

HSJ PATHOLOGY



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IN ASSOCIATION WITH ROCHE



**TESTING,
TESTING**
TIME FOR CHANGE

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By rising to both financial and quality challenges doctors could be at the forefront of change in pathology services. Page 3

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Q&A SESSION



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SESSION ONE

FIT FOR THE FUTURE

Pathology is undergoing big changes in order to deliver efficiencies that will have an effect on other clinical areas

Pathology is in the vanguard of change that will go on to affect other clinical areas of the NHS, *HSJ* editor Alastair McLellan told an *HSJ* pathology conference. The Pathology: fit for today, fit for future conference – run in partnership with Roche – attracted more than 100 pathologists, pathology managers and independent sector companies.

Opening the conference, Mr McLellan spoke of the extent of change being seen in pathology across the country as services tried to deliver efficiencies and to use their workforce differently, often making increased use of technology. “I can imagine myself for the next four to five years chairing conferences around the redesign of other services in which we will have a speaker from pathology saying this is what we did,” he said.

The conference started with a presentation on the future requirements for services from Richard Dolby, who has worked on many controversial pathology projects – “frontier country”, as Mr McLellan termed it. Among them are the current procurement for services in the East of England and the emerging plans for service tendering in the East and West Midlands, both now run by NHS Midlands and East strategic projects team.

Mr Dolby, commercial manager on the transforming commercial pathology programme, said he had spoken to many GPs over the past three years and initially they felt their pathology systems worked and change was not needed.

Digging deeper highlighted that GPs wanted a service that could deliver a number of things. Key to this was “quality

with no surprises”. This included testing being accurate, results timely and GPs having access to trusted advisors – and here, GPs saw relationships with fellow clinicians as important. “The biggest barrier we have with GPs is their allegiance to local consultants,” he said.

GPs also wanted easy-to-use communications systems that would reduce the administrative burden on them. This included aspects such as automatic ordering of consumables and flagging of delayed results, as they come to expect a more customer-focused service.

But they did not want this at the cost of destabilising other elements of the pathology service. “They don’t want us to take out the GP work and the rest of the system falls over,” he said. The tenders he worked on included compensation clauses for providers that did not retain GP work. But integration also included the sharing of information – for example, test results being shared between primary and acute care.

The fourth element was a high standard of customer support. This ranged from accepting ownership of problems and resolving them, to working with GPs on demand management and ensuring that tests were only ordered appropriately.

From a commissioner’s perspective, GPs did not want to change anything if it risked jeopardising service quality and reliability. But he said there were opportunities to make savings of between 20 and 30 per cent. Transparency could also be increased – with itemised billing rather than a bill for millions of pounds of unspecified work. There was frustration with the lack of

transparency over costs. But he highlighted phlebotomy as a difficult area that was ultimately excluded from tenders because of the plethora of different arrangements.

The desire not to destabilise local acute trusts was key for many commissioners but the threat of change could act as a catalyst. In some areas, trusts and groups of trusts had already responded to this.

What was needed by commissioners was robust but flexible contracts with a focus on outputs – GPs in particular wanted clear targets around key elements such as turnaround time. Key performance indicators and escalation measures to deal with problems were critical.

So what will this mean for the future? Mr Dolby highlighted the need for more consolidation to meet commissioners’ needs. He drew a comparison with petrol stations, where the numbers had reduced from 20,000 to 8,000 in the UK over 20 years – but people could still find fuel when they needed it. He suggested that the 240 full service pathology laboratories could reduce to 60 in 10 years. “The mightier will be mightier... there won’t be room for so many labs in the UK,” he said. IT connectivity would be important.

More point of care testing – using mini labs – might emerge but this could go against the benefits of consolidation.

And with new expensive tests that involved investment in equipment, the NHS might look to outsource to private companies with that money to invest. Cost would also need to be assessed against patient benefits and overall value for money. ●

DRIVING CHANGE

Despite opinions to the contrary, doctors could be at the forefront of change in pathology services, rising to both financial and quality challenges as well as delivering innovations

Clinicians are often presented as opposing change but this view was challenged by speakers in the second session, who showed how doctors could be at the forefront of change.

Rachael Liebmann, registrar at the Royal College of Pathologists and clinical lead for the Kent and Medway Pathology Network, outlined how the college was offering a consultancy service for areas looking at the provision of pathology and the tendering and commissioning process.

Dr Liebmann said there were many drivers for change in pathology – some of which had existed for many years – but the financial challenge and the need to avoid “slash and burn” were crucial. She wanted to move through “snip and sing” to “dissect and cauterise”.

But she warned that “we can’t just look at efficiency, we need to look at quality as well. One of the other drivers for change – which in my network got things off the ground – is crisis,” she added.

“Quality is not a given. I’m sorry to destroy any commissioner’s faith in pathology services but they are not all the same and they are not all providing a quality service.”

She pointed out that services were not all standardised, using

data from services in Kent to illustrate widely differing turnaround times for tests and rates of different diagnoses after needle biopsy tests for prostate cancer. The rate of ordering of some tests was also variable – with one hospital having 10-12 times the rate of another. Yet all of these services had fantastic user satisfaction rates, she said.

There were various issues affecting commissioning pathology services. The Clinical Pathology Accreditation scheme – often used as a quality marker for services – looked at processes rather than outcome. There was also a tendency to look at the easily measurable outputs of services – such as cost and volume. The added value of clinical advice was more intangible and difficult to measure.

Pathology director Jonathan Berg talked about how his trust – Sandwell and West Birmingham Hospitals Trust – had responded to some of these drivers for change. The trust had already undergone considerable reconfiguration of its pathology services, and was handling 7,000 samples a day.

Its ethos now was one of doing the basics well – offering a joined-up, effective and efficient service – while also being innovative. The basics



Jonathan Berg

‘We can’t just look at efficiency, we need to look at quality as well’

included looking at transport of samples – a vital part of the pathway – and ensuring GPs could get in touch with consultants through emails and telephone if they needed to.

Innovations included developing new tests for drugs of abuse which are not picked up by current screening tests. These drugs – usually legal – were becoming more prevalent and could be bought easily in

many places. His team had demonstrated this by visiting shops and even petrol stations to purchase them.

“Classic drugs of abuse are becoming increasingly irrelevant,” he said, yet many trusts were spending tens of thousands a year testing for them.

Another area where the trust had developed additional services was around vitamin D screening. As well as being available through GPs, this was now being made available to the public as a paid test. Those ordering the test take a finger blood spot, which is then sent to the laboratory for testing and results and interpretation given to the patients.

Although the percentage of self-payers with a deficiency is well below the rate with GP referrals, 15 per cent are still found to be deficient in vitamin D.

But Dr Berg also raised the question of whether “disruptive change” risked becoming destructive change. His department had already made huge changes, was delivering savings, and was looking for further ways of doing so. It may also face a tendering process run by NHS Midlands and East.

“Fundamentally we are a clinical service. The examples of privatisation we have seen around the country... is that they have split the lab from the clinicians,” he said. ●



Rachael Liebmann

Organi

MARKET LEADERS

The commercial sector could play a crucial role in the provision of pathology services, with collaboration, competition and partnerships all helping to deliver change

The potential role of the commercial sector in providing pathology services was explored in the third session of the conference.

Matthew Custance, a partner from KPMG, highlighted two areas where change was likely: the centralisation of “cold” – non-urgent – pathology work; and the traditional approach to phlebotomy. A “hub and spoke” method of dealing with the first issue was likely to be the most efficient approach, with one laboratory handling non-urgent work surrounded by “hot” laboratory spokes. He said that this “probably makes the most sense both clinically and commercially”.

He highlighted how long change in pathology had been talked about – an Audit Commission report back in 1993 and then a stream of reports, leading to the Carter Review. Lord Carter himself had said that his proposals would not be “another false dawn”.

Mr Custance said his experience around blood tests in Australia was very different to that in the UK. Blood tests in Australia could often be taken in shopping centres or office blocks – convenient for many people – and it was rare to wait very long. Coming to the UK, he had found a sharp contrast, being sent to a hospital for the test and facing a long queue in a waiting room.

He suggested three approaches to delivering change:

collaboration between trusts; competition which could be driven by GP direct access work being opened up; and partnerships with commercial operators.

So what was blocking change? Mr Custance said there was a reluctance to consult and co-operate, which was fundamentally human nature. Managers and consultants also blamed each other.

But the work in the Midlands and East had showed an external threat by commissioners could drive change. To respond, managers and staff in the trusts had to work together and this had increased the rate of change. These “flashpoints” got people to collaborate at least in trusts, if not over a group of trusts.

‘They can potentially bring investment, ideas from other areas and other countries’

A second lever was the independent sector. “I think they can potentially bring investment, ideas from other areas and other countries, because they have different incentives to the NHS. They drive pace and they can drive cultural change.” They could

Matthew Custance



even act as honest brokers, Mr Custance suggested.

But of the available models there was no definite winner. “The key is which model in the circumstances of your area is most likely to drive co-operation... and most likely to [lead to] a higher quality and efficient service.”

In contrast Rachel Carrell, chief executive officer of Dr Thom, talked about what she termed the retail revolution in pathology. The online service Dr Thom started when a doctor realised many patients were embarrassed when accessing conventional health services and others might not access them at all.

The site now offers a variety of sexual health-based tests as well as treatments. But it also offers asthma inhalers and malaria pills.

Since being set up, Dr Thom has served more than 500,000 patients in the UK – half of them within the past six months. It is now owned by Lloyds Pharmacy

Its approach “industrialises the back end” with highly automated systems: this allows it to spend on what she terms “the front end” – the patient interface. Its patients looked for a service that was comfortable, accessible and convenient – and they were prepared to pay for services that they could have accessed free

through the NHS. For example, a chlamydia and gonorrhoea test – which would be available on the NHS – cost £48.

Ms Carrell said there had been a wide variety of regulatory and other barriers the site had had to overcome – including, for example, a Google prohibition on showing search engine results for HIV home tests.

But what can this offer the NHS? She pointed out that there are groups that are reluctant to engage with existing health services. Sexual health is obviously one of these: sexual health services often cater for all patients, regardless of age or sex, which can be off-putting.

Dr Thom has worked with Oxfordshire PCT on chlamydia testing and does HIV testing in association with Chelsea and Westminster Hospital and gay dating site Gaydar. This allows visitors to Gaydar to complete an online assessment to see if they are at high risk of HIV. If they are, they are offered a free test kit. This has a substantially higher detection rate of HIV than other methods. In Oxfordshire, cases of the disease were being detected and treated at half the normal cost. Ms Carrell suggested this sort of internet targeting of risk groups could be extended to other disease areas.

“There is no reason why the NHS can’t take on this technology and I really hope it does,” she said. ●

Rachel Carrell



PACE OF PROGRESS

Despite some progress being made, the pathology service needs a significant injection of pace in order to speed up the delivery of business improvements, according to Lord Carter of Coles

Lord Carter of Coles led two reviews into pathology services and his recommendations have provided the direction of travel for many services. But the conference heard he was disappointed with the pace of progress.

But as someone with wide experience of Whitehall, he seemed not to be surprised. "My experience in working with the government is that if you have a good idea they don't want to know but when they are in a jam they call for you," he said.

"If I did not know Whitehall I would be deeply disappointed. Knowing Whitehall, I would have hoped it would be a bit quicker but I'm not totally dismayed."

Lord Carter recalled how the NHS's role had been highlighted in the Olympic opening ceremony. He said: "You can't hang on to history and hope to maintain the affection of the public. We have got to continue and reform the service, particularly pathology."

Pathology was a £2.5bn a year business for the NHS and employed 25,000 people, directly and indirectly, carrying out 700 million tests a year. But services across much of the world were experiencing growth in demand of 10 per cent a year

His first report had highlighted the lack of information about what was happening across the service. The second revealed a high state of autonomy in trusts and a wide variation in costs – sometimes up to five times as much. "On call" in some areas was run to suit staff rather than the benefit of the patients.

Point-to-point management was often lacking – and sometimes this was about transport logistics as much as the technology. One trust had made a large investment to deal with a rush of samples arriving at about 2pm. This turned out to be because it arrived with a laundry delivery: the cheaper solution of rescheduling vans



Lord Carter of Coles

'We have got to continue and reform the service, particularly pathology'

"What are CCGs going to do? The multiplicity of commissioners in CCGs is interesting. People will try to do different things."

Looking back, he recalled how GP fundholding led to innovations – including a GP who sent samples to a veterinary laboratory leading to a *Sun* headline: "It should not happen to a dog."

But he warned there was also likely to be conflicts within PCTs with the possibility of some clinicians having interests in the provision of services as well, as has happened with radiology in the US.

And he pointed out that when he wrote the first report it was seven years ago and the UK had just won the right to host the Olympic Games. In those seven years the games had been organised, infrastructure built and £10bn spent. "In the same period of time we spent £20bn on pathology... I'm not suggesting we need Usain Bolt to run pathology but I do hope we can get a bit quicker in the next few laps." ●

had not been considered.

His second report had concluded that service consolidation was needed for better quality and safety, and also for efficiencies which could then be reinvested.

Turning to how these recommendations had been taken up, he said that change was happening in some areas. "The involvement of the private sector has been bumpy. What has happened in the East of England – I think there is progress being made."

About 30 major laboratories were in discussions regarding mergers. Work on areas such as standards and tariffs was beginning to happen.

"But you have to be a bit sceptical about the speed. My scepticism was reinforced by events at Sherwood Forest," Lord Carter said, referring to the recent revelations that 120 women had been given false negative results for cancer.

"It's not clear what really went wrong. Was the service too

small and remote? The two hospitals service half a million people – was that the right scale? It took six years to discover that the results were not right."

Turning to the Health and Social Care Act, he said an improvement in quality was its primary purposes. But it did not matter whether changes in pathology were commissioner or provider-led.



A WORD TO THE WISE ON PATHOLOGY

In the final panel session of the HSJ Pathology Conference, all eight speakers took to the stage to answer questions from the audience. A frank and lively exchange followed

The final session of the conference began with Alastair McLellan asking for the panel's thoughts on what Lord Carter of Coles had to say during the conference.

Rachel Carrell pointed out the difficulties in bringing about change while the reforms were going on. She had heard commissioners say that they can't innovate at the moment because of the changes.

Jonathan Berg pointed out that many laboratories had already been making huge cost savings – including his own department, which was making savings of £1.4m a year on a budget of £20m. Yet they were now being confronted with possible tendering, which was creating concern among staff about their jobs.

Matthew Custance said that

Lord Carter had challenged them on the pace of change and this needed to be listened to. But there was also a challenge to the private sector about how effective it was in the projects it was involved in.

Rachael Liebmann pointed out how quickly the Royal College had reacted when it was asked to develop key performance indicators by the Department of Health – within four months. But it had taken from Lord Carter's 2008 report to 2011 for the department to ask for the indicators.

She also said it was important not to cut costs without thinking through the effects on quality.

Richard Dolby saw GPs as a potential force for change, especially as tackling pathology might be less contentious than other services. "GPs will want to

optimise pathology – why would they not want to start with pathology first?" he asked.

But the process of procurement was questioned by Dr Berg, who said that his department was already saving 7 per cent a year – more than Lord Carter had asked for – but future plans were on hold. "The East of England is on hold. The East and West Midlands are on hold," he said. The following day he had to attend a meeting to discuss how to respond to a tender he had not even seen, he added.

Christopher Parker, managing director of Roche Diagnostics UK and Ireland – who has recently moved to the UK – said how valuable it was for him to listen to Lord Carter.

"I agree with many of the speakers around the change aspects – clearly it is an issue of change management," he said. Everyone was in it together and no one could sit to the side of the process.

Automation could drive savings but the money saved would be needed for new innovations in testing and high value tests such as around personalised healthcare, he added.

"For me, one of the most important things that I'm looking for and trying to understand is around this reinvestment of savings, especially in the adoption of innovation," Mr Parker said.

Lord Carter said it had been an increasingly disruptive time. "What model are we following?



I'm not sure even now what government policy is. I'm not sure where choice and competition even fit into this. I'm not sure who believes what any more."

Mr McLellan said he had looked at health secretary Jeremy Hunt's speeches and could not find choice and competition mentioned.

Lord Carter said the most competitive players in this market were actually NHS trusts and that he had seen "vicious competition" between them. But he added in any situation incumbent providers always retreated slowly – this had been seen in telecoms, for example.

"If you look around there are so many people who have lost large amounts of money by believing the NHS is about to reform itself," he said. World class commissioning, for example, had been predicted by those involved to be "really big". His advice would be that understanding the pace of change was critical – and it tended to be slow.

He added the mixed economy for the health service had not been the beacon it was expected. It would be good to understand whether this was because the



Christopher Parker



Alastair McLellan and Lord Carter of Coles

'I don't think there is a hope in hell of any central dictat working'

But Ms Carrell pointed out that in London some substantial changes had been forced through by SHA action – such as stroke reconfiguration.

Another questioner asked whether there would be a level playing field between the NHS and the independent sector. Richard Dolby outlined the issues around reclaiming VAT, which he said was “scuppering deals”.

Mr Custance said research he was involved in for the Department of Health showed there were both financial and behavioural issues around a level playing field. As well as the VAT issue, there was the cost of tendering and the pensions issue. There were already a number of informal actions by the Department on pensions.

“It does get us very much closer to a level playing field but I don't think we are there yet,” he said.

Ms Carrell said TUPE was a major issue and she had pulled out of tenders because of this. “The way the system is set up does not encourage innovation because incoming providers are subject to TUPE risk,” she said.

Mr Parker talked about technological changes, after a member of the audience raised the issue of bar coding samples. “The key is getting those bar codes to drive real efficiencies,” he said.

Dr Liebmann pointed out that laboratories that had invested early in IT were in a

difficult position: they now had old systems, which they feared could not cope with innovation.

Mike Tomkiss, from the Shrewsbury and Telford Hospitals Trust, spoke of his problems with retaining staff and the effect on them of the uncertainty around change. Of the 25,000 people working in pathology, how many of them would be around over the next five to 19 years, he asked?

Dr Liebmann said the issue of uncertainty increased as people were lower down the pecking order, as each layer believed the ones above were keeping things from them.

Valerie Bevan, a council member of the Institute of Biomedical Science, raised the expense involved in competition. Lord Carter said that in some places it was entirely unrealistic to talk about competition because of the geographical constraints. But this might be different for urban areas. “I'm not for unbridled competition, I'm for managed markets,” he said.

Mr Parker said his experience in Canada was that there was an incredible resistance and lack of progress around reforming the healthcare system. Progress had frozen because there was not a coherent system around driving change. Despite the pain that was being described in the UK, he thought there was progress happening.

Dr Berg said that he was not going to undercut other people on price but he was prepared to deliver tests in one day that would take two weeks elsewhere. “Doing stuff better and innovating is good for staff,” he said.

The panel heard about Pennine Acute Hospitals Trust where the pathology services had been centralised from a number of hospitals – only to now face demands to put back services at one it had vacated. Dr Liebmann suggested telepathology might be the way ahead for some parts of the work.

Finally, Mr McLellan asked Lord Carter whether he would make many changes if he was writing his report now.

Lord Carter said: “At the risk of sounding defensive, not much different. The reality is that the drivers of consolidation are pretty self apparent.

“The thing that destroys most organisations is denial and I don't see much of that,” he said. ●

independent sector had not understood the market or the market not embracing it.

Dr Berg said his fear was that primary and secondary care pathology would be split up – despite the investment his trust had made in putting in IT systems to allow GPs to see hospital results. While he was not scared of tendering, there could only be one winner.

And he raised the question of whether tendering for full blood counts was really harnessing the power of clinical science to help patients – something he saw as key to its role.

Lord Carter questioned how

the money could be released to pay for genomic tests, for example, and said there was a need to industrialise some tests. But Dr Berg pointed out that was already happening and consolidation could reach a point where there were no more economies of scale to be had.

Responding to a question from the floor about whether change could be pushed through by the centre, Lord Carter said: “I don't think there is a hope in hell of any central dictat working,” and the thrust of policy direction was towards localisation.



The speakers are grilled by the audience