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All-Party Parliamentary Group  
for Diagnostics

# CDCs Unveiled: Challenges & Triumphs

An Inquiry into Community  
Diagnostic Centres



The Royal College of Radiologists



The Royal College of Pathologists  
Pathology: the science behind the cure





# Foreword

I am delighted to present the first report from the All-Party Parliamentary Group for Diagnostics (APPGD) following our inquiry into Community Diagnostic Centres (CDCs).

The APPGD is dedicated to highlighting the value of diagnostics, advocating for the diagnostic workforce, raising awareness of the challenges faced by the sector, and proposing solutions. The group plays a vital role in improving overall diagnostic provision, which is particularly timely given the existing diagnostic backlog.

I would like to thank all those who gave evidence to this inquiry via our roundtable meetings, which took place in June and July 2023, to investigate the current state and future of the CDC programme.

The inquiry focused on assessing the effectiveness of the CDC programme in contributing to the government's strategy for expanding diagnostic capacity. Priority was given to gaining transparency on how and where the CDCs are established and their impact on patients. This led to extensive discussions on the location of CDCs, the services they provide, physical and digital infrastructure, and workforce capacity.

The inquiry identified clear benefits to the programme. Diagnostic capacity has been expanded to bring down waiting lists in some areas and, when situated in the heart of communities, CDCs offer convenient services to those who may not typically seek healthcare. The 2021 Spending Review investment has facilitated trust acquisition of new equipment, ensuring accurate tests and improved patient care. Innovating patient pathways and digitising services has streamlined operations and enhanced patient experiences. Finally, allowing healthcare professionals to rotate between CDC and acute settings provides valuable training and skill development, boosting staff retention.

However, challenges persist, especially in terms of delivery speed. Workforce capacity remains a limiting factor. It is impossible to realise the benefits of the programme without adequate staffing to operate CDCs. Currently, CDCs rely on a rotation model due to short staffing. Questions remain over how the programme plans to expand the workforce to meet demand and how NHS England's Long Term Workforce Plan will play into this.

Limited data on services at each CDC, including the absence of phlebotomy data in NHSE Monthly Diagnostics Data, restricts full transparency and our ability to critique the programme. Regardless, I believe there are missed opportunities for point-of-care testing, which could truly establish CDCs as "one-stop-shops."

In conclusion, this inaugural report thoroughly examines the CDC programme, aligning with the All-Party Parliamentary Group for Diagnostics' dedication to advancing diagnostic services for the benefit of all. The report underscores the clear benefits and challenges of the CDC programme, providing solutions and examples of best practice which we hope will be taken forward by NHS England and others.

It has been a privilege to serve as the APPG's Chair for the past year and I am committed to ensuring that the diagnostic sector receives the attention it deserves. Better patient outcomes depend upon it.

Maggie Throup MP  
APPG Chair



# Executive Summary

## Progress against targets

NHS England (NHSE) representatives reported progress on two of the four CDC program targets, as 127 CDCs are currently operational, ensuring the presence of at least one regular or large-sized CDC in each Integrated Care System (ICS) in England.

However, the pace of activity is slow, as only 6.5% of the total diagnostic activity reported on by NHSE occurred in CDCs in September 2023, and around 5 million tests have been conducted since July 2021 against a target of 17 million by 2025. While collaboration with the private sector has expanded service provision, persistent high demand and limited capacity present ongoing challenges, and the impact on patient outcomes remains unclear, emphasising the need for continuous evaluation and transparency.

1. In addition to grouping CDC sites under providers, NHSE should also ensure that activity of individual sites is reported in the NHSE Monthly Diagnostics Data dataset so that local activity levels and progress to address waiting lists can be better scrutinised.
2. NHSE should publicly release data – by patient pathway – showing the time taken between referral to the reporting of all tests, checks and scans undertaken within CDCs, to allow greater scrutiny of diagnostic pathways.

## The location of CDCs

CDCs aim to enhance diagnostic capacity in underserved communities, with NHSE prioritising their placement in areas identified through health deprivation maps to target and address disparities in life expectancy. Bids undergo a thorough approval assessing local diagnostic capacity, health inequalities, transport links, and cost-effectiveness.

Many initial CDCs were set up on acute hospital sites, but recent data shows a shift, with 5.2% of approved sites on acute hospital estates and 41% on community hospital estates. Evidence suggests that embedding CDCs in the heart of communities, after overcoming public scepticism using NHSE communication toolkits, significantly improves access to and uptake of diagnostic services, especially for those less likely to seek healthcare. Yet challenges remain as only about half of CDCs are situated in the heart of communities due to Trust budget deficits, high upfront costs, and risks associated with private renting hindering ICSs from making the “brave” choice.

1. In future Spending Reviews, the government should allocate further funding to establish CDCs in the remaining areas with high levels of deprivation, health inequalities, and limited healthcare resources.
2. NHSE should regularly review changing demographics and healthcare needs to ensure CDCs continue to be established in areas of greatest need.
3. To overcome low risk attitudes to establishing CDCs in community-based sites like shopping centres, NHSE should:
  - a. Provide financial incentives to ICSs willing to set up CDCs in community-based locations, so long as these locations meet the deprivation criteria. These incentives can help offset the high initial setup costs and mitigate concerns around risks associated with renting from private landlords for instance.
  - b. Expand support for ICSs pursuing partnerships with private landlords or commercial property developers to secure sustainable lease agreements for CDCs which are embedded in the heart of communities.

## The right tests, checks and scans

CDCs offer a range of diagnostic services, with minimum provision covering imaging, physiological measurement, and pathology due to their critical role in healthcare and high demand. Additional services, tailored to meet local needs, have and should continue to be integrated to confirm CDCs as true “one-stop-shops” for patients. Unfortunately, a lack of data and research limits the assessment of the programme’s effectiveness in achieving this goal.

1. NHSE should include phlebotomy data in the CDC NHSE Monthly Diagnostics Data datasets to allow scrutiny of the delivery of community phlebotomy services.
2. NHSE should commission research into the benefits and risks associated with integrating a) screening services and b) pre-assessment services for elective care into CDCs.

## Physical and digital infrastructure

Ensuring CDCs are equipped with up-to-date machines is crucial for accurate and efficient diagnostic procedures. NHSE are committed to providing new equipment for CDCs and are actively monitoring the condition of machines to maintain a high standard of care.

Digital tools, such as the iRefer tool and NHS App, are vital to streamlining diagnostics, improving efficiency and patient engagement. Unfortunately, despite pilot programmes like Feedback Medical’s digital infrastructure solutions at Queen Victoria Hospital showing significant gains, challenges with basic infrastructure and data sharing, plus inconsistent digital advancements, persist, underscoring the need for additional funding for robust digital infrastructure.

1. NHSE should provide more centralised digital leadership by developing a national strategy for the integration of patient data and digital tools within CDCs. This strategy should outline a roadmap for the adoption of digital solutions, including clinical decision support systems, to streamline the diagnostic process.

2. After CDC approval, system leads should conduct outreach with primary care providers within the ICS to increase awareness of the new site. If patient referrals from these providers do not reach the expected level, leads should engage in personalised outreach. This approach addresses misconceptions, resolves hesitations, and tailors communication to improve collaboration for effective CDC integration in healthcare.

3. NHSE should prioritise bolstering digital infrastructure and patient data sharing in CDCs. Periodic assessments should be conducted to address integration challenges.

4. NHSE should develop and enforce interoperability standards for digital tools used within CDCs to ensure seamless data exchange and collaboration between primary and secondary care settings. This standardisation will enable clinicians to access patient information across different points of care, improving coordination and decision-making.



## Workforce

The Richards' Review advocated for a substantial increase in the diagnostic workforce. However, persistent staff shortages, evidenced by shortfall figures and reports of unmanageable workloads, compounded by inadequate workforce planning and funding, continue to impede the effectiveness of CDCs.

Proposed solutions to the workforce crisis include hospital/CDC rotation models, international recruitment, "grow your own" initiatives, and collaboration with the private sector, though none offer a complete solution, with each carrying its own advantages and drawbacks. Ultimately, there is an urgent need to expand the diagnostic workforce in line with growing patient demand.

1. NHSE should regularly assess the workforce needs for the CDC programme. These assessments should feed into the NHS Long Term Workforce Plan, the modelling for subsequent workforce projections, and any workforce expansion plans.

2. To encourage local recruitment and training, NHSE should expand the development of dedicated healthcare academies and strategic workforce development partnerships between CDCs and educational institutions. CDC bids adopting the latter approach should be prioritised.

3. NHSE should monitor whether standardised onboarding procedures are implemented across all CDCs, and ensure that comprehensive training, oversight, and support mechanisms are in place for staff. To uphold high standards for patients, robust quality assurance mechanisms should be established by NHSE.

4. CDC system leads must implement a range of retention strategies tailored to the CDC context. To ensure the effectiveness of these strategies, continuous feedback mechanisms with healthcare professionals should be established, allowing them to pinpoint measures that can make a significant difference.







# Overview

Community Diagnostic Centres (CDCs) are multi-diagnostic facilities created to bolster local diagnostic capacity; enhance patient access, experience and outcomes; alleviate hospital burden; and address regional disparities in healthcare. They provide a range of imaging, endoscopy, physiological science and pathology services.

Initially proposed in Professor Sir Mike Richards' report, *Diagnostics: Recovery and Renewal*<sup>1</sup>, CDCs stemmed from the need to separate emergency and elective diagnostics for improved efficiency. Richards' report also advocated for investments in new service models, equipment, digitisation, and workforce. These topics formed the core focus of the APPG for Diagnostics' inquiry.

CDCs play a key role in achieving the government's goal of reducing waiting lists by expanding capacity and implementing the NHS Elective Recovery Plan. Consequently, there is a pressing need for rigorous scrutiny to ensure the programme's accountability and effectiveness.

As part of its inquiry into CDCs, the APPG for Diagnostics held two roundtables in June and July 2023 to investigate the current state and future of programme. Chair and former health minister Maggie Throup MP led discussion with the support of the joint secretariat, The Royal College of Radiologists and The Royal College of Pathologists.

The following experts gave evidence:

**Alex Pinches**

*Head of Community Diagnostic Centres at NHSE*

**Bob Kirton**

*Managing Director and Deputy Chief Executive at Barnsley Hospital NHS Trust*

**Charlotte Wickens**

*Policy Adviser at the Kings Fund*

**Daniel de Rozarieux**

*Elective Care Director at NHS Sussex*

**David Hare**

*Chief Executive Officer of the Independent Healthcare Providers Network*

**Dr Clive Vandervelde**

*Clinical Lead for Andover Community Diagnostic Centre*

**Dr Katharine Halliday**

*Consultant Paediatric Radiologist & President of the Royal College of Radiologists*

**Dr Rhyddian Phillips**

*Director of Diagnostics & System Improvement at NHSE*

**Dr Tom Oakley**

*Chief Executive Officer of Feedback Medical*

**Jonathan Gardner**

*Director of Strategy and Corporate Affairs at Whittington Health NHS Trust, Senior Responsible Officer at North Central London Community Diagnostic Centres*

**Philippa Robinson**

*Regional Director at Community Health Partnerships*

**Professor Michael Osborn**

*Consultant Histopathologist & President of the Royal College of Pathologists*

**Professor Sir Mike Richards**

*Chair of the UK National Screening Committee*

This report summarises expert evidence and recommendations, primarily presented as case studies in the report, to provide a blueprint for the future of the CDC programme.

Drafted by Hannah Drew of The Royal College of Radiologists, the report is independent: neither the APPG for Diagnostics nor secretariat organisations received donations.



# Progress against targets

The inquiry aimed to assess the CDC programme's effectiveness in reducing waiting lists and expanding diagnostic capacity. Senior representatives from NHSE provided updates on progress against various targets both during the roundtable discussions and in follow-up conversations with the APPG's Secretariat afterward.

## The Government will open 160 centres across England by March 2025

The Department and NHSE count CDCs delivering activity and accessing national CDC revenue funding as open<sup>2</sup>. This may include activity delivered in temporary facilities while the full CDC is built.

At the first roundtable (21 June 2023), NHSE representatives reported that rapid progress has been made, with 165 CDCs being approved, 105 of which were up and running. In December 2023, NHSE representatives revealed in unpublished data that 174 CDCs have now been approved and 127 CDCs have opened across the country, suggesting that the government is on track to deliver against this target.

## Each ICS will have at least one standard or large model CDC<sup>3</sup>

At the roundtables NHSE confirmed that the programme has achieved its target of ensuring there is one regular or large sized CDC in every Integrated Care System (ICS) in England.

However, concerns arose during discussion about the geographical distribution of CDCs. During the roundtables NHSE representatives acknowledged an uneven CDC distribution nationwide. Unpublished data shared by NHSE representatives showed that 6 of the 7 regions in England have between 23 and 31 CDCs each. The 7th, London, is geographically the smallest but has the highest diagnostic capacity provided by CDCs.

At the roundtables, NHSE representatives agreed that there was a need to focus resources on improving availability in regions like southwest England, the East of England and the Midlands, where coverage lags behind the national average and fails to meet demand adequately. To enable scrutiny of this area moving forwards, data on exactly how many CDC sites are in each region per population must be made publicly available.

In the 2021 Spending Review HM Treasury committed to investing £2.3 billion to transform diagnostic services<sup>4</sup>. In December 2022, former health minister Will Quince MP said that "the majority" of this funding will be dedicated to expanding the CDC programme<sup>5</sup>. However, roundtable experts gave funding constraints as one reason for limited CDC expansion into the areas listed above, suggesting further sustained investment is needed.

To guarantee that the programme can extend its services to areas of need, it is important to maintain scrutiny of this target.



## Up to 17 million checks, tests and scans will be delivered by CDCs by March 2025<sup>6</sup>

The tests, checks and scans reported on by CDCs across England in NHSE Monthly Diagnostics Data include MRI, CT, Non-obstetric Ultrasound, DEXA Scan, Audiology Assessment, Echocardiography, Electrophysiology, Peripheral Neurophysiology, Respiratory Physiology, Urodynamics, Colonoscopy, Flexi Sigmoidoscopy, Cystoscopy, Gastroscopy<sup>7</sup>.

NHSE started capturing data on the diagnostic activity delivered by CDCs from July 2021<sup>8</sup>. As of September 2023, the latest data release during the drafting of this report, 71 CDC providers regularly reported activity, prompting questions about the dataset's<sup>9</sup> completeness. Without full transparency, it is hard to predict whether the CDC programme will meet the 17 million target, but the evidence suggests not.

The latest DHSC press release (31 October 2023) states that "over 5 million" tests, checks and scans have been performed since July 2021<sup>10</sup>. This figure is confirmed in NHSE performance data showing that the cumulative number of tests, checks and scans by August 2023, the latest month for which this dataset is available, was 5,062,263<sup>11</sup>.

Delivering around 5 million tests, checks and scans in 25 months indicates a gradual pace of progress. While a slower productivity rate was understandable during the CDC programme's initial establishment, it is clear that faster progress must be made if the 17 million target is to be met by March 2025.

However, progress has been made over time: in July 2021 0.5% (10,420)<sup>12</sup> of the total number of diagnostic tests, checks and scans (1,923,900)<sup>13</sup> were carried out in CDCs. By September 2023, this percentage had risen to 6.5% (142,126)<sup>14</sup> of the total number of diagnostic tests, checks and scans (2,197,991)<sup>15</sup>. The steady increase in the number and percentage of tests, checks and scans being delivered in CDCs indicates an important role for these healthcare facilities in the delivery of diagnostic services.

At the roundtables, NHSE experts stated that they collaborate closely with ICBs to enhance services and boost productivity. They share CDC performance data with DHSC and government health ministers, with rapid measures being taken to improve productivity.

This has clearly had an impact: NHSE Monthly Diagnostics Data 2023-24 reveals that more diagnostic tests, checks and scans have been carried out in the past 12 months than the year before - a testament to hardworking staff<sup>16</sup>.

### Spotlight on the private sector:

The Elective Recovery Taskforce set out plans to leverage additional diagnostic capacity within the independent healthcare sector to reduce waiting times<sup>17</sup>. According to experts at the roundtables, this was deemed a pragmatic and appropriate way to deliver CDCs in the timescales that were necessary.

It was acknowledged that independent healthcare providers have since made a substantial contribution to enhancing capacity and productivity in England's healthcare system, helping to reduce waiting times.

8 CDCs are led by the independent sector, and there are a further 22 CDCs located on the NHS estate where the independent sector is providing diagnostic services<sup>18</sup>. They function like NHS-run CDCs but, by making use of the available capacity in the independent sector, patients can access additional diagnostic capacity free at the point of need.





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## Case study: Oldham Community Diagnostic Centre

*Oldham, Rochdale and the Bury area of Greater Manchester has some of the highest levels of deprivation and poorest population health in England. Alliance Medical Limited was commissioned by the Northern Care Alliance NHS Foundation Trust to establish a new facility to provide much needed diagnostic capacity.*

*The CDC has greatly improved patient waiting times. Between December 2022 and March 2023:*

- *Success in meeting the 28-day Faster Diagnosis Standard target improved from 52.2% to 71.6%.*
- *The average number of days from referral to a cancer diagnosis being confirmed or ruled out reduced from 34 days to 28 days.*

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However, the undeniable fact remains that demand for diagnostic tests remains high and the data suggests that capacity across both the independent sector and NHS is still not sufficient. Indeed, the latest NHSE waiting time data for September 2023 shows that there was a total of 1,582,700 patients still waiting for a diagnostic test, check or scan in England<sup>19</sup>. Diagnostic delays are more than an inconvenience to patients; patients could have a worse outcome as a result of their health deteriorating while they wait to receive care<sup>20</sup>.

### Patient outcomes

During the discussion on progress against targets, the Chair of the APPG aimed to discern the tangible impact of the CDC programme on patient outcomes, despite there not being a formal target on the topic.

Experts at the roundtable spoke about the improvements they had seen to patient waiting times as a proxy for specific data showing an improvement to patient outcomes. It is widely accepted that an early diagnosis, in cancer for instance, is more likely lead to successful treatment<sup>21</sup>. Experts argued that CDCs' ability to reduce waiting times increased the chances of early diagnoses for patients, ultimately improving survival rates.

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## Case study: NHS Sussex

*A representative the ICB for Sussex stated that the introduction of CDCs in the region resulted in a 69% decline in the number of patients waiting for over six weeks. Additionally, approximately 74% of eligible patients now receive care within the 28-day timeframe of the Faster Diagnosis Standard, reflecting a 6% improvement since the establishment of CDCs.*

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However, it is not currently possible to validate the perception that patient outcomes are improving because of the CDC programme due to a lack of data.

### Recommendations:

1. In addition to grouping CDC sites under providers, NHSE should also ensure that activity of individual sites is reported in the NHSE Monthly Diagnostics Data dataset so that local activity levels and progress to address waiting lists can be better scrutinised.
2. NHSE should publicly release data – by patient pathway - showing the time taken between referral to the reporting of all tests, checks and scans undertaken within CDCs, to allow greater scrutiny of diagnostic pathways.



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## The locations of CDCs

### Enhancing equitable access

Roundtable speakers agreed that CDCs have the potential to revolutionise patient access to diagnostic services. However careful consideration of their nationwide distribution and ongoing efforts to address challenges is imperative to realise the vision of CDCs as equitable, community-centred diagnostic hubs.

### Approving the locations of CDCs

CDCs signify a transformative approach to healthcare delivery, aligning with the government's commitment to addressing health disparities, by bringing diagnostics closer to underserved communities.

NHSE representatives explained that CDC locations and configurations are determined collaboratively by ICSs, diagnostic networks, and primary care services, tailored to local population needs. Proposed CDCs undergo a thorough approvals process led by NHSE and local systems before ministerial approval, with assessments considering impact on health inequalities, NHS cost-effectiveness, and implementation speed.

### Areas of greatest need

During the roundtables, experts were queried about CDC placement in areas of need. It is widely understood that people living in more deprived areas have lower life expectancy, poorer quality of life and suffer higher prevalence of long-term conditions<sup>22</sup>.

NHSE representatives emphasised their focus on prioritising CDCs in regions marked by deprivation, health disparities, and limited resources. To substantiate this commitment, NHSE said that prospective CDC locations are overlaid on maps showing public health inequalities and other deprivation metrics. To improve accountability, they have recently introduced a key performance indicator to monitor how well CDC bids in areas of deprivation perform.



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## Case study: Wood Green Community Diagnostic Centre

*The Wood Green CDC, run by Whittington Health NHS Trust, is bringing diagnostic tests into a shopping centre in the heart of Haringey. Wood Green was approved due to its proximity to communities with the highest levels of deprivation, its excellent transport links and the low level of diagnostic capacity in the area.*

*Haringey is the 4th most deprived borough in London, with deprivation more concentrated in the north east<sup>23</sup>. There are significant gaps in healthy life expectancy between populations in Haringey: the gap in healthy years of life between richest and poorest deciles is fifteen years for men and seventeen years for women<sup>24</sup>. 72% of patients using the CDC are from the three worst deciles of deprivation, demonstrating the success of placing this site in the area of greatest need.*

*Currently the CDC provides ophthalmology, ultrasound, x-ray and phlebotomy services. The latter two services are drop-ins, providing patients with increased access to these important diagnostic tests. As of October 15 2023, the CDC has conducted around 57,000 tests, averaging 4,600 a month, which has had a significant impact on health inequalities.*

### Community-based initiatives

After the broad location of a CDC has been decided, experts at the roundtable reported on the process of deciding on its exact site within the community.

#### Acute and community hospital sites

A report by The Kings Fund in October 2022 claimed that, at that time (October 2022), 82% (75/92) of CDCs were situated on acute or community hospital sites<sup>25</sup>. Although representatives from NHSE disputed these figures, the data indicates that, in the initial stages of the CDC programme at least, there was a preference for choosing the 'easy' option of locating CDCs on these types of sites.

When questioned why, experts listed benefits of using acute hospital sites such as faster setup – highlighting the pressure ICSs were under to set up CDCs – convenience for rotating staff, and the availability of existing public transport options for patients. Nevertheless, there was consensus at the roundtables that placing CDCs on acute hospital sites undermines the programme's aim of separating emergency and elective diagnostics.

NHSE have stated in unpublished data that currently 5.2% (9/174) of approved sites are on acute hospital estates, suggesting a move away from taking this 'easy' option.

However, 41% (72/174 approved CDC sites) are located on community hospital sites. Experts defended this decision at the roundtables, explaining that many community hospitals are already positioned in well-connected areas of high deprivation, therefore still meet the aims of the programme.

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## Case study: Clacton Community Hospital Community Diagnostic Centre

*Clacton-on-Sea ranks among the top 1% of most deprived neighbourhoods in England<sup>26</sup>. Within this neighbourhood, the second most deprived area is the vicinity around Clacton Pier, located along the Marine Parade, where the CDC is situated<sup>27</sup>.*

*The community hospital site received £9.6 million to refurbish the site and establish a CDC which includes new CT, phlebotomy and cardio-respiratory suites. Here patients can access lung function tests, echocardiograms and ECGs.*

*The CDC has free parking and is served by 4 bus routes. The train station is a 15-minute walk away or accessible via 2 bus routes, demonstrating the CDCs placement in a well-connected area of high deprivation.*

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Experts at the roundtable further justified the refurbishment of community hospital estates as a method to "sweat the assets". Making better use of existing space and repurposing vacant NHS property increases the value of both the NHS and taxpayers' investments.

However, the construction of CDCs within repurposed community hospitals can be expensive and sometimes falls short.

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## Case study: Andover Community Diagnostic Centre

*In early 2023, Hampshire Hospitals NHS Foundation Trust began converting a community hospital in the heart of Andover into a CDC, to eliminate the need for people to travel to hospitals in Basingstoke, Winchester, or beyond for diagnostic services.*

*Construction challenges led to delays. Instead of adjusting expectations for operational readiness, NHSE and DHSC leadership pressured the center to maintain diagnostic activity, leading to the establishment of a mobile MRI unit – a less than ideal situation for staff and patients.*

*MRI scanning is the sole service provided at this CDC and only continues to be delivered due to the hard work of staff. From March 2023 to September 2023 a total of 2,281 MRI scans were delivered, an average of 380 scans per month. This falls short of the national average of 549 MRI scans per month for the same time period. This suggests that challenges persist.*

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This case study raises questions over whether community hospital sites can be seen as the 'smarter' choice over embedding new CDC sites in the heart of communities.



## In the heart of communities

When embedded in the heart of communities, CDCs have the potential to offer easier access to diagnostic services to individuals who might not usually seek healthcare.

### Patient trust

Health disparities can stem from individuals belonging to specific social demographics being less likely to interact with the healthcare system due to distrust<sup>28</sup>. However, as exemplified by the successful COVID-19 vaccine roll out, community-integrated healthcare sites based in familiar locations can help boost participation in health initiatives<sup>29</sup>. NHS Trust representatives at the roundtables confirmed witnessing this trend.

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## Case study: The Barnsley Glass Works Community Diagnostic Centre

*Across Barnsley borough, the 38th most deprived borough in England, there is an eight-year gap in life expectancy between the best- and worst-off areas<sup>30</sup>.*

*Collaboration between Barnsley Hospital NHS Foundation Trust and the council resulted in a CDC being established within a regenerated retail centre, The Glass Works: the first of its kind. The CDC now offers a range of health services including ultrasound, x-ray, breast screening, phlebotomy, and bone density scanning, conveniently placed next to commercial outlets often frequented by members of the public.*

*The CDC has allowed patients to access diagnostic services in a more relaxed environment, encouraging those who are intimidated by a hospital to attend appointments. The site is “loved by patients” and uptake of healthcare services has increased. For instance, breast screening uptake increased 50% in the first 6 months (April 2022-October 2022).*

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Despite the success in Barnsley, NHS Trusts must not be complacent with trust-building efforts. Effective communication campaigns are vital. During the roundtable, experts mentioned that some patients expressed safety concerns and a preference for certain diagnostic services, such as x-rays or MRIs, to be done in hospitals. To address this, some Trusts have launched public awareness campaigns to enhance patient trust.

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## Case study: Wood Green Community Diagnostic Centre

*Wood Green CDC, situated in a local shopping centre, initially faced public mistrust due to its unconventional healthcare location. To address this, the local trust implemented highly effective communication campaigns, including bus advertisements, to establish the CDC as a secure, modern medical facility. This effort resulted in a noticeable increase in foot traffic, particularly for drop in phlebotomy services, with queues forming. This prompted the CDC to provide buzzers for patients to shop, eat, or drink in the shopping centre while waiting.*

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Roundtable experts identified that Trusts must evaluate whether initial work to promote CDCs in non-traditional healthcare settings is necessary and clearly communicate their benefits if so.

NHSE have confirmed that multiple national communication toolkits have been created and distributed to all regions with key lines around benefits to patients to encourage locally led communications to a range of audiences. These toolkits include social, internal and media materials, with the latter resource leading to a wave of supportive regional based media stories.

### Convenient access

During the roundtables, CDCs placed in the heart of communities were labelled as more successful because of their convenient access for the local population.

Roundtable experts believed that the cost and time taken to travel to hospitals created access barriers. They agreed that locating CDCs in the economic heart of a community, which is usually well connected and frequented by the public, could overcome these issues and increase patient participation.

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## Case study: The Barnsley Glass Works Community Diagnostic Centre

*This CDC is located in a regenerated shopping centre in the centre of town. The site is close to Barnsley Transport Interchange, a combined rail and bus station, and has easy access to a multi-storey carpark. This initiative has improved convenience and accessibility for patients, boosting uptake.*

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Due to the benefits of this approach, it was argued that transportation links should be considered prior to the establishment of a CDC. NHSE confirmed that all bids for new CDCs must include detail on the accessibility of the proposed site, including the available public transport links, indicating the value placed on providing patients with convenient access to diagnostic services.



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## Case study: Wood Green Community Diagnostic Centre

*Previously Haringey residents had to travel further for diagnostic tests than residents in Barnet, Camden, Enfield and Islington. The Wood Green CDC is in the middle of the borough and is served by 12 bus routes, making it easy to get to for most people. This was one of the reasons it was selected.*

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NHSE stated that if there are insufficient transport links to the proposed CDC site it is for individual health systems, working with their local authorities and private operators, to consider whether new transport links are required. One roundtable expert shared the proactive action taken to overcome access obstacles once the local CDC had been established.

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## Case study: Bexhill Community Diagnostic Centre

*In November 2022, East Sussex Healthcare NHS Trust transformed a deserted car show room into the Bexhill Community Diagnostic Centre. To raise the profile of the CDC, Trust employees presented to local bus drivers. Seeing the value in the innovation, this group went on to successfully campaign to change buses routes to ensure the CDC was more accessible to patients.*

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The evidence suggests that patient utilisation and equitable access to CDCs hinge on their accessibility, and that CDCs embedded in the well-connected economic heart of communities offer promising opportunities for achieving this.



## Are CDCs successfully being embedded in the community?

As previously stated, currently 5.2% (9/174) of approved CDC sites are on acute hospital estates and 41% (72/174) are located on community hospital sites. These figures suggest that only around half of CDCs have been newly constructed in the centre of communities.

The clear examples of success, such as CDCs being set up in shopping centres, deserve to be celebrated as best practice. However roundtable discussions revealed that these are currently the exception rather than the norm.

Experts at the roundtable explained why this was the case. Setting up diagnostic services in new, community-based sites is expensive and requires a persuasive business case. Not only are upfront costs high, but there are risks associated with private landlords leveraging of the inconvenience and cost of relocating equipment like MRI scanners to increase the rent.

Senior leaders of NHS Trusts and others highlighted how many ICSs are reporting deficits, which has a direct impact on risk attitudes. Consequently, Trusts are hindered in their ability and willingness to make the 'brave' choice of embedding a CDC in the heart of the community. This poses a concerning situation that is not viable for impactful, sustainable long-term diagnostic planning.

NHSE stated that, where possible, they have pursued partnerships with private landlords and commercial property developers to secure long-term affordable and sustainable lease agreements for CDCs within shopping centres or other community hubs, such as Barnsley Glassworks and the Metrocentre. Negotiating long-term leases with reasonable rent increases can alleviate cost concerns, making it easier for CDCs to be embedded in the heart of communities.

### Recommendations

1. In future Spending Reviews, the government should allocate further funding to establish CDCs in the remaining areas with high levels of deprivation, health inequalities, and limited healthcare resources.
2. NHSE should regularly review changing demographics and healthcare needs to ensure CDCs continue to be established in areas of greatest need.
3. To overcome low risk attitudes to establishing CDCs in community-based sites like shopping centres, NHSE should:
  - Provide financial incentives to ICSs willing to set up CDCs in community-based locations, so long as these locations meet the deprivation criteria. These incentives can help offset the high initial setup costs and mitigate concerns around risks associated with renting from private landlords for instance.
  - Expand support for ICSs pursuing partnerships with private landlords or commercial property developers to secure sustainable lease agreements for CDCs which are embedded in the heart of communities.





## Right tests, checks and scans

Key to the CDC programme's efficacy is the ability to encompass a wide spectrum of diagnostic services. The Department of Health and Social Care often publish press releases referencing 'tests, checks and scans' without detailing explicit information on which diagnostic services they are referring to and why these have been selected. The inquiry therefore aimed to understand which tests, checks and scans should be prioritised to ensure patients receive the early diagnosis they need.

### CDC services

During the roundtable, NHS Trust representatives celebrated the success of CDCs in offering a comprehensive range of diagnostic facilities, effectively creating "one-stop-shops" for patients. This strategic approach was celebrated for not only streamlining patient care but also empowering healthcare professionals to systematically eliminate multiple conditions through a comprehensive sequence of tests, all conveniently conducted within a single facility and appointment.

There are three CDC models: standard, large and spoke. In line with the recommendations of the Richards' Review, CDCs must offer a minimum set of diagnostic services across the following core modalities:

- Imaging, for example, MRI and CT
- Physiological measurement, for example, echocardiography, spirometry
- Pathology, for example, urine testing and phlebotomy

Large CDCs must also offer endoscopy services, for example, gastroscopy and colonoscopy, as part of their offer<sup>31</sup>.

The latest NHSE Monthly Diagnostics Data<sup>32</sup> reveals that the tests, checks and scans currently reported on by CDCs across England include:

- MRI
- CT
- Non-obstetric Ultrasound
- DEXA Scan
- Audiology Assessment
- Echocardiography
- Electrophysiology
- Peripheral Neurophysiology
- Respiratory Physiology – Sleep Studies
- Urodynamics – Pressures & Flows
- Colonoscopy
- Flexi Sigmoidoscopy
- Cystoscopy
- Gastroscopy



The Chair of the APPG noted that it was concerning that phlebotomy is not captured in NHSE CDC data, which makes it hard to analyse the provision of this vital diagnostic service. One of the key actions outlined in the Richard's Report was for community phlebotomy services to be improved, so that all patients can have blood samples taken close to their homes, at least six days a week, without needing to enter acute hospitals. Without data transparency it is impossible to scrutinise whether the CDC programme is meeting this ambition.

### The 'ideal' tests, checks and scans

When discussing the ideal CDC and its range of services, there was a consensus at the roundtables that it is essential to tailor services to the local population's needs. Experts said that the goal should be to build CDCs that effectively address local prevalent health conditions. For instance, areas with high bowel cancer incidence should have expanded endoscopy services. Similarly, areas with high rates of alcoholism should offer fibroscan services. NHSE representatives confirmed that the inclusion of any additional services is based on local assessments of clinical need.

CDCs are encouraged to offer tests beyond the minimum requirement where this is appropriate and deemed to be a priority locally<sup>33</sup>. How often this is the case is unclear, so greater scrutiny of this area would be beneficial to understanding how CDCs are meeting local need.

Despite the need to tailor services to the local population's needs, certain diagnostic services were identified during the roundtable as essential due to higher levels of demand. The surge in requests for CT and MRI scans, as well as the indispensable role of phlebotomy services, was emphatically highlighted by experts. Blood tests frequently enhance the accuracy of imaging diagnostics, underscoring the pivotal value of these services in delivering accurate diagnoses.

A point was made that CDCs could provide more point of care testing (POCT) as technology develops to truly embody the goal of being "one-stop-shops". One example would be blood glucose monitoring. Greater integration of POCT would enable patients to access more rapid and on-the-spot diagnostic results. It would also allow healthcare providers to make immediate decisions regarding patient care. However, POCT should not be seen as a replacement for the extensive, main laboratory services.

### Optimising CDC services

By leveraging available capacity, CDCs can aid the delivery of screening programmes and strategically address elective care waiting lists. This integration streamlines patient access, maximises resources, and enhances overall healthcare efficiency – all while aligning with the broader goal of comprehensive and patient-centred care within a centralised healthcare setting.

### Screening services

Although screening tests, such as breast, cervical and bowel cancer screening, were not included in the scope of CDCs, the roundtables revealed that in practice some CDCs have integrated these services.

Experts at the roundtables stated that this integrated approach not only reduces the need for multiple appointments, saving patients and staff time, but offers a holistic health profile view to healthcare professionals. It enables proactive patient health management by identifying potential risks pre-emptively, facilitating early interventions, and empowering patients – all within a single location.

## Case study: The Barnsley Glass Works Community Diagnostic Centre

*Through negotiations with central NHSE teams and close collaboration with service commissioners, breast screening services were successfully integrated into the Barnsley CDC, demonstrating the adaptability of CDCs. Despite not being the initial focus, the Managing Director stated that this was "the most successful aspect" of the CDC.*

Experts identified a commissioning quirk that delineates funding for screening services from the overarching funding allocated to the CDC programme as the key challenge. This distinct funding structure poses a potential barrier to CDCs truly becoming "one-stop-shops".

### Elective care

Although CDCs were established to build diagnostic capacity, clinicians have found that the tests, checks and scans offered within these healthcare settings have the potential to significantly alleviate waiting times for elective care procedures too.

Experts at the roundtables explained how, from an elective surgery standpoint, securing a pre-assessment appointment can be a critical bottleneck hindering the quick delivery of elective care, consequently prolonging patients' waiting times. By capitalising on the capabilities of CDCs, healthcare professionals could assess patients' health and surgery readiness to ensure that they are "waiting well".

In an NHS marked by extensive waitlists and a strained healthcare workforce, innovations such as CDCs must optimise available services.

### Recommendations

1. NHSE should include phlebotomy data in the CDC NHSE Monthly Diagnostics Data datasets to allow scrutiny of the delivery of community phlebotomy services.
2. NHSE should commission research into the benefits and risks associated with integrating a) screening services and b) pre-assessment services for elective care into CDCs.



# Physical and digital infrastructure

The Richards' Review recommended replacing obsolete equipment and improving digitisation across all aspects of diagnostics to drive efficiency, deliver seamless care, and facilitate remote reporting<sup>34</sup>.

## Equipment

Experts at the roundtables agreed that providing CDCs with sufficient levels of equipment is a cornerstone of effective healthcare delivery. The consensus was that up-to-date equipment ensures that diagnostic procedures are conducted with accuracy, efficiency, and precision, ultimately contributing to timely diagnoses and improved patient care.

### Access to new equipment

During the roundtable, NHSE representatives reinstated their commitment to equipping CDCs with new machines rather than upgrading existing equipment to maintain diagnostic accuracy and efficiency. Indeed, roundtable experts representing NHSE Trusts did not report challenges purchasing new equipment. However, given the limited number of participants at the roundtables, their statements do not conclusively rule out the possibility of CDC sites nationwide encountering obstacles, leading to regional inequality.

In fact, then health minister, Maria Caulfield MP, has admitted that “some sites may have used existing equipment”<sup>35</sup>. NHSE representatives stated that this only occurs when an established service is moved from an acute site to a CDC, though the frequency of such occurrences remains unclear. When questioned, NHSE representatives claimed that there were only a very small number of cases where equipment that had been purchased for another purpose were relocated to CDCs. The reason given for why this occurs was the need to ensure that taxpayers' funds are used effectively and efficiently.

### Maintaining equipment provision

To guarantee CDCs retain sufficient levels of equipment as the CDC programme develops, NHSE representatives said that they are actively monitoring the quantity and condition of equipment. This proactive approach enables the identification of obsolete machines, ensuring that equipment upgrades or replacements are carried out promptly to uphold high diagnostic standards.

NHSE representatives revealed that they have expanded the scope of the annual National Imaging Data Collection to cover CDCs. This Collection provides information on the age of imaging machines, like CT and MRI scanners, to support planning decisions and bids for funding to replace equipment<sup>36</sup>. NHSE representatives also confirmed that they have recently launched a new data collection, specifically looking to capture equipment for CT, MRI, and non-obstetric ultrasound, and treatment rooms for endoscopy and echocardiography, to provide the most up-to-date counts of CDC assets for these main CDC services.



## Digital infrastructure

The digitisation of diagnostic services within healthcare facilities, particularly in CDCs, was identified as a transformative advancement by experts. This digital shift was reported to streamline operations, accelerate communication between healthcare professionals, and enhances patient experiences. Participants agreed that the importance of robust digital infrastructure cannot be overstated, particularly in pathology laboratories and medical imaging.

## Basic infrastructure

Experts noted recent advances in diagnostic digitisation but highlighted ongoing challenges with basic digital infrastructure in many CDC locations. An NHS Trust representative gave the example of having multiple inefficient and unreliable Wi-Fi systems at one site.

Securing basic digital infrastructure was recognised as essential for a robust and sustainable digital healthcare environment. Participants agreed on the importance of CDCs adopting a step-by-step digital transformation approach, prioritising foundational elements before introducing advanced diagnostic tools.

The Frontline Digitisation programme, aims to level up NHS Trusts to a baseline level of digital capability<sup>37</sup>. Timelines for this programme are unclear, but the various challenges around basic infrastructure revealed by the experts at the roundtables suggests change is not being implemented quick enough and creating inequalities.

## Patient pathways

Experts at the roundtables highlighted the need for proactive collaboration between CDCs and primary care providers, including General Practitioners (GPs), to ensure patient pathways lead to CDCs when necessary.

There are various barriers to healthcare providers referring patients to CDCs, now that access has been opened to all primary care referrers. One example given by experts at the roundtables was the digital referral system. GPs follow streamlined procedures for referring patients to hospitals, often requiring just one click. In comparison, referring patients to a new CDCs can be more complex, possibly causing hesitation. Therefore, working with GPs is crucial to simplify the referral process and remove barriers, ensuring smooth and equitable access to CDCs for all patients.

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## Case study: Wood Green Community Diagnostic Centre

*When data showed that several GPs were not referring patients to the Wood Green CDC, the team enacted a targeted and individualised approach to transform referral practices. They spoke to every non-referring GP in the Haringey area to discern whether this was due to patient choice, a lack of awareness of the diagnostic services, or digital system challenges.*

*This proactive outreach not only led to increased referrals but also facilitated a deeper understanding of the local factors influencing referral patterns. The success of Wood Green CDC highlights how personalised engagement is instrumental in shifting referral patterns to enhance integration between CDCs and primary care providers, thereby improving patient care.*

## Digital tools

At the roundtables, experts discussed how digital tools were playing a pivotal role in enhancing the efficiency of patient flow to and within CDCs. These tools streamline the diagnostic process, starting in primary care with the referral of diagnostic tests, to appointment scheduling within CDCs, to tracking and managing patient progress.

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## Case study: iRefer in NHS Sussex

*As imaging becomes ever more complex it is essential that primary care professionals can book the right scan. This avoids unnecessary and repeat investigations, brings down the diagnostic backlog and long waits for patients, reduces patient exposure to unwarranted ionizing radiation, and reduces pressure on radiographers and radiologists.*

*The Royal College of Radiologists, in partnership with MedCurrent, has developed the digital iRefer Clinical Decision Support System to enable GPs to book the right scan first time, speeding up diagnosis and saving money, time, and lives.*

*As part of efforts to level up digital diagnostics throughout England, NHSE and DHSC have made funding available for all ICBs to adopt the iRefer tool. So far, only 49% of Trusts have adopted this digital tool. NHS Sussex, the ICB for Sussex, was one of the first to trial using it, resulting in greater efficiency across CDCs in the region.*

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Turning to the patient experience, the introduction of online booking systems for CDCs was highlighted as a simple but essential patient-facing innovation by experts. These digital tools not only empower patients to schedule convenient appointments, reducing the number of no shows, but also enable CDCs to maximise their resources. NHSE representatives have said that submitting a clear digital strategy, with patient accessibility as a key component, is necessary in the CDC bidding process.



## Case study: NHS App

*Two ICBs will be getting additional functionality on the NHS app, which could revolutionise how patients manage their care. Patients will be able to cancel or book CDC appointments through the app, mitigating instances of missed appointments.*

*One expert at the roundtable said that an important aspect of this digital tool is the capacity for patients to access essential information in their preferred language, contributing to the reduction of health disparities.*

The strategic integration of digital tools, coupled with patient-oriented communication methods, could significantly enhance the effectiveness and operational efficiency of CDCs.

### Patient data

An investigation by The King's Fund found that sharing data, including diagnostic images and pathology records, between sites is often difficult, meaning that diagnostic tests are often repeated to obtain the result in a timely way or when the patient moves between CDC and acute hospital settings<sup>38</sup>. Experts at the roundtables concurred that data sharing was a huge barrier to efficiency. Specialists such as pathologists and radiologists, who interpret cell, tissue, blood, bodily fluid samples and images respectively to diagnose disease, depend on smooth digital integration between CDCs and other healthcare sites, as they are typically situated in acute hospitals or laboratories.

NHSE representatives explained that CDCs can effectively be viewed as an extension of the host Trust, in the same way as a minor injury unit or another department with diagnostic capability is. Where this is the case, the CDC should be using the same Picture Archiving and Communication System (PACS), Radiology Information System (RIS), Laboratory Information System (LIMS), and / or Order Communications as the host Trust.

During the roundtables, experts also spoke about the use of Imaging and Pathology Networks to enable the sharing of requests, tests, results and reports across organisational boundaries. The Diagnostics Digital Capability programme, established in 2021, was set up to accelerate the uptake of technologies that underpin the formation of these regional networks and promote the safe, efficient sharing of data<sup>39</sup>. This programme enabled Imaging and Pathology Networks to procure and implement the necessary infrastructure to enable effective data sharing across the Networks and into CDCs. NHSE representatives revealed that 6 monthly assurance reviews are being conducted with each Network to analyse progress on the integration of CDCs.

However, while the seamless integration and interoperability of patient data has been a longstanding goal within the NHS, experts agreed that advancements have been inconsistent and persistently challenging.

Participants outlined the ideal scenario in which relevant information is readily available to clinicians reviewing cases, facilitating coordinated care among different healthcare providers to improve patient journeys and outcomes. One pilot was celebrated as achieving this.





## Case study: Feedback Medical Community Diagnostic Centre Pilot at Queen Victoria Hospital

*Queen Victoria Hospital in Sussex is one of the first to deliver end-to-end symptom-based pathways through the CDC programme. Collaborating with Feedback Medical, a pilot programme was established using Feedback Medical's digital infrastructure solutions – CareLocker and Bleepa.*

*CareLocker integrates with multiple clinical systems and centralises data around an individual patient. This means that all the diagnostic results can be seen in one place across all provider groups, ensuring that relevant data can be collected from multiple clinical settings, travels with the patient and is always available to clinicians.*

*Bleepa is a digital clinical communication platform that captures patient investigations, aligns them with specific patient pathways, and presents them to clinicians in both primary and secondary care settings for review, discussion and strategic onward management.*

The pilot achieved an impressive 70% reduction in patient waiting times for the breathlessness pathway. Leveraging digital infrastructure through Bleepa and CareLocker, this initiative achieved remarkable efficiency gains, releasing £1.7 million for every 10,000 patients without requiring extra staff or CDC expansion.

When asked what the barriers to scaling up the pilot were, Feedback Medical referred to the lack of centralised digital leadership historically in the NHS and with the evolution of ICSs.

When asked whether there was sufficient funding to establish strong digital infrastructure within CDCs, the consensus was that although there is some funding set aside for digital infrastructure, further funding would be necessary.

## Recommendations

1. NHSE should provide more centralised digital leadership by developing a national strategy for the integration of patient data and digital tools within CDCs. This strategy should outline a roadmap for the adoption of digital solutions, including clinical decision support systems, to streamline the diagnostic process.
2. After CDC approval, system leads should conduct outreach with primary care providers within the ICB to increase awareness of the new site. If patient referrals from these providers do not reach the expected level, leads should engage in personalised outreach. This approach addresses misconceptions, resolves hesitations, and tailors communication to improve collaboration for effective CDC integration in healthcare.
3. NHSE should prioritise bolstering digital infrastructure and patient data sharing in CDCs. Periodic assessments should be conducted to address integration challenges.
4. NHSE should develop and enforce interoperability standards for digital tools used within CDCs to ensure seamless data exchange and collaboration between primary and secondary care settings. This standardisation will enable clinicians to access patient information across different points of care, improving coordination and decision-making.





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# Workforce capacity

Alongside adequate levels of diagnostic equipment and digital infrastructure, workforce is a key limiting factor in the delivery of CDCs. Without the workforce to deliver services, it is impossible to maximise the opportunity CDCs offer.

## Staffing CDCs

When asked whether and to what extent the CDC programme has impacted the diagnostic workforce, specialists from diverse diagnostic fields at the roundtables unequivocally agreed that CDCs have introduced a notable increase in workload.

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## Case study: Radiology

*The Royal College of Radiologists' 2022 Radiology Workforce Census found that 41% of Trusts in England are working with a CDC. 88% of CDCs are staffed with existing Trust employees, with 91% of the radiology Clinical Directors in England stating that reporting scans for CDCs had increased their workload. 41% stated that the increase was unmanageable.*

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## Case study: Pathology

*One member of the Royal College of Pathologists told the College: "Demand is higher than ever and there are complaints every week from various departments about how long it's taking to clear red flag cases. We send as much work out as possible but it's still not enough to stay afloat...Every day I go to work in a war zone and fight a battle already set to fail."*

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The experts at the roundtables agreed that, as the demand for diagnostic services continues to surge, it is imperative that this growth in demand is met with a proportionate expansion of the workforce. Expanding the workforce not only bolsters the capacity to meet patient needs but but would also uphold the government's commitment to timely and accurate diagnoses.



## Staff shortfalls

While the CDC programme has increased the physical capacity to deliver more diagnostic services, experts pointed out that there has not been a similar increase in the workforce. Experts identified years of poor workforce planning and inadequate funding across the health and care system as the causes of chronic staff shortages. All diagnostic specialties are suffering significant shortfalls, but imaging, pathology and endoscopy were identified as notably under strain.

## Case study: Radiology

*The Richards' Review recommended a major expansion of the workforce, including an additional 2,000 radiologists, as well as other support staff<sup>40</sup>.*

*According to the Royal College of Radiologists' 2022 Workforce Census<sup>41</sup>, the clinical radiology workforce grew by just 3% in 2022, lower than the five-yearly average of 5%. The census found that there is a shortfall of 30% clinical radiology consultants (1,530 doctors). Without further action this shortfall is forecasted to increase to 41% (2,890 doctors) by 2027. Staff shortfalls are undermining the efficiency of the CDC programme.*

## Case study: Pathology

*One member of the Royal College of Pathologists told the College: "We are an 8-consultant whole-time equivalent (WTE) department that's trying to make do with 3.8 WTE consultants. We're all exhausted ... We're about to drop down to 2.8 WTE consultants in a couple of months. I feel burnt out and I can't see it changing any time soon. I am seriously considering leaving the NHS."*

An FOI submitted to the Department of Health and Social Care found that, according to NHSE projections, CDCs will have up to 6,500 fewer staff than they need by 2025<sup>42</sup>. Across 14 staffing groups examined, only five are not projected to have gaps by 2025. The biggest gaps are in scientists available to examine pathology specimens and in assistant imaging practitioners (e.g. for CT and MRI scans).

Due to workforce shortfalls, demand for diagnostic professionals outstrips the available supply, creating fierce competition among healthcare providers to recruit staff and fill vacant posts. Representatives from NHS Trusts concurred that staffing was a key challenge in getting CDCs up and running, due to the difficulties faced when recruiting. Despite funding in place for diagnostic staff, many roles have been left vacant.

## Case study: Andover Community Diagnostic Centre

*Representatives from the Hampshire Hospitals NHS Foundation Trust shared their difficulties in recruiting CT radiographers in order to extend the CT working day. The scarcity of individuals in this specialised field – like many others – was identified as the key issue. This issue has been exacerbated by the prevalence of similar vacancies across neighbouring Trusts, making the job market highly competitive.*

At the roundtables, NHSE representatives confirmed that they are working to develop a plan to ensure sufficient workforce capacity in CDCs. This was confirmed by health minister Andrew Stephenson in November 2023<sup>43</sup>.

## Solutions

During the roundtables, experts were questioned about possible solutions to overcoming recruitment issues, including what the benefits and challenges to each were.

### International recruitment

International recruitment is often seen as a solution to workforce shortfalls, however this strategy comes with risks, as explored during the roundtables.

An essential point emphasised during the discussion was the substantial time required to familiarise international recruits with NHS procedures and systems. Properly structured onboarding procedures, oversight, and support mechanisms are essential to ensure that international recruits can seamlessly integrate into the CDCs.

NHSE representatives highlighted the introduction of funded, 12-month onboarding procedures to address this. The onboarding process begins with induction and training in the home country before arrival in the UK. Trusts receive funding to support mentors aiding in the onboarding process, and action learning sets are being developed within regions to facilitate a smooth transition for candidates. These procedures are designed to train international recruits, providing them with the necessary skills and knowledge to excel within CDCs, however not all CDCs have them in place.

Additionally, delivering onboarding procedures to a high standard can be challenging for staff already working under pressure. Further concerns were raised around the saturation of international recruitment potentially destabilising departments. Similarly, experts raised concerns about the long-term viability of relying heavily on international recruits, as well as the ethical concerns surrounding this approach since there is a global shortage of medical professionals.

These risks underscore the need for a balanced approach, where international recruitment complements local workforce recruitment and training.



## 'Grow your own'

Nurturing local talent and expertise is instrumental in securing a skilled and sustainable workforce. Experts at the roundtables shared inventive strategies to address this crucial need, resulting in more effective staff recruitment and training.

One of the prominent approaches adopted by CDCs involves establishing healthcare academies to address resourcing challenges.

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### Case study: North Central London (NCL) Ultrasound Academy

*North Central London Integrated Care System, through Royal Free London Foundation Trust acting as 'host' trust, and working with Community Health Partnerships, established an early CDC adopter site at Finchley Memorial Hospital.*

*This site, like many nationwide, faced substantial challenges in recruiting sonographers. To combat this issue, the NCL Ultrasound Academy was pioneered. One of the first initiatives of its kind, the Academy was conceived to tackle the scarcity of sonographers. It did so by providing advanced training and support to prospective sonographers within a specialised training facility, equipped with cutting-edge technology and simulation units.*

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Furthermore, CDCs have recognised the importance of collaboration with established educational institutions. By co-locating CDCs with universities, for instance, a more sustainable approach to workforce development can be achieved.

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### Case study: NHS Sussex and Chester University

*In collaboration with the Dean of Chester University, NHS Sussex successfully secured approval for the establishment of a CDC co-located with the university. This strategic partnership will enable the university to integrate CDC specialties into their curricula, streamlining the training of local students. These students are subsequently well-prepared to actively participate in their local healthcare services, contributing to the community, and will hopefully exhibit a higher likelihood of remaining in the local area.*

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These strategic partnerships foster an ecosystem where education, training, and workforce retention align seamlessly, ensuring that CDCs have access to a pool of skilled professionals. Experts at the roundtables highlighted multifaceted benefits, including improved staff retention, enhanced local recruitment, and the creation of a robust healthcare workforce.

This approach exemplifies a forward-looking strategy, ensuring that CDCs remain well-equipped to meet future healthcare demands while fostering strong connections with the local community.

## Private sector

Independent sector-led centres, operating similarly to NHS-run CDCs, employ their own staff and own the facilities. Experts representing the independent sector explained how clinicians working with private providers may currently or have previously worked in the NHS or entered the workforce through international recruitment routes.

Nonetheless, looking to the private sector to solve the workforce crisis was recognised as a flawed strategy by experts. Independent providers draw from the same global talent pool as NHS Trusts. The discussion acknowledged that merely relocating staff from the public to the private sector does not resolve the broader workforce shortfall.

One concern raised during the discussion was the competition to recruit between private diagnostic centres and acute hospital sites. These independent centres, often offering attractive benefits such as improved parking, better compensation, and flexible hours, might draw staff away – often after the NHS has invested significant resources in training up these healthcare professionals.

However, the ability for healthcare professionals to fluidly move between public and private sectors according to their personal circumstances was recognised as preventing individuals from leaving healthcare entirely, which is a favourable outcome in the long run. Healthcare professionals working across both sectors were said to consider themselves part of a unified team delivering NHS-funded care regardless of their employer.

Experts summarised that using independent sector-led CDCs was necessary and well-tested approach, given the longstanding symbiotic relationship between the NHS and private sector. Importantly, the independent sector-led CDCs work closely with their commissioners to minimise local workforce disruptions through joint workforce strategies, ensuring effective collaboration.

## Staff retention

In addition to recruitment challenges, the retention of the current workforce was highlighted as a significant challenge by experts during the two roundtables. For instance, The Royal College of Radiologists revealed that in 2022 over 75% of clinical radiologists retired before the age of 60<sup>44</sup>. NHSE representatives agreed with the need to focus on retention.

A range of retention methods within the context of CDCs were discussed, with the most prominent method being staff rotation between acute hospitals settings and CDCs. Experts voiced concerns with this approach but overwhelmingly agreed that it was beneficial.

Under the rotation model, staff in CDCs come from different NHS Trusts and private providers, each with its own standard operating procedures (SOPs). This diversity can lead to inconsistent patient care, which goes against patient expectations of standardised care. These differences in SOPs can create uncertainty, posing potential risks to patient safety.

However, this rotation model provides staff with valuable training and skill development opportunities. Exposure to a variety of healthcare settings and patient populations broadens the skill sets of healthcare professionals. This diversity in experience not only enriches their capabilities but also equips them with a more comprehensive understanding of diagnostic practices and patient care.



## Case study: Andover Community Diagnostic Centre

Staff at Hampshire Hospitals NHS Foundation Trust rotate between hospital and Andover CDC sites, significantly boosting job satisfaction. Some prefer CDC settings for their sociable hours, predictable routines, and less stressful environment compared to hospital settings. This improved work-life balance contributes to staff retention.

Despite the benefits to staff retention, experts emphasised the rotation model's long-term unsustainability. It was agreed that CDCs cannot rely solely on hospital staff, necessitating the expansion of the diagnostic workforce to fulfil the programme's potential and meet patient demand.

### The NHS Long Term Workforce Plan (LTWP)

The LTWP was yet to be published during the roundtables, so experts could not comment on the contents. However, they expressed hopes that it would boost recruitment and retention, and emphasised the importance of aligning the CDC workforce strategy with the LTWP.

### Recommendations

1. NHSE should regularly assess the workforce needs for the CDC programme. These assessments should feed into the NHS Long Term Workforce Plan, the modelling for subsequent workforce projections, and any workforce expansion plans.
2. To encourage local recruitment and training, NHSE should expand the development of dedicated healthcare academies and strategic workforce development partnerships between CDCs and educational institutions. CDC bids adopting the latter approach should be prioritised.
3. NHSE should monitor whether standardised onboarding procedures and SOPs are implemented across all CDCs, and ensure that comprehensive training, oversight, and support mechanisms are in place for staff. To uphold high standards for patients, robust quality assurance mechanisms should be established by NHSE.
4. CDC management must implement a range of retention strategies tailored to the CDC context. To ensure the effectiveness of these strategies, continuous feedback mechanisms with healthcare professionals should be established, allowing them to pinpoint measures that can make a significant difference.





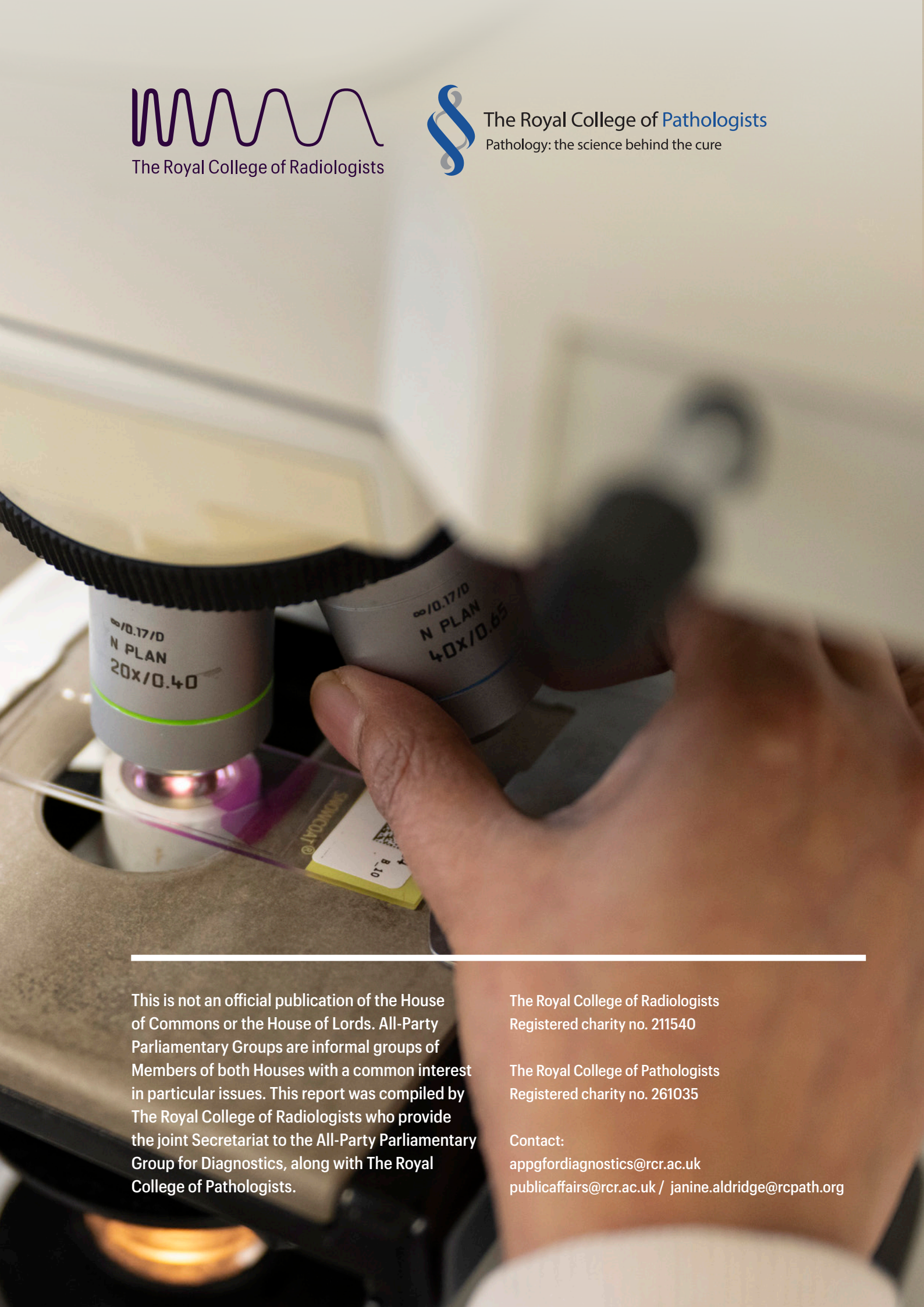
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