The Royal College of Radiologists

63 LINCOLN'S INN FIELDS, LONDON WC2A 3JW
T. +44(0)20 7405 1282 enquiries@rcr.ac.uk
www.rcr.ac.uk

***Dr Nicola Strickland BM BCh MA Hons (Oxon) FRCP FRCR***

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By email to: Luisa.Stewart@officeforlifesciences.gsi.gov.uk
Ms Luisa Stewart
Department of Health

Dear Ms Stewart

**Clinical Leadership and the Accelerated Access Review**

The Academy of Medical Royal Colleges drew the attention of colleges to sub-recommendations in the draft Clinical Leadership and the Accelerated Access Review which are aimed at promoting and incentivising a working culture of innovative practice within the clinical community. We were invited to send you our comments and below I have set out our views on the sub-recommendations that are directly aimed at Colleges.

***Clinical revalidation processes and professional reward schemes should require demonstration of evidence-based innovative practice***

1. *The medical royal colleges should support an increased focus on innovation by providing access to training and development which is then reflected in relevant clinical revalidation processes. Where health professionals are demonstrating evidence-based innovative practice, this should be recognised in appraisals, through awards schemes such as the Royal College of Nursing awards scheme, or through pay advancement such as that awarded by the Advisory Committee on Clinical Excellence Awards (ACCEA).*

The Royal College of Radiologists (RCR) wholeheartedly supports innovation in practice, but we cannot see how this could reasonably fit within revalidation, which is focused on ensuring a doctor is fit to practise and safe. Revalidation has proved to be a very considerable administrative and time consuming burden, most of which has to be performed in a doctor's spare time, and as yet we have not had any evaluation as to its effectiveness. The GMC is conducting that work now and we understand that it is due to conclude in 2018. Revalidation is also proving to be a major deterrent to keeping in practice many doctors later in their careers. This is denying the NHS valuable and highly experienced members of the workforce. We desperately need not only to retain, but to grow, the workforce to meet unprecedented and unrelenting growth in work and underinvestment for years.

Innovative practice requires a number of factors including appropriate training and mentorship as well as time to achieve this aim. Many colleagues have limited access to study leave, both in terms of time and funding, to allow them to develop and enhance their skill set in change management to implement innovative practice. Mentorship in this area is key, but again heavy work commitment militates against a suitably supportive mentoring relationship becoming established and maintained. The training curriculum requires trainees to demonstrate evidence of quality improvement activities but due to pressure of service commitment and lack of training, a number of training schemes struggle to find consultants who feel properly equipped to support juniors in these tasks, let alone performing them themselves.

The vast majority of doctors are very keen to promote innovation but are prevented from doing so due to lack of funding and lack of equipment. I would urge you not to make revalidation even more demanding at this time, and to seek to achieve any increased focus on innovation by another, more appropriate, route.

Linking this to the achievement of CEAs would lack credibility with the medical workforce, which has seen the CEA scheme eroded and become almost worthless in recent years.

***Professional leadership bodies, including the Royal Colleges, should include adherence to NICE clinical guidance as a criterion for achieving professional standards in clinical care***

2. *Professional leadership bodies can provide a clear picture of what good clinical practice looks like and support the uptake of innovation, by building on NICE clinical practice guidance and standards, and by ensuring that the promotion and use of the best, evidenced, value for money innovations is included within continuing professional development.*

3. *Healthcare professionals themselves are often the innovators, responding to the challenges they encounter in practice and finding practical solutions. These individuals should be identified and supported by employers locally.*

Once again, the RCR would not question the importance of delivering good clinical practice which includes implementing NICE standards and guidelines. However, the workforce issues set out above mean that the implementation of NICE guidelines is simply unachievable in some instances. Below are two examples.

**Clinical radiology**

The NICE guidelines which came out last year advocating whole body MR for the investigation of multiple myeloma instead of plain X-ray skeletal survey are problematic to implement in the NHS. This requires four or five overlapping body coils, a special MR protocol to perform the scan, and complex post processing of the images. The majority of hospitals do not have sufficient MR machine capacity to perform such lengthy MR imaging studies, neither can they afford to purchase the necessary number of coils to perform this whole body protocol. The post processing of the images requires “stitching” the various sequences together, so each can be viewed in as a continuous whole body stack in the correct anatomical order. If this is not done prior to sending the images to PACS the resultant 3000+ images appearing as non-linked series, in random non-anatomical order, makes reporting of these scans almost impossible and very time consuming. Many hospitals do not possess the necessary post processing workstations to stitch these image series together as required, and do not have sufficient radiographers to train them to perform this post processing work.

**Clinical oncology**

NICE guidance, while welcomed for its rigorous approach to identifying clinical and cost effective therapies, does not come with any extra funding. For example, if a systematic anti-cancer therapy (SACT) agent is approved by NICE the clinical oncology department has 90 days to implement fully the use of the drug with no extra funding. Drug costs are reimbursed centrally for most SACT, but not all. Bisphosphonates and denosumab, for instance, are recommended for patients with a number of solid tumours and bone metastases. In these situations, these drugs reduce fractures, thus reducing the cost of trauma interventions and improving patients’ quality of life. So many centres cannot access the funding to provide these, that commissioners have chosen not to support the implementation of this recommendation. Patients are suffering as a result of slow uptake of these therapies. For many newer agents, there is a requirement to educate staff, both medical and non-medical, about the delivery and side effect profiles of these drugs. This has a cost implication which cannot be budgeted for in the time frame allowed, inhibiting uptake of these therapies. Increased therapy is the norm, rather than substitution, so there is an extra time premium to find in addition. In a clinical oncology service which is nationally at least 70 WTEs below requirements, time to innovate is increasingly difficult to carve out of service delivery.

I hope our concerns are clear, but please do not hesitate to come back to me if there is further information you need.

Yours sincerely

Dr Nicola H Strickland
President
president@rcr.ac.uk

Copy to: Professor Dame Sue Bailey, Chair, Academy of Medical Royal Colleges