The Royal College of Radiologists

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NHS England: Proposed procurement of phase 2 PET-CT services

Response from the Royal College of Radiologists (RCR)

1. Do you agree with the proposal to request a single unit price for all PET-CT scans in a lot area, regardless of tracer, service location or patient condition

No.

A single price would be unfair, would not reflect market reality and would adversely effect patient outcomes through the unaffordability of non FDG radiopharmaceuticals.

The cost of radiopharmaceuticals varies widely e.g. F-Choline costs £800 more per dose than FDG. Other radiopharmaceuticals may be developed during the course of this contract that may be more expensive than conventional FDG.

It would be fairer to set a tariff for the cost of a PET-CT scan excluding the radiopharmaceutical cost which could be added to the scan cost at the purchased market rate. The cost of PET-CT imaging should, as with all other unbundled imaging modalities, be determined through the reference cost, HRG and tariff structure.

This requires mandated reference cost returns from all providers, not just NHS Trusts. There should be regular revisions to HRG4+ to ensure it is relevant. This would enable cost differentials dependent on age, radiopharmaceutical and scanning complexity (e.g. with iv and oral contrast, additional bed positions) to be applied, ensuring a robust and properly funded service for the future.

2. Do you agree with the proposed lot structure?

No.

Phase 2 PET-CT procurement covers a population currently served by several well established services which should be able to bid independently provided they are compliant with the service specification.

The Phase 2 PET-CT procurement differs from Phase 1 in that it comprises many established services. The tendering specifications should therefore also differ.

There may be no need for centralised image reporting as the sites involved already have robust reporting systems. If however they are not able to comply with turnaround times expected in the tender, then they should show how they will address this problem, transferring images to a central hub as required.

Reporting by local radiologists is favoured because of -

- **access to full imaging history and images and retrospective image analysis capability**

- **access to histopathology and blood results**
- **access to MDT outcomes, clinical letters, discharge summaries**
- **PET-CT reporter participation in local MDT meetings with instant feedback from other team members, interval outcome feedback and close clinico-radiological liaison**
- **workflow efficient electronic feedback to original reporters of CT, MRI radiographs as recommended by the RCR in "Quality Assurance in Radiology Reporting : Peer Feedback" - https://www.rcr.ac.uk/quality-assurance-radiology-reporting-peer-feedback**
- **ease of issuing supplementary reports onto local PACS with treatment benefits for patients and accuracy improvement in subsequent imaging reporting**
- **local radiologists have optimal insight of and participation in patient care pathways, including interventional oncology, surgical and radiotherapy planning**
- **improved PET-CT training access for radiology registrars who also attend local MDT meetings**

The population covered by this procurement currently has 15 well established PET-CT scanning units in hospitals. The number of PET-CT scans done in this population is currently 41,000. This is expected to rise to 84,700 within five years and 163,900 within 10 years.

A nine lot structure would therefore be far too few in number and would address neither current, much less future patient requirements. The RCR favours a Phase 2 PET-CT procurement that reflects patient care pathways, including bids from individual NHS hospitals.

While Phase 1 PET-CT procurement by NHS England last year largely sought to increase capacity and access to static site PET-CT, **the current Phase 2 PET-CT procurement covers populations where the existing PET-CT scanning units are already well established and integrated more fully in local NHS Trusts, most of whom are involved in the training of radiology registrars.**

Hence the outcome of this procurement should ensure delivery of more training and research than has occurred in Phase 1.

The RCR has had feedback of difficulties and delays in radiology registrars having access to PET-CT images with last year's Phase 1 PET-CT procurement. This is unacceptable and must not occur in Phase 2 PET-CT procurement.

3. Do you agree with the proposal to restrict the maximum number of lots awarded to any individual provider? (Current thinking being no more than 3 out of the 6 lots outside of London and 1 out of 3 in London.)

Monopoly provision of PET-CT scanning provision and/or radiopharmaceutical provision is unlikely to be in the best interests of patients or taxpayers. A single provider across a geographical area may produce a local monopoly of service provision. This could have a detrimental effect on the service provided to patients from existing PET-CT scanning units and could adversely affect patient outcomes by inhibiting development of other sites. The

geographical areas of nine or other fixed number of lots are unlikely to correspond to current or future patient care pathways. Lots make it much less likely a local NHS hospital would secure a contract to provide a PET-CT service for its patients with risks and losses as set out in the bullet point sections of answer to question 2.

The RCR favours a Phase 2 PET-CT Tender that is open to all possibilities including bids from individual NHS hospitals.

4. What characteristics do you consider important for patients when accessing PET-CT services, e.g. quality of the service, quality of the outcome, travel distance, accessibility by public transport, car parking, hours/times the service is available?

Quality of outcome and quality of service are self-evidently important because these scans are so expensive and their results often determine costly treatment decisions, some with patient side effects.

Public transport access and car parking nearby are particularly important for patients having PET-CT scans as the proportion of them being very unwell is much higher than those referred for other imaging modalities.

5. Do you agree with the proposed minimum criteria an ITT (Invitation to Tender) submission must satisfy prior to being considered further?

   Please provide comments to support your answer.
   The proposed minimum criteria are:
   - confirmation with compliance to service specification https://www.england.nhs.uk/wp-content/uploads/2013/06/b02-positron-emis-tom.pdf
   - the submitted scan price being equal to or less than the maximum scan price

The RCR considers that scan prices should be realistic and reflect actual costs.... see detail in answer to Question 1.

The intercollegiate RCR-Royal College of Physicians of London (RCPL) “Evidenced-based indications for the use of PET-CT in the UK 2013” has undergone extensive revision in the past six months. The new edition is expected to be approved by both colleges on 31 March and promptly published thereafter.

Quality requirements of diagnostic reports
An intercollegiate RCR-RCPL “Statement on the reporting of hybrid imaging” is also expected to be agreed on 31 March and promptly published thereafter.

The RCR publication “Quality assurance in radiology reporting: peer feedback” recommends that 5% of imaging investigations should have demonstrable electronic text feedback to those who reported them: https://www.rcr.ac.uk/quality-assurance-radiology-reporting-peer-feedback

IT criteria
The service specification has very specific IT criteria which mandate the software to be used rather than the functionality that is required and could be achieved with alternative software. The focus should be on clinical functionality rather than specific software.

6. Are there any other criteria that should be applied at this ITT stage?

The RCR recommends that further extensive clinical consultation take place about Phase 2 PET-CT procurement given this current very short “engagement” period. The limited access webinars announced during the Christmas break with little more than two weeks’ notice has compounded this. The duration of the contract has not been published. It is less than one year into the Phase 1 PET-CT procurement contracts. The RCR considers that it would be more appropriate to wait until Phase1 is fully established, its governance methodology assessed and any lessons learned from that contract analysed before embarking on Phase 2. The clinical advice received should be acted upon.

The RCR recommends that current scanning sites be considered with care as they have been established with long term investment in staff as well as equipment. Patient care pathways need to be considered in detail in Phase 2 PET-CT procurement along with -

- local reporting of PET-CT;
- instant access to PET-CT images on local PACS by all potential users;
- likelihood of service development; and
- research capability.

Joint bids submitted in a short timescale from different organisations could be very hazardous as has been demonstrated by the recent collapse of the £800 million Cambridgeshire and Peterborough CCG United Care or healthcare for those over 65. The outcome of the NHS England inquiry into this contract is expected within eight weeks - http://ift.tt/1PD0DWW

No decision on this PET-CT procurement should be made until the lessons of the Cambridgeshire United Care commissioning failure are published.

The Royal College of Radiologists
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