The Royal College of Radiologists

63 LINCOLN'S INN FIELDS, LONDON WC2A 3JW
T: 020 7405 1282 enquiries@rcr.ac.uk
www.rcr.ac.uk

National Assembly for Wales

Health and Social Care Committee

Access to medical technologies in Wales

Evidence from The Royal College of Radiologists Standing Welsh Committee – MT 13

17 October 2013

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay CF99 1NA

Dear Sir

Response of The Royal College of Radiologists Standing Welsh Committee to the National Assembly for Wales' Health and Social Care Committee Inquiry into Access to Medical Technologies in Wales

The Standing Welsh Committee (SWC) of The Royal College of Radiologists represents the specialties of Clinical Radiology and Clinical Oncology within Wales and would make specific observations as follows, based on our consultation with colleagues in Wales.

CLINICAL RADIOLOGY

1. Clinical Radiology uses many different imaging modalities for diagnosis and treatment – conventional X-Rays, ultrasound, CT, & MRI scanning, as well as nuclear medicine studies, such as isotope scans and PET-CT. Radiology is also a major user of digital technology for the handling of patient data and images. Digital image and data storage and transfer are central to contemporary radiological practice. Radiology departments have been at the centre of major technological developments in healthcare, and rapid changes in such technology used in patient management presents a challenge to healthcare purchasers and commissioners.

2. A few specific examples will highlight the complex commissioning issues that NHS Wales faces currently from recent technological advances in Clinical Radiology.

2.1. PET CT scanning. This is now an established technique in the diagnostic assessment of many cancers. In Wales this service is commissioned centrally, subject to the PET commissioning policy of WHSSC. Fewer numbers of scans are commissioned than in England. Wales currently performs about 700 scans per million population per year, while England has reached 1000 scans per million per year and are moving towards 1200. The number of funded indications is more restricted than in England e.g. gynaecologic cancer is poorly covered. New intercollegiate PET-CT guidelines were introduced in 2012 and are under discussion with WHSCC. Evidence-based indications for PET scanning are almost certain to increase, yet there appears to be no clear plan as to how this will be achieved for

Wales. Access remains geographically restricted, with a single Welsh PET scanner based in Cardiff
There is increasing evidence for the use of PET-CT co-registration for radiotherapy planning: this is likely to become a standard technique, which will require close co-operation between a PET centre and the radiotherapy centres: it is difficult to see how this can be co-ordinated for radiotherapy in South West or North Wales.
2.2 CT colonography: The SIGGAR study published in Lancet 2013 (Halligan et al) clearly demonstrated that CT colonography is a more sensitive test than Barium enema and should be the preferred radiologic investigation for patients with symptoms suggestive of colonic cancer. This is a common clinical scenario and will require commissioning of considerably increased CT studies across Wales.
2.3 Neural tube screening for Down's syndrome
NICE guidelines on Antenatal care (2003) support the use of Nuchal translucency (NT) assessment in the antenatal screening for Down's syndrome. Welsh health boards have been required to provide this service, yet no additional funding has been provided for this to be achieved.
2.5 Prostate cancer diagnosis: Recent advances in multi-parametric prostate MRI have the potential to radically change the investigation pathways for the diagnosis of patient with prostate cancer - the most common cancer in men. This would diminish the number of ultrasound guided biopsies with their associated morbidity but wide adoption of this new approach would have very significant cost and resource implications as
1. Prostate is the commonest cancer in men,
2. MRI capacity is limited in Wales,
3. the multi-parametric approach is a very lengthy procedure requiring very long MRI scanning times and needs very highly specialist interpretation of the scan images.
2.6 CR: PACS, Image transfer, IT issues IT is central to modern radiology and our specialty has been at the forefront of promoting digital solutions for image acquisition and storage, image transfer and the requesting and reporting of imaging studies. Efficient transfer of digital information between hospitals is essential in the management of many patients, yet has often been hampered by variable interpretation of data security by the Caldicott guardians in different health boards.
All Welsh hospitals have PACS systems for radiology; cardiology departments may have different PACS requirements that prevent them using a common PACS solution.
An all Wales approach to digital data and image storage, and new radiological IT developments is essential.

3. In her Annual Report for 2012-2013, the Chief Medical Officer stated that NHS Wales and the Welsh Government should ensure that the approach to healthcare constantly adapts to meet the needs of the 21st century, for example, through effective use of technology and rebalancing the role of specialised services and care delivered in communities.

4. The adoption of new technology in Clinical Radiology is not just about buying a machine. Staffing, training, servicing costs, record keeping are all part of the package, and there may be issues of radiation safety. The introduction of new imaging technologies should be encouraged but there should be an All Wales strategic approach to commissioning, which seeks to ensure that the running costs as well as capital costs are met. There is likely to be ongoing service reconfiguration in Wales and the National Imaging Programme Board (NIPB) within NHS Wales is well placed to advise commissioning on all Wales basis. The commissioning process should identify the mechanism for future service developments, that will allow access to this technology for patients living in other areas within Wales. There should be joined up thinking between directorates within a LHB to prevent similar (and sometimes incompatible) equipment being duplicated - e.g. overlaps between Cardiology and Radiology in PACS provision, cardiac catheter labs and CT equipment. The patient's perspective must also be considered in this commissioning process, which should also consider what is available for Welsh patients outside Wales, bearing in mind the relatively small population of Wales.

Clinical Oncology

5. Wales lags behind England and the rest of the EU with regards to commissioning new technology for radiotherapy. Cancer patients do not have equitable access to treatments that are available in England, and there is a marked disparity in provision within Wales itself. Commissioning in Wales is cumbersome, often requiring duplication of work already done in England. The commissioning process needs to be critically reviewed to see how it might be made faster, easier, and more proactive. At present the onus is on individual clinical groups in each of the 3 Welsh radiotherapy centres: this is slow, inefficient and parochial. When new services are commissioned it is important that the views of patients and carers are sought. To ensure equity, any potential barriers to accessing the service, such as travelling long distances for treatment and follow up, need to be addressed and funded.

6. For new techniques where the evidence-based, accepted indications are limited and patient numbers are likely to be small, it makes sense to have all-Wales commissioning and funding to establish the technique at a single centre initially. A good example of this is SABR for non-small cell lung cancer. This has been set up in Velindre at considerable expense, but with no funding provision to actually manage routine patients : IPFRs will be required for NHS patients, and there is significant concern for those patients from South West Wales.

7. Some technologies, such as Proton therapy are unlikely ever to be commissioned in Wales, but there will be a requirement for Welsh patients to access these specialised treatments on the same terms as patients from the other 3 UK nations. For Protons, where at present there is no UK facility, all UK patients are considered by a single panel, and suitable cases are sent abroad for proton therapy. This process does not discriminate with respect to where in the UK the patient comes from. The Proton Panel is likely to be dissolved when 2 British Proton units become operational in the next few years. It is vital that Welsh patients continue to have equitable access to Proton therapy. How this will be achieved is not clear.

8. Unlike new drugs, technological advances in Oncology do not have a pharmaceutical company backing to push through a NICE review. Advances in radiotherapy such as IMRT or IGRT are processes and techniques, rather than individual pieces of machinery. As such, appraisal with regards to efficacy and QALY does not work in the same way as for a NICE-style drug appraisal. A better and faster way of assessing these techniques for Wales is required. New techniques require training, MDT coordination, as well as hardware and software installation: this takes time to establish, and the revenue costs need to be recognised. A pro-active approach is required. There needs to be a greater willingness to accept major appraisals from England or elsewhere.

9. New interventions are sometimes considered through NICE under a technology appraisal guidance which may find that the procedure is safe but cannot make recommendations for routine use as there is insufficient data. As an example rectal brachytherapy for rectal cancer was the subject of a technology appraisal in 2006 and found to be reasonably safe but there was insufficient data at the time to recommend its use and the case has never been re-reviewed.

10. In some circumstances clinicians have been advised not to submit IPFRs as they will not be considered (SIRSPHERES is an example where the Hepatobiliary MDT would recommend this therapy but WHSSC would be reluctant to accept an IPFR). Patients have a right to request funding so clinicians need to support them. In many cases the expertise is available in Wales (i.e. SIRSPHERES) and could be performed at a lower cost than in England without the need for the patient to travel.

11. The inability of PACS systems to talk between LHBs and sometimes within an LHB is a major impediment to effective, efficient, and safe MDT function. Welsh MDTs commonly aggregate patients from a wide geographical area, and to try to make expert decisions when radiological information is lacking is a major clinical governance issue. Sometime this is due to incompatibility, but more often it is the result of data protection issues. This also applies to

specialist regional clinics. Clarification and simplification of data-sharing is potentially a big gain for relatively little cost.

12. Availability of cutting-edge technology is necessary to attract and retain good staff in clinical oncology, physics, and radiography. This is important for the development and sustainability of Clinical Oncology in Wales: trainees and consultants want to be able to practice their craft to the highest standard possible. There is a competitive market nationally for the best staff, and Wales is at a disadvantage compared to England.

With kind regards,

Yours faithfully

Dr Richard Clements
Chair, Standing Welsh Committee
The Royal College of Radiologists