

YORKSHIRE CANCER NETWORK

Imaging Services Group

Minutes of the meeting held on
Tuesday 7th September 2004, 6.00pm
Park Avenue Room, Ramada Jarvis Leeds North Hotel

Present:	Dr Sean Blake	Airedale NHS Trust
	Dr C Kay	Bradford Hospitals NHS Trust
	Dr S Gurney	Calderdale & Huddersfield NHS Trust
	Dr S Carradine	Harrogate Health Care NHS Trust
	Dr B Carey Dr J Spencer (Chair) Dr S Swift	Leeds Teaching Hospitals NHS Trust
	Mrs Aileen Moss	West Yorkshire Strategic Health Authority
	Professor M Baker Mrs H Ryan Ms F Stephenson Mr B Tinkler	Yorkshire Cancer Network

1. Apologies for absence

Dr N Spencer.

2. Yorkshire Cancer Network Update

Professor Baker explained that previously the group had worked on mapping out the needs for CT and MRI scanners across the Network, which has been completed and implemented in national or local programmes up to 2005/06. Imaging guidelines were also developed which included a mixture of primary diagnostics of the lung and breast and more focussed guidelines on post diagnostic use of imaging for pelvic cancer. Staffing issues were discussed and the electronic transfer of images was addressed with no conclusions.

Professor Baker explained the following recent Network issues to the group:

- Configuration of Specialist Services

Gynaecology

Professor Baker highlighted that there is a partially centralised service in Leeds serving Mid Yorkshire, North Yorkshire and some of Calderdale and Huddersfield. The Network is reconsidering the provision of the gynaecology service for West Yorkshire (Airedale, Bradford and Calderdale and Huddersfield). This is partly due to the revised cancer quality measures which now place less emphasis on specialist surgical teams being based at Cancer Centres and more of an emphasis on teams and localities, and partly due to the lack of progress in this part of the Network to transfer surgery. A formal process is ongoing to address this. Trusts were invited to submit expressions of interest by 26th June and formal proposals by 30th September. Presentations to a review panel, made up of Network representatives and external assessors will take place on 16th November. The outcome of the panel discussions and recommendations will be submitted to the YCN Board meeting shortly afterwards.

Urology

Professor Baker explained that three specialist surgical teams have been agreed in Mid Yorkshire, Leeds and Bradford. Each team is currently working on individual business cases.

Professor Baker explained that there were concerns about support services e.g. pathology and radiology.

Upper GI

Professor Baker highlighted that the upper GI specialist service is divided into oesophago-gastric and pancreatic cancer. The oesophago-gastric cancer work will be divided between Leeds and Bradford. The Bradford service is established and functioning well.

All pancreatic work will be centralised at Leeds once the new Cookridge Wing has been built. In the interim the Bradford Upper GI MDT deal with their pancreatic cases, Leeds surgeons attend these meeting. A separate meeting has been established at Leeds for their own cases, there is no input from the other partners.

Haematology

Professor Baker explained that Harrogate will be required to form a single team with York. Airedale will combine with Bradford for chemotherapy induction therapy. The population of Calderdale and Huddersfield is too small for a free standing MDT therefore they are likely to develop a partnership with Leeds.

Professor Baker highlighted that he hopes that all service reconfigurations will be complete by 2007/08.

Dr Spencer asked what provision there is to ensure the right number and skill of radiologists are in place for specialist team arrangements. Professor Baker explained that funding is included this financial year for another specialist radiologist and pathologist at Bradford to support existing colleagues. The Network is currently looking at the need for urology. If the need is there then the resources will be made available.

Dr Kay explained that the lack of a system to transmit and review images at the MDT's is becoming an increasing hindrance. Professor Baker confirmed that the National Programme for IT has highlighted that transmission of images should be resolved by PACs within a year – 18 months. Some of the group thought that this was optimistic timeframe.

Dr Kay highlighted the problems associated with the Diagnostic and Treatment Centre at Bradford in terms of staging scans. Professor Baker highlighted that Treatment Centres should not be staging, the Clinical Governance arrangements for the Treatment Centre in Bradford specifies that once the diagnosis is made patients are referred to an MDT in a recognised unit of the Network.

Dr Spencer highlighted that there in a number of malignancies the diagnostic scan serves as the staging scan, they are not separate examinations. In other areas, for example pelvic malignancies, diagnosis is often clinical.

Dr Spencer highlighted that the Diagnostic and Treatment Centres should adopt the Network Imaging Guidelines and Professor Baker confirmed that this was the expectation.

Manpower Problems to Deal with Reconfiguration.

Professor Baker highlighted that there is a shortage of radiologists in Mid Yorkshire, especially in urology and gynaecology, and in Leeds including breast screening staff.

Dr Blake confirmed that Airedale have recruited their seventh radiologist.

Mr Tinkler tabled a paper of the current MRI and CT scanner allocated in the YCN. The group were asked to forward any amendments to Mr Tinkler.

Dr Gurney highlighted that the Calderdale CT is now a multi-slice and not a spiral.

Mr Tinkler highlighted that although the YCN were offered 1 CT and 1 MRI through the additional allocation, 3 CT's and 2 MRI's and a replacement MRI for York were received. Dr Spencer congratulated Mr Tinkler and Professor Baker for their hard work in obtaining the additional equipment.

Professor Baker explained that when the original programme was drawn up in mid 2002, Mid Yorkshire and Calderdale and Huddersfield were lowest priority for additional scanners principally due to the lack of radiologists. It was noted that Calderdale and Huddersfield are now limited by equipment rather than consultants therefore they would be the next highest priority.

Professor Baker highlighted that a limiting factor is the willingness of PCT commissioners to fund the use of equipment, which is particularly an issue in Airedale and Harrogate.

Dr Carradine highlighted that the PCT have not increased funding. A mobile MRI unit is run once a week for twelve hours. Mr Tinkler thought that there was an agreement to increase the running to three days. He agreed to take this issue up with the PCT.

Action: All to forward amendments of CT and MRI information to Mr Tinkler.

Mr Tinkler to address funding issues with Craven, Harrogate and Rural District PCT and Airedale PCT.

- Funding Cancer Services

Professor Baker explained that there is no longer any designated national funding for cancer services. The funding promised from the NHS Plan is in the system. Funding required for cancer services is in PCT baselines.

The Network wide Specialist Services Programme is the subject of collective commissioning both in West and North Yorkshire and produces a steady flow of about £2 million per year most of which goes to Leeds, some to Bradford and a modest amount to Mid Yorkshire in respect of Urology and some haematology. This system is likely to continue in the short term however all the mechanisms for funding services will change between now and 2008 as the 'payment by results' system is implemented.

3. SHA Capacity Planning for Diagnostic Process

Mrs Moss, Portfolio Manager for West Yorkshire Strategic Health Authority was invited to the group to discuss the impact of capacity planning for diagnostics.

Mrs Moss explained that there are many political drivers within the system towards provider plurality through Treatment Centres but particularly around diagnostics. Another driver is the recognition that the ready availability of diagnostics has been a blockage in achieving access targets.

As from 2008 access targets will be 18 weeks from first referral to treatment, therefore work is required to improve access to diagnostics. Part of the capacity planning initiative is to address this and to work through from the capacity plan to local delivery planning.

Procurement within the private sector is the main underpin of the capacity plan. The SHA is working with PCT's to address what is needed in terms of elective activity and diagnostics to facilitate the 18 week target.

Mrs Moss highlighted that drivers for endoscopy and scanning diagnostics relate to work carried out by Greater Manchester Health Authority looking at how to improve rates, which would lead to the 18 week target. There is evidence that to achieve an 18 week target 40-50 scans per thousand population is required.

Within West Yorkshire the Greater Manchester model has been run and shared with PCT's and Trusts. It is evident that there are significant disparities in terms of access rates. This is especially the case in Leeds due to the facilities and specialties provided; it is hitting around 32.5 per thousand scans. Within other places there is a marked difference partly due to MRI's substituted by CT's and capacity which is not utilised. As part of the capacity plan the SHA is working with PCT's to achieve, in a staged way, 50 per thousand scans. A clinical debate is required with PCT's and Trusts regarding the desirability and impact of this.

The cost for West Yorkshire to achieve 50 scans per thousand is around £20 million pounds in revenue terms, which is 1% of the overall budget.

Dr Spencer highlighted that the group have been non-centralists in the allocation of MRI and CT scanners. The group have ensured that there are quality static site MRI's in all of the units and that there has been an upgrading in the quality of the CT machines. There are clear issues about the appropriate use of CT and MRI.

An in-depth group discussion followed and concerns were expressed regarding the move towards use of private facilities when there are good quality machines in local hospitals which require revenue, the lack of engagement of PCT's with radiologists, quality issues and the lack of priority to maximise and use capacity in NHS organisations.

Mrs Moss agreed to take the issues discussed back to the Strategic Health Authority.

4. PET Scanning

Professor Baker highlighted that the Department of Health PET discussion document is out for consultation with a closing date of 21st October. Calculations of need are based on current evidence and would equate to around 2,000 scans for the YCN, which is the capacity of one PET CT scanner. Professor Baker encouraged the group to comment on the document.

The mobile PET scanner on loan to Hull has been withdrawn; Hull is currently composing a business case for PET. Professor Baker has asked colleagues in Leeds to do the same, Bradford may also be interested.

Dr Kay highlighted that if commissioners will not fund the provision of MRI scanners, as previously discussed then there will be difficulty in achieving funding for PET CT. Professor Baker explained that there is a national framework for the use of PET and strict guidelines and it will become government policy.

Mr Tinkler highlighted that the NICE Lung Clinical Guidance will specify that Networks should have access to a PET scanner for appropriate lung patients.

Dr Spencer pointed out that the joint RCP/RCR document on PET had envisages two machines for a Network of the size of Yorkshire. Professor Baker indicated that new machines would achieve twice the number of scans.

There was agreement that the priority for PET scanning was to obtain PET-CT machine and that the machine should be in the Leeds Cancer Centre new build.

Mr Tinkler explained that through the capacity planning work the Network has accounted for a PET scanner as there is expected to be central funding for diagnostics.

A survey on requests for PET scans has been carried out and the results are currently being calculated and will be circulated once complete.

Action: Mrs Ryan to circulate the PET scan survey results once complete.

5. Quality Measures for Cancer Peer Review – Diagnostic Standards

The Manual of Cancer Services Measures was published on the Department of Health website on 5th July 2004. The manual is aimed at all commissioners and providers of NHS cancer services to support self-assessment and peer review.

Professor Baker highlighted that he is Lead Clinician for the North Zone Peer Review Team.

Ms Stephenson explained that the YCN is expected to receive notification of Phase I and II Measures in March 2005, followed by self assessment (by June), pre visits and training of reviewers, with the visits taking place in September and October 2005.

Professor Baker confirmed that CQuINS, the Cancer Quality Information Network System will be used for data management of the National Cancer Peer Review Programme 2004-2007. The database is currently view only.

Ms Stephenson explained that there are one set of measures for the Imaging Group and a set of measures for each cancer site including Breast, Lung, Colorectal, Upper GI, Urology and Gynaecology. The measures can be downloaded from the Department of Health website (www.dh.gov.uk) or CQUINS (www.cquins.nhs.uk).

Work of the imaging group must be documented, for example the Network site specific imaging guidelines and terms of reference of the group. A work programme must also be produced.

Professor Baker confirmed that membership of Network groups is defined in the Quality Measures. The current membership of the Imaging Group does not comply with the Measures, a department manager, radiographer and user input is required.

Ms Stephenson agreed to produce a timeframe with action points for individuals units.

The group agreed to form a Peer Review Sub-group. Dr Spencer, Ms Stephenson and Dr Gurney volunteered.

Action: Ms Stephenson to produce timeframe.

Mrs Ryan and Ms Stephenson to arrange a peer review sub-group meeting.

6. New Cookridge Wing Update

Dr Carey highlighted that the 1:50 plans will be signed off at the end of December by the Imaging Sub-group.

The equipment for the new wing has been chosen, it is now up to the PFI group to negotiate purchase. Issues regarding staffing and pre-recruitment are now underway.

Dr Carey explained that there are continued concerns regarding the ability of imaging to cater for clinical demand in the new build. Specialities will include medical and clinical oncology, haematology, thoracic, hepatobiliary, upper GI and pancreatic cancer. No service level agreement has been agreed with the various clinical specialities, another significant issue which will need to be addressed.

Professor Baker explained that financial close is expected at the end of September.

7. Any Other Business

• Imaging Fellows

Dr Spencer informed the group that Leeds have appointed two imaging fellows, it is possible that one may want to become involved in research network projects regarding follow-up in one of the common cancers.

8. Date of the Next Meeting

**Next meeting Thursday 17th February 2005, 6.15pm
North Leeds Ramada Jarvis Hotel**