Specialist Healthcare Commissioning

Minutes

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National Demand Optimisation Group (DOG) Phase III
4 December 2019
10.30 am – 1.30 pm
Hopkins Suite
Millennium Hotel, Glasgow

Attendees:
Dr Bernie Croal, DO Chair, Consultant Chemical Pathologist, NHS Grampian **(Chair**)
Mrs Liz Blackman, Senior Programme Manager, National Services Division
Ms Grace Cervantes, Programme Support Officer, National Services Division
Dr Ben Hall, GP consultant and Scottish Clinical Leadership Fellow
Mr Gavin Hallford, Data Analyst, Information Management Service
Dr Janet Horner, Consultant Biochemist, NHS Greater Glasgow & Clyde
Dr Niove Jordanides, Programme Manager, National Services Division
Mrs Claire Lawrie, Programme Manager, Information Management Service
Dr Ewen Millar, Specialty Trainee in Chemical Pathology, NHS Grampian
Mrs Sonja Wright, Clinical Scientist, Haematology, NHS Grampian

By Tele-conference

Mr Mike Gray, Healthcare Science National Lead Life Sciences, NHS Lothian

Apologies:

Dr Charu Chopra, Consultant Immunologist, Royal Infirmary of Edinburgh
Dr Caroline Clark, Consultant Clinical Scientist
Dr Alistair Hart, Consultant Haematologist, NHS Greater Glasgow & Clyde
Dr Sara Jenks, Clinical Biochemistry Registrar, NHS Lothian
Ms Linda Mulhern, Operational Science Manager, Microbiology, NHS Lothian
Dr Lucy Munro, Associate Medical Director for Primary Care, NSS
Dr Rebecca Pattenden, Consultant Biochemist, NHS Lothian
Dr Fiona Payne, Consultant Pathologist, NHS Grampian
Ms Karen Stewart, Healthcare Science Officer, Scottish Government
Dr David Stirling, Director of Healthcare Science, NHS National Services Scotland
Mr David Topping, Clinical Lab Manager/Lead BMS, NHS Tayside

1. Welcome and Apologies

Welcome and introductions were given.

2. Strategic Direction of Phase III DOG

B Croal provided a summary of the programme to date and presented some slides. B Croal then elaborated on the Phase III aims, which include continuing to refine the data collated and use the trends to provide some targeted interventions. Access to the interactive Atlas access can now be given to an extended group of staff. The DOG will also continue to promote and assist in the quality improvement initiatives that the networks identify and ensure the continued support for demand optimisation.

B Croal advised that he had met with key members of the group to discuss potential options and concluded that the programme was not yet in a position to launch the Atlas with interventions nationally. It would be more beneficial to focus on the areas where there is enthusiasm to become involved from laboratory staff and referring clinicians as a pilot to prove the validity. Direct engagement with primary care colleagues would be pivotal to success and suggested GPs and networks could select one or two tests which we could focus in on.

B Croal suggested that some Atlas education could be in the form of a comment on the Atlas screenshots. In the current format the Atlas contains some complex data and it was suggested that the development of a simple screenshot providing just a single test by either region, Health Board or nationally would be beneficial. This required further discussion. B Hall highlighted that GPs receive a similar update for prescribing, so maintaining the same format will retain consistency and may be useful in this work also.

3. Atlas of Variation update

C Lawrie advised that a teleconference with IT managers from all the health boards was organised to discuss the challenges faced in collecting the data for the Atlas. This was attended by a representative from every health board bar one. It was agreed that, for future collections, one point of contact will be used for each health board. All the tests will be collated so there will be only one ask per time period rather than separate requests from each discipline; this was preferable as in some cases the same individual was involved in the extraction of multiple requests. A more regular collection was also agreed with quarterly collections being viable. C Lawrie envisaged that with more regular data collection, we may see the impact around June.

C Lawrie also highlighted that in producing a template in an attempt to make the data collection easier, it resulted in causing more work for the health boards. It was agreed that in future, health boards may send their data in any file format, as long as it contains all the relevant fields.

B Hall queried whether it would be more resourceful to have a template instead of receiving data in various formats when thinking ahead for the future resources in sustaining the Atlas data collection. C Lawrie agreed but hoped that this type of collection is only temporary until the NLIIP programme has developed a datamart storage where the data can then be directly fed without the need to manually extract.

The Group heard that tests can be added or amended at a future date but cautioned changing them too frequently as this would affect the results.

C Lawrie advised we now have data (bar one) for Biochemistry up until end of March. Some Haematology data was missing and she had requested those gaps to be completed.

N Jordanides confirmed that she had a note of the key contact people in each area who will be providing the data. J Horner added that as a courtesy, those staff should inform the correct person that they are carrying out this task.

J Horner suggested C Lawrie should liaise and discuss possible pilot projects with Neil Greig, Consultant Scientist for NHS Tayside. C Lawrie agreed to pursue this action.

Action: C Lawrie

B Hall felt HIV and Hepatitis C were high on the Scottish Government's agenda and should be included. L Blackman added that SMVN had suggested collecting antenatal serology. B Hall did not feel this would be beneficial as true figures are not always easily available from GP practices.

L Blackman advised that NHS Lothian had introduced antenatal serology testing as standard however other Board areas had not.

The Group heard that the total number carried out per GP practice would provide better and more accurate information.

C Lawrie stated that ECOSSE were approached as a route for collecting the data, however their collection is not complete (only collect positive numbers) and hence would not be suitable. An alternative avenue will need to be explored.

B Hall reiterated that the aim was to ascertain whether antibody testing/screening test for HIV had been done. He agreed to prepare some trend information to share for consideration by the SMVN Steering Group who are to meet on 12 December 2019.

Action: B Hall

The Group heard that NHS Tayside carry out most of the screening but would not necessarily report back on tests and could perhaps provide screening figures for Primary Care.

The Chairman suggested the Biochemistry network should consider including qFIT to the Atlas and J Horner agreed to take this forward.

Action: J Horner

The Chairman reiterated that we have limited time and resources for Phase III. N Jordanides and C Lawrie advised that they had discussed and identified data collection deadline dates and had provided a schedule to the healthboards on when the data requests will be sent out.

C Lawrie offered to present all the data collected and included in the Atlas in a table format and share it with the Group.

Action: C Lawrie

4. Atlas Education

B Croal sought advice from B Hall on what format of education package would be useful for GPs.

A screenshot showing a single test per practice and comparing it nationally, by health board, by cluster group and by peer group. In addition, some guidance would be required in the form of a summary explaining what the results mean, why it is important to be highlighted and some quick guidance on when to request a test. In addition, a link to the guidelines would be useful and any Quality Improvement projects already developed. It was agreed guidance would need to be considered on different screens of tests.

GPs would develop their own improvement projects. A template pro forma would be helpful to capture the problem and detail how they addressed it as part of an appraisal. B Croal asked for suggestions on who would develop this and heard that the primary care development group and key stakeholders would be involved.

B Hall advised that a Health Improvement meeting was due to take place in May and suggested that that would be an ideal opportunity to present the Atlas and get GPs on Board. Additional suggestions included GP practice meetings and linking with the cluster QI and Practice QI Leads.

B Croal recapped that IMS should develop snap shot views, with an interactive box, plotting every test within the normal distribution or in shaded areas that represent +/- S.D 1, 2, or 3. A further view can be presented on clicking of the dot representing a test to present a graph of the test per 1000 in the practice over time in comparison to the cluster, health board or peer group. ISD could provide details of peer group practices.

Action: C Lawrie

B Croal suggested that we use our existing data to date and use it to develop some of the screenshots with space for education materials discussed today.

Action: C Lawrie

B Hall suggested each individual Board area should ascertain approximately three tests to drill down and ensure linkages with the professional groups and GPs. To facilitate this feedback should be provided to networks on the up to date variation data that exists.

The Atlas will be launched in piloted areas in February and it will be pertinent that the education material is also ready at that point.

Tests suggested included free T4 and calprotectin, where there was large variation in practices in NHS Shetland in particular for the latter test. Additionally, MSSU was suggested as new SIGN guidance was due to be published and there had been a

variation observed in NHS England. High variation was also observed with High Vaginal Swabs.

B Hall suggested that two or three very simple and clear cut tests would be easiest to begin with and to carefully consider the frequency of requesting data. The tests identified should also be where background work has already begun or completed in order to get 'quick wins'. Furthermore, there should be clear communication with GPs that this is not a 'punishment tool' but that the goal is for a single shared vision.

J Horner agreed and added that this is how Biochemistry had considered which tests to choose and based their decision on their current demand optimisation projects.

B Croal raised the point of laboratory costs being included in the Atlas. He stressed that assigning a cost per test is extremely difficult and can mislead the user. M Gray agreed that there is no accurate costing model. B Croal added that the company who had prepared the costings information for NHS Improvement had acknowledged that the laboratory costs was inaccurate. A better method for assigning costings would be to compare the burden for diagnostic testing as a whole.

B Hall suggested that the Atlas is launched first and costings can be revisited at a later stage.

J Horner hoped that the outcome of this work would be that referring clinicians realise there is not always the requirement to carry out tests as frequently and would highlight their own savings.

B Croal felt this was the right time to produce the static booklet/ chapter book with the most appropriate tests, to include standardised statistics and metrics with commentary. The booklet should include why this is being done, why the variation is important and include recommendations. C Lawrie to begin collating the variation dashboards.

Action: C Lawrie

The Phase III report/publication will be shared with the usual recipients e.g. Scottish Government.

B Hall discussed how choosing the correct QI interventions were critical to success as a wrong intervention will not have the desired effect. B Hall iterated that this would be trial and error over the coming cycles.

He queried if NHS Lothian were a confirmed pilot Board area and that we should get their gold standards for guidance and ensure we have educational materials for the snapshots we use. He stressed this should be created before the end of January and launched before the end of May. The cluster group potentially piloting the data could also be added to the list of user access.

Action: N Jordanides/S Jenks

5. Other Demand Optimisation Work streams

The Chairman discussed the demand optimisation atlas within secondary care. RCPath were expected to issue V0.2 guidance Minimum Retesting Intervals for consultation and had asked DOG to be stakeholders. The consultation would be circulated to the Group when it was published.

Action: PSO

We need to define some important retesting, which will depend on the LIMS and Board IT systems. Some Board's provide their own minimum retesting levels, depending on the mechanism used.

B Hall highlighted the risk around turn-around times of testing and J Horner added that some systems do not capture the information on the first test in such a way that it is obvious when a second test is requested. J Horner added that in her experience, doctors would welcome advice and guidance on this as many may not be aware of retesting guidelines for example.

B Croal also spoke of what is coined 'internal demand optimisation', primarily something that can be viewed with SPAN. This is extremely relevant to the programme.

6. **Quality Improvement and Demand Optimisation Updates**

i) Biochemistry

J Horner updated on the current projects being progressed:

iLFT - Lothian and Fife are actively working on introducing iLFTs but few other healtboards appear to be progressing this. They were considering conducting a survey with different Boards to understand the progress nationally. The iLFT profile went to the network on Friday.

Lipids - SCBN are in the process of standardising Lipid requesting across Scotland. The document has been sent to the Scottish Lipid forum for an opinion.

MRI - A document detailing SCBN Minimal requesting interval recommendations was approved by the network and will shortly be published on the SCBN website.

AKI - SCBN have agreed to review the current status of AKI alerts in each healthboard.

Vitamin D - NHS Glasgow are still waiting on a new ICE interface at point of requesting for GPs. This has not yet been sent to the local medical committee. This is a specific project within Glasgow and will use Atlas data. Sarah Jenks had been keen to also use it as one of the identified targeted tests at NHS Lothian.

ii) Microbiology and Virology

L Mulhern had provided an email update to N Jordanides.

Capacity issues had meant they had not been able to progress Quality Improvement initiatives.

HVS- No further update with regards to discussing and identifying guidance with NASH. B Croal added their input would be beneficial.

Urines- Forth Valley have not seen a drop in their urine numbers for quite some time despite using the 'Pharmacy First' plan.

Leg ulcers- The guidance has yet to be taken to PLIG in Lothian. The next meeting is in January, however on internal discussions within the lab suggests that the guidance is already out amongst district nurses and that there may not be any further action possible

iii) Pathology

N Jordanides updated that Pathology would look placentas and possibly block numbers of gall bladders.

iv) Immunology

No update had been received and no representative was present.

C Lawrie advised she had been invited to talk at the next SCIG.

v) Haematology

S Wright advised that three projects were identified, B12, Folate and Ferritin. Laboratory guidelines have been produced for these tests.

An additional two tests have been suggested as target for producing guidance but not yet agreed upon:

- D Dimer
- Inappropriate use of coagulation screening

B Croal queried if D Dimer tests could be counted accurately and highlighted that care should be taken when interpreting this data.

S Wright advised that the HaTS network guidance on B12, Folate and Ferritin were in draft form and would be published on the HaTS webpage. It was agreed that it was important for this to be visible to Primary Care staff to raise awareness of it as the HaTS webpage may not be known to referring clinicians. C Lawrie advised that the guidances could be added to the Atlas.

Action: C Lawrie

B Hall discussed how local guidance would take precedence over national guidance. It was important to use the best repository for guidance.

vi) Genetics

No representative was present to provide an update however; Genetics have provided data on Familial Hypercholesterolaemia

B Hall felt that HFE testing for Haemochromatosis would be a relevant test for Genetics to pursue. Dr Jordanides will raise this at the next DSG advisory group meeting.

Action: Dr Jordanides

7. Next Steps

- Ascertain what data to use.
- Provide a snapshot view of how the flash report may look like.
- Consider options of interactive views/if GP can directly access.
- How to project e.g. clusters within peer groups, Boards/national.
- Attempt to get more network and Board buy in.
- Continue to develop pilots with GPs.
- Secondary Care – Networks to take forward Minimum Retesting Interval work.
- QI initiatives link to Demand Optimisation.
- Consider and highlight future funding.
- Publication of a static application of the Atlas.
- Consider DOG leadership, Dr Croal may not continue as Chairman after May 2020 due to other work commitments.

8. Any Other Business / Updates

No other business was raised.

9. Date of Next Meeting: To be confirmed.

Action: PSO