The Faculty of Clinical Radiology of The Royal College of Radiologists
Response to:

Healthcare for London: *A Framework for Action*

The Royal College of Radiologists (RCR) is very pleased to see this publication come to fruition on such a relatively short time frame and was pleased to be able to contribute.

Radiology is in the unique position of delivering imaging services at all levels of care and is therefore involved in provision for primary care, acute care, planned care and long term conditions.

General Comments
While agreeing that some extension of Health services out of hours will be essential the demographic changes to an increasingly elderly population is unlikely to put further strain on the out of hours services as these individuals usually wish to access healthcare during daylight hours and when not at work, are able to do so. The overall move to hub and spoke provision of services is very much in line with the RCR model of delivering imaging services (1).

Challenges to the implementation of the plan will be to convince healthcare professionals, and in particular doctors, that, after previous reports have seen little change, this will be different and the move to establish well functioning prototype units will be essential to counteract the understanding scepticisms.

The motivation of the majority of consultants and general practitioners is to provide a good service and many ideas in recent years have been stifled by short term financial pressures. There will need to be evidence that this will change with improved commissioning.

'Hear and Treat'
Proposals in this section are welcome but a robust, accurate and efficient service will be essential if patient safety is not to be compromised. Lessons must be learned from problems encountered with NHS direct and other telephone advice arrangements. There may be an element of over optimistic estimation of [in particular] the older population's use of electronic and telephone communication, and of non English or non first language English speaking populations.

Urgent Care Centres
It appears these are proposed in two scenarios, one as a front of A&E triage and the other as a stand alone centre. The A&E triage model may be more viable as there will already be full X-ray, ultrasound, CT and possible interventional radiology service available as backup to A&E, particularly if associated with specialist care hospital.

However providing imaging for 'Stand Alone' urgent care centres is more problematic. The RCR was very disappointed to see ultrasound again equated with 'simple blood test', as it was in the preliminary report. This unfortunate and inaccurate reference has been included despite assurances that this was a mistake and would be corrected in the final report.

Paragraph 1.3.1, suggests that stand alone urgent care centres will have diagnostic equipment on site including x-ray and ultrasound. As these care centres are to be based

in primary care environments with extended opening hours, in some cases for 24 hours, ultrasound provision would be undeliverable in these circumstances. Little recognition has been given to the establishment of x-rays with expensive equipment and ionising radiation regulations which will need to be complied with and could be very costly if duplicated across all urgent care centres.

Ultrasound provision remains one of the challenges for delivery of the 18 week targets as it is demanding of expert staffing. Extending this service further into primary urgent care centres will be undeliverable even if it were necessary.

Emergency Surgery
The RCR would fully support the suggestions for arrangements for emergency surgery. This very much gels with the *hub and spoke* model we have been advocating and would enable full CT and interventional radiological procedures to be available and fully staffed in the fewer centres where emergency surgery was to be performed.

Paragraph 1.5.8, states *'tariff unbundling will support centralisation specialist care'*. For radiology this will be essential to fund expensive and high quality interventional services which are increasingly an integral part of trauma and emergency treatment and which has been the province of surgery in the past.

Planned Care
The stated key proposals *'to move routine diagnostics out of large hospitals'* are misleading. Some diagnostic services may be provided in urgent care centres outside large hospitals. However, the routine imaging aspects of diagnostics will still be an essential part of a comprehensive imaging service and will need to exist in large hospitals in parallel to those in the community.

Paragraph 1.6.1, suggests that good practice should be developed across the country. The challenge here is to translate good practice developed by enthusiasts into other settings.

Paragraph 1.6.5, suggests that access to imaging by GPs and in the community should be more available. The Royal College of Radiologists has already addressed this issue in the joint publication with the Royal College of General Practitioners '*The Framework for Primary Care Assess to Imaging – Right Test, Right Time, Right Place'* (2).

Paragraph 1.8.1, again the RCR would strongly support the hub and spoke model. With the increasing provision of electronic transfer of imaging this would be feasible but the success of this would only be possible when good robust and efficient transfer of images between Trusts is established. Despite good progress on PACS rollout, this is not yet available but hopefully will be over the period of time this document addresses.

References
1. Academy of Medical Royal Colleges. *Acute health care services. Report of a Working Party*. September 2007. Pages A67 – A70.
2. The Royal College of Radiologists and The Royal College of General Practitioners. *Framework for Primary Care Access to Imaging*. The Royal College of Radiologists, September 2006.

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