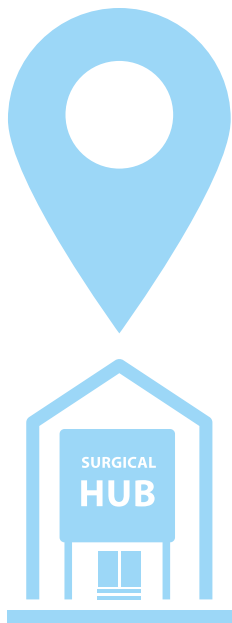


Tackling the Elective Backlog:

A Spotlight Report on the Implementation and Impact of Surgical Hubs and Community Diagnostic Centres



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Executive Summary

Elective recovery plans in part rely on the strengths of Surgical Hubs (SH) and Community Diagnostic Centres (CDC) to provide additional support. The MTG welcomes the introduction of these additional tools for the NHS; but following research into their development and implementation, has questions about the establishment and decision making processes at SHs and CDCs.

Key findings from MTG research showed:

- Only 44% of ICSs that responded indicated they actively review their surgical hubs to ensure efficiency.
- Almost 40% indicated that decisions over the creation of local surgical hubs were led by clinical decision making.
- Just 20% of ICSs that responded stated that they have attempted to learn from best practice in other ICSs when planning for their surgical hubs.
- Just two ICSs consulted their patient populations comprehensively on the procedures and equipment used within their surgical hubs.
- Around three quarters of community diagnostic centres involved the public or patients in some capacity in their establishment.
- A lack of central engagement by NHS England and the Department of Health and Social Care in establishment of CDCs.

The MTG believes that there is an opportunity for ICSs to expand their processes and models of care to address the patient backlog more quickly, particularly through enhanced use of medical technology and with increased patient involvement.

The MTG makes four recommendations to help improve the workings of SHs and CDCs:

- 1.** The Government and NHS England should commit to a comprehensive review into the performance, success and cost-effectiveness of surgical hubs and community diagnostic centres.
- 2.** The Government and NHS England should mandate the proper inclusion and involvement of patients in the future establishment of surgical hubs and community diagnostic centres to ensure they are shaped consistently to meet the needs of the local populations they are serving.
- 3.** The Government and NHS England should ensure that appropriate medical technologies are at the heart of the efforts to tackle the backlog.
- 4.** The Government and NHS England should develop formal platforms and forums for the sharing of best practice between Integrated Care Systems.

Introduction

The elective backlog has put the NHS under significant strain since the Covid-19 pandemic. Although not the sole cause, the pandemic has exacerbated growing waiting lists and patients across the country are now waiting longer than ever for care. The Government, the NHS and frontline staff have made tackling the elective backlog a key pillar of work, given the impact on patients and the system.

In addition to the impact of Covid-19, industrial action has had a significant knock-on impact on waiting times and the increasing backlog. The BMJ has said that industrial action across the NHS for the last 10 months has delayed nearly one million patient procedures and appointments, and that does not include those patients who don't get booked in on strike days so the impact is likely more significant.^{xi}

The elective backlog refers to the mounting number of elective, or non-urgent, medical procedures and treatments that have been postponed or delayed due to the overwhelming demands placed on the NHS.

While the NHS tackled surges in COVID-19 cases, a significant number of elective surgeries, diagnostic tests, and treatments were deferred to prioritise resources, and protect both patients and healthcare workers from the virus.

As a result, thousands of patients have found themselves waiting longer than ever for procedures such as hip replacements, cataract surgeries, and cancer screenings.

As of August 2023, there were around 7.75 million people waiting for treatment in England, a significant increase from the pre-pandemic level of 4.4 million patients waiting for treatment.^{xx}

This backlog not only poses a serious threat to the well-being of those patients awaiting treatment, but also places immense strain on an already stretched healthcare system.

The NHS published its 'Delivery plan for tackling the COVID-19 backlog of elective care' in February 2022, which sets out a number of ambitious targets for the NHS to tackle the elective backlog before 2025. One of the key strategies outlined in the plan is the development of surgical hubs (SHs) and community diagnostic centres (CDCs).

Surgical hubs are stand-alone facilities that are specifically designed to carry out elective surgery, with CDCs designed to provide a range of diagnostic tests, such as x-rays, scans, and blood tests. The NHS believes that by bringing together the right people and equipment in one place, surgical hubs and community diagnostic centres can play a key role in tackling the elective backlog.

In this spotlight report, the Medical Technology Group will examine how successful this ambition has been, reviewing the process of creation for CDCs and SHs; how patients, industry and wider stakeholders were involved in this process; and what assessment has been by NHS England on their success.

The NHS is facing a challenging task in clearing the elective backlog, and the MTG believes that if medical technology and meaningful patient involvement are included as key considerations in the development and deployment of CDCs and SHs, there will be greater success for NHS England, the NHS frontline and for patients.

Recommendations

- 1. The Government and NHS England should commit to a comprehensive review into the performance, success and cost-effectiveness of surgical hubs and community diagnostic centres.**

This review should include an assessment of the effectiveness of medical technologies within surgical hubs and community diagnostic centres, with associated recommendations for the improvement and development of their use, and appropriate funding to ensure their success.

- 2. The Government and NHS England should mandate the proper inclusion and involvement of patients in the future establishment of surgical hubs and community diagnostic centres to ensure they are shaped consistently to meet the needs of the local populations they are serving.**
-

- 3. The Government and NHS England should ensure that appropriate medical technologies are at the heart of the efforts to tackle the backlog. It is vital that they are utilised within surgical hubs and community diagnostic centres to improve outcomes for patients and create efficiencies for the NHS.**
-

- 4. The Government and NHS England should develop formal platforms and forums for the sharing of best practice between Integrated Care Systems.**

Instances of best practice are widespread across the NHS, however, can appear isolated and varied nationally. The MTG is calling for the discovery and dissemination of this in all forms, whether it is through the appropriate utilisation of medical technology, the meaningful involvement of patients or other structural or organisational practices.

Establishment of SHs/CDCs

As of September 2023, NHS England has 94 operational elective surgical hubsⁱⁱⁱ, which have delivered 10,253 elective procedures and 41,067 outpatient appointments.

The government has announced that all 160 planned CDCs will be open by March 2024, a year ahead of the original March 2025 target.^{xvii}

Between July 2021 and June 2023, 152 Community Diagnostic Centres have successfully delivered over 4.2 million tests, checks and scans, ranging across 61 individual diagnostic procedures^{iii,iv}, from Plain Film X-Rays and Colonoscopies to peripheral neurophysiology and non-obstetric ultrasounds.

The establishment of both CDCs and SHs followed clear guidance and regulation from NHS England. However, there remain questions around how consistently they use effective medical technologies and meaningfully involve patients in their development and ongoing work.

Medical technologies have the potential to transform the delivery of care across the NHS, including within CDCs and SHs, providing numerous benefits:

- 1. Improved efficiency and accuracy**, leading to faster diagnosis and treatment.
- 2. Reduced waiting times** for diagnostic tests and elective procedures by making them more efficient and by increasing the capacity of CDCs and SHs.
- 3. Improved patient experience** by making diagnostic tests and elective procedures more comfortable and less invasive.
- 4. Increased patient safety** by reducing the risk of errors and complications.
- 5. Long term cost-effectiveness** by reducing the need for more expensive treatments and by improving patient outcomes.

It is critical that the appropriate medical technologies are used across SHs and CDCs, and that out of date technologies are replaced by more innovative and effective solutions.

The meaningful involvement of patients in the set up and review of SHs and CDCs can provide a range of benefits to their ongoing performance, such as:

- 1. Improved quality of care** by ensuring that patients' needs are met and that they are involved in decision-making about their care.
- 2. Increased patient satisfaction** by making patients feel more in control of their care and by giving them a voice.
- 3. Reduced complaints** by ensuring that patients' concerns are addressed and that they feel listened to.

As laid out in the MTG's recent reports on Meaningful Patient Involvement^v, meaningful patient consultation at all levels of NHS decision making is critical, especially in gathering feedback and insights for enhancing service performance and improvement.

With SHs and CDCs still in the early stages of delivery, the NHS should look to embed meaningful patient involvement in their structures throughout the process of setting them up, and on ongoing basis, including in any review of efficacy, to ensure the delivery of better outcomes.

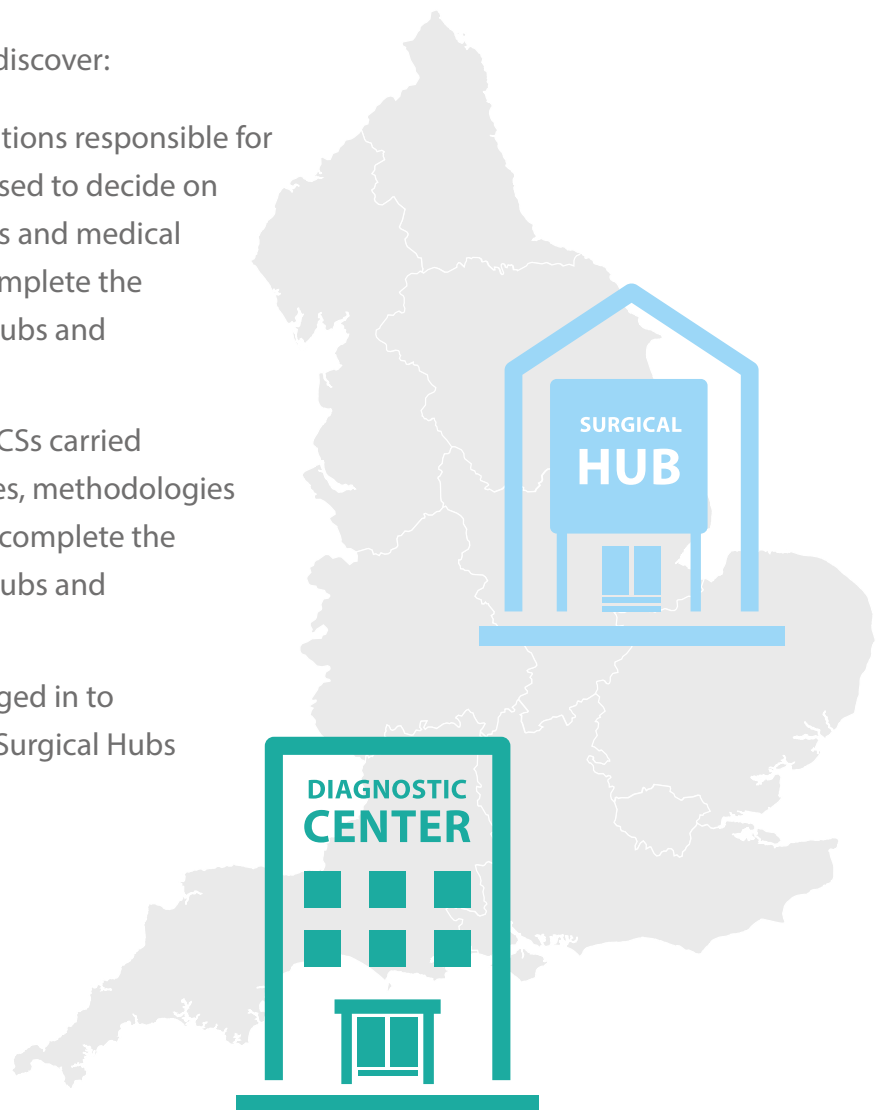
The Planning and Delivery of Diagnostic Centres and Surgical Hubs

It is clear that appropriate medical technology use and meaningful patient involvement have benefits for the development and deployment of CDCs and SHs. In the development of this report, the MTG has reviewed NHS England's plans to utilise each in their planning and delivery of CDCs and SHs through Freedom of Information Requests, Parliamentary Questions and desk based research.

By requesting information from the 42 Integrated Care Systems (ICSs) of England, alongside the 145 NHS Foundation Trusts, the MTG examined instances of variation and best practice in the setup of SHs and CDCs.

Within this context, the MTG has looked to discover:

1. What criteria have ICSs, as the organisations responsible for the commissioning of SHs and CDCs, used to decide on the specific procedures, methodologies and medical technologies that would be used to complete the procedures delivered by the Surgical Hubs and Community Diagnostic Centres?
2. What public and patient consultation ICSs carried out surrounding the specific procedures, methodologies and equipment that would be used to complete the procedures delivered by the Surgical Hubs and Community Diagnostic Centres?
3. What review processes ICSs have engaged in to adjust how activity is delivered by the Surgical Hubs and Community Diagnostic Centres?



Surgical Hubs

The Creation of Surgical Hubs

The MTG has found four areas of focus for ICSs in the development of surgical hubs across England.

1. Getting It Right First Time Guidance

In the responses to the MTG's FOIs, ICSs referenced GIRFT's recommendations and clinical pathways as the guidance used to establish the SHs. An example of this guidance is GIRFT's *'Planning effective surgical hubs: A Guide for NHS England Regions and Systems'* which looks at contribution to the elective recovery effort, value for money and clinical and operation transformation as the key criteria for decision making related to SHs.

Of the 42 Integrated Care Systems of NHS England, 14 (40%) referred to Getting It Right First Time (GIRFT) or Royal College of Surgeon (RCS) Guidance as the leading driver of decision making when it came to establishing the SHs in their catchment area^{vi}.

Within these responses, ICSs highlighted their focus on GIRFT and the RCS's High Volume, Low Complexity (HVLC) programme, a priority, data-led transformation programme supporting the recovery of elective care services post COVID-19 pandemic.

The HVLC programme focuses on six specialties^{vii} and develops standardised patient pathways that define the best practice for the care of patients. The intention of the HVLC programme is to reduce the waiting list of those procedures that can be done quickly with the fewest complications, aligning their purpose with that of the surgical hub model.



2. Clinically Led Decision Making

Thirteen (37%) ICSs^{viii} suggested that decisions over the specific procedures, methodologies and medical technologies used to complete the procedures delivered by the Surgical Hubs were led by clinical decision making.^{ix}

Reasons for this are varied between ICSs, including some noting that equipment for SHs is selected according to the most cost effective, clinically effective solutions or is decided by operational teams, in line with previous procurement practices, with sign off from clinical teams.

South East London ICS said that decisions surrounding the specific procedures, methodologies and equipment used within their SHs are a matter for local operational and clinical consideration, building on best practice guidance such as NICE and national GIRFT guidance relating to HVLC, not collective decision making.

3. Needs Based Decision Making

Nine (26%) ICSs^x said decision making over the establishment and selection of procedures and equipment for their SHs was largely shaped in accordance with the needs of the population and the biggest potential impact on waiting lists.

This includes looking at what would have the biggest impact on patients and waiting times, reviewed in conjunction with the current backlog, size of waiting list and disparity between demand and current capacity. For many of the ICSs, productivity, efficiency, safety, and patient outcomes were also utilised to adjust the clinical pathways. From our research, the types of medical technology available were not considered in this decision-making process.

Herefordshire and Worcestershire ICS noted that those elective specialties with long waiting lists were identified as the priority procedures, designed to separate elective from non-elective flows and providing ring-fenced elective facilities.

4. Learning Best Practice

Although uncommon, there were indications from seven ICSs^{xi} (20%) that they have attempted to learn from best practice within other ICSs when planning for their SHs, namely:

- a. **Cambridgeshire and Peterborough ICS**
- b. **Coventry and Warwickshire ICS**
- c. **Derby and Derbyshire ICS**
- d. **Nottingham and Nottinghamshire ICS**
- e. **Cheshire & Merseyside ICS**
- f. **Hertfordshire and West Essex ICS**
- g. **South East London ICS**

Derby and Derbyshire ICS, South East London ICS, and Nottingham and Nottinghamshire ICS reference GIRFT best practice, found in documents such as GIRFT's *'Planning effective surgical hubs: A Guide for NHS England Regions and Systems'*. Cambridge and Peterborough ICB said they are looking at pathway learning from best practice sites across the country. This includes investigating areas of the country that have already delivered SHs to learn from their experiences.

Cheshire & Merseyside ICS's approach has been guided by publicly available "best practice" recommendations, which guide how best to deliver elective surgical pathways. Hertfordshire and West Essex ICS also referenced "taking learnings from elsewhere."

Review of Surgical Hub Efficiency

Only 18 ICSs responded to the MTG request for insight into the reviews or discussions the ICSs have had on the need to adjust the way procedures are delivered by the SH.

Of those that responded to the MTG, results were varied, with 8 (44%) suggesting they actively review their surgical hubs to ensure efficiency. Within this, Hertfordshire and West Essex ICS outlined an aspiration to transform and innovate as part of this system-wide review. Cambridgeshire and Peterborough ICS detailed reviews of priority procedures in relation to outcomes and lengths of stay in relation to regional peers.

A further 7 (39%) expressed their intention to review efficiencies in the future, with 3 (17%) of the 18 respondents expressing little appetite to review.

Some ICSs did not express any intention to review the performance of their SHs, including Cheshire and Merseyside ICS, who noted that their SH approach has been guided by best practice, with no requirement for unique adjustments. North East and North Cumbria ICS have said it is a matter for providers to decide how best to deliver surgery using best practice guidance, not commissioners.



44%

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Patient Involvement in the Establishment of Surgical Hubs

Patient involvement in the establishment and review of surgical hubs across NHS England is limited.

Much of the creation of SHs rested on national guidance from GIRFT, the Royal College of Surgeons and NHS England, with many ICSs therefore claiming no patient or public consultation was necessary.

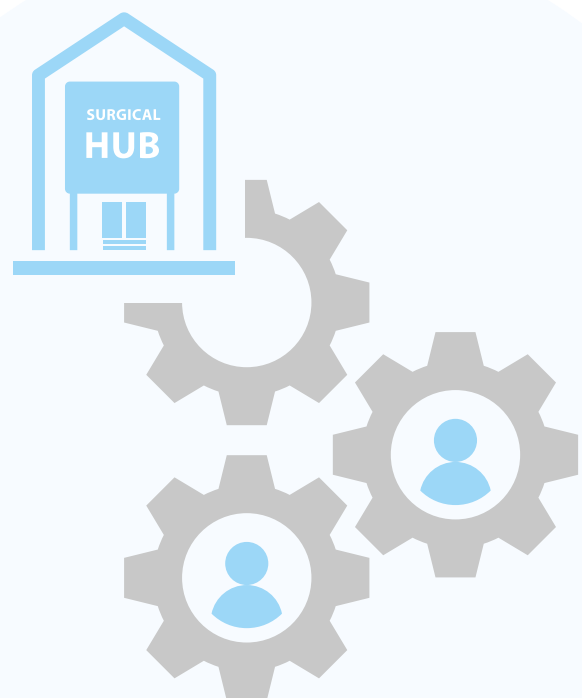
Only two (6%^{vii}) of the ICSs who responded noted that they had conducted public and patient consultation surrounding the methodologies and equipment used to complete procedures delivered in Surgical Hubs.

Hampshire and the Isle of Wight ICS undertook a general questionnaire on elective waiting times and experience, as well as several focus groups to engage with patients about the plans for the elective hub, and the potential benefits of a dedicated orthopaedic centre. Further consultation and communication is planned whilst the hub is being built and operational delivery worked through.

North Central London ICB undertook a patient and public consultation in relation to elective orthopaedic surgical hubs, with further patient and public engagement due to be undertaken in the future in relation to other surgical specialities delivered by the hubs.

Following a FOI request into the patient or public involvement conducted by GIRFT during the development of their guidance work on Elective Surgical Hubs, NHS said the following work was undertaken:

- Health Innovation Network (HIN) Report from September 2022, commissioned by NHS England London Region to support the scaling up of the HVLC programme nationally: “High Volume Low Complexity Hubs: Patient and Staff Insights”.
- NHS England – GIRFT nationally commissioned insights report from the Patient Association (July 2023) into the experience of patients being referred to and treated at Elective Surgical Hubs as part of mutual aid between trusts, plus development of patient-focused video outlining the concept of hubs (published Aug 2023).
- NHS England – GIRFT Engagement with the Royal College of Surgeon’s Patient Group (during Autumn of 2022) to inform the development of our Surgical Hub Accreditation Scheme and associated criteria and guidance.



Community Diagnostic Centres

The Creation of Community Diagnostic Centres

The MTG found five areas of focus for ICSs in the creation of CDCs, including in relation to their selected procedures and use of medical technologies.

1. NHS England Guidance

Of those ICSs that responded to the MTGs FOI request, 27 (69%^{viii}) referenced NHS England guidance as the leading influence for their plans and strategies surrounding CDCs.

The main pieces of guidance released by NHS England to support the creation of CDCs were the Richards Review^{xiv}, released in 2020 following an independent review of NHS England's diagnostic services, and the 'Community Diagnostic Centres: Guidance for planning, design and implementation' published in 2022.

The Richards Review was chaired by Professor Sir Mike Richards, who was commissioned to undertake a review of NHS diagnostics capacity. The independent report recommended the need for a new diagnostics model, where more facilities are created in free standing locations away from main hospital sites, providing quicker and easier access to tests.

Following the release of this guidance, NHS England published its formal CDC Planning Guidance. This guidance included the core modalities needed to for a standard community diagnostic centre, meaning, in many cases, decisions have not been decided locally at the ICS level, this includes decisions about which tests to provide and the suitability of the facilities at the chosen locations.

NHS Planning Guidance also included support for the development of 'spoke' CDCs, which can provide a reduced range of tests but still with a minimum level of imaging modalities and core physiological tests. A spoke offers the ICS the ability to create additional CDC sites without having to meet the criteria set out for its standard or large sites. Each ICS cannot have a spoke site without a full standard or large site being in place.



2. Public Consultation

From the responses to MTG questions, patient involvement in the decision making over the establishment of community diagnostic centres by ICSs found that 72% involved the public or patients in local decision making in some capacity.

Four ICSs (14%) used organisations such as HealthWatch to provide patient engagement and consultation. Four (14%) did not consult patients at all.

Of those who consulted with patients and the public in decisions surrounding the specific procedures, methodologies and equipment used to complete tests delivered by CDCs, the level of engagement varies. For ICSs such as Staffordshire and Stoke-On-Trent ICS, Hampshire and Isle of Wight ICS or Bedfordshire, Luton and Milton Keynes ICS, a patient survey was carried out, using questions such as:

- How far would you be willing to travel to a Community Diagnostic Hub?
- Thinking about the diagnostic services you have accessed, please outline what could be improved?
- Please tell us what other services you think could be provided at CDHs.
- Please tell us your views on where Community Diagnostic Hubs could be provided.

For other ICS, more extensive public and stakeholder engagement took place. Hertfordshire and West Essex ICS carried out a public survey, public focus groups, utilised existing patient network groups, and engaged with voluntary sector stakeholders, diagnostic staff and GPs. This information was then incorporated into the diagnostic strategy used to transform diagnostic services, including CDCs.

Coventry and Warwickshire ICS and Cambridgeshire and Peterborough ICS were among those that utilised their local Healthwatch service as part of their approach. Herefordshire and Worcestershire ICS used their local HealthWatch as the sole approach to engagement. While these ICSs should be commended for engaging with patients and the public, there are more holistic methods of engaging with patients and the public in their areas, which may have been explored.

ICSs that did not consult patients during the creation of CDCs include Lancashire and South Cumbria ICS, which said the CDC planning and financial approval process was fast-paced and did not allow adequate time for public and patient consultation. Derby and Derbyshire, Nottingham and Nottinghamshire ICS and Devon ICSs, all noted that there was no consultation due to the clarity provided by the national guidance document.

Devon ICS suggested that “if they prefer,” patients can choose to go to their local hospital for a diagnostic test over their local CDC, marking sufficient involvement in their care.

3. Needs Based Decision Making

Twenty-six (67%^{xvi}) ICSs indicated that the construction of their CDCs was needs-based, with demand and capacity identifying additional procedures or tests required to meet future diagnostic demand.

Staffordshire and Stoke-On-Trent ICB, following a review of spirometry services, will align service provision more closely with the CDCs.

Decisions surrounding the medical technologies used within local CDCs also appear to have come into these needs-based decision making. Hertfordshire and West Essex ICS have said they assessed capacity and utilisation of existing machines to develop plans for their CDCs.

Other needs-based considerations into the creation of CDCs include local patient access, waiting times, health inequalities data and local population, geographic and deprivation profiles.

4. Clinically Led Decision Making

Fifteen^{xvii} (38%) ICSs suggested that decisions over the creation of local Surgical Hubs were led by clinical decision making.

For ICSs such as Norfolk and Waveney ICS, clinical involvement revolved around the appropriate pathway and service needs for CDCs, including the viability of implementation, impacted by workforce, equipment, consumables, and referral and discharge requirements.

South East London ICS provided a clear indication that CDC equipment requirements have been planned as part of system wide clinical pathways groups to ensure purchases complement existing Trust equipment and staff training. This approach is shared by ICSs such as Birmingham and Solihull, who said clinical leads were involved in the design phase of CDC room layouts and equipment specifications.

Procurement processes in West Yorkshire ICS have been led centrally by NHS Supply Chain, with the diagnostic tests delivered by local CDCs determining the type of equipment required.



38%

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Review of Community Diagnostic Centre Efficiency

Only 41% of ICSs suggested that they reviewed how diagnostic tests are delivered by their CDCs^{xviii}. The remaining 59% of ICSs either made indications of future intentions to review CDC performance, or suggested their CDCs are commissioned, monitored and managed to the same standards as other diagnostic tests within the system.

The extent to which the 41% of ICSs have reviewed their CDCs is varied, but provides NHS England with sufficient examples of best practice to disseminate more widely. Examples include:

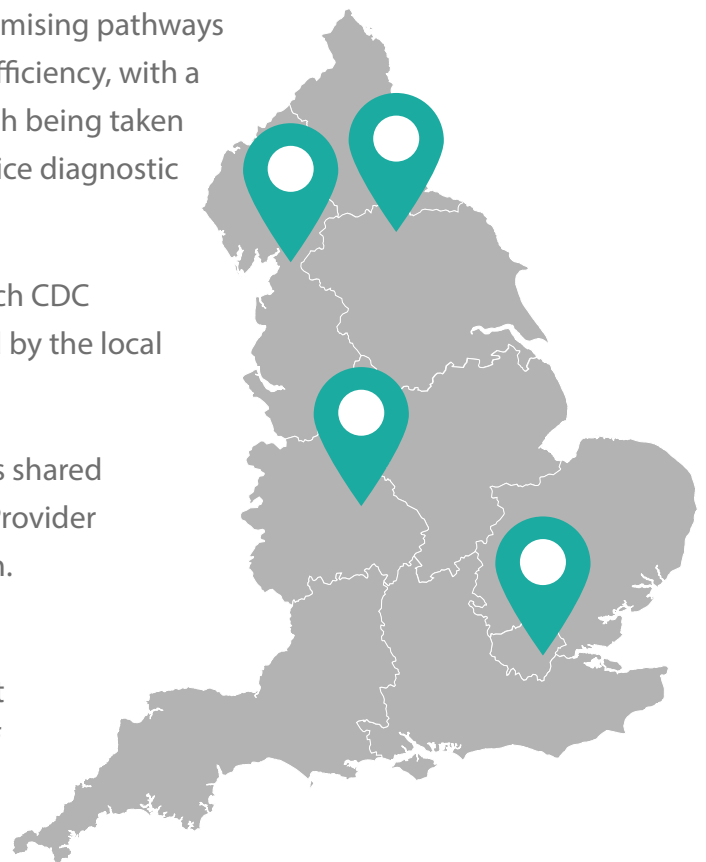
- **Birmingham and Solihull ICS** have established a Diagnostic Delivery and Improvement Board (DDIB) which will monitor the performance of CDCs and the diagnostic pathways they deliver, establishing new ones where required.
- **Humber and North Yorkshire ICB** have taken a multi-disciplinary approach to review, with key groups within the ICB, including the Executive Group, the Acute Collaborative Board, the Clinical and Professional Leads Group and the Cancer Alliance Board, having regular discussions regarding the CDC programme.

Humber and North Yorkshire ICS highlighted in their response that all these groups acknowledge the importance of optimising pathways of care to increase clinical effectiveness and cost efficiency, with a clinically led, collaborative and structured approach being taken to the adoption and implementation of best practice diagnostic pathways.

- For **Lancashire and South Cumbria (LSC) ICS**, each CDC locality has an implementation working group, led by the local NHS Provider Trust.

A monthly CDC implementation highlight report is shared with both the Integrated Care Board and the LSC Provider Collaborative Board for information and discussion.

- **South East London ICS** is working with primary care clinicians, community representatives, patient groups, and public voice representatives as part of a clinical pathway development programme, to ensure CDC pathway design is not replicating acute sector diagnostic models, and instead offers unique approaches to diagnostic delivery.



Patient Involvement in the Establishment of Community Diagnostic Centres

Whilst patient involvement and engagement across the establishment of CDCs is relatively widespread – with 72% of ICSs involving the public or patients in local decision making – national level engagement from the Government and NHS England is limited.

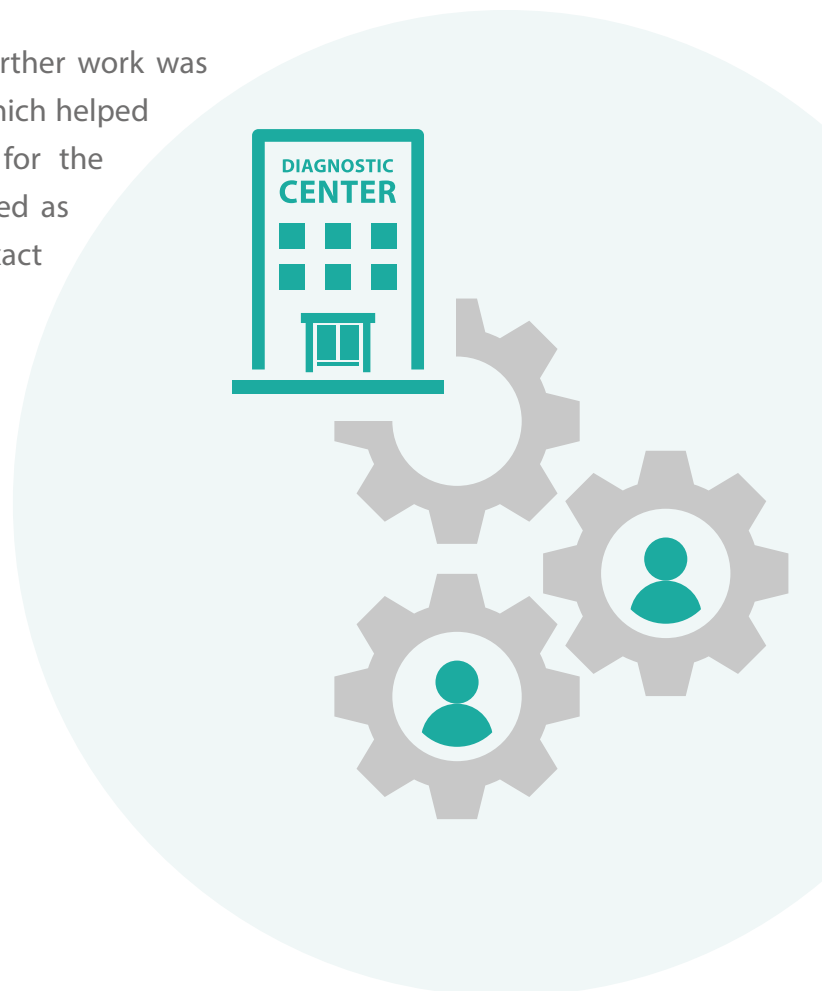
Following a Written Parliamentary Question tabled to the Department of Health and Social Care^{xix}, Helen Whately MP, Minister for Social Care noted that neither the Department nor NHS England conducted a public consultation on the diagnostic tests, procedures and equipment available at CDCs.

The Government has said this is because the selection of core services offered by CDCs is a clinical decision and based on the requirements of patients on the waiting lists. For individual CDCs, the inclusion of additional services is also based on local assessment of clinical need.

Following the indication that the core services for CDCs are based on recommendations from the Richards Review, the MTG submitted an FOI to NHS England centrally to learn what patient involvement had been conducted during its creation and recommendations.

NHS England informed the MTG that Professor Richards consulted widely with clinicians and charities on the concept of CDCs during the development of an independent review of diagnostic services commissioned by NHS England.

Following publication of the Richards Review, further work was undertaken by the NHS England strategy team which helped to define those models. Public engagement for the location and design of CDCs is also recommended as part of national guidance, decisions over the exact locations of CDCs are made locally by ICSs.



Conclusion

The elective backlog presents a significant challenge to the NHS and demands a multi-faceted approach to ensure success. However, it is clear that the establishment of surgical hubs and community diagnostic centres needs review to ensure consistency in output and delivery. While progress has been made, there remain areas of concern and opportunities for improvement.

The deployment of SHs and CDCs reflects a significant step toward addressing the elective backlog through innovative means. These facilities are designed to increase efficiency, reduce waiting times, improve patient experiences, and ultimately, enhance the overall quality and speed of care.

However, as this report highlights, challenges to their success remain. Limiting the input from vital stakeholder groups such as patient groups in developing and deploying CDCs and SHs could potentially lead to less-effective systems.

A comprehensive review of the performance, success, learnings, and cost-effectiveness of SHs and CDCs should take place. Outdated medical technologies can hinder progress and negatively impact patient care, so this review should also include an assessment of the effectiveness of medical technologies utilised currently and recommendations for their improvement and development.

Meaningful patient involvement in the establishment and review of SHs and CDCs is crucial. Patients' voices should be heard and considered in decision-making processes to ensure that the facilities meet their needs and preferences. The involvement of patients and the medical technology industry can contribute valuable insights and expertise to the development and operation of these centers.

However, only two ICSs properly consulted their patient populations on the procedures and equipment used within their surgical hubs.

While an overwhelming majority (72%) of ICSs consulted patients on the establishment CDCs, the lack of central engagement by NHS England and the Department of Health and Social Care shows evident gaps in current practice. The MTG recommends that the Government and NHS England mandate the proper inclusion and involvement of patients and the medical technology industry in the future work of surgical hubs and community diagnostic centres.

The establishment of Surgical Hubs and Community Diagnostic Centres is a promising method to address the NHS elective backlog. However, variation in current practice is clear, and it is vital that NHS England promotes existing best practice, and encourages its 42 Integrated Care Systems to learn from the places providing best practice, rather than continuing the status quo and exacerbating variation across the country.

The appropriate and proper use of innovative medical technologies, alongside the meaningful involvement of patients, has the potential to support SHs and CDCs to deliver an impact in tackling the elective backlog. NHS England must promote these solutions, and share best practice and learnings nationwide. By addressing these challenges and seizing opportunities for improvement, the NHS can make significant progress in clearing the elective backlog and enhancing patient care. The recommendations presented in this report serve as a valuable roadmap to guide these efforts.

Recommendations

- 1. The Government and NHS England should commit to a comprehensive review into the performance, success and cost-effectiveness of surgical hubs and community diagnostic centres.**

This review should include an assessment of the effectiveness of medical technologies within surgical hubs and community diagnostic centres, with associated recommendations for the improvement and development of their use, and appropriate funding to ensure their success.

- 2. The Government and NHS England should mandate the proper inclusion and involvement of patients in the future establishment of surgical hubs and community diagnostic centres to ensure they are shaped consistently to meet the needs of the local populations they are serving.**
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- 3. The Government and NHS England should ensure that appropriate medical technologies are at the heart of the efforts to tackle the backlog. It is vital that they are utilised within surgical hubs and community diagnostic centres to improve outcomes for patients and create efficiencies for the NHS.**
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- 4. The Government and NHS England should develop formal platforms and forums for the sharing of best practice between Integrated Care Systems.**

Instances of best practice are widespread across the NHS, however, can appear isolated and varied nationally. The MTG is calling for the discovery and dissemination of this in all forms, whether it is through the appropriate utilisation of medical technology, the meaningful involvement of patients or other structural or organisational practices.

Annex

- i. [Jim Shannon MP](#) "To ask the Secretary of State for Health and Social Care, how many procedures have been delivered by NHS England's Surgical Hubs as of 13 September 2023."
- ii. Of the 94 elective hubs, 63 have implemented unique data codes which allow for their activity to be measured separately from the wider activity of the hospital trust which runs the hub. This data is as of the week ending 30 July 2023, the most recent available data.
- iii. [Jim Shannon MP](#) "To ask To ask the Secretary of State for Health and Social Care, if he will list the diagnostic tests being provided by each Community Diagnostic Centre operational as of 4 May 2023."
 1. Ambulatory blood pressure monitoring
 2. Ambulatory heart rate recording
 3. Audiology - Audiology Assessments
 4. Audiology - Audiology Assessments
 5. Barium Enema
 6. Biopsy: Top up for Colonoscopy
 7. Biopsy: Top up for Gastroscopy / TNE / Flexi Sig
 8. Blood gas assessment
 9. Breast Screening
 10. Cardiology - echocardiography
 11. Cardiology - electrophysiology
 12. Colonoscopy
 13. Colposcopy
 14. Computed Tomography
 15. CT Colonography
 16. CT Coronary Angiogram
 17. CT with Contrast
 18. CT without Contrast
 19. Cystoscopy
 20. Dermatology
 21. DEXA Scan
 22. Ear Nose and Throat Tests
 23. ECG
 24. FeNO
 25. Fibroscan (Liver)
 26. Field exercise tests
 27. Fit Test - Clinical Biochemistry Processing
 28. Flexi sigmoidoscopy
 29. Fluoroscopy
 30. Full lung function tests
 31. Gastroscopy
 32. Holter
 33. Magnetic Resonance Imaging
 34. Mammography
 35. Mammography - Symptomatic
 36. Microvascular
 37. MRI with Contrast
 38. MRI without Contrast
 39. Neurophysiology - peripheral neurophysiology
 40. Non-obstetric ultrasound
 41. NT-Pro BNP
 42. Ophthalmology
 43. Orthopaedics
 44. Oximetry
 45. Phlebotomy Plain Film X-Ray
 46. POCT Anticoagulant Change of Dose
 47. POCT CRP
 48. POCT EGFR
 49. POCT Pregnancy Test
 50. POCT Urinalysis
 51. Point of Care Testing (POCT)
 52. Respiratory physiology - sleep studies
 53. Simple biopsy
 54. Spirometry +/- bronchodilator response
 55. Transnasal Endoscopy
 56. Urinalysis DipStick
 57. Urodynamics - pressures & flows
 58. US (NOUS) with Contrast
 59. US (NOUS) without Contrast
 60. US Guided Joint Injection
- v. Delivering Meaningful Patient Involvement: The MTG's Guide for Integrated Care Systems, <https://mtg.org.uk/wp-content/uploads/2023/09/MTGs-Guide-for-Integrated-Care-Systems.pdf>
- vi. Based off of the 35 ICSs that responded to the MTGs FOI question on the establishment of surgical hubs.
- vii.
 1. Ophthalmology
 2. General surgery
 3. Trauma and orthopaedics (including spinal surgery)
 4. Gynaecology
 5. Ear, nose and throat
 6. Urology
- viii. Based off of the 35 ICSs that responded to the MTGs FOI question on the establishment of surgical hubs.
- ix. This figure is inclusive of some of those ICSs that used GIRFT guidance, but does not determine following GIRFT guidance solely as 'clinically lead', despite most GIRFT processes being so.
- x. Based off of the 35 ICSs that responded to the MTGs FOI question on the establishment of surgical hubs.
- xi. Based off of the 35 ICSs that responded to the MTGs FOI question on the establishment of surgical hubs.
- xii. Based off of the 35 ICSs that responded to the MTGs FOI question on the establishment of surgical hubs.
- xiii. Based on the 39 ICSs that responded to the MTGs FOI question on the establishment of CDCs.
- xiv. Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England. <https://www.england.nhs.uk/publication/diagnostics-recovery-and-renewal-report-of-the-independent-review-of-diagnostic-services-for-nhs-england/>.
- xv. 21 of the 29 ICSs that answered the MTGs question on how patients were involved in decision making. The remaining 13 ICSs either did not answer any of the FOIs, did not hold the relevant information or did not answer the question on patient involvement specifically.
- xvi. Based off of the 39 ICSs that responded to the MTGs FOI question on the establishment of CDCs
- xvii. Based off of the 39 ICSs that responded to the MTGs FOI question on the establishment of CDCs
- xviii. Based off of the 22 ICSs that responded to the question "What discussions has the ICS had the on need to adjust the way diagnostic tests are delivered by the community diagnostic centres commissioned by the ICS?"
- xix. [Jim Shannon MP](#) "To ask the Secretary of State for Health and Social Care, whether his Department conducted a public consultation on the diagnostic (a) tests, (b) procedures and (c) equipment available at Community Diagnostic Centres."
- xx. Consultant-led Referral to Treatment Waiting Times Data 2023-24, August 2024. <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2023-24/#Aug23>
- xxi. <https://www.bmj.com/content/382/bmj.p2143#:~:text=Industrial%20action%20across%20the%20NHS,booked%20in%20on%20strike%20days>
- xxii. [Government to deliver 160 community diagnostic centres a year early - GOV.UK \(www.gov.uk\)](#)

