How will the Carter reports reform pathology?

Pathology, or laboratory medicine as we prefer to call it, represents approximately 4% of the overall NHS budget, provides information for up to 70% of clinical decisions and is highly regarded by hospital clinicians (Heathcare Commission, 2007). Yet despite this, laboratory medicine is not regarded as a clinical service but a cost pressure and has been subjected to a number of reviews over recent years by the Audit Commission and now the Department of Health through Lord Carter of Coles with an aim of improving efficiency.

Variations in service

In his first report, Carter advocated managed pathology networks as the optimal model for service delivery (Lord Carter of Coles, 2006). His initial view was that there were significant differences between teaching and non-teaching hospitals and between urban and rural services. This was tested with a full economic service review across 12 different sites culminating in his second and final report (Lord Carter of Coles, 2008).

This has been the most far reaching of all reports into pathology with 20 main recommendations. These have largely have been accepted by the Department of Health (2008) as there are estimated savings of £250–500 million. The Carter recommendations build on Darzi's vision of a patient-focussed, more accessible NHS (Lord Darzi of Denham, 2007). So what are these recommendations and how will they affect the clinical service delivered to front-line clinicians by hospital departments of laboratory medicine?

Recommendations

There are a number of recommendations that the authors believe will significantly enhance the service. The consistent theme from both Carter reports is the need to adopt new technology and ways of working and that this requires consolidation of services into networks, with one to three networks in each of the 10 strategic health authorities. There are already some networks in England but they are on a much smaller scale; in Wales, subject to a different administration (Hart, 2008), such consolidation will be contiguous with merged trusts, which may maximize conformity of support to clinical services.

Logistics

The current system of laboratory services that are managerially disconnected from phlebotomy, and a logistics system for sample transport that is designed for transporting hospital mail, does not work well. The proposal that laboratories take full control of the service from initial request to delivery of the result is therefore welcome. Second, the critical importance of information technology is recognized for laboratory communication with all service users, be they physicians, patients or other laboratories. Third, the recommendation that the service should be more user friendly is helpful; this would include designing phlebotomy services so that it is easy to have blood taken at times and places that are convenient to the patient.

Knowledge for patients

Carter and the newly published NHS Constitution both demand that patients should be given more information about their care. The Association for Clinical Biochemistry has been providing user information for several years with the widely praised Lab Tests on Line (www.labtestsonline.org.uk). This is presently available to both patients and professionals and is soon to be extended to a professional level which will sit with Map of Medicine (www.mapofmedicine.com) and the GP-focussed Better Testing website (www.bettertesting.org.uk).

Community services

The evolution of the NHS envisaged by Darzi (2007) proposes dissemination of services into the community. This will include performing traditional laboratory tests for chronic diseases in general practices and pharmacies. This raises important issues regarding cost effectiveness (which has not been tested) and clinical quality which may not be solved by accreditation, even if it does becomes mandatory. The Department of Health recognizes that work needs to be done in these areas. It is important for those commissioning community laboratory services to recognize that such services will require accreditation to assure analytical and clinical quality.

Networks

Carter has proposed that laboratory medicine should be delivered by a small number of networks with integrated management that will have to be autonomous from participant foundation hospital trusts. It is uncertain how these networks will come into being, as Carter envisages that they may not be contiguous with strategic health authority boundaries nor is it clear whether it is in foundation trusts' interests to relinquish control. No doubt as commissioning becomes more mature, these issues will become clearer.

However, despite these caveats, the creation of networks has huge potential benefits for patients. First, networks can be expected to use the same diagnostic protocols and assays. Therefore the results will be interchangeable throughout the network meaning that patients can move with their data throughout the network irrespective of where their blood is taken or in which trust they have their clinical care. This will be essential with shared clinical care and protocols for chronic disease monitoring.

Second, from a laboratory professional's point-of-view, there will be a critical mass for cross-cover, thereby ending the unsustainable system of individual practice, as well as enhancing training opportunities for succession planning. There will undoubtedly be a change in working practices; there will be fewer generalists and

more specialists each of whom will cover several trusts. This will reduce the informal contact that currently occurs and make formal multidisciplinary team meetings a critical operational mode for clinical liaison.

Carter envisages these networks consisting of a large regional 'cold' laboratory with on-site hospital laboratories performing only those tests that need short turnaround times. This consolidation has advantages in improving analytical quality as well as the economies of scale. Moreover, it will provide sufficient volume to justify some within-network specialist tests. An alternative network could be built on a confederative model with common standards and practices which would be as effective and 'green', by minimizing the need for frequent transportation over significant distances, hence minimizing the carbon footprint. However, the Department of Health has a pragmatic view recognizing that network structures need to be locally determined.

A further factor determining the shape of future networks will be the commissioning process. At present, pathology commissioning is a poorly understood area. The nature of the service specifications will determine which tests are done in which laboratories and how many are done in GP surgeries and high street pharmacies. Indeed, it is uncertain whether the service specification will enable expert clinical laboratory opinion to be accessible to service users. The proposed model contracts in the Department of Health response may provide some clarity.

Specialist services

Both Carter and the Department of Health response recognize the importance of specialist services which the authors welcome. The specialist services have suffered under the short-term fiscal demands of the host trusts and need urgent support. The optimal design of specialist services has not been established but consolidation into regional and national networks would provide the critical mass necessary for a sustainable future. Unfortunately, there is no coherent vision for delivery nor how they will be commissioned as the English model will rely on commissioning at local level by primary care trusts under the guidance of their parent strategic health authority, which may not be optimal for national small volume services.

Quality

A large plank of the Carter proposals involve quality; however, it should be recognized that clinical laboratories have been in the vanguard of developing analytical and clinical standards over the past 50 years. The authors believe that the significant contributions to patient care made by clinical specialists in laboratory medicine are often overlooked. This needs mandatory clinical audit which will help us to contribute to the establishment of national quality standards which Carter suggests should be established by the National Institute for Health and Clinical Excellence.

Most important of all, Carter has recommended that pathology should be represented by a clinical lead in the Department of Health. Pathology has to date been unrecognized at policy level, having to play 'catch-up' in national initiatives. A National Pathology Clinical Director will be able to ensure that the focus of delivery is intertwined with the national clinical programmes.

Workforce reform

A major strand in Department of Health thinking is the modernization of career pathways; recruitment of medical staff into laboratories seems to have improved with Modernising Medical Careers. Modernising Scientific Careers (Hill et al, 2008) will create a more flexible scientific workforce.

Conclusions

It will be understood that while the professions broadly welcome Lord Carter's recommendations there are some that require an understanding of the financial and organizational constraints and what may be considered by some as misapprehensions. We believe appropriate dialogue at the Department of Health and at strategic health authority level needs to be structured to obtain best practice advice from senior innovative thinkers from within the profession. We would suggest there is a need for a credible experienced pathology lead in each strategic health authority to ensure primary care trusts and commissioners understand the nature of the services proposed and offered. BJHM

Ian D Watson
President
Julian H Barth
President-Elect
Association for Clinical Biochemistry
London SE1 2TU

Department of Health (2008) *The Department of Health's response to the Report of the Second Phase of the Independent Review of NHS Pathology Services in England.* Department of Health, London

Hart E (2008) *The Future Delivery of Pathology Services in Wales.* Welsh Assembly, Cardiff

Healthcare Commission (2007) *Getting results. Pathology services in acute and specialist trusts.* Healthcare Commission, London

Hill S, Bingham DC, Lunday J, Crawley O (2008) *The Future of the Healthcare Science Workforce. Modernising Scientific careers: The Next Steps. A Consultation.* Department of Health, London

Lord Carter of Coles (2006) *Report of the Review of NHS Pathology Services in England. An Independent Review for the Department of Health.* Department of Health, London

Lord Carter of Coles (2008) *Report of the Second Phase of NHS Pathology Services in England. An Independent Review for the Department of Health. Department of Health, London*

Lord Darzi of Denham (2007) *Our NHS, our future.* NHS next stage review, Interim report. Department of Health, London

KEY POINTS

- The Carter reports inform changes required to meet *Our NHS, Our Future.*
- They endorse the use of pathology networks to ensure uniformity and efficiency.
- They recognize the importance of specialist services.
- The reports should enable changes in service delivery while supporting quality.