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The biomedical scientist: Interview with Frank Wood March 24, 2011

Frank Wood is a biomedical scientist at King's College Hospital in Camberwell, London. He is the chair of the Joint Staff Committee and sits on Unite's Executive Committee for Health. In this interview, conducted on 8th March 2011, he talks about how pathology departments have changed over the last 20 years and the problems with outsourcing to private companies, the development of King's as a foundation trust hospital and the negative impacts of the new Health Bill.

What kind of services do you provide?

The pathology department at King's is quite a modern unit which brings together microbiology, biochemistry, haematology, virology and molecular biology. It was renovated about three years ago to the tune of about £3 million. It's a large purpose-built facility, which is now part of a private sector company, a joint venture company with Serco.

We provide pathology services to King's and to other trusts that buy their services, mostly diagnostic testing, therapeutic testing and monitoring. The vast majority of the testing is done by a large automated system, and then people like myself carry out specialist assays, which are mostly using quite advanced scientific equipment.

How did it become a joint venture with Serco?

They came in to St Thomas' hospital first and signed an agreement with Tommy's [St Thomas' hospital]. Tommy's gave them the 600 pathology staff and the pathology laboratories, and Serco brought in the "expertise" and signed into a public company called GSTS. That company had 50-50 ownership but with the golden share owned by Serco.

King's felt that, as we're part of King's Health Partners, the academic health science centre [with Guy's and St Thomas'], that we would also join that company. The trust said we could join that company if the staff were also retained, i.e. that we continued to be employed by the NHS and that we would retain our pensions.

You couldn't possibly transfer a group of staff like us - mostly on band 5 to band 8, so mostly on average paid in excess of £25,000 - £40,000 with about 20 years of service – without the retaining of pensions. The staff wouldn't accept it at all. You wouldn't get pathology staff out for very much but, for pensions, you probably could do it. And so that had a Retention of Employment model.

Our trust's new chief executive formerly worked as a Director of BT Global Systems, so we were sure that, if we got a big-shot executive, then in the deal with the new company we'd be protected. They came out of it and said the new company, formerly having been 50-50, with the golden share to Serco, was 51% Serco, and 24.5% King's and 24.5% Tommy's. So we're thinking, "it's worse, isn't it?" Tommy's doesn't really care about its pathology department at all because, otherwise, they would have invested in it for the past 20 years and King's, who did invest in it, have given it away on a sort of dodgy basis.

And that's a new pathology company?

Yes, that's a new private sector company that doesn't have a very catchy name: we're calling it GSTS London.

What we're doing is bidding for pathology departments. So at the moment, GSTS are looking at persuading Peterborough to transfer their work.

You're still employed by the NHS?

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Yes, and then we're seconded.

So Serco is bringing equipment?

They'll bring nothing, to be honest. We've given the equipment, the building and the staff and they provide the procurement service, HR, management and marketing. The vision that they've adopted from the Carter [report], which was done about four years ago, is that there will only be a single provider for each region. I don't agree with that for London. Nobody in London thinks there'll be one provider. It's not feasible because of the size. So the idea was that, by enshrining ours in the private sector, it was untouchable. We keep ours whatever happens and it is of significant size to be the provider. All absolute bloody nonsense, in my view, but that was the vision. Wouldn't it be great and wouldn't it give us more job security to be on the inside of the tent? Now I don't think any of our staff were so stupid as to buy into it.

Can you give us an example of the type of case you do.

I screen for multiple sclerosis, so I do an assay looking for the pattern of IDG through the spinal fluid and serum. That's the screening test for multiple sclerosis, which will be referred to us by specialist neuroscientist units. It provides a material aid to a doctor who's done a physical assessment of a patient but needs more in order to assist in making a decision. It's also to provide them with something concrete to justify their decision. Frequently a lot of decisions, whilst not entirely based upon a pathology test, do tend to require a pathology test, so the estimate was that some 80% of clinical decisions are made with a pathology test. So when you get a patient referred to a hospital, it's pretty much central to their care that there would be an extensive protocol of pathology tests as part of the way the clinicians diagnose, treat and monitor the patient.

And how has the work changed since you've started?

Initially, when I started - which was 1990 at King's, about 1987 in the service - pathology, like a lot of other hospital services, was coming to the point where it had been under-invested for a significantly long amount of time. Frequently pathology departments were based in unsuitable, former ward areas, even porta-cabins. The fabric of the buildings was poor. There were problems in terms of the equipment, which was old, and in terms of the staff, who were as old as the equipment in many cases. The basis of the way that the pay review bodies worked meant that the nurses got awards that were significantly higher than ourselves, because we were not in a pay review body, and so pay was falling back as well.

So in the past 15 or 20 years, there's been significant primary investment in some pathology departments, and King's made quite a significant investment to bring it up to a quality service.

Can you give us a quick sketch of how the equipment has improved in the last 20 years?

We used to do things manually, and we still do. But because the work has gone up by about 10% a year, there's a definite need to get the results more quickly, so there was a need to automate the processes. Also, with the significant element being the staff cost, automation seemed to be advantageous anyway.

Initially automation was quite limited and the pieces of equipment would be for bench-tops. They would sit on a bench and they'd be linked together by a crude conveyor system. The initial one, Auto 1, was based on bicycle chains. In the one we now have, there are 13 floor standing analysers, which are about two metres long and about a metre high. They are then linked by a 25 metre track which transports the samples between the analysers. The samples are loaded into a tray which contains about 100 of them. They're loaded into an automated unit which has a robotic arm, picks them up, transports them along the track to two centrifuge units, where they are spun down to separate out the blood cells. Then they're transported between the analysers. That means most routine profiles are done in two to three hours. That unit will analyze in excess of five to ten thousand samples a day, and we do in excess of 2 million tests a year.

And where are you?

I'm upstairs, thank god. I do a manual assay on a small bench-top unit, which does iso-electro focusing – protein analysis. The majority of specialist staff will still be doing that upstairs. The staff who are running units like that downstairs are mostly supervised by a few scientists, but they're mostly support workers.

The analysers are automated arms with pipettes on the end of them – basically us. What I do is pipette, what the machine does is pipette. I put it into the reaction vessel, I do other things, I time it, and then I put it for analysis, and that's what it does, it automates that process. It's a

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stopwatch, it's a constant temperature unit, it's all those things.

We lease it [the machine] from Siemens. This is such a big unit that Siemens gives us our engineer, so we've got our own engineer with us, who looks after the equipment for us.

The equipment will never be bought. You never buy things in the NHS any more, because you pay 6% on it for the "level playing field". The government says, if we were private sector companies, we'd probably have to pay back loans and stuff, and because we don't – we just get given money – it sort of levels the playing field. We value all our stores, our equipment, the estate, and then each year we pay back 6% to the government. So we get given money, then give some back to represent that levelling up.

Isn't that a bit of a waste of money?

Yeah, there's a lot of money circle that goes on. It's the same as the fact that we have people who exist to internally charge in the NHS. It's all a huge waste. This is part of that system which John Lister says costs about £20 billion a year in the NHS, and which we have huge groups of people whose job it is to do.

You think, "what on earth are you doing that for?" We have an entire department to code things. You know, you have a hip operation and they say, "he came in, he had a hip operation, he did this, this and this." There are codes for that to make sure there's an accurate record of what they do. Well, why?

There's a career pathway for this job of coding things, you know. We have finance departments, we have procurement departments. In the old days, I used to phone up and order things and fill in a payment sheet. Now I'm referred to procurement departments and they phone up and order things. That was what I was doing. The idea is that they can bargain and incentivise purchasing and all this sort of thing. There are loads of market things that go on in the NHS.

But there are several advantages in leasing [the machine from Siemens]. Most equipment has a five- to ten-year cycle, so you'd replace it anyway. You tie in the engineering and you tie in the re-agent cost, because all the analysers use re-agents, the chemicals and so on. They're the most significant cost. So with Siemens, it's not particularly like a lease; they almost give you the analysers because that ties you in to using their reagents for 10 years. It's quite standard. There's no way we'd manufacture our own analysers. It's quite a standard arrangement in terms of pathology because of the increasing equipment. It's like the NHS buying a fleet of cars. Of course they'd buy from a private sector company.

But what I do object to is tying up to sole provider status. If Siemens come in and say, "we'll provide you your track equipment and as part of the deal, we'd like to provide you with every piece of equipment," by which point Siemens would have sought other providers to come in with them if they didn't provide a full repertoire, then that makes a mockery of what I do. Because one of the things I do is say this is the piece of equipment I have most faith in, that I have assessed and I believe I need. Then for somebody to come along and say, "no Frank, what you need is this, because we've got a contract for it."

Most of our maintenance services are outsourced, on the basis that it's more efficient to get, say, a painter in to do some painting when it's needed, rather than employing one all the time. You don't employ a plumber all the time, you just phone a plumber when you need one. For a lot of people that makes sense, except that most of the time in a trust of this size, actually we do need a painter. We used to employ a painter, and you'll find that the contract painters and all the other people in the [maintenance] services we contract are here all the time, so much so that at least two of them have just moved on site.

So I don't understand what the efficiency was. The people who look after our heating and ventilation have just moved on site. We've just tendered out a lot of the contract services together just to tie them all together. We had too many separate contracts that weren't efficient and they're moving on site. I don't understand why they're more efficient than the people we had anyway. Also, you can't manage them directly, you have to manage them through the contract, which means we have to have people looking after the contract. And the [maintenance companies] will sub-contract their work anyway, so they're doing exactly what it's argued we should be doing for efficiency; they're just sub-contracting the thing and we're paying them to do that, plus administration on top of that! So I don't appreciate there's any efficiency to it. Medirest has the contract for most of our support services [at King's]. It was Sodexo.

Could you talk about the changes in the hospital since it's become a foundation trust?

We applied to be a foundation trust as part of the first wave and we certainly had an advantage because, for early foundation trusts, the tariffs were extremely favourable. We went from a situation of hand-to-mouth to suddenly having money around for investment, and that certainly encouraged people to become a foundation trust.

In the early years, we were certainly able to invest in the estate, able to invest that money in pathology, able to establish a strong security of employment. In fact, the trust went from 3,500 staff to 7,000 staff since the early '90s, so it was a very significant opportunity to establish King's, not only as a high performing trust but also as a good employer. And that benefited all the staff, including pathology.

The pathology project [wanted to] establish an NHS pathology laboratory which would be a major provider for a lot of the local District General Hospitals (DGHs). We would take the work and network with them and it was better that they came with us because we'd be NHS and a good employer.

Certainly Kings' foundation trust has seen itself as very much a thrusting go-getter for whatever reforms are there. So for example, King's has led on the stroke care pathway (and often we had the doubtful benefit of Alan Johnson or somebody coming down to have a look at it). So we tend to be seen as cooperative in government projects and so on.

But where King's may have attracted investment, others have suffered?

Very significantly, especially the PCTs, because they're the ones that are paying. And of course what happens is more of the healthcare costs within the area, especially when you consider the size of King's and St Thomas', more and more of that money goes to foundation trusts, which aren't necessarily the cheapest ways of providing the care anyway. King's will be in excess of £560 million a year. God only knows how much the budget is for Tommy's, but if you take those two together for this local area, you're looking in excess of £1 billion. If you look at the academic health science centre overall, our entire budget is about £2 billion - 20,000 staff, 14,000 students.

So what's losing out?

I think a lot of the soft primary care: health promotion, services that would be better provided in smaller hospitals. If you went to Sidcup, you'd see that very little survives. And yet there are patients who travel beyond Sidcup to come to us. In most cases, they don't need a specialist service, they just need routine care near them.

But patients may have to travel longer but, when they do get here, the services will be good, right?

Yes, they'll get the best services in Europe. Great, but a lot of the time they won't need access to them. Our interventional cardiothoracics, I'm told, is probably one of the best in Europe. What they can do now is fantastic, it's brilliant. You can have a cardiac intervention on an 80-year-old, which you could never dream of doing before now, using all these pipes and tubes and stuff, rather than having to open up the entire chest cavity. So what they can do is fantastic but for the majority of people coming in, 300,000 outpatients, it's just a routine check or monitoring.

Take the most basic thing: child care. Is there really an argument that Sidcup maternity unit is closing and that patients instead are coming to King's? In most cases, they don't require major specialist intervention.

Do you do pathology for public and private patients?

Pathology comes with the patient, so if a patient is private and goes into a private hospital, the chances are that most of it, the routine pathology, is done in the hospital. Most private work is what you call elective operations: you go and decide to get your nose fixed. Maybe you've gone in to get a surgical procedure which is probably longer on the NHS, say IVF or something. They would do the pathology then.

It has always been that, when we come to do specialist testing, some of which can cost between £50 to 200, if not more, the expertise and investment has always been there [in the NHS], so it's not that we're finding any more new private sector markets. Labs like ours will always do tests for other hospitals anyway and charge for it. And ours is an established market. In the old days, we never charged for it at all. It was just part of the funding of a recognised regional service. Now we charge for it in a bidding system.

But pathology is fantastic. You're reasonably fit and healthy but all we have to do is get you worried enough about your cholesterol level and say we can measure it. In fact, we could give you a reasonable heart risk

assessment for about £20 and plenty of people out there would pay it.

So in terms of marketing, we could market pathology at the well as well as the sick. Most of health care is predicated on treating people who are actually ill and not particularly well off a lot of the time. A lot of the people [living] at King's and around King's are poor and probably couldn't pay for much health care anyway, the bastards. So it's fantastic; pathology has a significant potential as well.

So you're paid for the pathology per the particular unit of work that you do?

Yes, so usually, for specialist work, a single request; and for more routine work, you might do a volume contract, or you might do a particular set of work and include that in what you call a screen.

It's necessary that the IT system that enables you to book in and follow for the results also works as a bidding system. It's not usually a problem because most IT systems are global and so based upon American systems, in which billing is very significant. In terms of what we understand, in the American healthcare system, up to a third of the entire bill – bearing in mind health costs are the main reason for bankruptcy – can be pathology, so quite significant costs can be generated through pathology testing.

And the bill you're sending is going to private hospitals but also foundation trusts?

All trusts, yes. But as I say, in most cases, a lot of our work comes with the patient. So you wouldn't separately bill it, it's an aspect of the patient care costs. By removing pathology from the trust, we have to separate it. You need to say to the trust, "that hip operation we did all those tests on, that money that came with them, we need some of that for our pathology tests." So you have to separate it out. And that then assumes that you can accurately cost what we did. We really can't because, even though it might have seemed perfectly normal, there's a lot of people in pathology whose entire role is to explain to some poor doctor what the pathology meant. And that's something that's less easy to cost.

Also, an aspect of pathology is to maintain development and look for new tests; to work through things to develop the service and keep it up to the sort of standards that enables King's to be not just a trust providing patient care, but also developing patient care. In the search for the bottom line, we worry that these things will be lost.

At the moment that is just a worry?

I don't think it is. The private sector has always been small in pathology, precisely because of the inability to attract, retain and develop staff. The proportion of what you might call finance managers, or dead-weight management, based at GSTS, is quite high compared to what it was previously, because everything has to be duplicated as to what existed for the trust. Secondly, I think there are very real examples at St Thomas' of scientists who have left and not been replaced.

But in terms of our experiences at King's, it's too early for me to say. If, say, we have to replace a senior scientist with 20 years service, those staff will be hired on a GSTS contract, they won't be NHS. We will employ them in the private sector. I'm protected, I'm retained, it's very good for me. But every new person is GSTS, and therefore they've got a standard, slightly amended, Serco contract and the opportunity to get a Serco pension (hurrah!). Their other pension will be frozen and they will be outside of the NHS for their employment cycle, breaking their service.

There is an enormous element in the contract about confidentiality. So all these things, I think, will make it less likely that they can attract and retain the staff that will be leaving, just as a matter of course. I'm not saying they will have upped sticks and left out of any principle (they're scientists, they're not that principled!). But even so, I don't believe they'll be able to maintain the same quality of staff. Why on earth would you? The NHS pension is a deferred pay of very significant value. When I look forward to retiring, it'll virtually be on half my salary and it'll go up in line with pay awards (CPI, not RPI, but even so, still reasonable).

The other thing we were very concerned about was that, if they were the sort of person who were actually quite excited about science – I'm assuming some of them are – the fact that there is such confidentiality about it, and the fact that it is a business, means that the basic tools of their science - peer review, sharing of information - are pretty much limited. So I just wonder how difficult that's going to make it for them to do their job.

We've already seen some companies saying to us, "oh, we're not happy with you coming in and looking at our work." They're quite aggressive with their marketing, so they're not happy with us to see how they do things.

Similarly, I can't imagine that GSTS will, in the long run, be happy for us to invite people to see how we're doing our [work] so they can set it up themselves, when we provide it at a cost. It doesn't meet their business mentality, does it?

What's the impact of the Health and Social Care bill, being passed through parliament now, going to be?

The idea will be that King's, and all the foundation trusts, will get a lot more freedom. I'm not sure how much more freedom we can possibly get, but we'll get a lot more.

The first thing I understand is that they will remove what is, for us, quite a modest private patient cap. When foundation trusts came into being, each foundation trust had a cap applied at that point. So for example, the Royal Marsden Hospital, which gets a lot of private patients, their cap was at 30%. That's the highest cap. Ours is about 5%. We're only getting 5% private work, and most of that was externally, from countries purchasing work for liver transplants. So we weren't really getting the lords and ladies. For some reason, they didn't choose to have anything done in Camberwell. I don't know why.

So there is an option for starting to attract more private work, and obviously we'd have to fit that in, and that would extend some of our routine waiting lists, particularly because we are pretty limited in terms of the numbers of beds. Especially with our high bed occupancy rates, there will be a certain delay in routine, elective surgery anyway, so I do worry about that. There will also be further opportunities for the trust to outsource, or to create further business. Certainly they've shown with pathology that they've got that temperament. And they say they're looking beyond pathology. One area is pharmacy, and certainly you can imagine quite beneficial partnerships in terms of business with Boots and other companies. So there is a risk there.

In terms of pathology, Serco's not been very successful in gaining new contracts, but we're thinking that, with the government being more aggressive on trusts to make savings, [other hospitals] will be forced to outsource pathology; they'll be forced to make savings in clinical support areas like pathology, and so we may find ourselves picking up some of that work.

So that would be other hospitals giving service to you [at King's]?

Yeah, the vision I have of the future is that hospitals like King's will continue to get bigger and we will not be attracted to some types of work because of the margins. Last year, for example, old people fell over and ended up coming into our casualty department, rather than take responsibility for their own health as the government has advised them to do. We had to get agency staff, very expensive agency doctors, [which] meant we were losing money. If only people who had ventured out realised they risked costing us more money, then I'm sure they wouldn't have bothered. But as it was, they foolishly went out, had an accident and cost us more money. The trust board informed us, with quite serious faces, that we lost money because of it snowing, and because of Christmas.

What's not to plan for? It's winter, it tends to snow, and Christmas is every year. But there you are, I'm not a manager; I don't know these things.

Do you worry that certain pathology services are going to be seen as more cost-effective than others?

Let's say you have a cardiac test, which determines whether a patient has had a heart attack. A patient comes in having had a chest pain six hours ago, and you have to put them onto a cardiac ward. That's costing you a significant sum of money, and you have to keep them there for about three days. However expensive this test is, it won't be more than £30, but it will enable you to kick their expensive arse out of the cardiac bed and send them home and say they've sprained their chest muscles gardening or whatever. So there's a high efficiency anyway to pathology tests.

There have been repeated attempts to stop doctors needlessly requesting pathology tests but doctors are in such a habit that they feel the need to gain information in terms of diagnosing the patient. So all the attempts to limit pathology tests have failed completely and will probably continue to do so. The problem is, if you're charging for them, what's the incentive to stop them, I suppose?

But I don't think there will be a case of anybody saying, let's not do that pathology test or anything. As I say, most of our work comes with the patient, so you can't stop it.

If you were going to reform pathology services, what would you do?

First of all, I think you have to realise that a service that is so linked in with

the clinical service is a front-line service. It’s not a support service; it’s not catering - even though I don’t agree that [catering] has benefited from years of privatisation anyway. But certainly it’s a clinical service and has to remain part of those protected. It shouldn’t be privatised.

There needs to be a proper audit of the facilities to identify where there is the need to resource and bring them up to standard. The way the system operates at the moment is that hospitals with pathology labs like King’s – successful ones – continue to improve because they get money. They have a better degree of efficiency, they can attract specialist tests with a higher margin. We will continue to improve, but other hospital labs will get worse and worse because there isn’t that investment. So they need to be given very significant investment to bring them up to standard.

The terrible risk is that you will go to a casualty department in a district general hospital having had a heart attack and they will do your tests. At the moment that’s fine; they meet the same quality standards that we do. But there’s a real risk in future that the availability of some pathology testing work there means that you won’t have the same service; there won’t be the same timely intervention; there will not be the same access to specialist advice; there will not be the same inter-connected clinical work that relies upon interventional pathology and clinicians. So the real risk is that there will be a bit of a postcode lottery, partly driven by the fact that they’ve not invested in pathology at all. And often, I think the reason hospitals don’t bother investing in it is that no-one knows what the bloody hell we do anyway.

But there’s a big budget deficit. Isn’t there an argument that private companies can bring the investment?

I don’t think they’ve brought any investment in to us. They don’t seem to have done much. King’s didn’t need big investment but Tommy’s did. The pathology was scattered, in separate bits. I’ve been round their labs. It doesn’t seem like they’ve done any more than give it a coat of paint. Most of what they seem to be bringing is marketing, which comes at big extra costs. The entire aim of that is to move work from one [hospital] to another, which doesn’t add any value. It just means that work being done at hospital x is now done by us instead. I don’t see that’s any investment in pathology; it’s just moving it around.

We are seen as another easy target, another cleaning service. We do wear white coats, oddly enough.

A lot of [other hospitals] that we see now face the same problem of what to do with their pathology department. Some of them are addressing that with private finance initiative (PFI) schemes, some by signing up leases with companies that provide the equipment, which is incredibly expensive and technically advanced. Some of those are looking to outsource some aspects of that work because they no longer possess the skills and capabilities to continue providing the specialist work they used to provide. A person leaves and they don’t have the continuity replacement there.

So pathology is an area at the brink of almost being completely and utterly outsourced. In fact, there was one proposal by [former Labour Secretary of State for Health] Andy Burnham before the end of the last government to outsource the entire thing as a block, which would have been basically a £20 million outsourcing exercise. It’s quite remarkable really. I don’t think any organisation would have the capacity to take it.

What do you think people who are reading this can do to stop these new reforms coming through?

The problem with a lot of these reforms is that they’re not meant to be reforms at all. They’re entirely ideological. They are of the view that a service to the public is better off being provided by the private sector. So in terms of the response, if a pathology service is being privatised, I’d encourage people to take up the issue and support the staff and to join any campaign against it.

The union’s taking up the issue that the blood service shouldn’t be privatised or outsourced. We consider it completely iniquitous that a vital service – the supply of blood for transfusion - could ever be thought of as a profit-making venture. To refuse somebody a pint of blood does seem a bit harsh, doesn’t it? On account of what, a bad credit rating? But there you go, ideology.

The irony is that we faced the danger of being almost entirely outsourced by the previous government, so it wouldn’t be fixed by us changing the government, when the previous government really did for us as well! The next government [needs to] have a position of not privatising pathology services and recognising that we are frontline staff.

If you go to our [Unite's] website, you can find various campaigns. There is one for pathology and you can find stuff there.

See also:

The GP
May 10, 2011

The community nurse
March 24, 2011

The radiologist
March 24, 2011

More interviews with public sector workers can be found here

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