Attendance	Action
	Present:	
	Chair: Christopher James (CJ), Consultant Haematologist, Portsmouth Hospitals	
	Acute: Siraj Misbah (SM), Consultant Chair, Laboratory Medicine, Oxford Radcliffe Hospitals	
	Other: Chris Gibson (CG) Lead Scientist, NHS South Central	
	Acute: John Nelson (JN), Laboratory Services Manager, Buckinghamshire Health Care Trust	
	Acute: Geoff Lester (GL), CSUD Pathology, Royal Berkshire Hospitals Trust	
	Acute: Guy Davies (GD), Pathology Manager, Oxford Radcliffe Hospitals	
	Acute: Derek Roskell (DR), Clinical Director, Oxford Radcliffe Hospitals	
	Acute: Lorraine Amos (LA), Pathology Services Manager, Winchester and Eastleigh Healthcare Trust	
	Acute: Dave Cowlishaw (DC), Clinical Director for Pathology, Portsmouth Hospitals	
	Acute: John Wood (JW), Head of Pathology, Southampton University Hospitals Trust	
	Other: John Paul (JP), Regional Microbiologist, SE Region, Health Protection Agency	
	Other: Bronwen Vearncombe (BV), Programme Director, Regional Enabling Programme (REG)	
	PCT: Chris Slade (CS), System Manager for Cancer Care, NHS Hampshire	
	Other: Debbie Kennedy (DK) – Programme and Project Team SHA & REG	
	Other: Aarti Chapman (AC) – Programme and Project Team SHA & REG	
	Other: Wendy Walder (WW) – Programme and Project Team SHA & REG	
	Apologies:	
	Acute: Anne Eden (AE), Chief Executive – Buckinghamshire Health Care Trust	
	Acute: Mark Hackett (MH), Chief Executive, Southampton University Hospitals Trust	
	Acute: Nicola Bienz (NB), Deputy Director Pathology, Heatherwood & Wexham Park Hospital	
	Acute: Robert Simpson (RS), Operations Manager – Pathology Manager, Portsmouth Hospitals	
	Acute: Nick Athanasou (NA), Nuffield Orthopaedic Trust	
	Acute: John Kersey (JK) Pathology Manager – Milton Keynes Hospital	
	Acute: Martyn Knapp (MK), Consultant Biochemist, Basingstoke and North Hampshire Foundation Trust	
	Acute: Nikki Hutchinson (NH), Director of Pathology Services, Basingstoke and North Hampshire Foundation Trust	
	Acute: Gavin Bennett (GB), Pathology Manager, Heatherwood & Wexham Park Hospital Trust	
	Acute: Adriana Basarab (AB), Consultant Medical Microbiologist, Southampton University Hospitals NHS Trust	
	Acute: Kathy Cann (KC), Consultant Microbiologist & Medical Director, Buckinghamshire Hospitals	
	Acute: Elisabeth Thorne (ET), Pathology Manager, Isle of Wight NHS Trust	
	Acute: Helen Eagleton (HE), Clinical Director Pathology, Buckinghamshire Hospitals	
	Acute: Kate Bolam (KB), Pathology Manager, Basingstoke and North Hampshire Foundation Trust	

	Acute: Sarah Kidd-May (SK-M), Pathology Manager, Nuffield Orthopaedic Trust	
	PCT: Sonia Mills (SMi), CEO, NHS Oxfordshire	
	PCT: Francesca Tait (FT), Head of Commissioning, NHS Berkshire West	
	PCT: Nicola Gurr (NG), Assistant Director Contracting Acute Services, NHS Berkshire East	
	PCT: Francesca Tait (FT), Head of Commissioning, NHS Berkshire West	
	Other: Mike Murphy (MM), Professor of Blood Transfusion Medicine, University of Oxford Consultant Haematologist, NHS Blood and Transplant and Oxford Radcliffe Hospitals	
	Other: Geoff Watson (GW), Clinical Director, Planned Care, NHS South Central	
	Other: Rachel Wakefield (RW), Associate Director of Planned Care, NHS South Central	
2.	**Membership, Purpose of the Meeting and Future Meetings**	
	Chris James introduced the meeting adding that it was his turn to chair the meeting. The attendance was low at the start of the meeting and Chris drew attention to the discussion at the meeting on 27th May 2011 when there was poor attendance and it was agreed that the need for the meeting be regularly reviewed. BV said that the subsequent meeting on 26th July 2011 had been well attended and productive – those present agreed. When others arrived in the first half hour of the meeting – it was agreed that there was a need for a "networking forum". DK asked for contributions to the agenda in future so that she could ensure that the meeting was tailored to people's needs. DK to arrange a meeting at end Nov/beg Dec and then further meetings bi-monthly next year.	**DK**
3.	**Minutes of the Meeting of the Pathology Modernisation Board held on 26th July 2011**	
	The minutes were agreed as an accurate record of the discussion.	
4.	**Minutes of the Last Meeting – Summary of Actions Arising**	
	The actions arising (which were not on the agenda) were how the clinical reference group could use the presentations given last time to shape a business case for improvement and savings across NHS South: **4.1. Modernising Blood Transfusion Services** – DK asked what actions those present had taken away following the presentation from Professor Murphy at the last meeting. There was a discussion but no actions were agreed – to revisit at the next meeting. **4.2. GP Demand Management** – DK asked what actions those present had taken away following the presentation from Geoff Lester at the last meeting. There was a discussion but no actions were agreed – to revisit at the next meeting. **4.7. Letter to Sonia Mills** – SM led the discussion about the letter. A change to the wording of the last paragraph in particular the use of the word "meander" had been suggested by HE by e-mail. SM was further asked to emphasise the level of buy in to the Pathology Modernisation Programme, the destabilising impact of tender action and the potential cost to the health economy. It was agreed that Anne Eden be asked by SM to send this letter on the group's behalf.	**ALL** **ALL** **SM**
5.	**Health Protection Agency – Strategic Direction and how HPA can help with Pathology Modernisation**	
	JP talked about the public health infection service and developments in data mining and data linking techniques for disease surveillance purposes. These developments offered potential for predicting changes/outbreaks and real time monitoring. The HPA has a role in developing new technologies in microbiology and to design approaches to deal with development in disease. There was also innovation in the form of automated plate culture management systems. Oxford has recently become a HPA academic centre and will be looking at rapid sequencing from the bug to what is happening in a geographical area. An example of how quickly this could be achieved was this year's E. Coli outbreak in Germany where the DNA was isolated in five hours. The HPA has to plan for surge capacity if there is a major outbreak/need and to work	

	optimally needs to be flexible about partnering with Trusts providing routine laboratories. It was noted that PHLS owned the pathology laboratories but the HPA does not and has no capital for new laboratories. There was a question about the future of reference laboratories as everyone is repatriating their specialist tests so it was likely that reference laboratories would only see the more esoteric tests. The time between a test being esoteric and it becoming routine would also reduce in the future. Local HPA laboratories have some expertise e.g. Southampton has Lyme Disease but there are commercial kits on the market now which would enable routine laboratories to conduct these tests. Due to better use of IT, new hubs could provide information which would surpass that currently obtained from national reference laboratories. Julian Sutton from HPA Southampton is linking in with Gifford Batstone on the British National Formulary Project. There are problems with the quality of GP data – obsolete Read codes are often used. The objective is to have some governance framework around the combinability of data. The HPA has to make 30% savings over 3 years and at the same time will transition into an Executive agency of Public Health England. The model provided by the CDC in Atlanta is a possible future model with a mega reference site. A question was asked as to whether there is a role for the HPA in overseeing the standard of molecular tests as they are introduced. This needed further consideration. SM asked whether the group could recommend that future microbiology hubs should have close links with the HPA – this was agreed.	**ALL**
6.	**Benchmarking and Dashboards**	
	DK presented the heat map which she had worked on with Kim Perry, Finance Lead at the Hampshire and Isle of Wight Consortium and the finance lead at the SHA. This spread sheet would be populated with planned versus actual savings to keep track of the achievements of the Pathology Modernisation Programme. DK confirmed that 2010/2011 would be the index/reference year against which progress was measured. There were some exceptions to this where snapshot data/one off data was collected: a) Workforce data from ESR would be compared between end March 2010 and end March 2011. DK presented the spread sheets with analysis for all NHS Trusts and asked whether those present were happy to share their data with their colleagues. DK said that there were some oddities in the data which needed to be amended before they were sent out (for example: all of the under 25s disappeared in 2011). This was agreed. The data would be discussed at the next meeting. b) Lean data which would be collected before and after the NHS Improvement involvement c) Specialist Test data which would be collected at end December 2011 if resource is available. DR added that use of 2010/2011 as the base year would disadvantage Trusts who had started their pathology modernisation before the SHA programme commenced. Those Trusts who had done less would potentially gain more. DK said that she was happy to add data from earlier years into the spread sheet but those present would need to give her the figures. DR drew attention to the pricing project which was discussed at the last meeting and DK presented the table that she showed last time comparing the different GP Direct Access tariffs in the contracts with PCTs across South Central. DR asked whether considerable savings could be made by setting a single tariff across NHS South Central. Could we set a tariff at a reasonable sum which everyone could meet? There were concerns that if organisations did do this then commissioners could make a decision to cut the tariff by a %. Some Trusts	**DK** **ALL**

believe that they need to reconfigure services in order to reduce costs because they have done everything that it is possible to do internally. It was agreed that this be discussed further. JW added that H&IOW have carried out a piece of work to set out the financial implications of a single tariff.

GL pointed out that it was difficult to measure savings against GP demand management as RBH had managed to stabilise the demand but not reduce it. GL pointed out that there are barriers to reducing the demand still further such as QOF where some practices just creep in above the diagnostic limit for diabetes which is half of what is desirable.

Actions agreed were:

- DK would start to populate the heat map from figures already available — **DK**
- The gaps in the heat map would be discussed by e-mail before and at the next meeting — **ALL**
- DK would explore how to add a quality-related measure to the heat map — **DK**
- Further consideration would be given to how the GP demand management achievements are presented — **ALL**
- Costs for the most common tests should be shared — **ALL**
- Use of Sun quest ICE systems for demand management should be further explored. — **ALL**

7. Update on North & South

7.1. SHIP – CJ & JW reported that the model had been agreed at the task and finish groups where all pathology departments and specialists were represented: 2 x microbiology hubs, 1 or 2 x blood sciences hubs, 1 x cellular pathology central processing hub and 1 x cervical cytology hub. In the model, the cellular pathology cut up will be at local laboratories and the histopathology slides will be sent back to the local laboratories. They used takt time and cycle time to work out the staffing models for the hubs and essential services laboratories on each hospital site. An attempt was made to reach consensus agreement on the geographical location of the laboratories but this only resulted in the elimination of the least obvious options. A decision had therefore been taken to refer this matter to CEOs and a proposal with a number of geographical options was due to be discussed by them shortly.

A question was posed as to whether medical staff members were in or out of scope. JW said that it depended on the specialty and how much time the doctors spend in the laboratory, which does vary across organisation so a pragmatic approach was taken. If doctors spend more than 50% of their time out of the laboratory then they would be employed by the acute trust and the H&IOW consortium would buy in their services and vice versa.

A question was asked on the cellular pathology set up and whether this would be contrary to the green agenda adopted by most organisations. JW replied that the existing transport arrangements were far from efficient. Southern Health, who have been working on a plan to retender transport services, identified one hospital with over 60 different drop offs and pickups in one day.

A question was asked about the staffing levels of the Blood Sciences “Essential Services” or “Hot” laboratory and JW confirmed that the model allowed for 12 x Band 6 staff working on agenda for change under a shift system (D=Day, N=Night, O=Off)

Staff member 1	D	D	N	N	O	O	O	O
Staff member 2	O	O	D	D	N	N	O	O
Staff member 3	O	O	O	O	D	D	N	N
Staff member 4	N	N	O	O	O	O	D	D

DR added that ORH prefer a load balancing model with the Horton Hospital where they make sure that staff are working to full capacity with some GP work around acute work.

	On IM&T, the consortium's preferred approach was for a single LIMS system but it was recognised that this could take at least two years to procure and implement. In the short-term the consortium would make best use of Sun quest ICE and the National Pathology Exchange. 4% of the cost saving would come from local CIPs. Some Trusts in H&IOW renegotiated reduced tariffs for GP direct access pathology this year so this is being counted towards the target. A question was asked as to whether the costs of IT would be prohibitive given that NHS Wales implement a single LIMS in 18 laboratories at a capital cost of £12million within a two year period. JW said that the consortium were looking at leasing as an option and were currently spending £500,000-£750,000 supporting their existing systems. CJ added that the biggest challenge to consortium members had been to get them all in the right mind set where they were operating as one organisation and pathology laboratories and equipment were sites and assets without any emotional investment in them. The other important message that got lost was that they were setting out a vision of what could be achieved in 2014 not what would happen overnight. **7.2. Berkshire** – GL reported that the joint venture between RBH and HWWP and a third party had progressed to a short-listing of two partners who are both commercial/private sector companies. The proposal was for 2 x rapid response laboratories covering Blood Sciences, some Microbiology and Cellular Pathology tissue handling with 1 x core laboratory. The timescale was for final bids by the end of October followed by business cases to Trust Boards with the transition to the new service starting on 1st April 2012. Savings were expected to be in the order of £4m against a total budget of £20m. A question was asked about the level of risk for the third party – what commitment would the PCT/Clinical Commissioning Groups give in terms of length of contract given that the change costs are likely to fall in the first two years and the average contract length is three years? GL replied that the third party would bear the risk. DK asked whether the Berkshire Consortium had a fall-back position if the partnership did not result in the anticipated savings or whether the Consortium had undertaken a gateway review yet which would assess how likely it was to achieve the benefits. GL replied that a similar project to the H&IOW consortium was the Berkshire fall-back position and that the Project Board was due to discuss undertaking a gateway review at its meeting on 28th September 2011. **7.3. Oxfordshire and Buckinghamshire** – DR said that the scope for savings had greatly reduced with the Berkshire decision to "go it alone". However, ORH had been able to achieve a reduction of 15% in the cost of their GP Direct Access Tests over the past two years and both Oxfordshire and Bucks had a good relationship with Milton Keynes and Northampton. ORH was collaborating with the University top identify the research resource and to set up a joint partnership which would bring in income. They had invited a GP Clinical Commissioning Group Lead to join their management team meetings with the aim of discovering what GPs really want. JN added that Bucks were in the process of consolidating microbiology on one hospital site and that there is a plan to deliver all cellular pathology on one hospital site. On cervical screening, Bucks is mindful that no more than one focal point in the North and one in the South is needed and discussions are underway.	
8.	**South Central wide projects**	
	The South Central wide projects had been discussed briefly under item 6 but it was agreed that DK send out an interim report before the next Clinical Reference Group meeting	**DK**
9.	**Good Practice Events**	
	The H&IOW event had taken place but the North event had yet to happen so it was agreed that discussion be postponed until the next Clinical Reference Group meeting.	**ALL**
10.	**Items for the next meeting**	
	Standardisation of practice was suggested. It was noted that most Trusts were in the process of moving or had moved to Agenda for Change compliant shift systems. The shift system proposed by the H&IOW Pathology Consortium in item 7.1 was Agenda for Change compliant	**DK**

	and when it was introduced in SUHT saved money.	
11.	**Date of Next Meeting**	
	The next meeting is to be arranged.	**DK**