

Volume 5 - Issue 3,2006 - Country Focus - The UK

The Future of Workflow Management in the NHS

Author:

Dr Giles Maskell

Title: Consultant Radiologist

Email: GILES.MASKELL@RCHT.CORNWALL.NHS.UK

A normal day in CT. Several outpatients waiting in the waiting room drinking their oral contrast. Some were given their diagnosis of cancer in a clinic a month ago and have been waiting for staging investigations. Two or three patients in beds: some admitted a few days ago and waiting for a scan ever since; some waiting for porters to take them back to their wards. The resuscitation room in A&E rings – there are two multiply injured patients from an RTA who will both require immediate CT scans as soon as they have received urgent treatment and someone has declared them fit enough to move to CT. Everyone else will have to wait - probably a familiar scene if you work in an acute general hospital in the UK.

The managers have carried out capacity and demand exercises and declared that there is no reason why anyone should have to wait for CT. The CT staff are doing their best and will give additional help where needed or stay late, with repercussions on staff personal lives. With unpredictable work, the superintendent might cancel afternoon outpatient slots to control working time, adding to the waiting list.

Does it have to be like this? The traditional justification would have been that a department only has one CT scanner and it has to cater for the needs of all these different groups of patients and staff. It is very expensive so the department probably cannot afford another one. If it could, it would like to site it next to the existing scanner because there are only a few staff that can operate these machines and the department can make better use of them that way.

But things have moved on a bit in recent years. CT (and MRI) has got better and better and ever more useful. It can replace much of what used to be called 'general radiography'. Thanks to centrally funded programmes such as the New Opportunities Fund, radiologists no longer have to run sponsored marathons as they did in the 1980s to raise the cash for a CT scanner. A hospital probably has two or three of them now. Moreover, it is likely that a radiologist no longer has to limit access to a precious machine by fighting off 'inappropriate requests'. A radiologist is probably keen to try and encourage your clinical colleagues to make more use of CT because you know, for example, that if you came into hospital with an acute abdominal problem you'd rather trust the CT (and the radiologist) to make a correct initial diagnosis than the surgeon.

And what about the staff? While there is no doubt that some high-end CT applications work a great deal better with experienced and motivated CT radiographers, the user interfaces of CT scanners are now probably less complicated than most other pieces of radiographic equipment. There is a growing body of evidence and experience to suggest that much 'basic' CT can be carried out by non-specialist radiographers and by suitably trained assistant practitioners. So is it still essential or even desirable to have all CT machines in one place?

Which brings us to the subject of separating acute from elective work. If departments have more scanners, and staff who can use them, they no longer need to make cancer staging outpatients wait while inpatient stroke victims are scanned or the monitor attached to the patient with multi-system failure from ITU is adjusted.

Having accepted that, the key question becomes the location of the scanners. Leaving aside the issue of reporting, which I will come back to, there is no need for outpatients to come into the acute hospital simply to have a CT scan. There may be times when it is convenient for the patient to have a batch of tests performed on one visit to the hospital but a great many of the outpatients who come to as CT department could just as well have the test performed somewhere else. And this is where the politics comes in. The scale of the recently announced Second Wave capacity expansion exercise for diagnostic tests in the NHS suggests that radiologists should prepare themselves for a future in which acute hospital radiology departments in the UK carry out radiological tests only on patients with acute conditions. The elective outpatient work can all be performed somewhere else. This is exactly what is happening in the UK in some clinical specialties such as orthopaedics.

Hospitals need to think about how close the CT department is to the point at which patients are admitted to the hospital and about ensuring that porters use their time efficiently when they bring patients in to scan from other departments. Patients should be scanned as they come through the door of the hospital rather than have to send for them the next day. This will move radiology back to the front line of diagnosis and improve radiologists' standing amongst the clinical community.

And where do the radiologists fit into all this? Much as they may enjoy acute clinical problem-solving, there are other aspects of the job that are also enjoyable – intervention, perhaps, cancer staging or high-resolution lung scanning. The skills needed to make a diagnosis of omental infarction on CT are not much different from those required to detect recurrent ovarian cancer. This is the joy of PACS. In theory a radiologist does not have to be anywhere near the CT scanner to view the images, make a diagnosis and communicate it to the relevant clinician. So it won't matter if 'cold' CT images are being generated in a different place from the acute images. The radiologist will be able to view them all from the comfort of his own reporting station.

Published on : Thu, 20 Apr 2006