Questions from Harrogate staff meetings

24 October 2019

1. **Would you expect to have a core of staff that need to move round?**
   We would expect most staff to be based in a specific laboratory, and know this is what many staff would prefer. However, where appropriate there may be some rotation – for example to enable staff to develop particular skills or experience.

2. **So will it be voluntary – won't arrive at work and be told have to go to Airedale?**
   Any rotation would need to be carefully planned in agreement with staff, although there may be a need to ask staff to work elsewhere if cover is needed urgently and provided they would be able to do so.

3. **Is this consultation?**
   No. Consultation with staff and unions will take place on any changes to terms and conditions, such as change of location if this becomes relevant. We need to work through all the details before we get to this stage though and will continue to involve staff in the process.

4. **Think it should be recognised that people with certain circumstances should get priority**
   We will try to take account of people's individual needs and preferences wherever possible in an equitable way.

5. **So is the final goal a WYAAT contract rather than a HDFT contract?**
   We want to minimise the disruption for staff so are hoping to avoid changes of employer if possible. It's a balance between not causing unnecessary disruption and ensuring we can work effectively as a network. (NB: WYAAT is not an organisation so cannot employ staff).

6. **The cynic in me says that if we were moved to a WYAAT contract, we could be made redundant and not have our years of service taken into account**
   That would not be the case and we are not anticipating the need for any redundancies, based on the modelling we have done so far and the experience of other areas that have already formed networks. Although HDFT has not needed to use locums this is a big issue for other trusts and there are a large number of vacancies across the network, which is one of the challenges we are aiming to address by working together. (NB: As stated above WYAAT is not an employing body, therefore all contracts would be issued by a trust and if you move between NHS trusts your service transfers with you.)

7. **Why don't Airedale give some of the GP work back to Bradford if struggling staff-wise?**
   The GP work going has been going to Airedale for a long time as many GPs moved their work there prior to the joint venture being established.

8. **Band 6 terms and conditions at Harrogate are pretty favourable and am concerned that this will be dragged down**
   We need to understand and learn from what works well at the different trusts so will make sure this is considered. Retaining staff is fundamental to delivery of a successful pathology network in the region.

9. **The perception will be that labs are Pinderfields, Airedale and Leeds laboratories rather than network laboratories – will take a long time to change**
   This will be a big change for everyone but it is not going to be a quick process so hopefully this will help us all to adapt to the different ways of working and working as a network rather than individual trusts. We will be developing joint standards and processes for the network so these will be used by all laboratories and help us to work together effectively irrespective of where people are based.

10. **Would microbiology see any changes before 2023/the new lab is ready?**
    It is unlikely that there would be significant consolidation in microbiology ahead of this time. No testing will be moved until all the quality gateways have been met and we still need to develop a full business case to make sure it will deliver the anticipated clinical and financial benefits.

11. **Do the new lab plans address parking?**
    Car parking facilities at LTHT will be reviewed as part of the building programme that includes the new laboratory.

12. **Understand that money has been given to LTHT for SJUH so will LGI be an AHL then?**
    Yes, LGI will also need an AHL to support urgent and acute testing needs on that site.

13. **Surely we won't need a 24/7 service as what will be in the hubs won't be urgent?**
    We will need to look at this based on the testing that will be required for the network. It maybe that extended days would support the requirements and volume of testing.

14. **Will microbiology need to do some other work at AHLs so we don't have staff sat round with nothing to do?**
    We still need to determine what microbiology testing is done at each hospital site, through the AHLs or POCT. This will be developed by clinical and scientific staff to determine the most effective and efficient model for the Network. The idea behind having AHL+ laboratories is to make sure our services are efficient and staff are sufficiently occupied.

15. **Isn't it better to have different antibiotic policies so not all get resistant?**
    The consultant microbiologists are already in the process of discussing a regional antibiotic policy as they believe this will offer a better approach. Local variations may be required owing to individual circumstances, such as outbreaks of resistant organisms.

16. **People are muttering that microbiology is shutting so staff might as well stop now and leave**
    It will take a long time to develop the network and there will not be any changes for several years. Staff will have chance to be involved in developing the new ways of working so we hope they will want to be part of this and contribute to the development of microbiology services for the region. We will also be as flexible as possible and take account of staff circumstances and preferences wherever we can to encourage staff to stay working within our services.

17. **I'm worried that staff will jump ship now when we still need to run service for the next 10 years**
    We understand that is a concern and that staff may feel anxious about the changes and will do all we can to support staff and encourage them to stay. This approach is being taken across the country and all areas are developing regional networks but we hope that by being open about the process and involving staff in developing the network that they will want to stay working in the region and help us shape pathology services going forward. We appreciate that staff may feel unsettled or anxious about the changes but we also hope that staff will be able to see the benefits working as a network can offer them, such as increased training and development at all levels and progression through WYH-wide apprenticeships and trainee schemes. In addition, we hope to develop and support new roles such as consultant clinical scientists in microbiology and blood sciences and advanced practitioners for cut-up and reporting in cellular pathology. It's really important that there is an open dialogue and we would encourage staff to come and speak to us about any concerns as they arise so that we can work these through with them at the time.

18. **Will staff get a parking space if they have to move?**
    We appreciate this is an important issue for staff and will be looking at parking and transport as part of the implementation planning.

19. **What would happen if HDFT lost its FT status? (Re being part of the joint venture)**
    There is no suggestion that this will happen so is not something we have planned for.

20. **If we get a new government, could all this change?**
    We can't be sure but think it is unlikely. The drive to create networks is based on the recommendations of the Carter Reports which set out the benefits this approach delivers and these have not been disputed by any other parties.

21. **The scoring is very complex but it looks as if all the blood sciences hubs have been selected because they are private rather than due to quality or location**
    One of the key considerations at the shortlisting stage was financial viability. Some of the commercial and financial arrangements in place across the region would mean that changing the sites to AHLs would not be cost effective. Lack of capital to refurbish or build additional space on to existing sites was a constraint that had to be considered in

identifying potential hub sites. The aim for the network is that all laboratories will be delivering the same high-quality services, to the same core standards.

22. **It is a shame that microbiology is to be disbanded when it's the best laboratory in the region**
We understand that people are proud of their services and the quality of service. It is important that best practice standards from across the existing laboratories in the region is shared to create the best possible service for patients in all part of the Network. We absolutely want to maintain expertise and experience of the existing workforce in the region.

23. **We invest heavily in our staff and training – there will be a cost for others to bring their staff up to the same standard**
Training and development will remain a priority for the network and working together will enable us to continue to invest in this. It will also give us chance to explore working more closely with the universities and developing tailored programmes for our staff, as well as opportunities to develop and expand new roles, such as consultant clinical scientists.

24. **Is there a view to move training around – eg spend month working in different lab?**
That could be an option for staff who want to do that. There will also be opportunities to think about bringing people together for specific aspects of work, which will also offer colleagues chance to learn from each other.

25. **There is a rumour that PFI and finances meant Airedale and Pinderfields had to be picked as hubs**
These were factors that we had to take into account in the financial element of the scoring. The costs of exiting the contract with the JV's commercial partner and MYHT's PFI contract would and leaving the space unused would significantly undermine the savings generated so it was agreed both Airedale and Pinderfields needed to be a hub for at least one discipline.

26. **Why couldn't we replace equipment earlier?**
We were planning to do this but NHS Improvement told us to put this on hold when it was agreed that we should form a regional network. Working as a network will mean we get greater economies of scale when purchasing new equipment and also a new LIMS.

27. **Why is HDFT working with Leeds and West Yorkshire rather than York and Hull?**
Although geographically Harrogate is part of North Yorkshire, our patient flow is mostly towards Leeds rather than York or Hull so it makes more sense for us to work together within the West Yorkshire & Harrogate region.

28. **UKAS documentation for deviated samples and transport – will be hard to live up to with a single hub for microbiology**
    We will need to look at this as part of the more detailed planning and ensure we meet the requirements. Logistics will need to be carefully planned to support the operation of hub-based models in all disciplines.

29. **How will we book in and track samples?**
    We will need to develop a sample tracking system to support working as a network.

30. **Will other AHLs not need 2 analysers anyway – need back-up**
    We'll need to consider carefully our analyser platforms to ensure business continuity whilst maximising our buying power collectively to the benefit of our services.

31. **Will we still be assessed individually for UKAS?**
    We don't know at the moment and need to see what UKAS do regarding this. However, it is unlikely we'd be moving to a single number for the network in the near future. We need to assess the relative benefits and risks of making any changes to our registration, both within the joint venture and within the network.

32. **Is there a view to standardise SOPs?**
    Yes, we are aiming to do this as closely as possible where appropriate. Once we have a common LIMS and equipment then standardised SOPs would naturally follow.

33. **What provision is being put in place for microbiology staff – need sooner rather than later**
    We understand that microbiology staff will be concerned about the recommendation to move towards a single hub. However, there is a lot more work that needs to be done before any changes could take place and we are working with HR colleagues to ensure support is put in place. We will also be holding further discussions for microbiology staff to talk through the proposals and any concerns they have.

34. **You can't expect MLAs to travel further**
    We recognise that moving location may not be feasible for some staff, particularly for staff in lower-banded roles. Detailed work will be undertaken to understand the impact of proposals on all members of staff and how alternative options such as redeployment or retraining can be offered where location is the most important factor for people.

35. **What about ancillary staff – they are worried too**
    The development of the full business cases will undertake a detailed assessment of any consolidation and consider the impact for administrative, clerical and ancillary staff as well as scientific staff.

25 October 2019

1. **When will digital pathology be in place?**
   This has already been rolled-out to LTHT and there is a plan in place to roll-out the technology to all the trusts in the region by the end of 2021.

2. **Given our current test volumes, will we be getting more work as an AHL+?**
   Pathology is seeing growth in test volumes by approximately 3% per year so we will have some capacity to accommodate growth in test volumes.

3. **Will the AHL+ status mean our service looks similar to / as it does now in blood sciences?**
   The test suite will likely be similar to what we provide at the moment and it is not anticipated that we would gain or lose any GP practices in terms of direct access work at this stage.

4. **Do we have scope to look at staffing levels on later shifts and out of hours?**
   Yes, we will need to look at the volume of tests we'll be processing at different times and determine the staffing levels need to support this.

5. **Why isn't Bradford a hub?**
   Bradford is already operating much a like an AHL and delivers work to support urgent and acute needs generated from the hospital. The routine testing is mainly already delivered by Airedale as part of the Joint Venture.

6. **How will samples get to Leeds?**
   We'll need to invest in logistics to support the model, including specimen tracking. The modelling done so far has considered the logistics requirements of each of the shortlisted models, in heavy and light traffic, indicating the new routes and numbers of drivers required to support these routes. The full details will need to be modelled as part of a full business case.

7. **Where is the change in blood sciences?**
   Much of current blood sciences testing is already aligned to the laboratories that have been proposed as hubs. The most significant change will be where sites are currently delivering routine and GP direct access testing but will in the future proposal operate as AHLs (rather than AHL+ or hub sites). Growth changes and movement of specific suites of testing would also change the movement of tests between sites.

8. **What is the consultant model? Don't they want two microbiology hubs?**
   This has yet to be determined. It is recognised that the consultant models will need to be reviewed, particularly in microbiology to support a single hub, whilst providing a clinical service from each site. There has been much debate between consultants and with laboratory managers in respect of the benefits of a two-hub and single hub model. The key factor was the ability of the hubs to run 24/7 if necessary. Overall the majority of consultants support moving towards a single hub but agree that if two hubs could run the

same suite of tests over a 24/7 period, then this would be equally as beneficial as a single hub model in terms of clinical effectiveness and patient experience.

9. **Has provision been made for staff by this trust? Staff may choose to leave given the direction of travel described.**
   Significantly more detailed work will be required to understand the impact for staff. We have involvement from HR colleagues and we can assure staff that any proposed changes to their current roles including base will be subject to a formal consultation process with staff and trade unions. In any process we will need to take account of personal circumstances and arrangements and be flexible in supporting this. We will also look at options for redeployment and retraining where required.

10. **Is the Programme Board made up of equal membership from each trust?**
    Yes, each trust has one executive director representative – it is not based on relative size of the trust, or the size of the pathology service.

11. **Will £12million be enough for the LIMS?**
    We expect this to cover most of the capital cost of the new LIMS. In addition to the capital cost there will be ongoing revenue maintenance costs to support the system on an ongoing basis. Every trust pays these costs now so would be expected to contribute moving forward. Our current assessment indicates that the ongoing maintenance costs for the new system will be lower than the costs of running our existing systems across the six trusts.

12. **By joining the JV do we need to replicate their equipment?**
    UKAS requires us to specify our equipment requirements. If the equipment currently deployed by the JV can meet our needs, then there is an opportunity to replicate the same equipment. However, if there is an impact on quality or the equipment does not meet the needs of the service then we can still purchase alternative equipment through the JV. The JV contract with the commercial supplier Beckmann runs until 2032 but there is an equipment replacement cycle every seven years.

13. **Will we have to rotate across sites?**
    We expect that there will be opportunities for rotation for staff who want to work at different sites to develop their skills and experience. However, we are also conscious that this is a concern for some staff, who would rather have a regular base so this will also need to be factored into the workforce planning.

14. **Will out of hours arrangements be changing?**
    We will need to look at how we will manage all the testing as a network and review arrangements to make sure we have an equitable approach across all trusts that meets the needs of the network.

15. **Is this still an attractive profession to enter?**
    The profession is changing but there are new opportunities from the changes. All services have had restricted local training budgets to date and working as a network will

bring more opportunities in terms of training and development e.g. new roles such as advanced practitioners in histopathology and consultant clinical scientists in blood sciences and microbiology.

16. **How will UKAS accreditation work going forward?**
    This has not been determined yet but it is unlikely we'd be moving to a single number for the network in the near future. We need to assess the relative benefits and risks of making any changes to our registration, both within the joint venture and within the network. We also need to see how UKAS will respond to this issue, given that nationally all areas are forming regional networks.

17. **How is the pathology programme linked into the long-term plan and future-proofed to meet the needs of changing clinical services?**
    The consolidation of pathology services is part of a national directive from NHS Improvement, following the Carter Reports which identified the potential benefits that the NHS could achieve through consolidation of pathology services. We don't have clarity on the future strategy for all clinical services, but we need to be proactive in developing a future pathology service. We'll need to be intelligent in the way we procure our managed service contracts and work with suppliers to ensure we can adapt to new changes in equipment, particularly with the development of POCT.

18. **Who reviews the strategy and subsequent full business cases?**
    These are reviewed by the Pathology Programme Board (and in future as part of the Network Collaboration Board) which makes recommendations to the West Yorkshire and Harrogate Committee in Common (CiC). The CiC is made up of the chief executives and chairs of each of the six trusts and will review the proposals and make a recommendation to the six trust boards. The boards hold the statutory decision-making authority for each of the six partner trusts so will make the ultimate decision.

19. **Are the trade unions involved?**
    Yes, through local representatives. In addition, we discussed proposals with the Area Partnership Group of regional trade union representatives on 18 October. Within Harrogate, we've been attending local partnership groups to discuss joining the JV.

20. **Is the LIMS timescale realistic?**
    We've based this on discussions with other networks that have already rolled-out multi-site and multi-organisational LIMS. However, we'll need to test this with suppliers as part of the procurement process. Once we've undertaken the procurement we'll need to put together a full business case with a detailed timeline which will need to be approved by the WYAAT Committee in Common, the six trust boards and NHS Improvement, in order to obtain the capital allocation.

21. **What about estate / accommodation issues?**
    There will need to be consideration of refurbishment costs for each laboratory and how these are met. The roofing contractors should be visiting the Harrogate laboratory in two weeks to resolve some of our current issues with the roof.