Community Diagnostic Centres

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A leaked internal report by Mike Richards on Community Diagnostic Centres (CDCs)s is pretty grim reading when considering the financial concerns and operational usage. Especially as these facilities did not exist at the start of this decade, and should have given us a unique opportunity to reform the elective care pathway. Making significant inroads into reducing waiting times.

However, this internal document doesn't raise any new concerns or observations. I merely builds on what the NHS has already known.

I was invited to an All Party Parliamentary Group for Diagnostics round table, as part of the Royal Collage of Pathologists commission, to understand and unveil the challenges and triumphs of the CDCs.

Their excellent report, published in 2023/4 is in-depth and well researched and published publicly.

What is stark to me, is that three years later in Mike Richard's report the same observations and recommendations are being made.

The NHS continues to stand still and not act on recommendations made, including to isolate the activity and waiting times and making this public, clearly two key metrics to understand their benefit, yet is information that the centre does not have sight of, yet it continues to increase the rollout of new sites.

Having responsibility of the CDC programme while at NHS Sussex, I can say with experience, that these two reports and their findings reflect the position I faced, identified and raised formally within our planned care governance reporting.

Yes, they are delivering more tests, numbers that are truly eye watering, but at what expense …

… both financial contracting and workforce, and with +300,000 extra tests completed in Sussex, alone, why was their no real impact on the elective waiting list… both DM01 and RTT?

It's just not plausible that the CDCs are being optimised and utilised to bring down the DM01 and reduce demand into the acutes, the key rationale to justify their existence. The additionally of activity at a national level is mind boggling but the diagnostic waiting times have not reduced in line with the increased activity.

The DM01 remains stubbornly high and nowhere near achieving the constitutional standard of 1%, a key metric to deliver and sustain the RTT 18 week standard.

Referral demand into secondary care has not reduced as a result and hence the live discussion on A&G and clinical triage models.

Of the referrals still coming into secondary care, the percentage of patients discharged after their first Out Patient Appointment has not reduced.

Indicating any pre work-up to referral has not altered treatment plans and reduced steps in the elective pathway and increase clock stops earlier on in the pathway.

ED attendances continue to rise, especially in the minor / non admitted patient cohort, and likely to be the patient group that with primary care access to CDCs could be helped and prevent them to go to A&E?

With all this extra diagnostic capacity, why are we not seeing the dial shift for both elective and emergency patients?

My key frustration with the CDC programme, is just that – the labelling of it is a programme. The silo approach structurally meant this continued down through the layers of the NHS and into the system.

For some reason these are not considered as embedded capacity within

the NHS and therefore how with good operational planning, can drive waiting times improvement, and so rarely part of operational discussions but…

… reporting separately as part of improvement reports.

And, of course, coupled with the financial arrangements,

Mike Richard's report recommends that NHSE have a communication and PR campaign to help raise the profile of the CDCs.

I disagree.

I am not aware of any PR campaign needed for non CDC diagnostic departments, so why should these be any different,

If acute trusts simply, as part of annual planning, include CDC capacity into their activity plans as a separate line, to lock down their elective trajectories, by doing so, without CDC activity delivering, performance will be at risk.

This simply rarely happens. But if it did, no PR campaign needed to maximise their usage.

I tried but failed to get the acutes within Sussex to

see another opportunity with the CDCs.

With bed capacity high and corridor care continuing,

contributing to this will be inpatients waiting for a diagnostic test before a decision to discharge can be made.

A solution I put forward, is to understand the miss-match between onsite inpatient diagnostic capacity and the demand from the wards…

… and to then amend their templates accordingly by; reducing the elective ambulatory slots and using the CDC capacity to offset the elective capacity.

All to often during winter, as this flexing of capacity across the system doesn't happen. Elective diagnostic activity is cancelled to manage the non-elective demand. It's often for CT and MRI scanners to breakdown in the acutes and so the elective cohort suffers . Rarely did these patients get moved to a CDC resulting in a spike in waits.

But its not just test-access but reporting where on the whole is turned around quicker, crucial for moving a patient on the elective pathway and a key bottleneck at either clock stopping a patient or flipping them onto the admitted waiting list.

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