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Minute

Subject: National Demand Optimisation Group (NDOG) Meeting
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Author: Miss Susan Fairley, Programme Support Officer
Date: 1st July 2016

Present:

Dr Bernie Croal	*Unit Clinical Director - Laboratory Medicine, Consultant Chemical Pathologist, NHS Grampian (Chair)*
Dr Bill Bartlett	*Consultant Clinical Scientist, NHS Tayside*
Mrs Liz Blackman	*Senior Programme Manager, NSD*
Dr Fiona Hawke	*SCIN Imaging Manager*
Caroline Clark	*Consultant Clinical Scientist, Honorary Research Fellow, Deputy Head Molecular Genetics, NHS Grampian*
Mrs Deidre Evans	*Director, NSD*
Miss Susan Fairley	*Programme Support Officer, NSD*
Dr Liz Furrie	*Lead Clinical Scientist, Clinical Immunology, NHS Tayside*
Mr Mike Gray	*Health Care Science National Lead Life Sciences, Scottish Government*
Chris Hind	*Clinical Laboratory Manager, NHS Tayside*
Dr Sai Murng	*Consultant Immunologist, NHS GG&C*
Dr John O'Donnell	*Consultant Biochemist, NHS Borders*
Dr Gregor Smith	*Deputy CMO Scottish Government*
Ms Karen Stewart	*Healthcare Science Officer, Scottish Government*
Dr David Stirling	*Director of Healthcare Science, NHS NSS*
Mr David Topping	*Clinical Lab Manager/Lead BMS for NHS Tayside Pathology*
Dr Craig Wheelans	*National Medical Advisor (PCF SBU), NSS*

Apologies:

Dr Janet Horner	*Consultant Biochemist, NHS GG&C*
Dr Anne Katrin Lampe	*PhD, FRCPEd, Consultant in Clinical Genetics, NHS Lothian*
Mr Brian McConnell	*Business Analyst - Information Management Service, NSD*
Dr Lynn Manson	*Consultant Haematologist (representing Blood Banking)*
Linda Mulhern	*Operational Science Manager, Microbiology, NHS Lothian*
Dr Ewan Olson	*Consultant Microbiologist, NHS Lothian*
Mr Jimmy Paul	*Programme Manager, NSD*
Dr Steve Rogers	*Consultant Haematologist, CMO Speciality Advisor, NHS Fife*
Mrs Alley Speirs	*Programme Manager, NSD*

1. Welcome and apologies

Dr Croal welcomed everyone to the third meeting of the Demand Optimisation group. Dr Croal highlighted that the remit of this group was not so much about the implementation but the collation of advice and guidance going forward. He further advised that by the next meeting of the group in October, the intention would be to be in a position to formulate the report and initial guidance papers, which would form the formal outputs of the group.

2. Minutes from NDOG meeting 22nd April 2016

Dr Stirling noted that his surname was incorrect within the body of the minutes, Miss Fairley to update. The rest of the minute was accepted as an accurate representation of the meeting.

Action: Miss Fairley

3. Agreed actions update

3.1 Atlas Pilot

Dr Croal had produced a paper on the requirements for the Atlas pilot in relation to what needed to be achieved, noting that the English Atlas used data that fortuitously became available as a one off from the National Laboratory Medicine Catalogue team in Leeds. This would be very difficult to repeat and highlights the problems with sourcing data automatically from a variety of heterogeneous data sources.

Dr Croal and Dr Stirling had spoken with colleagues in ISD as to what data could be collected and through which sources; and it had become clear through these discussions that it would be difficult to obtain the required level data through ISD – given that GP practice level requesting data would be needed. Dr Stirling advised that the best quality data could be delivered direct from the laboratories themselves and once it was clear what could be delivered in the data sets it could then be further reviewed as to how ISD could assist with data collation. All agreed that it was essential that there were standard data definitions to allow aggregation of data and comparison of results. Mrs Evans added that ISD had good knowledge of data definitions and would be able to contribute with defining these. It was agreed that Dr Hawke would review how national data could be collated for radiology and report back.

Action: Dr Hawke

Dr Smith noted that the discussion had been around the extraction of data from the laboratories instead of GP's and asked if there was a reason that a decision had been taken to use this instead of data that could be produced using SPIRE which would be available from January 2017. Dr Croal advised that there had been discussion on this and it was felt that there was not confidence at present that the SPIRE system would allow the extraction of the data within the required timeframes. He also noted that the laboratory data was more detailed than the SPIRE GP level data, the laboratory data could show detail such as tests that were taken but never analysed which led to more accurate data to work with.

Dr Croal also noted that there was no standardisation across NHS Boards in terms of lab data. The naming process itself had created issues as different labs named tests differently which meant there was not a succinct way to compare one test across all boards; keeping the data limited for reporting purposes would allow the best exploration of what could be achieved.

Dr Furrie asked how the tests reported on in the paper produced were chosen. Dr Croal confirmed that they were examples taken from the English Atlas, however, members' suggestions on which tests to focus would be welcomed. Dr Furrie advised that she would discuss with colleagues and feed back any suggestions on tests of interest.

Action: Dr Furrie

Dr Croal advised that there was a new Diagnostic Data Standards Board (NHS Digital) which was in the process of setting up five new groups, one of which would be a Pathology Specialist sub-Committee. The groups would be both advisory and user based to take forward some of the work that had been started by NHS digital. They were experiencing difficulty with stakeholder engagement, given the need for engagement with clinicians and no easily available backfill.

Mr Gray asked if there was an existing infrastructure that could be replicated within Scotland; Dr Croal advised that there was the possibility of this, in terms of the National Laboratory Medicine Catalogue as there was already more than 90% of items catalogued for some disciplines; in terms of prioritisation there was a cohort of information which could be utilised, blood sciences could define the standard as well as the definitions. Dr Croal added that the difficulty would be implementation; Mrs Evans highlighted that shared services work should provide some enablers in IT and cross boundary working.

Dr Croal advised that there were issues with implementation as any changes in coding would need to be made to all systems and not just LIMS - so: TrakCare, ICE and SCIStore etc which would take a lot of time and resource.

In Summary, Dr Croal reiterated that it was not within the power of this group to deliver an Atlas of Variation but would be for the group to show proof of concept and the potential benefit from this. It was highlighted that the standardisation work would be very challenging, as each NHS Board or lab had developed their own system. It was acknowledged by Dr Bartlett that these issues would be picked up by the shared services laboratory programme with support from the NMDNs.

It was agreed that by the next meeting of the group in October there should be a data set produced between NHS Grampian and Tayside which could be further reviewed. Dr Croal and Dr Bartlett would go back to their respective boards and work up a preliminary report for next meeting.

Action: Dr Croal / Dr Bartlett

It was also agreed that everyone present from other laboratory disciplines would contact Dr Croal to advise of any additional tests that they thought would be useful to have reported on in the atlas.

Action: Group

3.2 GP feedback pilot

Dr Croal introduced a document that outlined work that had been carried out in NHS Grampian to support GP education on testing requests. The report used GP practice level data and fed this back to the GP's along with educational information. This could be provided electronically and there had been indications that GPs were keen to have this type of information. Dr Croal advised that NHS Grampian was keen to progress this pilot. The group were asked for feedback, ideas and comments on the report and were also asked whether they thought there was support to take this type of work forward with other health boards. It was confirmed that NHS Lothian and Tayside would be interested in this type of feedback and they had been working with their respective IT departments to ascertain how data could be pulled from their LIMS system. Dr Bartlett highlighted that there was a possibility to make this a "shop window" to showcase what could be achieved in a targeted approach with possible national delivery without any additional expense.

Dr Smith advised that QOF had been taken out of GP contract from April 2016 and that from April 2017 there would be a new contract that would incorporate input from stakeholders like BMA, RCGP, HIS, NSS. The new approach would be a peer led approach to quality; this would be an intrinsic function incorporating peer support, peer education, quality improvement, sharing data and initialling actions that appear to be important to GPs.
The 2017 GP contract would be the starting point and it would be implemented using an incremental approach and would probably take 5-6 years to achieve its full potential. SPIRE would be used as the extraction tool as it would be able to interrogate the GP data.

Dr Croal advised that NHS Grampian had taken this education a step forward and produced a live Sharepoint system that held the information. GPs could be allocated with a log in and

therefore able to dial into this data and pull information on tests as and when required. The Sharepoint system could also be fitted with limits to flag up over requesting for tests. It was agreed that it was not possible to ensure the education of every GP but this type of educational tool and information was useful and beneficial.

Dr Smith added that the key point was how to educate across practices with Dr Croal advising that there needed to be a cultural change across Scotland and appropriate pathways would have to be produced in relation to this; it was important not to provide more variation but to ensure that action was taken on the information available.

Dr Furrie highlighted that there was a huge opportunity to educate GPs on specialist tests as well as being able to show that there are more targeted tests available while helping to educate on tests they are requesting; it would also be beneficial to demonstrate outliers.

Dr Croal advised the group that he would continue to update them with any progress on this and noted that if any other health boards were interested in this he was happy to share the information. Dr Stirling noted that NHS Forth Valley had carried out some similar work and would most likely be interested in this.

It was agreed this work would be highlighted in the next DOG newsletter, inviting expressions of interest from NHS Boards.

Action: Miss Fairley

3.3 Top ten DO guidance document

Dr Croal advised that he had produced a paper in which he had tried to pull together the obvious top ten interventions that could be reviewed. This followed on from work within the RCPath to review the work of the Fryer and Smellie Demand Optimisation toolkit. There had been an exercise undertaken to look at and score 37 recommendations based on their impact and variation. The tests in the guidance paper produced by Dr Croal had taken some of these as an initial review.

Dr Croal advised the group that this was a working draft and he would welcome any comments on items to be added or items that were missing. Mrs Evans suggested the group should focus on the recommendations which if agreed by the group would form a good basis for a report. The group was happy with the paper as a contribution to its initial report and agreed the recommendations.

3.4 Establishing the importance of Minimum Retesting Intervals (MRIs)

Dr Croal noted that within the recommended document there would be further guidance issued on MRIs. Following on from the initial Demand Optimisation questionnaire it had been recognised that there were differences in areas on how they reported on MRI's. It was highlighted that this was a work in progress and input would be required from individuals in each discipline to input information for their areas to advise which tests could be included. Dr O'Donnell agreed to send data from Borders to Dr Croal and copy in Miss Fairley. The main focus should be to define the subset of MRIs that should be prioritised across all boards.

Action: Group / Dr O'Donnell

Mr Gray advised that there was a need to include microbiology through the network to input into this; Dr Furrie added that she would be able to provide a full list for immunology, this was something that immunology had been doing for a number of years due to the fact they were able to vet out inappropriate requests more easily due to lower numbers than Biochem/Haematology. Dr Furrie would check with colleagues on this also.

Action: Dr Furrie

Input from cellular pathology discussed, it was agreed that there was less need to define MRIs in cytology as cervical screening was a national initiative coordinated through SPAN and the national cervical screening programme. The cytology service worked to national standards, using SCCRS system. Mrs Evans added that there were huge advantages when pulling together data through a national system. It was agreed that Transfusion Medicine would be added to the list of disciplines.

Action: Dr Croal

It was noted that there was nothing in the report in relation to imaging. Dr Hawke advised that MRIs were not an issue for imaging as they used National PACS which shared images. Any re-testing within imaging was dependant on the clinical requirement, if requesting another image within a set timescale then this would be flagged up however if additional images were required due to patient deterioration then this was acceptable.

Dr Stirling added that minimum residual disease testing within genetics could be added in also.

The system in use in NHS Tayside was discussed. Whilst they use Trak as their patient management system, they do not use Trak order comms, they use ICE. This is because they can use the same system to communicate with primary as secondary care, enabling them to generate efficiencies across both levels of care. Dr Smith added that this was the second time in a week that he had heard about obstacles coming across in TrakCare and there were concerns that this was having an impact on patient care and patient safety, there needed to be a better understanding on how this impacted.

3.5 End of Year Report Requirements

Mrs Evans advised that, in terms of the end of year report, it would good to incorporate the papers produced by Dr Croal and Dr Bartlett to start to produce a report. The key thing would be to report on the objectives and the work that had been produced by the group to date. It was agreed that Radiology would be a separate chapter reflecting the separate challenges. There would also be a caveat in the report advising that there were some areas, such as physiology, where the group had no control/insight. It was agreed that a draft report would be produced for review at the next meeting. The report could contain recommendations for further work.

Action: Miss Fairley

4. Local Governance Guidance sub group update

Dr Croal advised that in order to implement demand optimisation properly, there needed to be robust governance infrastructures within NHS Boards to support Demand Optimisation activity – this needed to not only involve diagnostic services but also clinical services, management and finance departments.

Dr Bartlett had produced a paper which provided an outline of what was required and based upon structures forming in Tayside; he advised that this was not the final paper but it gave an indication of the direction of travel. Dr Bartlett advised that he had found it hard to find traction to get ownership from clinicians in order to drive changes through; they had therefore focused on the low hanging fruit by managing demand in certain areas.

Dr Bartlett added that diagnostic services should have a local and national perspective; there were challenges as to why some were not using proven initiatives that would benefit them within their local environment. There would also need to be a lead in each board to oversee any works but with national links it would be possible to ensure that there was synergy. Dr Bartlett highlighted that this should be going on alongside realistic medicine, there was a need to demonstrate the value of using diagnostics in the correct context. Dr Bartlett agreed

to produce a two page summary on this for the review report and the group thanked him for the work carried out on this.

Action: Dr Bartlett

5. Test cases

There had been further work carried out in relation to the original DO survey that was reported on at the April meeting. Mrs Blackman had contacted some of the participants to request more detailed information on some of the DO work that they routinely currently out and presented this to the group. Mrs Blackman noted her thanks to all that had participated and provided an overview.

It was agreed that this was useful reference information and that the participants would be contacted to ask if they were happy for the information given to be shared on the Demand Optimisation website. The resource provided to date would be augmented to build a thematic reference library within the website. Miss Fairley would contact participants on this and amend the website to include an area for this if participants agreed.

Action: Miss Fairley

It was agreed that it would be useful to show any cost and efficiency savings that were being made through DO work in the review report with a summary of the effectiveness. Dr Croal highlighted that there was caution needed in this as it was not always necessarily best practice but agreed that it would be a useful as a resource providing examples of the things that are going on. The variation in demand optimisation activity itself highlighted the need for consistency, standardisation and governance structures.

6. Effective Diagnostic Pathways / HIS work update

Following the last meeting Dr Wheelans had continued to explore the wider arena with regard to care pathways. He had raised the work of the Demand Optimisation group with Healthcare Improvement Scotland (HIS), the Scottish Association of Medical Directors, Dr. Brian Montgomery (NSS Shared Services) and has arranged to meet with Dr. Angus Cameron (National Clinical Strategy) on Thursday 7 July. It had become apparent that as a result of this dialogue that there did not appear at present to be a co-ordinated approach to the delivery of change in the areas of rationalisation, equity and removal of waste.

Dr. Wheelans reported that HIS had chosen in their efforts to drive forward improvement at a local level by providing the evidence and support to allow local teams to deliver clinically meaningful change which is relevant to the local organisation. Their feeling was that without the buy in and sponsorship at a local level there would be little enthusiasm or engagement in the delivery of change. HIS had also intimated that they planned to work in co-operation with NHS24 to look at appropriate decision making tools. Dr Smith added that NHS Education Scotland (NES) were already carrying out work on decision support. The wider group commented that they were unaware of this initiative and Dr. Wheelans suggested to Dr. Smith in his role as Deputy CMO that there would be benefit in strategic planning and oversight of all relevant projects in this area to avoid duplication and waste in the actual process to deliver change.

HIS had intimated in their discussion that they would be working with NHS National Services Public Health Intelligence to collect and report in real time, routine, meaningful data. Following this data capture and analysis they would aim to provide support in its interpretation and the use of Quality Improvement Methodology to deliver change.

The wider group expressed some concerns that the method suggested by HIS would result in increased work for those in the Boards without any increase in local resource to support the work. They also expressed their concerns that without some central expert working group

advising on national best practice that there was the potential for continuing inefficiency and variation in how and what is being done across Scotland.

It was agreed that Dr Wheelans would update the group on any further progress in on this in advance of the next meeting.

Action: Dr Wheelans

7. IT Update

7.1 General IT Guidance

Dr Croal had produced a paper in conjunction with several others on General IT Guidance to support Demand Optimisation activity and welcomed any feedback from the group after the meeting on this.

7.2 TrakCare

Mr McConnell was unable to attend the meeting but had provided an update on TrakCare which Dr Croal used to update the group. It was unlikely that there would be any further progress with changes to Trak as the development window had been missed and these changes had also been set as medium priorities so any changes would not be reviewed or implemented until 2017/18. It was agreed that this would be something that would be out with the remit of the group at this time and would be reviewed again in future.

8. Update from SCIN

8.1 Standardisation of Protocols – future work in the workplan

Standardisation of vetting – all referrals are vetted under IRMER but work on standardisation of vetting process is in the future workplan. Both of these support the Shared Services agenda.

8.2 SCIN have discussed Clinical Decision Support Software

1 vendor has a product which is up and running and has been demonstrated. This integrates with order comms. The company has advised that they intend to run a pilot in NHS England

2 others have products which have not yet been seen
NES has Decision Support Software but this is on a separate platform and cannot be integrated with order comms and has nothing relevant to radiology.
SCIN have support the concept of a pilot study of Clinical Decision Support Software in Scotland. Decision has to be taken in which Health Board. Dependent on the progress with the pilot in NHS England this may involve the same HIS/order comms arrangement or may select a HB with different HIS and order/comms. NES have expressed interest in this progress and may be able to offer support this evolution. Metrics to evaluate the pilot have to be agreed such as user acceptability, technical acceptability and effect (fewer or more appropriate referrals). There would be various steps dependent on the pilot eg procurement and funding streams.

8.3 SCIN have agreed to progress workload/workforce data.

8.4 Data Collection:

All HB have local data collection programmes for demand/activity dependent on local initiatives. Many HB have quality programmes which review referrals per specialty or individual/practice. This a however sporadic practice.
All HBs send annual information to ISD for the cost book. Thus National data is collected and available but the collation is simple tabular presentation. The data submission is also inconsistent across Scotland as there is no consistent rule for completion of the data collection template.

SCIN has agreed to work with IMS to collate data in a useful format to inform boards using the common denominator of per 100,000. This will be produced in a visually informative format rather than tabular display. This may evolve into a variation of the Atlas of Variation. Progression of this work will follow to enhance the information available nationally such as by the addition of CHI numbers, possible outcome data would be available supporting realistic medicine.
Further national information is available via PACS (Patient Archiving and Communication System) which could inform on very many aspects of workload/ referral patterns/protocols. There are governance issues surrounding sharing of this data.
There is a great deal of local data available via RIS (Radiology Information System). Data from this platform can be, and has already been, extracted and analysed via SCIN, however work is progressing on obtaining this national data via other mediums.
SCIN have been recently been invited to discuss, with Shared Services, the data points already obtained in the hope that duplication of work can be avoided.

9. AOCB

Dr Croal noted that he was interested in promoting the Demand Optimisation work across the whole of the UK and, as such, had made the RCPath aware of the work of the National Demand Optimisation group and the work that was being carried out. Dr Croal hoped that the work and outcomes of the group could be modified to suit any population and it would be a major bonus if NHS Scotland could show a positive piece of work that could be adopted by other countries in the UK and beyond.

10. Review of actions from meeting

The actions of the meeting will be followed up by Miss Fairley with the appropriate group members.

Action: Miss Fairley

11. Date of next meeting

- Friday 7th October, 10am-3pm, Boardroom 1, Gyle Square, Edinburgh