THE ROYAL COLLEGE OF RADIOLOGISTS

Response to:

NHS England and NHS Improvement
Consultation on National tariff payment system 2017/18 to 2018/19

1. General comments

The general proposals such as proposing two year tariffs and moving to the more detailed HRG4+ phase 3 seem to have reasonable justification.

However the Average National Radiology Reporting Tariffs below that are proposed are inadequate.

£20–1 body part CT

£22–MRI

£28–2 or more body part CT

Whilst this may be appropriate for remote teleradiology office style reporting—which does not require participation in Multi Disciplinary Team Meetings (MDTMs), or discussion with clinicians about complex/critically ill patients etc it is inadequate for local expert radiologist reporting.

Unless there is recognition of the quality enhancement of reporting by "local experts"— (by local experts we mean those who participate in regular face to face MDTMs and work in local teams) this type of reporting tariff is going to encourage inappropriate use of teleradiology with long term serious consequences for patients.

Radiologists participating in regular duty radiology sessions which require regular dialogue should be considered specialists in emergency and inpatient diagnostic reporting.

"Local experts" are more likely to issue *actionable reports* which give advice on next step of clinical management, improve outcomes for patients, and save money for the NHS by triggering more efficient care pathways.

Actionable reports in turn reduce the need for second opinions both ad-hoc and also formal second opinions at MDTMs.

2. Recognition of Local Expert level of reporting

This should be required in the tariff system for use of expert reporting

- *An uplift to the basic reporting tariff of 25% is recommended when local expert reporting is delivered*
- *Local expert defined as those radiologists who participate in regular and relevant specialist clinic/radiological MDTM, or have local sessions as duty radiologists and/or work in person with relevant local clinical teams*

3. Tariff recognition needs to be made for the following important core components of NHS services:

1. Acute and emergency reporting
2. Out of hours reporting where the radiology report influences immediate patient management
3. Training junior doctors

If the tariff system does not recognise such activity there is a risk of loss of local expert radiologist involvement in the care of acutely ill patients with potentially extra additional expensive investigations, delayed discharge and compromised patient outcomes in some areas. There will be a likely failure to train the future imaging service workforce the NHS needs.

We therefore suggest

- *Acute & emergency inpatient reporting 0800-2000 – 20% uplift over and above existing tariff*
- *Overnight reporting 50% uplift*
- *Reporting as supervision of radiology trainees 20% uplift as there is robust evidence that reporting throughput in such a session is significantly impaired*

4. Tariff for combined pre/post contrast studies is totally inadequate

A pre-post contrast study generates usually ≥50% and sometimes up to 100% more images (in case of CT) than a single pre or post contrast study alone. It is impossible to adequately and safely report them in the same time (which is what the current same tariff – RD03Z - amounts to)

- *An uplift to reporting tariff for combined pre and post contrast study of 50% is recommended.*

5. Tariff for multiple areas is totally inadequate

It is impossible to adequately and safely report two-three areas (examinations) in the same time as one examination. Patients will be harmed as corners are inevitably cut to try and achieve impossible reporting targets. This will again result in downstream probably greater costs.

- *We advocate a 50% uplift for each additional examination performed – so 50% from 1 to 2 and 100% from 1 to 3 areas examined*

6. Tariff for young childrens MRI/CT imaging is too low

Many will require sedation or GA (especially for contrast studies <12y or MRI in those <8y) with additional major costs to providers to deliver these scans

- *a 20% uplift is advocated for children <6 and 10% for older children.*

7. There should be tariff recognition for particularly complex and time consuming radiology scans and their interpretations

This should include:

- *Non-contrast cardiovascular CT - including coronary artery calcium scores and non-contrast thoracic aortic scans*
- *Standard cardiac CT - including CT coronary angiography and standard morphological assessment with CT (these patients will usually require cardio-active drugs and preparation as outlined above)*
- *A combination of 1. and 2. i.e. CACS prior to CTCA.*
- *Complex cardiac CT - congenital assessment (both adult and paediatric) of both cardiac and cardio-vascular structures, including graft cases*
- *Whole body cardiovascular assessment - this includes TAVI - essential a standard cardiac plus head& neck, chest abdo and pelvis angiogram and wide field of view assessment. Greater contrast needed and significantly greater reporting time required for multiple body areas.*

Without this granularity, radiology departments and provider organisations will not be able to deliver the required services without making a significant financial loss.

8. Greater use of Best Practice Tariffs (BPT) in Radiology

Including:

- *straight to test imaging ....enhanced tariff for GP referred MRI/Ultrasound/CT.....with local expert generated "actionable reports"*
- *biopsies performed in radiology departments as day cases.*

The Royal College of Radiologists
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