COMMENTARY

Primary care access to diagnostics: a paradigm shift

DANIEL BIRCHALL, MA, MB, BCHIR, FRCP, FRCR, MD

Neuroradiology Department, Regional Neurosciences Centre, Newcastle General Hospital, Westgate Road, Newcastle-upon-Tyne, NE4 6BE, UK

ABSTRACT. There is increasing medico-political impetus for the provision of direct access imaging services to primary care. This is likely to have fundamental effects on the way that imaging services are organised and provided, and radiologists need to be aware of the paradigm shift that is being promoted. This commentary summarises some of the key issues arising, and has been written to complement a recent conference organised by the British Institute of Radiology.

Received 7 October 2009
Accepted 8 October 2009

DOI: 10.1259/bjr/88648707

© 2010 The British Institute of
Radiology

There is increasing momentum in improving access to diagnostic services for primary care physicians and allied health professionals, in particular, to imaging [1]. Although direct access to plain film imaging in particular has existed for several years in many centres in the UK, the implied shift of diagnostic resource from secondary to primary care creates a new paradigm for the way in which patient care pathways operate. Hence, fundamental change regarding the ethos of imaging service provision may be underway. Many issues relating to this process were discussed in a recent one-day conference organised by the British Institute of Radiology's Industry Committee entitled 'Diagnostic Imaging Partnerships between Independent Sector Providers and Primary Care Trusts'.

The drive to improve primary care access to imaging services is encapsulated in the Department of Health's 2008 documents *Care Closer to Home* [2] and *NHS Next Stage Review: Leading Local Change* [3], chaired by Lord Darzi. These documents champion the introduction of change through "disruptive innovation", i.e. change involving radical service redesign, centred on improving the quality of care that patients receive and with an emphasis on devolving key aspects of care pathways from secondary to primary care "to empower the frontline".

As part of this process, there is an explicit medico-political impetus to reconstruct the processes through which patients undergo imaging as part of their clinical pathway. The aims include equalising access to diagnostic provision across primary and secondary care, and hence improving the perceived quality of service that patients receive during the diagnostic component of their care. Specifically, there is a powerful drive for direct access to all aspects of imaging for primary care physicians and allied health professionals.

The shift of 'power' from secondary to primary care has, in effect, already undergone large-scale piloting. On the basis of these pilots, the process is developing very powerful political and clinical support within Government, Strategic Health Authorities and Primary Care Trusts (PCTs) and among primary care providers. As part of the process of shaping the nature of imaging services in primary care, independent-sector providers — possibly the most high-profile of which is the London NHS Diagnostic Service — have been closely involved in the planning, delivery and auditing of direct-access diagnostics in primary care.

The London NHS Diagnostic Service was established by the InHealth Group in 2007 following a competitive tendering process organised by the Department of Health. Local PCTs and federated general practice groups utilise the service, which charges for imaging services including ultrasound, plain film and MRI at standard tariff costs. The London NHS Diagnostic Service currently operates at more than 60 sites across London — including sites within general practices and shopping areas — and currently delivers more than 7,000 MRI scans and ultrasound studies to primary care each month. The Service is undergoing continuing expansion, with a new independent imaging site being established in London every two weeks. MRI reporting is provided by groups of NHS-based Consultant Radiologists operating within an independent organisation affiliated with the private provider. As such, InHealth claim that they "lead the way in open access to a wide range of diagnostics for both GPs and designated specialists in primary care", and that they do so in a way that is timely and of a quality at least equivalent to that provided in secondary care.

The response to this service from primary care in London has been positive. For example, the Croydon Federation of General Practices has audited its interaction with the London NHS Diagnostic Service, and concluded that the Service provides a high-quality service and rapid access to imaging in a way that provides 'value-for-money', improves clinical management, and enhances

Address correspondence to: Daniel Birchall, Neuroradiology Department, Regional Neurosciences Centre, Newcastle General Hospital, Westgate Road, Newcastle-upon-Tyne, NE4 6BE, UK. E-mail: Daniel.birchall@nuth.nhs.uk

the patient experience. In this respect, the perception in primary care and medico-political circles is that the new direct-access service sets new standards of service delivery. Patient-centricity is promoted at the heart of the Service, through attempts to optimise choice and convenience by providing imaging not only closer to home but also at an appropriate time. The timeliness of the Service has also been optimised, with a maximum waiting time for diagnostics of two weeks (as compared with standard six-week waiting times at many local secondary care institutions). The nature of the interaction between primary care and the independent provider is also reported to be 'mould-breaking' in terms of the 'can-do', proactive, facilitative and communicative attitudes of the provider, which is held up in contrast to relationships with local secondary-care providers. The Croydon Federation has also audited the outcomes of its interaction with the Service, and concluded that there is overwhelming 'buy in' from local general practices and their patients. The Federation reports that clinical management in primary care has been facilitated and onward referral to secondary care reduced by a third. The beneficial effect of direct-access imaging on the effective functioning of the Department of Health 18-week referral-to-treatment targets within secondary care centres is also cited by all parties as a real and objective outcome of the Service.

A range of independent-sector providers are similarly supplying direct-access imaging to primary care elsewhere in the country – for example, by using static and mobile MR scanners within PCTs and GP practices, and through mobile ultrasound services. The London NHS Diagnostic Service differs from these other disparate arrangements by being centrally procured and by effectively acting as a formal pilot scheme for primary care direct access.

Many hospital trusts have developed direct access services for plain radiography provision to primary care over the past few years, with a smaller proportion providing access to ultrasound and MRI. Similarly, a high proportion of independent hospitals also offer direct access to imaging to GPs, usually through local engagement with PCTs. In support of this practice, the Royal College of Radiologists continues to update guidance on appropriate criteria for referral for imaging, primarily through *Making the Best Use of a Department of Radiology* [4] and, until recently, through the *Framework for Primary Care Access to Imaging: 'Right Test, Right Time, Right Place'* [5] (now withdrawn). It remains the case, however, that primary-care physicians in many locations feel that there are significant limitations in their freedom to access imaging, particularly CT and MRI, at secondary-care locations. Furthermore, there continue to be issues relating first to the timeliness and convenience of access to imaging and subsequently to the communication of imaging results provided by hospital trusts. In short, there are issues relating to the level of 'customer service' provided by secondary care to primary-care physicians.

From the point of view of PCTs, there are strong incentives to promote direct access to primary care. There is a new focus on 'outcomes' and on the development of 'strategic partnership working' to achieve the desired outcome standards'. In relation to imaging provision to patients, many PCTs are seeking to facilitate the 18-week pathways by improving the efficiency of the service

supplied by the imaging providers with whom they choose to contract. There is an impetus to reduce waiting times for diagnostics to two weeks or less; to improve patient choice and convenience in terms of the location and time of scanning; and to refocus diagnostic provision onto primary care. This process will be further supported by the planned break-up of the Department of Health's Commercial Directorate and the devolvement of its procurement responsibilities to PCTs. This will result in the further development of PCT provider arms, accompanied by the freedom to negotiate with any imaging provider – whether based within the NHS or in the independent sector. Indeed, many PCTs are embracing the market in an attempt to achieve their desired operational outcomes, particularly in relation to the timeliness of diagnostics provision, and in doing so to devolve access to diagnostics far more widely and 'closer to home'.

The Department of Health has been explicit in its support of all aspects of this process. There is a stated belief that imaging needs to be tailored to the needs of primary care, and that there is a requirement to overcome a perceived 'secondary care imaging agenda'. The need to involve the independent sector in achieving this aim is also stated – in part due to the perception in medico-political circles that provision of diagnostics by the independent sector has had an overwhelmingly positive effect on the national standard of imaging services, especially in relation to waiting times but also in relation to quality of service. The involvement of the independent sector in the process of shifting imaging from secondary to primary care is perceived as being disruptively innovative and as breaking down cultural boundaries. It is viewed as being important in the continuing drive to achieve 'zero waits' for the diagnostic aspect of clinical pathways. In support of this process, tariffs for primary care direct access have been unbundled from overall clinical pathway tariffs.

Consequently, the active engagement of the independent sector (as providers of equipment, radiographic technicians or radiologist reporting resource) is being encouraged at all medico-political levels. This 'power shift' from secondary care to primary care and from NHS-led provision to the independent sector has major implications for UK radiologists and radiology services.

It may well be that radiology services in secondary care will have to redesign radically the imaging services that they provide – either as part of a competitive tendering process in which they compete with the independent sector or in response to locally reduced demand as a result of independent provision of direct-access imaging.

Where a secondary-care provider aims to compete in the 'direct-access imaging market', it is likely that local increases in equipment and staffing resource would be necessary in many cases, and that there will be significant pressure on radiology services and on radiologists themselves either to demonstrate optimised efficiency or to adapt to new working arrangements tailored to increase throughput and work intensity. This may also increase pressure on the profession to undergo benchmarking of its performance. Provision of primary-care imaging will also require radiology departments (including radiologists) to become more 'customer-friendly' both to primary-care professionals and to their

patients. As part of this process, the way in which reports are structured and communicated by radiologists will also need to be adapted to for primary care.

Alternatively, in a situation in which direct access imaging is supplied locally by the independent sector, secondary-care providers may have to react to decreasing demand from primary care by downsizing, with resultant effects on radiologist recruitment and on existing work plans and patterns. In this scenario, it is not inconceivable that radiologists may increasingly adopt a portfolio of professional commitments – working not only for their NHS employer but also for independent-sector providers. The conditionality clauses that prevented NHS-based radiologists from interacting with the First Wave MRI Programme do not appear to be an active concern medico-politically, although several independent reporting houses are also figuring prominently in the mix. It is also likely that there will be an increased need for secondary-care radiologists to provide ‘second opinions’ on imaging and reports sourced externally for their clinician base, and it is likely that this will have to be factored into job planning in the future.

There are other logistical difficulties relating to the independent provision of direct-access diagnostics. For example, it may well be that suboptimal clinical referral information or lack of access to previous imaging in the

primary-care setting will, in a proportion of cases, increase the need for unnecessary subsequent investigation or referral. Nevertheless, the political momentum behind the shift to direct access for imaging seems to be so strong that it is unlikely that such considerations will be seen as ‘show stoppers’.

Radiologists need to be aware of the paradigm shift in imaging provision that is being promoted. It is likely to have fundamental and wide-reaching effects on the way in which radiologists practice, and requires proactive involvement by UK radiology bodies.

References

1. Cherryman G. Imaging in primary care. *Br J Gen Pract* 2006;56:563–564.
2. Department of Health. *Care Closer to Home*. London: Department of Health; 2008.
3. Department of Health. *Our NHS Our Future: NHS Next Stage Review – Leading Local Change*. London: Department of Health; 2008.
4. Royal College of Radiologists. *Making the best use of a department of clinical radiology: guidelines for doctors*. 6th edition. London: Royal College of Radiologists; 2007.
5. Royal College of Radiologists. *Framework for Primary Care Access to Imaging: ‘Right Test, Right Time, Right Place’*. London: Royal College of Radiologists; 2006.