

The Alliance Medical Dossier:

How not to go about cutting
diagnostic waiting times

An analysis of documents supplied by the
NHS under freedom of information rules



Paul Burstow
Shadow Health Secretary

Introduction

In June 2004, the Department of Health announced a new contract for mobile MRI scans with Alliance Medical to carry out around extra MRI scans for NHS patients using 12 mobile screening units¹. In January 2005 Paul Burstow, Liberal Democrat Shadow Health Secretary, wrote to the Chief Executives of each of the 28 Strategic Health Authorities under the Freedom of Information Act seeking copies of any briefings or submissions concerning experience of the roll out of the national contract with Alliance Medical to provide scans.

The responses are summarised in this report. What they demonstrate is that the Secretary of State's claim that "*there is not a shred of evidence*"² that there are problems with the contract is completely untrue.

A written answer to Paul Burstow³ in March stated that the Government collect information about the running of the contract but will not publish this information on grounds of confidentiality and commercially sensitive. This means the running of a contract spending £90m of public money is unaccountable to the taxpayer.

Summary

The information obtained under the Freedom of Information Act provides a dossier of serious problems with the contract:

- Lack of clarity over what activity was covered by the contract
- Contract hastily introduced before systems were in place for implementation and quality control
- Many patients could not be treated under the scheme because of the complexity of their condition
- Changes made to the contract so that only European staff could be used meant that there was a shortage of staff to undertake extra scans
- Changes made to the contract nearly six months after implementation, to exempt a large number of referrals on neurology scans due to serious clinical reservations. This has put into question the quality of those scans of this type carried out before they were made exempt; wasted time of clinicians and managers who had already prepared these referrals prior to notification about the change in the contract; and rendered the service of little use to the trust who main backlog was of this type.
- Speed of introduction of the contract meant a lot of pressure had to be put on local trusts to send patients to the scheme
- Test results which should have been back within hours taking weeks and sometimes months to arrive, over three months in some cases, delaying follow up appointments

¹

http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4084758&chk=hcV03k

² Hansard, 22 Feb 2005, Column 138

³ 9 Mar 2005 : Column 1911W

- Misinterpretation of scans, which could have resulted in inappropriate diagnosis and treatment.
- Many areas reluctant to reuse the service
- Poor organisation leading to scans not being done and extra costs for host trusts
- Patients referred to be scanned not being scanned but not being referred back to the trust, so could not be scanned within the NHS either
- Substantial extra costs for the host trust, for example provision of reception staff
- NHS scanners sitting idle while the trust under pressure to use the private scanner instead
- The Department of Health downplaying concerns in reporting back to the NHS
- Poor consultation with the NHS over lessons learnt concerning the contract process

Chronology

May 2004

Department of Health (DH) writes to Strategic Health Authorities informing them of the tender for contracts from the Independent Sector to provide scans.

It says: “This represents an increase in capacity nationally of around 10%. The service will be in the form of a number of mobile units which will be deployed to the areas of greatest need.”

... “The aim of the service is to provide additional capacity in a key diagnostic service.”

October 2004

Department of Health wrote again to Trusts to inform them that “6 bids were selected to proceed to the Invitation to Negotiate (ITN) stage. A single provider was selected following this process and a five year contract awarded to Alliance Medical Limited (AML). The contract commenced on 22 July 2004 and runs until July 2009.”

“AML will provide 110,900 scans in year 1 and will increase capacity to 131,200 scans per year for the remaining four years of the contract. Altogether this will mean an additional 635,000 scans will be undertaken during the life of the contract.”⁴

“The additional scans will be provided by a fleet of twelve mobile MRI units that will cover all 28 SHAs...”

Summary of responses from SHAs

Avon, Gloucestershire and Wiltshire SHA

⁴ NB – year 1 output is the same level as other years, pro rata

Provided a number of letters and briefing papers from DH and CCMU but withheld “other documents relating to your request... under the exclusion terms of the Act and in particular Section 43 relating to commercial interests.”

In addition, they enclosed a **copy of a letter dated 24th Nov 2004 from five of the six Cluster Leads**, representing the 28 SHAs to Ty Robinson the National Implementation Director and Matthew coats, Head of Secondary Care at the DH, in response to their progress report of October 2004.

Of interest were the following sections (our underlining):

Not reporting/down playing initial difficulties with the implementation of the contract.

“You provided a progress report to SHA Directors of Performance in October on the operation of the national contract for mobile MRI services. Given the scale of the operational problems being experienced, and formally reported, by that time, the five Cluster Leads, representing the 28 SHAs, were surprised that your progress report made no mention of these difficulties.”

Lack of consultation with Cluster Leads regarding a “lessons learned” process

“Some Cluster Leads were informed that DH/NIT have undertaken a ‘lessons learned’ exercise into the failings of this contract. Cluster Leads are both surprised and troubled not to have been involved in this ‘lessons learned’ process.”

The letter went on to highlight the Cluster Leads’ concerns regarding the contract.

“The five Cluster Leads are in agreement that there are two key underlying causes of the current parlous position. These stem from the failure to involve the NHS in the development of the service specification and governance arrangements incorporated in the contract. The two issues are : -

- Lack of clarity about the nature of the activity to be covered by the contract and/or failure within the contract specification adequately to describe the target activity.
- Mobilising the contract before contract delivery systems, and clinical and contract governance arrangements had been agreed and established.

Lack of clarity –

“The clinical exclusions detailed in the contract and the lack of any requirement under the contract for sub-specialisation in reporting... make this contract unsuitable for much of the case mix currently waiting on NHS lists for MRI.”

Insufficient mobilisation (start-up) time –

Due to a separate legal decision concerning [NOT DISCLOSED] made after the contract was signed, the DH advised Alliance Medical that they should not use non-European

reporters. But as Alliances' service provision was heavily based on non-EU reporters they had to abandon the plans they had made to underpin service delivery and start recruitment from EU countries. **"The contract was mobilised... with a known problem of lack of appropriate Radiologists to report the scans taken under the contract. The NHS was never informed of this issue."**

The mobilisation period was insufficient also for the NHS to prepare adequately. –

"A good deal of pressure had to be put on host sites to undertake the additional work required (to deliver referral schedules) at such short notice and this was only achieved with the promise, from the SHA representatives, of the high quality of the service specified by the contract."

Furthermore, the contract was mobilised with no governance structures established and no clinical governance/clinical guardianship in place. "Consequently for the NHS there has been no recognisable system for raising and logging concerns, particularly concerns about the clinical performance of the contract... it is only now, over four months into the contract, that we have started to discuss the establishment of proper governance structures."

The impact of the above has been threefold:-

Suboptimal care – "Patient care has been compromised" as a result of inadequate availability of Radiologists. Reports, which under the contract should be delivered in 96 hours without PACS and 48 hours with PACS have been taking over 6 weeks, resulting in delays in outpatient appointments taking place without the benefit of the radiological opinion requested."

"As a result of reports being provided by generalists, where in the NHS they would have been provided by sub-specialists (particularly Neuro-Radiology) there are also examples of misinterpretation of scans, which could have resulted in inappropriate diagnosis and treatment."

Reduction in credibility/co-operation – Due to lateness of reports and concerns about reporting quality many areas have expressed reluctance to have the mobile service again.

"The inability of Alliance Medical to deliver technical solutions to link with NHS organisations which are currently PACS compliant has further reduced credibility in both the providers and in the contract."

Under-use of the contracted activity – the first quarter report indicates a scanning level of just 9,406 against a minimum take of 16,317. "One could argue that this is part of the gearing up of a contract and that some under-performance could be expected. It could however also be argued that in the early days of this contract, when the focus was on those areas with the longest waits, the utilisation should be at its highest."

An email dated 5th January 2005 from Steve Emerton at CCMU confirmed the decision to exclude a number of neurological cases – intracranial cases for a neurosurgeon or neurologist.*

An email dated 17th January 2005 from Chris Moore outlined aspects of the complaints procedure for the contract.

Bedfordshire and Hertfordshire SHA

Not prepared any internal briefings/initiated any research/prepared any representations or sent any letters to DH on the contract.

Enclosed copies of 3 circulars from the DH.

Birmingham and the Black County SHA

An internal email dated 7th January 2005, in response to news of the neurology exemptions identifies significant issues it now faces in trying to identify enough suitable referrals for the Alliance mobile units:

“I apologise for the gripe, and I know that this decision is out of your hands... but this is really depressing news.

In particular, it is extremely disappointing and frustrating given all the concerns I’ve already raised (not sure if others have similar) around the very wide range of exclusion criteria in the contract. This is the only cohort ie non complex neurological referrals, that we can offer in significant enough numbers to make an impact on our waiting list. If I’ve interpreted this correctly, it basically means we can send relatively fit, English speaking, non follow-up spines, knees and MRCPs and we’ll run out of those very quickly if we haven’t already. It constitutes around 50% of the forms we submit to Alliance.”

A service review of the second visit by Alliance units to University Hospital Birmingham Foundation Trust dated 16th December highlights underperformance of the mobile scanning unit. It shows the unit using only 56% of allotted time:

- Potential scanning time over the period – 84 hours
- Total number of patients scanned – 129
- Average number of patients per hour over the period – 1.5
- Numbers scanned per day were as follows: 22, 17, 14, 18, 26, 7, 17
- Total time identified as “free time” on the patient schedules – 2260 minutes (37.6 hours) of non scanning time
- Therefore total scanning time for the period – 46.4 hours

During our own extended day, we routinely scan 20 patients, taking into account that these are complex, multi area, contracted examinations.

Cheshire and Merseyside SHA

Email dated 25th August 04 forwarded to Carol Wilby at Diagnostic Branch, DH re scans dated up to a week prior at Broadgreen but no reports received and low rate of scans.

“Up to yesterday Alliance have scanned a total of 102 patients for us over a possible 6 days... We were told they would scan about 32 patients per day so you can see it falls well short up to now. Today they expect to scan 6 patients!...”

Reasons listed - patients turned away as failed safety questionnaire; patients couldn't be contacted; refused to be scanned in mobile.

Email dated 12 Aug 04 from Mark Brough of Diagnostics Branch, DH, requesting last minute host site to come forward to start scanning 31st August to early mid Sept, following Southampton pulling out of their slot.

Email dated 24th Aug 04 from Alan Hodgkinson, Director of Capacity Development at C&M SHA to Carol Wilby requesting a formal investigation as a matter of urgency re patients being contacted 1-2 days in advance of scanning (despite receiving referrals on time); Alliance Triage Centre sending referrals back stating 'not contactable' (despite no problems experienced by Trust in contacting these patients); taxi fares incurred by Trust as patients have been misdirected to the wrong site; low turnover of scans – including only 4 done on one day.

Further email dated 25th August 04 from Alan Hodgkinson at C&M SHA to Carol Wilby reiterating request for a formal investigation on 'lost' procedures in C&M due to errors on part of Alliance.

Email from Carol Wilby, 25th Aug, back to Alan Hodgkinson – “Looking at the issues you describe it certainly looks as though we need to investigate further and will pursue this matter, on your behalf, with Elizabeth at CCMU...”

Email, 5th Oct 04, from Carol Wilby to Cluster Leads to prepare for meeting between CCMU and Alliance on 8th Oct – requesting “that we are aware of all the issues you have with AMLs delivery of the contract, **in fact we would like them in warts 'n' all detail (we will sanitise if necessary!)...**”

Email dated 26th Oct from NHS Infrastructure Security Manager re issue of AML requesting broadband - NHS sites required to make arrangements.

Email dated 22nd December from the Director of Capacity Development and Elective Care at Cheshire & Merseyside SHA and North West Cluster Lead to Christopher Moore at the Department of Health outlining concerns about a delay in the announcement of the neurological exemption.

“As we have no statement put out yet, what will AML be doing with such referrals? Will they be scanning and reporting on all such patients that have been referred prior to the issue of the statement? Or will they be bouncing them back? Will they still be paid if they

bounce them back? Certainly Trusts will still be incurring costs in making such referrals until a definitive statement is issued. It seems incongruent for AML to be paid for not doing the work when the Trusts will have incurred costs in referring!"

Policy change (and change back again) without notice and transitional arrangements for patients already booked.

Email dated 10th Feb 05 From Alan Hodgkin to Elizabeth (at CCMU?) – One of C&M's hospitals received a fax from Alliances' Triage Centre stating 7 Pit Fossa scan patients were being returned as they required Gadolinium injections. Followed up by phone and told the protocol for Pit Fossa scans had been changed on Thursday 3rd February. One patient was phoned on Fri 4th Feb and had his appointment on Sunday 6th cancelled. "I think this is totally unreasonable for the patients. You need to allow time to make a change like this and not cancel existing appointments."

Email, 15th Feb, from Steve Emerson at NIT, CCMU, suggesting that AML would now provide the Gadolinium injection (contrast).

County Durham and Tees Valley SHA

Question sheet/briefing note from South Tees NHS Trust – Mobile MRI Operational Issues 6.8.04 concerning clinical standards, assurances and logistics.

1. "At least 90% of the work of South Tees will be referred from Neurosciences, the trust would like assurances that the MRI scans are reported by a suitably qualified and accredited Neuro Radiologist. Evidence if the reporting radiologist's experience is necessary.

Progress report prepared by the E. Colleridge at the Trust?? /SHA(?) at the end of Nov 04. Key issues include:

"1. At 30th November, 7 cases still have not been reported from the September/October take. This is despite numerous phone calls and e-mails to the Triage centre. The reporting time for these patients is in excess of 8 weeks.

2. There has been concern raised over the quality of some of the reports that have been received. These concerns cannot be fully assessed until all reports have reached the referring clinicians and the clinicians have fed back to the radiology division.

3. There has been no progress in the request for Alliance Medical to provide a reporting Neuroradiologist.

The second visit commenced on 18th November 04. "195 patients were referred to Alliance (sent to Triage centre on 25th Oct and therefore within 3 weeks, all with patient contact details). Only 84 patients were scanned = 43% of the total."

From an audit performed by the SHA to ascertain the number of patients who had received information prior to their appointment: for the November take "only half of the

patients actually scanned (which is equivalent to 42 patients) had received a phone call informing them of the appointment.”

“Of the remaining patients who were not scanned, 75 requests are outstanding. As at 30th November 04, these requests have not been returned to the Trust, therefore cannot be actioned.”

“Trust staff are paid overtime to cover reception duties for 12 hours a day, 7 days a week. But there are very few patients scanned - an average of 12 patients a day... The patient numbers at this visit could have been condensed into 7x8 hour scanning days. This would have saved the Trust 28 hours overtime in a week).

At the end it states:

“If the mobile MRI service continues with no measurable improvement, we as an organisation appear to be condoning and supporting this inferior service.”

Email dated 1st Feb 05 detailing the experiences of the service at North Tees:

- “No notification re date and time van will arrive on site...”
- “Any (patients) not scanned are returned 2 or 3 weeks following end of visit. To ensure such patients are not disadvantaged with regard to static site scanning appointment requires considerable admin time and effort by Trust staff.”
- Suspect Triage centre does not book appointments until last minute “which will contribute to the low acceptance rates.”
- “Any appointments after 5pm weekdays and on weekends require additional reception staff to be on duty. We are not informed of a day’s appointments until late afternoon the day before. The logistics of giving staff adequate notice that they are required to work extra but not bringing them in unnecessarily are a nightmare.”
- “Delays in reporting! Our first visit was week commencing 6th November. Toward the end of Dec we still had 30+ reports outstanding. We brought this to the attention of Alliance several times, we received the last report mid Jan, a 2 month delay, totally unacceptable... In the normal course of events some patients would have received an appointment on our static scanner, with subsequent prompt reporting by Trust radiologist faster than the fast track! And with less hassle.”

Cumbria and Lancashire SHA

An internal briefing that was “recently” (as at 7th March) considered by the SHA’s chief executives states:

“Local confidence has been considerably reduced following the publication of Alliance’s Clinical Quality Report, stating that 50% of radiologist reports sampled contain errors of various degrees. Alliance have informed the SHA that in fact the 50% was only taken from one group of radiologists and that some of the quality issues would not affect patient care, but it is clear that confidence in the Alliance Contract is currently of some concern.”

“Some examples of concerns are highlighted below and, although have been dealt with appropriately, given Alliance’s Clinical Quality Report, they raise the question of how many other inaccurate reports are currently in our system.

- Patient scanned had two reports prepared and sent to referring hospital, each giving opposing views. This was only picked up by the hospital staff...
- Film image for a patient received by hospital with two reports attached, all three documents having patients of the same surname, each referring to the same part of the body, but the hospital staff being unable to differentiate which report, if any, related to the film...
- DH Clinical Guardian has suspended neuro surgery referrals of patients. Radiologist reports received to date by hospitals have included many such referrals reported on prior to the suspension. None have been recalled by DH or Alliance.

Dorset and Somerset SHA

Letter dated 28th October from the SHA’s Head of Service Improvement to Matthew Coates, Head of Secondary Care at the Department of Health outlines a number of concerns:

- “Referral process: it is understood that although 517 referrals were dispatched to the Triage Centre at Alliance Medical by the required deadline, the Triage Centre only acknowledges receipt of the referrals at the 27 August 2004 and therefore refuses to make up the shortfall in scanning capacity amounting to at least 149 scans. Incidentally it is noted that a large proportion of referrals taken by Alliance Management staff on the 17 August 2004 to the Triage Centre were not contacted to have their scans.
- Booking process: the Triage Centre at Alliance Medical appeared dysfunctional and unable to cope with the workload from the 7 national clusters, and were working in a last minute state to try to fill some slots ... with some days having as little as 7 patients booked, against a plan of 30 patients.
- Waiting times: in terms of the 6 week block planned for 17 January to 27 February 2005, given that Alliance Medical require all 1290 referrals 3 weeks prior to the 17 January 2005, this means patients scanned in week 6 will have had a 9 week lead in time, which means that by using the mobile scanner NHS Trusts will be increasing patients’ waiting times for diagnostics, given that our local providers are currently operating a 8 week wait for MRI. ...
- Reporting process: the reporting system of 96 hours turnaround, within the contract has not been delivered... The Referral Management Centre... are incapable of delivering the electronic reporting and delivery of paper reports to the referring clinician, regardless of the fact we have sent by Trust the contact details of each referring clinician. Additionally Alliance Medical were unclear who of the 604 referral sent had been scanned and have promised to clarify this by 31 October so we can scan the remaining patients. It is estimated 376 patients of the agreed 525 have been scanned, but we are concerned of the number of patients stuck in the system.

Overall communications appear poor and disjointed both internally at Alliance Medical and between all parties. This is coupled with the fact the contract appears only to be subject to change and flexibility to the advantage of Alliance Medical, and the local parties are disadvantaged.”

Email from the SHA’s Service Improvement Manager dated 9th November 2004 outlining the key messages from a recent meeting with Trust representatives:

“Key concern is the need to resolve the clinical governance and risk issues around the wait for reports to be sent out and the quality of the report. RBH (Royal Bournemouth Hospital) have had to re-scan patients and re-report a lot of scans... Also xxx said a lot of their clinicians do not now wish to use the service given the reports received.”

A briefing for the Southern Cluster Meeting on 19 November 2004 reveals “Reports from scanned patients are still outstanding from 16/9/04... and total 17 patient scans.”

An email from the General Manager, Radiology and Ophthalmology at the Royal Bournemouth, to Bournemouth PCT dated 31 December outlines difficulties in getting enough referrals for scheduled Alliance visits due to clinicians’ reservations:

“We think it unlikely that we will have enough patients for the first planned week at RBH... As I said we have had objections by certain Consultants from some of the specialities which has rather narrowed our window of appropriate referrals.”

A letter dated 12 January 2005 from Matthew Coates, DH, in response to the letter dated 28 October from the SHA’s Head of Service Improvement reports “Systems are now in place to reduce waiting times, from 1 January 2005, to four working days and ensure all outstanding reports are completed by the end of January... Furthermore all reports are to be double read ”

Hampshire and Isle of Wight SHA

Included copies of internal briefings into Alliance contract and copies of representations from SHA to DH.

Also included some guidance on the contract from DH and “confirm that additional material is held by the SHA, however, it is my opinion that this is exempt under Section 43 Commercial Interests. You will note that the information disclosed was not received directly from the DH but via a cascade system through another SHA.

Southern Cluster Update – notes from DH meeting 11 June 04

SHA briefing note 16 July 04, Yasmin Stammers – HIOW SHA

Mentioned ...

“The agreed contract activity rate is 2.65 patients scanned per hour, which translates to 175 scans per week, based on a 70 hour operating week, moving to 84 hours by the end of November 2004, with core hours of 08.00 to 20.00 hours.”

Note for BMT – MRI Scanners 19 July 04, Yasmin Stammers – HIOW SHA
Says...

“Nationally, it has been recognised that this procurement will enable trialling of delivering diagnostics in primary care settings, but recognise that there is a way to go yet for the systems to be established to enable work to take place. Therefore it has been agreed that the first year or two of work should be to reduce Trust waiting lists.”

“Although actual cost of the scans is free, there are some costs that will need to be borne by the host site. These include:

- Reception area for patients;
- Reception staff to greet patients;
- Clerical staff to identify potential patients within Trust RIS system;
- Radiology time to assess patient protocols to identify appropriate patients to be treated on the mobile;
- Trusts ITC input to enable Alliance equipment to ‘talk’ to Trust system;
- Provide theatre suits for patients to change into plus areas for patients to change;
- Provide contrast dye for MRI as required;
- Provide other minor consumables (swabs, needles etc)
- Provide an on call estates service.

DH have indicated that there is a small amount of funding available to each SHA to help facilitate this work, (about £20-£30k per year) but this is not sufficient to fund the above. No organisations spoken with so far have indicated any willingness to be able to take on these costs.”

Letter from Matthew Coates and Ty Williams to all SHA Directors of Performance, 1 Oct 04

Email from Graham Terry at Southampton City PCT to David Knowles at Alliance

“We have one final locality in HIOW SHA area who we have been struggling to engage on the programme, and a number of the hurdles are around the infrastructure on site to support the unit, and in terms of getting it ready would costs the area considerable investment beyond which organisations are able to fund.

“A suggestion/request that was raised at an emergency meeting on Friday in the locality between the PCTs and the local acute Trust, was is there scope within the programme for instead of the images being taken on the Unit (for which the Trust site is going to struggle to accommodate) whether the Alliance MRI radiographers/tech’s able to see the identified patient cohort and scan using St. Mary’s Hospitals idle scanner? This would be a fantastic success if this were possible as it would engage this locality finally and provide the service that this programme is intended to deliver.”

Email from Alison Knowles at Avon, Gloucestershire and Wiltshire SHA to Phil Evans at Alliance, 2nd Dec

Scheduled visit at Andover cancelled – previously “hosted the mobile in the w/b 8 Nov and the clinicians in Winchester have not had reports on that cohort of patients – so are not willing to refer a second cohort at this time.”

Also mentions a request from Portsmouth Hospitals to use fixed MRI at their site instead of mobile unit for contract work (as above) – refused by Steve Emerton @ CCMU.

Notes from meeting on 12 Jan 05 held at SE London SHA between reps of DH and several SHAs.

Neil Godwin (Greater Manchester SHA) opened the meeting saying it had been requested by the SHAs because of several concerns about the mobile MRI contract which centred around 3 main areas:

“the poor quality of clinical reporting, in terms of content, timeliness and administration; the diminishing number of investigations that can be undertaken via the contract, with the inherent risk of its not being fully utilised; national management of the contract.”

Norfolk, Suffolk and Cambridgeshire SHA

Notes from an Executive Team Meeting dated 6th December points to substantial delays in receiving reports:

“Trusts have raised concerns regarding the amount of time it has taken Alliance Medical to provide reports to referring clinicians. The waits for receipt of reports have ranged from 3 weeks to over 8 weeks.

Norfolk & Norwich University Hospital has experienced delays of up to 8 weeks due to problems with the compatibility of reporting systems between Alliance Medical and the Trust. The Norfolk and Norwich University Hospital is now faced with having to re-scan patients scanned by Alliance Medical at King’s Lynn.”

North East London SHA

In response to Paul Burstow’s freedom of information request, North East London SHA supplied the following, and telling, reasons for withholding information:

“Prejudice to the commercial interests of Alliance Medical

The information we hold which has been provided by Alliance Medical to us is commercially sensitive and its disclosure would therefore be likely to prejudice Alliance Medical’s commercial interests. The disclosure of this information is likely to have a detrimental effect on Alliance Medical’s ability to do business by giving commercial advantage to its competitors.

Prejudice to the commercial interests of the Department of Health

We consider that releasing the information which we hold which has been provided by the Department of Health would be likely to have a detrimental effect on the Department's own commercial interests by deterring private sector contractors from entering into future contracts with the Secretary of State... Releasing the information would be likely to deter contractors from participating in future procurement processes, thus weakening the Department's ability to secure contracts on best terms in the future."

North West London SHA

A briefing note from Ealing Hospital NHS Trust, dated 7th January 2005, regarding a visit from the Alliance Medical mobile units at the end of November, reveals poor uptake in the third week of the visit due to Alliance's call centre staff working to a two week timeframe rather than three. This was discovered by Trust staff on the Friday before the third week of their visit. This reveals poor communication between Alliance Medical's central office and call centre.

The briefing also outlines delays in receiving reports of an average of three weeks. The Trust describes the process for receipt of reports as "fragmented and unreliable. Despite regular follow up with AML guarantees were consistently unmet."

An email dated 26th January reporting back on an Operational Governance Group meeting the day before states that Alliance Medical data shows 15 outstanding reports from October.

An internal email from North Middlesex Hospital dated 2nd February 2005 regarding the level of outstanding reports and their decision to suspend all referrals to Alliance's mobile units until the backlog is cleared. "Alliance claims only 15 outstanding and promises all backlog to be cleared by 7th Feb 2005 but this is at odds with SE London who have a significantly higher number outstanding than Alliance would appear to acknowledge. The timing is now crucial – the next cluster meeting is on 9th Feb 2005 and perhaps we can wait till then to see if indeed the backlog has been cleared and other operational issues sufficiently ironed out to see if we should continue with London deployment."

An email dated 4th February 2005 from the Assistant Director of Operations at Ealing Hospital NHS Trust to a colleague at the SHA outlines delays in receiving reports. "We have just reviewed our Alliance Reports Received database. We thought we were waiting for about 12-16 but there are actually 58 outstanding. So much for the 4 day turn around time!"

An internal email between SHA and Trust colleagues dated 21st February speaks again of plans for a London-wide decision to suspend new referrals until the backlog has been cleared.

South East London SHA

Documentation supplied by the SHA shows that an independent investigation was requested towards the end of 2004 to review 39 scans and reports due to “clinical disagreements about the diagnoses between Alliance Medical and local radiologists. The most serious relate to head, neck and spine examinations.”

This independent assessment was carried out by Professor Adrian Dixon, who was later to be appointed Clinical Guardian of the contract by the Department of Health. The following points are taken from Professor Dixon’s response, dated 3rd December 2004:

1. The image quality is generally good.
2. The gap between the examination and report appears to be in the order of 2 weeks
3. The language is difficult to decipher at times – eg frying instead of fraying – I wonder if the ‘transcriber’ is fully experienced in English medical terminology
4. There are wide cultural differences between reports issued in mainland Europe (and USA) and the UK. There, radiologists tend to report every minor abnormality in great detail. Here, we might dismiss minor findings as ‘normal for age’, especially in the elderly. As health care elsewhere is often funded on ‘item per service’ there is a hidden incentive to request extra tests, further clinical follow up, etc
5. I rather suspect that the reports are being issued by radiologists with somewhat general radiological experience. In the UK most MR report would be reported by radiologists with particular sub-speciality.
6. Nevertheless, there are areas of concern. For example I was particularly anxious that only a partial differential diagnosis was offered to the single patient in this series who had potentially serious disease (eg possible cancer). The possibility of Paget’s was not offered. And further MR was advised which would not help much.
7. The other discrepancies, as noted by me and your local radiologist, tended to be that of over-reporting... This may bring some patients back to out-patients unnecessarily. I doubt any surgeon would act on any of these reports of ‘cord compression’ without assessing the images or discussing them with their local radiologists.

In answer to your direct questions:

1. There are numerous discrepancies, mostly in the emphasis of the report, as pointed out by your local radiologists. While none are life threatening, some might interfere with standard NHS management.
2. However it is debatable whether there is greater risk to the patient not having MRI at all (some patients have been waiting more than a year) rather than having an MR with a report that over-emphasises age related abnormalities.
3. On that basis it is probably safe to continue using the service for low-risk outpatient examinations pending more detailed investigation.
4. In an ideal world, the SHA would try to get all these reports checked by the local radiologists – but staffing constraints may preclude this. It might be worth formally exploring whether local radiologists might get more involved in the reporting process.

5. In the short term it might be worth suggesting that referring clinicians should discuss the findings of these reports with local radiologists in case of doubt and especially before any planned intervention. Again this would mean extra work for the local radiologists.”

A briefing dated 6 December highlights a high volume of concerns regarding reports, or lack thereof:

Numbers involved

738 patients for whom there is uncertainty or concern

- 47 patients at Bromley, whose reports have been received but not formally checked...
- 652 patients who have been referred to Alliance, but for whom Trusts have not received reports nor any further information as yet. In these cases, Trusts have to manage endless queries from patients about what is happening and wasted clinic capacity as follow-up clinics have been booked to give patients their results.
- Plus the 39 patients in Lewisham and King’s who were identified for independent assessment.

An update on outstanding reports supplied by Bromley Hospitals, dated 17th January, highlights 58 reports still outstanding after over 3 months. “58 patients referred in September 2004 are still awaiting resolution of problems with Alliance. For 35 of the patients referred in September, AM claim to have done scan but no report available. 19 of the patients referred in September are totally unaccounted for in Alliance’s systems. 4 patients referred in September have problems in reports, identified to Alliance but not yet resolved.”

An update on Alliance Medical reports from SE London SHA, dated 27 January 2005, show that reports are outstanding for at least 89 patients (including 53 from Bromley Hospitals).

South Yorkshire SHA

An internal email dated 12th January 2005 following the news of the neurology exemptions outlines a current neurology waiting list at one of the local Trusts of 131 patients initially earmarked for the mobile service. “With the introduction of Prof Dixon’s exclusion criteria this renders 100 of the 131 patients initially selected, unsuitable for referral to Alliance.

The above email was then forwarded by an SHA representative to DH officials with the following comment which outlines Government resources being wasted and time wasted by local health communities in identifying patients for the mobile units, to later be exempted:

“This relates to Rotherham who have less than 1 month waiting list for general MRIs but have circa a 40 week waiting list for neuro scans at Sheffield. We have invested capital

in their site through DH monies to allow utilisation of the mobile contract. We are of course happy to have Prof Dixon as newly appointed clinical guardian and his clinical advice about new exclusions to the contract however this now leaves the wait times at an unacceptable level with no funding identified to resolve this – PCTs had allowed for this activity through their free allocation only. We have obviously also invested capital for no gain.”

South West London SHA

A letter to John Bacon, Group Director, Health and Social Care Delivery at the Department of Health from the SHA’s Chief Executive dated 6th January reports that:

“London is experiencing considerable operational problems which have resulted in delays in patient care and has created a significant burden for the referring acute trusts. The problems range from delays in scans being reported and sent to the wrong referring hospital to concerns about the clinical content of those that are reported. In addition, large numbers of referrals considered ‘routine’ by the NHS have been returned.

The following are just a few examples of the problems we are encountering in SW London. One acute trust has sent approximately 60 patient referral forms, 19 of which have been returned as Alliance Medical are unable to scan them. According to the trust these are straightforward scans which appear to be within the protocol. They have also been puzzled by some of the terminology used. For those images that have been received, once they have been scanned into the local PACS and the reports transcribed onto the local system the additional workload has been considerable. We know from our colleagues in SE London that some of our reports have been sent to them. Another Trust has sent 190 referrals, almost 40% of which were returned as Alliance claimed the patients were non-contactable. The delays experienced in receiving the reports are such that only those patients waiting in excess of 11 weeks are likely to be seen sooner via the Alliance service. We are not encouraged by the service we have received so far and it seems to mirror the experience of other parts of London.

In light of this early experience we have advised our acute trusts to stop referring patients until we have formal assurance that the operational and clinical governance issues have been resolved.”

Following the above letter a briefing with the title “Alliance Medical Mobile MRI Service: The London Experience” dated 12 January was produced by SW London SHA, and co signed by executives of South West London, North West London, North Central London and South East London SHAs. This highlights that out of 4124 referrals by the five London SHAs to Alliance Medical, only 1440 (35%) have been returned.

In summary:

“The AM mobile service for London has so far proved untenable... Three of the five SHAs have advised their Trusts to refer no more patients until further notice.

Conclusions

As this analysis of the documents supplied by SHAs reveals, the way in which the Government went about letting the contract for extra scans has compromised patient care, wasted taxpayers money, and exasperated hardworking NHS staff.

For the Department of Health to fail to put in place from the outset a system for raising and logging concerns about the clinical performance of the contract is unbelievable. Lives have been put at risk by the failure to put in place the necessary specialists skilled in interpreting scans. This could have resulted in inappropriate diagnosis and treatment. It is very worrying that the contract went live despite a shortage of appropriate radiologists to report on the scans. It is inexcusable that the NHS was not informed of this problem before the contract began.

It is hard to see out the Secretary of State could say as recently as February 2005 that “there is not a shred of evidence to show that there were undue problems with the first contract.”⁵

On the contrary, there is substantial evidence of serious problems with the first contract for extra diagnostic scans. It is essential that lessons are learnt from this state of affairs to ensure that services are joined up with the NHS at a local level and that future contracts for extra diagnostic capacity do not encounter the same problems.

⁵ Hansard, 22 Feb 2005, Column 138