Aneurin Bevan Health Board
Radiology Directorate Strategy 2013 – 2018

Introduction

The aim of this paper is to inform the Board of the Radiology Directorate’s Strategy for the next 5 years. Radiology has been closely involved in Clinical Futures planning from the outset in conjunction with secondary and primary care teams. As a result radiology has aligned its strategic plans to support the implementation of the Clinical Futures Model and significant progress has already been made.

During 2012 the Radiology Directorate reviewed in detail the ongoing plans made for Clinical Futures against progress to date and what else needs to be achieved in the next 5 years. It also sought to validate and detail the workforce and service issues. The review of the workforce included the impact of demand on imaging services and staffing to support the SCCC. The strategy highlights the need to implement the plan from 2013 in order to support Clinical Futures and the SCCC in 2018.

The appendices included demonstrate radiology activity, staff and services provided by site, the impact of demand and the addition of the SCCC.

The Executive Team is asked to approve the Radiology Strategy prior to submission the Aneurin Bevan Health Board’s formal meeting in November 2012.

| Financial Assessment and link to Financial Recovery Plan | Investment in diagnostic imaging was always recognised as essential in order for the Clinical Futures model to be implemented. The concept from the early Clinical Futures planning was that savings on bed numbers and care focussed in primary not secondary care was a means of funding the investment required in Diagnostics. The estimated cost of implementation of Radiology Strategy is £6 million. |
### Risk Assessment

If the investment in diagnostics is not achieved the implementation of Clinical Futures is at risk. Potential areas of risk within the strategy are related to staff recruitment in particular Consultants and sonographers. The Deanery is increasing the training numbers for Radiology and in house training of sonographers will mitigate the risks associated with recruitment difficulties.

### Annual Operating Framework

Linked to:

- AOF 8 Length of Stay
- AOF 10 RTT
- AOF 20 Cancer Targets
- AOF 22 Stroke
- AOF 12 A & E 4 hour targets

### Standards for Health Services Wales

Standards:

1. Medical Devices, Equipment and Diagnostic Systems
2. Information Management and Communications Technology
3. Managing Risks and Health and Safety
4. Workforce Planning
5. Workforce recruitment and Employment Practices
6. Workforce Training and Organisational Development

### Equality Impact Assessment

Plans have been reviewed with Workforce and OD Directorate.

### Child Impact Assessment

The impact on children and young people will be assessed.

## 2 Introduction

Radiological services are central to the healthcare of patients and should be provided in a manner that facilitates the ability of clinicians to diagnose and treat patients efficiently and effectively. The Clinical Futures Strategy sets out the re-configuration of health services within Aneurin Bevan Health Board and acknowledges that improved access to diagnostics is critical to improving healthcare for patients. This document attempts to outline how over the next five years the Radiology Directorate will deliver improved access to
radiological services and thereby underpin the move to Clinical Futures.

3 Planning Basis

Ideally the Radiology Directorate should develop plans based upon the requirements of the clinicians using the service. This is the long term aim of the planning process but is difficult given the number of users, the varying demands made upon the radiology service by different users and the pace of clinical and technological change.

In order to support Clinical Futures the current radiology service needs to be transformed in terms of timeliness, volumes, working relationships and geography. Skilled staff, along with improvements in technology, are key to making this happen and the Directorate believes that it will take 5 years to achieve the required improvements in access. This paper takes a broad brush approach to outlining how Radiology over the next five years will work with referrers to implement “Clinical Futures”. The document explains in general terms how investment will be required to ensure service needs may be met. By having an appropriately trained workforce with “strength in depth” the Radiology Directorate will be able to work with referrers as their plans develop. This paper summarises the actions required to ensure radiology services are able to be flexible and provide the optimum level and type of service required to support new pathways of care.

4 Improved Access to Radiology Services

Within this document “Improved Access” is understood to mean:

- Continued increases in service levels.
- Reductions in waiting times – at the SCCC in patient examinations will be required within a matter of hours, at the ELG within the same day.
- Reduction in report turnaround times – for in patients and emergency patients these are currently same day but there are delays of up to 2 weeks for OP and GP when staffing levels (supply) do not match demand.
- Increase in hours of service – with the exception of plain films the in patient radiological service is generally provided between 9 – 5 with out of hours cover for urgent requests.
• Continuing improvements in technology leading to more effective examinations being available for patients – eg CT scan instead of barium enema.
• Continuing changes in clinical practice, eg interventional radiology, leading to more effective care for patients.
• Responding to NICE guidelines – contributing to more effective healthcare.
• Supporting the reconfiguration of healthcare services – more one stop clinics.
• Developing screening services.

5 Where are we now?

The Radiology Directorate is comprised of approximately 284 wte staff providing a range of services across 8 sites. Details are included in Appendix 1.

The graphs in Appendix 2 illustrate that in the 14 years to 2009/10 there was an over 40% increase in radiological examinations from around 296,000 to 419,000. Within this there has also been an increase in the complexity of reporting with cross sectional imaging such as CT and MR requiring much more Consultant Radiologist time to report.

“Imaging has become central to the management of almost all branches of healthcare. The role of the radiology department is crucial for the efficient diagnosis, management and discharge of the vast majority of patients in the health service” (Royal College of Radiologists) According to the RCR the percentage increase in imaging from 1997 – 2007 are approximately:

• Plain film x-rays 15%
• CT 60%
• MRI 260%
• Ultrasound 70%
• Radioisotopes 25%
• Fluoroscopy 20%

The National Imaging Programme Board (NIPB) of Wales provides the national forum for the strategic development of radiology services. The NIPB is chaired by a Chief Executive representative and links directly to all Chief Executives in Wales. Some of the current workstreams being undertaken by the NIPB are:

• Workforce
Regional planning of vascular and Interventional Radiology has been in place for some years. Plans are currently being devised to centralise the elective aortic aneurism service in South Wales. In November 2012, Aneurin Bevan HB and Cwm Taf HB introduced an interventional radiology on call service which Cardiff and Vale HB will join at a later date. Patients who would otherwise have had to wait with the associated risks or have been cared for by the Surgeons are now treated by Interventional Radiologists. This has benefits for patient care, clinical outcomes and savings in terms of bed days and theatre time.

Over the past 10 years the Radiology Directorate has risen to the challenges imposed by:

- Changes in clinical practice
- Changes in technology
- Increasing demand for radiological tests
- Skill shortages
- Waiting Time targets
- Healthcare service reconfiguration
- Limitations of facilities

The Clinical Director led a programme of modernisation that achieved:

- The implementation of PACS
- Widespread use of digital dictation (G2)
- RGH extension of radiology facilities
- 8 week waiting time target
- Extended skills
- Patient focussed booking
- Integrated service provided across ABHB
- Ability to support changes required by referrers

The modernisation programme was successful because the emphasis was upon changing working practices to improve efficiency and develop a radiology service that was better able to meet the demands being made upon it. The integration of staff and services across sites enabled economies of scale.

- The introduction of PACS was accompanied by the requisite changes in working practices that PACS afforded. For example, Consultant Radiologists agreed the organisation of
the reporting workload into folders and how they would work as a team to manage the new “workflow”.

• With the adoption of digital dictation and voice recognition the reporting process was re-designed. Digital dictation enabled the prioritisation of the typing workload so that urgent reports were always dealt with first. The workload was distributed across secretarial staff working at different sites. Voice recognition enables reports to be typed and validated in one step and this was key to the introduction of sonographer reporting being efficient and effective. Digital dictation and Voice recognition have enabled more reports to be produced with less secretarial support. The number of medical secretaries per Consultant Radiologist has reduced over time with a Medical Secretary now able to support a number of Consultants.

• The principle of “treat in turn” was embodied in the move to patient focussed booking. As a result differential waiting times across Aneurin Bevan Health Board sites were removed. Investment in clerical staff and a formalisation of booking templates and procedures made the process transparent and reduced the input required by clinical staff thereby freeing them to spend more time on clinical duties.

• Operational planning for ultrasound, nuclear medicine, MRI and CT was managed by staff from across the Directorate working together and it became common for staff to work at different sites. This has helped to break down barriers between sites and developed a more flexible radiology service better able to respond to the peaks and troughs of demand and supply.

• Skill shortages encouraged “role extension” with different staff groups undergoing training to develop their skills further. Sonographers took on much of the ultrasound reporting. Radiographers trained to undertake plain film reporting and examinations such as barium enemas, barium swallows and HSG’s. This enabled Consultant Radiologists to address the increasing cross sectional imaging workload. Health Care Support Workers and Assistant Practitioners roles were developed to perform some of the tasks formerly completed by radiographers.

• The improvement of facilities at the RGH was central to improving patient care, workflows, and staff morale. It was feared that against the backdrop of national shortages the
recruitment of skilled staff would not be possible given the poor working conditions at the RGH.

Some of the progress made in reducing waiting times (improving access) has been lost over the past year or so. Ultrasound waiting times are now over 16 weeks and this is largely due to the national shortage of sonographers. MRI routine waiting times are 12 weeks but a significant number of patients are choosing to wait longer to have their scan at the RGH rather than travel to YYF or NHH. Achieving waiting time targets for radiology services is largely about matching capacity and demand and ongoing investment is required to maintain the 8 week standard.

Some of the other pressures currently being faced by the Radiology Directorate are:

- Improved screening for Down’s Syndrome, due to be implemented in Wales, involves a more detailed initial ultrasound scan. It is estimated this will require an additional 1.5wte sonographer time.
- One stop sarcoma clinic
- Supporting 3 out patient clinic session days at YYF
- Cardiac Imaging
- TIA patients improved diagnosis
- National guidelines for improved standards for the time taken to report
- Direct access to CT to support the frailty project
- Extended CT access for MAU patients
- Colonoscopy guidelines – possibility of increased requests for CT Colon scans
- MRI monitoring of patients who have had hip replacement and the product has been found to be defective
- Interventional radiologists supporting obstetricians undertaking high risk deliveries.

As we look forward to the gradual implementation of Clinical Futures, Radiology must address the elements previously outlined within “Improved Access” along with:

- Demand management – so that resources are concentrated on effective examinations.
- National Skill shortages particularly for Consultant Radiologists and ultra-sonographers.
- The need to reduce costs and continue to improve efficiency.
6  Where do we want to be in 5 years time?

In summary, “Providing the right test as quickly as possible” by working:

- Across 4 main sites.
- Within hours at the SCCC.
- Same day service for in patients at the ELGH.
- As part of one stop clinics for OP.
- 8am – 10pm, 7 days per week.
- With Consultant Radiologists part of MDT's.
- Within a variety of patient care pathways.
- And delivering screening services requirements.

Over the next 5 years the Radiology Directorate has to adjust the current balance that exists between the efficient use of radiology resources and responsiveness to service users. The focus for the past 10 years has been about improving processes within radiology, strengthening the skill base and improving facilities. The approach used to reduce waiting times was to focus on the modalities within radiology separately eg CT, MRI and plain film services.

However during this time the Radiology Service has also continued to strengthen its role within the healthcare team with:

- Consultant Radiologists increasingly providing a sub specialised service
- The introduction of one stop clinics such as Haematuria, PMB, Sarcoma
- Membership of Multi Disciplinary Teams (MDT's) – approximately 24 sessions per week of Consultant Radiologists time is spent in MDT's and other external department meetings.
- Consultant Radiologists being an integral component of clinical care - eg Breast services
- Interventional Radiology now provides more cost effective and appropriate treatments. With radiology led ward rounds and outpatient clinics now a routine.

Clinical Futures requires radiology to continue to evolve in terms of working with referrers. It may be argued that Clinical Futures
requires Consultant Radiologists to be more involved in clinical decision making earlier in the emergency patient pathway.

Improved access to diagnostics is key to the re-balancing of care between primary, community, secondary and tertiary services. Longer hospital opening hours will enable some emergency patients to be sent home rather than admitted to wait for a scan. Improved access to radiology for primary care referrers will enable:

- more patients to be cared for by their GP
- a more comprehensive series of diagnostic tests to be completed prior to out patient attendance at Consultant clinics.

As a result there is potential for an improvement in the quality of referrals from primary care and a reduction in the number of follow up out patient attendances required.

By 2018 it is envisaged that a comprehensive series of radiological examinations will be undertaken at the SCCC and three ELGH. The graphs in Appendix 3 show the current provision of services by site and by patient type, eg in patient, out patient, and the envisaged distribution of this activity across the new configuration of hospitals. The total number of sites providing radiology services is planned to reduce from 8 to 5. However the number of sites providing an IP/AE service will increase from 3 to 4. The SCCC represents a new type of hospital site that is restricted to emergency patients and there is concern this may reduce some of the economies currently associated with mixing routine OP and GP patients with IP/AE patients. This is particularly noticeable for the MRI service where currently only 15% patients scanned are requests for patients from either the wards or the accident and emergency department. To provide an MRI service for emergency patients there will be 2 scanners at the SCCC although ideally 85% of MRI patients will be scanned elsewhere.

The re-design of clinical services should lead to more one-stop clinics and the provision of a more effective service for patients. The recent introduction of a weekly sarcoma clinic has involved changes to the Job Plans of 4 Consultant Radiologists (MSK sub specialty), bringing a 1 in 4 element to the already complex clinic booking templates. The ultrasound service has already found that one stop clinics are fixed and reduce the flexibility of the rest of the ultrasound service at times of pressure eg staff illness. It is envisaged that over the next 5 years more radiology staff time will be allocated to one stop clinics reducing the current level of
flexibility within the service to respond to demand on a daily basis. Also given that clinicians will decide on the day whether a scan is required it is not clear that throughput per clinic will be the same as currently achieved.

In 5 years time the Radiology Directorate needs to be a strong, robust service that has enough flexibility to facilitate the transformation of healthcare services across Aneurin Bevan Health Board. This inevitably involves building more capacity.

7 How do we get there?

In order to play our part in delivering the healthcare improvements enshrined within Clinical Futures the Radiology Directorate must build upon its current strengths, expand its skilled workforce and continue the move towards closer working with referrers. This section outlines the main issues that must be addressed.

Providing the Right Test

Request forms for a radiological investigation are completed each time a test is required. Over 360,000 request forms are received each year. The request form is an A4 sheet completed by the referring doctor (or in some cases nurse or physiotherapist) and seeks patient details and clinical information to support the decision for such a test being required. Each request form is vetted by a Consultant Radiologist or radiographer prior to the test being carried out to:

- Justify that the radiation risk is outweighed by the potential benefits of the test.
- The test is the most useful course of action given the clinical information provided.

Referral guidelines are produced by the RCR and Radiologists work closely with medical colleagues to ensure the most appropriate tests are being provided. In a small number of cases forms are sent back to the referrer because the information is incomplete or the test is not the most appropriate form of diagnosis for the particular patient.

Providing the right test will require:

- Effective electronic referral
- Continued service improvements to ensure the latest clinical guidelines are adopted
• Increased presence of Consultant Radiologists at the SCCC to contribute to the clinical decision making process earlier in the patients pathway.
• Continued audit of the effectiveness of diagnostic tests

The All Wales Test Requesting Reporting Results Project (TRRR) will deliver a method of electronic requesting and this is crucial to reducing the time taken to provide scans and providing acknowledgement that the results have been received and acted upon. Within radiology the request form and vetting processes will have to be re-designed. The aim will be to streamline the current system, reduce the current administrative workload associated with request forms, improve booking processes and thereby enable the patient to be seen more quickly.

Re-configuring hospital services

As previously noted the graphs in Appendix 3 illustrate the proposed changes in the pattern of radiology services. The full detail of what services will be where and the implications for radiology have yet to be fully discussed. Some of the general radiology issues to be considered are:

• The SCCC must have an MRI service and to reduce the risk to patient care there should be two MRI scanners available. (One is needed to back up the other in times of planned maintenance or breakdown). However only 15% of the MRI workload concerns ward or accident and emergency patients.
• What opening hours are required for emergency patients at the Enhanced Local General Hospitals?
• The ultrasound service is currently provided Monday to Friday 9 – 5. Does this need to be extended to fit patient pathways?

Appendix 4 sets out the Radiology Directorate’s assessment of equipment and staff changes required to implement Clinical Futures over the next 5 years. Within this general framework there is much detail to be worked out within the planning process. The re-balancing of emergency and elective care across sites is a major challenge for the Directorate that we need to begin to understand more fully.
Equipment

Radiology is essentially about equipment and the skilled staff who use it. Advances in technology extend the range of tests and interventions that can be provided and also scanner processing times. It is important that equipment is maintained regularly and replaced at the appropriate time. This is achieved through the Radiology Directorate Equipment Replacement Plan. The priorities reflected within this plan are agreed by the Directorate and reviewed regularly.

Using NWSSP the Directorate purchases equipment via a framework agreement combining requirements with other Health Boards and has achieved considerable savings.

Appendix 4 summarises the changes in equipment levels planned by 2018. There will be one more CT scanner, 2 additional MR scanners and 2 additional ultrasound machines. The number of screening rooms is planned to reduce by 1 as some of this work transfers to CT and other modalities. The Radiology Directorate will continue to work within the national framework to commission this equipment.

Staff

Appendix 4 also summarises the results from the workforce planning exercise that has been undertaken for Clinical Futures. It is estimated that over the next 5 years an additional 139 wte staff will be required. These staff changes have been identified by modality and are the product of a workforce modelling exercise that starts with the services and opening hours of each department. An attempt has been made to explain where staff increases are needed purely because of changes in hospital re-configuration and where increasing demand would require investment regardless of changes in facilities.

The main issues associated with developing the staff base are:

- Timeframe for in house training of sonographers, radiographers, healthcare support workers and assistant practitioners.
- Expanding existing services such as CT between now and 2018.
- The extension of interventional radiology to undertake services currently undertaken in other specialties eg oncology, vascular surgery and gynaecology.
- Extending the working day and moving towards a 24 hour, 7 day service being provided at the SCCC.
- National shortage of Consultant Radiologists, sonographers.
- Promoting the extension of skills eg radiographer plain film reporting.

Graduate radiographers join Aneurin Bevan Health Board at Band 5 Level and generally are promoted through a programme of in house training and external courses that leads to the achievement of required specific skills and experience. In house training has become almost the only way of recruiting ultra-sonographers and given that the course takes two years to complete it is important that up to 3 members of staff begin training each year from 2013. There is a need to develop a 5 year training plan to ensure leavers and existing staff are replaced and that staff numbers are increased. There is a limit to the number of in house trainees that can be accommodated at any one time and it is therefore important that in house training begins in 2013.

If dependent upon the training of radiographers within Wales there are grave concerns that sufficient radiographers may be recruited. However in recent times there have been high numbers of applicants for radiographer posts. This appears to be because there is a mismatch between the number of training places in England and the posts available.

Clinical Futures is a journey and the pressure to extend opening hours for the CT service is already evident. As the number of hospital beds is reduced between now and 2018 the demand for prompt diagnostic tests will increase. Appendix 5 models the impact upon staff of an 8% increase in activity for CT annually over the next 5 years. The recruitment (to backfill trainees) and training of CT radiographer and support worker staff from 2013 would enable additional hours to be worked.

It is important to maintain radiology waiting times at 8 weeks or below in order to support the RTT targets. In order to do this capacity must be increased in line with demand. A further increase in MR opening hours requires additional MR radiographers to be trained with recruitment to backfill existing posts.

The on call workload for Consultant Radiologists is increasing with changes in clinical practice and will likely continue to do so as we move towards the opening of the SCCC in 2018. The provision of longer opening hours for radiology patients requiring prompt reporting is a challenge given the national shortage of Consultant
Radiologists. Consultant Radiologists work as individuals rather than as the head of a Clinical Team and any extension of the hours for reporting to be covered will require more Consultant Radiologists to be appointed. The ability to support sub specialised services for extended periods may well be limited by the availability of appropriately skilled staff. Extending the current working day for Consultant Radiologists is a major step change from the current stated pattern of Monday to Friday, 9am – 5pm. The type of reporting service required from radiology on an extended hours basis now needs to be defined in the planning process. The recruitment of sufficient Consultant Radiologists, with the required breadth of sub specialist skills, is a risk and the implications of this must be considered further.

The recruitment of sufficient Consultant Radiologists to deliver “improved access to diagnostics" will be a major challenge given the current national shortage. It is important that a Consultant Radiologist recruitment plan is developed for the next 5 years so that:

- Increases in demand over the next 5 years are responded to
- Radiological services may be re-designed to meet user requirements and ultimately benefit patients.
- Sub specialisation is developed whilst also maintaining the ability to provide cover for a core base of “general radiology”.

The Royal College of Radiologists (RCR) have recently noted that to cope with increasing demand the aim should be for 6 Consultant Radiologists per 100,000 population. The need to increase the number of Consultant Radiologists has been recognised by the RCR and the Deanery in Wales. The workforce plan indicates that more Consultant Radiologists will be trained from 2012.

The Radiology Directorate must continue to extend the skills of staff wherever possible. A further two radiographers are being appointed to enable the current group of radiographers to spend more time plain film reporting. This will enable Consultant Radiologists to address the current shortfall in MR reporting. Sonographers have been trained to undertake some of the Consultant subspecialty scans in order to improve waiting times.
Developing Plans with Referrers

Consultant Radiologists work with their colleagues in MDT's and other departmental meetings and this provides a basis for secondary care clinicians working together to implement Clinical Futures. It is envisaged that Consultant Radiologists will also work with the twelve Neighbourhood Care Network leads to develop and implement primary care radiology services. Such an approach will facilitate the re-balance of primary and secondary care. Care pathways will be developed by clinicians and designed to ensure that the relevant tests are provided at the appropriate time.

As costing models develop within Aneurin Bevan Health Board there is the potential to introduce cross charging for diagnostic tests. This would support dialogue with referrers and may help to ensure that the right test is provided.

The Clinical Commissioning framework is evidence based and presents an opportunity for the Radiology Directorate to identify the benefits of alternative treatment and secure funding. An example may be uterine fibroid embolisation rather than hysterectomy. The patient is discharged from hospital the next day and able to return to work within two weeks. The procedure is more cost effective and less disruptive for the patient.

There is also a need for structured training of all staff groups within radiology to understand the Clinical Futures overview, the role of radiology and how they can contribute to the change process. Alongside this there must be time for radiology to consider individual service plans as a whole and from this develop a co-ordinated solution for the provision of radiology services across ABHB in 2018. Without this there is a risk that radiology will determine the pattern of services to be provided rather than facilitate changes in services.

New Ways of Working

The estimated cost of improving access for radiology services within Clinical Futures is £6m. Improved diagnostics will support more efficient and effective healthcare in a variety of ways:

- Improved primary care access will reduce referrals to secondary care
- Rapid access will prevent some hospital admissions and reduce the length of stay for other patients
A more responsive radiology service will reduce the length of stay for patients.
Interventional radiology procedures offer improved patient care and are more cost effective.

It is the developing role of interventional radiology that in many ways highlights best the changing face of radiology in a critical care centre. A clinical approach with early access to treatments and imaging will prevent operations and facilitate a significant decrease in hospital stays.

The Radiology Directorate has a number of Interventional Radiologists providing patient treatment in addition to a diagnostic service. Interventional Radiology is providing care for patients that would otherwise have been surgical patients. Over the last 5 years:

- 80% of aortic aneurysms are now treated with stent grafts.
- Nearly all vascular bypass procedures are replaced by angioplasty as day cases.
- Patients opt for uterine fibroid embolisation rather than hysterectomy, with next day discharge and return to work within two weeks.
- Liver, lung and renal cancers are ablated rather than resected.
- Oncology patients are treated with catheter directed therapies rather than prolonged more costly chemotherapy regimes.
- Trauma and emergency treatment has seen Interventional radiology replace surgery in national guidelines for the treatment of life threatening haemorrhage.

These Interventional Radiology treatments lead to:

- Less use of theatre
- Less use of Intensive Care
- Reduced bed days

Within Interventional Radiology, a good example of the potential to re-design services is line insertions. These are currently undertaken in a number of areas throughout the Health Board using a variety of types of lines. The creation of pathways for the appropriate lines to be used, the training of nurses to undertake some of this work and a more co-ordinated Health Board wide approach offers the following benefits:
• Reduced infection rates
• Reduced bed days
• Reduced consumable costs
• Skill mix changes

Efficiency improvements within radiology itself have already partly funded the expansion of services over recent years. In 2011/12 there has been a saving of £500,000 per annum in the PACS revenue contract cost which will be re-invested in improving the radiology service.

The Radiology Directorate must continue to develop new ways of working to address the challenge of changes in the pattern of healthcare provision. For example it was noted that the out of hours CT service would not be able to cope with the introduction of Head Injury and Stroke guidelines. The radiographers would probably be unable to work the following day and the core CT service would be severely disrupted. Funding was not available to introduce 24 hour cover and given that the majority of new work would be head scans it was agreed that all radiographers working in the general department would be trained to provide out of hours head scans. This was an onerous undertaking in terms of training a large group of staff and increasing the pressure upon the plain film service but it has protected the core CT service.

7 Conclusion

This paper sets out the areas to be addressed and the need for phased investment in Radiology Services to:
• Enable an increase in the level of services provided between 2013 and 2018.
• Develop the “strength in depth” needed for radiology to underpin the planned transformation of healthcare services in ABHB.

8 Recommendation

The Board is asked to approve the Radiology Strategy.

Sponsored by: Judith Paget, Chief Operating Officer/Deputy Chief Executive

Prepared by: Marilyn Williams, Radiology Directorate Manager

Date: 14 November 2012