



## The Royal College of Pathologists' response to Lord Carter's report on operational productivity, February 2016

### Executive summary

#### Background

Lord Carter's independent report, *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, sets out recommendations to improve efficiency in NHS hospitals.

#### College response

The College has concerns about several of the pathology-related recommendations in Lord Carter's report. These include:

- Pathology tests are an integral part of the majority of patient pathways in both primary and secondary care and cannot be considered in isolation
- The absence of reliable data makes comparison of trust expenditure impossible
- Few NHS pathology services have the capacity to take on the work of neighbouring trusts
- Not all consolidation has been beneficial; we are aware of examples of consolidation being detrimental to services
- Completion of the National Laboratory Medicine Catalogue (NLMC) will take time, centralised funding and IT infrastructure and require expertise
- The College has had limited input into the Pathology Quality Assurance Dashboard (PQAD), the final version of which has not yet been published.

#### Proposed solutions

The College is keen to be involved in finding solutions to the current challenges and suggests the following:

- A priority should be to gather reliable data so that valid comparisons can be made; the completion of the NLMC to the originally-envisaged standard will support accurate data collection
- Benchmarks should be based on evidence
- The whole health system should be considered when planning pathology services
- Reliable IT infrastructure is required to underpin implementation of the NLMC and support successful consolidation
- Consideration should be given to changing the way in which NHS pathology services are commissioned
- The establishment of a National Pathology Service should be considered.



## Full response

### Background

Lord Carter's independent report, *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, [<https://www.gov.uk/government/publications/productivity-in-nhs-hospitals>] sets out fifteen recommendations to improve efficiency in NHS hospitals, one of which refers specifically to pathology:

*"Trusts should ensure that their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation and outsourcing to, other providers by January 2017."*

The report estimates that £2.5-3 billion is spent on pathology services, of which £0.2 billion could be saved through increased workforce productivity.

Lord Carter commented that his team found it difficult to extract national data and understand the cost of pathology services. The cost of these services as a proportion of trust operating expenditure ranged from less than 1.5% to more than 3% and there was similar variation in the number of "qualified" staff.

The report notes that the 2008 Carter review recommended consolidation to improve quality and cost effectiveness. This is reiterated in this report.

Expanding on the recommendation relating to benchmarks, the report recommends that all trusts should achieve acute model hospital pathology benchmarks by April 2017 and introduce the pathology quality assurance dashboard (PQAD). The Health and Social Care Information Board (HSCIC) are tasked with publishing a definitive list of NHS pathology tests and how they should be counted. NHS Improvement should publish guidance notes for forming collaborative joint ventures.

### College response

The College has concerns about several of the recommendations in Lord Carter's report.

1. The absence of reliable data makes comparison of trust expenditure impossible. Different hospitals have different types of pathology services offering different ranges of tests. Specialist tests, for example, will inevitably be more expensive than routine ones. Small hospitals may provide expensive specialist services, making them appear less efficient than larger trusts providing only routine services. Comparing one with another irrespective of case-mix is meaningless.

We are also aware of trusts, including those surveyed in the report, where data is obtained from finance departments without consultation with pathology laboratories. Many finance departments do not fully appreciate the nature or scope of pathology services and are unable to provide accurate data in isolation. While laboratory budgets are held in secondary and tertiary care, primary care represents a significant part of workload in all laboratories. Primary care pathology is commissioned using different mechanisms, which do not fully reflect the incentivisation of primary care and prevent laboratories from retrieving their full costs. Different trusts also record expenditure in different ways. While benchmarking services and sharing best practice are to be encouraged, unreliable and inconsistent metrics will do more harm than good. Basing decisions to consolidate services on flawed data will not bring about the predicted benefits, and publishing specific targets runs the risk of budgets being cut irrespective of service needs and the unique geographical and clinical circumstances that each trust and laboratory services finds itself in. For the benefit of pathology services serving all sectors, we

welcome the efforts to implement a national system for counting tests (see 9 below). Common terminology will improve patient safety and render costings more transparent and comparable.

2. The report assumes that lower expenditure on pathology services as a percentage of overall trust expenditure reflects an efficient service. While some of the trusts surveyed for the report are indeed very efficient, there is no evidence of a direct correlation between the amount spent and the quality of a service. It is possible that trusts at the upper level of expenditure are the ones to emulate and that those spending less should invest to bring spending up to the optimum level. UK pathology should be aiming to be world-leading, not average. We are aware that the cost of pathology services in Scotland, where more reliable data is available, is significantly more than those quoted for England.
3. Pathology tests are an integral part of the majority of patient pathways and are particularly important in early diagnosis and screening for unsuspected disease as well as monitoring long term conditions and the effect of treatment. Most laboratories provide analytical and advisory clinical services for both hospitals and the community, and are thus well placed to influence and moderate integrated clinical practice across organisational boundaries. Investment in pathology services can reduce expenditure elsewhere on the patient's journey, reducing the incidence of cancer, for example, or detecting biochemical abnormalities before they are manifest as disease. There is a risk that reducing expenditure on pathology services will be a false economy and cost the health service more overall, as well as having adverse consequences for patients. Any service transformation should consider the impact on both hospital and community services.
4. This report comes ten years on from Lord Carter's review of pathology services. In that time there have been cost improvement programmes every year and new models of service delivery have been explored by many trusts. An important recommendation of the original Carter report was that savings should be reinvested in services, something that has happened in very few places. The examples of successful consolidations are those rare services where this investment did happen. It is unlikely that there are significant further savings to be made or that opportunities for consolidation have not already been explored.
5. While there are hospitals where consolidation of pathology services has been beneficial with significant cost savings, we are also aware of several examples of consolidation being detrimental to services. A huge amount of time and effort goes into exploring new ways of delivering services, with entire teams spending much of their time completing questionnaires and submitting bids, many of which are unsuccessful. It may be more cost-effective to divert the effort that goes into exploring consolidation into developing existing services. There is no one-size-fits-all solution to providing a high quality, cost-effective pathology service and variations are inevitable. Cost and turnaround times are relatively easy to measure but quality and staff morale are not. It would be short sighted to focus on the former to the detriment of the latter.

Members tell us that adverse effects of consolidation include a marked increase in never events and avoidable errors, significantly increased turnaround times, dissatisfaction with reduced multidisciplinary team (MDT) input and loss of highly qualified staff. Much of the evidence about outsourced pathology services demonstrates that they are more expensive and provide an inferior service to the ones they replaced.

6. Few NHS pathology services have the capacity to take on the work of neighbouring trusts. We are aware of trusts successfully bidding for additional work, only to have to outsource it themselves at great expense because they do not have capacity to provide the service.
7. There is also little evidence that private sector providers are willing and able to take over NHS services or enter into joint ventures. While these models of service delivery have had some success, there are many examples in which they have not improved the quality or cost of services and have often resulted in the irreversible loss of highly trained staff. Private sector

organisations are increasingly declining to bid for NHS pathology work as they recognise that many services cannot be delivered within the current cost envelope, let alone with efficiency savings.

8. The College awaits the publication of the final version of the PQAD. Pathology organisations, including the College, have had limited input into the content of the dashboard and are concerned that the metrics will be unmeasurable, unachievable and insufficiently accurate to allow meaningful comparison. There is a concern that metrics that are too vague, or too easy to achieve will encourage departments to aim for the target, rather than continually improving. Meeting PQAD targets may detract from more important and effective QI and QA initiatives.
9. The College has worked with NHS England and others to partially develop the NLMC. Completion of the catalogue to the originally-envisaged standard will take time and require expertise, which may not be easily available. It is essential that there is appropriate clinical input but clinicians with the required specialist informatics skills are few and far between. It is likely that the HSCIC list of pathology tests will provide the bare minimum of information and will not deliver all the potential benefits of the original NLMC. We believe that failing to develop the full catalogue, as envisaged at the outset of the project, would be a missed opportunity and would risk missing out on some of the most important benefits of the project. This work will take considerably longer than the time recommended in the report.
10. While we understand the need to increase the pace of change, we believe that the timetables for implementation of all the recommendations are unrealistic.

## Solutions

The College is keen to be involved in finding solutions to the challenges that face pathology services in the UK but cannot do that alone. In our opinion the following would be more constructive steps to take to allow informed decisions to be made about how future services are delivered.

1. A priority should be to gather reliable data about pathology services so that valid comparisons can be made. Data should be obtained from those managing pathology services and not finance departments alone.
2. Benchmarks should be based on evidence and promote continuous quality improvement.
3. Pathology covers nineteen diverse specialties, which cannot be lumped together meaningfully – different services should be considered separately.
4. The whole health system should be considered when planning how clinical pathology services are provided, not just acute hospitals.
5. The College is in the process of updating its Key Performance Indicators and overhauling the way in which personal proficiency is assessed – these may be better ways of assessing the quality and responsiveness of pathology services. Pathology services are already very well monitored and assessed, with UKAS now accrediting to the ISO15189 standard, which is substantially more rigorous than standards in place when the Pathology Quality Assurance Review was published in 2014.

Trust Boards receive multiple dashboards from a range of specialties and may not understand the implications of the indicators recorded. We believe that a simple dashboard that includes departments' ISO 15189 accreditation status and the fact that staff have annual appraisals meets all the requirements for quality assurance. Some indicators, such as the investigation of serious incidents, are already routinely monitored by boards.

6. The NLMC should be completed to the originally-envisaged standard to provide standardisation of pathology test requesting and reporting and to enable collection of

meaningful data to inform service reform. The College is doing what it can to support this process.

7. Reliable IT infrastructure is required to underpin implementation of the NLMC and support consolidation. This will also facilitate the collection of meaningful data.
8. Consideration should be given to changing the way in which NHS pathology services are commissioned to reflect realistic costs and the key role of testing in multiple patient pathways across networks.
9. Timescales for all of the above should be revised to reflect more realistic timescales, particularly for collecting reliable data on which to base recommendations for change.
10. One alternative solution to those described in the report would be the formation of a National Pathology Service, along the lines of the successful precedent set by NHS Blood and Transplant. Bringing together pathology services under a single organisation would have benefits including:
  - Enhancing our ability to collect and collate data around pathology costs and efficiency
  - Allowing the standardisation of tests and methodologies, informing the work needed to complete the NLMC
  - Ensuring the consistency of quality and service delivery in all pathology specialties nationally, but especially in molecular pathology and diagnostics, enhancing our drive towards the delivery of personalised medicine
  - Allowing us to more effectively manage current challenges around delivering the Coronial autopsy service.

## Conclusion

Although there is always room for improvement, cost savings have been repeatedly demanded from pathology services over the years and there is no slack left in the system. Departments are understaffed with few opportunities to employ reliable locums to fill vacancies. While consolidation may be appropriate for some of the pathology specialties it is inappropriate for others. It is important to recognise that pathology is a diverse group of nineteen largely separate clinical specialties and what works for one discipline may not work for another.

One of the main aims of the College is to set standards in pathology, something it has done since its inception in 1962. The College will continue to do this and will not compromise the quality of its advice. However, the College is very willing to contribute where it can to national discussions, and regrets the loss of the National Pathology Programme and the soon to be abolished role of National Clinical Director of Pathology.

Many pathology services are in crisis, having been easy targets for cost improvement programmes and having had little investment in recent years. Demanding further efficiencies and imposing meaningless targets will do nothing to improve the quality of services or the morale of pathology professionals. Trying to shoe-horn all pathology services into a one-size-fits-all model will be the final straw for many pathologists and departments and, once implemented, such change will be almost impossible to reverse.

While the College welcomes any attempt to provide more cost-effective services and is keen to be involved in initiatives to deliver this, we do not believe that the recommendations in the report will achieve their aims. Pathology is a clinical service that must not be considered separately from other clinical services with which patients are more familiar. Existing College processes that define quality and clinical effectiveness remain the best available and will continue to be used and updated until a better alternative becomes available.

The report's recommendations for pathology are unrealistic if taken in isolation and may cause significant harm by destabilising departments, increasing staff attrition rates and cutting essential resources. This is a very high risk strategy to adopt at a time when investment is required to more fully integrate and develop clinical pathology services to meet the current challenges through optimising patient pathways and supporting future innovation.