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Community Diagnostic Centres

23.06.22

Background

- Professor Sir Mike Richards' conducted an independent review of NHS diagnostic services in October 2020, *Diagnostics: Recovery and Renewal*.

- There were several recommendations of this report including separating acute and elective diagnostics and increasing the amount of imaging equipment.

- One of the key recommendations of the report was for the rapid establishment of Community Diagnostic Hubs (now called Community Diagnostic Centres/CDCs).

CDC Aims

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All CDCs must contribute to the following primary aims:

1. To improve population health outcomes by reaching earlier, faster and more accurate diagnoses of health conditions.
2. To increase diagnostic capacity by investing in new facilities, equipment and training new staff, contributing to recovery from COVID-19 and reducing pressure on acute sites.
3. To improve productivity and efficiency of diagnostic activity by streamlining provision of acute and elective diagnostic services where it makes sense to do so; redesigning clinical pathways to reduce unnecessary steps, tests or duplication.
4. To contribute to reducing health inequalities driven by unwarranted variation in referral, access, uptake, experience and outcomes of diagnostic provision.
5. To deliver a better and more personalised diagnostic experience for patients by providing a single point of access to a range of diagnostic services in the community.
6. To support integration of care across primary, community and secondary care.

CDC Aims

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All CDCs also have several cross-cutting aims:

A. To improve staff development and satisfaction by offering new roles, development opportunities, training excellence and an opportunity to work in flexible and innovative ways.

B. To Make Every Contact Count and deliver health promotion and/or signpost to other services where it is meaningful and impactful to do so.

C. To utilise CDHs as test sites for quality improvement, research, innovations and service evaluations.

D. To contribute to NHS Net Zero ambitions, by enabling fewer outpatient attendances and reducing patient journeys to acute hospital sites.

E. To act as anchor institutions, consciously supporting positive social, economic and environmental impacts locally, through workforce and training and wider local regeneration to advance the welfare of the populations they serve.

CDCs Must as a Minimum

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- Be located separately from the main acute hospital facilities or if on an acute hospital site have a separate entrance and accessed without passing through the emergency facilities.
- Be accessible for extended hours (12-14 hours per day, 7 days per week).
- Receive referrals from primary, community and secondary care. Referrals can cover both tests for new diagnoses and follow up patients. CDCs may consider accepting self referrals but this is not considered a minimum requirement.
- Book patients in for a coordinated set of tests and inform patients of the preparation they require before coming for their tests.
- Carry out the range of diagnostic tests required for a patient in as few visits and in as few locations as possible. The minimum required tests are included on a later slide.
- Report in a timely way to the referrer. CDCs must have the digital infrastructure and connectivity to share data outcomes of procedures and other relevant information for interpretation.

Other Considerations

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- **Achieving value for money**: This should be a guiding principle, balancing the ability to optimise funding in 2021/22 and deliver value for money in the long term.
- **Longer-term impact**: Systems should consider opportunities to continue to develop diagnostic services and CDC provision beyond 2021/22 in line with local need and subject to further funding.
- **Speed of deployment**: Sites should be selected that can be developed within the first year, to maximise elective recovery and transformation of diagnostics services. This may mean selecting a site to provide a limited range of diagnostic services in 2021/22, but with the ability to expand from year 2 onwards.
- **Coordination with local and regional priorities and estates plans**: Including access to and distribution of diagnostic facilities across a region.
- **Staff and patient engagement**: Systems should consider engaging staff and patients as part of location or site selection.

National Guidance for CDCs

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CDC Service Offer: Minimum Required Tests

NB: There is a clear need for local decision-making on what diagnostic tests to include in a CDC. Regions and systems should look at local need to identify what tests beyond the minimum requirements to include in their CDC design. For some systems, there may be a strong reason to not undertake a test that is nationally considered a minimum requirement. In this circumstance, systems will be required to justify their rationale to regions.

Draft minimum requirements for CDCs

		All CDCs	Large CDCs
Imaging	• CT • MRI • Ultrasound • Plain X-Ray	✓	
Physiological Measurement	• Echocardiography (ECHO) • Electrocardiogram (ECG) including 24 hour and longer tape recordings of heart rhythm monitoring • Oximetry • Ambulatory blood pressure monitoring • Spirometry, including reversibility testing for inhaled • FeNo, exhaled carbon monoxide & Lung Function Tests • Blood gas analysis via POCT • Simple Field Tests (e.g. six minute walk) • Issuing of multichannel equipment for recording home 'limited' sleep studies	✓	
Pathology	• Phlebotomy • Point of Care Testing • Simple biopsies • NT-Pro BNP • Urine testing • D-dimer	✓	
Endoscopy	• Gastroscopy • Colonoscopy • Flexi sigmoidoscopy		✓

Potential optional diagnostic tests appropriate for inclusions in a CDC

Diagnostic modality	Test	
Imaging	Mammography Elastography (e.g. Fibroscan) CT colonography	DEXA scan PET scan
Physiological Measurement	Simple pH monitoring Simple sleep studies Urodynamics	Audiology services Non-complex neurophysiology services Electrophysiological tests
Endoscopy	Colon capsule endoscopy Transnasal endoscopy	Cystoscopy Hysteroscopy Colposcopy

Diagnostic tests that are not appropriate for delivery through a CDC

Endoscopic Retrogade Cholangiopancreatography
Complex sleep studies that include monitoring of ECTG
Bronchoscopy and endobronchial ultrasound (EBUS)
Complex interventional procedures including biopsies of internal organs
Trans-oesophageal and stress ECHO
Cardiopulmonary exercise tests
Some challenge tests

Please note: this is a non-exhaustive list of optional and non-appropriate tests

CDCs should be COVID secure sites

Models of CDCs

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Archetype	Description
Standard Model	A CDC that provides the minimum diagnostic tests, except for endoscopy, and any other diagnostic test deemed a priority locally. Only diagnostic testing is required to be carried out in this archetype; however, provision of consulting rooms should be considered if there is an opportunity for streamlining and providing more efficient overall patient pathways.
Large Model	A large CDC that offers all minimum services and endoscopy, and potentially provides some of the optional components in the diagnostic pathway e.g. consultation**.** Delivery of endoscopy needs to be embedded within a Regional Network and be aligned to any local endoscopy training academies.
Hub and Spoke Model	The central hub must include all minimum diagnostic tests to support a coordinated service for patients that requires multiple tests. CDC 'spokes' provide further capacity to 'hubs' for specific tests through a satellite location, mobile unit or pop-up. Spokes can be used to meet specific service needs (e.g.to reach certain populations or increase local capacity for specific tests). The spokes can help integrate CDC models with other community diagnostic expansion (e.g. primary care diagnostic services) or to deliver care at home where this helps to progress the intended aims of the programme. Spokes should also be considered in areas that can support local recovery from COVID-19. There must be digital connectivity and interoperability between the different facilities comprising the hub and spoke model.

Pathways for consideration to include in CDCs

- Cardiorespiratory/ cardiovascular health
- Cancer pathways
- Musculoskeletal conditions
- Urology pathways
- Gynaecology pathways
- Maternity services
- ENT services
- Health Check and Screening services
- Gastro and liver services
- Ophthalmology
- Diabetes
- Long covid

Programme Leadership and Governance

- The CDC programme is jointly led between ULHT and the CCG. Claire Lloyd is the Programme Lead with Sarah Brinkworth supporting the project leadership; the Senior Responsible Officer role is done jointly between Clair Raybould, Director of Operations for the CCG and Simon Evans, Chief Operating Officer at ULHT.

- Th Project Board reports into the System Planned Care and Diagnostic Programme Group and into the Clinical Support Services Division within ULHT.

- There are 5 subgroups formed underneath the Project Board – estates, finance, workforce, comms and engagement and digital. There is also a working group that meets twice per week.

Work to Date – the last 12 months

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May 2021
Establish programme leadership and governance

14/06/21
Verbal feedback that bid was approved and business case needed drafting

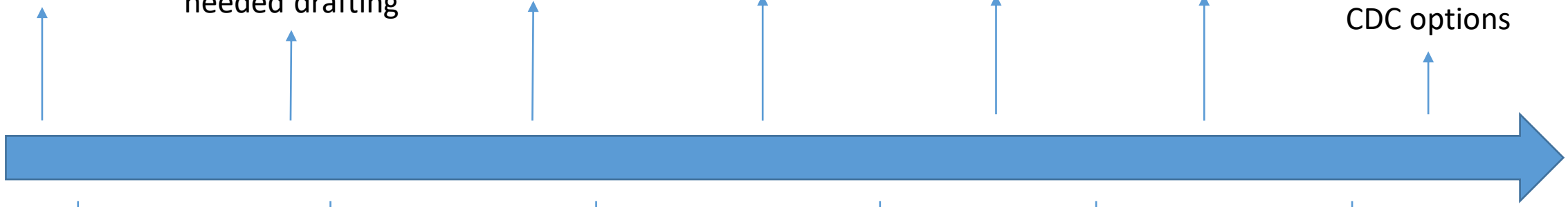
07/07/21
Grantham CDC business case submitted

28/09/21
Formal approval for Grantham CDC funding

03/01/22
Work started at Gonerby Road, Grantham CDC

25/04/22
First patients seen at Grantham CDC

End of April/ beginning of May 2022
Stakeholder engagement on second CDC options



17/05/21
CDC bid submitted for year 1 for Grantham

June 2021
Engaged with Lincoln University regarding starting a radiographer course

16/08/21
Spending review bid submitted for funding for the next 5 years. This focussed on 3 additional sites

24/12/21
Formal notification of capital outcome of the spending review

18/01/22 – 18/02/22
Phase 1 patient engagement

End of April 2022
Phase 2 patient engagement launched for 8 week period

Plans for Expansion of CDCs across Lincolnshire

- Expansion of the Grantham CDC business case to be drafted by end of June.
- Development of the second Lincolnshire CDC business case to be completed by the summer - the East Coast remains a focus due to poor access and high health inequalities.
- Public Health analysts have developed some proposed options on ‘where’ the next CDCs could be located based on health inequalities and access to current services.
- They are also working on the ‘what’ could be included based on health pathways that are prevalent in those areas.
- Further engagement with stakeholders and the public.

CDC Engagement and Involvement

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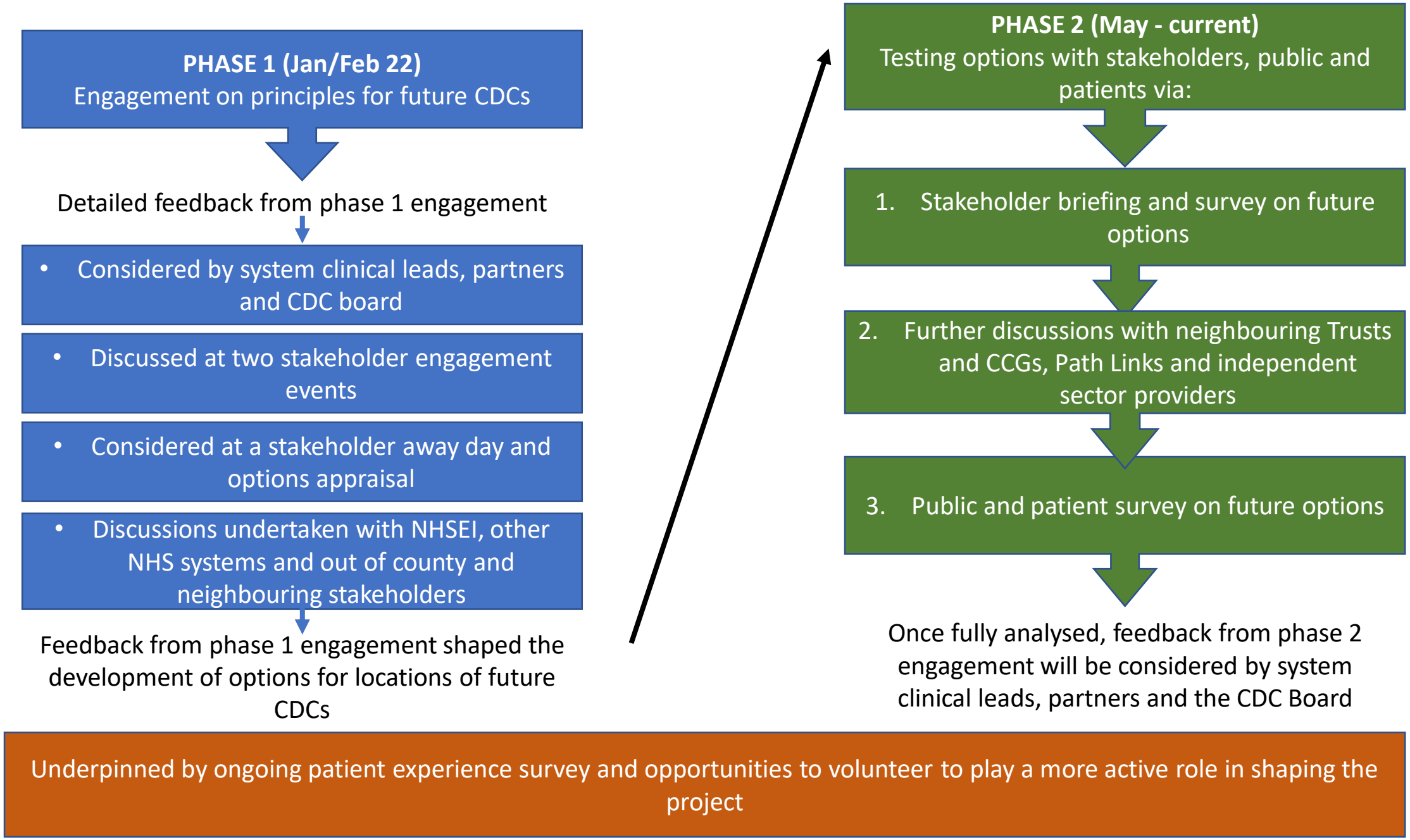
- Our patients, public, staff and stakeholders have been involved throughout the programme with their views and feedback shaping the principles and future options for the development of the CDCs.
- Our engagement has enabled a continuing and on-going process of developing relationships and partnerships so that the voice of local people and partners is heard and that our plans are shared at the earliest possible stages.
- This CDC programme is the development of additional services and not considered a substantial change or variation in the provision of a service and therefore a formal consultation is not required.


PHASE 1 (Jan/Feb 22)
Engagement on principles for future CDCs
Detailed feedback from phase 1 engagement
• Considered by system clinical leads, partners and CDC board
• Discussed at two stakeholder engagement events
• Considered at a stakeholder away day and options appraisal
• Discussions undertaken with NHSEI, other NHS systems and out of county and neighbouring stakeholders
Feedback from phase 1 engagement shaped the development of options for locations of future CDCs
PHASE 2 (May - current)
Testing options with stakeholders, public and patients via:
1. Stakeholder briefing and survey on future options
2. Further discussions with neighbouring Trusts and CCGs, Path Links and independent sector providers
3. Public and patient survey on future options
Once fully analysed, feedback from phase 2 engagement will be considered by system clinical leads, partners and the CDC Board
Underpinned by ongoing patient experience survey and opportunities to volunteer to play a more active role in shaping the project

Phase 1 Engagement

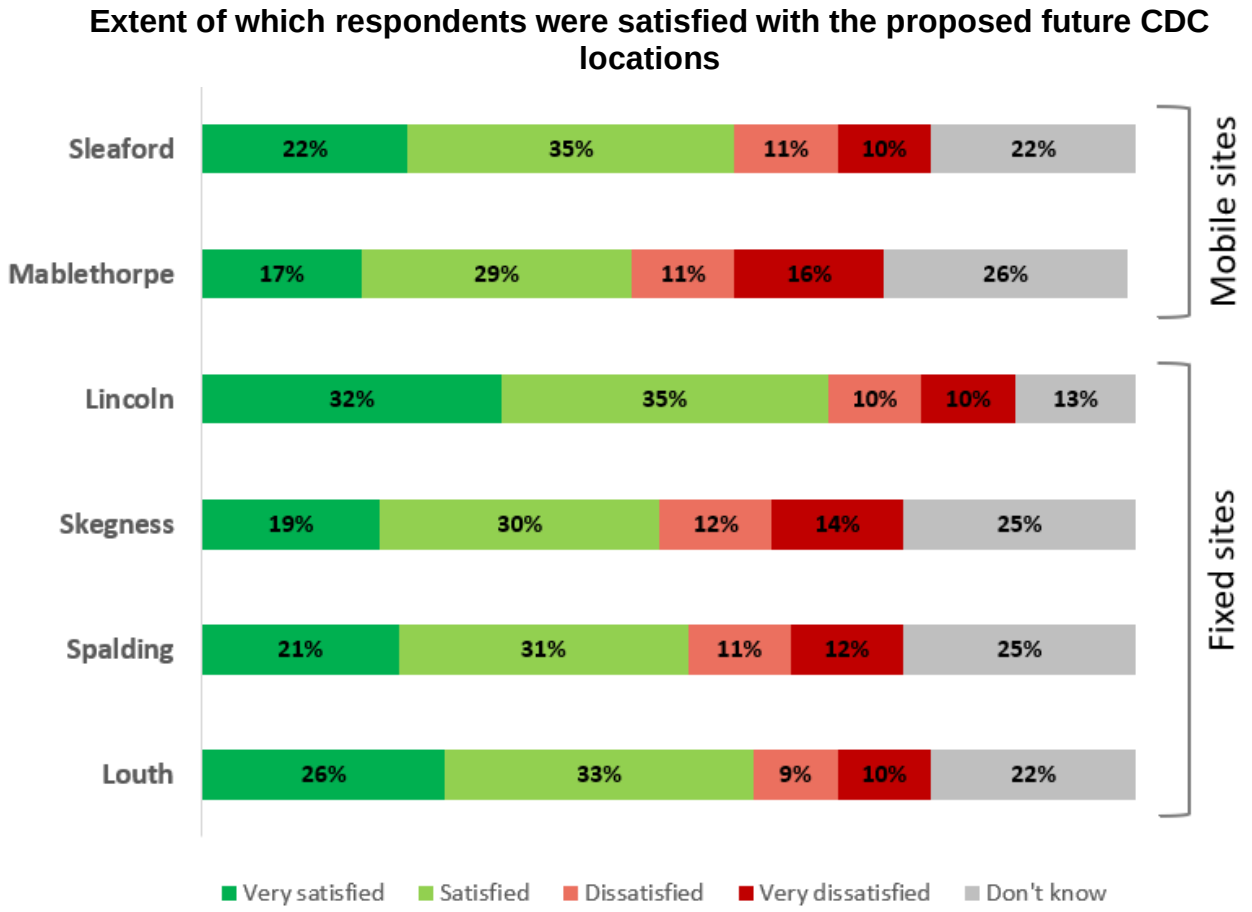
In addition to the activities discussed on the previous slide, initial CDC engagement was carried out between 18 January to 18 February 2022, and we received 1054 responses.

The aim of the survey was to understand what is most important to the public when providing CDCs and what the benefits and concerns are for them, so that we can mitigate these in the future. Feedback from this engagement informed the CDC decision making process to help shape the principles for the future CDCs and informed the development of the options for CDC2.

The graph to the right shows the extent of which respondents were satisfied with the proposed future CDC locations.

We heard that:

- Respondents felt most satisfied with Lincoln as a potential future location for a fixed CDC, this was closely followed by Louth.
- Overall, a higher number respondents were satisfied with Sleaford as a proposed mobile site, compared to Mablethorpe.
- Boston, Gainsborough, Horncastle and Stamford were regularly suggested as other appropriate locations.



Full analysis and reporting has been considered and looked at in workshops to help support the options development for future sites.

Phase 2 Engagement

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Engagement for the second CDC is currently underway:

- Stakeholder engagement on the potential location options for CDC2 and opportunities for collaboration was launched on Thursday 28th April and was available until Thursday 12th May. This deadline was extended and all entry submissions were allowed up until the point of report writing.
- The stakeholder survey and briefing pack was circulated to over 100 stakeholders. Subsequently further discussions were held with stakeholders such as Path Links, out of county and neighbouring Trusts and CCGs and private sector providers.
- A public and patient survey on the potential location options for CDC2 was launched Thursday 28th April and will run for a minimum of 8 weeks. This can be extended if time allows to submit the business case.
- A patient experience survey, which is ongoing is currently live to gather feedback on patient's experiences of the services received and what changes they would like to see in the future.

Options Being Considered for CDC 2

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Lincoln as a large CDC (one that includes endoscopy)

- Largest catchment area for both patient demand and workforce
- Would address the requirement to have a large CDC in the county
- Would support training facilities and urgent care pathways
- Doesn't address areas of highest health inequalities (East Coast) or challenges in access

Louth Hospital as the hub (including endoscopy), with spokes at Skegness and Mablethorpe

- Would address the requirement to have a large CDC in the county
- Would address health inequalities and some of the access challenges
- Capacity is currently difficult to use at Louth due to patients being unwilling to travel
- North Lincs may be looking at locations in Cleethorpes and Grimsby

Boston as a hub, with spokes at Skegness, Mablethorpe and possibly Spalding

- Would address health inequalities and some of the access challenges
- Has better transport links to/from the East of county than other two sites
- May not be able to have an endoscopy room – would need conversations with NHSEI about the expectation to have a large CDC in the county

Summary of Next Steps

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- Expand Grantham CDC
- Develop a second CDC
- Consider opportunities for future developments for CDCs

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Any Questions?