

## **ALLIANCE/IBA MERGER INQUIRY**

### **Summary of a hearing with Dr Wai Lup Wong, Chair of the Clinical Reference Group, NHS England, held on 25 April 2014**

#### **Background**

1. Dr Wong explained that the provision of PET-CT scanning services across England was organised as follows. Approximately 50% of PET-CT scans were provided under the PET CT-North and PET CT South Independent Sector Treatment Centre (ISTC) block contracts by Alliance Medical Ltd and InHealth Molecular Imaging respectively. The other 50% were provided in one of three ways: by NHS Trusts (eg Guy's & St Thomas's and the Royal Marsden) which had their own in-house scanning services; by independent medical charities (eg Paul Strickland unit, Mount Vernon hospital and Cobalt Health, Cheltenham); and by NHS Trusts in conjunction with private suppliers (eg the Nottingham InHealth PET-CT centre at the Nottingham City Hospital campus).
2. Around 50,000 scans per year were conducted in England and whilst particular volumes were prescribed in the contracts for PET-CT scans, usually no specifications were made for FDG (Fluorodeoxyglucose).
3. The producers of radioactive tracers used in PET-CT scans in the UK were either commercial suppliers or academic/research institutions, which produced tracers for their own use rather than the open market. As there were only three suppliers of such tracers available within the UK, there was an element of dependency on the security of supply. There was no indication that any commercial producers were planning to build new cyclotrons.

#### **The market and views on the merger**

4. Whilst cyclotrons were generally reliable, they did break down occasionally and at present companies provided back-up for each other. A recent breakdown of the cyclotron at the Mount Vernon site had meant that FDG-18 was supplied by the Royal Marsden (Sutton) for a period of time. Dr Wong was concerned that if one company undertook both scanning and the production of FDG, its primary concern would be to serve its own scanners first if a breakdown occurred and its secondary concern would be how much it should charge for the FDG needing to be supplied to its competitor. At present this was not an issue, but he feared that it could potentially have negative effects for patients.

5. Dr Wong said that it was understandable that a PET-CT scan provider would want to secure vertical integration (eg Alliance and Erigal) as this would give the scanning provider better control over its service provision. He also speculated that it might decrease the price for scans and hoped that vertical integration would therefore be beneficial for the consumer. He noted that to his knowledge all operable cyclotrons in the UK were operating to maximum capacity in the manufacture of FDG-18. Several factors hindered the manufacture of alternative tracers in the UK at present, including the complexities of changing the 'target' on cyclotrons in order to manufacture other tracers, and in turn having to take a cyclotron producing FDG-18 offline for a sustained period of time. A company which could provide multiple tracers, such as fluoride and choline (used in prostate cancer PET-CT scanning), would be useful.

## **Tenders**

6. Dr Wong said that whilst PET-CT scan contracts included key performance indicators (KPIs), for example scanning failure rates, it was left to the scan suppliers to put in place suitable back-up arrangements for the supply of the tracers. The ISTC PET-CT contracts did not contain specific targets or KPIs for scanning failures rates solely due to FDG production failure, but overall scanning failure. The primary provider was responsible for assuring adequate and robust supply, therefore the commissioners had very little authority over the tracer suppliers in this regard. The main concern for hospitals was that patients were provided with their scans on schedule/without any delays. Hospitals and the NHS were not overly concerned about whether a scanning provider had access to its own internally produced back-up supply of tracers. The main advantages a tracer producer (whether as part of a scanning provider or not) would gain if it had several cyclotrons would be the ability to provide a consistent supply of different kinds of tracers.
7. Looking into the future Dr Wong said that whilst FDG was the main tracer at the moment, other tracers would become increasingly important. He said that if one company could produce a whole range of tracers, it might be easier to negotiate better prices. However, such an approach would leave the NHS market dependent upon one supplier for the vast majority of tracers which in turn might create an over-dependency on one supplier.
8. Dr Wong said that the current division between the North and South had been an arbitrary split and plans were currently being developed by NHS England to re-procure the existing PET-CT South and PET-CT North provision. The re-procurement process specified four lots of provision to England; this might result in two or more providers, depending upon the outcome of the process.

## Pricing

9. Pricing of PET-CT scans within tenders was complex and variable depending on the contract. The tenders were also only concerned about the final product delivered, therefore in theory it would be possible for a company to bid for a contract without an FDG supply contract in place and without having a back-up supply guaranteed.
10. Unlike many other NHS services, there was no PET-CT mandatory tariff pricing. It was noted that the PET-CT reference group had recently given evidence to Monitor against the introduction of a mandatory tariff for these scans. Whilst pricing for FDG-18 was relatively straightforward, there were difficulties in pricing for other tracers used for other purposes (eg choline). There were also cost base differences in service provision with London operating at a 35% mark-up over the rest of the country.
11. Procurement currently for PET CT was undertaken through local area commissioning teams. Whilst hospitals might prefer to opt out of the block contracts and set up their own scanners or buy in services from a scanning provider, in part because fixed scanners were more versatile than mobile ones, it was often not practicable for hospitals to do so due to the higher set-up costs involved. Also, for a scanner's operation to be financially viable, a minimum of eight patients per day over three days a week would need to be scanned.
12. National specifications for PET-CT scans relating to standards and quality had come into force in 2013. A national diagnostic database did not yet exist, though the National Cancer Intelligence Network was working towards improving the collection of information about cancer patients to enable better analysis and research into patient needs, which included the creation of a Cancer Outcomes and Services dataset (COSD) in 2013.
13. Providing scanning services, as with many other areas of NHS procurement, might sometimes mean having to balance the tensions between the costs of delivering a quality service to patients and the price demanded from providers of the service. In other words, there needed to be careful consideration made to ensure that reducing the overall price of the service did not erode quality. Consequently, the extent to which the NHS could use its buyer power was tempered by these factors.