Regionalisation is no silver bullet for NHS diagnostic pressures – but it must not fail

Regional approaches to imaging are spreading in the NHS. This will end institutional tribalism, transform peer support, and allow patients to benefit from diagnostic expertise like never before, writes Richard Turner, executive director at Change Healthcare.

In the late 1990s, radiology was a very different place. Still analogue, departments relied on light boxes, and professionals performed more specific site-based roles. At the time, I worked in the radiology department of a London hospital, and started a change programme with my hospital colleagues to shake up roles.

We taught radiographers to give IV injections, and to do basic nursing care. We started teaching nursing staff to order imaging. And we encouraged radiographers to carry out reporting and procedures like barium enemas. The sort of approaches we instigated are now common. For example, when a patient goes for a maternity ultrasound today, a midwife might perform the scan. But 20 years ago, we were quite leading edge in the NHS, and even caught the attention of the then prime minister Tony Blair, who asked me on a visit to our ambulatory care service, 'should all hospitals do this?'.

Importantly, we were trying to spread skillsets and to break down boundaries over who's job a task might be. We were also innovating with technology like the hospital's picture archiving and communication system, or PACS, and centralised booking to achieve our aims. This was about focussing care delivery around the patient, rather than the professional or institution. It meant a seamless move for the patient throughout the organisation; that they could access services, professionals and appointments in a single attendance.

Jump forward two decades, and the diagnostic regionalisation agenda now spreading across the NHS, is not so different in ambition. This is just as much about pushing boundaries, spreading skills, and centring services around patient needs.

Care has left the hospital

A lot has progressed since my early NHS days. The digitisation of radiology, for example, has had a big impact on effective reporting, diagnoses and care. The question now being asked is whether technologies and even whether diagnostic disciplines can remain confined to an individual hospital.

In places like Ireland, PACS has already been deployed nationally, with significant positive implications for the ability to report on any patient, regardless of location.

And in England, similar sized populations are starting to benefit from region-wide PACS that cover multiple trusts to support visions where imaging records can be accessed and reported on from any appropriate location, by any appropriate healthcare professional.

Care really has left the confines of the hospital. What we did in the 90s and noughties is long past – and the siloed approaches for institutional diagnostics are no longer relevant for an NHS where greater collaboration is required, and where patients expect their imaging to follow them.

Regionalisation is fundamental to ending institutional level boundaries, and the benefits are so great that the agenda must prevail.

Prioritising: patients, providers, professionals

We are about to witness a major change in access to diagnostic services. Regionalisation will break down care and resource barriers, and by intelligently prioritising workflow across providers, there is an opportunity to deliver the equitable access to professionals and expertise that patients need.

Cancer referrals have a greater chance of being addressed in required timeframes. For screening, if your hospital's mammography specialist isn't available, then there is suddenly a regional number of professionals to draw on. A production level of diagnostics and referral can be maintained with a bigger pool of staff.

For emergency care like a head injury, a clinician in a busy hospital might struggle to find the radiologist needed. In a region, multiple consultants can review the image, allowing faster diagnosis.

And regional approaches can inform the best decision on where a patient receives care. Several years ago a patient presented to their hospital with flu-like illness. They had progressive shortness of breath, and pleuritic chest pain. The patient's imaging was read at another hospital, before the individual was transferred to the region's specialist centre – the best place to treat eosinophilic pneumonia. Only by working together could the three sites involved identify the illness and the most appropriate response. As diagnostic regionalisation spreads, this collaboration could become far more commonplace in the NHS.

Bigger peer review and regional best practice

An entirely new culture of sharing best practice could be on the horizon, with big implications for improving quality. Regionalisation can enhance expertise in a way that wouldn't otherwise exist.

Through peer support, and knowledge transfer, quality can be driven up regionwide. For instance, when hospital A is performing well at a particular function, can it share its approach with the lower performing hospital B?

Individuals too can benefit enormously from being part of a bigger setting. As data flows across the region, teaching resources can be built from far bigger datasets of a quality not previously seen, with implications for training a highly informed next generation of diagnostic professionals.

Larger peer groups can also allow for better working conditions – not only from the perspective of balancing worklists, but from better access to colleagues. In an ever increasingly pressured NHS environment, healthcare professionals can be slightly less stressed around making the right decision, when they can share peer review to allow validation they are making the right diagnosis for a patient.

Overcoming resistance

The NHS must be careful not to repeat the mistakes of the past around matters like engagement. Staff might ask themselves: "Am I still in control? Am I still the eminent specialist?" But the benefits for these individuals can be huge, with possibilities like home-based reporting, and the potential to play a bigger role across the regional community.

More importantly, in their DNA, professionals are singularly focussed on patient outcomes. When they can see the impact on outcomes from moving to regionalised diagnostics, they will undoubtedly support the ambition.

No silver bullet

A new regionalised landscape has tremendous potential to instil new confidence in the ways illnesses are diagnosed. But the NHS must be careful not to expect regionalisation to solely solve the rising demand and diminishing resource challenge so often cited in discussions.

Will it make a difference to the workload? Quite probably in the shorter term. But demand will continue to rise, and there will come a point where other interventions are needed – whether that is AI or new approaches to prevention, big data and population health.

Regionalisation is not the silver bullet, but for everything it does mean to improving care, it must not be allowed to fail.