HSJ PATHOLOGY CONFERENCE – 18TH NOVEMBER 2014

Conference Theme - *exploring the pressures for providers and commissioners in pathology*

Viapath topic – "*Modernising NHS pathology – lessons and observations of a public-private joint venture*"

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INTRODUCTION

Good afternoon. I am grateful to both the Health Services Journal and Roche for convening today's important debate on the current challenges facing NHS providers and commissioners of pathology services. Today's debate follows naturally from last month's publication by the NHS national leadership of its Five-Year Forward View. In it, Simon Stevens and his colleagues address the next government as much as the NHS community. They set out both a bold plan for NHS reform as well as a challenge to the electorate and political leaders – they praise the NHS for what it has already done to deliver efficiency for taxpayers and improve outcomes for patients. But they also make clear that both accelerated reform and extra real terms funding will be required to avoid a £30 billion shortfall by 2020 – not doing so imperils the sustainability of a tax-funded, comprehensive high-quality NHS.

I am optimistic that pathology modernisation will happen and that this is one of the preconditions of wider NHS reform called for in the Five-Year Forward View. But I am bound to acknowledge that progress on pathology modernisation since the Carter Reports in 2006 and 2008 has been disappointing. So I will try to learn some lessons from recent history in the hope that the disappointments of the last decade won't be repeated in the next.

AN ANALYSIS OF CARTER AND WHY SO LITTLE PROGRESS HAS OCCURRED

In preparing this talk I re-read both Carter Reports on NHS pathology. What struck me was on the one hand how much still applies today, but on the other hand how few of Carter's recommendations have been delivered. Why?

Carter acknowledged that in excess of 70% of NHS interactions with patients depend on the outcome of a pathology test, so getting this element right is an enabler to both better use of NHS resources and better outcomes for patients. He noted that whilst Britain leads the world in the scientific and clinical innovations that drive modern medicine, NHS pathology has fallen behind our global rivals in translating this into better value for taxpayers and better outcomes for patients. His diagnosis of the cause of this failure was that NHS pathology remains the captive of individual hospitals so the service is sub-scale and lacks the managerial focus to effectively invest in and deliver

a transformation of the current operating model through investment in scientific and clinical innovation. His prescription to cure these ills was threefold:

- Firstly, that pathology providers should consolidate their capacity into managed pathology networks with around 80% of non-urgent processing and specialist services occurring in large scale hub laboratories. These providers would be clinically-led but with first class commercial, IT, logistics and change management capability

- Second, that NHS commissioners should provide a contracting framework to incentivise the transformation by rewarding providers who could deliver improved outcomes in terms of both quality and efficiency. This in turn would depend on better data to compare outcomes, better IT, and greater standardisation along the lines of a medicines formulary

- Third, that the DH and the NHS Operating Framework should set out a national specification or plan for pathology and the regulation of the market

Whilst the prescription still seems logical to me, the NHS has made scant progress on the first and second elements of Carter's prescription whilst completely abandoning the third.

I will highlight just three of the reasons why Carter has not happened. In so doing, I will point to ways in which we might build the necessary momentum to deliver real benefit from NHS pathology modernisation:

Firstly, Carter was a casualty of the Lansley NHS reorganisation which was described by Sir David Nicholson at the time as being so enormous as to be visible from outer space. There is now no prospect of a national plan for pathology modernisation driven from the centre. Instead we must respond to Simon Steven's commitment to back diverse solutions and local leadership by building regional partnerships for pathology modernisation based on "coalitions of the willing" comprised of enlightened professionals, providers and commissioners.

Second, Carter was seized upon by some in the cash-strapped NHS as an opportunity to deliver 20% cost savings. My re-reading of Carter reminded me that this efficiency gain was never intended as an end in itself. But as Carter wrote in his second report "consolidation is necessary to transform pathology services so that they can respond swiftly to the challenges presented by innovation". The benefits of pathology modernisation need to be demonstrated in terms of enabling improvements in local access to diagnostics, a shift of care out of hospital and better patient outcomes from the new generation of genomic and molecular diagnostics. The cost savings from consolidation are merely part of the business case for strategic investment in pathology innovation. In short the benefit of pathology modernisation should be measured in terms of patient outcomes, economics are merely the enabler.

The third reason for the NHS's failure to deliver Carter is largely a consequence of the first two. That is a failure of the transformation process itself to be controlled and driven by the clinical and scientific leaders in pathology. Instead it appears that the "Carter Mission" was principally sponsored by the NHS QIPP (Quality, Innovation, Productivity and Prevention) programme, the

associated procurement processes and outsourcing specialists. Clinicians and scientists were not adequately involved in creating the vision for NHS pathology and the benefit was seen as financial, not patient-centric. Worse still it was sometimes seen as a threat to the professionals working in NHS pathology. Not surprisingly, the professions adopted a sceptical stance, focussed on the risks and threats, not finding ways to leverage their strengths to exploit the opportunity.

So my conclusion on Carter is that the need for pathology modernisation is still valid, but its implementation needs to be driven by the patient benefits of innovation in diagnostics. The case for change needs to be led by NHS clinicians and scientists forming effective coalitions with enlightened providers and commissioners. The efficiency savings from consolidation into managed pathology networks will support a business case for investment in new genomic and molecular diagnostics that will contribute to the wider transformation of the NHS as envisaged by the Five Year Forward View. Put simply, to succeed in pathology modernisation, NHS professionals, providers and commissioners need to think like patients and act like taxpayers!

LESSONS LEARNT FROM GSTS-VIAPATH – BENEFITS AND OPPORTUNITIES FOR THE FUTURE

Many of you will know that Viapath, formerly GSTS Pathology, was conceived by one of the country's foremost Academic Health Sciences Centres to leverage innovation in pathology for the benefit of its NHS customers and their patients. It is majority owned by two leading NHS Foundation Trusts – Guys & St Thomas' and Kings College Hospital, but its minority private sector ownership brings an additional source of investment and commercial capability. The management team, like me, has a mix of NHS and commercial expertise, but our clinical and scientific leaders are central to both our strategy and day-to-day delivery.

Viapath's creation was in part stimulated by the Carter Reports. So it's hardly surprising that in its early days Viapath suffered from some of the faults I have already attributed to the application of Carter by the NHS as a whole. But in so doing I believe we have applied some of the wider lessons necessary to succeed in supporting NHS pathology modernisation for the benefit of patients and the service as a whole. The HSJ has reminded me this is not an advertorial, so I will restrict my comments about Viapath to those factors which I think have a wider application for providers and commissioners of NHS pathology services:

There are substantial benefits to be had through investment in innovation. Our investment programme is unlocking quality improvements, efficiency gains and helping us to win new customers. We believe this is a virtuous circle that can align our stakeholders and accelerate the pace of transformation and growth. Our investment in the automation of routine laboratory services is increasing our capacity and reducing our unit costs. Our investment in specialist laboratory services, such as the 100k Genome Project, is enabling us to scale up our specialist capability and respond to NHS England's strategy of creating global leadership for the NHS in genomic and molecular diagnostics

A vivid example of how pathology modernisation can improve outcomes for patients with Leukaemias is the Haematological Malignancy Diagnostic Centre operated by Viapath in partnership

with clinicians from King's College Hospital. Research evidence shows that despite the publication of NICE guidelines, diagnoses of haematological cancers can still produce error rates of 10-25%.

Our response at Kings is to establish an integrated diagnostic process, covering an adult population base of over 5 million. The service has been fully NICE compliant since 2007 and now diagnoses about 250 new cancers each year. This enables us to offer specialist skills and invest in new molecular technology to produce an integrated report, enabling a more personalised approach to treatment and greatly reduced diagnostic errors.

Viapath demonstrates there is significant scope for efficiency savings. Our customer contracts have delivered year-on-year tariff reductions in real terms to the NHS. On top of the customer savings for the NHS we have generated an operating surplus that has enabled the business to invest increasing sums in modernising our laboratories and the capabilities of our workforce. This year we will invest about £7 million and this figure is expected to rise each year.

I note that today's HSJ Pathology survey refers to long patient waits for phlebotomy leading some patients to "give up and go home". We too experienced seriously long wait times in our outpatient phlebotomy clinics, so a combination of process improvement and investment has enabled us to reduce wait times below 30 minutes, and usually below 15 minutes, at a time of rising patient demand.

The human and organisational challenge in pathology transformation is more daunting than the technical challenge. My priorities are to fully engage our clinicians and scientists in the change process and equip our leaders with better change management capability. Our goal is to develop a compelling employee proposition for pathology professionals and to build loyalty and customer service across the entire Viapath network beyond purely local loyalty to the individual hospital services.

In conclusion, the opportunity and benefits from NHS pathology modernisation are more valid than ever. Change will not be centrally driven or prescribed, so it's up to pathology professionals, working in partnership with enlightened providers and commissioners to make it happen.

We need to rise to the challenge set out in the NHS Five Year Forward View. The case for change needs to be recast in terms of patient benefit rather than economics alone. NHS clinicians and scientists need to be at the centre of the transformation of NHS pathology.

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