Clinical Senate Council Meeting

Thursday 26th November 2020
South West Clinical Senate Council: **Pathology Laboratory Capacity Prioritisation and Optimisation**

Deliberative Topic

When there is a temporary reduction in Pathology Laboratory capacity, how can pathology demand be managed or reduced with the least possible risk of clinical harm?

Overview

Following discussion with the regional NHSEI medical directorate the Clinical Senate were asked to convene a session in order to provide recommendations on the most effective management of pathology testing, particularly when there is an unexpected reduction in capacity to process testing requests. This topic arose as a result of a national incident during October where an issue with reagents in the Roche supply chain meant that GPs were asked to only request urgent tests.

To inform discussions, the Senate Council heard from contributors giving perspectives that covered local pathology laboratories, regional pathology networks, the experience of providers during the Roche incident and the regional Citizens' Assembly along with input to the core council from regional clinical scientists, biochemists and laboratory managers. The Clinical Senate Council members and expert colleagues discussed principles both for managing demand in response to crisis as well as those which could be used to inform ongoing optimisation of capacity.

Background

Regional Pathology Testing

- There are 4 main pathology networks in the South West (one of which also covers Hampshire). Some of these work with hub laboratories and have consolidated IT whilst others have locally driven Trust prioritisation.
- Pathology testing numbers are high, for example 5000 samples of blood are tested per day in Cornwall.
- Annually there are around 145 million tests processed per year in the South West (one network is privately run and so there is less information on numbers for this network).
- 80-85% of all tests are blood science, 18-20% clinical microbiology and 2-5% cell pathology (excluding POCT).
- GP test requests comprise 49% blood science, 38% clinical microbiology and 5% histopathology.
- The Roche supply chain issue was a national incident which affected all specialties in different ways.
- When optimising demand and changing practice, consideration needs to be given as to whether it is the sample, request or requestable test group that is being counted. For example, there are 6.9 bloods tests and 2.2 clinical microbiology tests per request.

- Electronic testing platforms help to set and manage the criteria for requests however networks and labs cannot share or transfer workload easily when there are capacity issues.

- Tests give results that need to be acted upon and the reason for the test should be what is important. For example, a result that comes back slightly out of range can result in repeat tests and a secondary care follow up that may not be needed.
- The Roche supply chain issue was declared as a national incident which is now being reviewed formally.

Provider Perspective (Gloucestershire)

- There were no proactive communications from Roche who did not highlight the problem as soon as they could have, limiting the ability for local preparation.
- Response to the Roche supply chain issue was mitigated through the 6-8 weeks of stock kept in reserve for all assays as part of Brexit planning. The Trust has now informed Roche it will continue to stockpile a reasonable reserve going forward.
- Some labs were not in the same position in terms of stock and were due to run out of crucial supplies within the week. The decision was taken as a network to divide supplies, dependent on service need.
- The acute trust put a request out for urgent tests only to be put forward and saw a consequent 58% drop in GP requests. GPs retained decision making around which tests they considered to be urgent and the trust processed all requests during this period. For example, vitamin d testing although not necessarily classified as urgent, can delay treatment for osteoporosis.
- There is a pathology optimisation group in the Trust (includes GPs) that works to rationalise testing and improve pathways based on the right test for the right circumstances. They recently published their Thyroid Testing Pathway (see references). A deep dive by the GIRFT team to review testing processes and identify and reduce unwarranted variation is planned in January. The Royal College of Pathologists minimum retest intervals recommendations are also being followed.
- Electronic testing platforms such as ICE (Integrated Clinical Environment) can be very useful in helping clinicians choose the most appropriate test and will become more influential as the technology improves.

Patient Perspective

- Any prioritisation or optimisation should consider, as an overarching principle, which tests and pathways will have the greatest clinical benefit for the greatest number of patients.
- The need for clinically led decision making around test requests and prioritisation is well understood by patients however clear communication and shared decision making where possible should take place.
- Tests as alternatives to procedures should be prioritised.

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Recommendations

Whilst it is very difficult to plan for something such as the Roche supply chain incident, this experience saw a crisis mitigated through collaboration and co-ordination of resource between pathology laboratories and networks. The learning from this situation has highlighted that some principles to guide preparation for future capacity issues may be helpful, but also that there is significant enthusiasm for optimisation around pathology testing pathways and that principles to support ongoing optimisation work (which includes specialty specific work around criteria for different tests), and maximise collaboration across networks have the potential to use capacity more effectively. This may mitigate against reaching the stage where prioritisation of tests in response to a capacity shortage is necessary.

Overall
Building pathology testing optimisation into pathways, rather than just trying to reduce demand, will help mitigate against unforeseen capacity issues and make best use of resources for patients. This should be delivered through a combination of expert clinical judgement and development of the profiles set up for different tests on smart requesting platforms. Whilst these platforms should not become too stringent to allow for individual clinical decision making around testing, there is scope to reduce what is available on the testing 'menu' at times.

An infrastructure to facilitate clear communication between and to laboratories, hospitals, GPs and patients is essential. Any prioritisation process needs to be well communicated and supported by training.

Connectivity between different pathology networks and requesting and reporting IT platforms could significantly impact and facilitate consistency in the prioritisation of tests and learning across organisations and localities. It would be helpful if the same requesting modality was used aross a region.

Community patients are not always a lower clinical risk than hospital patients and clear consideration should always be given as to the reason for a test.

Principles for capacity management in a crisis
How capacity is managed will depend on the issue impacting capacity and how long capacity will be reduced for.

Network suppliers should be held to KPIs in contracts around the supply chain and communicating issues in good time.

Communication strategy for crisis/capacity management should identify in advance the key individuals that should agree an approach in a crisis and describe the questions senior clinicians should be asking to manage demand. Consideration should be given to identifying the percentage reduction amount and timescale involved.

Crisis management planning could use ICE or other platforms to agree and 'turn on' certain rules for a certain period of time. For example, tests for screening and prevention could be stood down. Where a platform does not allow a request to be made, it should be possible for the requester to speak to a clinical colleague to discuss the request if necessary.

A hierarchy of safety for delaying "monitoring" bloods to allow the ability to safely delay tests could be developed.

All labs should consider holding several weeks of stock and informing their suppliers of this.

Some potential initiatives to influence capacity management during a crisis were unlikely to be successful. These included sample storage for less urgent tests until lab capacity was restored, which was not considered practical and; Point of Care Testing which, whilst an innovative testing method, is also subject to the impact of capacity issues.

Principles for Ongoing Optimisation of Capacity

The ongoing work within pathology systems to optimise testing pathways in line with RCP guidance and consider the capacity opportunity savings through for example, unbundling of testing groups and testing intervals, should be encouraged and well resourced. Model hospital data and GIRFT work auditing the appropriateness of testing behaviour should also be encouraged. NHSEI pathology colleagues should consider a role to facilitate and coordinate optimisation across their region and pathology networks should be supported to share best practice. There are good examples that cover Bone Profiles, Gynaecomastia, Thyroid, Abn LFTs and LTC monitoring. Recent request optimisation work led by GPs in BNSSG, agreeing tests required for LTC monitoring to ensure GPs could simply request what was actually needed also reduced some demand.

Work to continue to define profiles on ICE or other platforms, by condition, to help reduce unnecessary test requests should be supported. For example, it may be possible to add pop ups, as used in radiology requesting, to monitor retest intervals for example, acknowledging there are many nuances as to what is clinically appropriate between tests.

Prioritisation via a platform or a clinical decision maker should consider the immediacy of action based on result; e.g. same day decision on giving chemo or decision to admit.

The importance of the role of primary care in reducing admissions and for GPs as senior decision makers often managing complex comorbidities, requiring some autonomy to prioritise tests for their patients was noted and supported.

There is a general consensus that there are too many tests being requested in secondary care by junior doctors and local communication as well as platform profiles could be used to reduce any unnecessary test requests.

Data sharing on the volumes and cost of tests being requested with requesters would be helpful, particularly in acute trusts.

The changes made to the QOF framework as a response to COVID could be built on to ensure that going forward there are no perverse incentives around GP funding and the submission of specific test requests.

Next steps

These recommendations will be shared with the NHSEI medical directorate, pathology networks in the South West and with the Clinical Lead reviewing the Roche incident at a national level. They will also be shared with all STPs/ICS' in the South West, other Senates nationally, the South West Citizens' Assembly and published at www.swsenate.nhs.uk

Pre-Reading

1. Background Document (TOR) – Pathology Prioritisation, 2020
2. SWERG Advice on Patient Choice, 2020

Presentations from the meeting can also be accessed by emailing patricia.trim@nhs.net

Referenced Documents

GHNHSFT_Clinical_Bio
chemistry_Thyroid_Tes