



**Minutes of the Imaging Meeting
Held on Monday 20 March 2006
National Heart & Lung Institute**

Present:

Professor Richard Underwood, Professor of Cardiac Imaging (RU) (Chair)
Maria O'Brien, Director NWL Cardiac Network (MOB) (Minutes)
Dr Richard Grocott-Mason, Consultant Cardiologist Hillingdon (RG)
Dr Roxy Senior, Consultant Cardiologist NWL NHS Trust (RS)
Ian Haig, General Manager Specialist Medicine Ealing NHS Trust (IH)

Apologies:

Dr Simon Padley, Consultant Radiologist Chelsea & Westminster (SP)
Professor Dudley Pennell, Director Cardiovascular MR Unit RBH (DP)
Professor Jaspal Kooner, Consultant Cardiologist Ealing & Hammersmith (JK)
Dr Amol Kelshiker, CHD Lead Harrow PCT (AK1)
Dr Andrew Kelion, Consultant Cardiologist, Royal Brompton & Harefield NHS Trust (AK2)
Dr Jamil Mayet, Consultant Cardiologist, St Mary's Hospital NHS Trust
Ann Miskin, (AM) General Manager, NWL NHS Trust

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1.	Welcome & Apologies MOB and RU welcomed everyone to this first meeting. Apologies were noted as above.	
2.	Purpose of the Meeting RU opened the meeting stating the key aims of forming such a group. Namely: <ul style="list-style-type: none">• To review access and availability to the various established cardiac imaging modalities to include: stress echo, radionuclide imaging, X-Ray CT and magnetic resonance imaging.• To review achievement against any national guidance e.g. NICE and Royal Colleges• To benchmark performance nationally, internationally and locally.• To consider ways of improving access to these services• To review emerging future technology and assess impact upon the provision of future cardiology services• To make recommendations for the future use of diagnostic imaging services across NW London There was agreement from those present that these were the main aims of the group and that a coherent approach across the Network will enable clinical teams to access the most appropriate services.	

<p>3.</p>	<p>Review of existing cardiac imaging services across NW London: current activity, patient flows, access times, costs & adherence to NICE guidance</p> <p>RU presented some comparative data on the use of cardiac imaging and coronary angiography within the UK and US, (slides attached). The UK lags significantly behind the US in terms of non-invasive procedures per million of the population. RS and RG raised the issue of tariff and the fact that these procedures are not funded separately but are treated as a direct cost to the provider organisations. MOB agreed to clarify the position with these tests with the PbR team at the DH.</p> <p>The 2003 NICE guidance on myocardial perfusion scintigraphy was also reviewed (see attached). It was agreed that the guidance has had little impact in terms of commissioning additional activity because few trusts have taken specific measures to implement it and no penalties have arisen for non-compliance. Despite this, the number of MPS studies in the UK has been growing at 12.5% per year over at least 15 years. At the current rate of growth the recommended activity of 4,000 scans pmp would not be achieved until 2030. Because the recommended figures are geared to the number of revascularisations (PCI + CABG) at 1500 pmp and this figure is expected to rise shortly, recommended MPS activity is likely also to rise. Although the guidance applies solely to MPS, it is generally accepted that stress echocardiography and MPS can often be used interchangeably in expert centres. The NICE MPS guidance is due to be reviewed in November 2006 and it was agreed that we should attempt to influence the review to be consider broader aspects of cardiac imaging.</p> <p>It was agreed to review capacity, use and costs of non-invasive imaging alongside exercise ECG, coronary angiography and revascularisation procedures within the region. A distinction will be made between patients from within the region and those referred for imaging from elsewhere.</p>	<p>MOB</p> <p>RU/MOB</p>
<p>4.</p>	<p>The Impact of Choice and the role of the independent sector</p> <p>MOB discussed the recently issued “Choice of Scan: Phase 2” document which, from April 06, now covers all cardiac investigations including echocardiography and states that patients should be seen within a maximum of 20 weeks from referral. Where this cannot be achieved, the onus is upon the provider centre (hospital) to arrange imaging elsewhere, at cost to them, within the time frame. Furthermore, in order to achieve the 18 week wait, diagnostic waits have to reduce to 13 weeks by March 2007 and 6 weeks by 2008, (see attached).</p> <p>Waiting times across NW London are high in some areas and, potentially, patients may need to be “moved” to alternative providers from some of the sites. There is, however, concern that the pressure upon some of the areas will result in referrals being rejected due to insufficient capacity to treat within the required timescales. MOB agreed to liaise with the SHA as to how “Phase 2 Choice of Scan” is</p>	<p>MOB</p>

	<p>likely to be implemented.</p> <p>As these targets will pose significant challenges across the network, in common with other areas, our SHA have been looking at how much use can be made of the independent sector for various diagnostic tests. The impact of the independent sector was therefore discussed. Whilst it was acknowledged that there are some independent sector providers undertaking CT, MR, nuclear imaging and echocardiography, there is currently insufficient capacity in the independent sector to contribute substantially to NHS patients who require specialist imaging such as stress studies. RU was keen to enable other centres to establish their own nuclear imaging programmes with support provided in the initial stages from RBH. The overall costs of such a proposal would not be prohibitive and the cheapest cardiac gamma camera is now £80,000. Centres were asked to consider such an option.</p> <p>It was agreed that MOB would liaise with the SHA to discuss their plans for gaining additional capacity around areas of specialist imaging.</p>	<p>ALL</p> <p>MOB</p>
5.	<p>Assessing future imaging needs including new technologies</p> <p>This item was deferred to the next meeting when there is a clearer understanding of availability of existing technologies.</p>	
6.	<p>Next steps</p> <ul style="list-style-type: none"> • Existing service provision across NWL will be mapped • Referral patterns will be established • Costs will be identified • Activity levels for the various modalities over the preceding year will be estimated in comparison with exercise ECGs, coronary angiography and coronary revascularisation • Referral rates would be assessed to include activity from outside NW London • Waiting times would be monitored <p>This will provide a baseline understanding of where NWL stands with specialist imaging.</p> <p>MOB agreed to collate this information via existing project managers from the various centres in readiness for the next meeting. However, it was highlighted that the co-operation of the various leads would be required.</p>	<p>MOB</p>
7.	<p>Any other business</p> <p>Nil</p>	
8.	<p>Date, Time & Venue of Next Meeting</p> <p>The next meeting was arranged for 28 June, 9.30am – 11.00am at Northwick Park Hospital, (Cardiology Conference Room)</p>	

END OF MINUTES