Payment by Results and Impact on Pathology

Improving GH Compatibility

Des Kenny Remembered
The open solution for the management and control of decentralised laboratory tests

- Carry out decentralised laboratory tests using non-specialised personnel, under the supervision and remote control of laboratory staff.
- Streamline information via the integration of POCT instruments connected to dedicated software.
- Manage and control laboratory tests via Point of Care Testing (POCT) in satellite labs, and specialized wards.

Moving information, not people.
About ACB News
The monthly magazine for Clinical Science

The Editor is responsible for the final content. Views expressed are not necessarily those of the ACB.

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Front cover:
The Hull Team: Professor Eric Kilpatrick (arrowed!), Maria Wärner, John Shepherd, Ian Hanning, Rachel Wilmot, Karen Smith and Heidi Cox (see also page 6)
Trade Union Statement

Section 32A of the Trade Union and Labour Relations (Consolidation) Act 1992 requires the annual statement to members to be published as follows:

“A member who is concerned that some irregularity may be occurring, or have occurred, in the conduct of the financial affairs of the union may take steps with a view to investigating further, obtaining clarification and, if necessary, securing regularisation of that conduct.

The member may raise any such concern with such one or more of the following as it seems appropriate to raise it with: the officials of the union, the trustees of the property of the union, the auditor or auditors of the union, the Certification Officer (who is an independent officer appointed by the Secretary of State) and the police.

Where a member believes that the financial affairs of the union have been or are being conducted in breach of the law or in breach of rules of the union and contemplates bringing civil proceedings against the union or responsible officials or trustees, he should consider obtaining independent legal advice.”

Trinity Biotech Moves to Larger Premises

Following the acquisition in June of the Haemostasis division of bioMérieux, Trinity Biotech have relocated their business to a new facility in Theale. The new facility is just four minutes from Junction 12 of the M4 giving easy access to airports, London and the motorway network.

The new premises are custom designed and large enough to allow for the future growth of the company, which is the second largest subsidiary in Europe, as well as being the European training centre.

The bioMérieux acquisition, following the acquisitions of Sigma and Biopool, makes Trinity Biotech a UK market leader in Haemostasis, supplying a complete range of Haemostasis instruments and reagents.

Further details from: Mervyn Nicholas at Trinity Biotech on Tel: 07966-020871.
New Hull Chair
For Eric

Eric Kilpatrick, Consultant in Chemical Pathology at Hull Royal Infirmary, has become an Honorary Professor in Clinical Biochemistry at the Hull York Medical School (HYMS).

Eric is well known for his stimulating speaking and prolific publications - just look at the May 2006 edition of the Annals! He is also on a number of national committees, including Chairing the National Audit Committee.

Eric said ‘I am very proud to have been given this honorary appointment. It recognises the strides taken by Hull and HYMS to become an internationally renowned centre for medical research and teaching. It also acknowledges the good work being done by the teams of staff in areas such as Clinical Biochemistry, Pathology, Diabetes and Lipids to help improve the health of patients in our region, both now and in the future.’

Focus 2007
Opening Ceremony

The Focus 2007 Local Organising Committee has great pleasure in announcing that this year’s Focus meeting will be opened by Lord Carter of Coles.

As we are now all aware, Lord Carter’s review on NHS Pathology services recognises the importance Pathology plays in clinical service delivery, but acknowledges the need to build on success of the past and focus on the future. The opening ceremony will take place on Tuesday 24th April at 09.15, and this is your opportunity to hear from Lord Carter himself in what will be an enlightening start to the conference.

Annual General Meetings

Palatine Room, MICC, Manchester
Monday 23rd April 2007

The fifty-fourth Annual General Meeting of the Association for Clinical Biochemistry will take place in the Palatine Room, MICC, Manchester. The Federation of Clinical Scientists’ Annual General Meeting will commence at 17.15 and the Association for Clinical Biochemistry’s Annual General Meeting will commence at 18.00. These will be preceded by a drinks reception at 16.30.
ACB South West and Wessex
Spring Scientific Meeting

A Protein Cocktail

Tuesday 13th March 2007
Postgraduate Centre
Frenchay Hospital, Bristol

10.00-10.30 Registration and Coffee
10.30-11.30 A Protein Meander - from E1 via SS0, B16, EC1, SW1 to BS16
  Dr Robert Beetham, Frenchay Hospital, Bristol
11.30-12.15 Challenges of MGUS
  Dr Judith Behrens, St Helier Hospital
12.15-13.15 Lunch/Trade Exhibition
13.15-14.00 Modern Aspects of Myeloma
  Dr Jenny Bird, United Bristol Healthcare Trust
14.00-14.45 CRP . . . “now hang on”
  Dr Joanna Sheldon, St Georges’ Hospital, London
14.45-15.15 Tea/Trade Exhibition
15.15-16.00 The Kidney in Non-Renal Disease
  Dr Peter Gosling, Selly Oak Hospital, Birmingham
16.00-16.45 Mechanisms and Diagnosis of Tubular Proteinuria
  Dr Marta Lapsley, Epsom Hospital
17.00 AGM

Registration cost is just £20 for ACB and IBMS members, free for Grade A trainees, £25 to others.
Closing date: 6th March 2007

For further details and to register please visit www.acbsww.org.uk
or contact Dr Roy Fisher, Department of Clinical Chemistry, Royal Cornwall Hospital, Truro TR1 3LJ
Tel: 01872-252546. Email: roy.fisher@rcht.cornwall.nhs.uk
ACB NI Region and ACB in Ireland Scientific Meeting

Friday 23rd March 2007
Radisson SAS Hotel, The Gasworks, Belfast

10.00  Registration and Coffee
10.30  Opening Remarks
Dr M O’Kane, Chairperson ACBNI

Morning Session
Chair: Mr B Sheridan, Royal Victoria Hospital, Belfast
10.40  Current Issues in Partial Androgen Deficiency and its Treatment
Dr T Trinick, Ulster Hospital, Dundonald
11.20  Influencing the Policy Makers
Mr J O’Meara, Government Affairs Officer, ACB
11.40  Genetic subtypes of Diabetes and Obesity
Dr V Crowley, St James’s Hospital, Dublin
12.20  The Role of Gut Hormones in Obesity and Appetite Regulation
Dr C le Roux, Imperial College, London
13.00  Lunch

Afternoon Session
Chair: Dr P Sharpe, Craigavon Area Hospital
14.15  Minimum Retesting Intervals
Dr M Ryan, Antrim Area Hospital
14.55  Are Our Reference Ranges and the EPR Compatible?
Dr J Barth, Leeds General Infirmary
15.35  The Discovery of Insulin
Dr M O’Kane, Altnagelvin Area Hospital, Londonderry
16.05  Closing Remarks
Dr M Lynch, Meetings Secretary ACBNI
Followed by Tea/Coffee

All Staff Welcome
Please register before 12th March 2007 by contacting:
Dr Mark Lynch, Clinical Chemistry Laboratory, Altnagelvin Area Hospital.
E-mail: mlynch@alt.n-i.nhs.uk. Tel: 02871345171 ext 4321.
Ms Ruth O’Kelly, Coombe Women’s Hospital, Dublin
E-mail: rokelly@coombe.ie. Tel: +353-14085663
Nice idea to come up with a 'one fits all' formula for the true costs of tests....

...The only problem being the lack of the constant PI....

PI? What on earth is PI?

....political involvement!
Deacon’s Challenge

No. 71 Answer

Enzymologists recommend that whenever possible the substrate concentration in an enzyme assay should be at least ten times the Michaelis constant ($K_m$). What is the rate of reaction achieved (expressed as multiples of the maximal velocity), for an enzyme reaction which obeys simple Michaelis-Menten kinetics, when the substrate concentration is exactly ten times the $K_m$ value?

The Michaelis-Menten equation relating initial velocity to substrate concentration is:

\[
v = \frac{V_{\max} \ [s]}{K_m + [s]}\]

$v$ = initial velocity  
$V_{\max}$ = maximal velocity (at infinite substrate concentration)  
$K_m$ = Michaelis-Menten constant = substrate concentration at half-maximal velocity  
$[s]$ = initial molar substrate concentration

Substituting $10K_m$ for $[s]$:

\[
v = \frac{V_{\max} \times 10K_m}{K_m + 10K_m}\]

then cancelling $K_m$ gives the value of:

\[
v = \frac{V_{\max} \times 10K_m}{11K_m} = \frac{10V_{\max}}{11} = 0.91V_{\max} \quad \text{(2 sig figs)}\]

Therefore the initial rate is approximately 90 per cent of the maximal rate ($V_{\max}$).

Question 72

You receive two blood samples from a General Practice, each of which is labelled with the same pre-printed label, but you suspect that they are actually from two different patients. The measured serum sodium concentrations of the two samples are 140 and 143 mmol/L respectively. Given that the high control for your sodium assay runs a standard deviation of 1.07 mmol/L at 151.6 mmol/L and the intra-individual biological variation of serum sodium concentration is quoted as 0.6%, determine whether it is possible that these samples are indeed from the same patient, stating any assumptions that you make.
Paying for Pathology Services - Payment by Results

Corinne Pluchino, Managing Consultant, Hill & Knowlton

Introduction

Since the NHS Plan\(^1\) was published in 2000, the Department of Health (DH) has launched an extensive series of reforms encompassing every aspect of primary, secondary and community care designed to “transform the health service … around the needs of the patient.” Payment by Results (PbR) is seen as an essential tool to support the delivery of the modernisation agenda in England. It marks a fundamental change in the way in which money moves around the NHS and is being rolled out over a period of several years. It currently focuses on elective and non-elective care, outpatient appointments and emergency services. However, discussions are now underway to create a national tariff for pathology which could have far reaching consequences for the way the service is funded in the future.

What is Payment by Results Designed to Do?

The DH first set out its plans for financial reform in 2002, when it published Reforming NHS Financial Flows: Introducing Payment by Results\(^2\). The document stated that “fundamental change” was needed to the way in which money flowed around the Health Service in order to help deliver the modernisation agenda. A much more transparent system was required to match capacity and demand, reward increased activity and innovation, and facilitate patient choice and use of a much wider range of providers. The unprecedented increase in Health Service funding was also a major impetus for change - new financial systems were clearly needed to control costs and manage demand, and ensure that “demonstrable results” were delivered to patients and the wider public.

The Key Features of the System

PbR is based on the principle of using casemix adjusted payment for healthcare services delivered. This approach is already established in several other countries including Australia, Canada, Sweden and Norway. The key features are as follows:

- PbR is based on a system of building blocks known as
Healthcare Resource Groups (HRGs), which are standard groupings of clinically similar treatments which use comparable levels of healthcare resources for diagnosis, treatment and care. The concept was originally developed in the US and is now used widely internationally. HRGs are sometimes described as “units of currency” for the NHS; typical examples would be cataract extraction with lens implant, primary hip replacement and varicose vein procedures.

- The DH allocates a national tariff price to each HRG. These are based on NHS reference costs which have been collected every year since 1998, and show the average cost to undertake over 35,000 categories of different treatments. The national tariff is currently based on the average reference cost and is adjusted every year to take account of factors including expected inflation and efficiency targets. The tariff will also apply to Independent Sector providers in the future so that Health Service commissioners can make accurate comparisons between the different providers.

- The objective in setting a national tariff is to enable commissioners and providers to focus their negotiations on volume and quality rather than price. PbR is also designed to ensure payment is based on the actual activity undertaken - rather than a block contract or historical levels of funding. PbR makes limited provision for regional variations in wages and other costs through a system known as the Market Forces Factor (MFF), which is kept under continual review.

- NHS Trusts that provide the procedure below tariff price may keep the surplus to reinvest in new and existing services. In this way, the system is designed to reward efficiency and innovation – although there has been debate in some quarters as to whether Primary Care Trusts (PCTs) should also reap some of the benefits. If, however, the NHS Trust provides the procedure at above tariff price, it cannot demand additional payment. This model is designed to encourage Trusts in this position to either reduce their costs or consider whether they should continue to provide the service in this way.

- PbR was first introduced three years ago and is being phased in over a five to six year period. It currently covers everything from elective inpatient care to the emergency services and illustrated below, which currently equates to around £22 billion worth of expenditure. There are some very significant challenges to developing a suitable framework to cover areas such as critical care, chronic disease management and mental health services and projects are underway to develop a suitably robust system in these and other specialist areas.
The system operates in practice by using a system of coding, which is designed to enable all provider organisations to record the activities undertaken so that payments can then be allocated accordingly. PbR is currently based on the OPCS coding system, but the DH plans to switch to SNOMED shortly. The need to ensure accurate coding is fundamental to the success of the system, and there have been accusations that some organisations were adjusting their coding to increase their income levels. In an attempt to address this, the DH published a Code of Conduct for Payment by Results in January 2006 in order to establish “some ground rules for organisational behaviour and expectations as to how the system should operate”.

The system is reviewed regularly so that it can be expanded to cover new clinical areas and to ensure it can support the modernisation agenda effectively. The Casemix Service at the NHS Information Centre is responsible for developing HRGs, which are then passed to the DH PbR team to be finalised and costed. In May 2006 the Information Centre published Draft Version 4.0 HRGs for consultation. It consists of several significant developments, including a major increase in clinical coverage, unbundling to handle high cost drugs and devices and refinements to outpatient HRGs. The DH hopes HRG4 will be used for reference costing from 2007, and for the national tariff from 2008/9.

What is the Impact on Pathology Services?
As an integral part of the patient pathway, pathology services are already – or will be – affected by Payment by Results in several different ways.

Existing HRGs
HRGs for inpatient care and outpatient attendance already include provision for any pathology tests which are required as part of the wider package of care. However, anecdotal evidence suggests that this is not having an impact on hospital laboratory budgets – at least not yet. This may be because the national tariff gives an umbrella figure for the HRG as a whole, and is not currently broken down to show precisely how much should be allocated to each individual task undertaken.

Direct Access Pathology
There is currently no national tariff for direct access pathology tests commissioned in primary care. However, the DH would like to extend PbR to this area, and pathology services were included in the Draft Version 4.0 HRGs published in May. The draft included proposals for thirty two pathology HRGs, which in turn consisted of two further criteria: a procedural category to reflect the complexity of the test, and a resource category to reflect the clinical and pathology diagnosis. The professional bodies and the in vitro diagnostics industry have submitted their views.

The DH had hoped to introduce a national tariff for pathology in 2008/09. However, it has become clear that a significant amount of work still needs to be done before a sufficiently robust system can be launched and the date has now been postponed. Some fundamental issues were highlighted during the consultation period – one of the most important of which was the lack of robust and consistent data on which to build the new system. The Information Centre is now working on these issues and is being advised by an expert panel of pathology professionals.
Indicative Tariff

However, it is interesting to note that the DH has been publishing indicative tariffs for pathology for three years. Indicative tariffs are intended to provide commissioners with a rough guide to the costs of conducting procedures not yet to be covered by PbR. The figures for 2007/08 were published in December and make interesting reading:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2005/06 (£)</th>
<th>2006/07 (£)</th>
<th>2007/08 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Pathology</td>
<td>2</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chemical Pathology</td>
<td>2</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Haematology</td>
<td>3</td>
<td>2.87</td>
<td>2.94</td>
</tr>
<tr>
<td>Histology/Histopathology</td>
<td>20</td>
<td>14.30</td>
<td>14.66</td>
</tr>
<tr>
<td>Immunology</td>
<td>8</td>
<td>6.98</td>
<td>7.15</td>
</tr>
<tr>
<td>Microbiology/Bacteriology</td>
<td>7</td>
<td>6.14</td>
<td>6.29</td>
</tr>
<tr>
<td>Neuropathology</td>
<td>0</td>
<td>8.47</td>
<td>8.68</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>5</td>
<td>2.61</td>
<td>2.68</td>
</tr>
<tr>
<td>Virology</td>
<td>7</td>
<td>N/A</td>
<td>6.29</td>
</tr>
<tr>
<td>Biochemistry</td>
<td>2</td>
<td>1.56</td>
<td>1.60</td>
</tr>
<tr>
<td>Cytology</td>
<td>N/A</td>
<td>11.15</td>
<td>11.43</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>2.97</td>
<td>3.04</td>
</tr>
</tbody>
</table>

Please note: Microbiology and Virology have been grouped together for 2007/08.

As it currently stands, the indicative tariff can be seen as a very crude guide to the costs of conducting pathology tests, not least because of the enormous range, complexity and frequency of use of the tests in each category. However, they are a useful basic guide to the direction of thinking both in terms of short term commissioning and longer term developments.

The Bigger Picture

Even if the DH postpones the date for launching a national tariff for pathology services, it is important to remember the other drivers for introducing a more transparent pricing system. Lord Carter’s independent review of pathology services recommended that a national reimbursement system or pathology tariff should be developed. The report argued that this would act a key driver for change and improving the uptake of innovation by creating a link between cost and value and encouraging greater efficiency. Equally important is the fact that a tariff system will be one of the key building blocks needed to support wider use of independent sector providers. Twelve pilot sites will shortly begin to collect cost and other data to support further pathology modernisation.

Extra impetus is also provided by the White Paper Our Health Our Care Our Say, which set out a range of proposals to encourage “a sustained realignment of the whole health and social care system” in order to make a wider range of services available outside the traditional hospital setting. Further information was given in the guidance note Investing in the Future of Community Hospitals & Services published in July 2006. It specifically states that there is capacity to provide more pathology services in the community to support both more convenient diagnosis and better management of long term conditions. Clearly, if this
is to be encouraged there will need to be financial incentives in place – including a clear system for pricing.

Even if PbR does not come into effect for a little while, the development process is well underway and it is clearly essential that the pathology sector is fully engaged to ensure the new system supports an efficient, innovative and responsive service. The next year to eighteen months is likely to be critical.

References


Further Reading

Payment by Results: Home Page

NHS National Reference Costs: Home Page
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSReferenceCosts

NHS Health & Social Care Information Centre: Casemix Service
www.ic.nhs.uk/casemix

Hill and Knowlton

Corinne Pluchino is a Managing Consultant in the Public Affairs team at Hill & Knowlton. It includes a Health Policy & Health Public Affairs practice, which provides specialist advice on the development of healthcare policy, communicating with Government and its agencies, and managing wider stakeholder relations. Hill & Knowlton works with a diverse range of organisations in the private, public and not for profit sectors.

Further information can be found at www.hillandknowlton.co.uk/publicaffairs or please contact cpluchino@hillandknowlton.com
ACB Scottish Regional Meeting

Acute Medicine

Tuesday 20th March 2007
Business Learning Centre
Dunfermline, Fife

Morning Session
Chair: Dr Philip Wenham
10:30 Arrival, Registration and Coffee
11:00 Inflammation in Acute Illness
   Dr John Kinsella, Glasgow
11:40 Experience and Use of PCT in Clinical Practice
   Dr Francois DeVilliers, Greenock
12:20 Microvascular Response in Acute Illness
   Dr Peter Gosling, Birmingham

13:00-14:00 Lunch and Sponsors Display

Afternoon Session
Chair: Mr Alasdair McBain
14:00 Glutamine and Selenium in Critical Illness
   Dr Alison Avenell, Aberdeen
14:30 Title to be confirmed.
   Dr Cathy Dorian, Glasgow
15:00 eGFR – Audit of the Scottish Experience
   Dr Mark McGregor, Kilmarnock
15:30 Tea and Coffeee and Sponsors Display

15:45-16:30 Scottish Region AGM

The Business Learning Centre has good access from the M90. The meeting is free to ACB Members and includes lunch, coffee and tea.

For further details and to register please contact Alasdair McBain
Email: alasdair.mcbain@faht.scot.nhs.uk
ACB Southern Region
Spring Scientific Meeting & AGM

Wednesday 14th March 2007
Postgraduate Medical Centre, Lecture Theatre
Mount Vernon General Hospital
Northwood, Middlesex

09.30 Registration & Coffee
10.00 BNP: Laboratory Aspects
   Dr Laila Tibi, Principal Biochemist, Hemel Hempstead Hospital
10.30 BNP From a GP’s Perspective
   Dr Richard Pile, GP, St Albans & Harpenden PCT
11.00 Coffee
11.15 Catecholamine Secreting Tumours
   Dr Isla Mackenzie, Clinical Lecturer, Addenbrookes Hospital, Cambridge

12.00 Lunch

13.15 AGM

14.00 The Biochemical Diagnosis of Catecholamine Secreting Tumours
   Dr Bob Peaston, Consultant Biochemist, Freeman Hospital,
   Newcastle upon Tyne
14.45 Tea
15.00 Allergy Testing
   Dr Jo Sheldon, Consultant Immunologist, St George’s Hospital, London
15.45 Allergy Testing: Clinical Aspects
   Dr Hany El-Naggar, Consultant Paediatrician, Hemel Hempstead Hospital
16.30 Close

Cost of Meeting:
ACB members £25.00 (Grade A trainees/temporarily retired members/retired members
are required to submit a £25.00 deposit which will be returned at the meeting)
£40.00 for non-members.

Closing Date for Registration: Thursday 1st March 2007.

Further information:
Dr David R Collins, Consultant Chemical Pathologist, Hemel Hempstead General Hospital
Tel: 01442-287839. E-mail: David.Collins@whht.nhs.uk

Note: Postal mailing of booking forms has been discontinued.
More information and booking forms are available at
www.acbsouth.org.uk
The meeting was formally opened by Mike Penney who handed over to ACB Wales Region Chair, Gethin Roberts who chaired the first session. Dr Carel le Roux of Imperial College gave an update on gut hormone physiology with an emphasis on appetite control, posing the question “why do some people with excess gut adiposity have an increased appetite?” Whilst many people will spend a lot of money on fad diets, they may have an underlying physiological cause. The expression “never been so hungry as when on a diet” reflects a normal physiological response and Dr le Roux suggested that we should concentrate on the concepts of hunger and satiety rather than appetite. Ghrelin is a hormone which stimulates hunger (the tummy-rumbling hormone) whilst others such as Peptide YY, PP, GLP-1 and CCK work on the hypothalamus to slow GI transit time and thereby reduce hunger. Double blind studies have demonstrated up to one third reduction in food intake where Peptide YY is infused instead of saline and this peptide has been described as the satiety hormone. GLP-1 also reduces food intake but additionally stimulates insulin production and is marketed in the US as a treatment for type 2 diabetes mellitus. We were left with the interesting fact that we use more energy when asleep than when watching television.

**PTH for Treatment**

The use of recombinant Parathyroid Hormone to treat osteoporosis was the subject of Professor Bill Fraser’s presentation. A potted history of the discovery of the parathyroid glands and parathyroid hormone started with the fascinating story of the elephant that sat on a rhino; the parathyroid glands were discovered at the subsequent dissection of the rhino at the British Museum. Following the discovery of PTH, it was ultimately shown that it has both anabolic and catabolic actions depending whether tissue exposure is intermittent or continuous respectively. It also has a well defined circadian rhythm which may be lost during prolonged fasting, is blunted postmenopausally and significantly disrupted in osteoporosis. A number of therapeutic strategies have been developed, principally aimed at either osteoclast inhibition or osteoblast stimulation and current thinking is to use combination therapies such as PTH + HRT, PTH + anti-resorptive or PTH followed by anti-resorptive, the latter seemingly giving better long term outcomes. However, this is a very expensive treatment which NICE allows, but only after all other strategies have been shown to be ineffective. Biochemical monitoring with P1NP may quantify the effectiveness of the treatment. rPTH is currently administered by subcutaneous injection but in future this may be via inhalers, nasal spray or trans-dermal patches.
Getting Testosterone Just Right

Dr Mike Diver took us through the how, when and what to measure in the assessment of androgen status mindful that as far as testosterone is concerned, men don’t want too little and women don’t want too much. Physiologically, there is absolutely no cross-over between the reference ranges for male and female subjects. In the ageing male, total testosterone does not fall but free and bioavailable testosterone do, due to an increase in SHBG. A helpful on-line free and bioavailable testosterone calculator is available at http://www.issam.ch/freetesto.htm. When to investigate? In women, when hirsute, anovulatory, PCOS or CAH. In men when hypogonadal or with 1° or 2° erectile dysfunction, although most men with erectile dysfunction have normal serum testosterone levels. Where testosterone replacement is indicated, there are several routes of administration available including oral, trans-dermal, IM, sub-cutaneous and buccal. None of these mimic the normal circadian rhythm of testosterone, and some may induce non-physiological plasma levels.

Growth Hormone and IGF

After lunch Professor John Gregory took us through the clinical utility of growth hormone measurements and the indications for growth
hormone replacement therapy in children. The causes of short stature are varied and may be complex, including delayed puberty, chronic systemic disease, nutritional problems, IUGR, chromosomal abnormalities and endocrine disorders. A detailed clinical history including obstetric history is vital in the investigation of these children and the clinical investigation is complex even before growth hormone measurements are considered. There is no clinical utility of a random growth hormone level and these should only be performed as part of a stimulation test such as the insulin stress test or stimulation with glucagon, clonidine or other stimulants. From the clinician’s perspective, growth hormone deficiency remains largely a clinical diagnosis which remains challenging with many questions outstanding; is growth hormone resistance important, how far should the clinician go in investigating short stature, are there genetic explanations for all causes of idiopathic short stature? The research continues.

The final presentation was from Dr Gwen Wark of the SAS Peptide Section of the Royal Surrey County Hospital. The investigation of growth hormone status should include an assessment of IGF-1 and its binding protein IGFBP3. Gwen’s presentation focussed on some of the analytical aspects of the binding protein assays, particularly assay specificity and reference range issues. Whilst there are six IGF binding proteins known, IGFBP3 predominates but it was pointed out that current immunoassays do not measure biological activity. Both IGF-1
and IGFBP3 levels are growth hormone dependent and there is no significant diurnal variation. Unfortunately, biochemical investigations in suspected growth hormone deficiency are often difficult to interpret with a wide range of published sensitivities and specificities; normal results do not exclude growth hormone deficiency but low results may be suggestive and supportive of clinical observations.

The afternoon concluded with the annual Bayer Award presentations. This year’s presentations were: An interesting case of Cushing’s Syndrome by Sian Hancock, C5 Deficiency – molecular characterisation of a South African patient by Claire Edwards, Molecular characterisation of familial hypercholesterolaemia by Kelly Parham and A case of infantile hypophosphatasia by Charlotte Fifield. The 2007 Bayer Award winner was Dr Sian Hancock.

Testosterone in Clinical Practice

The second day kicked off with an interesting presentation from Dr Mushmi Biswas on testosterone in clinical practice. This included an informative overview of testosterone through the ages, from embryonic development to old age, and provided an insight into the clinician’s approach to the investigation of hypogonadism in males and hyperandrogenism in females. The talk followed on superbly from Dr.
Diver’s presentation on testosterone measurement the previous day and ended by allowing us to put theory into practice with a range of clinical cases. The high standard was maintained by the second speaker of the day, Dr David Sinclair from Portsmouth, who switched our attention to the thyroid gland with a comprehensive look at thyroid antibodies. He discussed issues surrounding when, how and where to measure thyroid antibodies and highlighted the problem of inter-assay variation and the need to discuss any method changes with clinicians.

Mr. Mike Fahie Wilson took centre stage to share some of his expert knowledge on macro-hormones and gel filtration. He pointed out that with most laboratories now screening for macroprolactin, the UK is ahead of many other countries, but stressed the need for post-PEG precipitation reference ranges. We were all reminded that, despite its fame, macroprolactin is not the only macro-hormone and this was illustrated with cases of macroTSH and macroFSH (followed later by an ‘over-a-pint’ discussion about ‘macroinsulin’). The final session of the morning brought us the vast experience and knowledge of the Endocrinology team from the Royal Gwent Hospital, consisting of Dr Peter Evans, Dr Owain Gibby and Dr Kofi Obuobie. They presented a number of interesting cases, including thyroid hormone resistance, lymphocytic hypophysitis in pregnancy and the clinical dilemma of ‘to treat or not to treat?’ in a patient with hypertension and a microadenoma.

**Troponin Assay Performance**

The afternoon session lived up to high expectations with four presentations from the All Wales Audit Group. Annette Thomas from WEQAS presented a troponin audit, concluding that we are now achieving CVs that comply with the IFCC guidelines. Dr Catherine Bailey presented a survey looking at the biochemical monitoring of threatened miscarriage and ectopic pregnancy that aimed to assess the services and protocols being used and their compliance with RCOG guidelines. Rachel Still presented an audit on the measurement of bile acids in obstetric cholestasis and Dr Louise Ward finished the day talking about her survey assessing biochemical monitoring of cystic fibrosis throughout Wales, which was prompted by her previous work to introduce CF annual review request stickers in Swansea. This brought a very successful ACB meeting to a close and delegates, having effectively engaged endocrinology, now look forward to the next ACB Wales regional meeting in the spring of 2007.
Growth hormone (GH) measurements contribute significantly to the diagnosis and treatment of acromegaly and growth disorders. This requires reliable and precise analytical methods which produce results that are readily comparable between centres. Somewhat disappointingly, however, despite major advances in assay technology over the last 20 years, results obtained in different methods may differ by more than two-fold.

Analytically, several factors contribute to these differences. Methods may be calibrated in terms of either of two calibrants, International Standard (IS) 80/505 or IS 98/574, and reported in either mass units or International Units, making comparison of results complex. Method-related recoveries vary from 88% to 104%, suggesting avoidable errors in calibration. Differences in antibody specificity, e.g. reflected in variable recognition of the minor 20 kD form of GH, are also relevant, as is always the case when attempting to “measure” mixtures.

The clinical implications of poor between-method agreement are significant, particularly in relation to application of guidelines and protocols that specify GH cut-off levels for dynamic function tests without taking account of method bias. Method-related differences make appropriate implementation of these recommendations problematic.

Encouragingly, this may at last be changing. Recent developments include:

- Availability of a WHO-recognised recombinant (rDNA-derived) calibrant (IS 98/574) that is gradually being adopted by manufacturers producing immunoassays for GH. Correct calibration of assays using this calibrator should improve between-method agreement.
- Development by an International GH Collaborative, convened by ACB members and supported by leading clinical endocrinologists, of a Consensus Statement which has been adopted by representatives of the clinical and laboratory communities, the diagnostics industry and EQA providers. The Statement is reproduced here.
- Publication of the Consensus Statement by leading endocrinology journals including Clinical Endocrinology, Growth Hormone and IGF Research, European Journal of Endocrinology. From Autumn 2007 these journals will only accept manuscripts with GH results expressed in terms of µg/L of IS 89/574.
- Establishment by the Scientific Division of the International Federation of Clinical Chemistry (IFCC) Scientific Division of a Working Group for the Standardisation of Growth Hormone, under the Chairmanship of Dr Martin Bidlingmaier (Munich).
Where Next?

The UK clinical and laboratory communities should work with the diagnostics companies towards successful implementation of worldwide reporting of GH results in µg/L of IS 98/574. Laboratories should take an active lead, both in ensuring that results reported in µg/L of IS 98/574 are analytically correct and appropriately derived, and in encouraging good communication about these changes with clinical users of their services.

UK NEQAS can also help to facilitate these changes and is convening a workshop at Focus 2007 to consider:

- Key objectives and milestones
- A realistic timetable for the change in GH reporting practice
- The role of individual stakeholders and EQA organisations

Following the Workshop, a summary of progress will be provided both via the UK NEQAS network, through publications in the clinical and laboratory press, and on a dedicated ACB Mailbase forum that will be established to report the Workshop outcomes, mirroring a similar forum being set up by the Society for Endocrinology. We would very much welcome your input and views before, during and/or after the Focus Workshop.

Consensus Statement of the International Growth Hormone Collaborative

The availability of calibrants with different characteristics, the use of two units (mU/L and µg/L), adoption of a variety of unit conversion factors, and variability in antibody specificity are widely acknowledged as contributing to discrepancies between growth hormone (GH) results. The discrepancies cause confusion and can have serious implications for the management of patients with GH-related disorders whose care is increasingly dependent on consensus guidelines employing mass concentration. The availability of the second International Standard (IS) for growth hormone (WHO IS 98/574), a recombinant material consisting of 22 KDa growth hormone of >95% purity, provides the opportunity for adoption of a single calibrant for growth hormone immunoassays. IS 98/574’s well defined chemical and physical properties allows it to meet European Union legislation calls for all laboratory results to be traceable to a defined material (In Vitro Diagnostics Medical Devices Directive, 98/79/EC). As a first step to standardising growth hormone measurement, we recommend the reporting of growth hormone concentrations in micrograms per litre (µg/L) of IS 98/574, (1 mg corresponding to 3 international units somatropin). A later step will be to reduce the discrepancy in results attributable to variable antibody specificity.
**Supporters of the Growth Hormone Consensus Statement**

<table>
<thead>
<tr>
<th>Association for Clinical Biochemistry [ACB]</th>
<th>National Institute for Biological Standards and Control [NIBSC]</th>
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<tr>
<td>Beckman Coulter, Inc.</td>
<td>PerkinElmer Life and Analytical Sciences</td>
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<td>BioSource Europe SA</td>
<td>Randox International Quality Assessment Service [RIQAS]</td>
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<td>British In Vitro Diagnostics Association [BIVDA]</td>
<td>Royal College of Pathologists [RCPath]</td>
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<td>Deutsche Gesellschaft für Klinische Chemie und Laboratoriumsmedizin – Reference Institut for Bioanalytics [DGKL]</td>
<td>Society for Endocrinology</td>
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<tr>
<td>Growth Hormone Research Society [GHRS]</td>
<td>TOSOH Bioscience, Inc.</td>
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<td>International Federation of Clinical Chemistry [IFCC]</td>
<td>UK National External Quality Assessment Service [UK NEQAS]</td>
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Focus on the Speakers

By Paul Newland and Catherine Collingwood

The Dade Behring Lecture entitled “Clinical Biochemistry 2011” will be presented by

Sir Muir Gray

Muir Gray is Programmes Director of the UK National Screening Committee, Director of Clinical Knowledge, Process and Safety for the National Programme for IT, and is responsible for the National Library for Health and the National Knowledge Service.

He has worked in public health for 25 years. In his previous post as Director of Research and Development for Anglia and Oxford Region, he was in a position to support the UK Cochrane Centre in its early days, and to set up the Centre for Evidence-Based Medicine. He is fortunate in being able to work with groups which have an interest in informed decision making and many different aspects of communication with patients. He is the author of Evidence-Based Healthcare and joint author of The Oxford Handbook of Public Health Practice. His most recent book is The Resourceful Patient.

As Programmes Director of the UK National Screening Committee, Dr Muir Gray has identified informed choice as one of the most important issues for people involved in screening in the 21st century. The Queen appointed him as a Commander of the Order of the British Empire in 1998 for his work on the Breast and Cervical Cancer Screening Programmes. He was knighted in 2005 for the development of the Fetal, Maternal and Child Screening Programme and the creation of the National Knowledge Service and the National Library for Health.
Professor Chris Packard

Professor Chris Packard is currently Professor of Vascular Biochemistry at the University of Glasgow and R&D Director for North Glasgow University Hospitals NHS Greater Glasgow & Clyde. During his career he has focused on two aspects of atherosclerosis research; lipoprotein metabolism and how it is affected by diets and drugs, and large scale clinical trials of lipid lowering agents. More recently his interest has widened to include investigations of emerging risk factors for coronary heart disease and the consequences of social deprivation for health.

Professor Packard has published widely on the kinetics of apolipoprotein B and apolipoprotein A metabolism. Key contributions include evaluation of the role of the LDL receptor in vivo, the discovery of metabolic channelling in the apoB lipoprotein delipidation cascade, and the formulation of models to explain the generation of small, dense LDL. More recent research has focussed on the metabolic consequences of insulin resistance and the causes of the dyslipidaemia in metabolic syndrome. As study director and one of the main investigators of the West of Scotland Coronary Prevention Study (WOSCOPS) and the Prospective Study of Pravastatin in the Elderly at Risk (PROSPER), Professor Packard helped establish the evidence base for statin use in CHD prevention. These trials provide confidence that statins are beneficial in primary prevention and in older adults and reveal a consistency of treatment effect that encourages their widespread use.

Atherosclerosis is now recognised an inflammatory disease and this paradigm was examined using biobank examples from the major clinical trials. Work from Professor Packard’s laboratory has helped elucidate the role of CRP in men and the elderly. Further observations have explored the contribution of other inflammatory markers such as lipoprotein-associated phospholipase A2 to CHD risk.

Current interests include expansion of kinetic studies to encompass the simultaneous study of the metabolism of plasma lipids and apolipoproteins, and exploration of the mechanism of action of novel lipid lowering drugs. Professor Packard is principal investigator of the ongoing pSoBid study, an epidemiological study of the psychosocial and biological determinants of ill health and premature CHD in deprived communities in the east end of Glasgow.

Outside the lab Professor Packard is active in local and national initiatives to promote health and wealth gains from medical research. He is founding chairman of Nexxus, the West of Scotland Bioscience Network which promotes community building and knowledge exchange between life sciences industry, academia and the NHS.

Professor Packard is a Consultant Clinical Scientist (EuroClinChem) and Chartered Scientist (CSci) with degrees from Glasgow University (BSc Hons (1st class), PhD and DSc). He was appointed Honorary Professor in the Faculty of Medicine in 1995. He was elected Fellow of the Royal College of Pathologists (FRC Path 1997), Fellow of the Royal College of Physicians & Surgeons in Glasgow (FRCP (Gla) 2002) and Fellow of the Royal Society of Edinburgh (FRSE 2003).
The AACC/ACB Transatlantic Lecture entitled “Haemoglobin A1c in the management of patients with diabetes: from chaos to harmony” will be presented by

Dr David Sacks

David Sacks is an Associate Professor of Pathology at Harvard Medical School and Medical Director of Clinical Chemistry at Brigham and Women’s Hospital. Dr. Sacks received his MB, ChB from the University of Cape Town, South Africa in 1976. He completed a rotating internship at Groote Schuur Hospital in Cape Town and residencies in both Internal Medicine at Georgetown University affiliated hospitals in Washington, DC and in Clinical Pathology at Washington University School of Medicine in St Louis. He is board-certified in both Internal Medicine and Clinical Pathology. Dr Sacks was elected a Fellow of the Royal College of Pathologists in 1998. In addition, he is a Fellow of both the American College of Physicians and the National Academy of Clinical Biochemistry.

Dr Sacks’s primary clinical focus is in Diabetes Mellitus, with an emphasis on the interface between the clinical laboratory and patient care. In this endeavour, he has worked very closely with the American Diabetes Association. He is Chair of the National Glycohaemoglobin Standardisation Programme (NGSP) steering committee and serves on several other diabetes committees, including the International Federation for Clinical Chemistry (IFCC) Working Group on HbA1c Standardisation.

Dr Sacks has lectured extensively and has published numerous papers in peer-reviewed journals. He has served on the editorial board of Clinical Chemistry since 1995 and is currently an Associate Editor of the journal. In addition, he serves on several editorial boards, including The Journal of Biological Chemistry, The American Journal of Pathology, and The American Journal of Clinical Pathology and is a member of the editorial advisory panel of the Biochemical Journal. His previous awards include the position of the Royal College of Pathologists of Australasia Visiting Professor for 2003, Outstanding Contributions to Clinical Chemistry in a Selected Area of Research from the AACC and the Norman P Kubasik Lectureship Award from the AACC.
ACB National Training Course

Hulme Hall, Manchester
25th-30th March 2007

- GI, Liver & Pancreas
- Nutrition
- Vitamins
- Trace Elements
- Plasma Proteins
- Spectrophotometry
- Flame Photometry
- Atomic Absorption
- Finance
- Spot Tests
- Calculations
- Practical & Interactive Sessions

Social events have been organised for each evening and include a drinks reception in the Whitworth Art Gallery followed by a curry, a visit to the Trafford Centre with a choice of Laserquest or bowling, with dodgems, and a Course Dinner and disco at The White Hart Inn.

Registration Fees:
Residents £595 (ACB Members), includes full board in en suite accommodation and social programme.
Non-Residents £495 (ACB Members)

A £100 levy will be applied to applications from individuals who are not members of the Association for Clinical Biochemistry.

For further information contact:
ACB Office, 130-132 Tooley Street, London SE1 2TU

Closing date for receipt of full payment: 23rd February 2007
ACB News Crossword

Keep sane at coffee time with the ACB News Crossword. Always relating to the science and practice of Clinical Chemistry, you will never cease to be astounded by the convoluted mind of the ACB News Crossword compiler.

Prizes for your department: The first five correct solutions to appear on the ACB News fax machine (Fax: 0121-765-4224) will receive a copy of the new educational Calcium Cases CD-ROM by Aubrey Blumsohn, Christina Gray, Neil McConnell, John O’Connor, Anne Pollock & Roy Sherwood and which retails at over £50. Please state clearly the name and address of the Department that is entering the competition.

Remember that ACB News appears first as a PDF on www.ACB.org.uk around the 7th of each month.

Crossword set by Rugosa

Across
6 Dedicate little support for commission (9)
8 Midshipman has new evidence for appeal (5)
10 Cut out bizarre diet (4)
11 Fearless batting is far from spirited, sadly (8)
12 Be unwell from a Thai lamb curry (3)
13 Prearranged exhibit lacks point (6)
15 Cursive diversified holding company becomes less myopic (8)
16 After last exhibit, Damien felt the need for a drink (6)
17 Ask for a soft roll (6)
20/18 Section of ours drunk at clerical picnic (8, 8)
22 Business of 6 is foolishly guaranteed although not true (6)
24 Initially available without prescription for students’ military training (3)
25 6 of ours scramble as I enter (8)
26 Reverse support (4)
27 Not suitable, should see 23 (5)
28 6 of ours, tripled by Blair (9)

Down
1 Join up as soldier when unit leaves (6)
2 Discharge when time is up (4)
3 Makes treaties as Blair does with 28 (8)
4 Aromatic food: the eleven cubes were served up with no vent (4, 6)
5 Grand sort of race meetings for us (with a 6) (8)
7 Becoming lively in a wicked way (6)
9 Shock from upsetting large barrels (4)
14 6 of ours with questionable specifications (no OAP allowed) (10)
16 Broad-minded but ran into a rent proposal (8)
18 See 20 Across
19 After getting rid of 12 localised trouble ended (6)
21 Cook part of brioche filling (4)
23 Treat as indoor computerised tomography (6)
26 Information unit is about to complete sting we hear (4)

Answers to Last Month’s Crossword

Across: 1 Valine, 4 Tactic, 8 Alanine, 9 Contest, 11 Amino acids, 12 Even, 13 Isle, 14 Tyrosine, 17 Wriggled, 19 Sham, 22 Lily, 23 Sandbagged, 24 Mimicry, 25 Organic, 26 Emerge, 27 Lysine

Down: 1 Volume, 2 Linings, 3 Nonpareil, 5 Aloes, 6 Tatters, 7 Cysteine, 10 Histidine, 15 Raspberry, 16 Arginine, 18 Glycine, 20 Afghani, 21 Serine, 23 Sprog

Recent Crossword Winners . . .

S Bailey, Haywards Heath
Nigel Brown, King’s College, London
Caroline Jagger, Royal Preston
Dr C M Colley, Swindon
Clinical Chemists around the world were shocked to learn of the sudden death of Des Kenny on 18th December 2006. A tireless worker for the profession and a good friend to very many people, he will be much missed in his native Ireland, in the UK and abroad.

Des was born on 31st December 1941, the only child of devoted parents who both died during his teenage years. After taking his biochemistry degree at University College, Dublin and a Masters degree in Clinical Biochemistry at Trinity College, Dublin, he joined the laboratory at Our Lady’s Hospital for Sick Children in Crumlin, on the outskirts of Dublin. He worked there for nearly 40 years, rising from trainee to Consultant Clinical Biochemist. A private and reserved man, he concentrated wholeheartedly on his scientific work at the Children’s Hospital, which became the centre of his life for decades. He died within a fortnight of his formal retirement from the job he loved and to which he gave so much, although arrangements had just been completed to allow him to carry on working.

Des Kenny made an immense contribution to clinical biochemistry in Ireland and further afield. He had been a member of the Association of Clinical Biochemists in Ireland (ACBI) since its foundation in 1967, and served continuously on its Council for 35 years, holding the offices of Secretary, Treasurer and three periods as Chairman during that time. Des also joined the ACB in 1967 and he did much to engender the close and harmonious working relationship between the two Associations. At the ACBI meeting in the autumn of 2006 Des confessed that he would like to be remembered as the individual that established the annual ACBI conference, which is now a 'must attend' event for many ACB members from across the UK.

Quality and Computing

Des had twin passions in laboratory computing and the quality of laboratory work. In the 1970s he was responsible with Barry McSweeney and Professor Barry Duggan for setting up an informal External Quality Assurance Scheme for ACBI members, which evolved into the Irish External Quality Assurance Scheme (IEQAS).
Des had chaired the IEQAS Steering Committee on many occasions and was the incumbent Chairman when he died.

His work for ACBI led to international collaboration, and Des represented ACBI at the inauguration of EC4 in 1977, when just six countries were involved. He was closely involved in the development of the EC4 Quality Manual and the EC4 Register of Specialists in Clinical Chemistry and Laboratory Medicine, and was the ACBI representative to the EC4 Register Commission. Perhaps his greatest achievements were in the areas of accreditation and international quality standards. He was invited by the National Standards Authority of Ireland (NSAI) to join ISO Technical Committee 212, which was responsible for the development of ISO 15189: 2003, the international standard for Quality Management in Medical Laboratories. He eventually chaired Working Group 1 of Technical Committee (TC212) on Quality and Competence in the Medical Laboratory, and made a considerable contribution both to the Standard itself and the understanding and implementation of ISO 15189 in laboratories in many countries. Des was also the Irish representative to CEN TC 140 on in vitro diagnostic devices, and played a leading role in the campaign to ensure appropriate interpretation of the EU In Vitro Diagnostics Directive – a contribution that was greatly appreciated in the UK. Within EC4 he chaired the ISO/CEN Standards Working Group and was a key member of the Accreditation Working Group.

Des Kenny was ACBI’s representative to FESCC and had served as an Editorial Board member for the European Journal of Clinical Chemistry and Clinical Biochemistry, the predecessor of CCLM. Within IFCC, he had served on the Committee on Plasma Proteins and the Working Group on Calibrators in Clinical Enzymology, and on the joint IUPAC-IFCC Committee on Nomenclature, Properties and Units, which he chaired from 1995 to 1997.

All this was in addition to a lifelong commitment to training and education for Clinical Scientists and medical students and to his exceptional contribution to laboratory medicine at the Children’s Hospital, described as “irreplaceable” by the Director of the Division of Pathology and Laboratory Medicine, Dr Niamh O’Sullivan, in her eulogy at his funeral, at which all the areas of his life and work were represented. He died suddenly on a Monday morning while he was getting ready for work. There was something fitting about that.

But we’re remembered for who we are as much as for what we do, and a great many people have cause to remember Des as a lovely man and a great friend. When the news of his untimely death was announced, tributes and messages of condolence poured in from colleagues in many countries. As well as his professional skills, he was remembered for his friendship and his kindness, his gentle nature and his enthusiasm, his infectious chuckle and dry wit. He was an excellent companion over a beer (whether Irish or continental), on which he could discourse with authority. He had a great knowledge of all kinds of music, and was well known in Irish traditional music circles. At social gatherings or with friends in Dublin pubs he would bring out his tin-whistle and entertain colleagues, friends and anyone else who would listen. He will be missed as a scientist, but also as a man who brought pleasure and laughter.

It was said at his funeral that “Desmond Kenny was a good man and did good and important work”. So he was, and so he did. There could be no better epitaph.

MJH, GHB
Situations Vacant

Bigger Challenges, Better Rewards

Diagnostics Directorate
Clinical Scientists Grade B (3 Posts)

Indicative Salary Range £22,857 - £42,807 (+ 2.5% on account) Subject to Agenda for Change (ABC bands are likely to be available before interview)
South Glasgow Biochemistry Department/Yorkhill Biochemistry Department

Applications are invited for the posts of Clinical Biochemist in the South Glasgow Biochemistry Service, initially 2 posts based at the Southern General Hospital and one at the Royal Hospital for Sick Children, Yorkhill but rotation will take place and it is planned that the two departments will come together on the Southern site in a new and purpose built laboratory in 2009/10 which will offer excellent working and teaching facilities. Both current Departments are well equipped including a newly installed tracking system with full pre-analytics and storage, advanced PDCT analysers, tandem-MS and are CPA accredited.

The Southern site will also be the location of the new South Glasgow adult and paediatric Hospitals, planned to open in 2012 which will provide state of the art, advanced medical care including local, regional (e.g. Neurosciences) and national (e.g. Spinal Injuries) centres of excellence in many specialties as well as several academic clinical departments from Glasgow University. Overall this development will form one of the largest hospital complexes in the UK.

These posts therefore offer an exciting opportunity for you to play a leading role in service provision and develop areas of specialist expertise within an expanding service with excellent potential for career progression. The department offers the opportunity for you to develop an interest in a wide range of activities from highly automated testing to highly specialised paediatric metabolic testing and point of care.

You will be expected to be an HPC registered Clinical Scientist, have an MSc or equivalent in Clinical Biochemistry, possess DipRCPPath and be actively working towards full MRCPath. Candidates who do not possess DipRCPPath are invited to apply on the understanding that initially they may be appointed at a lower grade. You will be actively encouraged to participate in CPD.

For further information please contact Dr Alan Hutchison, Biochemistry Clinical Lead, 0141 201 5625/1681, Mr Frank Finlay, Consultant Clinical Scientist, Southern General Hospital, ext. 0141 201 1528/1681 or Dr John Fyffe, Head of Department, Yorkhill Hospitals, 0141 201 8335

For an application pack Tel. 0141 201 1245, quoting Ref. No. G0105445/ACB.

To download a job pack and application form visit www.nhsggc.org.uk/recruitment and follow the links or e-mail your full address and job reference number to nhsggcrcruitment@nhs.net or call the recruitment line on 0845 3000 831.

Closing date 19th March 2007.

Visit all our vacancies on www.nhsggc.org.uk

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St. James’s Hospital, Dublin, Ireland

Principal Grade Biochemist Biochemistry Department

Ref: ACB046/07

Salary: €62,197 – €90,834

This post provides an excellent opportunity for a motivated and dynamic individual to contribute to the continuing development of clinical biochemistry services in St. James’s Hospital, Dublin.

Requirements:

Essential:

- MSc degree of a recognised university in Biochemistry, Physiological Chemistry or equivalent qualification
- Five years satisfactory experience in the procedures of Clinical Biochemistry and/or Chemical Pathology in the laboratory of a hospital or allied institution

Desirable:

- An MRCPath or PhD (or demonstration of substantive progress towards either of these qualifications)

Further information on the laboratory is available on the following web site

www.stjames.ie/PatientsVisitors/Departments/Biochemistry

Enquiries:

Dr. Vivion Crowley, Consultant Chemical Pathologist and Head of Department, Tel: +353 1 416 2935,
Email: vcrowley@stjames.ie

To apply for this position please forward a letter of application, clearly indicating job reference number, along with four copies of your C.V. to the Recruitment & Selection Division, Human Resources Department, St. James’s Hospital, James’s Street, Dublin 8, Ireland no later than Friday 23rd February 2007.

Email: humanresources@stjames.ie

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Leading the way in healthcare innovation

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ACB News Issue 526 • February 2007
Here at Sheffield Children’s NHS Foundation Trust, we’re dedicated to the care of children and young people. The atmosphere here is very friendly with the accent firmly on support and staff development – and particular emphasis on training and career progression. The following opportunity is now available, full details of which are available by visiting us at www.sheffieldchildrensjobs.nhs.uk

Department of Clinical Chemistry

Clinical Scientist

Ref: 1917

Band 7/8a (depending upon qualifications) 0.7 wte to full time

This busy Department offers newborn screening for the Health Region, a clinical chemistry service for the hospital and a wide-ranging metabolic disease service for the region and further afield.

You would be predominantly involved in the metabolic section of the laboratory with significant input in general or acute paediatric chemistry. Involvement in Newborn Screening will also be encouraged. This is a key role, which carries significant responsibility to shape and develop the service. The appointee will participate in teaching, research and audit and will share responsibility in the duty biochemist rota. There is also opportunity to work within the enzyme assay service. This service already provides a national service for the diagnosis of fatty acid oxidation defects as well as offering a range of other assays both for routine and antenatal diagnosis.

You would be expected to have experience of paediatric biochemistry including specialist metabolic assays such as organic and amino acid analysis. For the Band 8a post you will be expected to have successfully completed MRCPath Part 1 and ideally would have several years’ experience within a service providing investigations for metabolic disease. Whilst we are hoping to appoint as a full time post, it would be possible to accommodate an appointee wishing to work part-time at a minimum of 0.7 wte. The actual hours worked will be negotiated during the appointment process.

Study towards completion of MRCPath is encouraged and it will be possible to arrange experience of molecular genetic techniques from within this fully integrated PathologyGenetics Directorate.

Sheffield is a vibrant city offering easy access to the Derbyshire National Park. For further information or to arrange an informal visit please contact Dr Simon Olpin, Lead Clinical Scientist (Metabolic Section) on (0114) 271 7267 or Dr Jim Bonham Consultant Clinical Chemist on (0114) 271 7404.

An application pack can be obtained by visiting www.sheffieldchildrensjobs.nhs.uk by emailing jobapplications@sch.nhs.uk or by telephoning (0114) 226 0634 quoting ref 1917.

Closing date: Friday 23rd March 2007.

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The Dudley Group of Hospitals

NHS Trust

DEPARTMENT OF CLINICAL BIOCHEMISTRY

CLINICAL SCIENTIST


This is a busy well-equipped Department (including capillary electrophoresis, microchip technology and LC-MS) committed to quality and development. The laboratory moved into new accommodation in July 2004. The Department is an evaluation site for new instrumentation and has an extensive research and audit program, leading to regular publications and posters. Research interests include lipids, obesity and diabetes. We are looking for an enthusiastic person for this post which will provide opportunities for further training in all aspects of Clinical Biochemistry. You will be expected to participate in service development and develop an area of specialist interest. You would be encouraged to prepare for MRCPath for which appropriate support will be given.

For further information or an informal discussion please contact Dr M Labib, Consultant Chemical Pathologist on 01384 244078 or Dr D Vallance, Consultant Clinical Scientist on 01384 244081.

For application pack please contact Carol Share-Jones on 01384 244233 (24hr answer phone) or alternatively please email carol.share-jones@dgh.nhs.uk

Please quote Job Reference JF187.

Closing Date: 9 March 2007

An Equal Opportunity Employer
For details of all our latest vacancies and to apply online visit: www.dudley.nhs.uk

A Teaching Trust of the University of Birmingham
Consultant Clinical Biochemist and Director of Antenatal Serum Screening

AFC Band 8c (the banding of this post may be negotiable depending upon the experience and expertise of the successful applicant)

Salary Scale: £49,381–£60,880  Hours: 37.5 per week

We are looking for an enthusiastic and innovative Registered Clinical Scientist with appropriate interests and experience for this unusual and interesting post at Birmingham Women’s Healthcare (NHS) Trust, which is falling vacant due to the retirement of the current post holder.

The key responsibilities are twofold. They include the professional supervision of a rapid turnaround biochemistry service for neonates and women attending Birmingham Women’s Hospital and providing direction and leadership for the largest antenatal serum screening laboratory in the UK. Currently over 60,000 pregnancies a year are screened in this laboratory and specimens are received from over 40 client organisations. Supporting five different screening strategies, we are at the forefront of innovation in this rapidly changing field.

Birmingham Women’s Health Care NHS Trust is a leading provider of healthcare to women, babies and their families in South Birmingham. We are also a centre of excellence in the fields of Maternity, Gynaecology, Neonatology and Clinical Genetics to men and women throughout the West Midlands and beyond. As a teaching hospital, we have strong links to the University of Birmingham, the University of Central England and other academic institutions and deliver high quality research and development and education training.

Informal enquiries are most welcome to Ms Sue Standing, (current post holder) on 0121-627-2734; or Gary Cockayne, the Associate Director of Clinical Support on 0121-607-4758.

For an application form and job description please contact Human Resources, Birmingham Women’s Health Care NHS Trust, Metchley Park Road, Edgbaston, Birmingham B15 2TG.

Tel: 0121-607-4774 (24 hours) or apply online at www.jobs.nhs.uk quoting job reference number 07/CC/03.

Closing Date: 28th February 2007
Central Manchester and Manchester Children’s University Hospitals
NHS Trust

Royal Manchester Children’s Hospital
Medicine, Oncology and Out Patient Services

CONSULTANT
CLINICAL SCIENTIST

Band 9 £63,417 - £88,397

The Willink Biochemical Genetics Unit is dedicated to the prevention, early diagnosis and appropriate management of people affected by inherited biochemical defects. Based at the Royal Manchester Children’s Hospital, we have closely integrated laboratory investigation and clinical management to produce a unique, internationally renowned service. As such, our highly specialised diagnostic unit serves not only Manchester and the North West but also the whole of the UK and beyond.

We are looking for a highly experienced individual to lead the Unit and take responsibility for the delivery of an efficient diagnostic, biochemical genetics service. You will have experience in all aspects of inherited metabolic disease and you will be a HPC Registered Scientist with a BSc Honours Degree appropriate to Biological Science, a PhD in an appropriate Biological Science and or an MRCPath or equivalent.

For further information please contact
Jane Edwards on 0161 918 5154, email: jane.Edwards@cmmc.nhs.uk or Dr J Walter on 0161 922 2137, email: john.walter@cmmc.nhs.uk

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