



Welcome to the NHS Point of Care Testing Conference



05th May 2026
15 Hatfields Conference Centre, London,
SE1 8DJ

FUTUREPOCT 2026

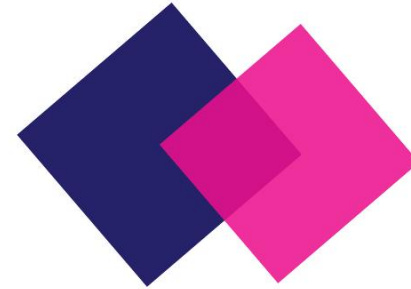
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Join the Healthcare Engagement Society (HES)

- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.





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Chair Opening Address

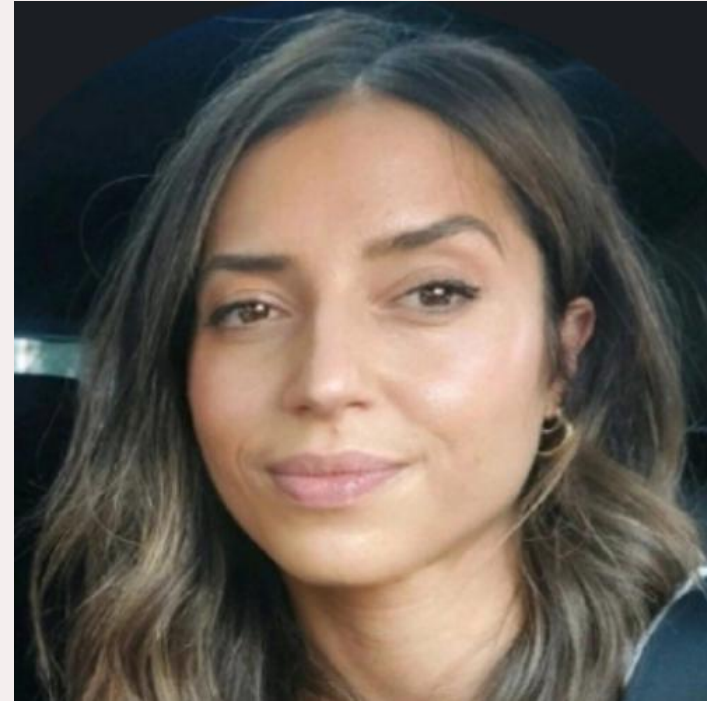


Gurnak Singh Dosanjh

Deputy CCIO | Digital Healthcare Consultant | CSO |
ICB Clinical Lead
NHS Leicester, Leicestershire and Rutland



Keynote Presentation



Venera Genco

Point of Care Testing Coordinator Community
Berkshire and Surrey Pathology Services



Skill Clinic



Dr Sirazum Choudhury
Consultant in Metabolic Medicine | Point of
Care Clinical Lead
North West London Pathology | Imperial
College Healthcare NHS Trust



Tobi Amadasun
Clinical Pharmacist & Partner
(Health Inequalities Lead)
Watton Medical Practice



Case Study





Refreshments & Networking



Case Study



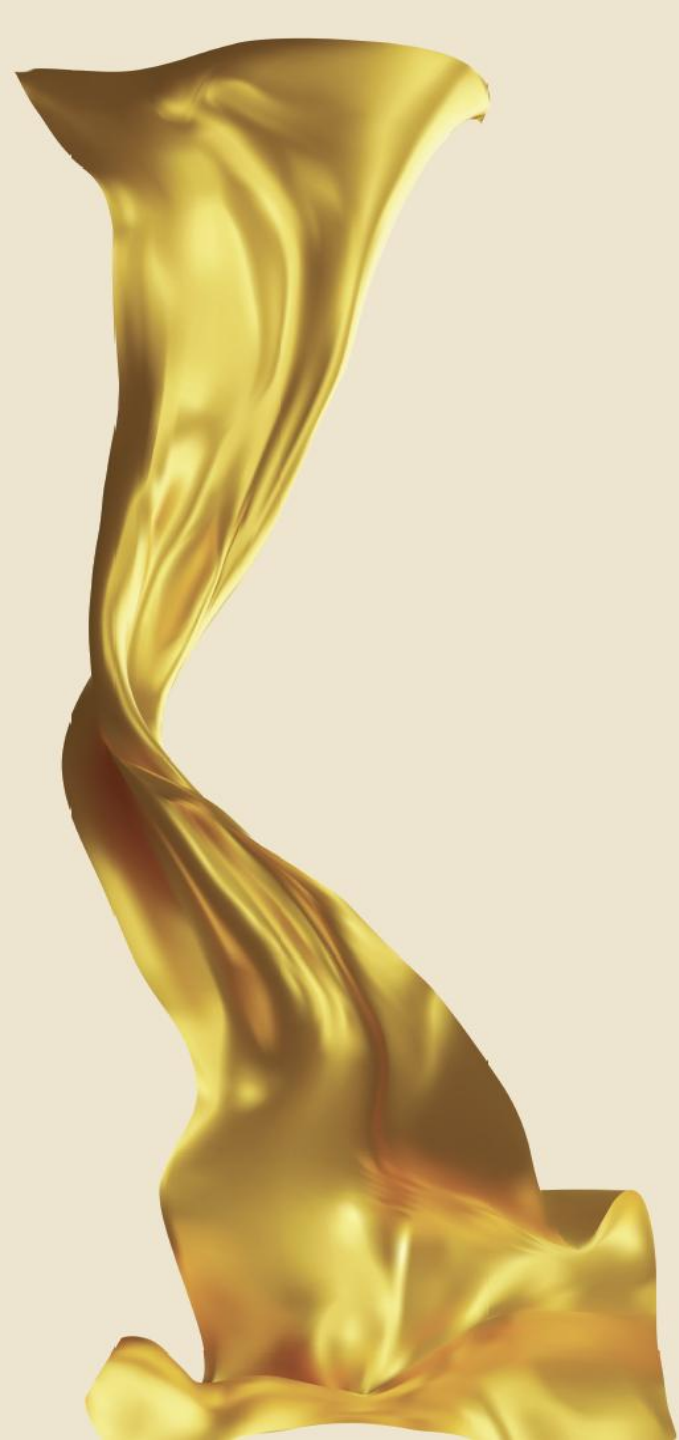
una
health



Case Study



Ms Giovanna Forte
CEO
Forte Medical Limited



Liquid gold

Precision urine collection
A point of care revolution

Future POCT 2026
Tuesday 5th May

Giovanna Forte, CEO, Forte Medical Limited in partnership with Una Health



Who are we?

Forte Medical is an R&D innovator partnered with Una Health to promote **precision urine collection** for right-first-time diagnostic outcomes, because urine is full of information. We focus on:

- Women's UTI and prenatal (*midstream*)
- STI, HPV, Some Early Stage Cancers e.g. bladder, prostate, pancreas ... (*first stream*)
- Sports and evidential forensic medicine (*twin stream*)





The prevalence of UTI in women

- Half of all women will experience a UTI in their lifetime $\leq 21.5\text{m}$
- Urines dipped for routine antenatal screening $\leq 4.3\text{m}$
- 1-3% of GP appointments are taken up with UTI ¹ $\leq 10\text{m}^*$
- 30% experience repeat within three months ¹ $\leq 3.3\text{m}^{**}$

*10-minute GP appointment costed at £37 = £370m

** 10-minute repeat GP appointment at £37 = £122m





Routine midstream urine collection

Hit-and-miss



All current vessels rely on patient dexterity to collect an MSU:

- Start to pee, stop, position vessel under body, start to pee again ... or
- Pee a little then push the collection vessel into the urine stream
- Specimen transfer into 10ml Primary Tube follows at lab or frontline

Undignified



Messy



20-30% national average specimen contamination / mixed growth



What a contaminated specimen can mean

- Potential for false-positive or false-negative dip
- Prescribing of immediate 3-day broad spectrum antibiotic
- Repeat visit to GP
- Repeat sample sent to lab
- *Potential for second 3-day broad spectrum*
- Targeted antibiotic with culture result
- Unreliable remote analysis and diagnosis – a growing sector

Blood collection has a strict protocol.

Where is the protocol for guideline compliant MSU?

Screenshot





AMR is already targeting women

≤ 60%

Women with UTI who receive a common antibiotic prior to culture ³

92%

Of UTI bacteria already resistant to at least one common antibiotic ⁴

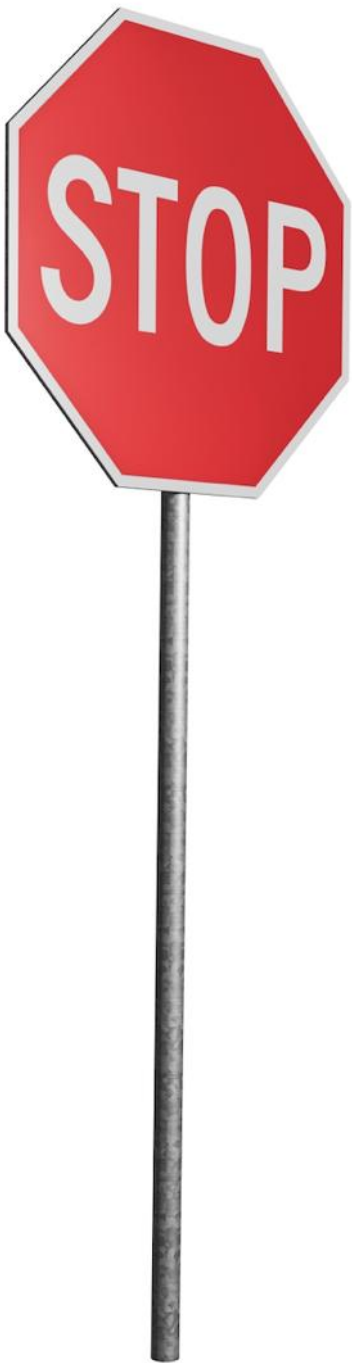
80%

Of UTI bacteria already resistant to at least two common antibiotics ⁴

! Around 50% of global rise of AMR has a urinary source: UTI is the main driver (NIHR)

! 20-25% of Sepsis cases have a urinary source





A broken diagnostic and prescribing pathway

- NICE/PHE guideline midstream urine collection is not mandated
- Dipstick technology is associated with false positive and negative results and “should not be considered for diagnosis if culture is available”²
- Empirical prescribing guidelines mean culture is not prioritized

An unreliable urine specimen can mean growing use of remote diagnostic systems is designed to fail





Introducing automated MSU collection

- Diverts first-void urine into the toilet
 - Captures midstream into lab-compatible 10ml Primary Tube
 - Rejects excess urine into the toilet
 - Reduces repeat appointments, repeat tests, repeat prescribing
 - 66% saving on lab spend for a GP surgery
-
- Non touch
 - Non spill
 - No decanting

X 3 Peezy Midstream systems cost less than one lab culture

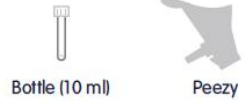




Please read before use

Primary urine collection kit (10ml)
PE50 Standard

This pack contains:



Get ready

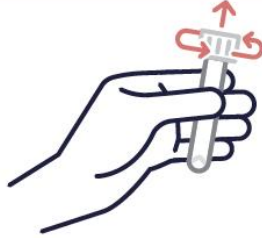


Make sure your bladder is full

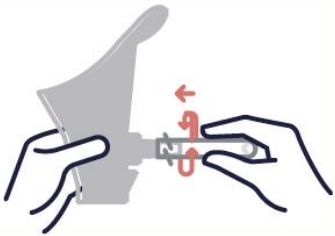


How to use Peezy in 5 easy steps →

1 Remove bottle lid



2 Screw bottle on to Peezy



3 Empty your bladder completely

Sit well back

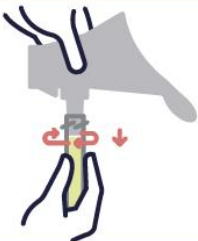


- Hold Peezy as shown and urinate.
- Urine also runs into the toilet.
- Keep holding Peezy in place - it will not overflow.
- When finished count to 10 - this lets Peezy drain.



4 Unscrew bottle

- Hold bottle upright.



5 Replace lid and return bottle

- Return full bottle to healthcare professional.



Dispose of used Peezy



Clinical evidence snapshot

Public Health Wales GP trial

Contamination reduced from 14% to 0%
66% saving on surgery lab spend

West Herts NHS Maternity Clinic

70% reduction of false-positive urines

Barts Health NHS Urology Clinic

Mixed growth samples reduced from 23% to 1.5%

[Animated IFU](#)

Forte Medical in partnership with Una Health



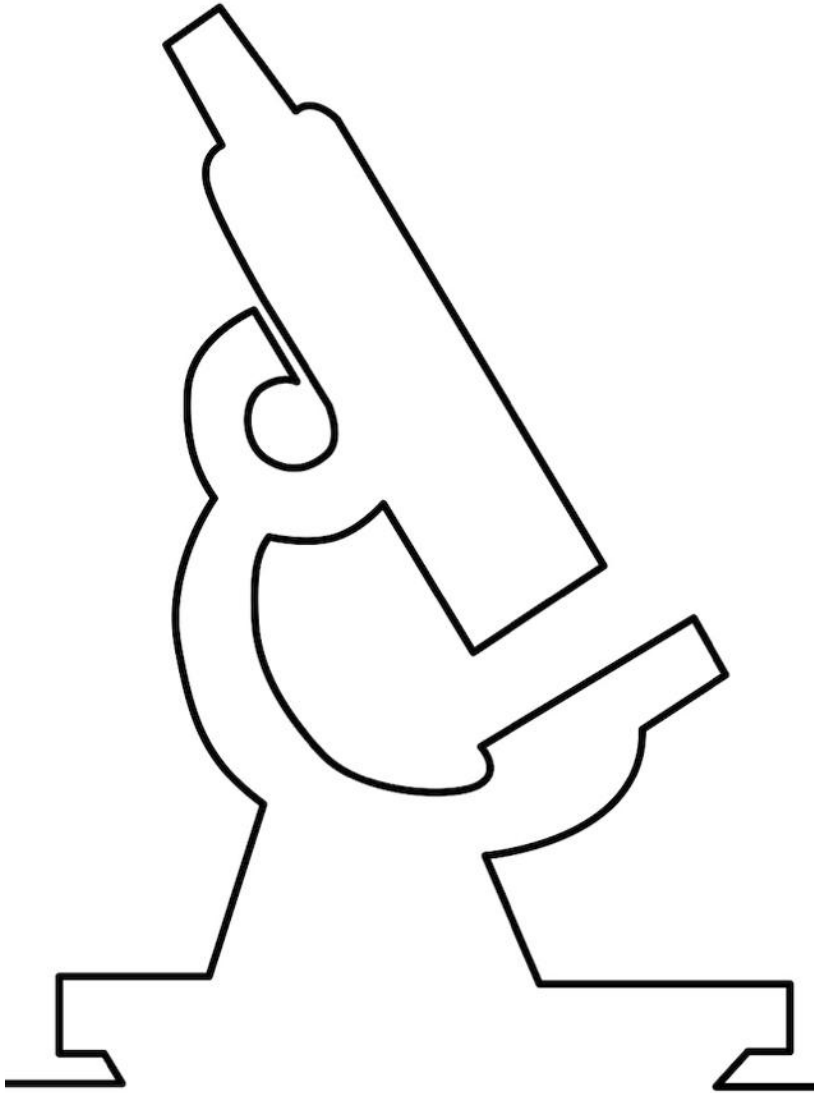
Do not use Peezy if the pack is open or damaged. Throw away and ask for a new pack.

Patient journey map: what's possible?

	Day 1	Day 4/5	Day 5/6	Day 8/9	Day 13	Day 20
Worst Case Scenario	Visit Pharmacy 2 symptoms No dip Receive 3-day antibiotic	UTI persists Call 111 / GP GP visit advised	GP appointment Positive dip 2nd 3-day antibiotic	Failed treatment GP appointment Urine lab culture 3rd 3-day antibiotic?	Lab report 7-day targeted antibiotic Collect from Pharmacy	Cure 3-4 x Antibiotics
	£15 + £2.90	£20	£37 + £2.90	£37 + £15	£2.90	COST: £132.70

	Day 1	Day 4/5	Day 7/8	Day 16/17
Guideline	GP appointment Positive dip Receive 3-day antibiotic	UTI persists 2nd GP appointment Positive dip 2nd 3-day antibiotic Urine to lab for culture	Lab report 7-day targeted antibiotic Collect from Pharmacy	Cure 2-3 x Antibiotics
	£37 + £2.90	£37 + £15 + £2.90	£2.90	COST: £97.70

	Day 1	Day 4/5	Day 7/8
Best Practise	GP appointment MSU collected Positive dip Urine lab culture Pain killer prescribed	Lab culture 7-day targeted antibiotic	Cure 1 x Antibiotic
	£37 + £15 + £2.90 + £4.99 (cost of Peezy Midstream)	£2.90	COST: £62.79



SOURCES

1. <https://cks.nice.org.uk/topics/urinary-tract-infection-lower-women/background-information/prevalence/>
2. <https://pmc.ncbi.nlm.nih.gov/articles/PMC8482205/>
3. <https://fundingawards.nihr.ac.uk/award/NIHR203362>
4. <https://www.scientificamerican.com/article/antibiotic-resistant-utis-are-common-and-other-infections-may-soon-be-resistant-too/>
5. <https://www.thepharmacist.co.uk/pharmacy-first/almost-five-million-pharmacy-first-consultations-delivered-in-first-year>
6. <https://cpe.org.uk/national-pharmacy-services/advanced-services/pharmacy-first-service/pharmacy-first-service-faqs>
7. <https://www.health.harvard.edu/bladder-and-bowel/when-urinary-tract-infections-keep-coming-back>





Together we're making
midstream, **mainstream**

Introducing  Peezy
MIDSTREAM



With thanks to you
and the
NHS Future POCT Team

unahealth.co.uk

Forte Medical in partnership with Una Health





Keynote Presentation



Tobi Amadasun
Clinical Pharmacist & Partner
(Health Inequalities Lead)
Watton Medical Practice

WATTON MEDICAL PRACTICE | BRECKLAND, NORFOLK

Before They Came to Us

*How Community Health & Wellbeing Workers
Transformed Care Delivery in Primary Care*

Tobi Amadasun

*MRPharmS | IP MAPCPharm | MBA | Doctoral Researcher
Clinical Pharmacist & Partner
Board Member (Breckland Alliance)
Watton Medical Practice (A Part of the Breckland Alliance)
Tel: 01953881247 M: 07447920926*

1741

patients reached

2

CHWWs deployed

£667k

system savings

A deprived community that wasn't reaching primary care



Deprivation

Watton sits within the 20% most deprived communities in England, with high rates of multi-morbidity, financial hardship and social isolation.



Non-Engagement

Many of the patients who needed care most were simply not engaging with services, not through choice, but through circumstance.



Reactive Model

Traditional GP-led care is reactive. Patients must come to us. But our most vulnerable residents often couldn't or wouldn't.

Go to the patient before they come to you

Proactive Door-to-Door Outreach

*Every door. Every month.
Every household in the
most deprived postcodes.*



Two CHWWs clinically supervised by WMP staff



Multi-lingual workers (7 languages spoken in the cohort)



Life-course approach covering all ages and conditions



Holistic support: health, welfare, housing, employment



Based on the proven Brazilian Community Health Worker model



Bridge between residents, WMP and statutory services

Improving QOF, vaccinations, screening & planned care

41% → 69%

Asthma check completion

+27.6 percentage points

303

Flu vaccines administered

post-intervention

291

COVID vaccines delivered

to cohort members

98%

Appointment attendance

when advised by CHWW

77% → 80%

Bowel cancer screening uptake

106

MMR vaccines delivered

90%+

Residents reported positive health impact

73%

Improved trust in WMP

What happens when you truly go to your patients



Housing Support

25 housing-related referrals helping residents access awards and resolve insecure accommodation.



Modern Slavery

CHWWs identified and supported victims of modern slavery invisible to traditional services.



Vulnerable Adults

Proactive safeguarding support reaching isolated and at-risk adults who would never self-present.



Employment

11 residents supported into work through employment referrals —saving £38,375 in benefits.



Food Poverty

110 food voucher referrals issued; 507 welfare check-ins completed across the cohort.



Lifesaving

7 lifesaving interventions delivered directly by CHWWs since the programme began.

IN THEIR OWN WORDS

What residents said about the CHWW programme

"Honestly, I was broken, and you put the pieces back together for me. I didn't even know this help was out there."

— CHWW Programme Resident

"They are both a lifeline for me. I don't know where I'd be without them."

— Resident, supported for over 12 months

"They allowed me to find the answer myself just through listening. They never judge. I just felt safe with them."

— Survey Respondent

90%+ of surveyed residents reported a positive impact on their health & wellbeing • One resident reported they "would have died" without the CHWWs' advice

The programme paid for itself — and then some

TOTAL COST

£623,068

*(including 12-month follow-on
intervention costs)*

TOTAL SAVINGS

£667,817

SAVINGS BREAKDOWN

Employment & economic independence	£38,375
Social isolation interventions	£629,442
Funding secured (initial pilot)	£81,662
Flu & COVID vaccines administered	£18,939
Lifesaving interventions	Priceless

Lessons for primary care and system leaders

01

Trust is the medicine

The CHWWs' proactive, non-judgemental approach unlocked engagement that years of appointment letters couldn't. Relationship-building takes time but transforms outcomes.

02

Clinical supervision matters

Embedding CHWWs within the practice with clinical oversight from GPs and pharmacists gave them the credibility and safety net to work effectively.

03

The 'settling in' period is real

Healthcare utilisation increased most at 9–12 months post-intervention. Commissioners and practices must allow time for the model to embed before judging impact.

04

Primary care as a platform

This model positions primary care as a hub for community health not just a destination for the sick, but an active force for prevention and equity.

Building a sustainable model of proactive primary care



Longer-term evaluation

A 3–5 year follow-up is needed to capture reduced hospitalisation rates and chronic disease complications prevented by early CHWW intervention.



Permanent contracts

CHWWs themselves recommended permanence. Continuity of the same workers in communities is fundamental to the trust-based model.



Shared data infrastructure

A common patient identifier across partners would unlock far more powerful analysis and allow earlier identification of high-risk individuals.



Scale across Norfolk

The evaluation evidence supports expansion to other deprived areas. Findings have been shared with Health Innovation East and N&W ICB.



Primary care research

WMP is building its research portfolio and CHWW data provides rich opportunities for PI and Sub-PI led studies in health inequality and community health.



System advocacy

This model makes the case that investing in community health workers is not a cost, it is a demonstrable saving, with profound human benefit.

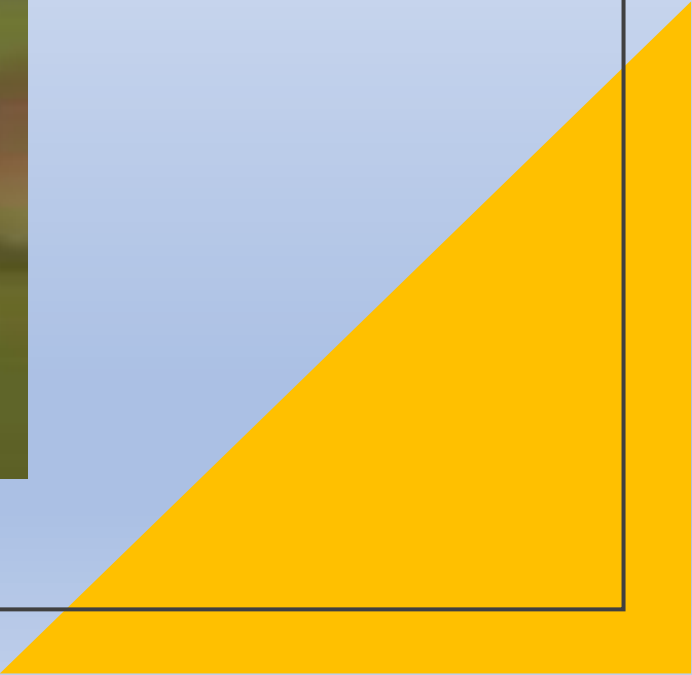
**With just two workers and a bold idea,
we reached 1741 patients
and found far more than illness.**

We found people.

Primary care can be proactive. It can be a force for equity.

It can reach the people who need it most

before they reach crisis.



CHWWs & Point of Care Testing: A Natural Next Step

What CHWWs Already Do

Already trained to carry out and record clinical measurements in the community:

- ✓ **Blood pressure** measurement & recording
- ✓ **Weight & height** (BMI calculation)
- ✓ **Blood glucose** testing
- ✓ **Temperature** monitoring
- ✓ **Urine dipstick** analysis

All results fed directly to clinicians at WMP in real time — the infrastructure is already there.

? Rapid Diagnostic Testing

CHWWs could deploy lateral flow and compact analyser tests — CRP, strep, flu, HbA1c — at the doorstep, feeding results to clinicians for same-visit clinical decisions.



? Reaching the Unreachable

For patients in deprived areas who struggle with transport or multiple appointments, POCT in the home removes a critical barrier to early diagnosis and timely treatment.



Smarter Clinical Decisions

Results reported in real time to WMP allow GPs and pharmacists to act immediately — reducing unnecessary antibiotic prescribing, improving antimicrobial stewardship and enabling targeted referral.

QUESTIONS

THANK YOU



CONVENZIS

Leadership Lessons from the Front Line



Mandy Townsend

Associate Director for Patient Safety
Health Innovation North West Coast

Leadership lessons from the front Line

Community Test and Treat

Mandy Townsend



HEALTH INNOVATION
North West Coast



Acute Respiratory Infection: Late Diagnosis leads to System Pressure

Late Presentation

Patients often seek care late, limiting treatment options and increasing health risks and system strain.

Impact on Urgent Care Services

Overcrowding at urgent treatment centers and emergency departments.

Structural System Pressure

The issue is widespread, structural, and worsens during seasonal surges, pressuring acute services year-round.

Need for Early Intervention

Identifying problems early can reduce demand on acute care and support community-based treatment models. And improve antimicrobial stewardship.



The tools exist – leadership and pathway design are the constraint.

Leadership Over Technology

Effective leadership is crucial to redesign clinical pathways, not just deploying technology.

Existing Diagnostic Tools and NICE approved Drugs

Point-of-care testing tools for respiratory infections are available and clinically validated.

NICE has approved Flu and Covid antivirals (short optimal window)

Prioritizing Prevention

Leaders must prioritize prevention and early intervention as strategic goals, not optional.

Simplifying Pathways

Simplifying clinical pathways and aligning incentives facilitates earlier clinician action.



Designing the new pathway around real constraints

Community Co-Design

Primary care teams co-designed test-and-treat models reflecting real workload and infrastructure constraints to ensure feasibility.

Workflow Integration

Testing and treatment were integrated into existing workflows to support decision-making without adding extra burden on staff.

Neighbourhood Scale Delivery

Service delivery was structured at neighbourhood scale to align with populations primary care teams are responsible for.

Trust and Collaboration

Successful transformation relies on trust and collaboration with frontline staff rather than top-down mandates.



Purposeful Use of Point-of-Care

Targeted Diagnostic Use

Testing is used selectively where results directly guide clinical decisions like treatment or care escalation.

Timely Result Access

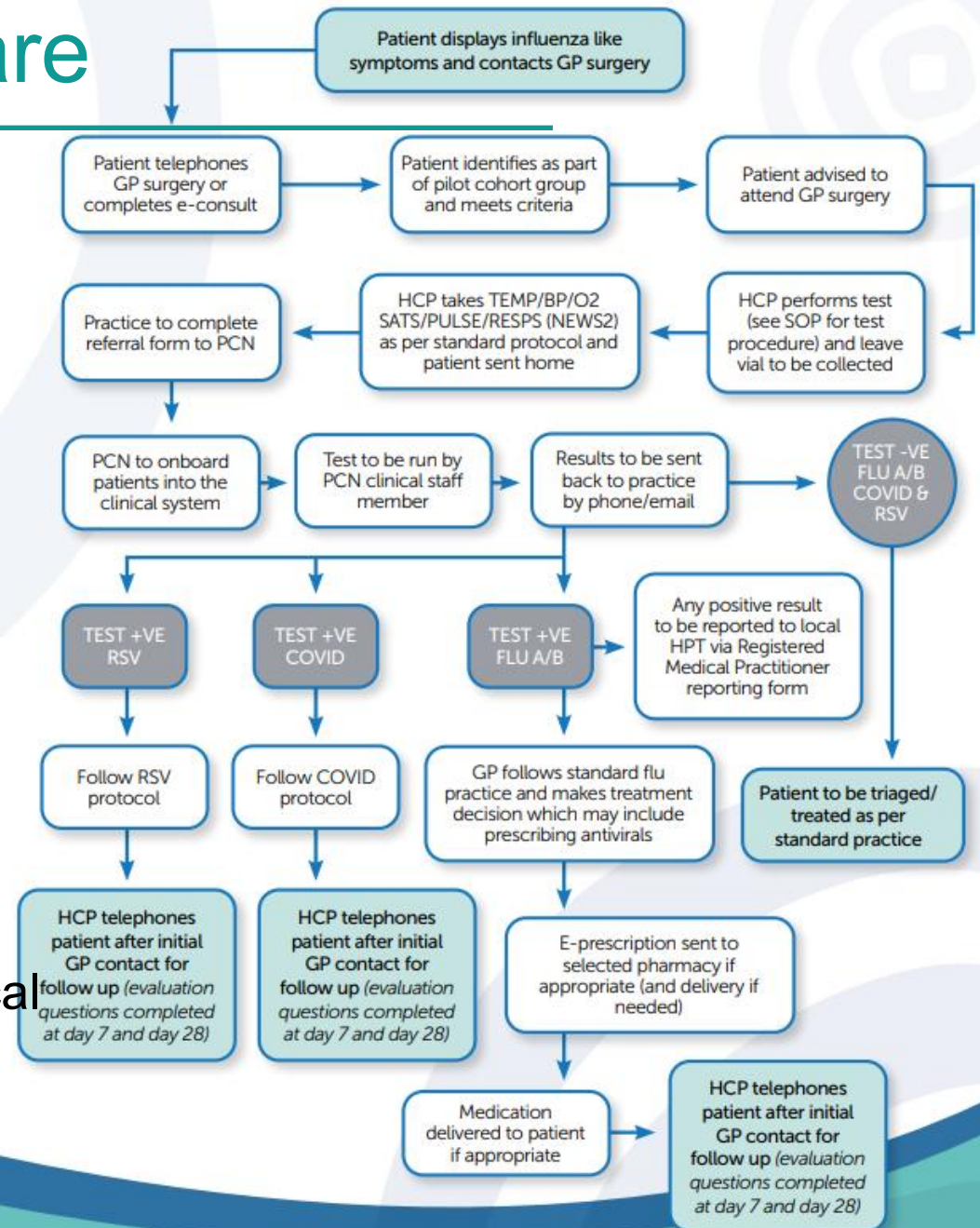
Fast test results enable rapid treatment decisions, reducing uncertainty in patient care.

Simplicity and Clarity

The model ensures testing processes are simple and clear to maximize clinical value without adding complexity.

Enhanced Patient Experience

Linking diagnostics directly to care actions builds clinical confidence and improves patient satisfaction.



Clinical Impact: Early action to prevent harm

Early Infection Identification

Timely detection of infections prevents patient deterioration and reduces the risk of hospital admission.

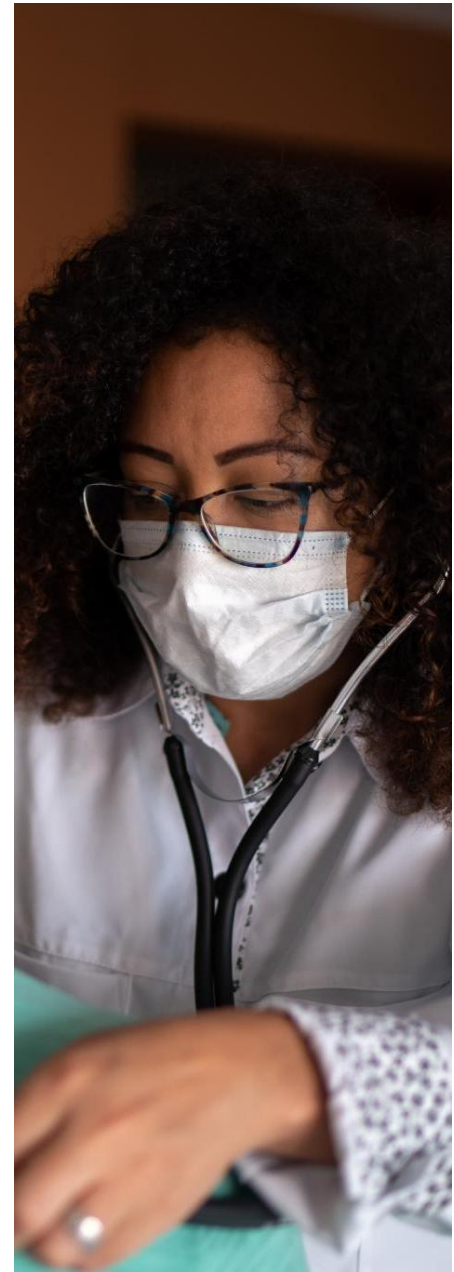
Community Test-and-Treat Pathways

Community-based test-and-treat models improve patient safety by enabling prompt treatment and reducing avoidable harm.

Aligning Clinical Priorities

Supporting earlier clinical decisions enhances professional practice and aligns with core healthcare priorities.

Support Antimicrobial stewardship.



System Impact: what our evidence shows

Reduced Emergency Care Usage

Pathways should lower urgent and emergency care visits by patients, easing pressure.

Economic Savings

Potentially, thousands of pounds saved per patient by avoiding hospital admissions and treatment escalation.

Policy benefits

Delivers all three shifts at once: prevention-first, neighbourhood-led, digitally enabled.

By improving diagnostic certainty earlier, this strengthens antimicrobial stewardship and directly delivers the AMR National Action Plan.

Scale aligns clearly with Fuller Neighbourhood model

Real-World Evidence

Benefits must be demonstrated through actual delivery outcomes rather than theoretical models alone.

Leadership Confidence

Emerging evidence supports future leadership decisions to invest in scaling community test-and-treat pathways to measure systemic gains.



Enabling adoption through decision-ready evidence

Neighbourhoods are the right scale



Neighbourhood as Scale

- Neighbourhoods offer a manageable population size where prevention efforts can be effectively seen and managed by local teams.



Primary Care Relationships

- Primary care teams have strong, trusted relationships with their populations, enabling early intervention and personalized care.

Test-and-Treat Pathways

- Neighbourhoods are optimal for delivering test-and-treat pathways, supporting timely diagnosis and prevention strategies.



Why do we need to build the case?

Prevention Versus Acute Spend

Local Investment Challenges

Investment in diagnostics and primary care occurs locally, creating budget allocation challenges for prevention efforts.

Savings in Secondary Care

Savings from prevention are realized in secondary care, causing misaligned incentives.

Leadership and System Alignment

Deliberate leadership choices and system-level alignment are essential to resolve prevention versus acute care funding tension.



Transferable leadership insights

- Start with whole-system outcomes
- Use neighbourhoods as delivery units
- Protect simplicity through co-design



North West Coast

Contact and questions?

www.healthinnovationnw.co.uk

mandy.townsend@healthinnovationnw.co.uk



The North West story so far...

Winter 2022/ 2023 – Development of a Flu Test and Treat Community Pathway. Testing for flu in the practice setting, providing diagnostic certainty and supporting more appropriate use of antivirals and antibiotics

Winter 2023/2024 – Development of a Test and Treat Community Pathway for Acute Respiratory Infections (ARIs): flu, respiratory syncytial virus (RSV) and coronavirus. PCN hub

Winter 2024/2025 - NW Point of Care Strategic Group, Manchester sites.

Winter 2025/ 2026 - Community ARI testing in UTCs and OOO

Next steps:

- Analyse data
- Cost:benefit analysis
- NW POC Summit
- Real-world evaluation publication

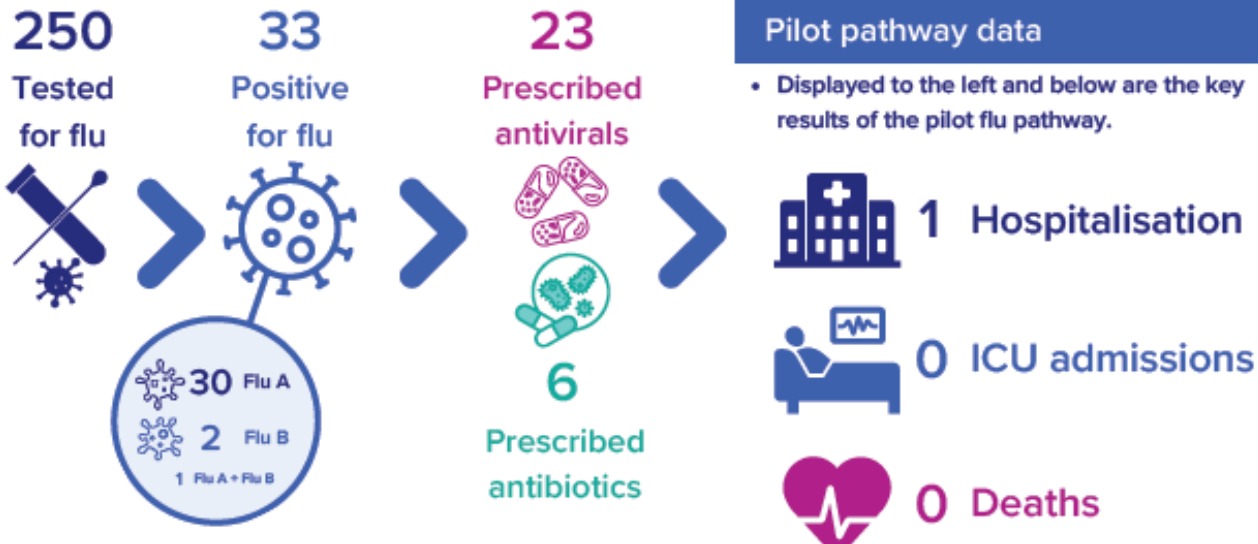
**Total time 18 months (seasonal) Industry Partners so far: Roche, Cepheid, Abbott
Office of the Chief Scientific Officer funding**

Flu Test & Treat Community Pathway

Winter pressures faced by the NHS are often exacerbated by cases of seasonal influenza. A collaborative working agreement between Innovation Agency, Roche Products Ltd. and Roche Diagnostics Ltd. aimed to demonstrate through a pilot whether using rapid diagnostics for Flu A/B alongside digital reporting in the community could improve patient outcomes, reduce the need for hospitalisations and therefore reduce the burden on secondary care, whilst identifying any further system benefits.

What happened?

- 9 GP practices¹ in Yorkshire and the North West took part in a pilot for a new flu patient community pathway using a point of care test
- A target population of around 43,000 clinically at-risk patients were encouraged to visit their GP to take a flu test upon developing flu symptoms
- Based on national averages for flu surveillance,² an estimated 17 hospitalisations, 4 deaths, and 1 ICU admission were avoided due to the pilot



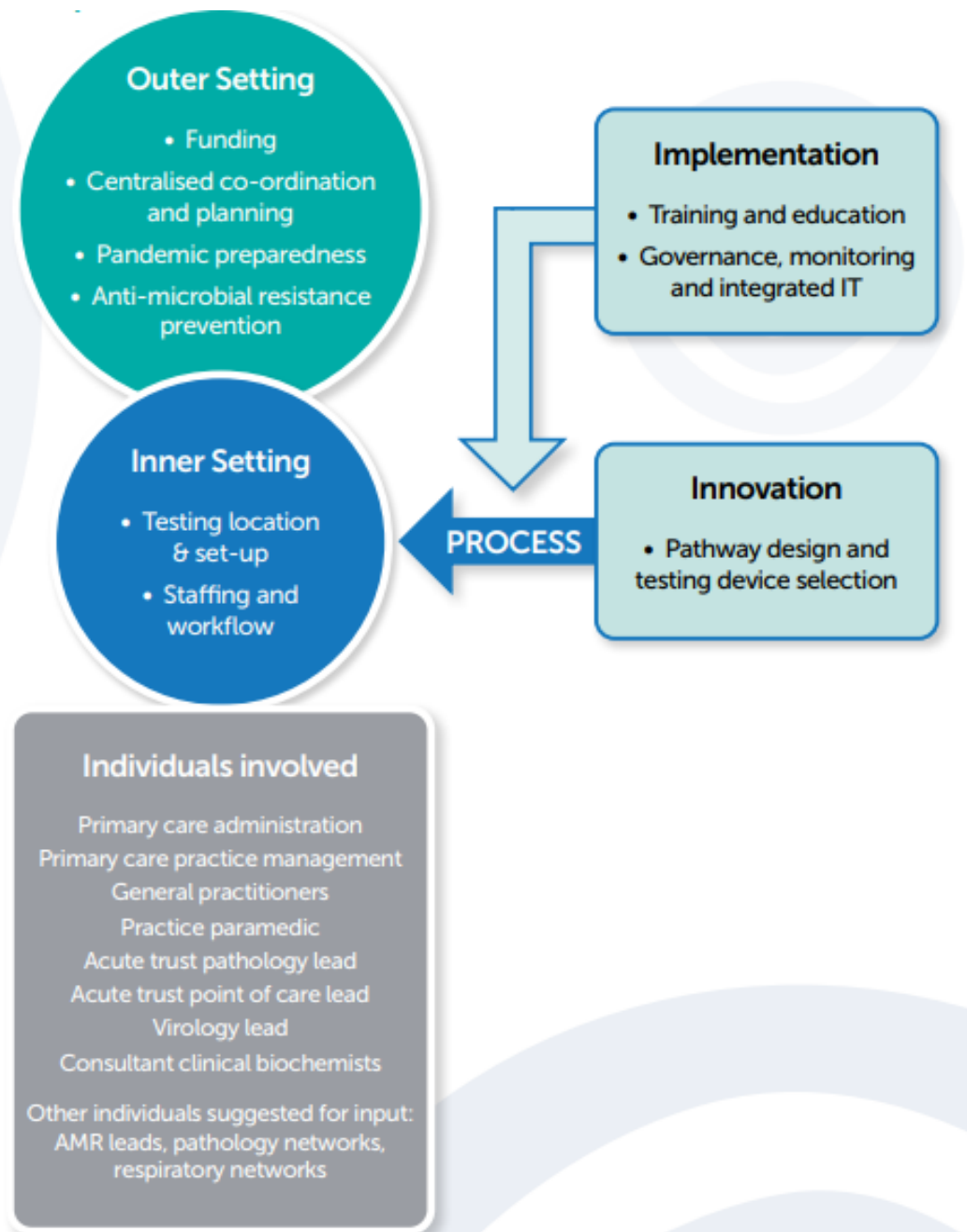
Evidence of impact

Estimated impact



1. Priory Medical Group comprises 8 practices but is counted as 1 by NHS Digital.
2. UK Health Security Agency. (2023, April 6). National flu and COVID-19 surveillance reports: 2022 to 2023 season. GOV.UK. <https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2022-to-2023-season>

Impact Data
from 22-23
pilot



CFIR Thematic Map

- Sustainable implementation is more complex than just providing the tests. All of these factors need to be addressed to enable primary care to do community testing properly.
- **System-wide action** - the key enabler for implementing primary care-based test and treat.
- **Involvement of pathology services** is key in; selecting appropriate tests and devices for primary care budget and workflow, supporting learning and communities of practice, and providing governance.

Key Insights

Overall, the 2023/24 community test and treat evaluation has found that:

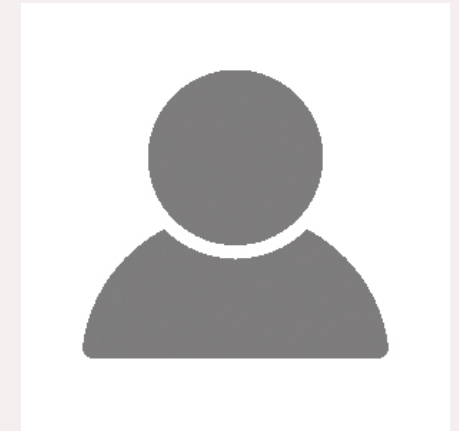
- Both clinicians and patients feel that community testing for acute respiratory infections is the right approach to care and would improve patient outcomes
- Diagnostic certainty would improve antimicrobial stewardship
- System level co-ordination is essential to implement these pathways and address identified barriers such as funding, primary care support and governance



Keynote Presentation



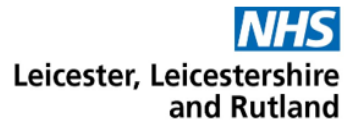
Alison Davis
Clinical Quality & Virtual
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Leicester NHS Trust



Karen Plowman
ACP
Leicester Partnership



VIRTUAL WARDS AT UHL AND LPT JOURNEY SO FAR ALI DAVIS AND KAREN PLOWMAN



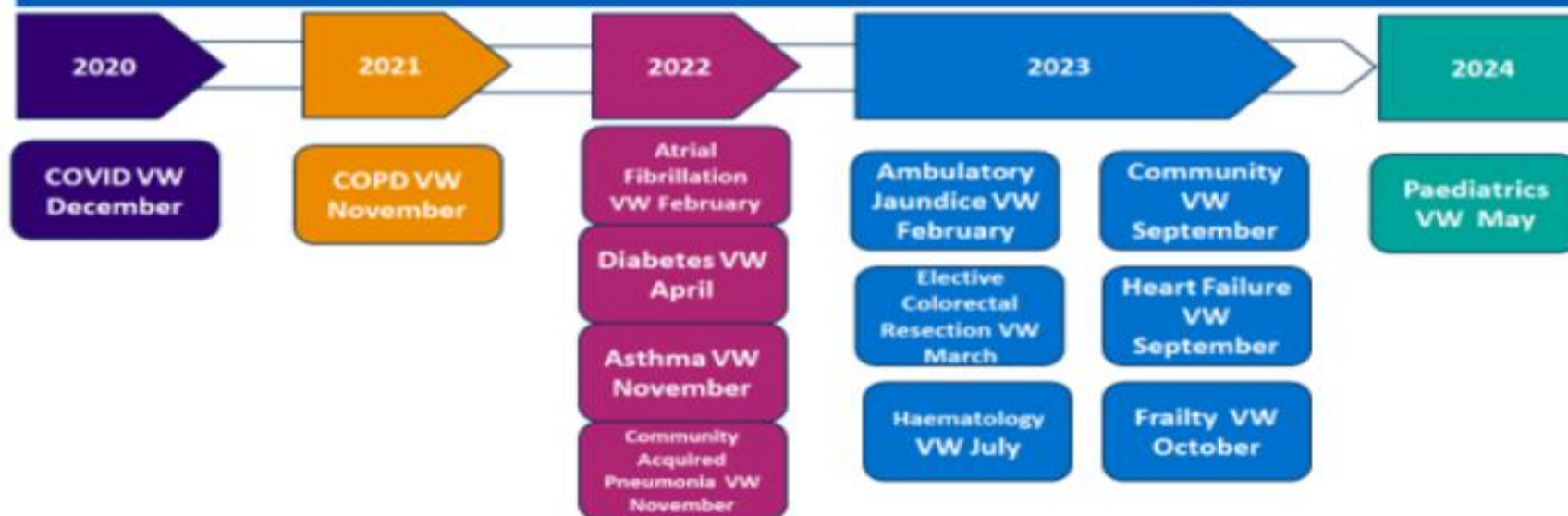
VIRTUAL WARD PROGRAMME – TIMELINE OVERVIEW

Early Programme Phase 2020

Virtual Ward programme established using Spirit Health /CliniTouch/Dignio/Doccla



Virtual Wards; Timeline of VW Mobilisation



OUR AIM OF VIRTUAL WARDS

To reduce length of stay

Reduce deconditioning

Prevent readmission

Reduce number of patients in a hospital bed waiting diagnostics

Aid flow through the hospital- providing early discharge

Reduce corridor care/POA's/ Improve turn around times for EMAS

Improve Emergency Department flow/ Admission avoidance

Keep families together.

Reduce patient distress and anxiety being separated from family.

Reduce financial cost Patient/ NHS Bed

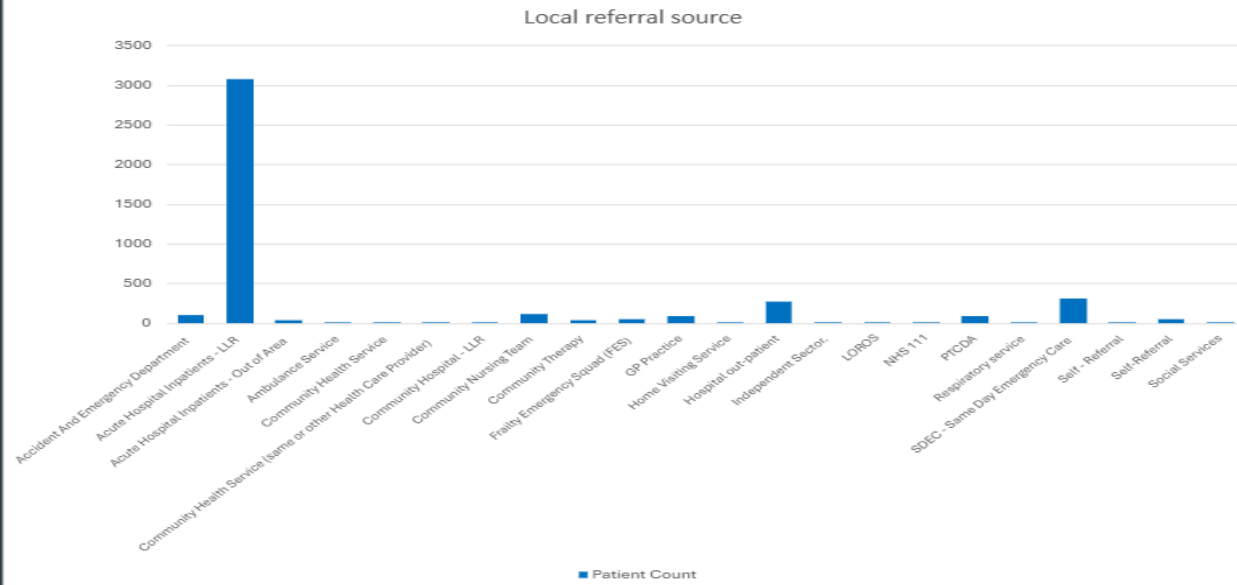
Improve patient experience- one to one care, in their own home with experienced staff to support them, quick response to concerns and further monitoring for patient peace of mind, reducing attendance to emergency department.

Reduce cost, travel expense for family, time from work, child care costs, parking etc.



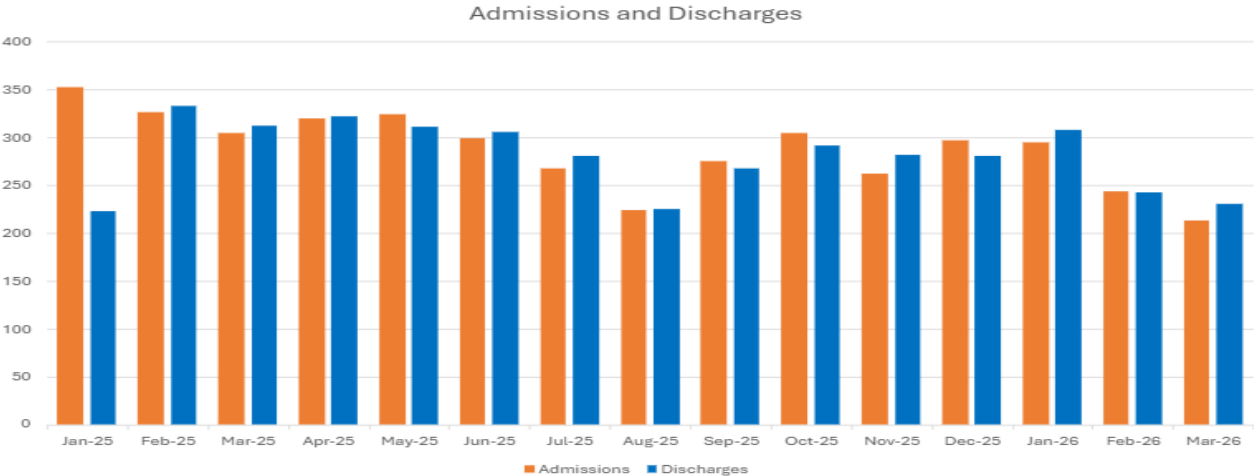
REFERRAL SOURCE

Local Referral Source	Patient Count
Accident And Emergency Department	99
Acute Hospital Inpatients - LLR	3076
Acute Hospital Inpatients - Out of Area	41
Ambulance Service	10
Community Health Service	8
Community Health Service (same or other Health Care Provider)	2
Community Hospital - LLR	15
Community Nursing Team	115
Community Therapy	35
Frailty Emergency Squad (FES)	52
GP Practice	94
Home Visiting Service	16
Hospital out-patient	276
Independent Sector.	2
LOROS	1
NHS 111	1
PTCDA	94
Respiratory service	1
SDEC - Same Day Emergency Care	309
Self - Referral	5
Self-Referral	55
Social Services	3



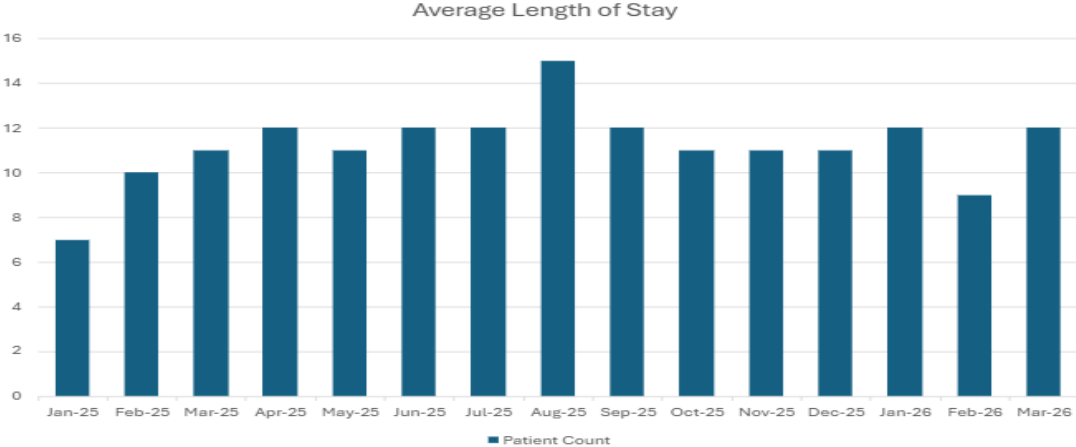
ADMISSION AND DISCHARGE DATA 2025-2026

Month/Year	Admissions	Discharges
Jan-25	353	223
Feb-25	326	333
Mar-25	305	312
Apr-25	320	322
May-25	324	311
Jun-25	299	306
Jul-25	268	281
Aug-25	224	225
Sep-25	275	268
Oct-25	305	292
Nov-25	262	282
Dec-25	297	281
Jan-26	295	308
Feb-26	244	243
Mar-26	213	231
TOTAL:	4310	4218



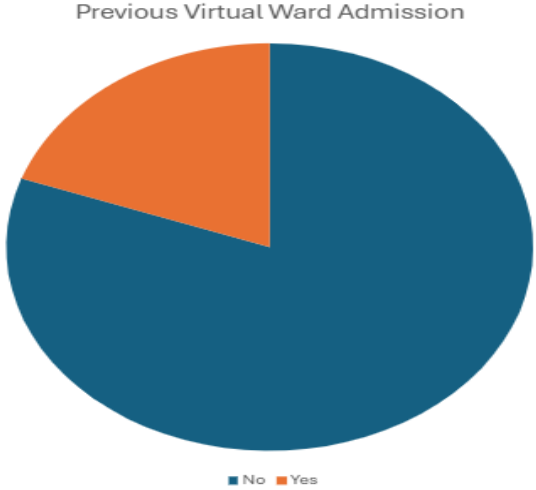
AVERAGE LENGTH OF STAY

Month/Year	Average LoS
Jan-25	7
Feb-25	10
Mar-25	11
Apr-25	12
May-25	11
Jun-25	12
Jul-25	12
Aug-25	15
Sep-25	12
Oct-25	11
Nov-25	11
Dec-25	11
Jan-26	12
Feb-26	9
Mar-26	12



PREVIOUS VIRTUAL WARD ADMISSION

PREVIOUS VIRTUAL WARD ADMISSION	Patient Count
No	3468
Yes	842



PROCUREMENT EXERCISE

Started 2024

Engagement day with 15 platform providers 10th October 2024

163 procurement questions asked to 15 suppliers

April 2025 6 Supplier presentations

Result announced 11th September 2025

Went live with our current provider in November 2025 3-year contract



6 MONTH ICB AUDIT AND DECOMMISSIONING OF WARDS

Asthma 20 beds

COPD 20 beds

Heart failure 15 beds

Colorectal 10 beds

Ambulatory Jaundice 10 beds

Community acquired pneumonia 30 beds = **105 beds decommissioned**

FRAILTY VIRTUAL WARD



Selected ward
Frailty Virtual Ward

-

Admissions

2024/25 YTD

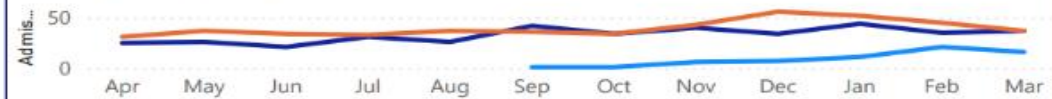
395

2025/26 YTD

475

Ward admissions - year on year

finyear ● 2324 ● 2425 ● 2526



Average length of stay

2024/25 YTD

10.3

2025/26 YTD

7.3

Average LOS - year on year

finyear ● 2324 ● 2425 ● 2526



Proportion of Admissions classified as "step down"

2024/25 YTD

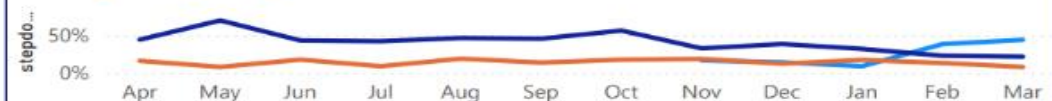
39.7%

2025/26 YTD

14.3%

Step down proportion

finyear ● 2324 ● 2425 ● 2526



POCT JOURNEY

- All virtual wards require timely access to diagnostic tests and their results.
- Access to diagnostics is key to enabling high quality personalised care, with the clinician able to accurately assess, treat and monitor a patient and proactively include them in shared decision-making about their care. This is as relevant to virtual wards as it is to any care setting in which patients are cared for. NHSE (2024)
Access to diagnostics on virtual wards
- October 2022 started conversations
- Acceleration bid 2025
- 22nd April 2025 Deputy medical director presented at POCT Governance meeting
- UEC Midlands Learning Improvement Network (LIN) UEC Midlands Learning Improvement Network (LIN) Accelerator scheme
- March 2026 presented at POCT Governance meeting

FUTURE PLANS

Acute Medical pathway

Reembed ambulatory jaundice and colorectal pathway/Reduce the time people wait for elective care

NSTEMI pathway

Rough sleepers respiratory pathway

Orthopaedic pathway

Integrate frailty pathway into UHL

Work with neighbourhood teams

Improve A&E waiting times

Reduce LOS by 5%

End corridor care and POA's

In order to achieve the above we need POCT/POCCUS/Mobile xray



Lunch & Networking



Chair Afternoon Address



Gurnak Singh Dosanjh

Deputy CCIO | Digital Healthcare Consultant | CSO |
ICB Clinical Lead

NHS Leicester, Leicestershire and Rutland



Keynote Presentation



Elizabeth Mullen
Consultant Clinical Biochemist
Northumbria Healthcare
Foundation Trust



Mrs Caroline Addison
Consultant Clinical Biochemist,
Director of North East Bowel
Cancer Screening Hub, and
Clinical Lead for Point of Care
Testing | Gateshead Health NHS
Foundation Trust

Point of care and its role in out of hospital care

Elizabeth Mullen

Consultant Clinical Biochemist, Clinical Lead for Point of Care, Northumbria NHS FT.
NENC PoC SRG co-chair

Caroline Addison

Consultant Clinical Biochemist, Clinical Lead for Point of Care, Gateshead Health
NHS FT. NENC PoC SRG co-chair

Background

- North East & North Cumbria Pathology Collaborative
 - POCT Speciality Reference Group
 - Support delivery of safe and effective care through use of POCT
 - Individual POCT Trust representation
 - Increasing awareness of POCT in out of hospital settings
 - Majority unsupported
 - Approached for support
 - Cross Trust boundaries
 - Engaging with ICB on how to deliver POCT safely in out of hospital settings

Advantages of POCT in out of hospital settings

- NHS 10 year plan

Equity & access:



POCT supports health inequality reduction by improving access to diagnostics for under-served, rural and vulnerable populations

Faster diagnosis & patient flow:



Rapid, near-patient testing supports earlier diagnosis, improved triage, and safer decision-making in urgent, emergency and community pathways. Improved clinical experience and overall cost benefit

Care closer to home:

Diagnostics in the community to reduce hospital attendance and support same-day decisions. POCT underpins new service models within the community



Workforce transformation:

Enables new multidisciplinary ways of working, enabling diagnostic and treatment decisions within a broader range of settings



Risks

COST
BENEFITS
NOT
REALISED

NOT COMPARABLE
TO LABORATORY
RESULTS

POOR
QUALITY OF
RESULTS

LACK OF
AUDIT
TRAIL

RESULTS
NOT
RECORDED
IN EPR

PATIENT
SAFETY

TESTING
CARRIED
OUT BY
UNTRAINED
STAFF

LACK OF
STANDARDISATION
OR CLEAR
PATHWAY

INCIDENTS/
SERIOUS
INCIDENTS

INEFFECTIVE

DUPLICATION
OF TESTS

Clinical issues

- **Varying quality of POCT tests:**

- Accuracy of result produced
- Reproducibility of result produced



- **User knowledge of device limitations or interferences:**

- When is laboratory confirmation required
- What can cause an inaccurate result – e.g. alcohol wipes, uncapping, poor mixing





POCT method may not be comparable to the laboratory method:

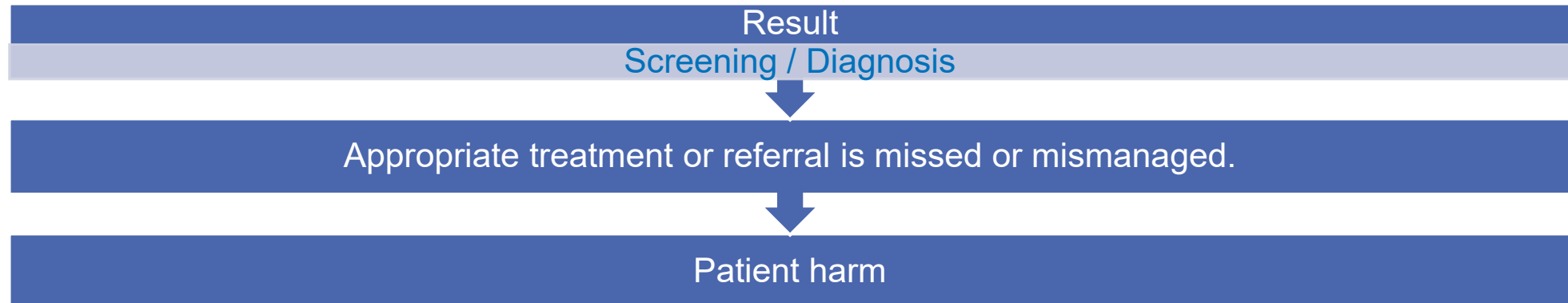
- e.g. Troponin, D-dimer
- Variability in ranges and units. Pathway values determined by assay.
- CANNOT be used interchangeably
- Extreme caution in pathway implementation



Clinical issues

- **Lack of available quality control:** 
- Ability to ensure initial and ongoing accuracy of results

- **Suitability for clinical scenario:** 
- Ball park figure or accurate numerical concentration



Practical issues

POCT is expensive:



- Average **~3-5x more (range 2-10x)** than equivalent central laboratory methods

Ongoing costs:

- Must be accounted for, as well as initial outlay



POCT may not be most appropriate:

- What is the workflow?
- Where would the benefit be realised?
- Same day triage or treatment?
- What can the lab not offer and why?



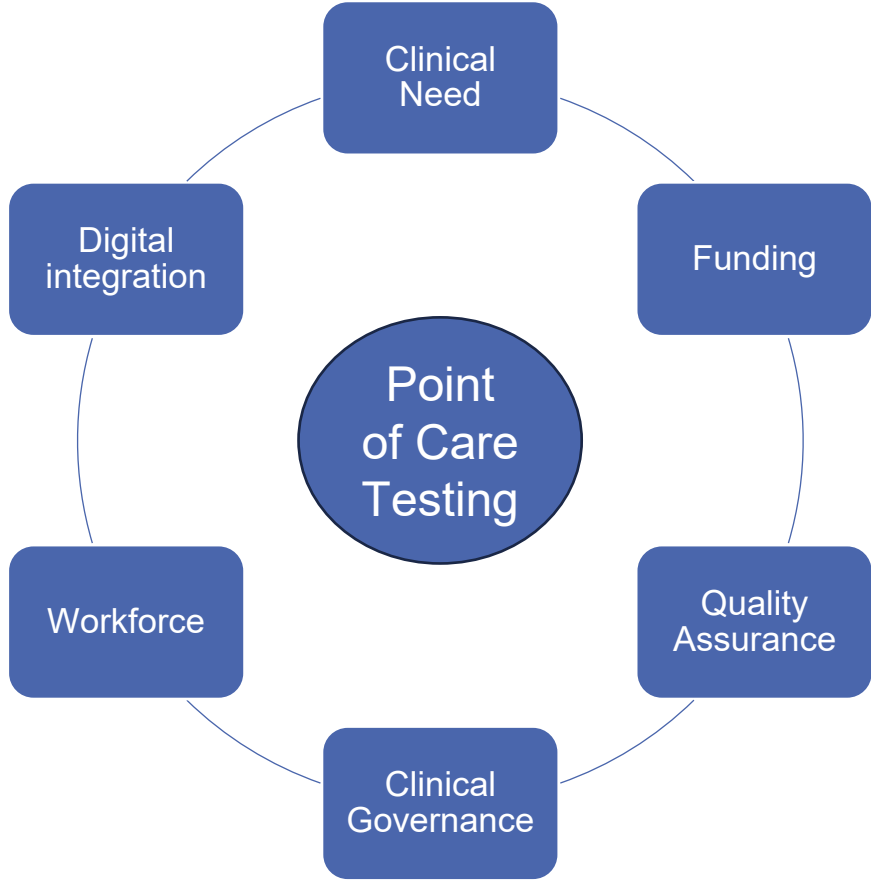
Business case approval:

- Cost-benefit analysis needs to stand up - Need to be able to tangibly evidence this against upfront cost
 - Different Budget lines
 - Theoretical assumptions



High quality, safe POCT in the out of hospital settings

Clinically owned, Laboratory-led, Workforce-competent, Properly commissioned, Safely regulated



Requirements - Unmet Need

- Clinical Need
 - How does POCT meet the need?
 - Clearly defined and documented
 - Agreed with key stakeholders
 - Engage with Local/regional Pathology POCT team
 - Can the laboratory offer an appropriate service?
 - If not, why not?

Requirements - Finance

- Costs & funding must be identified
 - Must be financially viable, with agreed funding and cost–benefit analysis
 - Implementation costs
 - Verification, evaluation, consumables, IT connectivity, capital costs, reagent storage
 - Ongoing revenue costs
 - Quality assurance, IT connectivity, maintenance, device costs, consumables
 - Both **INCLUDE** workforce costs – POCT team for oversight and clinical users

Clinical Governance

Quality Control/Assurance

- device performance is monitored and optimised

Accountability

- defined and formally agreed

Efficiently managed

- risks are effectively addressed
- high standard of service is delivered

Competence

- used by trained operators
- SOPs, training documentation

Requirements - Quality

- Initial verification
 - Does the device meet manufacturers claims?
 - Accuracy, precision, comparison to the laboratory
 - Laboratory involvement & oversight
- Ongoing performance monitoring
 - IQC and EQA
- Training & competency assessment/reassessment
- Documentation
- Troubleshooting

Requirements - Digital

- IT connectivity essential
 - Result reporting
 - POCT devices should be digitally connected to LIMS/EPR
 - Becoming integral to patient pathways
 - Auditability
 - Operational & user oversight
 - Ensure only trained users can access device
 - Performance management
 - IQC lockout

Case studies / examples

U&E and CRP in hospital at home

- In patient homes. Step down and step up. Reduce acute admission/readmission
- U&E - Diuretic titration, AKI, Highly precise and accurate - comparable to lab
- CRP - Screening tool for infection, specific numeric value less important
- Quality of tests required different.

Verified against patient population	✓
Training to users provided	✓
Pilot conducted successfully	✓
Scoping for digital integration completed	✓
Expansion to other virtual wards possible	✓

- **In one week's trial.....**
- 6 patients positively impacted at home = 6 patients fewer returning to ED and acute care.
- U&E - Enabled 3 patients to remain at home
- CRP – 3 patients commenced on antibiotics in their home

The catch....

- Business case failed....
- Could not implement

- One year's funding found!
- Can implement, however need to understand how 1 year of funding fits into a 5 year contract

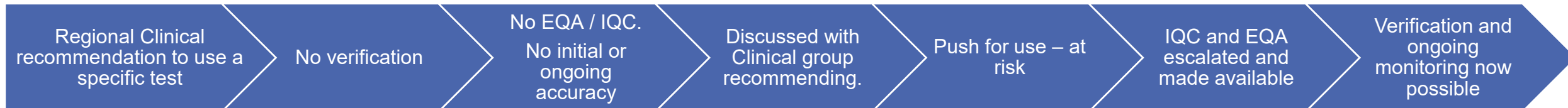
- Fully agreed finance now requested up front
- Preliminary costings provided
- Loan device provided IF expansion of existing device scope in appropriate population

Premature rupture of membranes

Financial decision – POCT not engaged



Clinician-led decision – POCT not engaged



- Accuracy and reproducibility not determined before use
- Ongoing accuracy not monitored
- Possible incorrect patient discharge/intervention associated with risk to mother and baby

Unverified tests already live in the community

Clinician-led decision – POCT not engaged – Lipids, HbA1c, Urine Albumin



- Screening, not diagnosis.
- False negative – may miss required care
- False positive – increased burden on NHS and patient anxiety
- Each individual result used independently in agreed clinical protocol, therefore each requires individual verification

Non-acute Trusts

- Unknown scope of devices, verification and governance
- Anecdotal evidence
 - Full blood count
 - Lithium
 - CRP
- Mental Health Trusts
- Ambulance service

What else is out there...?

- New issues raised every couple of weeks
- Size and scale as yet unknown
- To safely deploy and manage within the out of hospital setting we need to.....

How to address this?

Engagement at an early stage, ideally whilst its still just in idea!

- ✓ Establish governance framework for community and out of hospital for POCT
- ✓ Local or regional Pathology POCT approval
- ✓ Clear documentation & recording keeping in place
- ✓ Quality assurance (verification, IQC, EQA)
- ✓ Electronic capture of results
- ✓ Audit & incident reporting

POCT in North East & North Cumbria

- Expansion from acute care to
 - emergency, community, mental health, dentistry, and screening pathways
- NENC Pathology collaborative
 - Acute trusts all have a POCT team - limited resource
 - Differences in staffing, skills, and digital maturity
 - No resource or structure provided for out of hospital POCT

NENC strategic approach

- Raised with NENC ICS Diagnostic Programme Director
 - Guideline in development for introduction, use and governance of out of hospital POCT
 - Identified gaps and opportunities for growth
 - Baselining against comparable network
 - Strategy for reduced workload duplication commenced
 - Harmonisation of job descriptions and personal specifications across network

Summary

- POCT ability to improve access to healthcare
- But it needs to be done safely
- Scope of POCT in out of hospital settings unknown

Engagement with POCT teams, identification of appropriate funding & resource is fundamental to establishing a POCT framework to ensure a safe service



Keynote Presentation



Ryan Cooper

Point of Care Testing Program Lead
NHS National Services Scotland

NHS Scotland POCT approach: Innovation into a new era

Ryan Cooper BSc MSc FIBMS CSci
POCT Program Lead

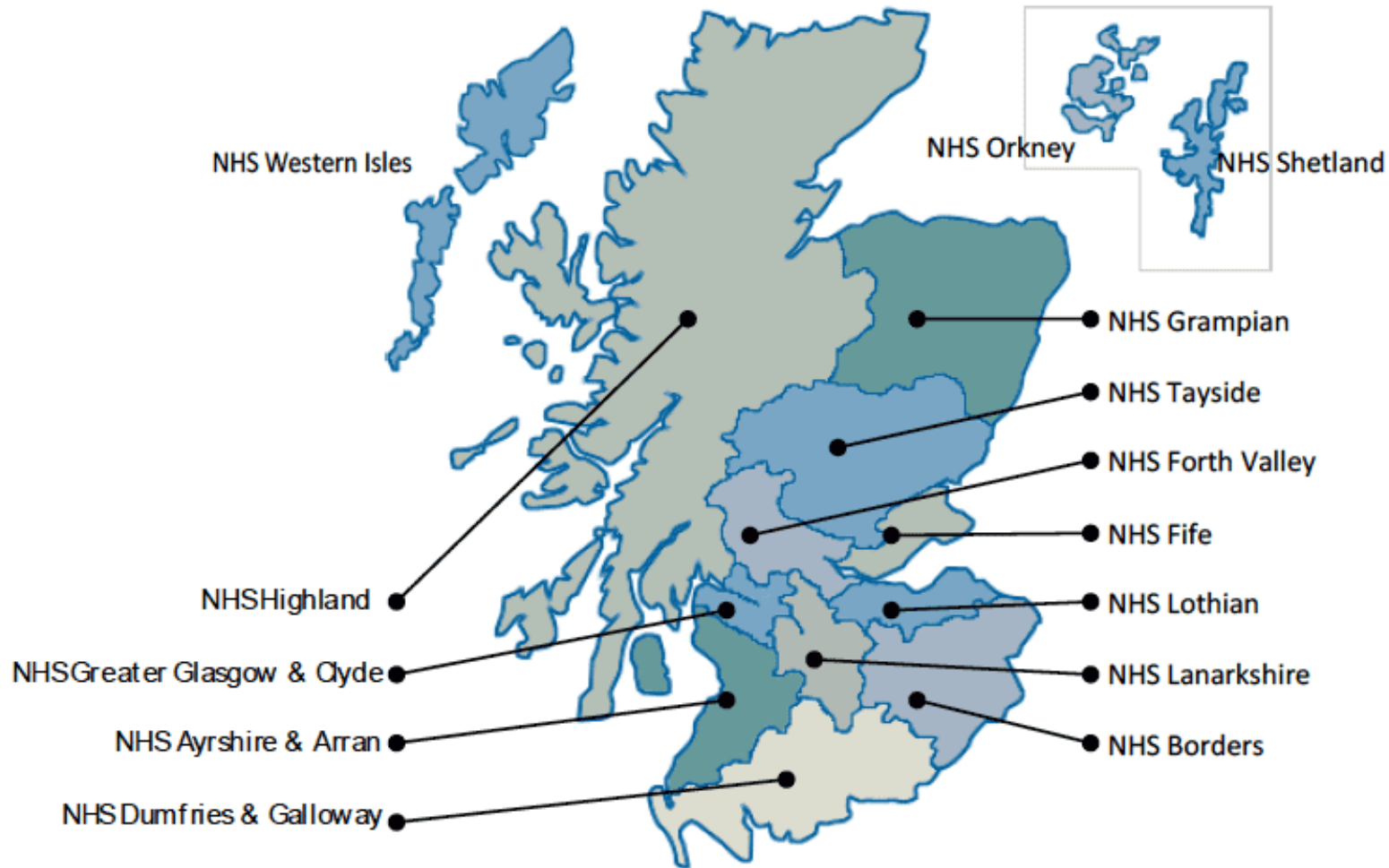


Aims

- NHS Scotland POCT Background
- POCT Lessons learned
- New era of Innovation
- Current Preventive Innovations
- National POCT resources
- POCT program objectives/next steps



NHS Scotland POCT background



14 NHS Territorial health boards

7 other health boards, incl.

- Public Services Delivery Scotland
- NHS National Waiting Times Centre (incl. CfSD/ANIA)

NHS Scotland POCT background



- 3 Innovation hubs
- Current proposal for sub-national planning with 2 hubs, East and West.



NHS Scotland POCT background

- Historically, each health board would have the decision on POCT services, without scalable implementation/intention.
- POCT services historically reside within the Medical Laboratory management, Quality management, Connectivity and Financial control.
- Local health board procurement of POCT services, creating their own DPIA, SSP and Tender documentation.
- Creating health inequality through disjointed POCT service implementation and governance.



Lessons Learned

- Covid-19 Pandemic highlighted the weaknesses of the NHS Scotland POCT landscape and the ability to increase testing capacity.
- IT connectivity hindered new POCT implementations.
- POCT resources varied across the country, no national POCT policy.
- Lack of local governance processes, no expert led escalation routes.
- The need to repeat all steps in each health board, validation, DPIA etc.

New Era of Innovation



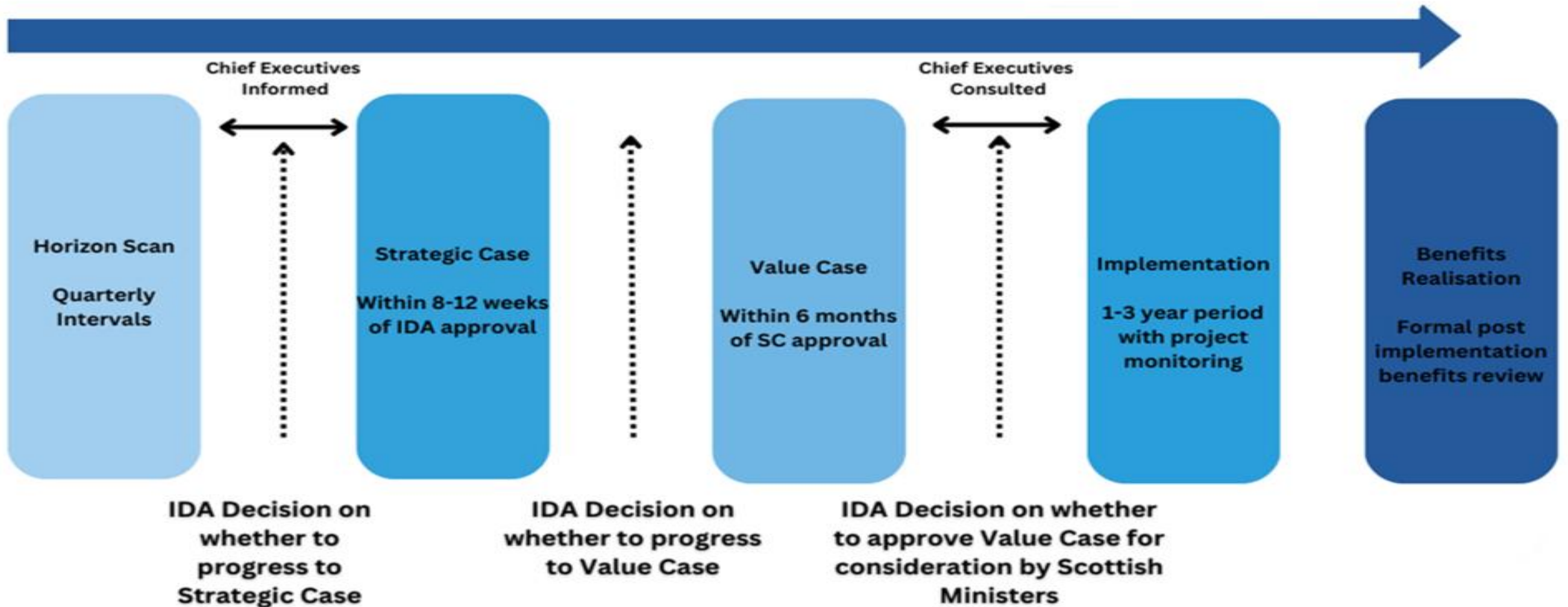
GOVERNANCE
Innovation Design Authority (IDA) brings together SG & NHS leadership



Proven innovations that can transform how we deliver health care



New Era of Innovation – ANIA Stages



New Era of Innovation - ANIA

1

CSO funded

ANIA is funded through the Chief Scientific Office in partnership with Scottish Government.

2

New Health Tech

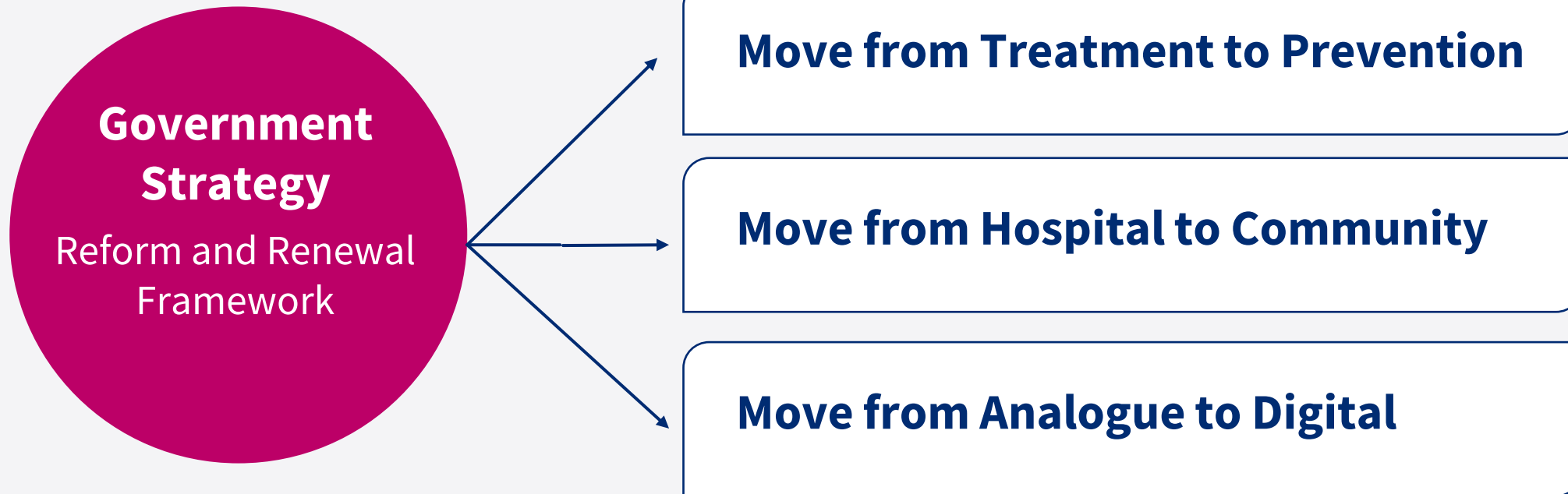
Identify and assess new health technologies with both the required impact and evidence base for accelerated adoption across NHS Scotland.

3

Implementation

Implement the national rollout of technology and associated changes to clinical pathways across NHS Scotland.

New Era of Innovation





Current Preventive Innovations

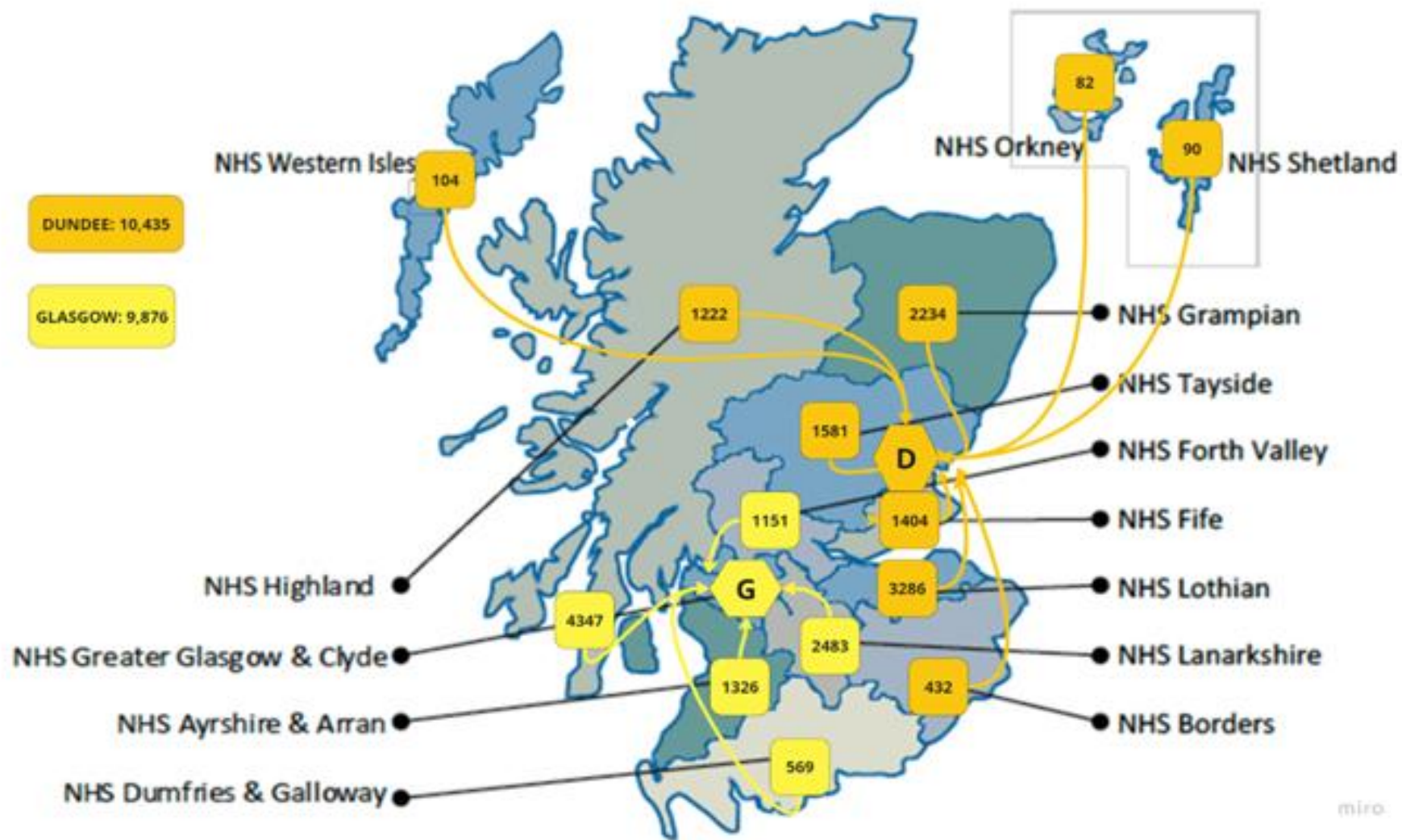
- Pharmacogenetics: April 2023 – NICE recommends genetic test to establish if newborn baby is vulnerable to hearing loss, if treated with aminoglycoside antibiotics.
- Stroke is one of Scotland's biggest killers and leading causes of disability.
- Clinical guidance recommends prescribing Stroke patients with Clopidogrel.
- Approx. 1/3 of the population has reduced effectiveness of Clopidogrel due to presence of CYP2C19 gene variant.
- NICE recommends CYP2C19 genotype testing to inform prescribing.



Current Preventive Innovations

- 2024 ANIA begins a dual value case for scalable Pharmacogenetics testing across Scotland, including a test of change for CYP2C19 POCT.
- Genetic variants MT-RNR1 and CYP2C19 were included in the same value case.
- MT-RNR1 POCT involving Neonatal intensive care units and CYP2C19 laboratory testing involving the Stroke pathway.
- Scottish Government approves the value case in January 2025, moving straight to implementation.

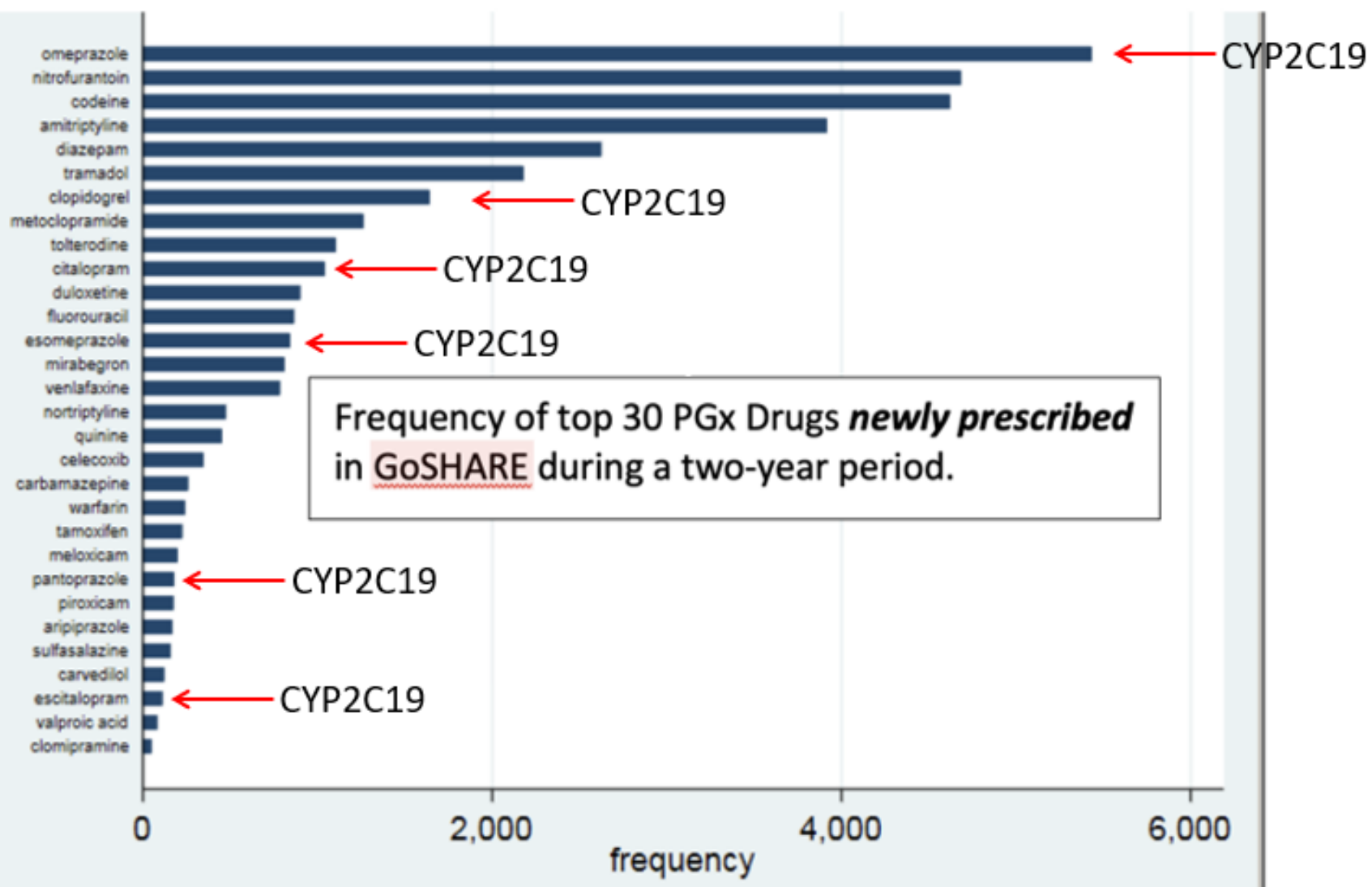
Current Preventive Innovations



Predicted number of tests to be testing by both Genomics Laboratories.

Turnaround time is a factor, which the test of change CYP2C19 POCT project will inform future process (Elgin and Western Isles)

Current Preventive Innovations



Top 30 actionable Medicines with CYP2C19 involved.



Current Preventive Innovations

- Pharmacogenomics is the study of how genes affect a person's response to drugs.
- 99% of individuals carry at least one genetic variant, which affects response to drugs.
- Adverse drug reactions (ADR's)
 - Impact on patient quality of life
 - Account for 6.5% of all acute hospital admissions
 - Cost NHS around £2.2 billion annually
- Population living longer but increasing polypharmacy
 - 3.8 million patients in England take 8 or more medications.

Current Preventive Innovations

- MT-RNR1 POCT – criticality of the test differs from CYP2C19, as antibiotic prescribing in Neonatal ICU required within ~60 mins.
- Laboratory testing would not be appropriate for the application of this test.
- It was originally estimated that ~80% of neonates (<28days) in NICU would require antibiotics, NICE recommends aminoglycosides – Gent.
- During the current 4 phase 18-month implementation, the number of neonates tested has increased due to inaccuracies with the data used at Value Case.
- In practice, neonates in NICU,SCBU and Post Natal wards are under the same clinical management.

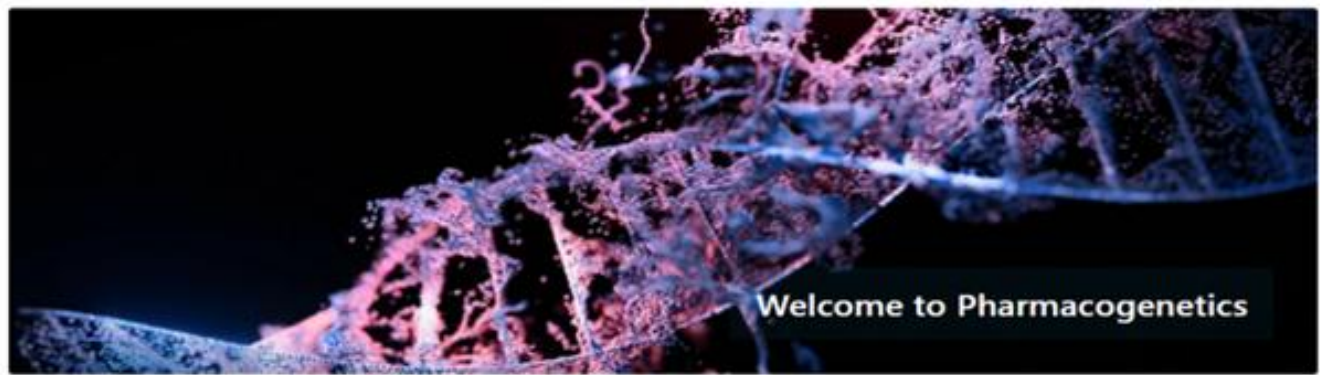


National POCT resources

- POCT resources in Scotland were captured during the value case landscaping exercise.
- Funding for two national POCT coordinators to help supplement the lack of POCT resources across all health boards.
- National Quality Management System via SharePoint.
- National Data Protection Impact Assessment
- Shared clinical pathway, including how the result is managed across multiple systems, not just chronological EPR entry.



Pharmacogenetics | Accelerated National Innovation Adoption



Programme Overview



Stroke Clopidogrel (CYP2C19) Genotype Testing



Neonatal Gentamicin (m.1555A>G) Point of Care Testing





Quality Management System (QMS)

Meet the National Point of Care Testing Team



Ryan Cooper
Programme Lead (Point of Care Testing)



Chloe Cumie
Point of Care Testing Coordinator

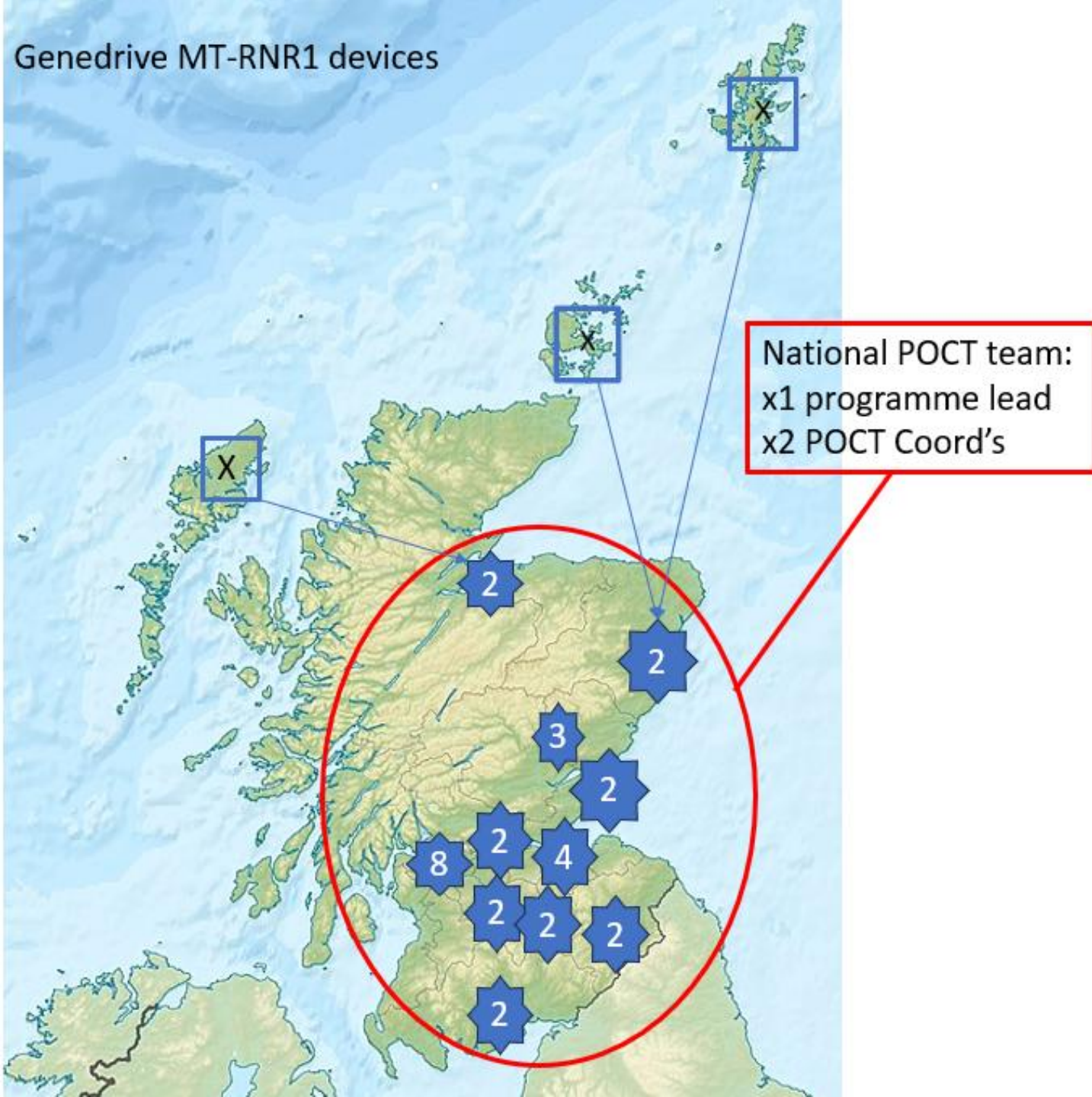


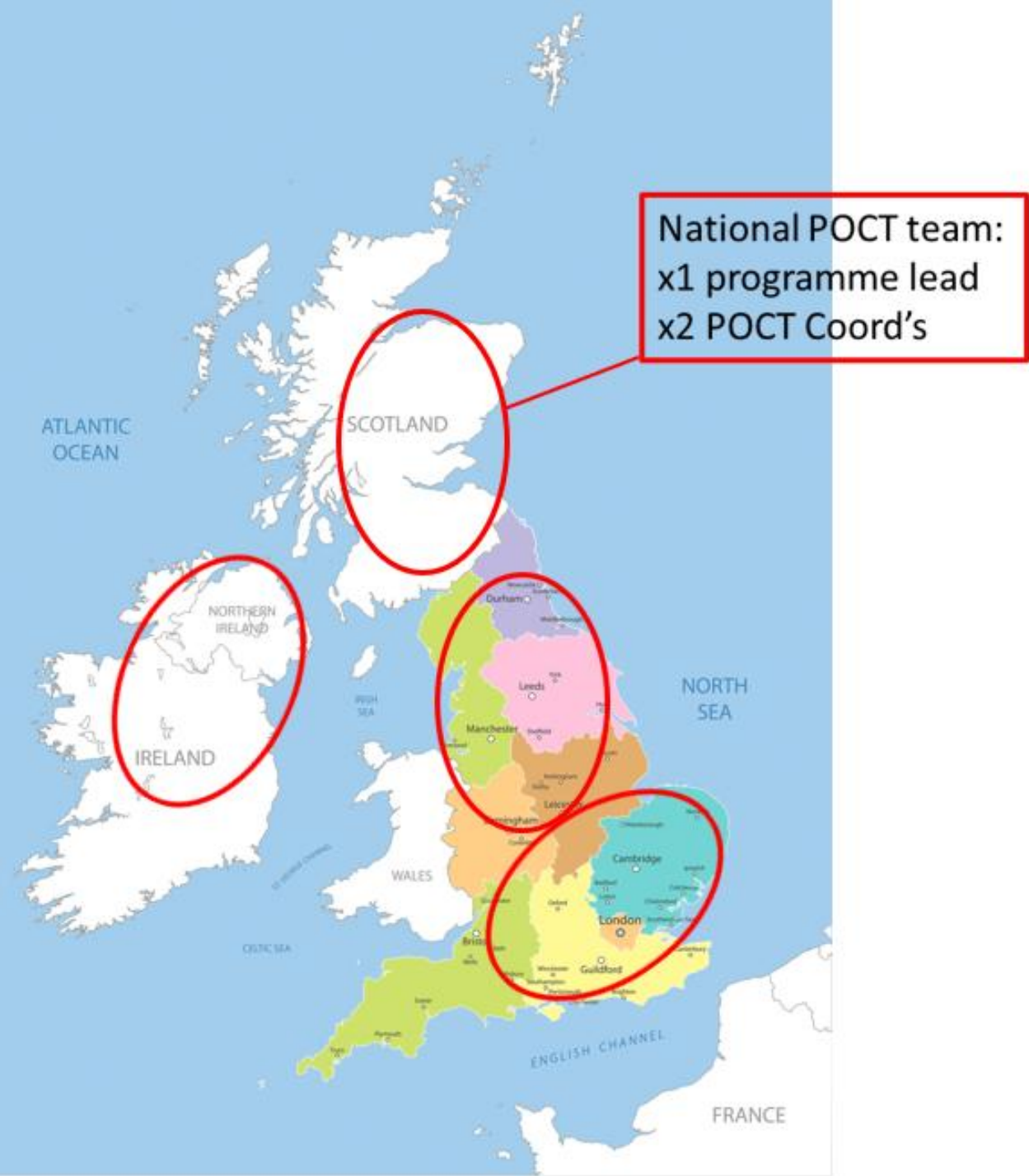
Steph Hay
Point of Care Testing Coordinator

MT-RNR1 POCT QMS

Name	Version No.	Status	Review date	Author	Modified
MT-RNR1 Change Control process					3 days ago
MT-RNR1 Document Control					December
MT-RNR1 External Quality Assurance (EQA) process					December
MT-RNR1 Non-conformance process					December
MT-RNR1 Quality Control (QC) process					December
MT-RNR1 Testing process					December
MT-RNR1 Troubleshooting process					December
MT-RNR1 Verification process					December

Genedrive MT-RNR1 devices



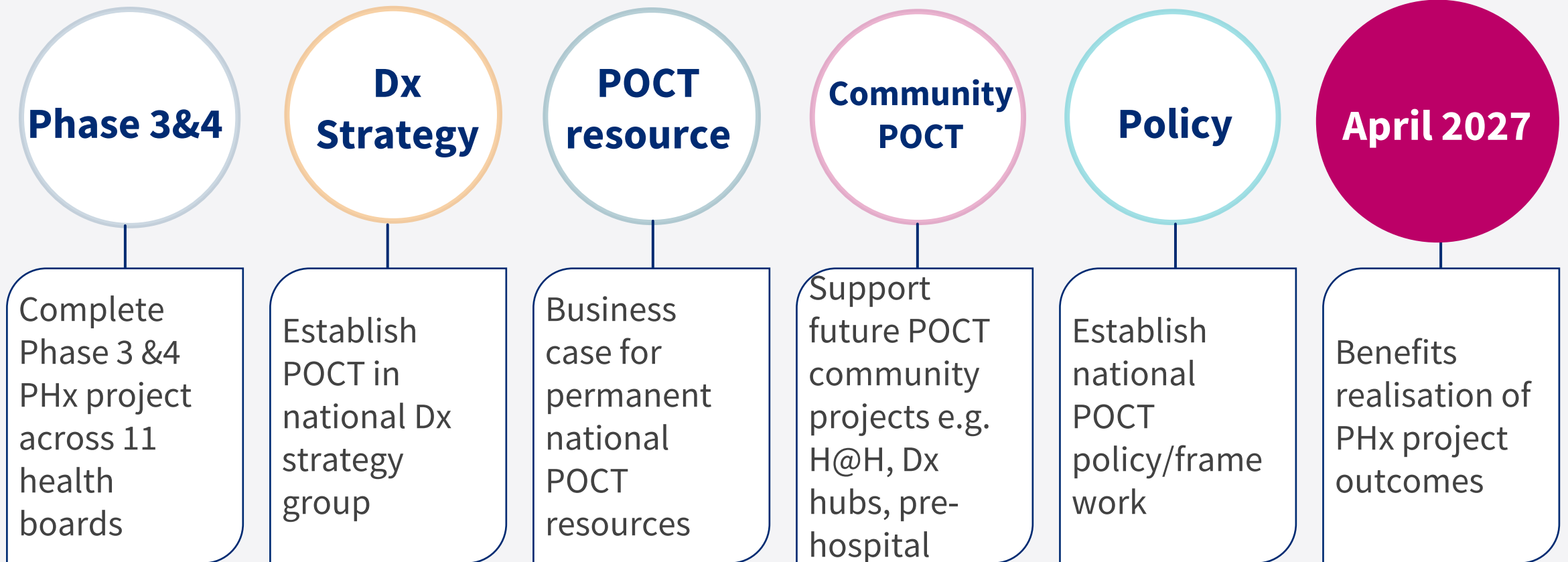




Summary

- Innovating on a national level is a game changer, reducing health inequalities.
- Reduces burden on local resources, increasing information sharing and best practice.
- Standardised procurement with costs based on national volume.
- Permanent national POCT resource is essential to continue the new era of innovation.
- National systems can be designed to prevent system silos.
- Innovations can be selected with equity across patient needs, not with local variation or bias.

POCT program objectives/next steps





Acknowledgements

- ANIA project team for the slides and support
- Genedrive for their continued support
- Public Services Delivery Scotland for support with POCT program
- NHS Tayside Genomics clinic lead – David Baty
- Tayside SHARE research network for data
- Convenzis for the opportunity to share NHS Scotland practice

Contact: ryan.cooper2@nhs.scot



This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 275 6000** or email **altformats@nhs.scot** to discuss how we can best meet your requirements.

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