1.6%

A TARGET SET IN STONE?

Almost two years have passed since **Lord Carter's** review on productivity in the NHS called for ambitious budget targets for pathology. Here we look at the progress that has been made since publication and ask if the plans have been a success.

On paper it makes total sense – when it comes to cutting costs (and to achieve pledged savings of £22bn in the NHS by 2020), no stones should be left unturned; no service is so sacrosanct that it is untouchable.

That was clearly the logic that was followed for Lord Carter's 2016 review into 156 acute hospital trusts.

So-called "unwarranted and inexplicable variation" in key areas of cost savings were looked at, compared, and contrasted, and among the many findings, one particular area was given its task – that when it comes to pathology providers, they should cost no more than 1.6% of a trust's operating expenditure.

That was the theory anyway. The report came out last year, and the deadline for meeting this target has long passed (in April 2017).

It included four recommendations for trusts to ensure that their pathology and imaging departments achieve their benchmarks, as agreed with NHS Improvement (see box, overleaf).

But not only have many not been able to achieve the budget target, plenty of questions remain unanswered, especially given NHS Improvement's recent announcement that it has gone ahead and identified 29 potential pathology networks where consolidation of pathology services should occur.

These didn't just apply to those trusts who failed to meet the 1.6% figure (as initially thought), but the detail of it even includes those that came

PHOTOGRAPHY: RICHARD GLEED

1%

Some pathology services come in at a total cost of less than 1% of a trust's operating expenditure

3%

Some pathology services come in at a total cost of more than 3% of a trust's operating expenditure

2.8

Some trusts spend around 2.8 times more on pathology provision as a proportion of operating expenditure than others

1.6%

There is a risk that reducing expenditure on pathology services will be a false economy and cost the health service more overall

under the 1.6% threshold (and who thought there were in the clear).

Calculating costs

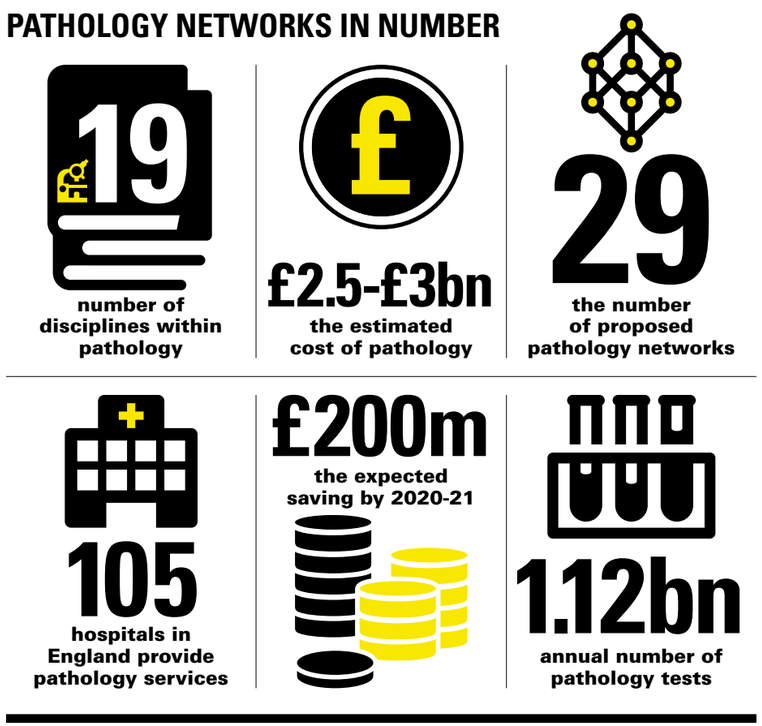
"The creation of the 1.6% figure always felt very arbitrary anyway; that it was the median figure of those trusts Carter looked at," says Gwyn McCreanor, Past President of the Association for Clinical Biochemistry and Laboratory Medicine and Consultant at Kettering General Hospital Foundation Trust. "But the announcement of moving into networks – well, if you look at the maps, some of them are rubbish, especially around the Midlands."

The full September networks document can be seen on the NHS Improvement website and the overall aim is to shave around £2m off the annual £2.5bn to £3bn that is estimated to be spent on pathology services in the UK annually (see box for statistics). Of the 29 potential pathology networks identified, one includes London's Imperial College Healthcare Trust becoming a hub with Chelsea and Westminster and the Hillingdon Hospitals Foundation Trust outsourcing to it. For this hub alone, NHS Improvement argues there will be around £2.5m in savings per year. But Gwyn remains unconvinced. "Some of the data is not accurate, due to lack of consistent guidance around what is required; there are errors in the calculations; to my mind it's impossible to claim the sort of savings they have."

Disgruntlement about how trusts could even identify pathology costs to the desired level was first raised when the 1.6% figure was suggested a year ago, and with the new document, this anger has clearly not abated today. At the time, Dr Suzy Lishman, President of The Royal College of Pathologists, said it wasn't possible to extract costs so easily, because pathology is a clinical, analytic and advisory service. Guidance by the Association for Clinical Biochemistry and Laboratory Medicine (ACB) has recently tried to help trusts identify which costs do, or do not, count. Those costs it says shouldn't count include the likes of blood and blood products, phlebotomy, costs associated with regional screening programmes, anticoagulation, DVT, VTE services, infection control, and also consultants (both medical and clinical scientists) and their secretaries. But now that NHS Improvement is channelling trusts into networks, Gwyn says it's simply creating more confusion. "In this hospital, we're well under the 1.6% figure as we've calculated it, but we've been asked to join up with six other hospitals."

She adds: "We were already working on our own plan, because we don't feel a hub and spoke model works. We think a more federated network model is better. It's better for logistics, and it's better for keeping work local, but it still gives us efficiency gains from better procurement and training."

PATHOLOGY NETWORKS IN NUMBER



False economy

What's clear is that the solutions being suggested to trusts aren't being swallowed. At the start of the review process, there was already vocal disagreement that Carter did not appreciate the varying types and frequency of workload trusts have, especially where different hospitals will have different types of pathology services, offering different ranges of tests. For instance, specialist tests will be more expensive than routine ones and small hospitals providing expensive specialist services will appear less efficient than larger trusts providing only routine services. But now, it seems the network idea is not hitting home either.

And then, of course, there's one more nagging issue that remains – the belief still that Carter did not understand the true cost-benefit-analysis of having more pathology rather than less. "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," argues Suzy Lishman.

"There is a risk that reducing expenditure on pathology services [just to meet a target] will be a false economy and will cost the health service more overall, because it could have adverse consequences for patients." In other words, spend upfront in tests early on would more than pay for themselves by substantially reducing later medical costs. Hitting a 1.6% figure, she argues just doesn't look at total costs in the round.

Challenging proposals

Tim Evans, National Director for Clinical Productivity, defends the networks, saying: "Patients deserve the best quality of care at good value." He says: "By bringing these services into larger, more efficient networks, patients will have better access to innovative services and receive test results quicker."

But Gwyn McCreanor for one is already questioning this. The responses to NHS Improvement from trusts within the current East Midlands Network have requested that the plan they are already working on should be the one that moves forward. She said: "The irony is that at least with the 1.6% figure, although it did seem plucked out of the air, it's ultimate ambition was to try to create efficiencies."

Gwyn continues: "But now, with the networking model proposed, this focus seems to have been dropped, and that it no longer seems to matter how efficient you are."

The ACB isn't happy either. In a statement last month its spokesperson said: "We indicated our scepticism that it would be possible to deliver the clinical and financial benefits intended and were not consulted during the development of the proposals."

Whether Gwyn is successful in her alternative suggestion remains to be seen – she said she is still waiting for a response. It's probable other trusts will be appealing too, pushing the likelihood of achieving reduced costs (a noble aim), much further into the long grass. Although the Carter report has not been the only advocate of change Cancer Research's own study (*Testing Times to Come? An Evaluation of Pathology Capacity Across the UK*, which was published last November) also found there are "inefficiencies in pathology services that must be reduced", including more "consolidation of pathology services", it's the legacy of the Carter report that is still being debated.

The Carter report came, it saw, but didn't conquer, and now it seems, its aims will have to wait as more wrangling about the details of how to achieve savings continue to be debated. BMS

RECOMMENDATIONS FOR PATHOLOGY

- ✔ Trusts introducing the Pathology Quality Assurance Dashboard (PQAD) by July 2016 to assure themselves and others that the pathology service provided to them is and remains of appropriate quality and safety, with NHS Improvement hosting the dashboard.
- ✔ HSCIC publishing a definitive list of NHS pathology tests and how they should be counted by October 2016, with NHS Improvement requiring trusts to adopt the definitions from April 2017.
- ✔ NHS Improvement publishing guidance notes for forming collaborative joint ventures and specifying managed equipment service contracts for local adaptation by October 2016.
- ✔ NHS Improvement introducing metrics that describe relative imaging departmental productivity related to the use of equipment and workforce activity by December 2016.

Lord Carter's review, *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations,* and associated documents are published online and can be downloaded by visiting bit.ly/BS_Carter_Review