NHS Improvement: 29 Pathology Networks in England
Are You Ready for NICE DG30?
Faecal Immunochemical Testing for Symptomatic Assessment

The recently published NICE Guidance DG30 now recommends “Quantitative faecal immunochromic tests (FIT) to guide referral for colorectal cancer in primary care”.

A patient with a FIT result of <10µg of Hb/g faeces will have a high NPV for colorectal cancer (CRC), high risk adenomas (HRA) and inflammatory bowel disease (IBD).

FIT are more sensitive and specific than guaiac based faecal occult blood tests, have easier and more acceptable sampling methods and enable automated high-throughput batch testing.

NICE DG30 states: “[FIT] assays were also cost effective when compared with no triage, with the HM-JACKarc dominating (that is, it was more effective and less expensive).”

The HM-JACKarc FIT system demonstrated excellent performance in the symptomatic patient population across the studies reviewed by NICE.

For more information on how to get your patient on the right pathway using HM-JACKarc visit: www.alphalabs.co.uk/FIT
Learn more with a free FIT seminar at your hospital. Email your seminar request to: marketing@alphalabs.co.uk

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**Front cover:**
The latest networks proposals
#FabChangeWeek 2017
Calling all Healthcare Scientists!
This year, FabChangeDay has been extended to FabChangeWeek, running from 13th-17th November 2017. Get involved by thinking of something you want to pledge to improve patient experience, patient safety, leadership and staff wellbeing, service improvements or anything else you want! Upload a photo of your pledge to the FabChange website and share with @WeHCScientists #FabChangeWeek. Commit to your pledge and share your successes!

Life Sciences Industrial Strategy Report to Government Published
The report, written by Life Sciences’ Champion, Professor Sir John Bell, provides recommendations to Government on the long term success of the Life Sciences sector. It was written in collaboration with industry, academia, charity, and research organisations and contains recommendations relating to science, data, the NHS and industry growth from global companies.

Business Secretary Greg Clark has announced that the Government is to invest £146m in discovering new medicines, in a bid to help the UK become a world leader in Life Sciences. A strong Life Sciences sector can simultaneously benefit the UK’s economy and help improve the nation’s health.

Condolences
It is with regret that we must inform you of the sad news of the passing of ACB Retired Member, Dr Ian Hunter, who died on 20th April.

Dr Hunter joined the Association in 1966 and was based in West Lothian until 2005 and then later in Boston, Lincolnshire.

ACB Microbiology Scientific Day: Registration Open
Registration is now open for the ACB Microbiology Annual Meeting on 24th November 2017. For further information and registration please visit: http://www.acb.org.uk/whatwedo/events/national_meetings.aspx

Sudoku
This month’s puzzle

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Solution for August’s Sudoku

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Lab Tests Online-UK is Recommended by GPs in *Which?* Magazine

Rebecca Powney, Lab Tests Online-UK, Marketing and Promotion Lead

“*Which?* exists to make individuals as powerful as the organisations they deal with in their daily lives”. It is the largest independent consumer body in the UK, with over 680,000 members subscribing to their magazine and 330,000 members online. *Which?* aims to provide consumers with advice to help them make informed choices, campaigns to make people’s lives fairer, simpler and safer and puts the consumer’s needs first to bring them better value.

The September edition of *Which?* members’ magazine featured the article ‘Help your GP to help you’ providing the reader with an insight into GP appointments. It provides pragmatic advice on how to prepare for a GP appointment, how patients can enhance interactions at a GP appointment and how to get the best outcome from the perspective of the patient. The article uses vignettes and feedback from GPs and patients alike to guide the reader through an appointment, how the GP structures the appointment, what information they need from the patient and how best to deliver it. The article features a story from a patient at Haughton Thornley Surgery, who advocates access to full medical records including test results and emphasises the importance of this service for developing ‘a partnership of trust’ with her GP and enabling her to monitor her condition and find out more about it in order to get the best health outcomes.

The article features ‘Useful websites recommended by GPs’, which includes Lab Tests Online-UK as one of only five recommended and trusted websites. The ‘bottom line’ of the article includes advice to ‘look at your patient records and use information such as test results’ in order to ‘have really informed conversations with your GP and minimise the need for appointments’. This fits seamlessly with the objectives of Lab Tests Online-UK to provide peer-reviewed, non-commercial information to patients to help them understand their test results and empower them to be involved in their own healthcare. The article stresses the importance of patient preparation prior to their GP appointment and Lab Tests Online-UK is well placed as a free, easy to access resource, that provides further understanding of their test results.

With the increase in GP practices providing online access to medical records and positive patient stories such as those included in this article, Lab Tests Online-UK is the perfect resource to support patients accessing their results. This then builds on the ‘partnership of trust’ between the patient and the GP by providing patients with reliable information before or after they have had their 10 minute interaction with the clinician to understand their condition better and get involved in their own care.

This is a great endorsement from a completely independent super power in the consumer body market and as one of the three stakeholders (ACB, IBMS and RCPath) for Lab Tests Online-UK, we appreciate your help in spreading the word about the website to your colleagues and bringing this article to their attention.

If you want to become a champion for the website, or have somewhere you can provide leaflets to patients please get in touch at labtestsonlineuk@acb.org.uk
Equality and Health Inequalities Analysis Capability Training

The national Equality and Health Inequalities (EHI) Unit is running one-day free workshops across regions for all NHS England staff to understand their legal duties under the Equality Act 2010 and the Health and Social Care Act 2012.

The training will also include advice on completing an effective EHI analysis.

For further information and to book your free space on 17th October 2017 in London follow this link: https://www.events.england.nhs.uk/events/6494/nhs-england-staff-equality-and-health-inequalities-capability-programme

NIHR CLAHRC North Thames Academy New Course: Becoming Research Active

In collaboration with the Research Design Service London and Clinical Research Network North Thames, the CLAHRC North Thames Academy is running a new short course in 2017: Becoming Research Active.

This one-day workshop will be held on 12th October 2017 and is designed for healthcare and public health staff from NHS Trusts, NHS CCGs, and Local Authorities who are interested in becoming involved in research.

Find out more details and how to apply here: https://clahrc-norththames.nihr.ac.uk/event/becoming-research-active-oct-2017

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ACB Statement on Proposals to Establish and Implement Pathology Networks in England

On Friday 8th September the ACB Office advised us that NHS Improvement has just written to NHS Acute Trust Chief Executives in England outlining proposals to establish and implement 29 pathology networks to deliver services for the whole of England.

The objective is to establish pathology services that deliver the highest quality services to patients and maximise value for money, and to rapidly realise the clinical and financial benefits which NHS Improvement believes will result. The letter includes detailed proposals for each of the 29 networks. It stresses that these are not intended to be definitive, and Chief Executives have an opportunity to propose alternatives which will achieve comparable benefits.

The ACB was made aware of the proposals through participation in the National Pathology Implementation Board. We were not consulted during the development of proposals, and there was not an opportunity for them to be amended. We indicated our scepticism that it would be possible to deliver the clinical and financial benefits intended.

The ACB supports the overall objective of delivering maximum clinical benefit from laboratory services, and minimising unnecessary variation. In addition services should be delivered as efficiently as possible. We recommend that heads of laboratories engage at an early stage with Chief Executives to discuss local proposals and suggest alternatives where appropriate.

The Pathology Alliance Statement is reproduced on page 10 and there is also an article on page 28 under BIVDA News.

Further details of the proposals can be found at https://improvement.nhs.uk/resources/pathology-networks/ (published 08/09/2017)

Upcoming Regional Meetings

ACB Southern Region Autumn Scientific Meeting
17th October 2017
Viapath, St Thomas’ Hospital

ACB North West Autumn Audit Meeting
6th November 2017
Wigan Hospital Education Centre

ACB Scotland Biennial Meeting
9th-10th November 2017
Norton House, Edinburgh

ACB Southern Region Scientific Meeting
4th December 2017
Guy's Hospital

Further information and booking for all these meetings can be found here: http://www.acb.org.uk/whatwedo/events/regional_meetings.aspx
ELF™ Score

The Enhanced Liver Fibrosis Score is an aid in the diagnosis and assessment of severity in liver fibrosis

- Recommended by NICE for the assessment and management of advanced liver fibrosis in people diagnosed with non-alcoholic fatty liver disease (NAFLD)
- Algorithm combines three serum biomarkers:
  - Hyaluronic acid (HA)
  - Procollagen peptide type 3 (P3NP)
  - Tissue inhibitor of metalloproteinase 1 (TIMP-1)
- Correlates to the level of fibrosis assessed by liver biopsy

**Sample requirements:**
One serum sample via 1st class post

**Turnaround time:** 1 week

Further information:
www.leedsth.nhs.uk/Pathology

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Blood Sciences enquiries:
Tel: 0113 39 26922
E-mail: leedsth-tr.biochemist@nhs.net

**Address for samples:**
Blood Sciences
Old Medical School
Leeds General Infirmary
Leeds LS1 3EX

Leeds Pathology
Business Unit:
Tel: 0113 39 26982
E-mail: leedsth-tr.pathologybusinessunit@nhs.net
Pathology services underpin NHS care. The Pathology Alliance, which represents the professionals developing and delivering these services, is committed to working with NHS Improvement to ensure that patients have access to high quality, cost-effective pathology provision wherever they live.

The Alliance endorses the optimisation programme’s aims to reduce unwarranted variation and maximise benefits of collaborative working. Networks will reduce the impact of the staffing shortages currently seen in many areas, although investment in staff and their training remains a key component of any successful service. Sufficient numbers of appropriately skilled professionals are vital to achieving the aims of the programme.

The collection of reliable data is particularly welcome, and provides an unparalleled opportunity to understand the scope and scale of pathology services in England. Going forward, it is important that data are as accurate as possible so that comparison between networks is meaningful and any savings recognised. Investment in pathology services must not be cut before the benefits of a networked approach can be realised. Many of the most successful consolidated pathology services have required significant investment in the early stages to maximise long term savings.

While some pathology services have already undergone successful consolidation, it is important that those that have not achieved their objectives are not forgotten. Good practice should be shared but some of the most valuable lessons are likely to come from unsuccessful ventures, particularly those that map closely onto the proposed new networks. Repeating the same mistakes is likely to result in the same outcome.

It is vital that staff across the networks are supported and engaged in the planning and transition to the new service configurations, with time provided for pathology professionals to understand and lead this unprecedented change.

Although this proposal focuses on acute trusts, pathology services are not delivered in isolation. The needs of the whole health system must be considered, including primary care and specialised services.

The Pathology Alliance welcomes the Optimisation Board’s assurance that the proposed networks are a starting point for discussion and not proscriptive. One size never fits all, particularly across pathology’s 19 diverse disciplines, but these proposals are an important step in assuring equitable access to high quality, cost-effective pathology services for patients.

Dr Suzy Lishman
Chair, The Pathology Alliance:

- Association for Clinical Biochemistry and Laboratory Medicine
- Association of Clinical Pathologists
- British Division of the International Academy of Pathology
- British In Vitro Diagnostics Association
- British Infection Association
- British Society of Haematology
- Institute of Biomedical Science
- Pathological Society
- The Royal College of Pathologists

Pathology Alliance Statement in Response to the NHS Improvement Document on Pathology Networks Published on 8th September 2017
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Defending the Clog!

Ian D Watson, Honorary Secretary, ACB Golf Society

Last year the ACB Golf Society hosted the NVKC ‘All in One Club’ in the first British-Dutch Open at Mottram Hall near Wilmslow; we won the clog trophy presented by the All in One Captain, Hans Jensen. Well now we had to mount a defence!

A select team i.e. those willing and able, comprising: Bill Fraser (Captain), Graham White, Rajeev Srivastava and yours truly, arranged to meet in Schipol with flights arriving within an hour of each other; air-traffic control had other ideas and three hours later we finally assembled and set off for our hotel in Zoetermeer; a hurried meal and so to bed to face the challenges of the morrow. We hadn’t realised the main Den Haag – Gouda railway line ran, fast, directly behind the hotel, which didn’t help the slumberers!

So, on to Golfbaan Bentwoud to meet our Dutch challengers. Despite some competent SatNav programming by Bill and Rajeev, the address for the golf club found us in a nature park: we weren’t alone, another lost soul was one of the Dutch players! Hans Jensen rescued us, took us to the club, and with minutes to spare, no practice, we had to tee-off, or as the Dutch say ‘our flight’.

Golfbaan Bentwoud is a golf complex of four 9-hole courses, we played B & C; being the Netherlands we were not too surprised to find every hole had water hazards of one kind or another, some more daunting than others as well as generous (big!) bunkers. Although there was rain for the first two or three ‘flights’, the weather cleared and a sunny calm day enabled us to enjoy the company and the competition.

Well we expected to lose a few balls and that expectation was met, but everyone found this a demanding course and median Stableford scoring was low.

After our ‘flights’ had ‘landed’ we congregated on the clubhouse veranda for drinks and nibbles whilst the cards were collected, checked, team scores calculated and individual scores ranked: after dinner the results announced . . . We knew that in the top four scores there was only one of us, so our expectations were low, however the aggregate team scores meant we edged it: we retained the Clog!

An enjoyable and convivial time was had by all and plans were laid for the 3rd match to be played somewhere in the UK, details will be posted when arranged.

If you want to join us in one of our domestic games get in touch with me at iandwat@me.com

The delighted ACB team with the trophy; Bill is holding a big cheese he won as the second highest scoring individual
The Diggle Microbiology Challenge

These multiple-choice questions, set by Dr Mathew Diggle, are designed with Trainees in mind and will help with preparation for the Microbiology Part 1 FRCPath exam.

Question 3 from August
Many antiviral drugs act by inhibition of a viral DNA polymerase enzyme. Select the virus for which this class of drugs would be effective:
A) Cytomegalovirus  B) Influenza  C) Measles  D) Mumps  E) Rabies

Answer
A) Cytomegalovirus (CMV) is the only DNA virus listed here, which encodes a viral DNA polymerase. The other viruses are RNA viruses and replicate via a viral RNA polymerase.

Question 4
You are informed of an outbreak of diarrhoea and vomiting amongst the 100 guests at a wedding reception. About two thirds of the guests became ill between 2 and 3 days after the reception. You obtain a list of guests and the menu for the buffet meal. Select the most appropriate epidemiological investigation:
A) A case-control study  B) A correlational study  C) A cross-sectional study  D) A randomized controlled trial  E) A retrospective cohort study

The answer to Question 4 will appear in the next issue of ACB News – enjoy!
A metabolic disease is known to result in decreased plasma activity of enzyme X. X was measured in 100 normal subjects and 100 individuals with the disease. A reasonable Gaussian distribution was obtained for each population with the following statistics:

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<th>Mean (m)</th>
<th>Standard deviation (s)</th>
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<td>Normal subjects</td>
<td>1025 U/L</td>
<td>100 U/L</td>
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<tr>
<td>Diseased group</td>
<td>530 U/L</td>
<td>200 U/L</td>
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Find the decision level at which sensitivity is equal to specificity? What is the sensitivity (and hence specificity) at this decision level?

Two-tailed values of the normal deviate (z-score) and probability (P) are:

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<td>1.65</td>
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<td>3.09</td>
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These data form two overlapping normal probability distributions in which the mean of the normal group \( m_N \) is higher than the mean of the diseased group \( m_D \). The decision level \( DL \) divides the normal group into true negatives and false positives. The diseased group is divided into true positives and false negatives:

If the sensitivity (proportion of true positives in the diseased group) equals the specificity (the proportion of true negatives in the normal group) then the proportion of each group in the shaded area must also be equal. If the data is normalised (by subtracting the mean from each value and dividing the difference by the standard deviation) then the normal deviates (z-scores) at the point of intersection with the decision level with each distribution must also be equal:
A patient in A&E with suspected adrenal crisis was given an iv dose of hydrocortisone at 18.00. The medical team on take wish to carry out a short synacthen test to confirm the diagnosis but there will be a significant contribution from the administered drug until its concentration has fallen to 10% of the peak value. Assuming that hydrocortisone elimination follows a single compartment (first order) model with a half-life of 2 h, what is the earliest time at which the test can be carried out?
FCS Briefing 14: “Retire and Return” Guidance for Employees and Employers

Geoff Lester, NHS Staff Council and Pensions Scheme Advisory Board Representative

Background

Back in 2015, that guardian of public morals, The Daily Mail, and other parts of the media, became agitated about NHS staff who exercised their legitimate right to take their NHS pension and then (request to) return to work.

The criticism was based on rather out-dated notions that “retirement” means stopping all work, coveting your gold-watch and withdrawing to the garden shed or rocking chair and knitting (no offence meant to gardeners or knitters!). In response to the Daily Mail’s indignation the Secretary of State, Jeremy Hunt, resolved to take action.

The NHS Pension Scheme Advisory Board recommended that the retirement flexibilities that have long been enshrined in the 1995, 2008 and 2015 scheme regulations are in the interests of both scheme members and NHS employers facilitating “wind down” in either volume or intensity of work and better work-life balance for those approaching retirement whilst permitting services to retain access to valuable knowledge and experience. Any response should therefore be in the form of guidance rather than restrictive regulation. That guidance was released in July 2017 and can be downloaded from the link below.
Flexible Retirement
Each of the NHS schemes has slightly different flexible retirement regulations. The 1995 scheme, with its Normal Pension Age (NPA) of 60, is the most stringent whilst the 2008 and 2015 schemes have more flexibility built in.

Important Points to Note
1. If you do retire with 1995 scheme pension benefits you cannot contribute further to that scheme after returning to work. You have to retire and resign in order to take your pension.
2. If you have a 2008 or 2015 pension then you can take some of your pension, referred to as draw-down, without leaving NHS employment and you can continue to contribute to your pension. See the sections in the 2008 and 2015 scheme guides via the links below.
3. The “Retire and Return” process mainly refers to the 1995 scheme with its attraction of taking a final salary pension at 60 and then returning to work.
4. Even though you may not be entitled to contribute further to a NHS pension scheme, under the pensions auto-enrolment legislation, the employer is legally obliged to enrol you into some pension scheme. This will probably be the NEST scheme. If you do not wish to make further contributions it is then for you to opt out. Note that you will have a limited time window after returning to employment to do that.
5. When you retire you do not have a right to return. Employers must be able to justify re-employing you publically if called upon. This is partly because the practice could be viewed as reducing career advancement opportunities for others and may not be the most efficient use of public money. The Retire and Return Guidance (Annex B) includes an employer’s checklist.
6. If you take your pension before the NPA for your scheme and then return your pension benefit will be subject to reduction (abatement). See the relevant sections in the guides below.
7. You should consider all flexible retirement options available to you before making any decisions.

Further Information
Equality, Diversity and Inclusion in the ACB

Rachel Wilmot (Hull), ACB Diversity Champion

The Science and Engineering sector has been attempting to address lack of diversity for decades. WISE (Women in Science and Engineering), for example, was started in 1984 (see www.wisecampaign.org.uk); Ethnicity in STEM (Science, Technology, Engineering and Mathematics) is one of the main areas of focus for race.bitc.org.uk. The sector recognises that if it fails to attract more women or people of a black and minority ethnic (BAME) background and hold on to them as they hit each educational or career hurdle, the skills shortage already apparent will continue to grow. The Biomedical Sciences do better at getting women into relevant degrees – over 50% of medical students are now female and recruitment into the Life Sciences STP programme is approximately 75% female; there remains a question though – is ours an area in which women thrive, survive or stall? Healthcare is seen as an area of good recruitment for BAME. However, whilst our hospitals and even our laboratory workforce may be becoming more ethnically diverse, Clinical Science still seems to struggle either to attract or employ people from outside a white demographic (The Workforce Survey, as reported by Jonathan Scargill in June’s ACB News, shows us to be over 90% white).

In 2016 the ACB signed up to the Science Council’s Declaration on Diversity, Equality and Inclusion: http://www.sciencecouncil.org/web/wp-content/uploads/2016/01/Science-Council-Declaration-on-Diversity-Equality-and-Inclusion.pdf As part of that agreement I was approached to act as the ACB’s first Diversity Champion.

Initially I, possibly like you, asked myself why would the ACB need such a Champion? After all it is largely the NHS that hires, fires and promotes us, the GMC or HCPC that determines if we are fit and proper people for our role and the Royal College of Pathologists that assesses our ability. The ACB just Champions the Science, right?

Firstly, we should acknowledge that it is ACB members who are at the business end of most of those decisions. Secondly, the ACB is a leading voice for Laboratory Medicine, it speaks for us across many platforms, scientific, educational and political; in doing so it should be reflective of all its members. In Focus and FiLM we have two of the most important UK meetings for presenting, celebrating and leading the debate about Pathology. It is vital we ensure equality of opportunity for all our members to participate and attend; similarly with our prizes, awards and grants. The FCS represents the interests of our Clinical Scientists and needs to be aware of issues that might be impacting on some sectors of our membership more than others.

Equality projects are generally regarded positively because “it is the right thing to do” and it is only fair and proper to ensure people are not discriminated against on the basis of their gender, race, sexual orientation or religious belief. But EDI initiatives do not just benefit those of us with a protected characteristic; Diversity brings major benefits to organisations themselves. The first Women Matter report from management consultancy McKinsey in 2007 concluded that corporations with women on their boards
perform better than those without across both financial performance and organisational excellence. Significant performance improvement is seen when a critical mass of female representation – 30% – is reached. In the NHS we work in a particularly rapidly changing environment, the ability to leverage a diversity of perspectives facilitates innovation and agility which can only improve our interactions and decision making.

So, where to start in this new role? I looked first at the data the ACB holds on its membership. In terms of protected characteristics this is limited to gender, so with apologies, the rest of this article has a gender bias. With a further apology to our Overseas Members I concentrated on UK based members, as these are generally most available to take on ACB roles and responsibilities. Table 1 shows our UK membership by category.

It has long been said that we are an organisation of old men and young women and that the ACB Leadership would be less male and pale once that demographic matured. If we concentrate on the active UK membership that statement merits further scrutiny.

Sixty-one percent of our active members are women with a pronounced bias to the younger end. The old men peak however is not so obvious (see Figure 1). If we look at members over 40 (at this age we are

**Table 1: Background Data Category**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Number</th>
<th>Active UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic</td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td>Biomedical Scientist</td>
<td>74</td>
<td>n/a</td>
</tr>
<tr>
<td>Clinical Scientist</td>
<td>1061</td>
<td>866 (+100 FCS + 26 temp retired)</td>
</tr>
<tr>
<td>Medic</td>
<td>257</td>
<td>222 (+1 temp retired)</td>
</tr>
<tr>
<td>Retired</td>
<td>666</td>
<td>?n/a</td>
</tr>
<tr>
<td>Student</td>
<td>12</td>
<td>n/a</td>
</tr>
<tr>
<td>Industry</td>
<td>37</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**Figure 1: Gender Distribution by Age of Active ACB Members**
generally considered senior members of the profession in terms of either time served or position), women make up 52%. Figure 2 contrasts the demographics of our Scientists and Medics. For Scientists at older age groups the gender breakdown is pretty even; at the younger end it is largely female and indeed we are starting to ask why we are not attracting young men into our profession. For our medics the older male peak is clear, there is also a demographic time bomb apparent. In the over 55s the Scientist to medic ratio is 2:1, in the under 55s it is 6:1. We need to consider how we remain inclusive of our medical members as this demographic change actualises.

Do the higher echelons of the ACB reflect its demographic? The current Executive has three female members out of nine, ACB Council fares better at 40% female, largely due to the good number of female regional representatives. All three current National Members (considered a route to higher office) are male. Table 2 shows the breakdown by gender of the high offices of the ACB over the last 30 years. Also included are the data on members who have been recognised for their contributions to the ACB.

Looking at Chairs and deputies of various ACB Committees over the same time frame (Table 3), it is a very mixed bag with Education and Publications faring well whilst the Federation and particularly the Scientific Committee are more of a concern. Over the same 30 year period our Trainees Committee has largely reflected the makeup of our Trainees. The data raise interesting questions: are there roles that are not attractive to our women members? Or does our difficulty in attracting volunteers mean bias (conscious or unconscious) comes into play when people are being persuaded to take up roles?

Ending the data trawl on a more positive note Figure 3 looks at regional Chairs and
Secretaries over the last 12 years.
Future articles will look more closely at scientific contributions and recognition, describe how we benchmark against other member organisations of the Science Council and introduce the team pulling together an action plan for our next steps. (You will have already noted a few more EDI questions on this year’s workforce survey). Meantime if you want to get involved or have issues you wish to raise, please contact me.

Table 2: Does the ACB Reflect its Membership?
30 Year Review: Higher Office and Contribution Recognition

<table>
<thead>
<tr>
<th>Position</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>President/Chair</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Years</td>
<td>48</td>
<td>4</td>
</tr>
<tr>
<td>Secretary</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Years</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>3</td>
<td>/</td>
</tr>
<tr>
<td>Years</td>
<td>30</td>
<td>/</td>
</tr>
</tbody>
</table>

| National Member         | People | 24 | 10 (20%) |
| (Last 10 years)         | 8      | 5  (38%) |

Recognition of Contributions to the ACB
Emeritus Member

<table>
<thead>
<tr>
<th>Post</th>
<th>Education</th>
<th>Publication</th>
<th>Federation</th>
<th>Scientific</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Chair/Director</td>
<td>People</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Years</td>
<td>13</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>Sec/Deputy</td>
<td>People</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Years</td>
<td>14</td>
<td>16</td>
<td>6</td>
</tr>
</tbody>
</table>
Finally, in Ian Young’s Meet the President piece in the last issue, you will see that we have buy-in to EDI at our highest level. Interestingly he put this alongside his desire to maximise Membership of the Association in all branches of Laboratory Medicine. I would suggest being an inclusive organisation open to diverse perspectives can only help the voices and interests of all these disciplines to be heard.

References

Definitions.

Equality. Ensuring individuals or groups of individuals are not treated differently or less favourably on the basis of their protected characteristics, including race, gender, disability, religion or belief, sexual orientation and age. Characteristics protected under UK law.

Diversity: Each person is an individual with visible and non-visible differences. Diversity is recognising, celebrating and valuing these differences and by doing so ensuring all are valued for their contributions.

Inclusion: Is about proactively fostering an environment where diversity is valued, barriers to participation eliminated and everyone feeling they belong and are able to contribute to their fullest potential. It is also about ensuring diversity of knowledge and perspective is sought and applied in the way we perform and make decisions.
As usual we had the topics of the day. It is at this time each year that our new members to Council get some insight into what being a Director (as a Council Member) means. As a brief introduction for anyone considering engaging in ACB activities, I will give the readership some insight, although it is all very much common sense. The role involves promoting the success of the company, ensuring the best interests are maintained, maintaining company standards and ensuring fairness between all members.

A brief and to the point fact sheet is available on [www.gov.uk/BEIS](http://www.gov.uk/BEIS)

Given one of the roles of the Directors is to ensure that there is equity within the membership, it is no surprise that we are engaged in work looking at how we can ensure equality, diversity and inclusivity (EDI). I did write about this a few months ago and informed the membership that we had embarked on a programme of work with the support of the Science Council. Rachel Wilmot has kindly taken a lead on this work and presented a significant number of facts about the ACB and how we as an organisation stack up against the standards of EDI. It makes interesting reading. Rachel will publish some of her findings in the ACB News, so please read what will be an interesting article.

The third topic discussed was the Membership, and the potential pressures that exist going forward as member numbers potentially decline as colleagues retire, with reduced new members joining. Our President, Ian Young, has pledged to ensure that the ACB Executive and Council work to rectify the current trend, ensuring we understand our current position and how can we make the ACB for everyone who is involved in Laboratory Medicine. Food for thought. Do you know a practicing Laboratory Scientist who is not a member of the ACB? Would you support an initiative to proactively recruit some of our colleagues? Do you actively encourage new members to the profession to join, if not, why not? I guess what I am saying is that we are aware of a problem coming our way, so what are we all going to do about it?

The final item I would like to mention was our Members’ Award ceremony held at lunchtime during this Council meeting. It was great to see some old and some not so old faces being recognised for their contributions to the aims of the Association. The awardees received their Awards from Gwyn McClean, our Past President. Congratulations go to you all.
As a proud Mancunian, I’m delighted to invite you to Manchester for Focus 2018. We hope that as many of you as possible will join us for the ACB’s National Meeting, where we will Focus on Value.

The conference will be held in the modern and environmentally-friendly Brooks Building, part of Manchester Metropolitan University, from 6th-8th June, 2018.

Manchester is the original modern city. What Athens was to Ancient Greece, and Florence was to the Italian Renaissance, Manchester is to the modern scientific and industrial age. It remains a powerhouse of science and the arts, sport and music, and is home to the University of Manchester, the second-largest university in the UK and the largest single-site university, Manchester Metropolitan University and the University of Salford.

Following the hugely successful Focus in Leeds last year, we have kept to the two-day format for the meeting, and Chris Chaloner and the Scientific Programme Committee have put together a dazzling programme with something for everyone, encompassing current research, horizon-scanning, clinical skills enhancement and the realities of delivering value-added services to today’s healthcare providers.

Focus 2018 will be packed with value – in the lectures, in the networking with colleagues and commercial partners, and in the opportunities to broaden your horizons scientifically, socially and culturally.

We’ve worked hard to make this a successful meeting on every level. We’d love to welcome you as a partner in that success.
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Heart UK, one of the UK’s leading cholesterol charities, hosts an annual conference on topics relating to cardiovascular risk. The 31st Annual Heart UK conference focussed on cholesterol including both clinical and laboratory components. Set in the beautiful location of Warwick University during the July heat wave, this conference offered a perfect combination of professional development and networking opportunities in a relaxed and friendly atmosphere.

The conference began with a free educational study day open to all delegates. This comprised a series of morning tutorials on hyperlipidaemia including subjects such as lipoprotein apheresis and non-alcoholic fatty liver disease. In the afternoon we had a workshop on behavioural change led by Dr Tim Anstiss, founder of the Academy of Health Coaching. For many of the attendees who are involved in lipid or cardiovascular risk clinics, this was a fantastic opportunity to practice a motivational interviewing approach to consultations.

The following two conference days were packed full of equally interesting and entertaining sessions covering all aspects of lipidology, with presentations from leading experts in the field. Highlights included a presentation on the evidence for childhood screening for familial hypercholesterolaemia by Professor David Wald from Barts School of Medicine, an update on the significance of a high lipoprotein(a) by Professor Erik Stroes from...
Amsterdam and the keynote Myant lecture on diet, lipids and cardiovascular risk delivered by Professor Tom Sanders from King’s College London.

There were also more interactive sessions including “Clinical Lipidology Live” where patient cases from lipid clinics were discussed by a panel of experts; and a courtroom-style debate on the case for current LDL-cholesterol treatment having solved the problem of hypercholesterolaemia. This allowed for open discussion, and at times heated debate, surrounding hot topics in lipid management with frequent audience participation.

As well as the multiple sessions delivered by expert speakers, there was also ample opportunity for trainee involvement. Abstract submissions for poster and oral presentations were encouraged from all delegates. All accepted abstracts will be published in Atherosclerosis Supplements on line, and every presentation was eligible for receiving a prize during the event. Travel grants were also available to help junior clinical and scientific staff attend the conference.

It wouldn’t be right to report on a conference without mentioning the social aspect and Heart UK was no exception. Situated on campus, en-suite accommodation was available to all delegates in newly built flats. There were plenty of opportunities for networking with a welcome reception plus a conference dinner, as well as many refreshment breaks during the conference and a guided campus walk.

I would recommend the Heart UK Annual Conference to anyone involved in lipid, diabetes or obesity clinics and to both trainee Chemical Pathologists and Clinical Scientists as it offers a comprehensive update on topics relevant to the FRCPath examination.

The next annual conference “Hot topics in atherosclerosis and cardiovascular disease” takes place 4th-6th July 2018 at Warwick University. Information can be found on the Heart UK website: heartuk.org.uk
Industry Insights: Darwinian Management

Doris-Ann Williams, Chief Executive, BIVDA

The Pathology community was sent reeling in September by the NHS Improvement announcement to establish and implement 29 pathology networks across England. At BIVDA we had an amazing insight at our Point of Care Working Party meeting on the machinations of NHS Improvement behind the scenes which I thought would be worth sharing and hope you will find this helpful and perhaps disturbing reading, but with a light at the end of the tunnel.

NHS Improvement have a clear but intimidating position – NHS England needs to stay in budget and keep public confidence and so has to control supply and demand. Only marginal funding increases are available from taxation. A small percentage of the population, probably about 5%, use about 50% of the NHS budget (and a slightly skewed 80:20 rule applies for the rest; 15% using 85%). The NHS has partially been a victim of its own success – 70 years ago we had a problem for most of the population with poor access to acute care but the reality is that by increasing the survival rate by almost 20 years with better care and new drugs, diagnostics and other medical technology, we have an increasing burden of elderly people with co-morbidities to look after.

This is leading to some dramatic changes by NHS Improvement with its Chief Executive Jim Mackey leading with Darwinian management – success breeds success and failure will be penalised. The hard fact is that while most hospital activity earns income, it does not make a positive margin; hospitals lose money caring for patients.

Drivers for hospitals are changing so that a hospital or secondary care provider will change from our current understanding. New business models are emerging such as Queen Elizabeth Facilities in Gateshead – an organisation with NHS employees but which exists to provide services outside the NHS to generate profit which is then ploughed back into supporting the local NHS Trust (Google them!). There will be consolidation, chains, ‘buddies’ and franchising.

It is now mandated for all Trusts and Foundations Trusts in England to use Patient Level Information Costing Systems (PLICs) which underpins service line reporting and is more accurate than reference costing. It is PLICs that will inform strategic and operational business decisions.

Primary Care will also be changing so hospitals, Primary Care and community will be redefined to become a connected system working at scale and – this is the good bit – they will need input from Pathology to make all this happen! It will need new thinking and processes and perhaps some change in the way we work but supporting patient pathways and ambulatory care in the community, as Pathology do from Oxford Universities NHS Trust for the Emergency Multidisciplinary Units. This could radically change the way laboratory medicine is perceived, taking it away from being seen as a back room service using consumables to the enabling specialty delivering patient solutions and leading the way for prevention and better health outcomes. All seems a long way from the immediate imperative to network and consolidate but this could actually be a huge opportunity hidden in the apparent chaos.
ACB News Crossword

Set by Rugosa

Across
1 Flavour enhancing salt causes nervous excitement (9)
6 Resident doctor on call, name is missing (5)
9 Openings of most iambic verse (5)
10 Act faster fabricating man-made objects (9)
11 Try, hope, rue presentation about idea lacking evidence (4,6)
12 Sounds around Skye (4)
14 Resolutely wily, rings solicitor (7)
15 Scoundrel having nothing to say about one toxic metal (7)
17 Allocates allotments (7)
19 If process pasteurises, not true pathogens completely absent (7)
20 Constituent of complex ampicillin susceptibility test (4)
22 Mislay tool used for measurement of particles in solution (10)
25 Mother’s replacement therapy surprisingly brief (5-4)
26 Built single unit for indigenous North Canadian (5)
27 Polish female, short, former Level Two Nurse (5)
28 Settles as migrant, not being a citizen (9)

Down
1 Not into uprooting unsettled class (5)
2 Declare the majority is extreme (9)
3 Adjustment of inapt job centre data (10)
4 Institute irons out aerodynamics difficulty (7)
5 About the gut secretions problem, no sign of distress? (7)
6 Pick up car ride (4)
7 Hiding place, store for quick retrieval (5)
8 ‘Digestive structures’ review essay looms but no article (9)
13 Learned in a fashion about a neurotransmitter (10)
14 Stops preparation of user’s case (9)
16 Found seminary, for example (9)
18 Charge nurses resist endless change (7)
19 A ‘senseless’ disturbance in Samoa (7)
21 A rejection of French conducting contact (5)
23 Last May turned up site of mythical humanoids (5)
24 Without ado, astound! (4)

Solution for
August’s Crossword
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