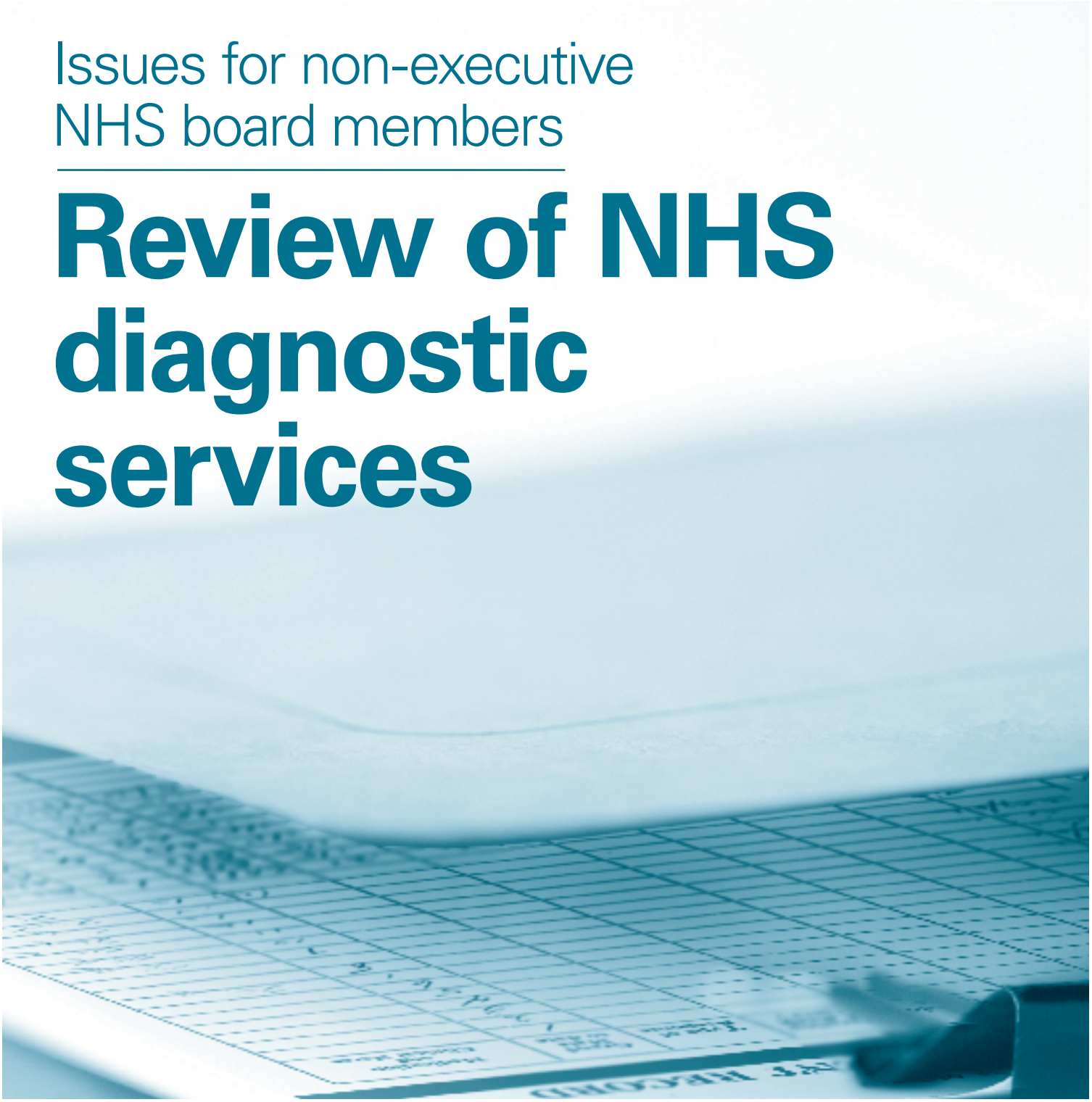
Issues for non-executive NHS board members

Review of NHS diagnostic services



AUDIT SCOTLAND

Prepared for the Auditor General for Scotland
November 2008

Introduction

1. Audit Scotland published its national report, *Review of NHS diagnostic services*, on 20 November 2008. This paper accompanies that report and sets out some issues that non-executive members may wish to consider in relation to how diagnostic services are managed within their own boards. It also aims to help them pose questions they may want to ask of executive directors to seek assurance about local service delivery.

2. Copies of the national report can be downloaded from our website www.audit-scotland.gov.uk

Reference to main report	Issue	Questions for non-executive board members to consider
Part 2. Improving the patient experience		
P11	Results from April 2008 Global Rating Scale self-assessment census show improvements in both patient experience and clinical quality of endoscopy services across Scotland. The NHS in England also uses the GRS system to monitor endoscopy services and performs better than the NHS in Scotland in all 12 elements.	▪ Is the board monitoring performance against the 12 elements of the Global Rating Scale? ▪ Does the board benchmark with endoscopy units across the UK which are returning better GRS score to identify good practice that can be applied locally?
P11	Not all hospitals offer patients the choice of date, time and location for elective diagnostic appointments.	▪ Do hospitals in the NHS board offer choice of date and time for all elective diagnostic appointments?
P12	Hospitals performed well in how quickly they carry out inpatient CT and MRI scans but the time it takes to report radiology and laboratory test results varies across hospitals.	▪ Does the board plan to set targets for test turnaround times that reflect their clinical urgency and to monitor performance against these?
Part 3. Approaches to improving diagnostic services		
P15	All NHS boards in our sample have taken longer-term steps to change how they manage and deliver services, many of which were promoted by the Diagnostic Collaborative Programme. For example, pooling waiting lists among consultants which means patients are referred to the diagnostic service instead of an individual consultant, helping to reduce the time patients have to wait.	▪ Has the board implemented the changes encouraged by the National Diagnostic Collaborative Programme? ▪ Do hospitals pool consultant lists for diagnostic radiology and endoscopy tests?
P15	NHS boards should know the source and level of demand for diagnostic tests to ensure the right staff and equipment are available. If NHS boards are aware of the source of demand, they can take	▪ Does the board collect and monitor information on the level and source of demand for diagnostic tests? ▪ Is the board taking measures to ensure demand is appropriate, for example, by checking referrals to make sure they are appropriate?

Reference to main report	Issue	Questions for non-executive board members to consider
	measures to ensure it is appropriate. Some NHS boards are taking measures to manage demand for diagnostic services for example, checking referrals	▪ Has the board put in place protocols and referral guidelines for diagnostic tests to help GPs and hospitals clinicians make decisions about which test is the most suitable? ▪ Does the board provide feedback on referral rates for radiology, endoscopy and laboratory tests to GPs and clinicians?
P16	Most hospitals take direct referrals from GPs for at least one radiology test. GPs referring patients directly for radiology tests reduces waiting times as it avoids patients having to attend an outpatient clinic first.	▪ Does the board have plans to increase the range of diagnostic tests that GPs can refer patients for directly through clear protocols?
P10 & 17	NHS boards have made significant progress in reducing waiting times for the key diagnostic tests and were very close to achieving the nine week target which was to be delivered by 31 December 2007. Between the end of January 2007 and the end of June 2008, 123 patients across Scotland waited longer than the nine week target. As a milestone in achieving the 18 week referral to treatment target, patients should not wait longer than six weeks for eight key diagnostic tests from March 2009. Achieving this milestone will place NHS boards in a better position to meet the overall target of 18 weeks referral to treatment.	▪ Is the board maintaining the current nine week diagnostic waiting times target? ▪ How is the board progressing with the six week milestone? ▪ Are diagnostic services included in longer-term planning for achieving and maintaining the new 18 week referral to treatment target.
Part 4. Efficiency of diagnostic services and performance management		
P20	NHS boards count the number of diagnostic examinations differently, which makes it difficult when making comparison on certain indicators of efficiency. The report has made recommendations for ISD and NHS boards to work together to standardise definitions.	▪ Does the board have plans to work with ISD to standardise the way diagnostic activity is counted and ensure data are recorded consistently? ▪ Are data recorded consistently across hospitals within the NHS board?
P20	There are inconsistencies in the information NHS board's provide on radiology and laboratory activity	▪ What arrangements does the board have to ensure that data reported to the Cost Book reflect data that are reported to Keele Benchmarking Scheme and NHSScotland

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	and costs. For example, there are inconsistencies in the information NHS boards report to the ISD Cost Book and other benchmarking schemes.	Radiology Benchmarking Project?
P22-25	The use of staff, equipment and facilities varies across radiology departments, endoscopy services and laboratories.	▪ How does the board ensure it is making best use of existing resources? ▪ Does the board collect and monitor local information of the performance of diagnostic services? ▪ Does the board review the performance of diagnostic service against indicators of efficiency and make use of benchmarking data to identify potential improvements on an ongoing basis?
P26	There are differences across laboratories in the numbers of repeat tests on the same patient. Although repeat testing is sometimes clinically necessary, there is rarely a clinical reason for having to repeat these tests within these timescales.	▪ Does the board monitor repeat testing? ▪ Has the board developed guidelines for clinicians and GPs to help reduce repeat testing?

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