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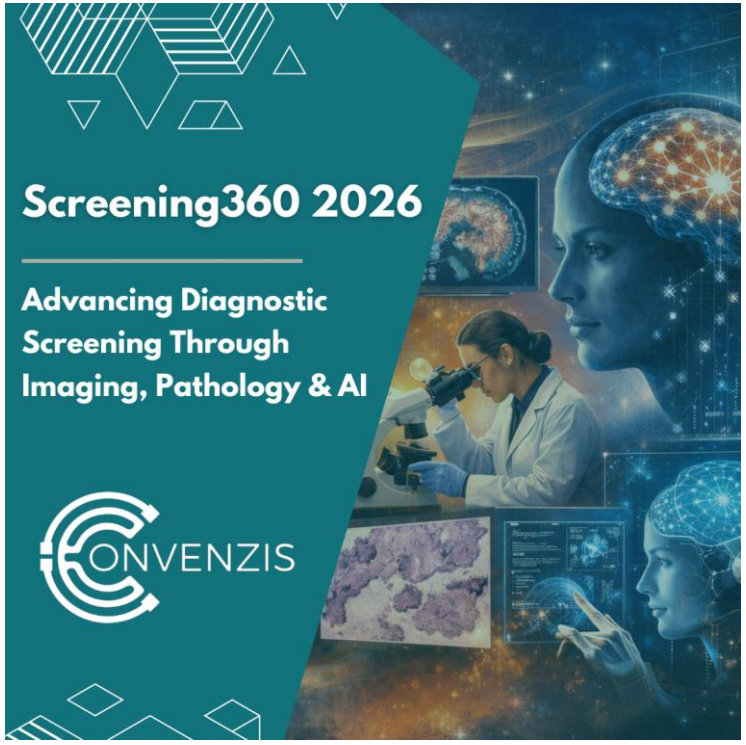

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Chair Opening Address

Huw Shurmer
AXREM Chair & Strategic and Government Relationship Manager FUJIFILM Healthcare UK
AXREM / FUJIFILM Healthcare UK

Keynote Presentation

Sheila Black
Head of the Community Diagnostic Centre programme (National Team)
NHS England

James Dennis
National Deputy Director, Imaging Transformation
NHS England

Bridging the Gap

Transforming Diagnostic Services Through Collaboration

James Dennis

National Deputy Director, *Imaging Transformation*

Sheila Black

Head of Community Diagnostic Centre

Transforming Diagnostic Services Through Collaboration

1. Bridging the Gap on Diagnostics Strategy
2. Driving Capacity Toward RTT Deliverability
3. Operational Focuses For National Commitments
4. The current picture: Snapshot of Assets, Activity, Throughput
5. An Update: CDC Programme Delivery
6. Developing the CDC workforce
7. Working with industry

Bridging the Gap In Diagnostic Strategy

1

The Government's 10 Year Health Plan for England, published in July 2025, aims to transform the NHS by focusing on community care, digital services, and preventive health measures.

2

The NHS medium term planning framework outlines the operational financial roadmap for integrated care boards to 2028/29.

3

From Spring 2026, both will be accompanied by a 10 Year Workforce Plan.

Transformation Themes Within the 10 Year Health Plan

Strategic Priorities

1. **Shift from hospital to community (Care Closer to Home)**
2. **Analogue to digital transformation**
3. **From sickness to prevention**

Opportunities For Collaboration

1. Earlier Diagnosis and Faster Access

- **Enable faster turnaround times by pooling radiology capacity across systems.**
- Support rapid access to CT, MRI, and ultrasound via Community Diagnostic Centres (CDCs).
- Reduce diagnostic bottlenecks in critical pathways like cancer, stroke, and cardiac imaging.

2. Tackling Health Inequalities

- **Reduce clinical variation by providing equitable access to imaging regardless of postcode.**
- Allow remote reporting from well-staffed areas to under-served regions.
- Standardise image quality, reporting protocols, and turnaround times across systems.

3. Building an Integrated, Digital NHS

- **Support clinical and operational flows between acute trusts, CDCs, primary care, and virtual wards**
- Deliver operational benefits of shared PACS, cloud-based image sharing, and AI-ready platforms.
- Lay the foundation for AI triage, quality assurance, and precision diagnostics.

4. Workforce Innovation and Flexibility

- Enable remote and cross-site reporting, supporting flexible/hybrid work models.
- Improve staff retention by reducing burnout through load-balancing.
- **Support upskilling through system-wide education and sub-specialty shared learning models**.

5. Financial Sustainability

- **Short term premium labour capacity (currently costing NHS >£250M/year)**.
- Increase productivity of NHS staff by matching demand with available capacity.
- Optimise utilisation of expensive capital assets.

6. AI and Innovation in Diagnostics

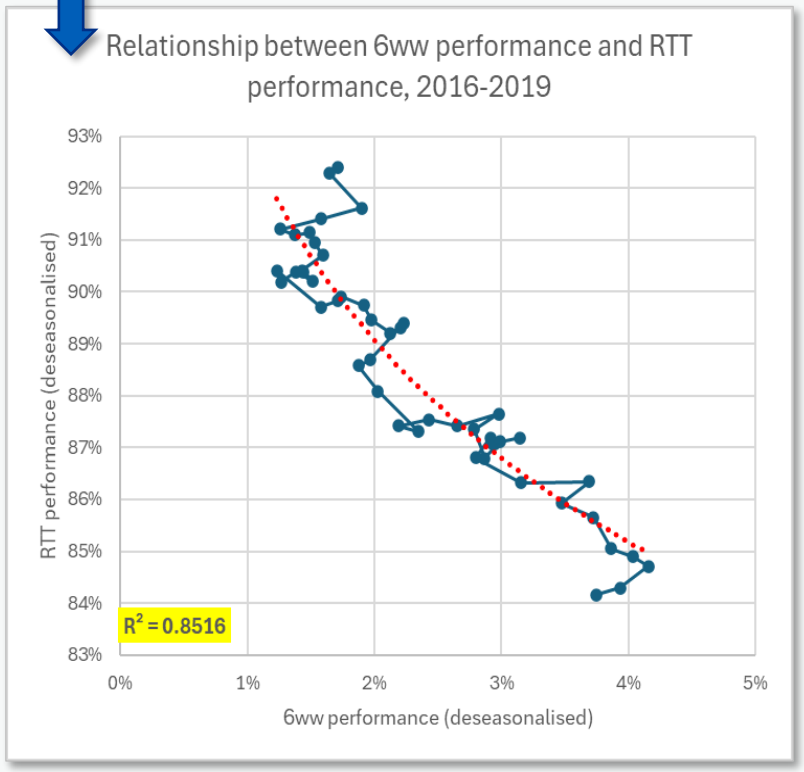
- **Operationalise scalable digital infrastructure needed for safe, effective AI deployment**.
- Facilitate validation, audit, and rollout of AI tools at a system level.
- Create data-rich environments for continuous improvement and innovation.

Implications of the Medium Term Planning Framework

To achieve the return to constitutional standards for referral time to treatment (RTT) required by the *Medium Term Planning Framework (MTPF)*

99% of patients need to receive a diagnostic test within 6 weeks, by March 2029

The trend line suggests that achieving the 92% RTT standard requires diagnostics to be close to the 1% 6-week wait standard.



Systems have been provided with a performance trajectory, that requires::

- **86%** of patients to receive a diagnostic test within 6 weeks by March 2027
- **93**% by March 2028
- **99%** in March 2029

This is directly aligned to RTT performance improvement trajectories

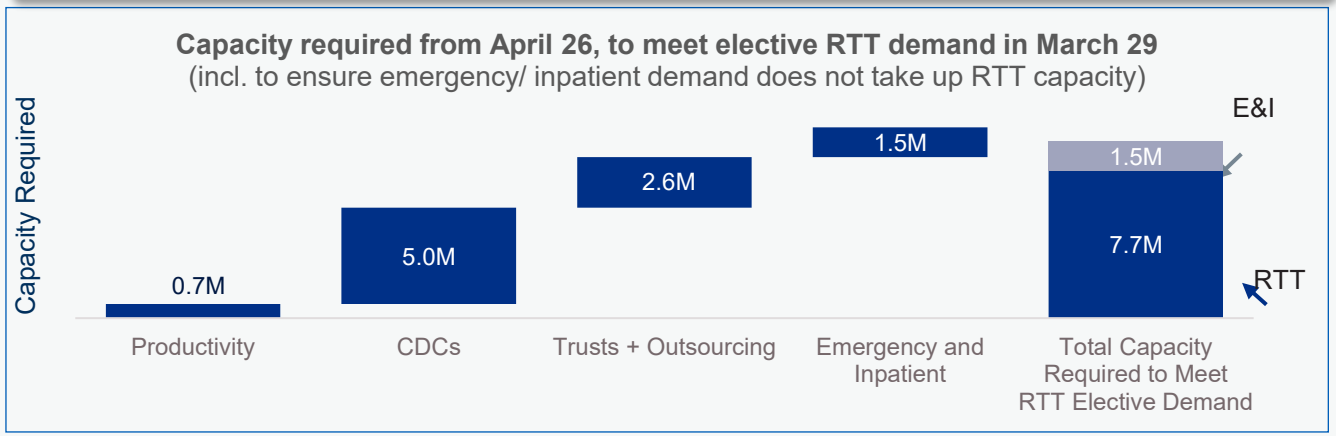
Success measure	2026/27 target	2028/29 target
Improve the percentage of patients waiting no longer than 18 weeks for treatment	Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%)	Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment
Improve performance against cancer constitutional standards	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	
	Every trust delivering 94% performance for 31-day and 80% performance for 62-day standards by March 2027	Maintain performance against the 31-day standard at 96% and 62-day standard at 85%
Improve performance against the DM01 diagnostics 6-week wait standard	Every system delivering a minimum 3% improvement in performance or performance of 20% or better, whichever level of improvement is greater (to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test)	Achieving the standard that no more than 1% of patients are waiting over 6 weeks for a test

Bridging the gap in RTT Deliverability

Government has committed to a target of **92% on RTT pathways receiving treatment within 18 weeks** by March 2029. To enable that we need **to deliver an extra 9.2m RTT pathway diagnostic tests** (2025-29), attain constitutional standard performance (**99% within 6 weeks**) and report **98% of histopathology tests** within 10 days

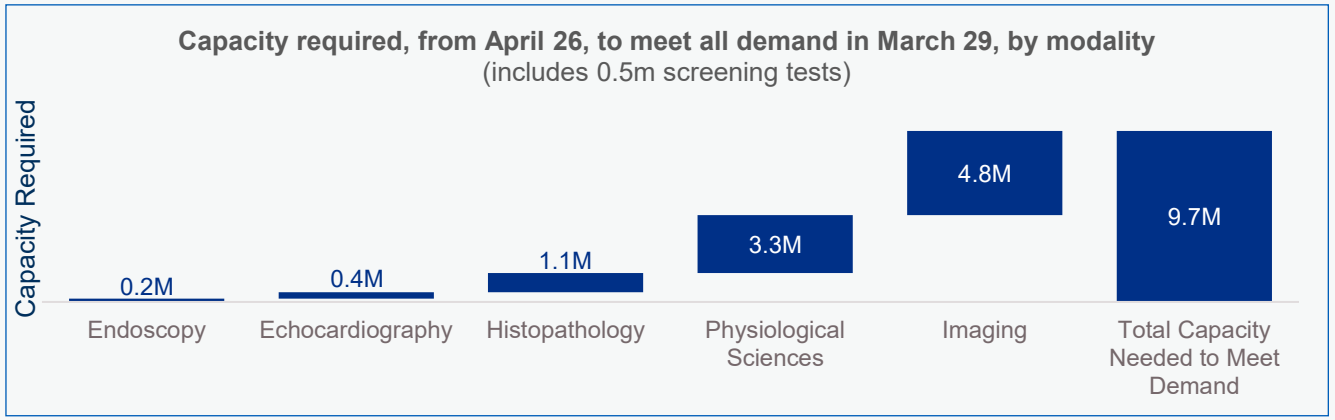
9.5m tests are needed to deliver the RTT target, 9.7m if screening is included

Diagnostic demand will continue to grow to March 2029 by an estimated 4.1% annually



Urgent Suspected Cancer demand is estimated to grow at 5%

Wider elective at 4%



Screening at 3.3%

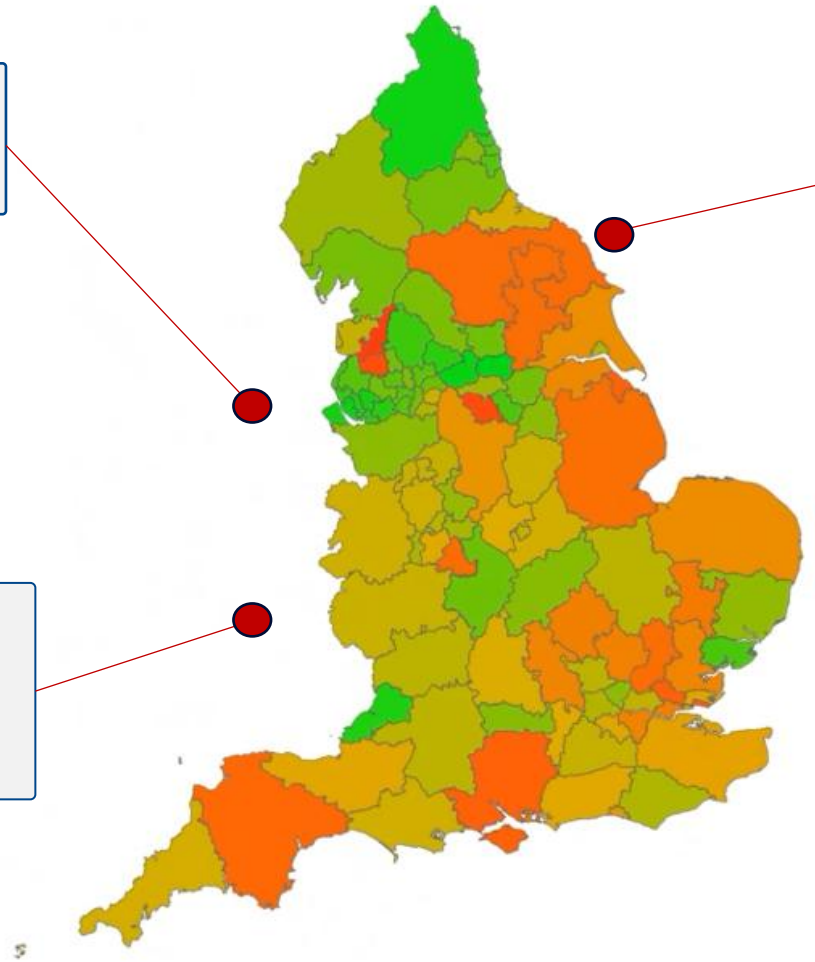
UEC at 3.1%.

Source: Combined models (DRAFT) v6.2 WIP - 12 46 42 - Non-RTT Excluded - 2526 WF Unconstrained

Current Map Of Diagnostic Deprivation

Insufficient Workforce To Meet Future Demand For Diagnostic Services

Financial sustainability of diagnostic services pressured due to escalating revenue/running costs in imaging



Diagnostics Postcode Lotteries For Patients Still Persist

(DM01 & waiting list variations)

Variation In Clinical Practice

(Differences in guideline adoption)

Operational Focuses For Delivering The National Commitment

Increasing capacity

- Expand **existing CDCs** to include clinic rooms and equipment for our most challenged DM01 modalities
- Build **new CDCs**, targeting these in our most challenged Systems – a sizeable proportion of these will be IS capital funded and delivered
- Deliver several **new endoscopy suites**, ensuring these have a minimum of 4 rooms to optimise them
- Increase and replace **physiological science equipment**, with a focus on audiology and echocardiography
- **Replace MRI and CT** equipment that is over 11 years of age
- Support **diagnostic networks** to achieve maturity and sustainability, creating more capacity for test reporting

Improving productivity and performance

- Finish **imaging and pathology digitisation**, while achieving networks' maturity so that they are self-funding

- **Automate histopathology**, as a key means to achieve 98% of reports turned around in 10 days required for RTT

- Continue to roll out **MRI acceleration** software to all eligible machines

- Motivate CDCs and acute providers to deliver **optimal equipment utilisation**

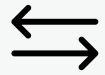
- Extend services' **opening hours**, incl. CDCs where we can deliver 12/7

- Delivering a **national imaging registry** (already live in beta testing) and national pathology platform to allow universal access, reducing repeat tests

Optimising demand

- Clinical engagement campaigns to reduce the use **low value tests**

- Implementing **clinical decision support**, including in ED to 100% of Trusts; continued roll out of **endoscopy** innovations like TNE



- Researching to understand the routine tests occurring in ED to **migrate** them into the community

- Expand the use of **Point of Care Testing** in virtual wards and across primary care and community services

- Delivering **straight to test pathways** in CDCs and across providers. Pilot of multi-pathway, whole ICS approach in Sussex could be rolled out nationally.

Trusts/ICBs are asked to deliver against three-year trajectories for 6WW performance and additional diagnostic activity delivered as part of the medium-term planning framework for 2026/7 to 2028/9 published in October.

Ensuring Patients Get the Right Test At The Right Time

Our Right Test, Right Time Campaign launched in Autumn '25 to support clinicians with reducing referrals that add little value to patient care

A national campaign

Focused on **12 tests** that national clinical leaders advise are used in breach of NICE Guidelines.

Key message: freeing up diagnostic capacity to provide faster access to tests that add value to patient care and reducing diagnostic waiting times; reducing patient harm from over testing.

Messages developed through engagement with **referring clinicians** and **patients**.

Delivered through **Royal Colleges**; supported by information on the alternative patient management, testing or Advice and Guidance that can be used in place of unwarranted tests.

Aim to **launch** via Royal Colleges in October with a comprehensive support package.

A **second wave** of tests is in development for 2026.

Test list	
	Gastroscopy in people <55
	Echo for suspected heart failure without a prior NT-pro BNP
	CT for resolved transient ischaemic attack (TIA) unless clinical suspicion of alternative diagnosis that CT could detect
	CT for suspected stroke unless indicated by National Optimal Stroke Imaging Pathway
	CT for established epilepsy
	EEGs to exclude suspected epilepsy when the clinical presentation supports a diagnosis of a non-epileptic event
	MRI for headaches, to rule out brain tumours
	MRI for non-specific low backpain
	MSK ultrasound for osteoarthritis without any atypical features
	Vitamin D testing in adults/CYP who are asymptomatic for vitamin D deficiency
	Chest X-ray in babies or children with suspected mild/moderate bronchiolitis
	Ultrasound to diagnose undescended testes in children

Bridging The Gaps In Imaging Assets & Infrastructure

Improvement in age and capability of scanners: 86% of MRI and CT scanners were under 10 years old in March 2025, an improvement from 80% in March 2024.
£13.9m investment has allowed a further 171 MRI scanners to be enabled with MRI acceleration software over the past 4 years.

Asset Count 2023-24 to 2024-25

Modality	31st March 2024	31st March 2025	Change	Change %
Accessory	1,357	1,602	245	18%
Bone Densitometer	146	155	9	6%
CT	723	757	34	5%
Dental	457	507	50	11%
Fluoroscopy	392	335	-57	-15%
General X-Ray	2,920	2,823	-97	-3%
Interventional Radiolog	384	397	13	3%
Mammography	441	506	65	15%
Mobile C arm	1,129	1,297	168	15%
MRI	624	656	32	5%
Nuclear Medicine	299	299	0	0%
Ultrasound	3,467	3,620	153	4%
Total	**12,339**	**12,954**	**615**	**5%**

- Overall, the number of assets has increased 5% between 2024 and 2025
- CT and MRI have increased 5%
- Ultrasound has increased 4%
- Fluoroscopy's decrease not real: assets were incorrectly assigned instead of Mobile C Arm
- General X-Ray has decreased 3%

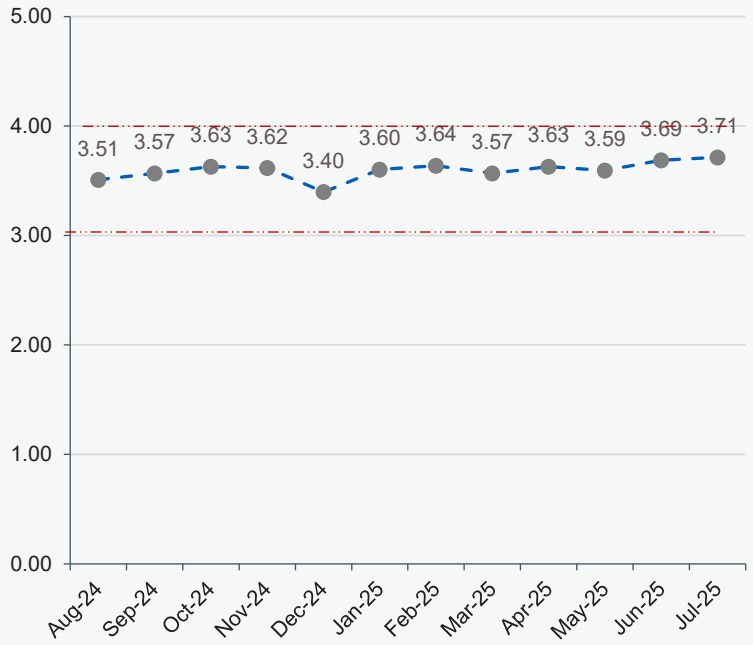
Overall, weekly hours available has increased 8% between 2024 and 2025
- CT has increased 9%
- MRI has increased 7%
- Ultrasound has increased 10%

A Snapshot Of Productivity: *National Throughput Rates*

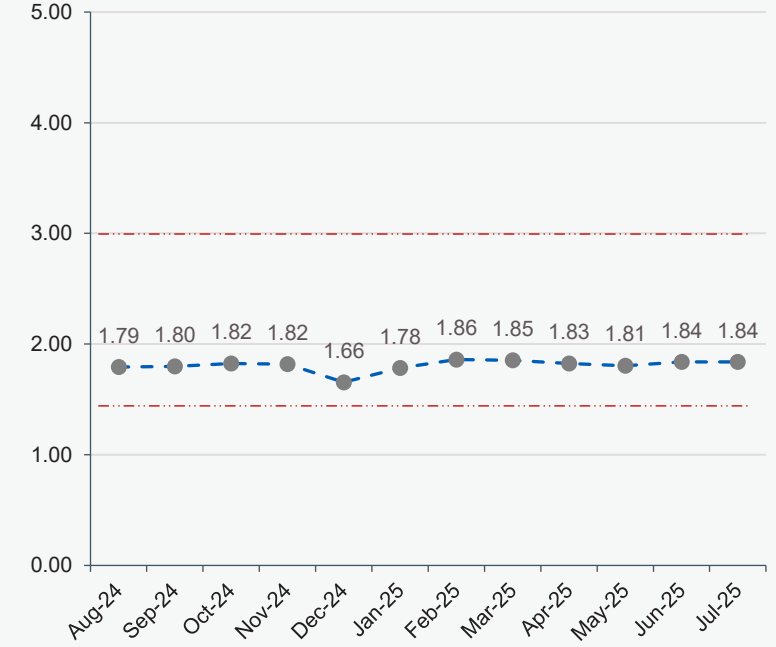
Source: Imaging Throughput Report (July 2025)

Graphs showing national CT, MRI and NOUS throughput position

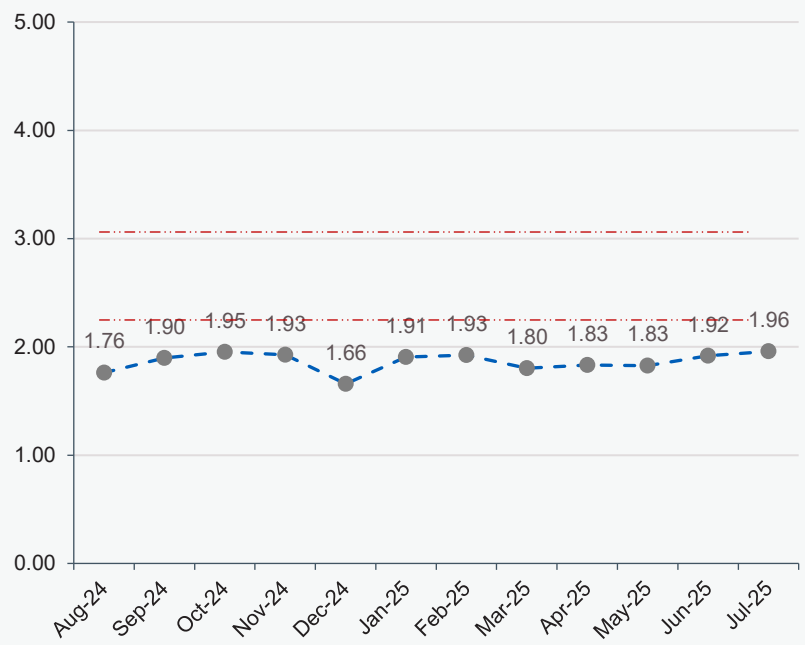
National CT Throughput



National MRI Throughput



National NOUS Throughput



Assets & core operational hours data are based on NIDC 2023/24 – CDC & Targeted Lung Assets and Activity excluded.

Optimal scan rates - CT: 3-4 scans/hour; MRI: 1.5–3 scans/hour; NOUS: 3 scans/hour.

Hourly throughput = Monthly DMO1 imaging activity (excl. CDC) / (daily scanning hours x calendar days).

Scanning hours = Daily core scanning hours × number of scanners.

Daily core scanning hours = Available hours per day over a 7-day week, excluding out-of-hours.

Analysis includes out of hours and outsourced activity, which may explain over-performance. Complex case mix is not accounted for, potentially explaining under-performance in some cases.

A Snapshot Of Retrospective Activity

Total Activity 2023-24 to 2024-25

Modality	2023-24	2024-25	Variance	% Change
Plain X-Ray (Static and Mobile)	21.8M	22.2M	419.9K	2%
CT	8.5M	9.0M	528.3K	6%
NOUS	7.6M	8.2M	538.6K	7%
MRI	4.4M	4.8M	326.0K	7%
Obstetric Ultrasound	2.8M	2.9M	104.1K	4%
Mammography	2.3M	2.2M	- 125.2K	-5%
Fluoroscopy	690.2K	711.1K	21.0K	3%
Nuclear Medicine	469.9K	509.7K	39.8K	8%
DEXA	454.8K	486.8K	32.0K	7%
Interventional Radiology	375.1K	403.1K	28.0K	7%
Other Modality i.e. Dentals	347.1K	442.8K	95.7K	28%
Catheter Laboratory / Interventional Cardiology	220.8K	212.2K	- 8.6K	-4%
PET CT	165.3K	178.6K	13.4K	8%

- General increase in activity
- Mammo decrease expected due to screening collection
- CT increase 6%
- MRI increase 7%
- NOUS increase 7%

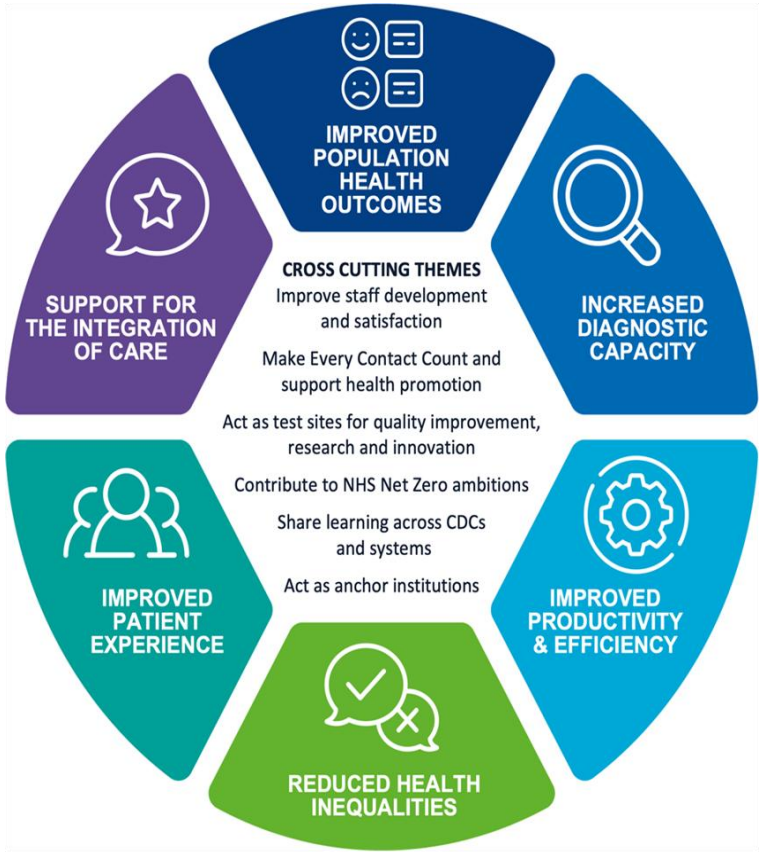
Total number of referrals by pathway 2023-24 to 2024-25

	GP Direct Access			Outpatients			Emergency Care			In-patients			Other Pathway		
Modality	2023-24	2024-25	% change	2023-24	2024-25	% change	2023-24	2024-25	% change	2023-24	2024-25	% change	2023-24	2024-25	% change
CT	611,208	604,266	-1%	3,631,517	4,057,336	12%	2,925,711	3,122,105	7%	2,034,310	2,141,606	5%	104,503	153,627	47%
MRI	731,696	793,040	8%	3,232,917	3,551,818	10%	173,662	185,245	7%	700,877	708,290	1%	105,109	67,675	-36%
NOUS	3,477,428	3,776,664	9%	3,697,187	4,114,495	11%	329,764	323,814	-2%	1,248,562	1,298,924	4%	142,812	124,393	-13%

CDC Programme – Delivery at Scale

By February 2026, the Community Diagnostic Centre programme has delivered national diagnostic capacity at scale.

- There are **170 CDCs live** across England, the majority operating from permanent sites, delivering 7-day, 12-hour services as standard.
- Since July 2021, CDCs have delivered **over 21 million diagnostic** tests and examinations, significantly increasing access to diagnostics outside acute hospitals and supporting earlier diagnosis across priority pathways.
- The programme is delivering **consistent operational performance**, with CDCs meeting planned activity levels, embedding Experience-Based Design, and expanding GP Direct Access and new diagnostic pathways.
- National **throughput standards** are now established, driving productivity and value across imaging, endoscopy, ultrasound and physiological diagnostics.
- Overall, **CDCs are improving patient experience, reducing health inequalities**, and supporting the **shift from hospital to community care**, while creating a sustainable, digitally connected diagnostic infrastructure for the NHS.



Spending Review 21 – Current Position

The latest reporting month is: January 2026

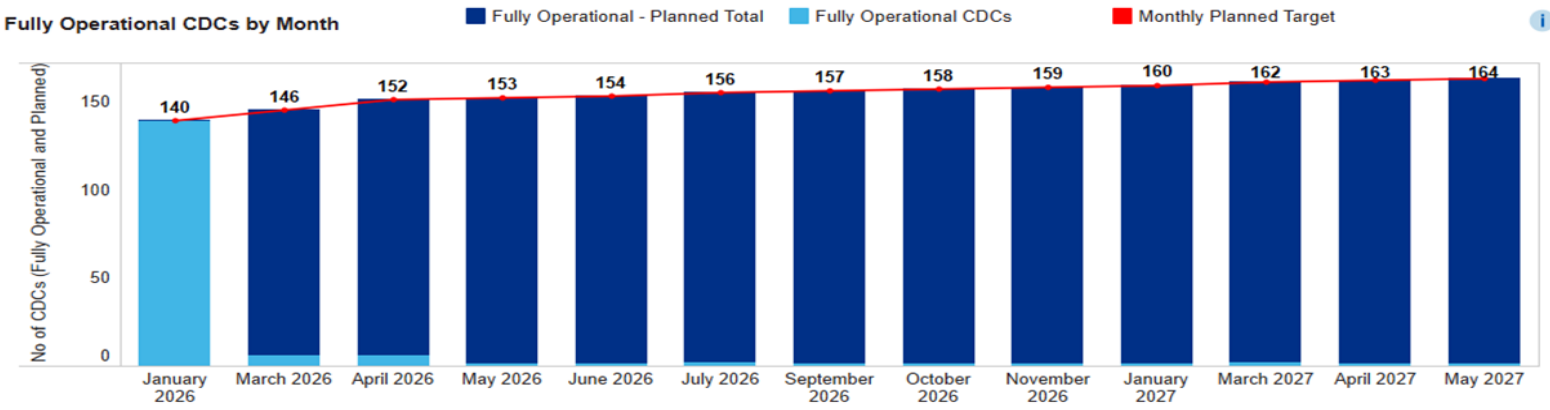
Build Tracker Assessment

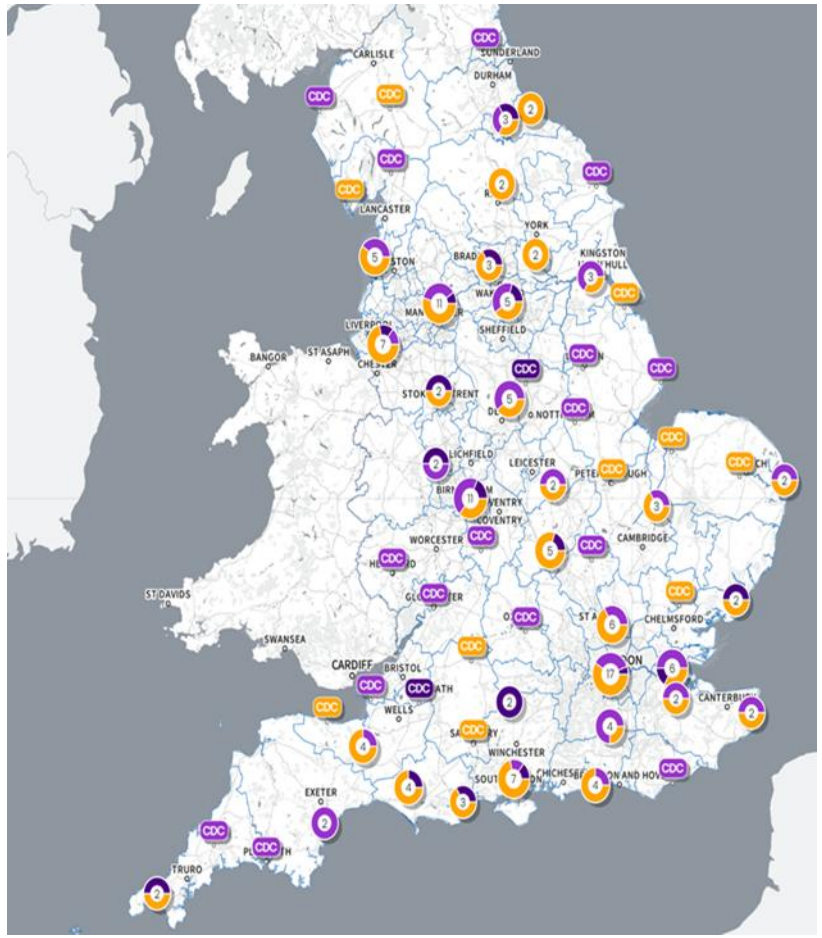
Site Status

Live	Live on Permanent Location
170	162
Live on Permanent Testing & Site	**Live on Temporary Site**
145	8

Region	Live	Live on Permanent Location	Live on Permanent Testing & Site	Live on Temporary Site
East Of England	22	19	14	3
London	14	14	14	0
Midlands	30	27	25	3
North East & Yorkshire	25	24	23	1
North West	25	24	24	1
South East	31	31	23	0
South West	23	23	22	0
Grand Total	**170**	**162**	**145**	**8**

Fully Operational CDCs by Month





SR25 – Significant capital was allocated in 25/26 to **expand existing** CDCs and support the **delivery of new CDCs**.

SR26 – Multi-year settlement period, which will continue to support the growth of imaging services in the community, including further expansion and new CDCs being developed.

CDC Performance: Progress Delivered, Gap to Close

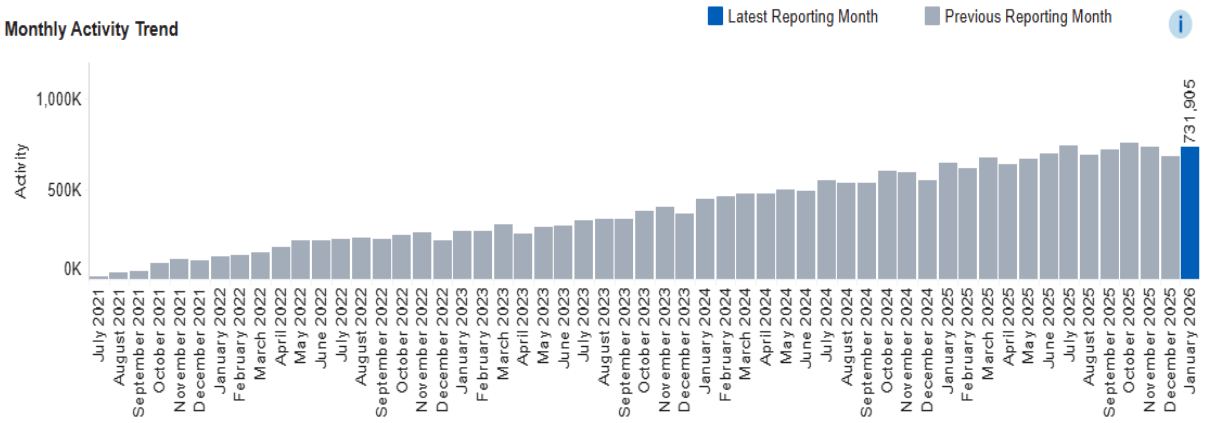
The latest reporting month is: January 2026

Monthly Headline Figures

	Latest Reporting Month	Current Year Cumulative	Programme Cumulative
Activity	731,905	7,060,729	21,827,624
Plan	931,103	8,414,379	
Variance	-199,198	-1,353,650	

Live Sites	Live Sites Submitted	Live Sites Missing	Live Sites - Not yet submitting
170	162	8	

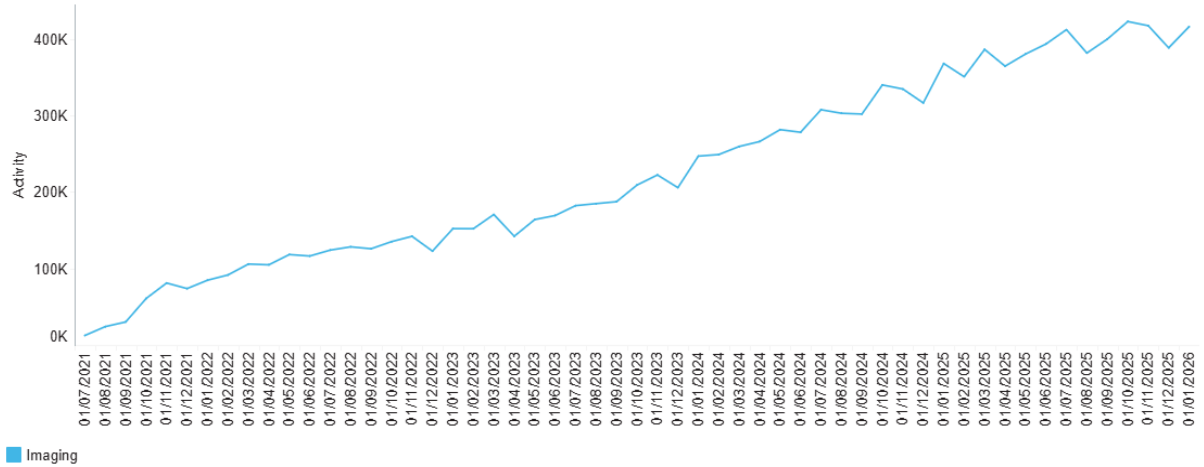
Monthly Activity Trend



Diagnostic Group/Core Modality Trend Analysis

Click on a diagnostic test group below to filter the charts in this section

	21/22		22/23		23/24		24/25		25/26	
	Activity	% of Total Metric Value..	Activity	% of Total Metric Value..	Activity	% of Total Metric Value..	Activity	% of Total Metric Value..	Activity	% of Total Metric Value..
Imaging	563,191	100%	1,590,191	100%	2,419,520	100%	3,830,436	100%	3,973,422	100%
Grand Total	563,191	100%	1,590,191	100%	2,419,520	100%	3,830,436	100%	3,973,422	100%



Core Modality Activity

		21/22	22/23	23/24	24/25	25/26
Computed Tomography	3,375,745	197,350	496,079	652,879	1,005,307	1,024,130
Non-obstetric ultrasound	3,255,787	119,027	413,655	661,752	1,005,539	1,055,814
Magnetic Resonance Imaging	2,552,907	154,166	372,453	496,828	777,342	752,118
Dexa Scan	211,943	3,787	17,707	31,460	69,813	89,176

Total activity across all CDCs (including temp.) – Jul 21 to Jan 26
25/26 YTD – CDC activity is under plan by **16% / 1.353m tests/images.**

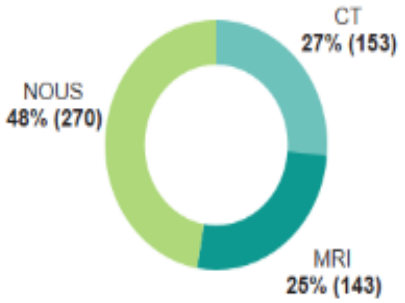
Imaging activity across all CDCs (including temp.) – Jul 21 to Jan 26
25/26 YTD – CDC imaging activity is under plan by **15% / 70.5k tests/images.**

National View – Operational Imaging Assets

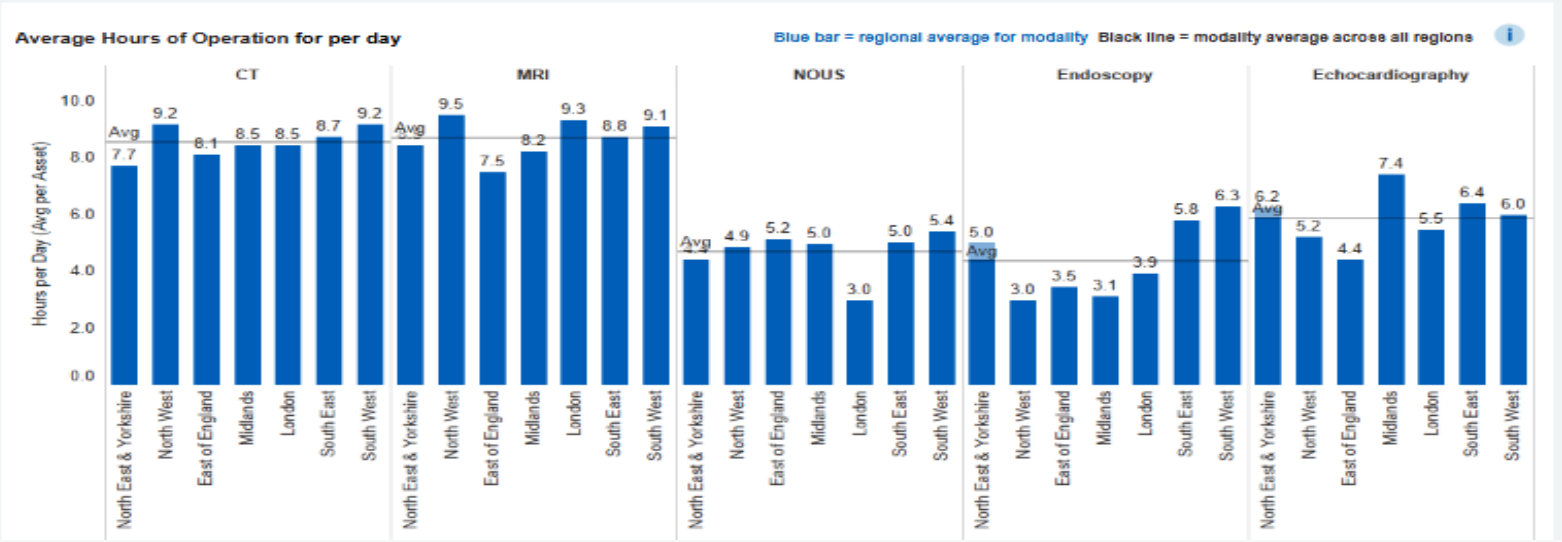
The latest reporting month is: January 2026

High Level Asset Breakdown

The total number of assets is **566**



	Overall		Static		Mobile	
	Assets (max quarter)	Average Hours per Day	Assets (max quarter)	Average Hours per Day	Assets (max quarter)	Average Hours per Day
Grand Total	566.0	44.3	498.0	42.3	68.0	64.1
North East & Yorkshire	82.0	6.1	74.0	5.9	8.0	8.2
North West	77.0	6.5	72.0	6.3	5.0	10.9
Midlands	103.0	6.4	88.0	6.1	15.0	9.1
East of England	56.0	5.7	53.0	5.7	3.0	5.8
London	75.0	5.8	67.0	5.3	8.0	11.0
South East	103.0	6.8	86.0	6.5	17.0	8.8
South West	70.0	7.1	58.0	6.6	12.0	10.3



Over the last 4 years, imaging capacity has grown in CDCs.

The chart to the right shows the number of operational **CT, MRI and NOUS scanners** from Nov 2025.

The graph shows the average **operational** hours by region for **'Core' modalities** in CDCs.

From the data collection – **General X-Ray** – 119 assets **Dexa – 31 assets**

CDC International Recruitment Programme 2023-2026

Aims

Nationally co-ordinated international recruitment initiative, developed jointly by the NHS England CDC and Workforce Training & Education teams, to facilitate recruitment to **CDC funded vacant posts over the last 3 years.**

The scheme was initiated as a model providing safe and sustainable recruitment, with a focus on the onboarding approach to support retention.

Successes

NHSE interview coordination- supporting NHS trusts to recruit IR candidates.

Reduced time and cost to hire

From interview to commencement in post is **16 weeks**.

Training and Induction

All IR recruited staff are supported to attend a residential induction.

New professions were added in 2025/26

Sonographers and Respiratory Physiologists with support and input from the relevant professional bodies.

	Numbers appointed			
Profession	**2023-24**	**2024-25**	**2025-26**	**Total**
Echocardiographers	11	15	2	28
Radiographers	**183**	**68**	**15**	**266**
Radiologists	**26**	**12**	**0**	**38**
Respiratory Physiologists	0	2	4	6
Sonographers	**0**	**0**	**5**	**5**
TOTALS	**220**	**97**	**26**	**343**

CDC Pathway Development Fund

Turning investment into faster diagnosis, better experience, and system-wide impact

Why this matters
The NHS England Community Diagnostic Centre (CDC) Programme Pathway Development Fund supports ICBs and trusts to design, test and scale diagnostic pathways through CDCs, building a strong national evidence base and spreading good practice across systems.

What's been delivered so far - From pilots to practice:
323 pathways supported, with 112 already operational

Clear improvements in:
- Time to diagnosis
- Patient experience (multiple tests in a single visit)
- Pressure relief on secondary care

Strong early evidence across priority pathways:
Breathlessness, Unscheduled Bleeding on HRT, and Children & Young People (CYP) Asthma

What's next (2026/27 and beyond)
Fund relaunched for 2026/27 to scale and embed successful pathways.

Aligned directly to:
- Elective Reform Plan
- Medium Term Planning Framework
- 10-Year Health Plan
- Cancer Plan

Multi-year funding provides confidence to:
- Sustain delivery
- Evaluate impact
- Embed long-term transformation through CDCs

The CDC Pathway Development Fund is no longer about pilots — it is a proven national mechanism for scaling faster diagnosis, improving patient experience, and delivering lasting elective and system transformation through CDCs.

CDCs – What This Means for Imaging Services

CDCs have expanded access to diagnostics.

The next phase focuses on making **sites work better, more reliably, and at scale.**

Operational priorities for imaging services (next 3–4 years)

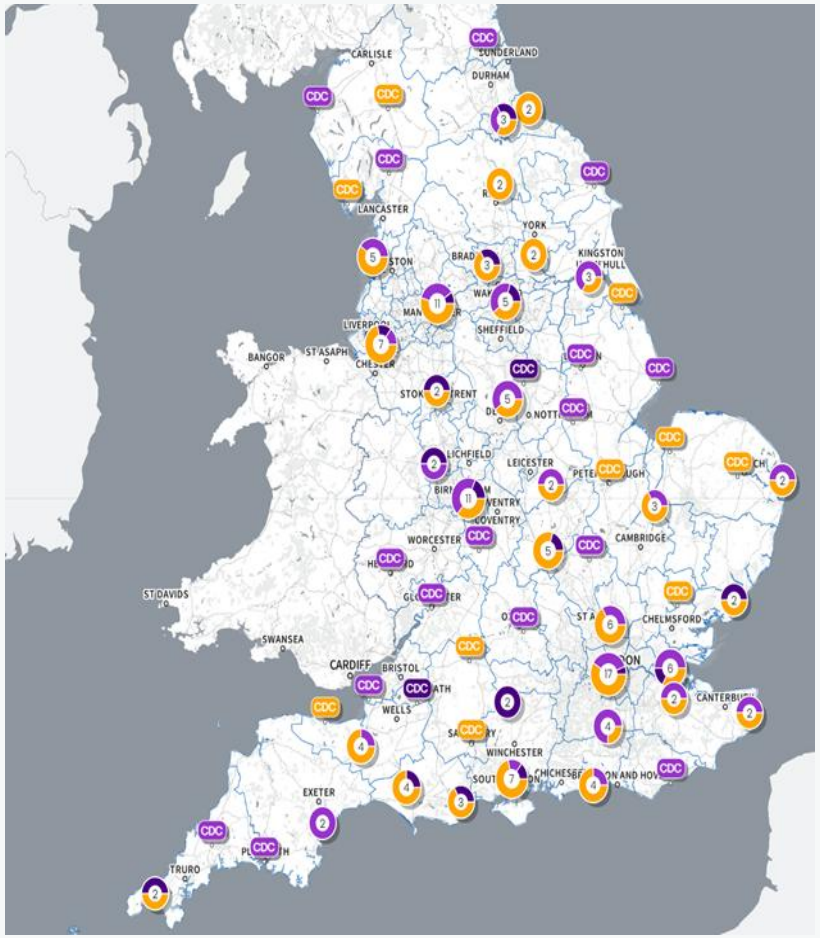
Make full use of existing capacity
Focus on getting the **most out of current scanners**, **rooms and sessions,** including extended hours where viable and reducing unused capacity.

Grow where demand is highest
Develop new CDC capacity only where demand and access gaps are clear, aligned to local imaging pressures and referral patterns.

Deliver pathway-led imaging
Move away from single-test thinking to joined-up diagnostic pathways, improving flow, reducing repeat attendances, and supporting faster diagnosis.

Build a sustainable workforce model
Use learning from CDCs to support new roles, skill mix, and flexible working, improving resilience and staff experience.

Integrate imaging across the system
Improve connectivity between CDCs, acute sites and primary care, reducing duplication and making imaging easier to access and manage operationally.



There are opportunities for digital investment, with diagnostic networks for each diagnostic modality currently developing digital roadmaps

Following several years of significant investment that has enabled radiology and pathology networks to improve their digital estates - enabling key network capabilities to improve collaboration, deliver faster diagnoses and improve patient safety - further funding lets us build on existing investments and deliver a fully integrated, patient-centred diagnostics model, ensuring equitable and timely care while improving outcomes and experiences for all

		Network type			
Workstream		Pathology	Imaging	Endoscopy	PS*
1	Delivering networked pathology systems	✓			
2	Connecting pathology with genomics systems	✓			
3	Connecting pathology with blood and transplant systems	✓			
4a	Optimising histopathology workflows - Automation	✓			
4b	Optimising histopathology workflows - Digitising histopathology slides	✓			
5	Creating a national digital pathology platform	✓			
6	Connecting neighbourhood pathology	✓			
7	Delivering networked imaging systems		✓	✓	✓
8	Delivering a national imaging registry (NIR)		✓		✓
9	Optimising MRI productivity		✓		
10a	Optimising diagnostic pathways - Embedding clinical decision support	✓	✓	✓	✓
10b	Optimising diagnostic pathways - Optimising referral, requests and results management	✓	✓	✓	✓
10c	Optimising diagnostic pathways - Intelligent booking and scheduling	✓	✓	✓	✓
10d	Optimising diagnostic pathways - Enabling single patient tracking and waiting list management	✓	✓	✓	✓
11a	Accelerating deployment of artificial intelligence (AI) - Scaling of chest x-ray and CT AI		✓		
11b	Accelerating deployment of artificial intelligence (AI) - National piloting and scaling of AI innovations	✓	✓	✓	✓

*PS - physiological science

Recovery plan

By combining diagnostics initiatives and adding performance improvement activities used for elective recovery, it is possible to generate a diagnostics recovery plan that will deliver a return to diagnostics constitutional standards

Leadership and governance

Elements to consider in a Diagnostic Recovery Plan	Applicable to: Endoscopy	Imaging	Phys Science	Pathology
Demand optimisation				
Liaise with GP practices with above average referrals	Y	Y	Y	
Waiting list validation	Y	Y	Y	
Implement robust referral triage	Y	Y	Y	
Maximise use of I-Refer		Y		
Advice and Refer service	Y	Y	Y	
Productivity				
Maximise admin and booking capacity to use all available slots	Y	Y	Y	
Review scans per hour against benchmarks		Y	Y	
Maximise use of MRI acceleration		Y		
Implement more straight to test pathways to release time from outpatients	Y	Y	Y	
Enable more remote reporting digitally		Y		Y
Re-design pathways to maximise use of CDCs			Y	
Use of AI to support reporting		Y		Y
Standardise operating procedures across the diagnostic network to enable inter-operability	Y	Y	Y	Y
Use play therapy for paediatric patients instead of GA		Y		
Streamline waiting lists to move towards a single PTL	Y	Y	Y	
Increasing capacity				
Review capacity in CDCs within patient travel geography to maximise use	Y	Y	Y	
Maximise mutual aid	Y	Y	Y	Y
Stock take of duties allocated to all endoscopists	Y			
Review job plans to maximise patient facing time	Y	Y	Y	Y
Extend opening hours	Y	Y	Y	Y
Filling of vacancies	Y	Y	Y	Y
Targeted use of IS	Y	Y	Y	Y

Working With Industry and Independent Sector Providers

We envisage a significant role for industry and independent sector providers to partner with the NHS to deliver the significant transformation required by March 2029.

Our modelling estimates that nationally 35% of the capacity needed between 2026/27 and 2029/30 will need to come from the independent sector (IS). To support this, we're undertaking a market engagement exercise to understand the 'IS offer' and share it with Trusts, including an insight into how this offer can be affordable to the NHS.

The IS offer is being explored across the following opportunities

Diagnostic capacity

1

Diagnostic capacity to support waiting list performance improvement, while supporting the shift from hospital to community and providing access to diagnostics and care for deprived communities.

This might include new static assets (equipment or facilities) that can be delivered by the IS or **through IS-NHS partnerships**, or by the **NHS commissioning activity** from existing IS assets e.g. CDCs

Services' co-location

2

The potential for IS diagnostics to be co-located with or incorporated into other **NHS community-based services** to support development of neighbourhood health.

This might also include IS provision of facilities that already co-locate services or new facilities that include diagnostics and treatment services

There is also potential for the IS to make infrastructure available

Remote diagnostics

3

Opportunities for **remote monitoring diagnostics,** wearable tech and at home sampling devices.

This can support neighbourhood health initiatives, while enabling hospital at home and manage outpatient attendance.

Additionally point of care testing can be available to urgent community response and ambulance teams to reduce unnecessary conveyances to emergency departments

Productivity

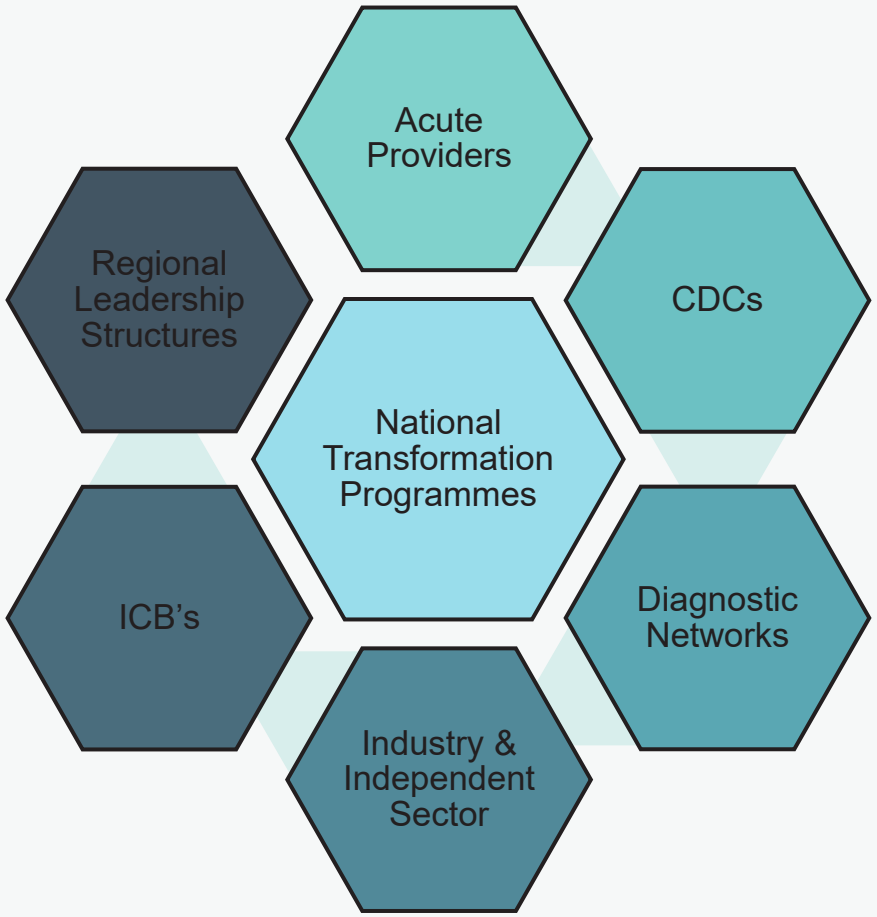
4

Details of pipeline **digital diagnostic innovations**, with evidence of clinical cost-effectiveness, that can enhance capacity, services and workforce productivity.

This can include middleware, as well as technologies / equipment.

Also, we will be procuring for roll out of digital infrastructure and tools such as LIMS, OrderComms, image sharing, AI and i-Refer CDS.

Conclusion – Ongoing Collaboration Is Required Both To Innovate & Operationalise



Call To Action

Technologies & operational procedures that support safe and effective demand management/optimisation.

Shared capacity within system this includes NHS and IS providers.

However it is key that this doesn't increase clinical variation and that clinical pathways are unified.

Innovate and utilise emerging technologies to improve workflows and resource effectiveness, enabling us to make best use of our workforce.

Need to innovate and work together across industry to reduce challenges with interoperability across digital systems

Q&A

Slido

Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.

SCAN ME

Skill Clinic

Jeffry Hogg
Clinical Assistant Professor (UoB), Clinical Innovation Officer in AI (UHB)
University of Birmingham & University Hospitals Birmingham NHS Foundation Trust

AI Readiness for Adopter Organisations

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Ass. Prof, University of Birmingham

Programme Director, MSc AI Implementation (Healthcare)

Deputy Director of Knowledge Mobilization, CERSI-AI

Clinical Innovation Officer in AI, UHB

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NHS University Hospitals Birmingham NHS Foundation Trust

CERSI-AI

Smarter Regulation for Better Innovation in AI & Digital Health

AI Readiness

The AI Readiness Checklist

February 2026

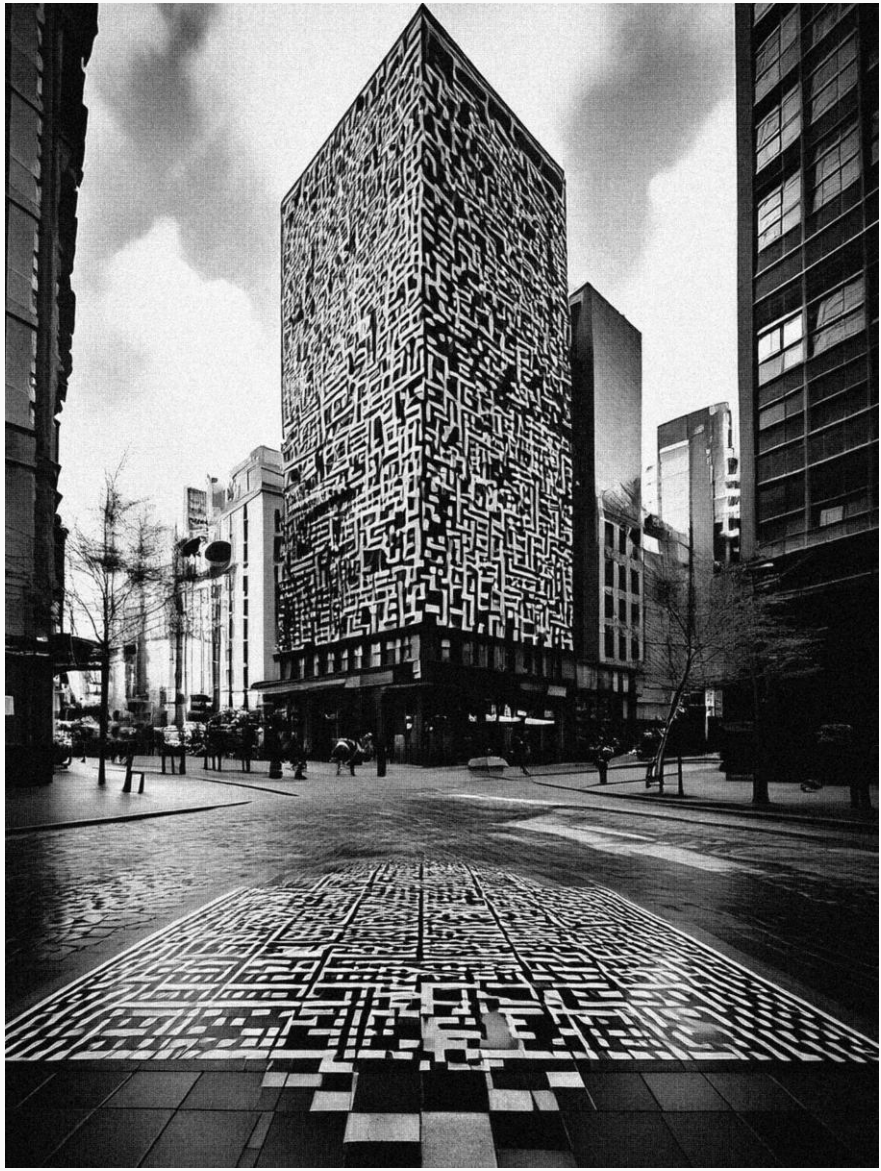
AI Readiness

AI Readiness for Health and Care Organisations

A Consultation Paper

February 2026

Three quick caveats…



Elise Racine & The Bigger Picture / Better Images of AI / Glitch Binary Abyss II / CC-BY 4.0

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1. Risk appetite and context varies between organisations

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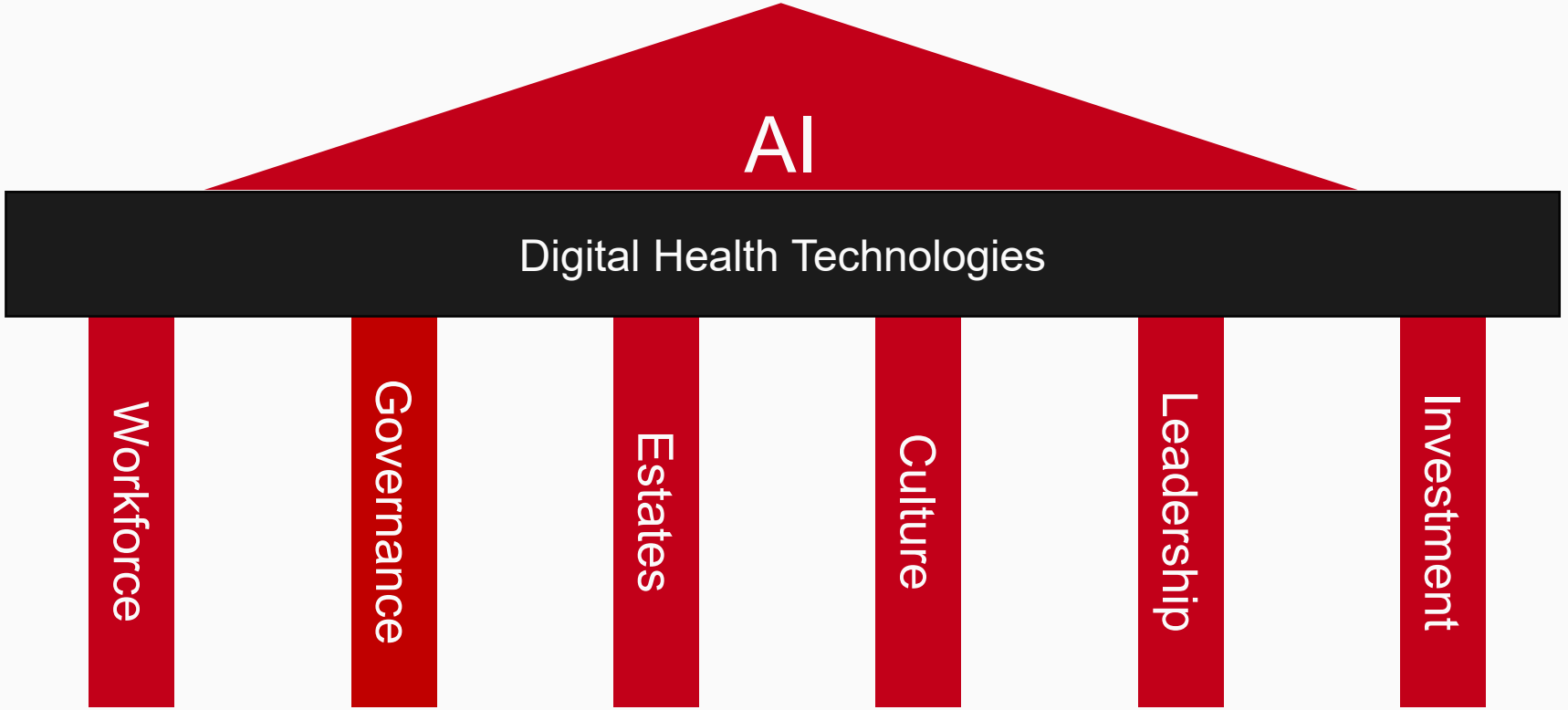
2. The demands of AI are not unique among innovations



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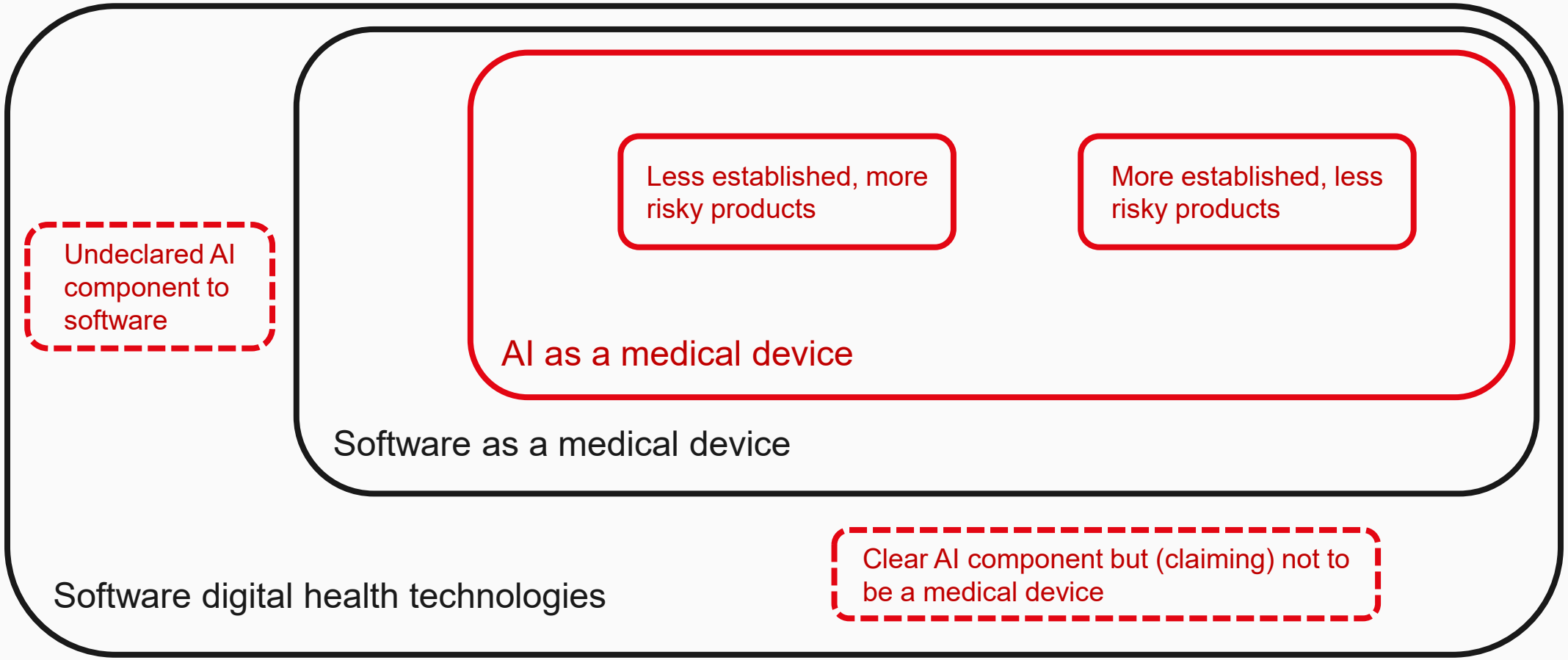
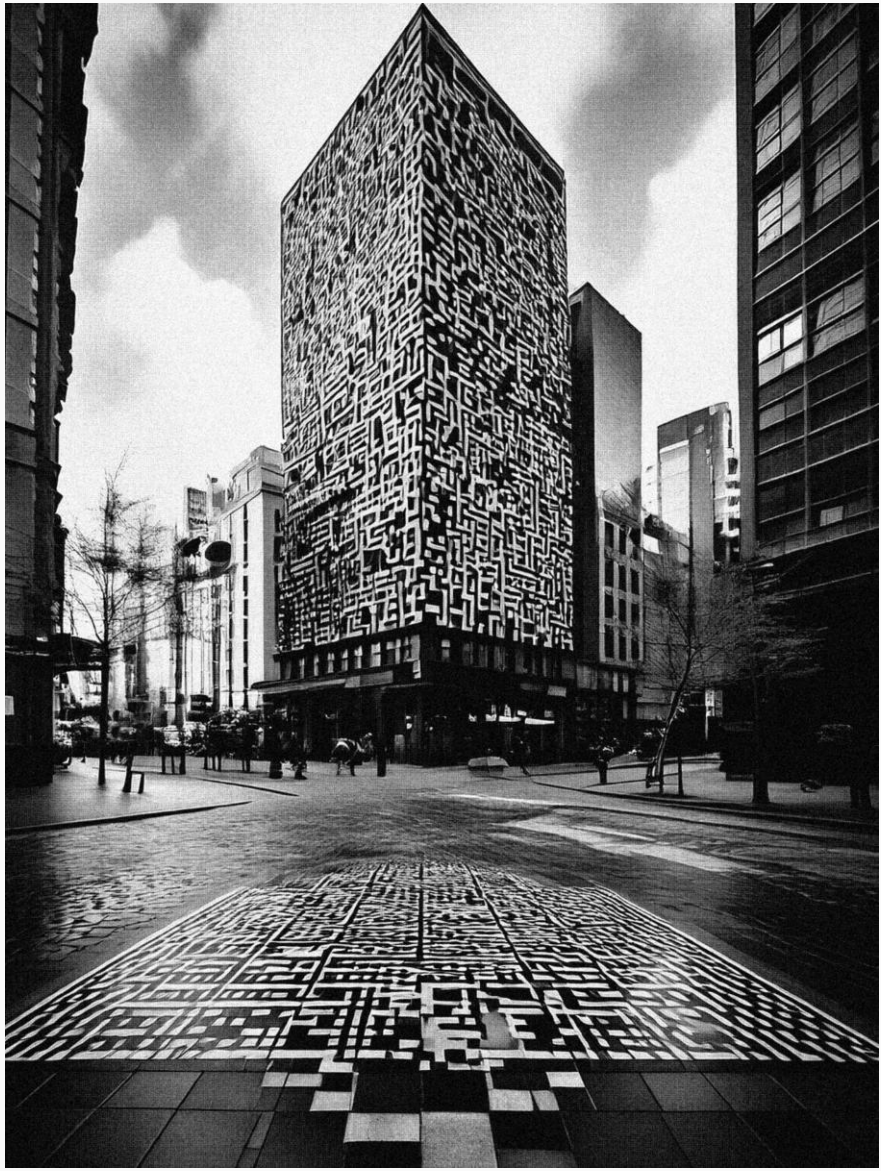
3. AI technologies and their demands are heterogenous



In the next 50 mins

- Symptoms of low organisational readiness for AI
- Defining AI Readiness for adopter organisations
- The AI Readiness Assurance Framework
- The AI Readiness Checklist
- Get involved with the consultation



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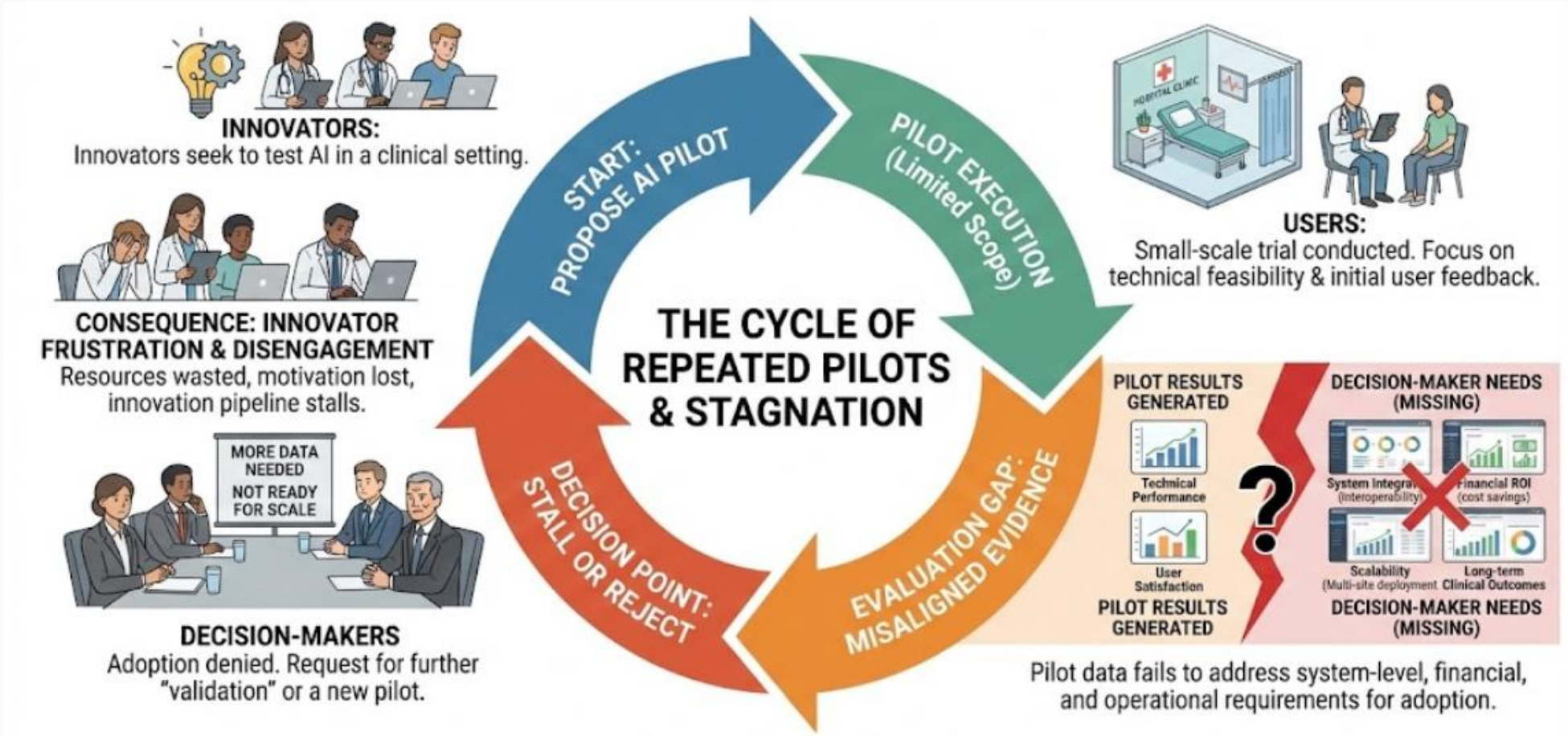
Symptoms of low organisational readiness…



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Symptoms of low organisational readiness…

Medicines & Healthcare products Regulatory Agency

Guidance

General information on the Health Institution Exemption

Updated 20 January 2026

Contents

Definition of a health institution

Clarification of important terms

Determining whether the HIE can be used

In Great Britain, medical devices are regulated under the Medical Devices Regulations 2002 (SI 2002 No. 618, as amended) (MDR 2002). The MDR 2002 set out the requirements that manufacturers must meet to place a device on the Great Britain market or put it into service.

Symptoms of low organisational readiness…

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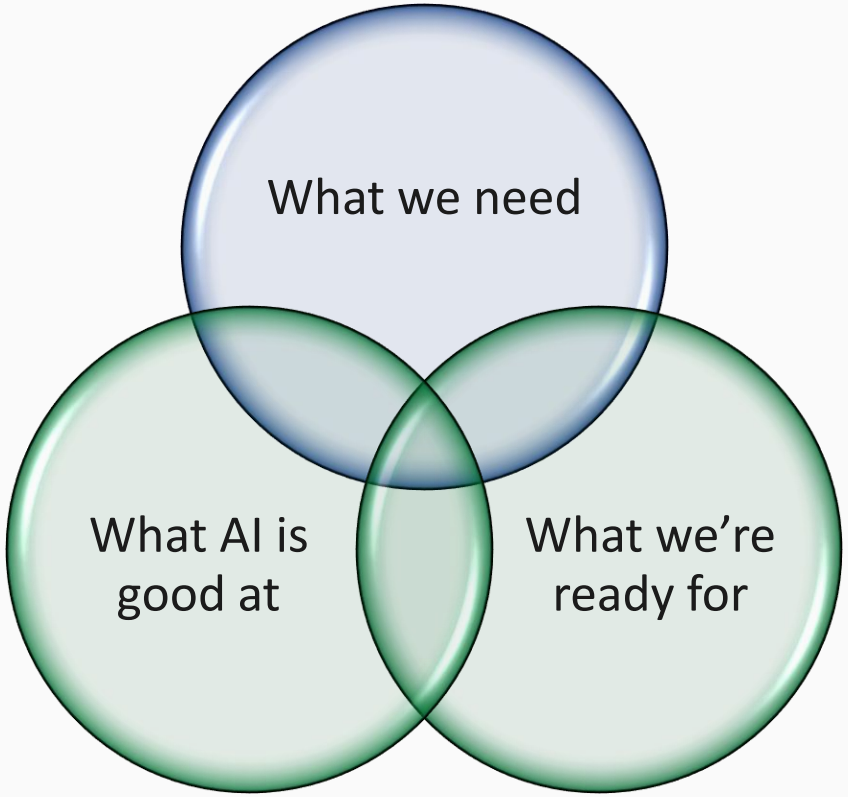
What does this mean for the value of AI in health?



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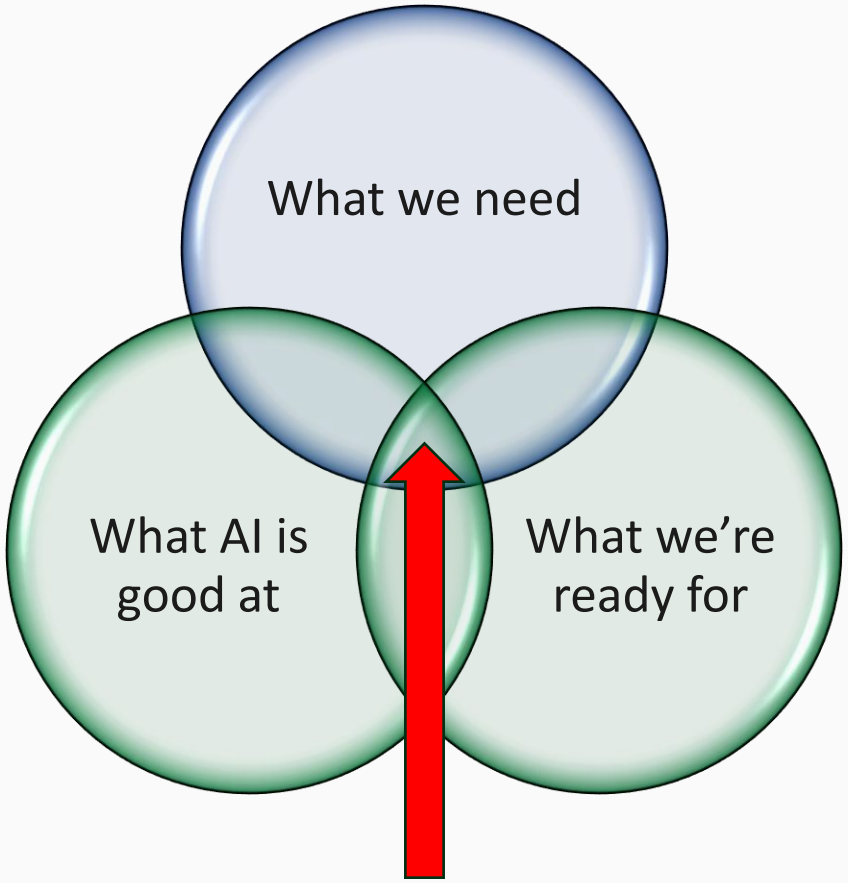

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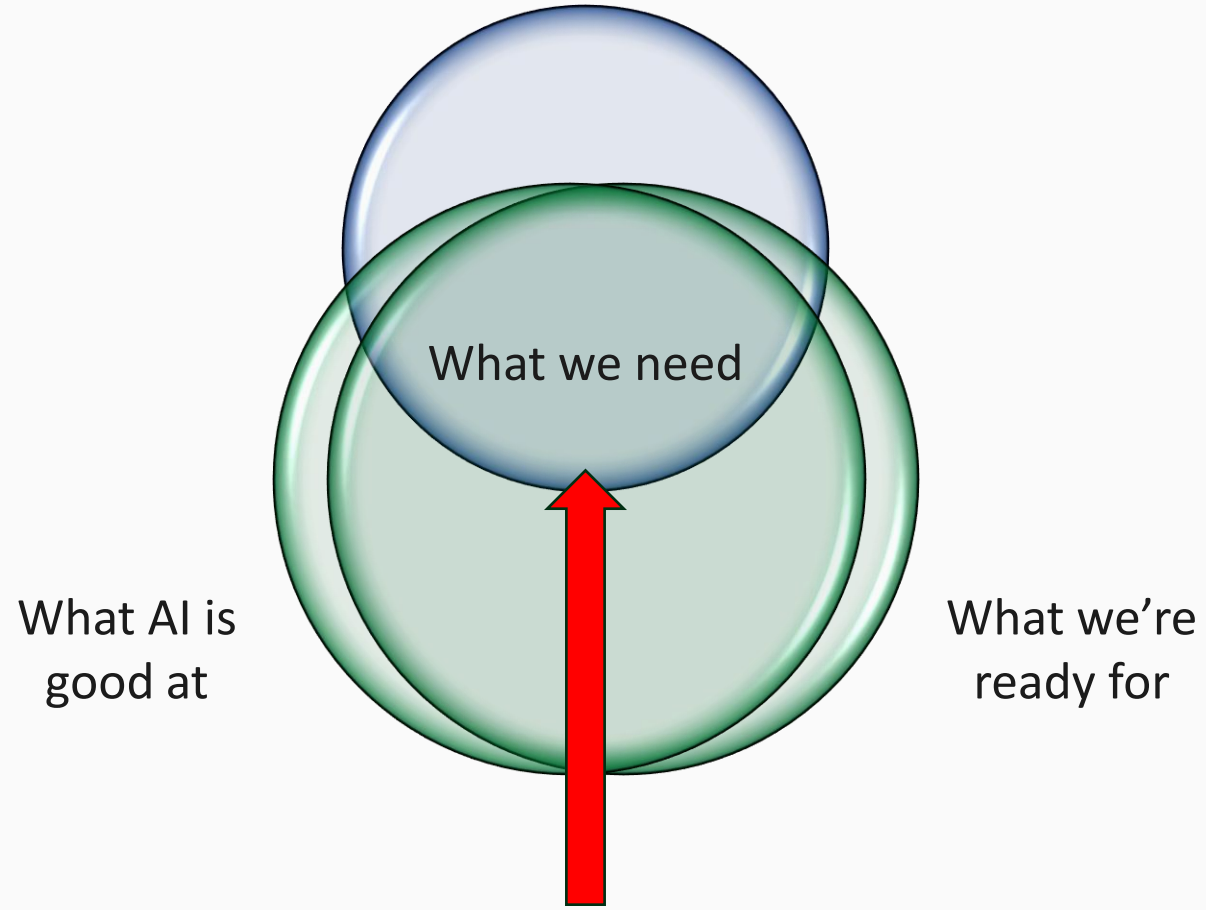
Our challenge is to build our readiness for AI



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AI Readiness **does not** mean AI everything, everywhere, all at once

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What is AI Readiness then?

AI readiness can be conceptualised in two distinct forms. Both independently offer major system benefit:

Decision-making readiness:

The ability of a provider organisation to accurately estimate the potential benefits and harms that AI technologies present to their services and their users

Implementation readiness:

The ability of a provider organisation to safely implement and use a specific AI technology

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AI Readiness

AI Readiness for Health and Care Organisations

A Consultation Paper

February 2026

We all want AI to benefit services and patients

Service User Benefits	Organisational Benefit
Faster access to information and advice	Enhanced operational efficiency (e.g. optimised capacity and fewer missed appointments)
More personalised care and support	Improved accuracy and precision of service delivery (reduced variation)
Reduced waiting times for services	Streamlined administrative processes and reduced duplication
Better health and care outcomes via early detection/intervention	Improved workforce wellbeing through reduced cognitive load
Empowerment through self-service tools	Improved population insights leading to enhanced research and innovation
Increased accessibility and equity for diverse or vulnerable populations	Enhanced coordination between departments

But low AI readiness is a problem because…

Both over enthusiastic adoption and excessive hesitance to adopt AI can **harm** services and their patients

We can evaluate readiness with a risk-based approach

Insufficient AI competency and collaboration among staff

Inability to accurately predict impact of implementing AI products

Low awareness of legal obligations relevant to AI-enabled service delivery

Poorly informed decision to adopt an AI technology

Service user harm (e.g. delayed diagnosis for treatable disease)

Service harm (e.g. prioritising AI innovation with poor ROI)

Cause

Risk Control

Hazard

Harm

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A charismatic MedTech vendor presents you with an AI-driven triage tool that promises to reduce waiting lists by 30% using 'proprietary generative models'. You think it will benefit your service and patients, what should you do?

a) Ask your departmental IT lead if you can pilot the tool to test local performance

b) Email information governance and procurement colleagues you've worked with before to get their perspective

c) Add the proposal to the agenda for your next departmental leadership meeting

d) Check to see if your organisation has an AI policy or single point of contact for AI proposals

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20 distinct causes of harm from AI

Workforce	Operational	Financial	External	Service Outcome
• Insufficient AI competency and collaboration among staff • Low acceptability for AI technology • Technology dependent behaviour • Lack of scalable and sustainable workforce	• Unclear allocation of responsibilities • Local technological infeasibility • Withdrawal of a technology in use • Compromised data integrity • Data inaccessibility	• Poor market position • Underestimating contribution in kind • Uncertain business case • Liability from patient and staff harm	• Regulatory or legal non-compliance • Low public acceptability and accessibility • Breaches of data confidentiality and permissions for use	• Unanticipated secondary consequences • Underperformance in the local context • Underperformance for population subgroups(s) • Reduction of performance over time

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18 distinct risk controls relevant to AI

Organisational structure	Human capital	Problem formulation	Adoption and Integration	Evaluation and Monitoring
• Single Oversight Group • Task and Finish Groups • External Ecosystem Connection • Effective Developer-Provider Collaboration • Ethics and Public Engagement • Standardised Processes	• Organisational Engagement and AI Policy • Staff Training and Development • Workforce Capacity to Sustain Responsible Use • Acknowledgement of Key Staff	• Needs-led Innovation • Workforce Ambassadors	• Digital Infrastructure and Integration • Mechanisms for Early User Feedback	• Information Asset Register • Non-interventional Evaluation of Performance • Sustained Performance Monitoring • Communication Post Implementation

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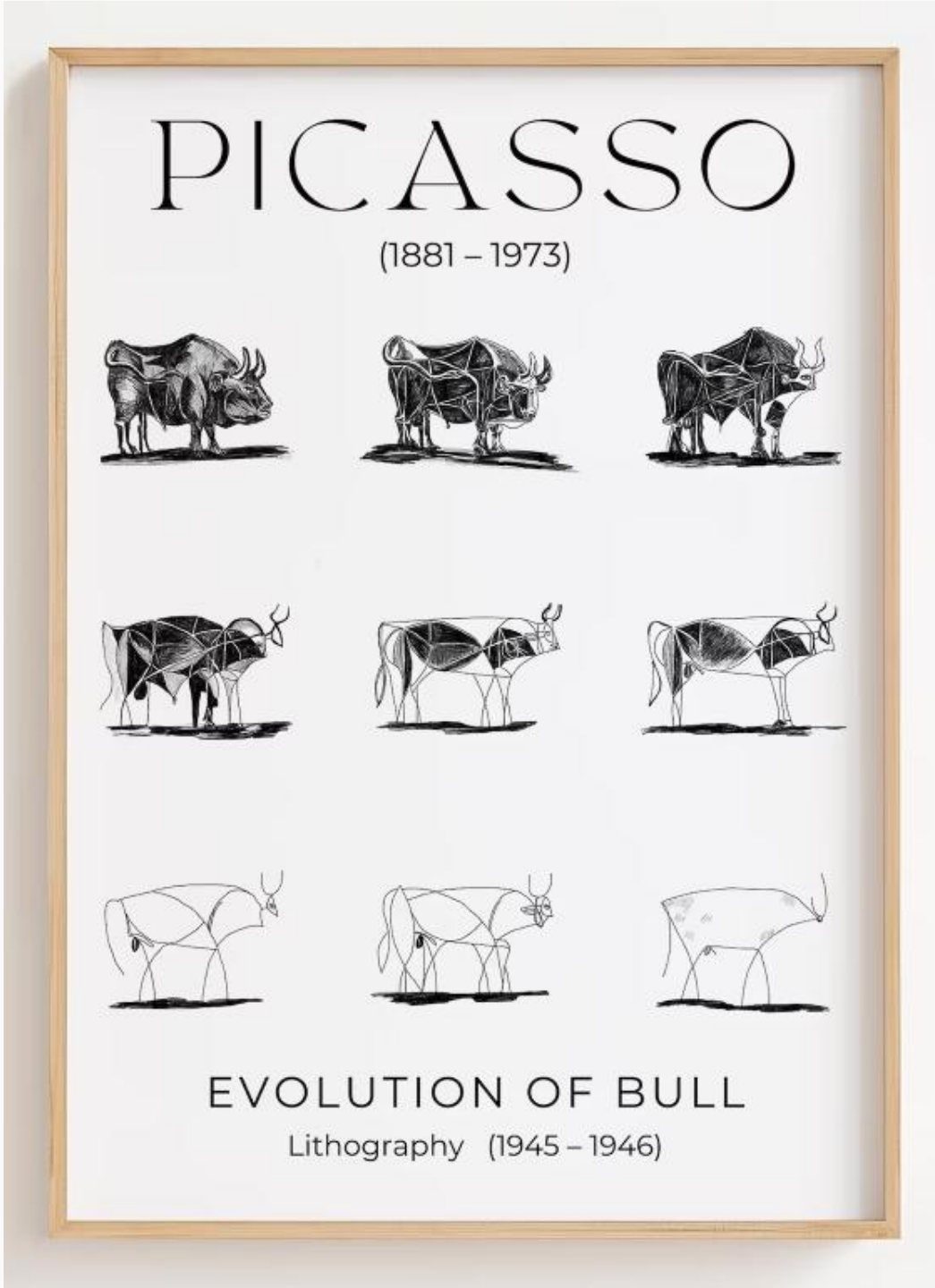
Isn’t this a bit abstract?

- These high-level concepts make up the AI assurance framework
- It supports decision-making readiness across varied technologies and contexts
- It is attainable for an organisation regardless of resource or digital maturity
- Decisions on whether to adopt or reject a specific technology require details…



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Underperformance for population subgroups(s) - service user harm

1 Recommendations

1.1 Deep Ensemble for Recognition of Malignancy (DERM, an artificial intelligence [AI] technology) can be used within teledermatology services in the NHS during the evidence generation period as an option to assess and triage skin lesions in adults referred to the urgent suspected skin cancer pathway. It can only be used:

- if the evidence outlined in the evidence generation plan is being generated
- once it has appropriate regulatory approval including NHS England's Digital Technology Assessment Criteria (DTAC) approval.

1.2 Mitigate the potential risk of missed or delayed cancer diagnoses when using DERM during the evidence generation period by:

- doing a healthcare professional review for people with black or brown skin
- regular monitoring of DERM's performance to maintain accuracy
- using additional protocols when necessary, such as:
  - a national governance framework to ensure local oversight of use of DERM
  - a healthcare professional review.

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NICE. Artificial intelligence (AI) technologies for assessing and triaging skin lesions referred to the urgent suspected skin cancer pathway: early value assessment. Health technology evaluation. Reference number:HTE24. Published: 01 May 2025

Unanticipated secondary consequences – service harm

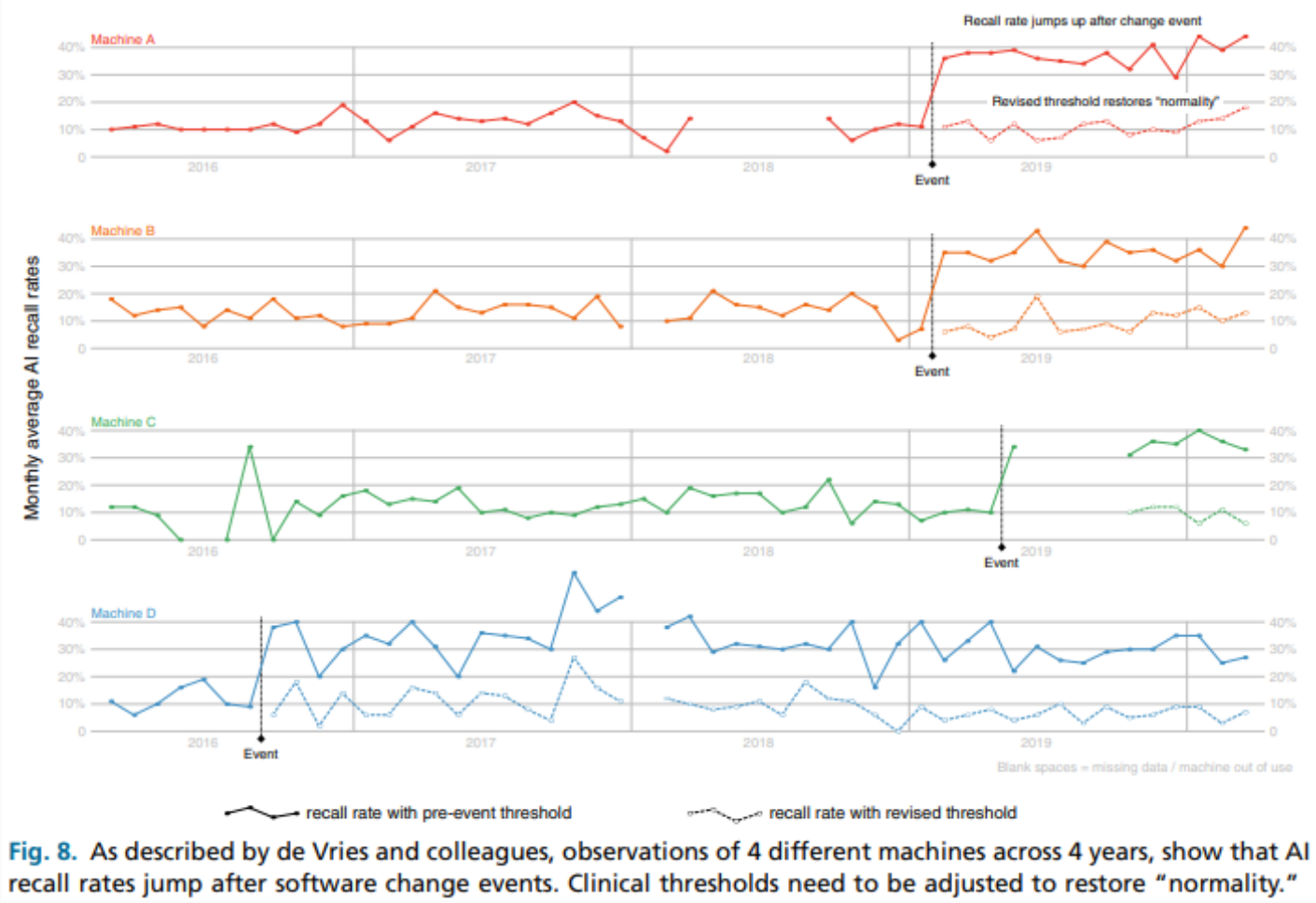

Fig. 8. As described by de Vries and colleagues, observations of 4 different machines across 4 years, show that AI recall rates jump after software change events. Clinical thresholds need to be adjusted to restore "normality."

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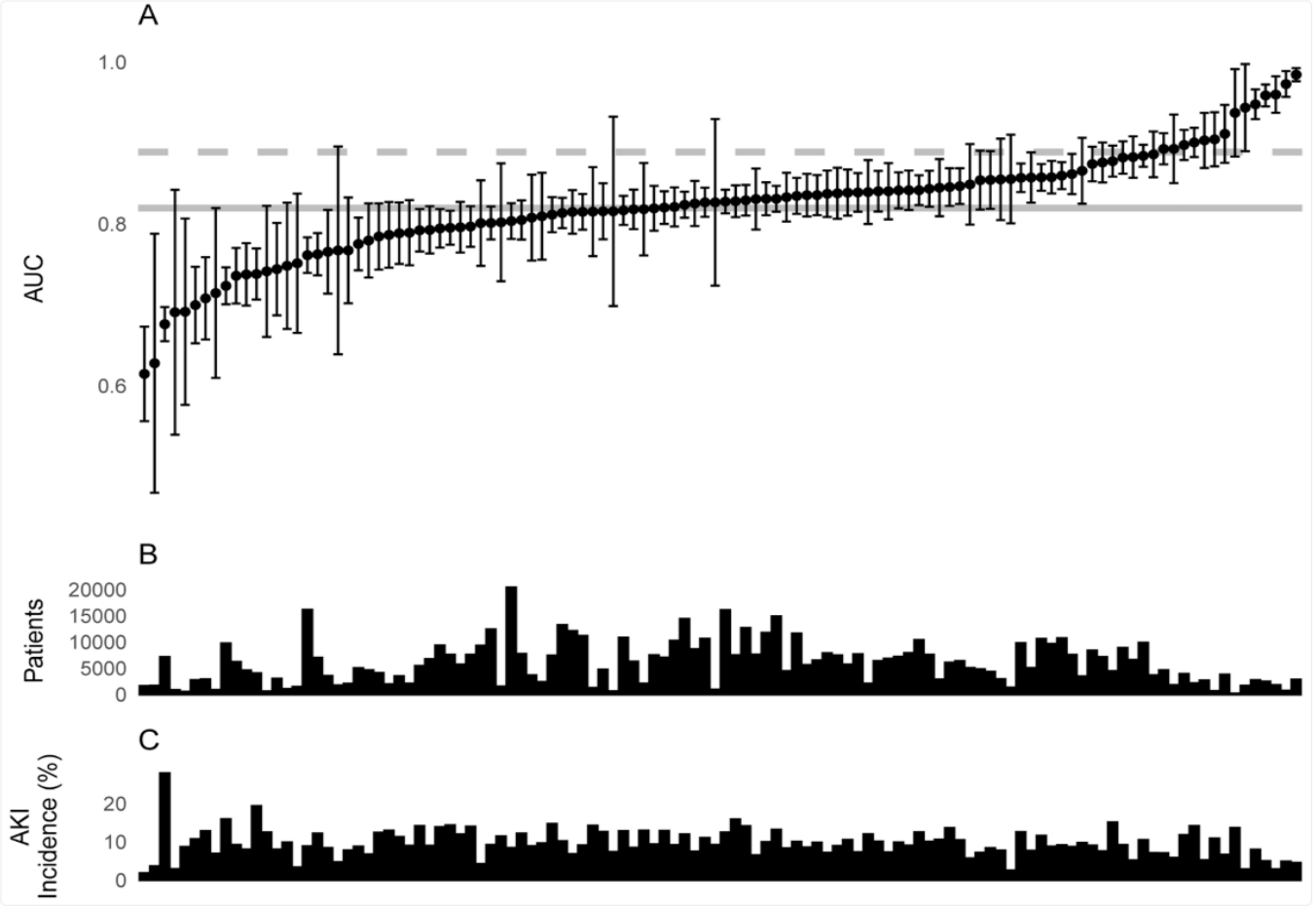
Wilkinson L, et al. Clinical Integration of Artificial Intelligence for Breast Imaging. Radiologic clinics of North America, 62 (4), July 2024.

Underperformance in the local context - patient & service harm



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Cao J, et al. Generalizability of an acute kidney injury prediction model across health systems. Nat Mach Intell. 2022 Dec;4(12):1121-1129.

18 distinct risk controls relevant to AI

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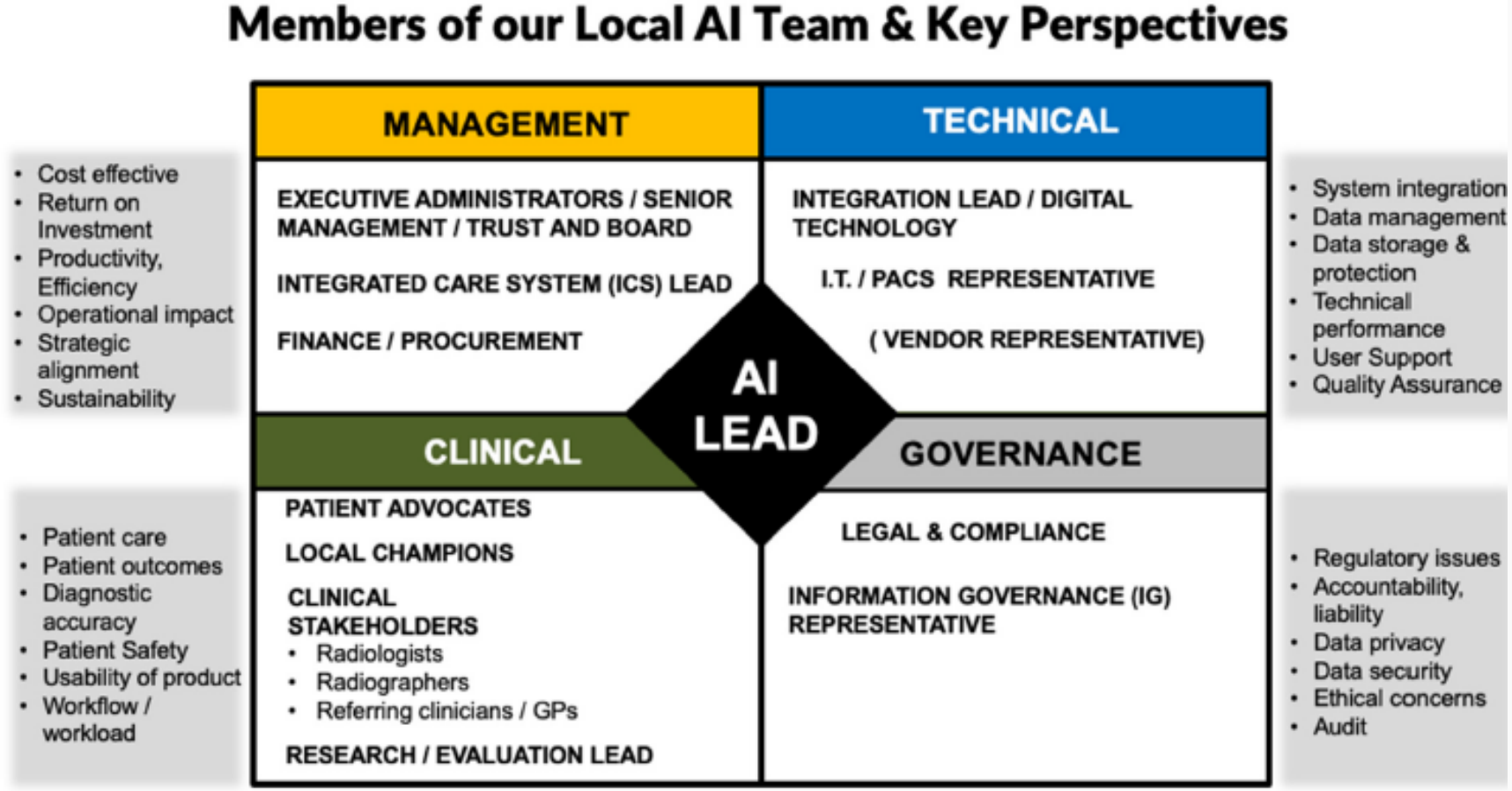
Governance structures



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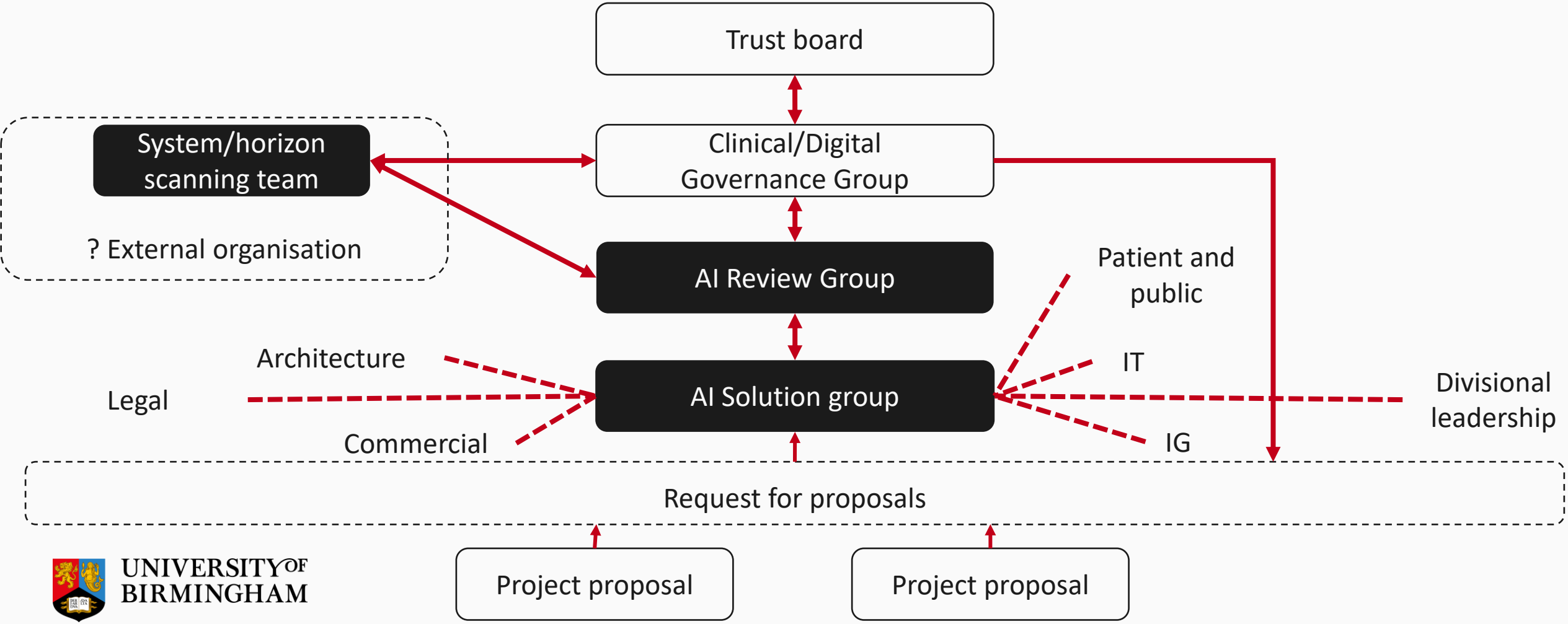
Shelmerdine SC, Togher D, Rickaby S, Dean G. Artificial intelligence (AI) implementation within the National Health Service (NHS): the South West London AI Working Group experience. Clin Radiol. 2024 Sep;79(9):665-672. doi: 10.1016/j.crad.2024.05.018. Epub 2024 May 31.

Governance structures



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What does this aim to do?

Make AI solutions accessible across an organisation

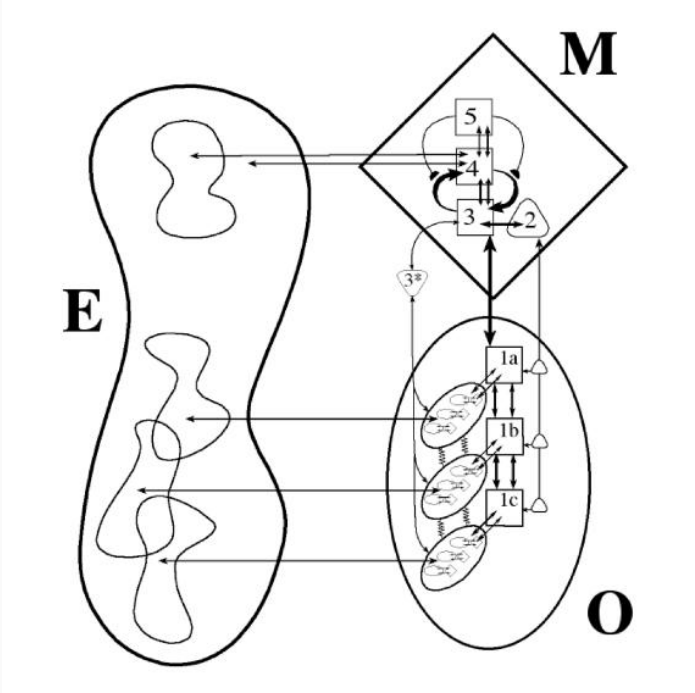
Earn broad trust for AI governance

Confidence that investments in AI could not deliver strategic goals more effectively if directed elsewhere

Mitigate clinical and corporate risk from AI

Minimise bottlenecks to progressing AI projects that have been approved for investment

Focus and minimise AI proposal review burden



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Stafford Beer, Brain of the Firm, 1972

Which of the following potential causes of harm presented by a scan segmentation tool to support radiotherapy planning could organisational structures help to mitigate?

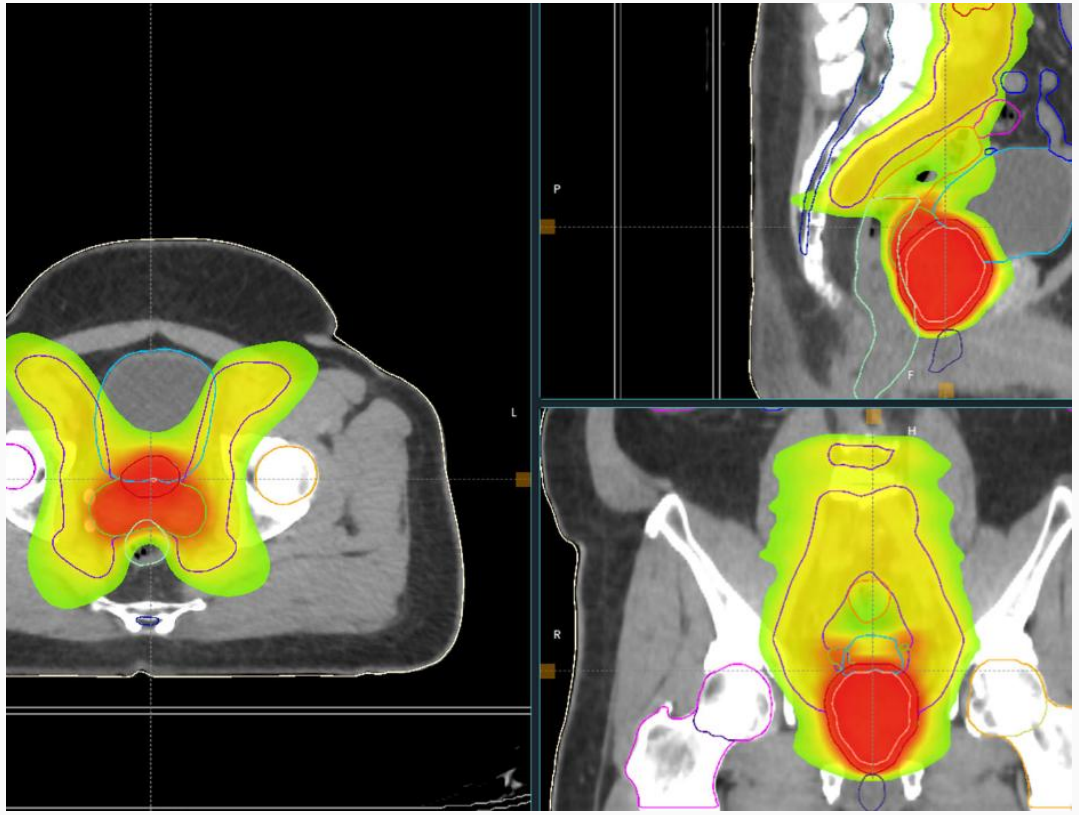
a) Regulatory or legal non-compliance

b) Lack of scalable or sustainable workforce

c) Unclear allocation of responsibilities

d) Uncertain business case

e) Local technological infeasibility



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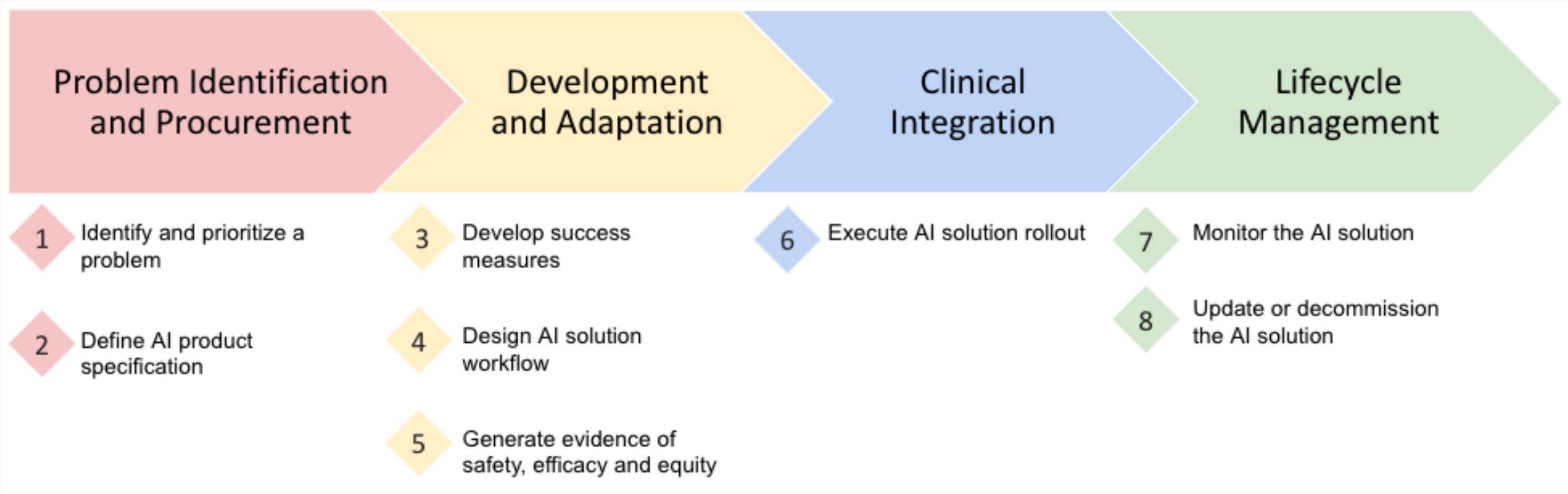
In addition to structure – process is also key



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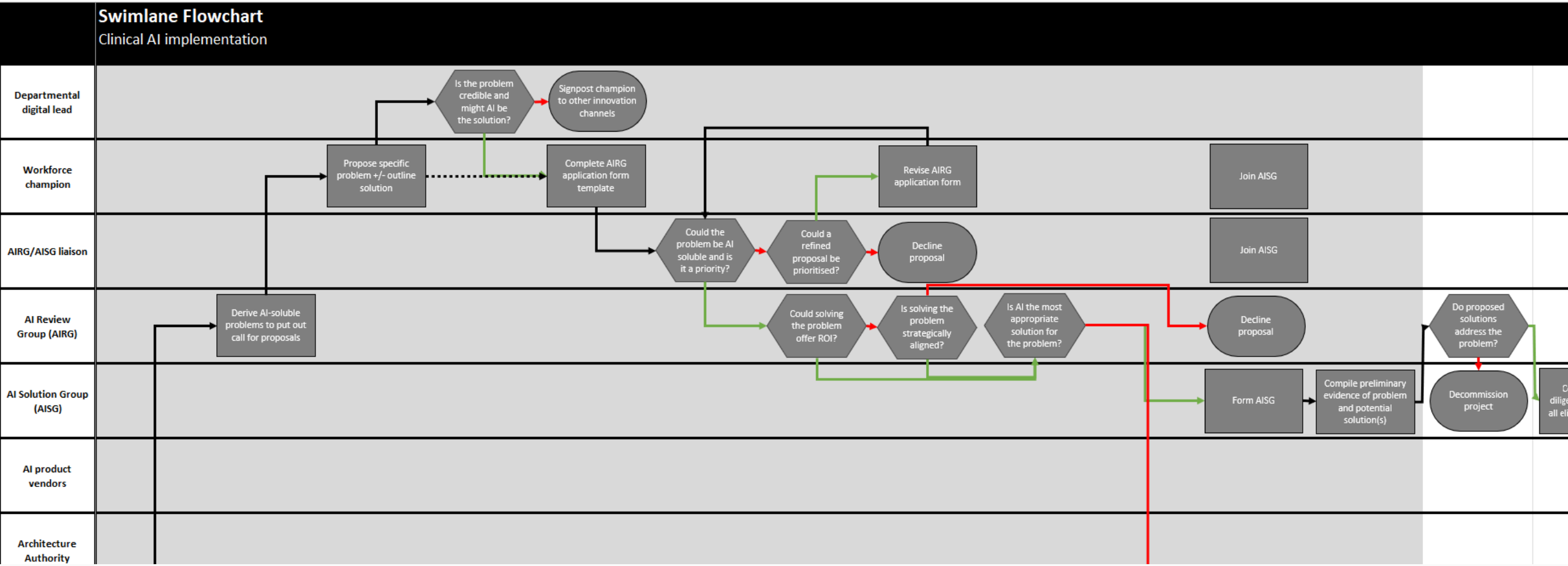

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Which of the following potential causes of harm presented by an AI scribe could standardised AI innovation processes help to mitigate?

a) Underperformance in the local context
b) Low public acceptability and accessibility
c) Compromised data integrity
d) Technology dependent behaviour
e) Insufficient AI competency among staff

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Organisational structure	Human capital	Problem formulation	Adoption and Integration	Evaluation and Monitoring
• **Single Oversight Group** • **Task and Finish Groups** • **External Ecosystem Connection** • **Effective Developer-Provider Collaboration** • **Ethics and Public Engagement** • **Standardised Processes**	• Organisational Engagement and AI Policy • Staff Training and Development • **Workforce Capacity to Sustain Responsible Use** • **Acknowledgement of Key Staff**	• **Needs-led Innovation** • **Workforce Ambassadors**	• Digital Infrastructure and Integration • **Mechanisms for Early User Feedback**	• Information Asset Register • **Non-interventional Evaluation of Performance** • **Sustained Performance Monitoring** • **Communication Post Implementation**

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Implementation readiness

- The AI Readiness Checklist allows users' to apply their detailed knowledge of an AI use case and its implementation context to make adoption decisions
- It does not prescribe an adoption threshold
- The systematic approach avoids overlooking risks and highlights relevant types of controls
- The documentation builds shared understanding
- It will highlight examples of specific controls from across the healthcare system

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AI Readiness

SERVICE OUTCOMES: 5.3 Underperformance for Population Subgroup(s)

Could this cause harm in your organisation?

Yes ☒ No ☐ Unsure ☐

If yes, please specify the harm that could arise:

The team discovers the AI tool was primarily trained on data from light-skinned populations. They are concerned it may not perform as accurately for patients with darker skin tones, which are common in the population they serve. This could lead to missed or delayed cancer diagnoses.

Do you have controls in place for this potential harm?

Yes ☒ No ☐

If yes, please specify what controls are currently in place. Relevant controls may include (but are not limited to) the following:

- **Task and finish groups** (Organisational Structure Control) – *N/A*
- **External ecosystem connection** (Organisational Structure Control) – *N/A*
- **Effective developer-provider collaboration** (Organisational Structure Control) – *N/A*
- **Ethics and public engagement** (Organisational Structure Control) - *The findings are discussed with the Trust's ethics committee and a patient focus group. The consensus is that the tool can still be beneficial, but requires additional clinician oversight in populations without clear evidence of safety.*
- **Standardised processes** (Organisational Structure Control) – N/A
- **Mechanisms for early feedback** (Adoption and Integration Control) – N/A
- **Non-interventional evaluation of performance** (Evaluation and Monitoring Control) - *Before going live, they run a non-interventional, retrospective evaluation on 1,000 anonymised local patient images, stratified by skin tone. The results evidence non-inferior performance for darker skin types.*
- **Other: Staff Training & Development** (Human Capital Control) - *The team develops mandatory training for all GPs using the tool, highlighting the performance differences and instructing them not to rely solely on the AI score for patients with darker skin tones.*

AI Readiness Checklist – Webtool prototype

1. Landing page

Sets out the scope and purpose of the tool and asks for user and project information

2. Dashboard

Displays current completeness of the tool and links to glossaries and case studies

3. Review causes

Users are asked to review the relevance of causes of patient and system harm in AI implementation

4. Map controls

Identify existent controls and of harm and areas of need

5. Readiness review

Review a summary of compliance with mandatory controls, overview of residual risk and priorities for action

www.aireadiness.uk

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NHS University Hospitals Birmingham NHS Foundation Trust

1. Landing page

Welcome to the AI Readiness Tool

Optimal Viewing Experience:
For the best experience, please use a desktop computer or tablet. This tool is not optimised for mobile devices and may not render correctly on smaller screens.

This tool is designed to help your healthcare organisation assess its preparedness for implementing new Artificial Intelligence (AI) technologies. It provides a structured way to think about potential causes of harm from AI use. These causes are split across various domains. The aim is to identify the controls you have in place to manage the associated risks for implementing a new AI technology, and any gaps. We recommend completing it with a proposed AI tool in mind, as different AI products pose different challenges.

You will be guided through a series of potential causes that can lead to harm through the deployment of AI. For each one, you will be asked to consider hazards and your organisation's existing controls to manage this. The controls may already exist as part of other processes in your organisation. Following completion of the assessment you will be provided with a report highlighting areas of readiness and potential unreadiness, as well as signposting to resources which may help improve your organisations readiness to utilise the proposed AI tool.

Before You Start

Please provide the following details. This information will be collected anonymously and used solely for the monitoring and improvement of this tool.

Your Institution Name (search by name)

e.g. University Hospitals Birmingham

Your Email Address

you@example.com

CERSI-AI · University of Birmingham · NHS England · The Health Foundation · NHS University Hospitals Birmingham NHS Foundation Trust

2. Dashboard

Your Organisation's Preparedness Assessment

Introduction | Controls Reference | Causes Reference | View Case Study

This tool is designed to help your healthcare organisation assess its preparedness for implementing new Artificial Intelligence (AI) technologies. It provides a structured way to think about potential causes of harm from AI use. These causes are split across various domains. The aim is to identify the controls you have in place to manage the associated risks for implementing a new AI technology, and any gaps. We recommend completing it with a proposed AI tool in mind, as different AI products pose different challenges.

Domain	Status	Progress	
1. Workforce	Not Started	0 / 4	Start >
2. Operational	Not Started	0 / 5	Start >
3. Financial	Not Started	0 / 4	Start >
4. External	Not Started	0 / 3	Start >
5. Clinical	Not Started	0 / 4	Start >

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3. Review causes

Domain 1: Workforce

Situation 1 of 4

Cause 1.1: Insufficient competency and collaboration among staff

Staff require skill and knowledge relating to AI, as well as digital and change management skills. These requirements differ depending on individuals' roles in AI adoption and use, the AI technology itself, and wider contextual factors. Without collaborative work from many staff with complimentary competencies and roles, AI health technologies are more likely to be used inappropriately. [?]

Could this cause patient or system harm? [?]

- (●) Yes
  - Please specify the harm to the patient or system that could arise from this:
  - A failure for users to integrate their wider understanding of the clinical case (comorbidities) could lead to excessive intervention, pressur ✖
  - + Add another
- ( ) No
- ( ) Don't know

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4. Map controls

Do you have controls in place for this potential harm?

Please select or add the controls your organisation currently has in place for this cause.

- Single oversight group [?]
- External ecosystem connection [?]
- Standardised processes [?]
- Staff training and development [?]

Please detail:

Product specific training will be given to any clinical decision makers prior to using the tool

Add a suggestion:

+ Training needs analysis + Register of completed training

- Workforce capacity to sustain responsible use [?]
- Workforce ambassador leading adoption [?]
- Acknowledgement of key staff [?]

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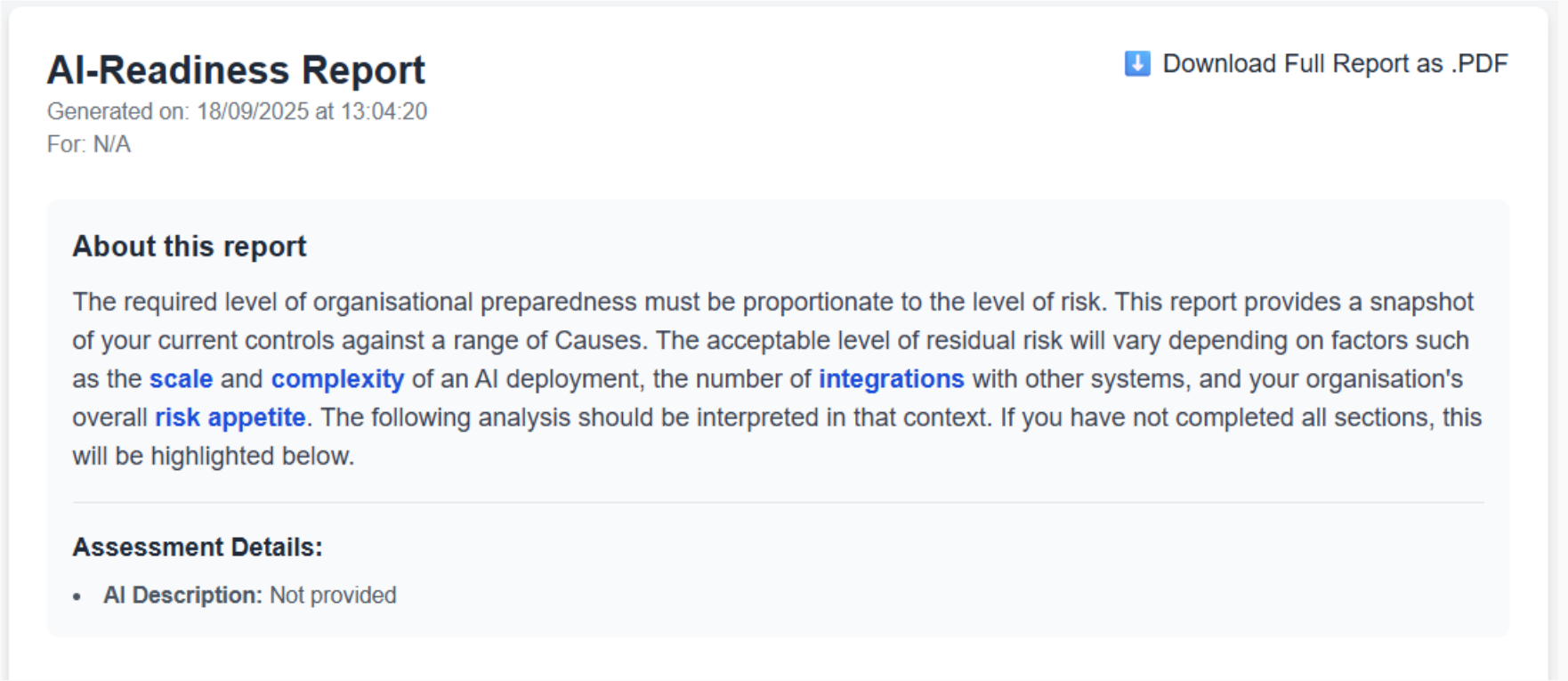
5. Readiness review



AI-Readiness Report

Generated on: 18/09/2025 at 13:04:20
For: N/A

Download Full Report as .PDF

About this report

The required level of organisational preparedness must be proportionate to the level of risk. This report provides a snapshot of your current controls against a range of Causes. The acceptable level of residual risk will vary depending on factors such as the **scale** and **complexity** of an AI deployment, the number of **integrations** with other systems, and your organisation's overall **risk appetite**. The following analysis should be interpreted in that context. If you have not completed all sections, this will be highlighted below.

Assessment Details:

- **AI Description:** Not provided

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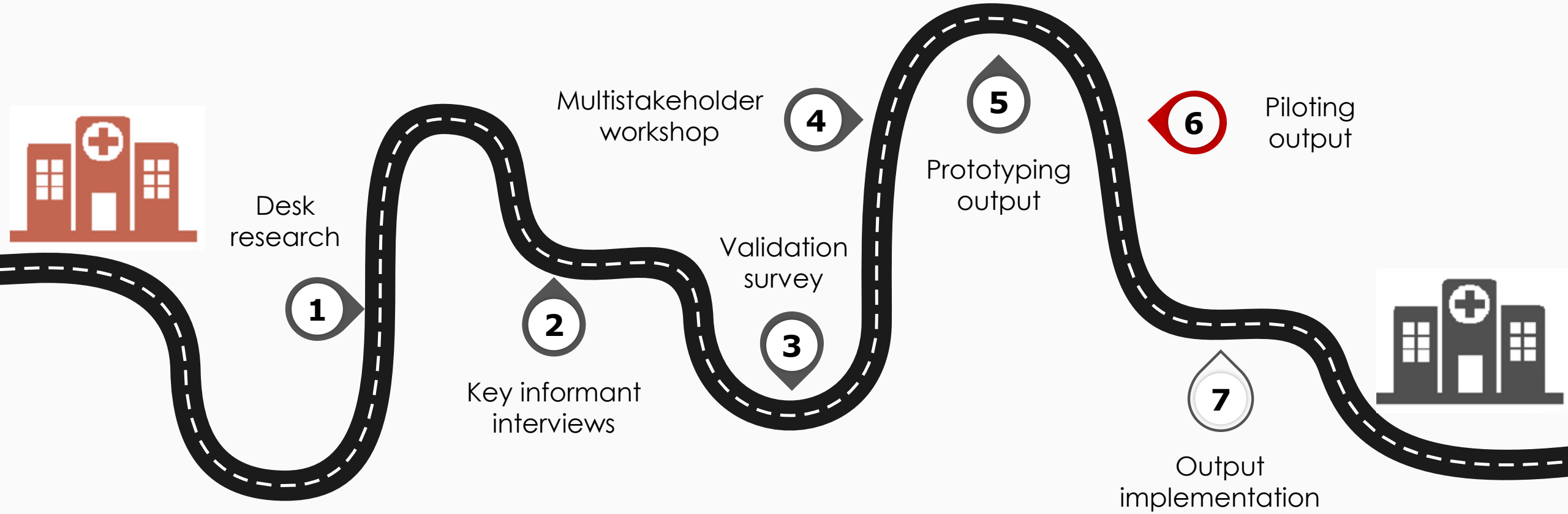
AI Readiness project roadmap



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Please support!

- Consultation papers published by CERSI this Monday
- All feedback welcome
- Please highlight any good practices (controls) we can catalogue and signpost

www.cersi-ai.org/the-ai-readiness-checklist/

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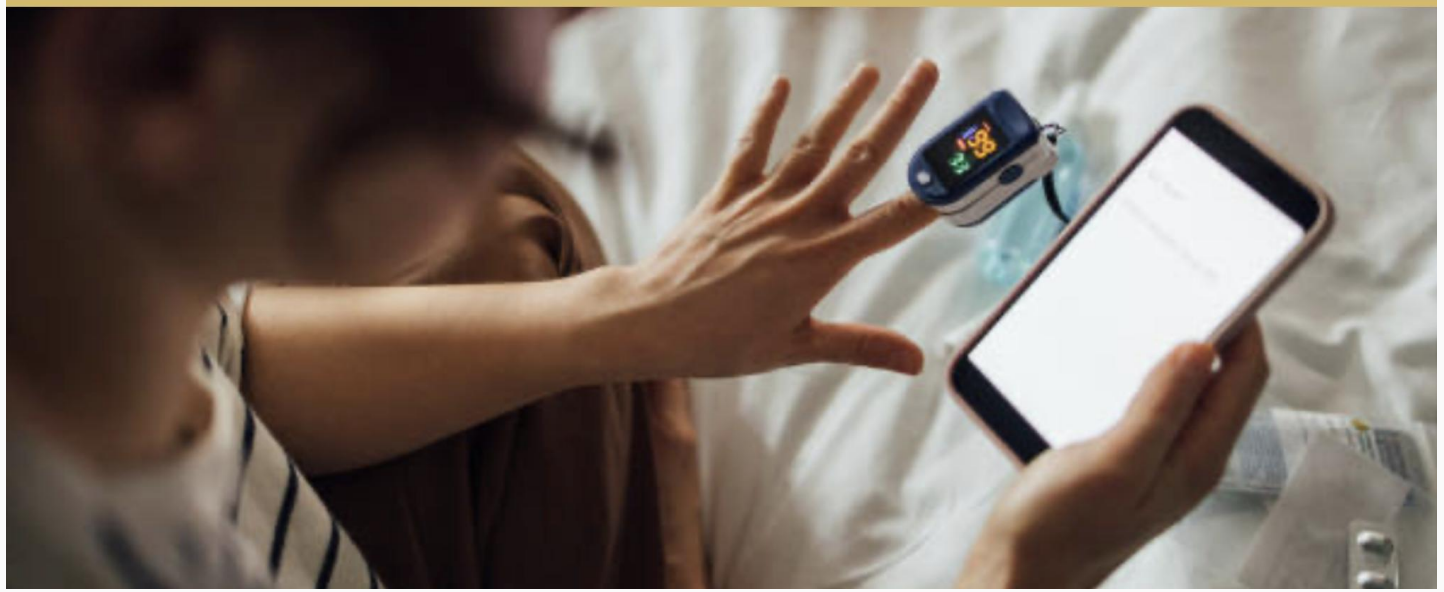
The Centre of Excellence for Regulatory Science & Innovation
in **AI & Digital Health**

CERSI-AI



A new national Centre of Excellence working with innovators, regulators, researchers, patients and the NHS to **optimise** the **regulation** of **AI & Digital Health Technologies** so as to **accelerate innovation** that will **improve people's lives**.

www.cersi-ai.org

CERSI-AI

Smarter Regulation for Better Innovation in AI & Digital Health

UK Research and Innovation

Medicines & Healthcare products Regulatory Agency

Office for Life Sciences

Department of Health & Social Care

Department for Science, Innovation & Technology

The last mile: training the innovators & adopters

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Search Menu

Home > Study > Postgraduate study > Subject areas > Postgraduate Medicine courses

Artificial Intelligence Implementation (Healthcare) MSc / PGDip

www.birmingham.ac.uk/heathcare-ai-msc

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AI Readiness for Adopter Organisations

Dr Jeff Hogg - J.Hogg.1@bham.ac.uk

Ass. Prof, University of Birmingham

Programme Director, MSc AI Implementation (Healthcare)

Deputy Director of Knowledge Mobilization, CERSI-AI

Clinical Innovation Officer in AI, UHB

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NHS University Hospitals Birmingham NHS Foundation Trust

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Smarter Regulation for Better Innovation in AI & Digital Health

AI learning needs across the workforce

For all: A foundational understanding of AI technology, e.g. to answer patient questions, to anticipate some risks

For most: An operational understanding of specific AI products, e.g. to adhere to instructions for use, to recognise errors

For some: An overview of the full lifecycle of clinical AI products within a healthcare provider, e.g. to engage appropriate expertise, to responsibly champion implementation efforts

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Developing healthcare workers' confidence in AI (Part 2). 2022. NHS AI Lab and Health Education England. https://digital-transformation.hee.nhs.uk/building-a-digital-workforce/dart-ed/horizon-scanning/developing-healthcare-workers-confidence-in-ai

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What everyone should know

1. What are the different types of AI and what are the basics of how they work?
2. How, where and why is patient data used with different AI technologies?
3. What types of errors do AI technologies tend to make and how can they be identified?
4. How does a technology qualify as a medical device and how does that constrain its use?

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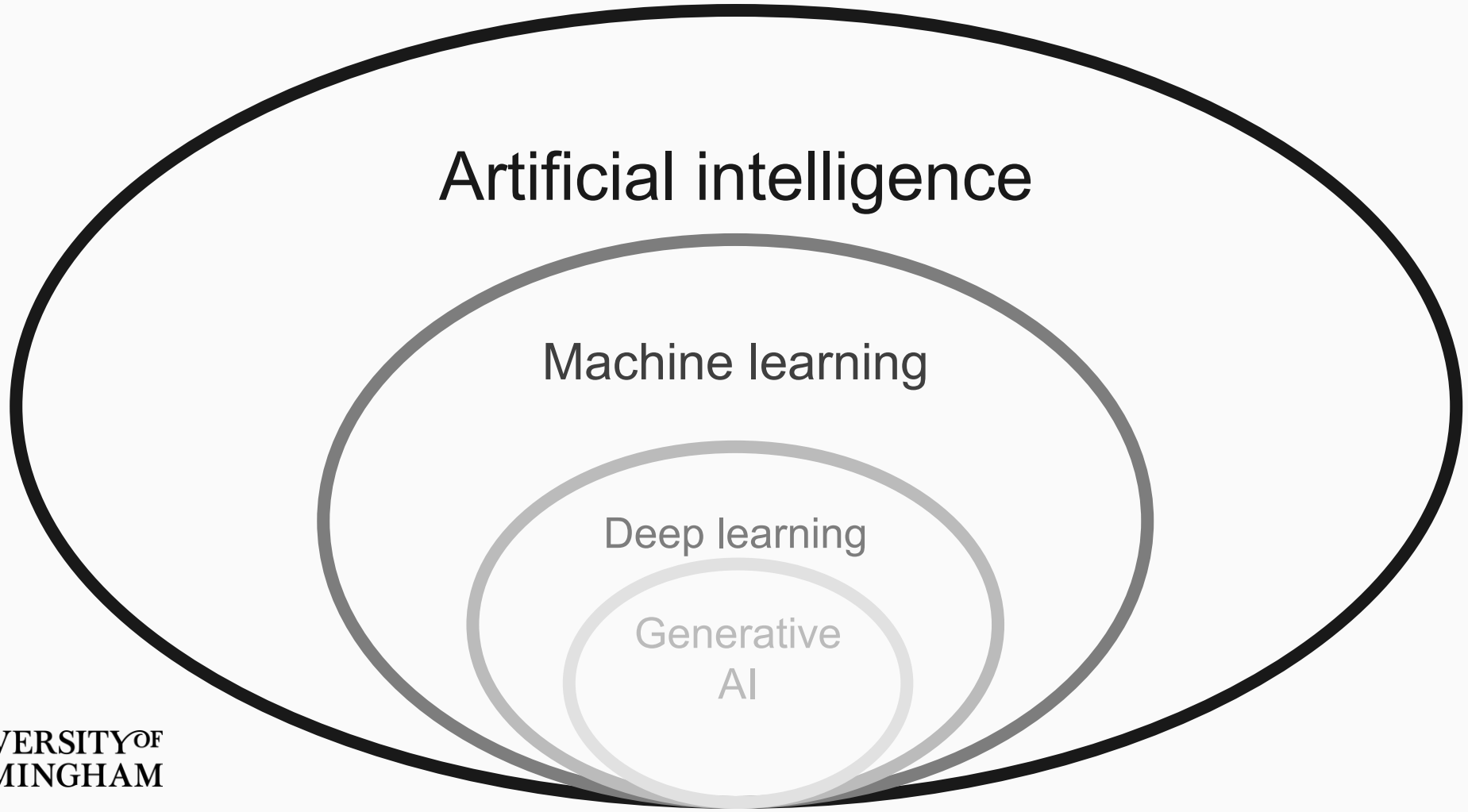
Developing healthcare workers' confidence in AI (Part 2). 2022. NHS AI Lab and Health Education England. https://digital-transformation.hee.nhs.uk/building-a-digital-workforce/dart-ed/horizon-scanning/developing-healthcare-workers-confidence-in-ai

1. Different types of AI and how they work



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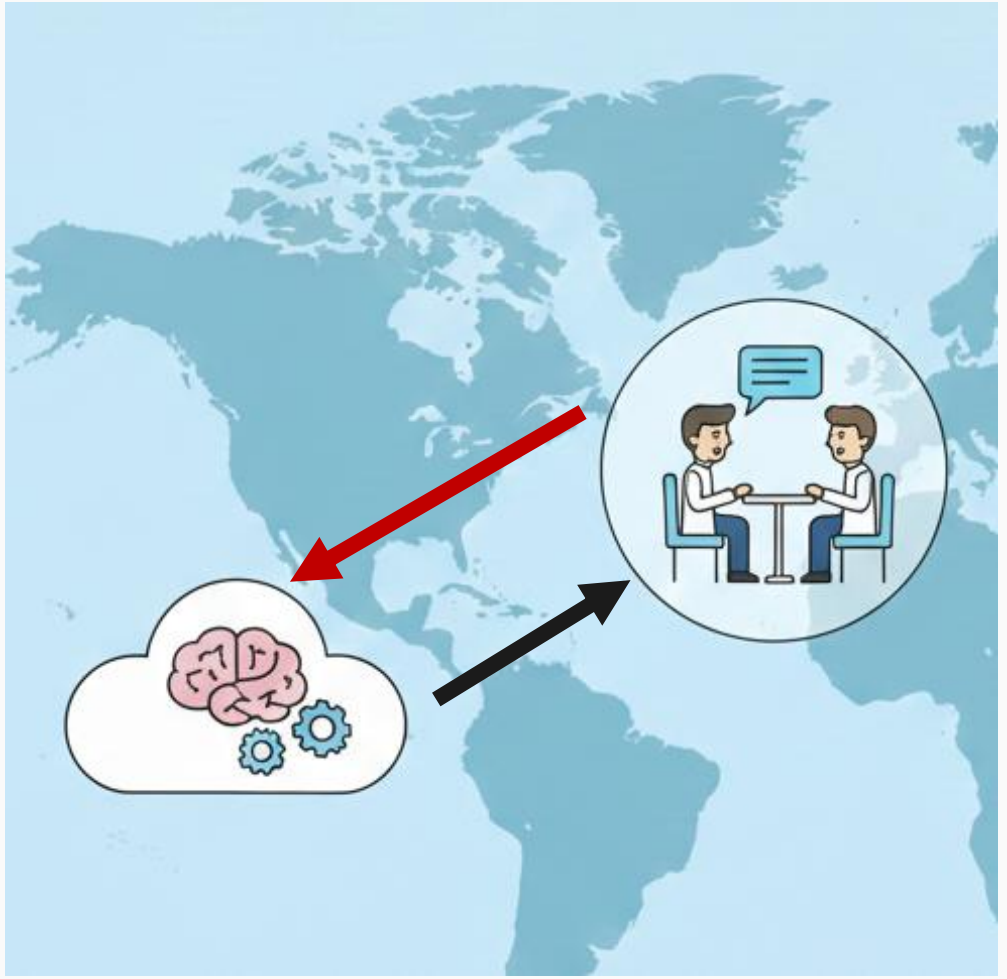
2. Who uses what data and why with AI

- **Patients** give healthcare providers their data to receive good healthcare
- **Healthcare providers** process data with AI products to enhance the quality or efficiency of the service they give patients
- **Healthcare researchers** process data with AI to evaluate the risks and benefits of AI
- **AI developers** process data to provide a service
- **AI developers** use data to develop and validate their products for future benefit



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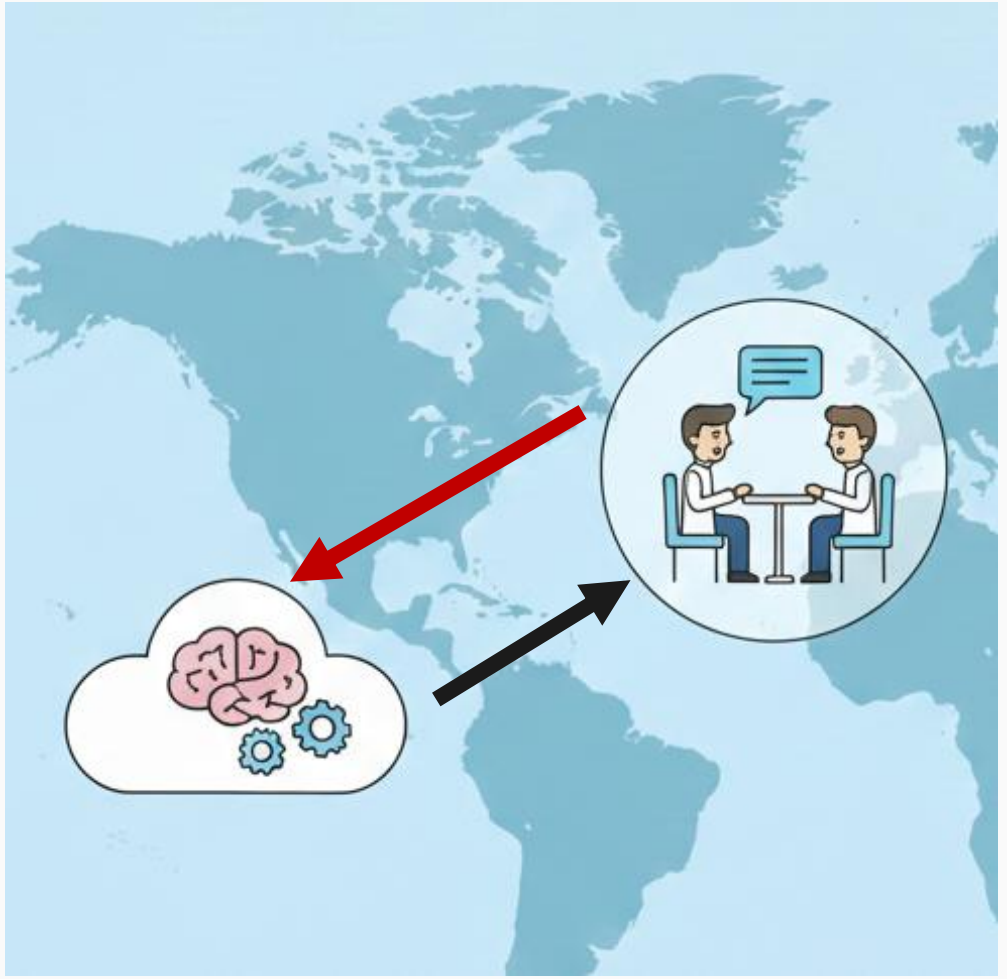

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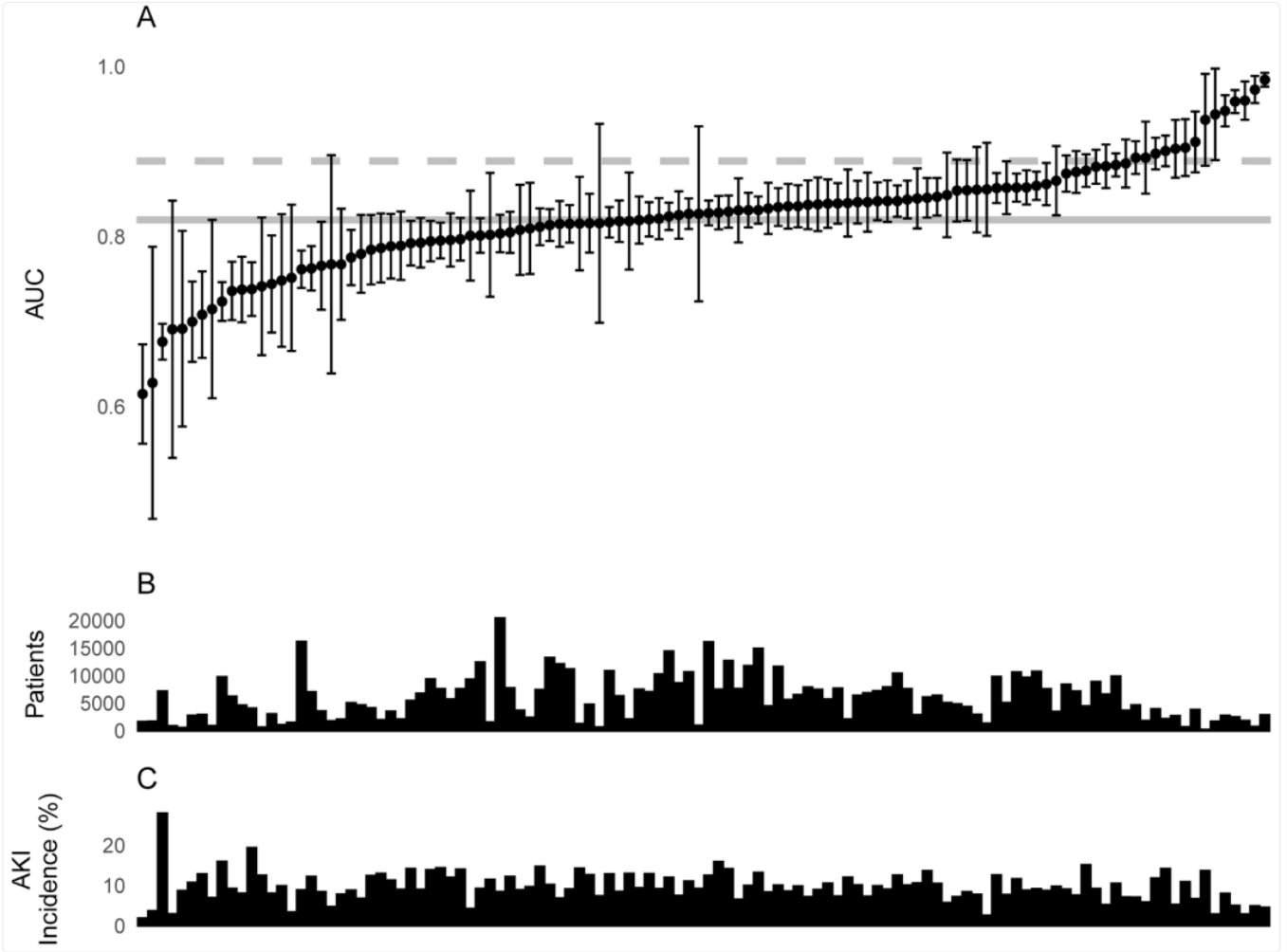
3. AI failure modes and mechanisms

- Misclassification (FP and FN)
- Inaccurate predictions
- Fabrication
- Inappropriate omission



Cao J, et al. Generalizability of an acute kidney injury prediction model across health systems. Nat Mach Intell. 2022 Dec;4(12):1121-1129.

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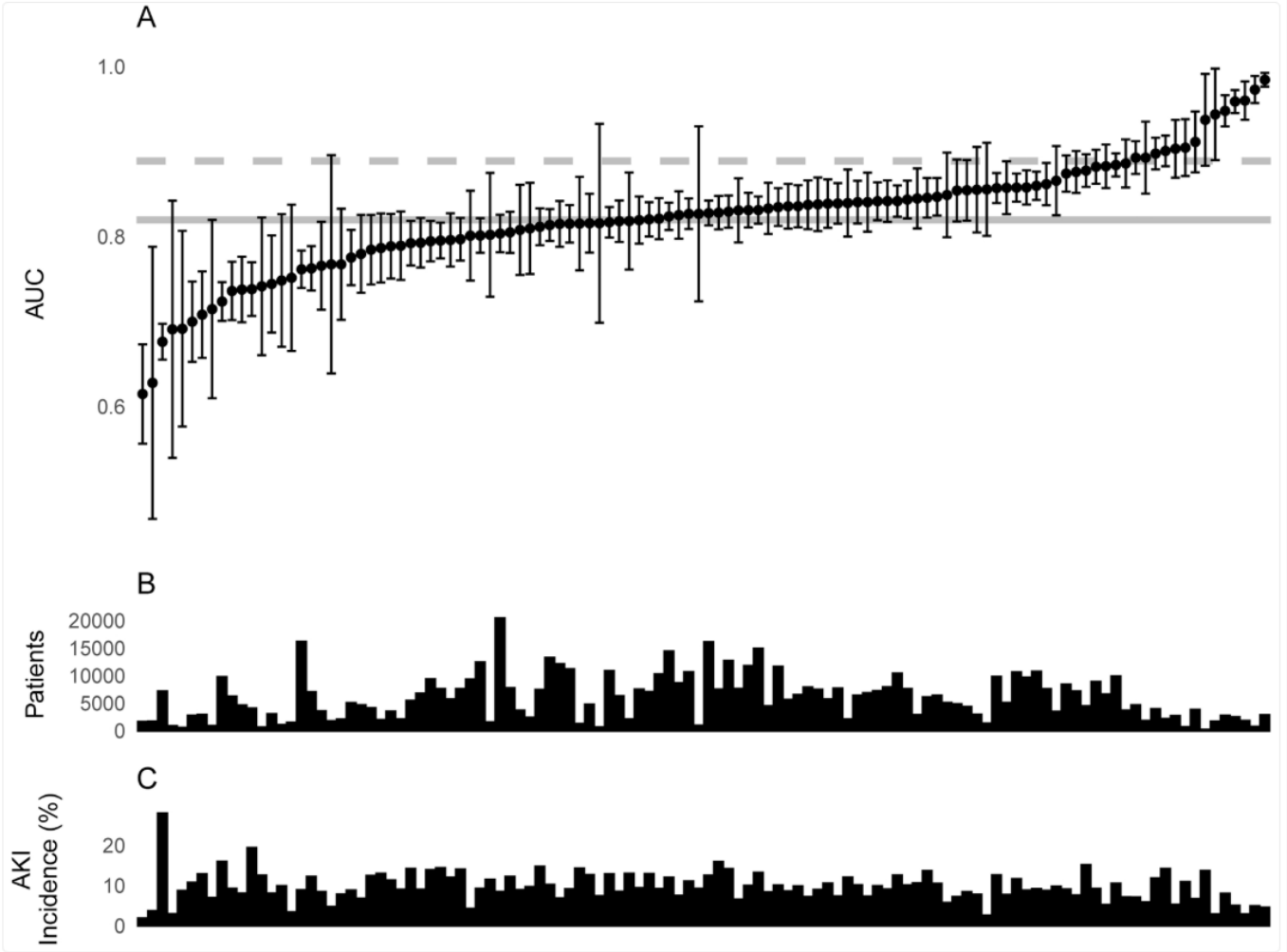

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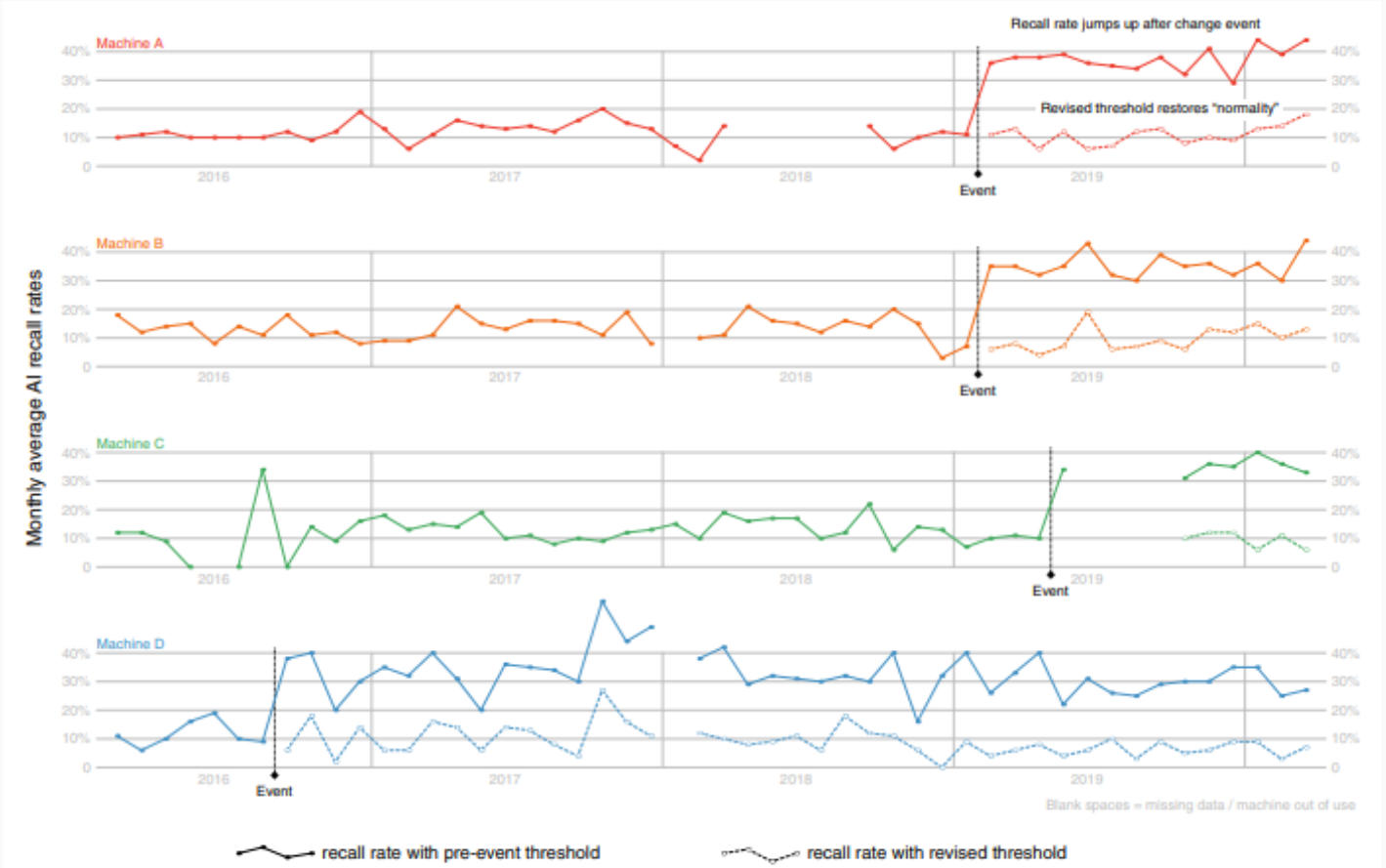

Fig. 8. As described by de Vries and colleagues, observations of 4 different machines across 4 years, show that AI recall rates jump after software change events. Clinical thresholds need to be adjusted to restore "normality."

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Wilkinson L, et al. Clinical Integration of Artificial Intelligence for Breast Imaging. Radiologic clinics of North America, 62 (4), July 2024.

3. AI failure modes and mechanisms

- Misclassification (FP and FN)
- Inaccurate predictions
- Fabrication
- Inappropriate omission

1 Recommendations

1.1 Deep Ensemble for Recognition of Malignancy (DERM, an artificial intelligence [AI] technology) can be used within teledermatology services in the NHS during the evidence generation period as an option to assess and triage skin lesions in adults referred to the urgent suspected skin cancer pathway. It can only be used:

- if the evidence outlined in the evidence generation plan is being generated
- once it has appropriate regulatory approval including NHS England's Digital Technology Assessment Criteria (DTAC) approval.

1.2 Mitigate the potential risk of missed or delayed cancer diagnoses when using DERM during the evidence generation period by:

- doing a healthcare professional review for people with black or brown skin
- regular monitoring of DERM's performance to maintain accuracy
- using additional protocols when necessary, such as:
  - a national governance framework to ensure local oversight of use of DERM
  - a healthcare professional review.

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NICE. Artificial intelligence (AI) technologies for assessing and triaging skin lesions referred to the urgent suspected skin cancer pathway: early value assessment. Health technology evaluation. Reference number:HTE24. Published: 01 May 2025

4. The purpose of use makes AI a medical device

<table>
<tr><th colspan="3">Any instrument, apparatus, implement, machine, appliance, implant, in vitro reagent or calibrator, software, material or other similar or related article:</th></tr>
<tr><td rowspan="2">A</td><td colspan="2">Intended to be used, alone or in combination, for human beings for one or more of the below purpose(s):</td></tr>
<tr><td>• Diagnosis, prevention, monitoring, treatment or alleviation of disease
• Diagnosis, monitoring, treatment or alleviation of/compensation for injury
• Investigation, replacement, modification, support of the anatomy or of a physiological process</td><td>• Supporting or sustaining life
• Control of conception
• Disinfection of medical devices
• Providing information for medical or diagnostic purposes (via in vitro examination)</td></tr>
<tr><td>B</td><td colspan="2">Which does not achieve its primary intended action in or on the human body by pharmacological, immunological or metabolic means, but which may be assisted in its intended function by such means</td></tr>
</table>

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GHTF/SG1/N29R16:2005 - Information Document Concerning the Definition of the Term "Medical Device"

4. The purpose of use makes AI a medical device

State of healthcare situation or condition	Significance of information provided by software medical devices to healthcare decision		
	Treat or diagnose	Drive clinical management	Inform clinical management
Critical	4	3	2
Serious	3	2	1
Non-serious	2	1	1

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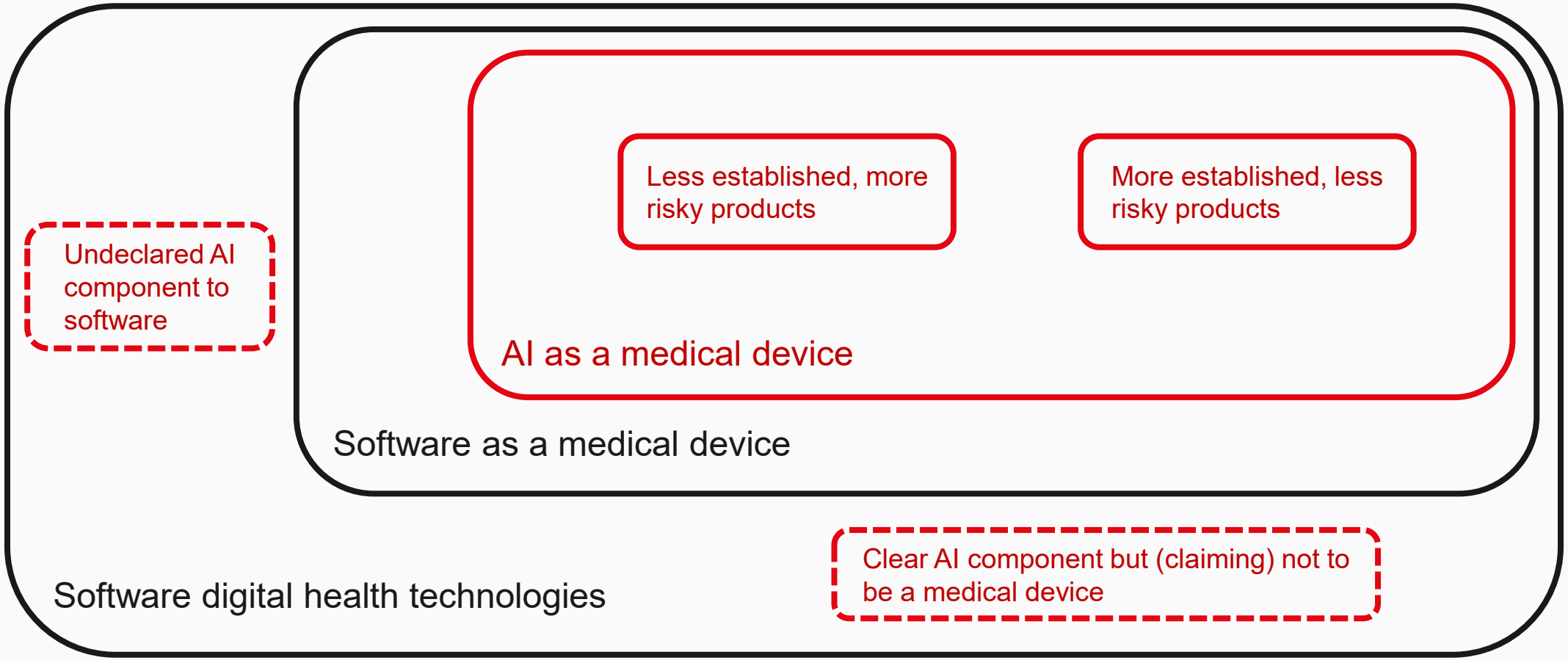
IMDRF/SaMD WG/N12FINAL:2014 – “Software as a Medical Device” (SaMD): Possible Framework for Risk Categorization and Corresponding Considerations

4. The purpose of use makes AI a medical device



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Refreshments & Networking

CONVENZIS

Welcome to the NHS Radiology Conference!

25th February 2026
Hyatt Regency Manchester, 55 Booth St W
M15 6PQ

AXREM

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- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.

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Chair Morning Reflection

Huw Shurmer
AXREM Chair & Strategic and Government Relationship Manager FUJIFILM Healthcare UK
AXREM / FUJIFILM Healthcare UK

Interview Session

Ashley Isherwood
Principal Superintendent Radiographer
Bradford Teaching Hospital NHS Foundation Trust

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Keynote Presentation

Dr Christiane Zelenyanszki
Programme and Service Development/Radiology Ops Lead
Barking, Havering and Redbridge University Hospitals NHS Trust

Beyond the Build: Workforce, Activity and Innovation Lessons from a Community Diagnostic Centre in North East London

Dr Christiane Zelenyanszki

25th February 2026

TAKING PRIDE IN OUR CARE

NHS
Barking, Havering and Redbridge University Hospitals
NHS Trust

Overview

1. **Setting up a CDC**
    - Mandate & Business Case
        - Outreach & Engagement
    - Type
    - Activity (planned activity)
    - Workforce
    - Programme
2. **Delivery and Optimisation**
    - Activity (actual activity)
    - Patient & Staff Experience (Experienced-based design survey, FFTs)
    - Optimisation
        - Appointment utilisation
        - Room utilisation
        - Equipment utilisation
        - Pathway transformation

Community Diagnostic Centres: Background

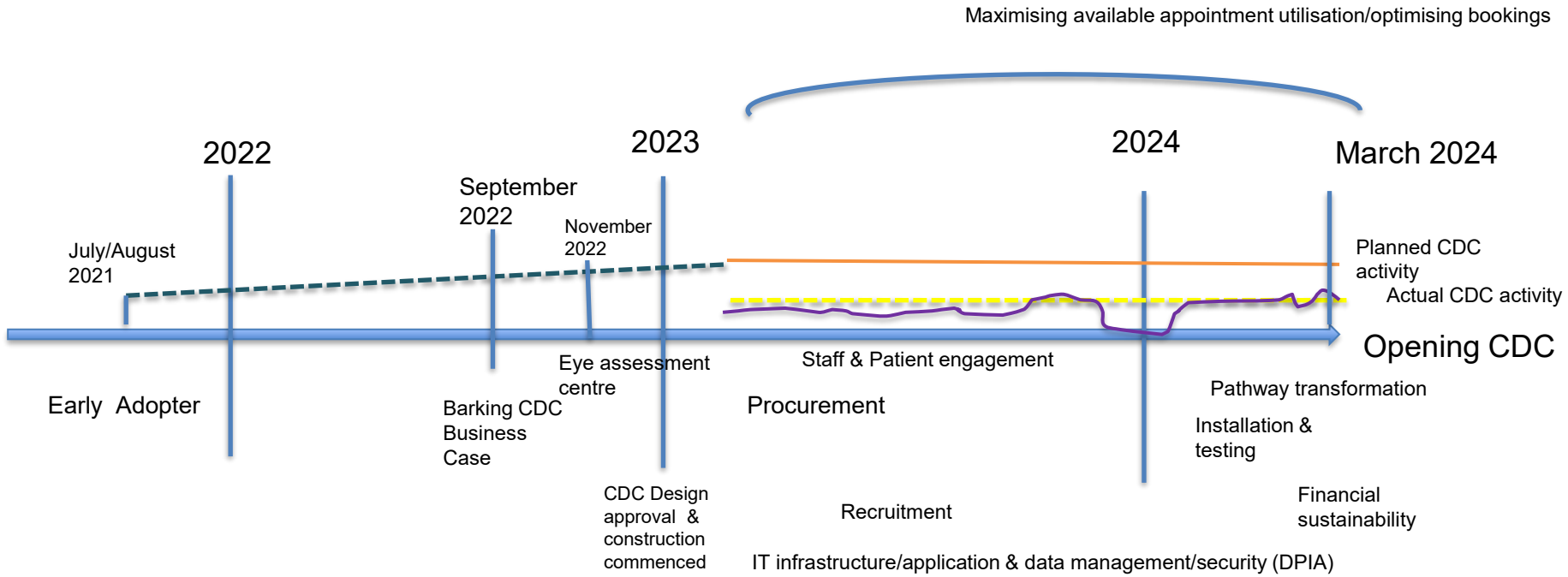
The Diagnostic Backlog That Changed Everything

- Professor Sir Mike Richards: Review of NHS Diagnostic Services (2020)
    - Several recommendations including separating acute and elective diagnostic services
    - Increase in diagnostic/imaging equipment
    - Establishment of Community Diagnostics Hub (i.e. Community Diagnostic centres [CDC])

CDC Programme aims and cross-cutting themes

NHS England » Community diagnostic centres accessed 10.2.25

BARKING CDC: TIMELINE



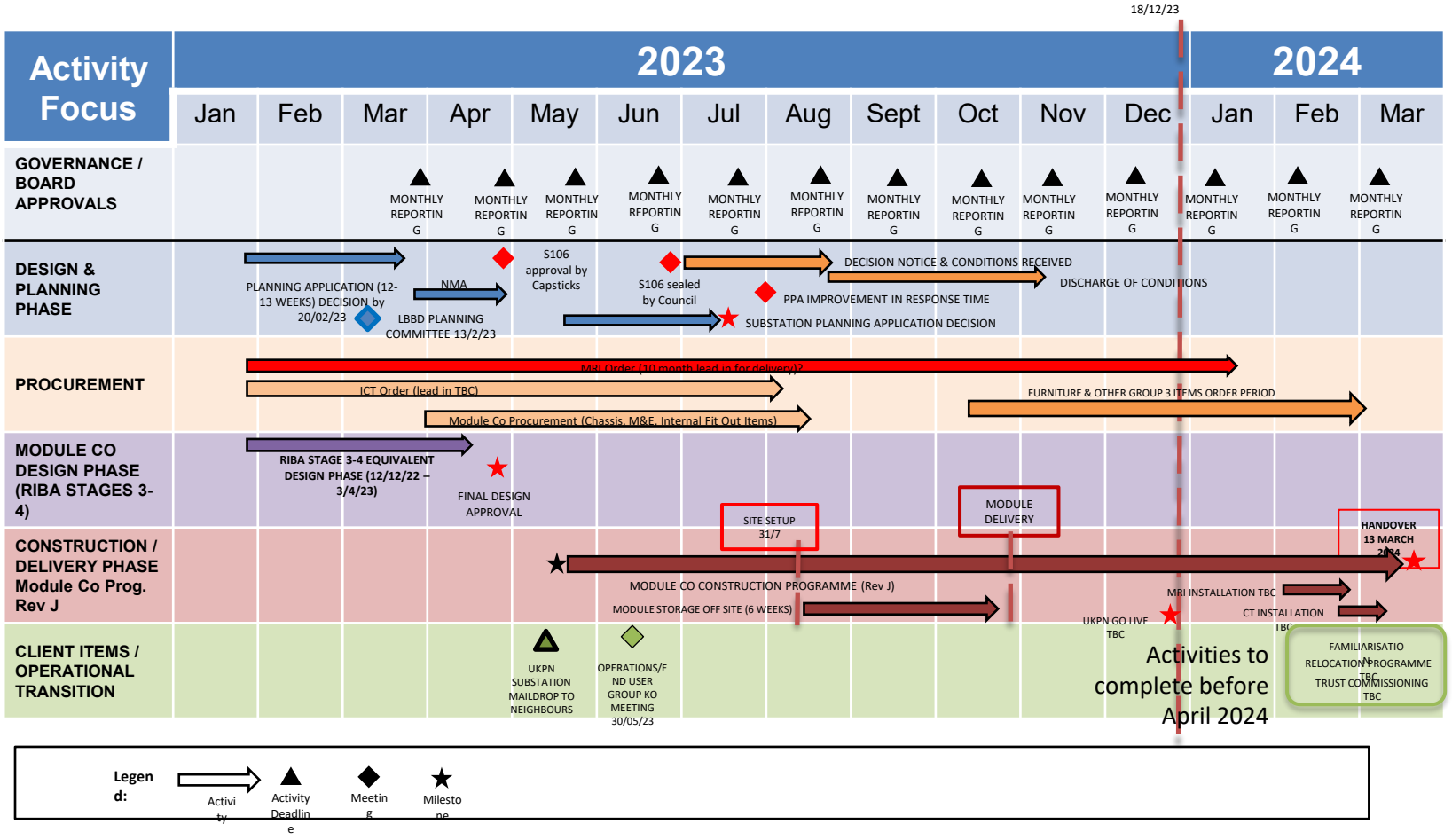
CDC design archetypes

Archetype	Description
Standard Model	A CDC that provides the minimum diagnostic tests, except for endoscopy, and any other diagnostic test deemed a priority locally. Only diagnostic testing is required to be carried out in this archetype; however, provision of consulting rooms should be considered if there is an opportunity for streamlining and providing more efficient overall patient pathways.
Large Model	A large CDC that offers all minimum services and endoscopy, and potentially provides some of the optional components in the diagnostic pathway e.g. consultation. Delivery of endoscopy needs to be embedded within a Regional Network and be aligned to any local endoscopy training academies.
Hub and Spoke Model	The central hub must include all minimum diagnostic tests to support a coordinated service for patients that requires multiple tests. CDC 'spokes' provide further capacity to 'hubs' for specific tests through a satellite location, mobile unit or pop-up. Spokes can be used to meet specific service needs (e.g.to reach certain populations or increase local capacity for specific tests). The spokes can help integrate CDC models with other community diagnostic expansion (e.g. primary care diagnostic services) or to deliver care at home where this helps to progress the intended aims of the programme. Spokes should also be considered in areas that can support local recovery from COVID-19. There must be digital connectivity and interoperability between the different facilities comprising the hub and spoke model.

CDC design archetypes

Design Principles
Built for Flow (Not Footfall), Elective separation

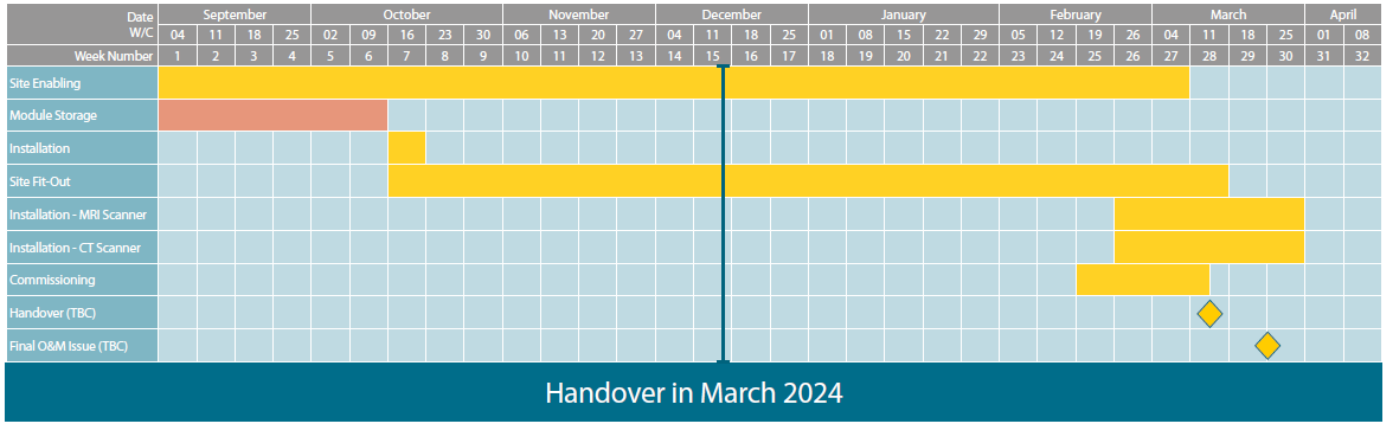
BARKING CDC – PLAN ON A PAGE



BARKING CDC – PROJECT PROGRESS UPDATE

Programme

Following discussions with Northmores regarding programme, we have updated the below high level illustration. However, the dates are not yet final as we await further coordination with UKPN.



Two-week Lookahead

UKPN inspection on 20th December.

Brickwork preparation from 18th December, with works commencing thereafter.

The electrical second fix will be complete by 21st December.

The front door will be installed on 18th December.

Painting and decorating will continue through the period.

Furniture installation will continue with increased numbers and should be 80% complete before the Christmas break.

Ceiling installation will be nearly complete aside from access areas.

Vinyl flooring will be 80% complete before the Christmas break.

Certain dead testing commissioning will begin.

Equipment Installation Plan: An example

Day	SA	SU	M	TU	WE	TH	F	SA	SU	M	TU	WE	TH	F	SA	SU	M	TU	WE	TH	F
Date	15-Feb	16-Feb	17-Feb	18-Feb	19-Feb	13-Feb	14-Feb	15-Feb	16-Feb	17-Feb	18-Feb	19-Feb	20-Feb	21-Feb	22-Feb	23-Feb	24-Feb	25-Feb	26-Feb	27-Feb	28-Feb
Equipment Delivery																					
Mechanical Installation																					
Calibrations & Commissioning																					
Snagging																					
Trust Med Physics																					
Clinical Applications Training																					

CDC: Planned Activity

Select CDC Name Below:	
---	Select CDC name using the dropdown >>
---	--
---	--

Key:
Requires Input
Pre-populated
Headers
Less than 5 Working Days

Total number of tests on this form:						Total Revenue With MFF:					
0						0					
Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

INPUT IN EACH OF THE FOLLOWING YELLOW BOXES

---	--
MFF Value	--
Select Working Week Length:	Select from list
Input Date of Completion (dd/mm/yyyy):	

		Working Days:		5	5	4	4	5	4	5	5	4	5	5	5	5	5	5	5	5	5	5	5	5
Row	Diagnostic_Group	Diagnostic Test	Cost per Test	06/04/2025	13/04/2025	20/04/2025	27/04/2025	04/05/2025	11/05/2025	18/05/2025	25/05/2025	01/06/2025	08/06/2025	15/06/2025	22/06/2025	29/06/2025	06/07/2025	13/07/2025	20/07/2025	27/07/2025	03/08/2025	10/08/2025			
P005	Endoscopy	Diagnostic Endoscopic Upper Gastrointestinal Tract Procedures (trans-nasal), 19 years and over	£399																					
P006	Endoscopy	Therapeutic Colonoscopy, 19 years and over	£644																					
P007	Endoscopy	Diagnostic Colonoscopy with Biopsy, 19 years and over	£600																					
P008	Endoscopy	Diagnostic Colonoscopy, 19 years and over	£526																					
P009	Endoscopy	Therapeutic Flexible Sigmoidoscopy, 19 years and over	£507																					
P010	Endoscopy	Diagnostic Flexible Sigmoidoscopy with Biopsy, 19 years and over	£431																					
P011	Endoscopy	Diagnostic Flexible Sigmoidoscopy, 19 years and over	£367																					
P012	Endoscopy	Diagnostic or Therapeutic, Rigid Sigmoidoscopy, 19 years and over	£178																					
P013	Endoscopy	Therapeutic, Upper Gastrointestinal Tract Endoscopic Procedure with Colonoscopy, 19 years and over	£1,025																					
P014	Endoscopy	Diagnostic, Upper Gastrointestinal Tract Endoscopic Procedure with Colonoscopy, with Biopsy, 19 years and over	£703																					
P015	Endoscopy	Diagnostic, Upper Gastrointestinal Tract Endoscopic Procedure with Colonoscopy, 19 years and over	£587																					
P016	Endoscopy	Therapeutic, Upper Gastrointestinal Tract Endoscopic Procedure with Sigmoidoscopy, 19 years and over	£871																					

CDC Patient Information

[Having an appointment, test or scan at our Community Diagnostic Centre]

2. Delivery and Optimisation/Delivered - The Model in Reality

CDC - Radiology - Tracker - Barking

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

Diagnostic Test | Month | Values

	Apr-23				May-23				Jun-23				Jul-23			
	Planned Att	Actual Att	Actual Scan	Perfor...	Planned Att	Actual Att	Actual Scan	Perfor...	Planned Att	Actual Att	Actual Scan	Perfor...	Planned Att	Actual Att	Actual Scan	Perfor...
CT with Contrast	588	272	273	46%	646	408	412	63%	665	391	393	59%	697	356	357	51%
CT without Contrast	316	458	478	145%	347	498	507	144%	360	535	558	149%	379	596	630	157%
MRI with Contrast	78	0	0	0%	86	0	0	0%	88	0	0	0%	93	0	0	0%
MRI without Contrast	524	491	576	94%	576	527	634	91%	593	519	621	88%	622	541	666	87%
US (NOUS) without Contrast	1200	992	1149	83%	1319	1100	1313	83%	1361	1266	1484	93%	1428	1147	1353	80%

Workforce: The True Bottleneck

- Recruitment challenges
- Skill-mix innovation
- Flexibility needs

Barking CDC 2024/25: First Patient Feedback

Patient Feedback

"*Dealt with a swift manner and fantastic service"*
"Very nice people made me feel at ease"
"The nurse was very helpful and gave us lot of info"
"The member of staff on reception was very courteous – the MRI Technician a with care"
"Was running late but everyone here supported

Barking CDC 2024/25: First Patient Feedback

Patient Feedback

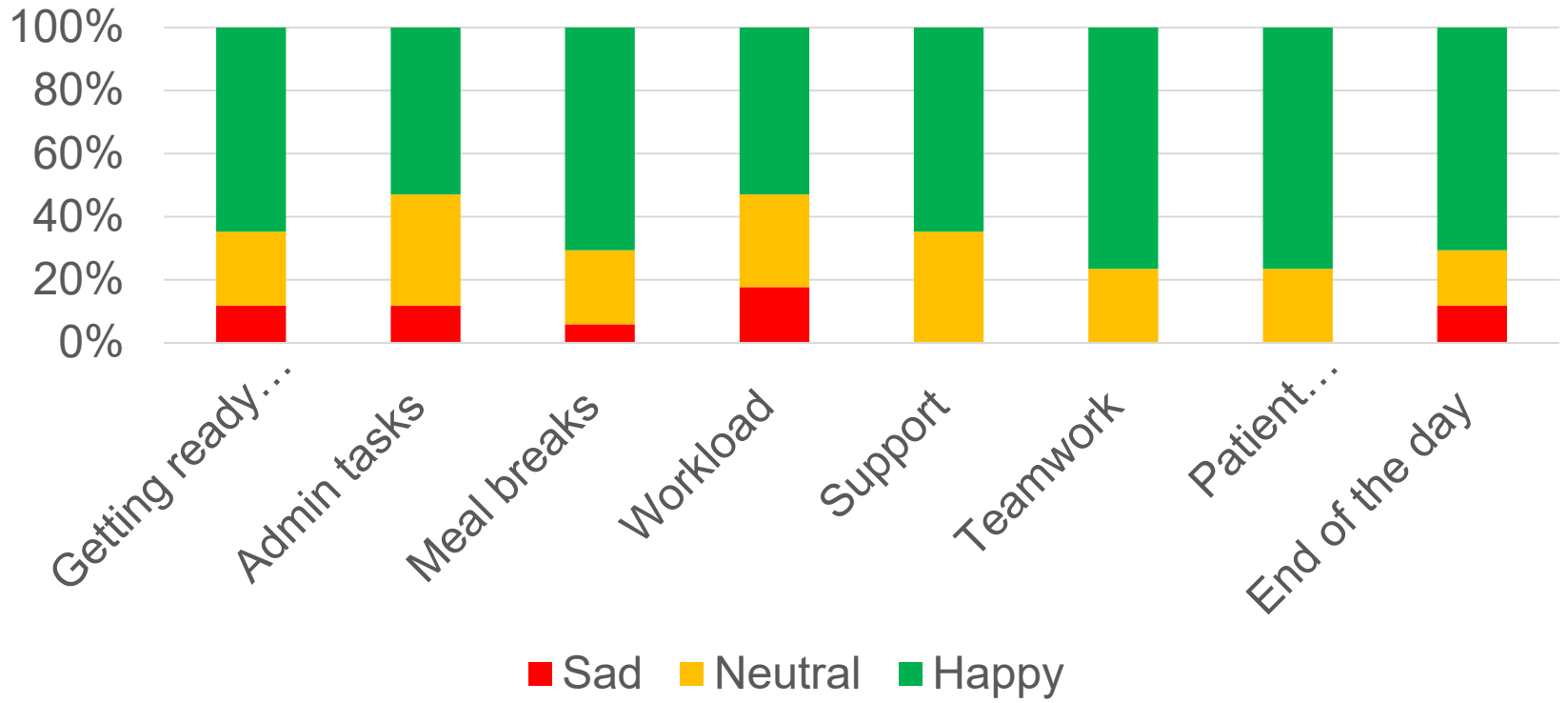
- *”A bit more information about the scan and how long it would take etc would have been appreciated”*
- *“hand sanitiser dispensers should be on communal areas and toiltes . Somewhere to get a cup of tea or coffee would be nice”*

Community Diagnostic Centre's Staff Wellbeing EBD Survey

Barking CDC

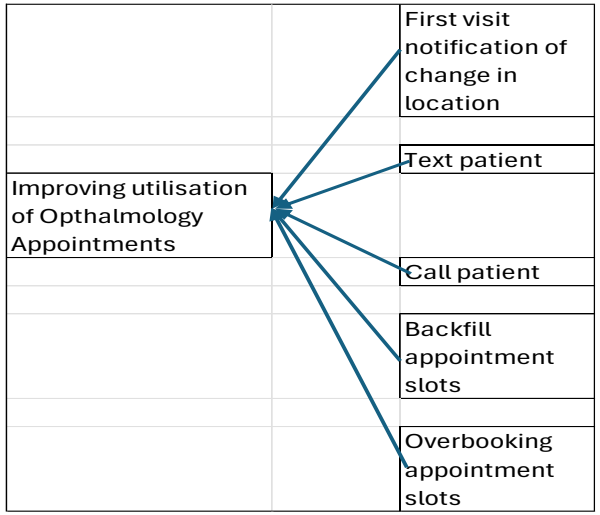
September 2024

Emotional Map



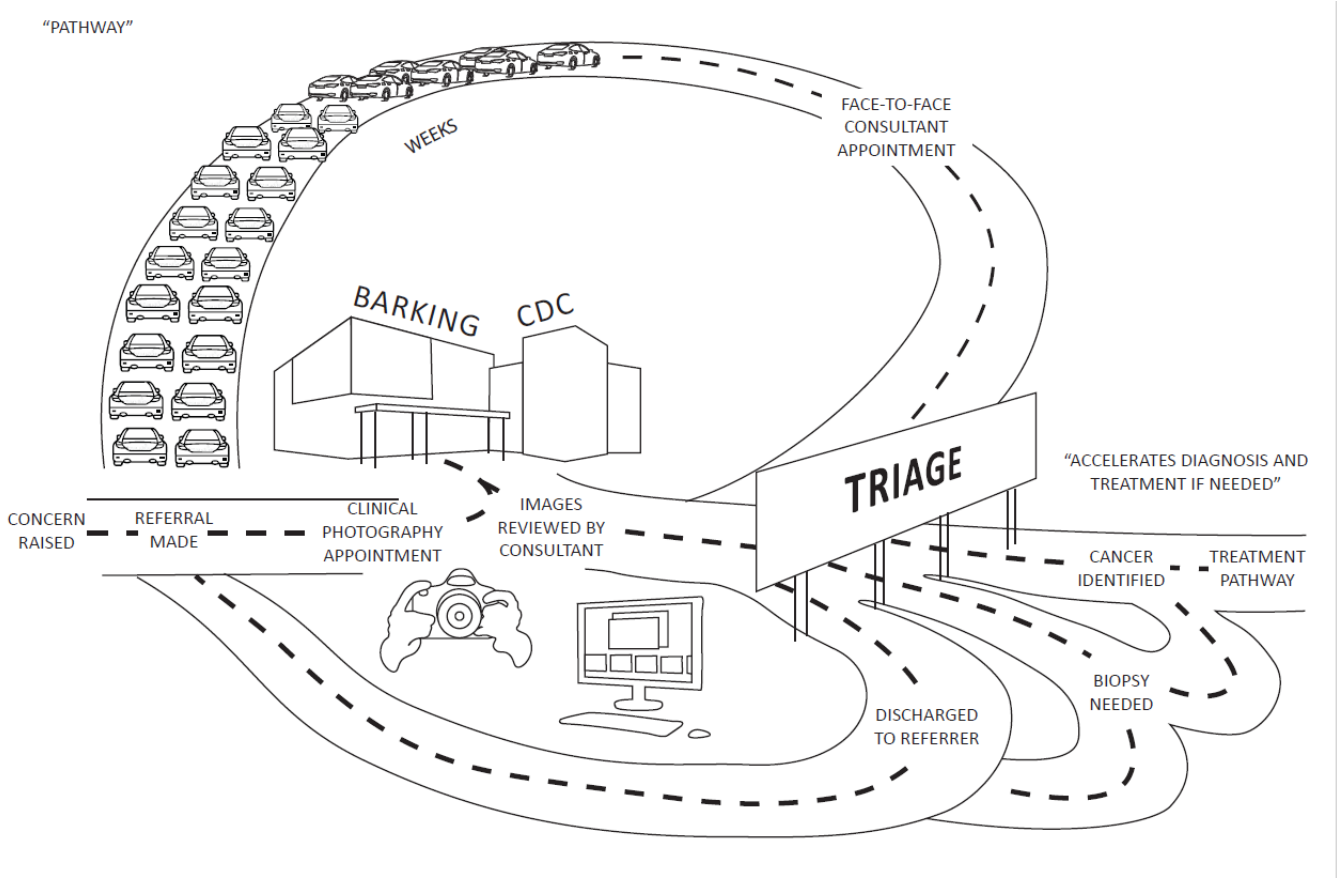
Optimisation: Ophthalmology

Forcast Date Recorded	Forcasted Appts		Clinic Day / Date		Clinic Day Actual Appts	Patients Attended	Patients DNA	Clinic Mean Attendance %	Clinic Mean DNA %	Appts Under / Over traget	Utilisation Under / Over %
	65		Thursday	22/02/24	65	46	19	71%	29%	-10	-13%
	36		Friday	23/02/24	36	17	19	47%	53%	-39	-52%
	51		Thursday	29/02/24	51	37	14	73%	27%	-24	-32%
	43		Friday	01/03/24	43	32	11	74%	26%	-32	-43%
	51		Thursday	07/03/24	51	42	9	82%	18%	-24	-32%
	53		Friday	08/03/24	53	42	11	79%	21%	-22	-29%
	67		Thursday	14/03/24	67	30	37	45%	55%	-8	-11%
	56		Friday	15/03/24	56	41	15	73%	27%	-19	-25%
	53		Thursday	21/03/24	53	34	19	64%	36%	-22	-29%
	59		Friday	22/03/24	69	33	26	48%	38%	-6	-8%
	67		Thursday	28/03/24	67	36	27	54%	40%	-8	-11%
ank Holida	0		Friday	29/03/24	0	0	0	0	0	0	0
23/02/24	54		Thursday	04/04/24	63	35	28	56%	44%	-12	-16%
23/02/24	59		Friday	05/04/24	67	55	12	82%	18%	-8	-11%
09/04/24	37		Thursday	11/04/24	33	16	17	48%	52%	+42	+56%
09/04/24	60		Friday	12/04/24	55	33	22	60%	40%	-20	-27%
09/04/24	76		Thursday	18/04/24	71	50	21	70%	30%	-4	-5%
09/04/24	70		Friday	19/04/24	70	52	18	74%	26%	-5	-7%
20/04/24	59		Thursday	25/04/24	48	23	25	48%	52%	-27	-36%
20/04/24	62		Friday	26/04/24	60	36	24	60%	40%	-15	-20%
29/04/24	72		Thursday	02/05/24	71	45	26	63%	37%	-4	-5%
29/04/24	90		Friday	03/05/24	73	57	16	78%	22%	-2	-3%
29/04/24	28		Thursday	09/05/24	24	16	8	67%	33%	-51	-68%
29/04/24	48		Friday	10/05/24	45	18	27	40%	60%	-30	-40%
29/04/24	67		Thursday	16/05/24	59	37	22	63%	37%	-16	-21%
29/04/24	73		Friday	17/05/24	72	58	14	81%	19%	-3	-4%
16/05/24	14		Thursday	23/05/24	12	6	6	50%	50%	-63	-84%
16/05/24	45		Friday	24/05/24	42	20	22	48%	52%	-33	-44%
24/05/24	70		Thursday	30/05/24	63	41	22	65%	35%	-12	-16%
24/05/24	74		Friday	31/05/24	68	41	27	60%	40%	-7	-9%
31/05/24	15		Thursday	06/06/24	51	40	11	78%	22%	-24	-32%
31/05/24	0		Friday	07/06/24	0					-75	-100%
07/06/24	76		Thursday	13/06/24	66	50	16	76%	24%	-9	-12%
07/06/24	80		Friday	14/06/24	70	48	22	69%	31%	-5	-7%
13/06/24	81		Thursday	20/06/24	62	44	18	71%	29%	-13	-17%
20/06/24	62		Friday	21/06/24	59	33	26	56%	44%	-16	-21%
20/06/24	80		Thursday	27/06/24	73	56	17	77%	23%	-2	-3%
20/06/24	79		Friday	28/06/24	67	54	13	81%	19%	-8	-11%
27/06/24	76		Thursday	04/07/24	60	45	15	75%	25%	-15	-20%



Utilisation rate, DNA, Growth Pattern

Transforming the suspected oral cancer pathway



Five Lessons for Imaging Transformation

1. Build for pathways, not just capacity
2. Workforce redesign must come first
3. Optimisation never stops (it start when formalising your vision)
4. Experience data drives operational change (NHS Elect)
5. CDCs are system levers, not estate projects

Final thought

Do CDCs work?

- it's whether we are willing to use them to genuinely redesign diagnostic care
  - rather than replicate hospital models in a different postcode
- if we get this right, CDCs won't just reduce waiting lists
  - they will give imaging teams the conditions to practise at their best

Any Questions?

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Leadership Lessons from the Front Line

Donna Holdcroft
Professional Officer
British Medical Ultrasound Society

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CONVENZIS

Keynote Presentation

Claire Angus
CEO
British Institute of Radiology

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Lunch & Networking

CONVENZIS

Welcome to the NHS Radiology Conference!

25th February 2026
Hyatt Regency Manchester, 55 Booth St W
M15 6PQ

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HESUK

Powered by - CONVENZIS

Join the Healthcare Engagement Society (HES)

- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.

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Chair Afternoon Address

Huw Shurmer

AXREM Chair & Strategic and Government Relationship Manager FUJIFILM Healthcare UK

AXREM / FUJIFILM Healthcare UK

Keynote Presentation

Tim Taylor
Medical Director UK
Teleconsult

Daniel Sourial
Chief Executive Officer UKI/MEA
Everlight Radiology

Dr Farzana Rahman
CEO
Hexarad

AXREM

Teleradiology Working Group Session

Please submit questions throughout the session via the QR code

Join at
slido.com
#1458 364

Meet The Panel:

Dr Tim Taylor

Executive Director, Teleconsult
AXREM Teleradiology Working Group Representative

Daniel Sourial

CEO UKI, ME and Asian Subcontinent, Everlight Radiology
AXREM Teleradiology Working Group Representative

Dr Farzana Rahman

Co Founder and Chief Executive Officer, Hexarad
AXREM Teleradiology Working Group Representative

Welcome & Introductions

AXREM
BRINGING THE MEDTECH INDUSTRY TOGETHER
WITH ONE VOICE FOR ALL

AXREM

BRINGING THE MEDTECH INDUSTRY TOGETHER
WITH ONE VOICE FOR ALL

Setting the scene of Teleradiology

Teleradiology is now a core part of NHS imaging, supporting capacity, resilience and continuity of care. This session, delivered with AXREM, explores how teleradiology can be embedded safely and effectively, not just as a technical solution, but as an integrated part of modern imaging pathways.

Please submit questions throughout the session via the QR code

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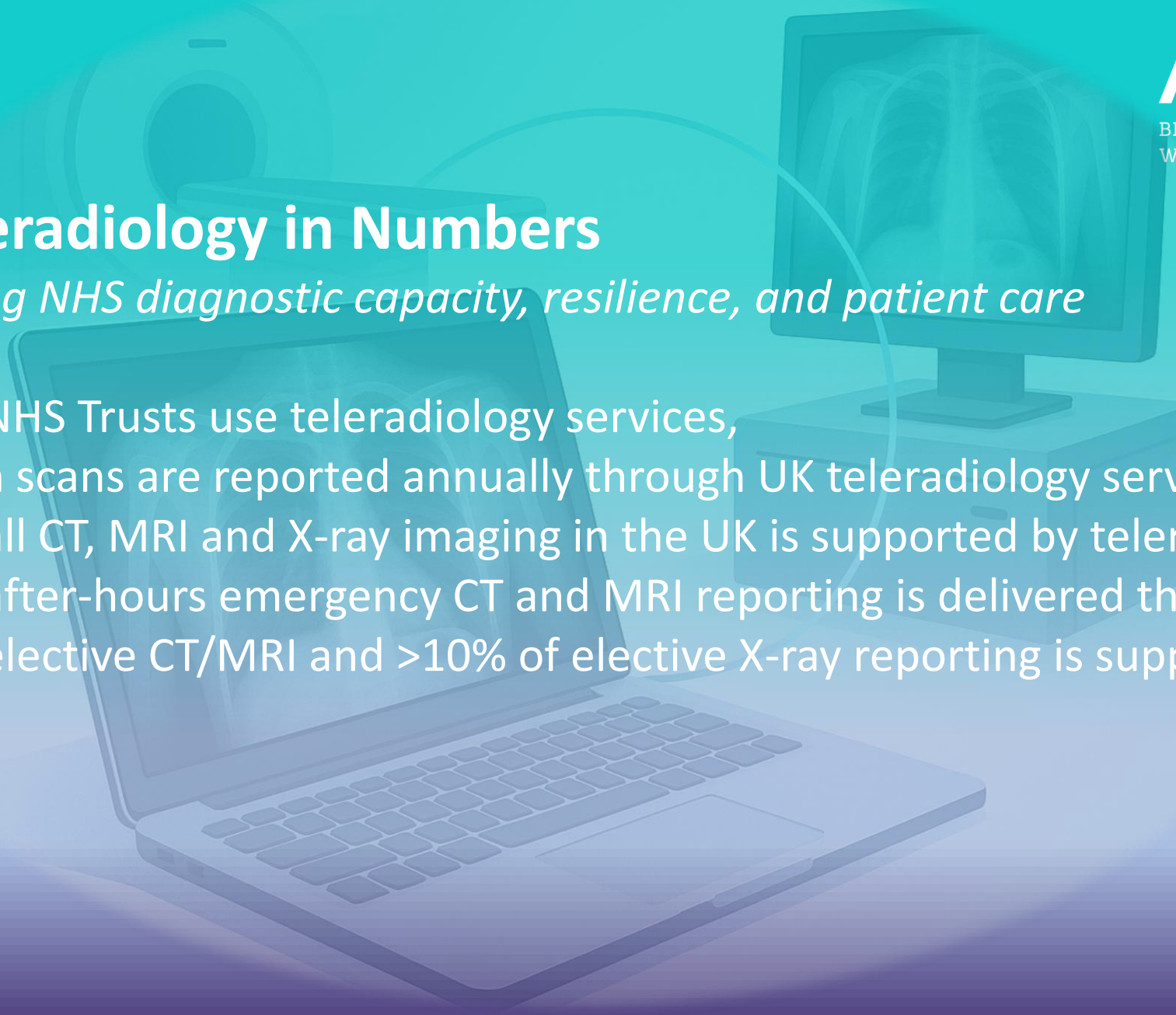
UK Teleradiology in Numbers

Supporting NHS diagnostic capacity, resilience, and patient care



>95% of NHS Trusts use teleradiology services,
>5 million scans are reported annually through UK teleradiology services.
≈15% of all CT, MRI and X-ray imaging in the UK is supported by teleradiology reporting.
>90% of after-hours emergency CT and MRI reporting is delivered through teleradiology.
>15% of elective CT/MRI and >10% of elective X-ray reporting is supported by teleradiology.

Please submit questions throughout the session via the QR code

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Perception of Teleradiology

What does good look like?

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What are your thoughts on teleradiology services?

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What does it take to go from being a provider to a partner?

What are the key elements for an effective partnership?

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What may Teleradiology look like in the coming years?

Please submit questions throughout the session via the QR code

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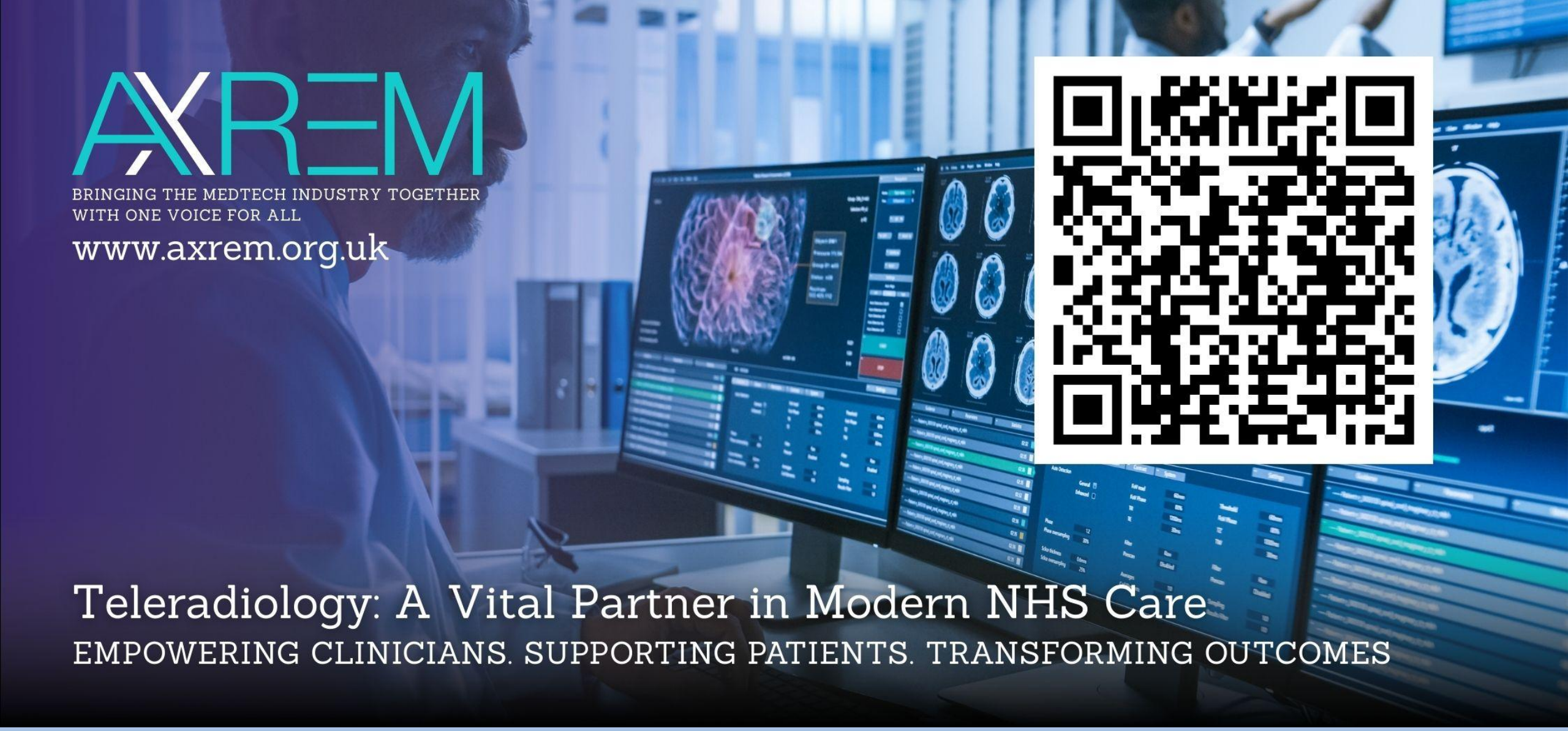
Future of Teleradiology

Audience Q&A
Please submit any questions here…



Close and thanks

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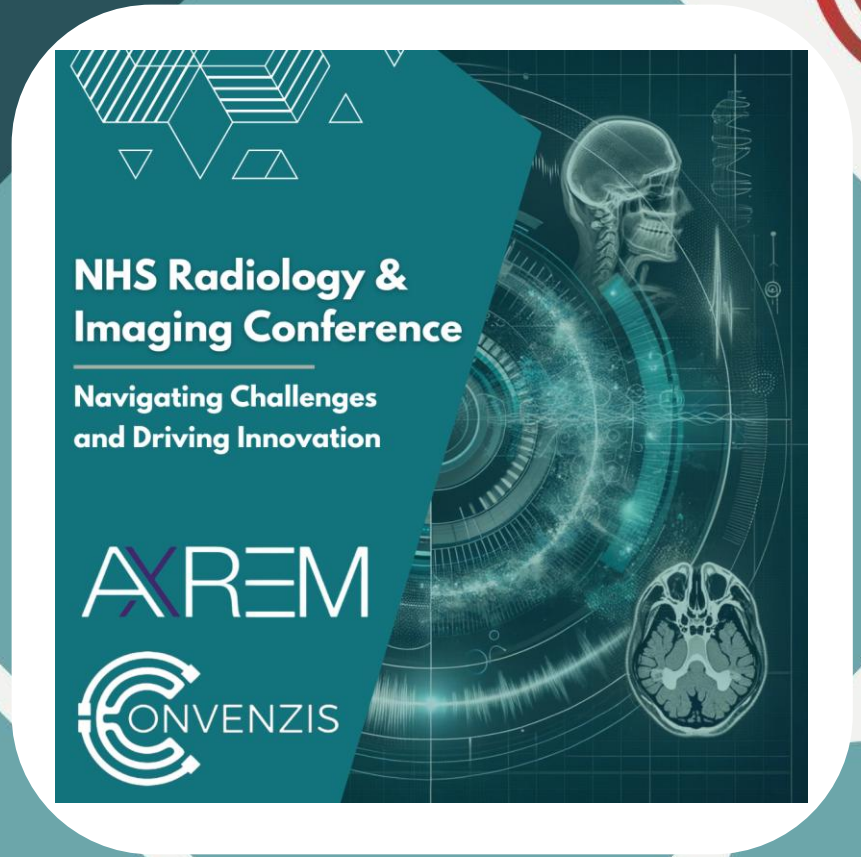
NHS Deep Dive



Carolyn (Caz) Dyer
Head of Radiology
Kettering General Hospital

Strengthening Workforce Development, Retention, and Wellbeing Across Imaging Services

Enhancing talent and resilience in imaging professions

Key Focus Areas for Strengthening Imaging Workforce and Networks

- Workforce Development in Imaging Services
- Retention Strategies for Imaging Professionals
- Promoting Wellbeing Across Imaging Networks
- Leveraging Technology and Innovation
- Building Resilient Imaging Networks

Workforce Development in Imaging Services

Workforce Development

Current and Future Role of Imaging Services

Rapidly rising demand, limited resources, and recent technological changes have increased pressure on these services and their staff.

Challenges Within the Workforce

The imaging workforce faces challenges in development, retention, and wellbeing, impacting service quality.

Significance of Workforce Development

A skilled, adaptable, and resilient workforce is key to providing effective and sustainable imaging services across healthcare systems.

Comprehensive training and career pathways

Career Progression Paths

- Defined career routes and mentorship enhance professional development and retain talent.
- Appraisals, talent mapping, and forward planning address staff requirements.

Structured Training Programmes

- Ongoing training ensures radiographers stay current with technology and best practices.
- Led by education specialists, externally funded courses, peer training, CPD lectures, audits, and ground level AI involvement.

Collaboration and Partnerships

Interdisciplinary Collaboration

Working in partnership ,effective collaboration between imaging modalities, IT, and clinical teams fosters innovation while supporting the development of staff competencies across multiple disciplines.

- Daily briefings with senior team members
- Designated manager of the day
- Enhanced visibility of senior leadership
- Shared Decision Council
- Dedicated Teams communication channels
- Interservice clinical team meetings
- Engagement with national and local patient support organizations

Education Partnerships

Strategic alliances with universities facilitate hands-on training and help maintain a consistent pipeline of qualified imaging professionals.

Retention Strategies for Imaging Professionals

Retention

High Workloads Impact

Heavy workloads drive retention issues by increasing stress and burnout.

- Review system pathways
- Flex staff between high and low impact areas

Technological Advancements

Ongoing tech changes require staff to adapt, impacting retention and satisfaction.

- Shared Decision Council
- Radiology-led AI initiatives

Increasing Service Demands

Rising service needs add pressure, challenging retention without proper support.

- Manage demand collaboratively, work with external and internal partners

Flexible Working

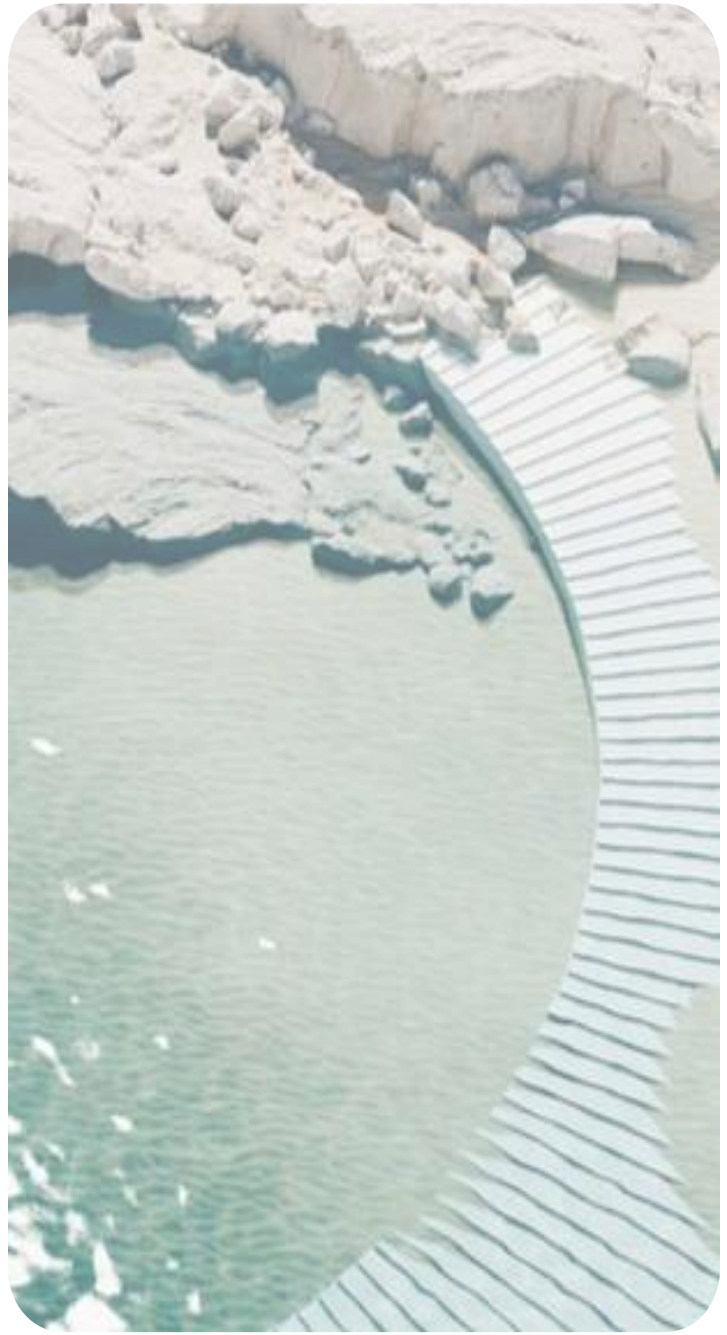
Flexible Working Arrangements

- Part-time, bank, remote options, and adjustable schedules accommodate varied staff needs and promote work-life balance.

Recognition and reward

Recognition and Reward

- Performance recognition and long-service schemes encourage retention, including:
- Rose awards
- Greatix
- Annual Trust awards
- Thank-you cards
- Appreciation tree



Professional development and effective leadership

Continuous Professional Development

Supporting ongoing education and training enhances skills and knowledge for career growth.

Conference and Course Funding

Providing financial support for attending conferences and courses fosters learning and networking opportunities.

Compassionate Leadership

Leadership that listens and shows empathy encourages open communication and trust among staff.

Inclusive Decision-Making

Actively involving staff in development and decision processes leads to better engagement and outcomes.

Promoting Wellbeing Across Imaging Networks

Wellbeing initiatives and mental health support

Importance of Staff Wellbeing

Promoting staff wellbeing is critical for sustaining optimal performance and mitigating the risk of burnout within healthcare settings.

- Restorative supervision
- Professional advocacy
- Wellbeing initiatives
- Recognition of our culturally diverse team

Mental Health Support Services

Ensuring access to counselling services, peer support groups, and mental health champions empowers staff to effectively manage workplace demands.

Workload management and healthy work environments

Efficient Workload Management

Technology and redesigned workflows reduce administrative tasks, enabling healthcare professionals to prioritise patient care.

Ergonomic Healthy Workspaces

Providing ergonomic workstations, rest areas, and healthy food options supports staff well-being and productivity.

Open Communication Channels

Regular forums and surveys help monitor staff morale and address workplace concerns effectively.

Leveraging Technology and Innovation

Role of technology in enhancing service delivery and staff experience

Artificial Intelligence Integration

AI technology enhances service delivery by automating repetitive tasks and supporting smarter decision-making.

Remote Reporting and Flexibility

Remote reporting tools enable flexible working patterns and enhance staff experience by supporting mobility.

Building Resilient Imaging Networks

Benefits of regional collaboration and shared resources

Shared Best Practices

Regional networks enable sharing of best practices to improve imaging service quality and resilience.

Resource Sharing

Pooling resources and staff across regions enhances efficiency and service availability.

Training and Expertise

Joint training programs strengthen expertise and support continuous professional development.

Flexible staff deployment and joint wellbeing initiatives

Flexible Staff Deployment

Staff can be flexibly deployed to meet fluctuating demands and cover shortages effectively.

Joint Wellbeing Initiatives

Collaborative wellbeing programs support staff mental and physical health across multiple locations.

Standardised Protocols

Unified protocols and policies ensure consistent and high-quality care delivery across all sites.

Conclusion: Advancing Imaging Workforce Strength and Wellbeing

Workforce Development

Investing in training and professional growth builds a skilled and competent imaging workforce ready for future challenges.

Retention Strategies

Implementing effective retention strategies helps maintain experienced staff and reduces turnover in imaging services.

Prioritising Wellbeing

Focusing on mental and physical wellbeing creates a healthier, more resilient imaging workforce.

Leveraging Technology and Networks

Utilising advanced imaging technology and fostering resilient professional networks enhances service quality and workforce support.

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Knowledge Exchange Panel

Mr Chris Sleight MSc BSc FIBMS
Ex Diagnostics Leader within the NHS

Penny Storr
EMRAD Network Director

Dr Alistair Craig
Director of Clinical Strategy and Development
Northern Care Alliance NHS Foundation Trust

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Breakout Skill Clinic

Glenda Shaw
Quality Improvement Partner
Royal College of Radiologists & College of Radiographers

Quality Standard for Imaging (QSI) ©

A Practical Workshop on QSI Implementation- XR-208
staff wellbeing focus

Glenda Shaw
Quality Improvement Partners
RCR/CoR

Welcome

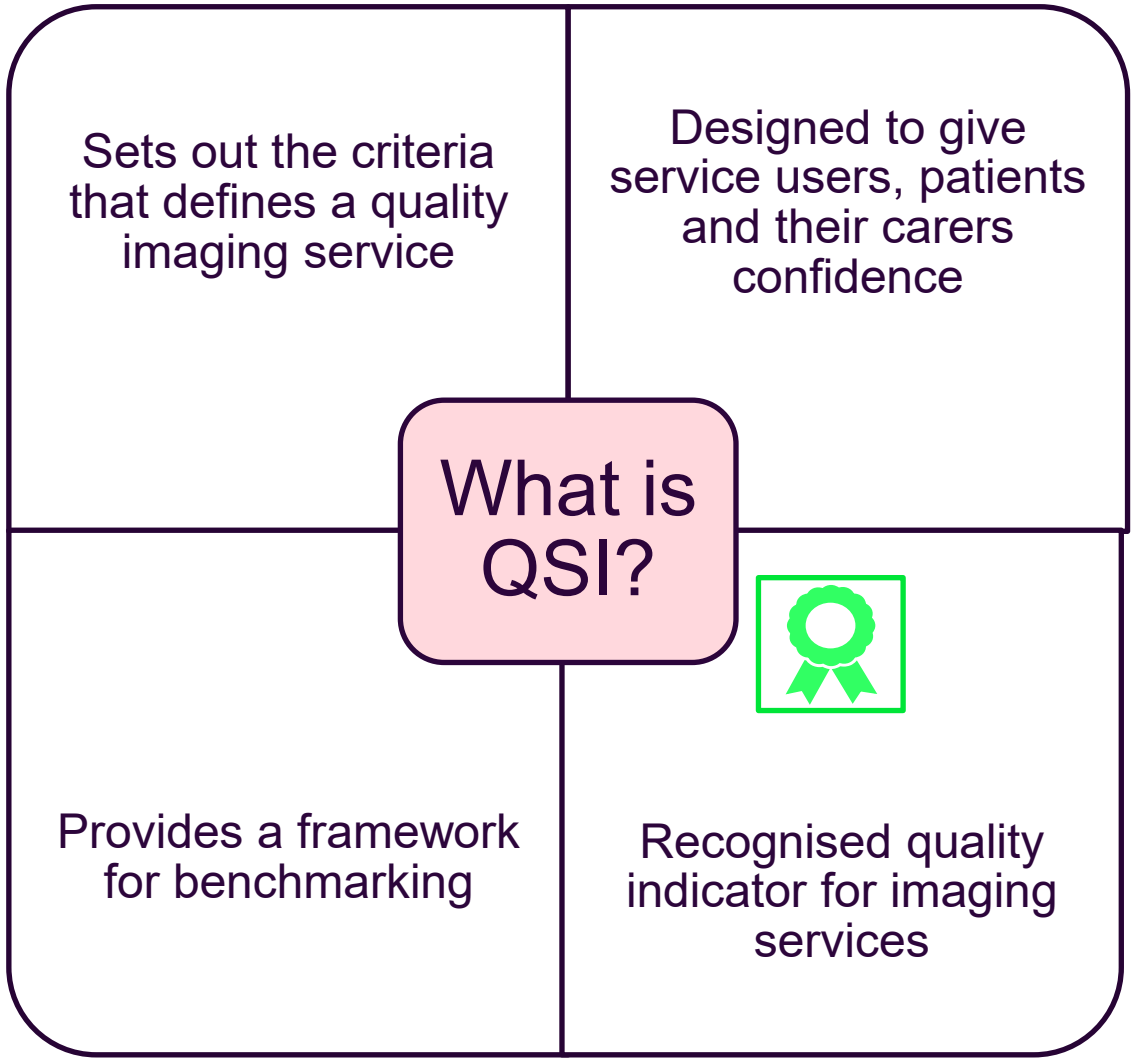

Quality
Standard
for Imaging
CoR
The Royal College of Radiologists
Setting the
a Unilabs company

Session Aims:

- Brief overview of QSI and Colleges Scheme
- Experience a deep dive into a specific QSI standard-look at the application of QSI in everyday practice
- Demonstrating staff wellbeing through identification of:
  - Meaningful evidence
  - Internal Assurances
  - Thinking about improvement
- Applying this method across the QSI

Welcome to QSI

[The QSI]



How QSI works

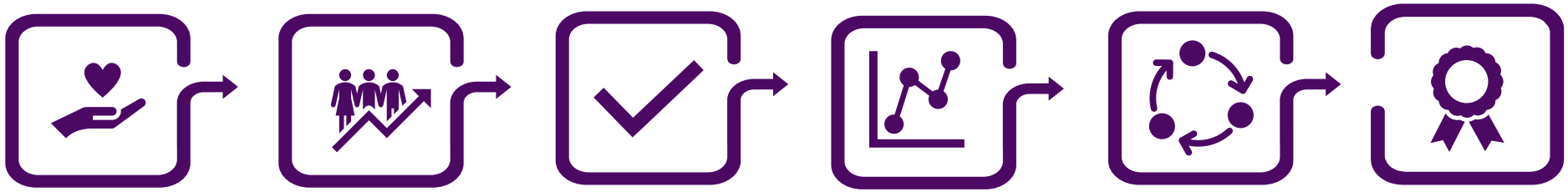
QSI Hub — Member support platform supporting imaging services with their QSI journey.

Working Towards — Awarded when a service demonstrates measurable progress.

Quality Mark Review — Formal peer led review, against the Quality Standard for Imaging.

QSI Quality Mark — Achieve the QSI Quality Mark and continue ongoing quality improvement

Why QSI matters



Improves patient safety

Enhances staff development

Provides insight into performance

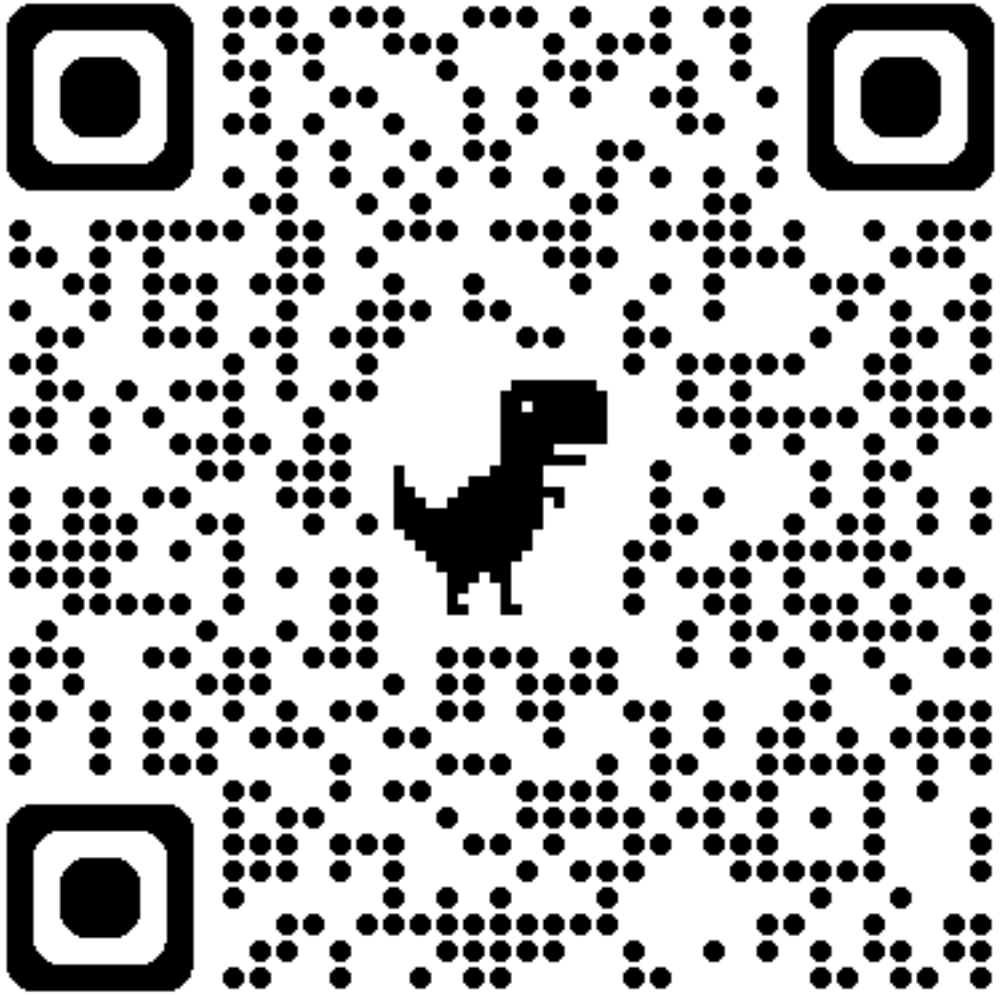
Drives continuous improvement

Boosts operational efficiency

Formal recognition through QSI Quality Mark

The Standards

The Quality Standard for Imaging



QSI Broken Down:

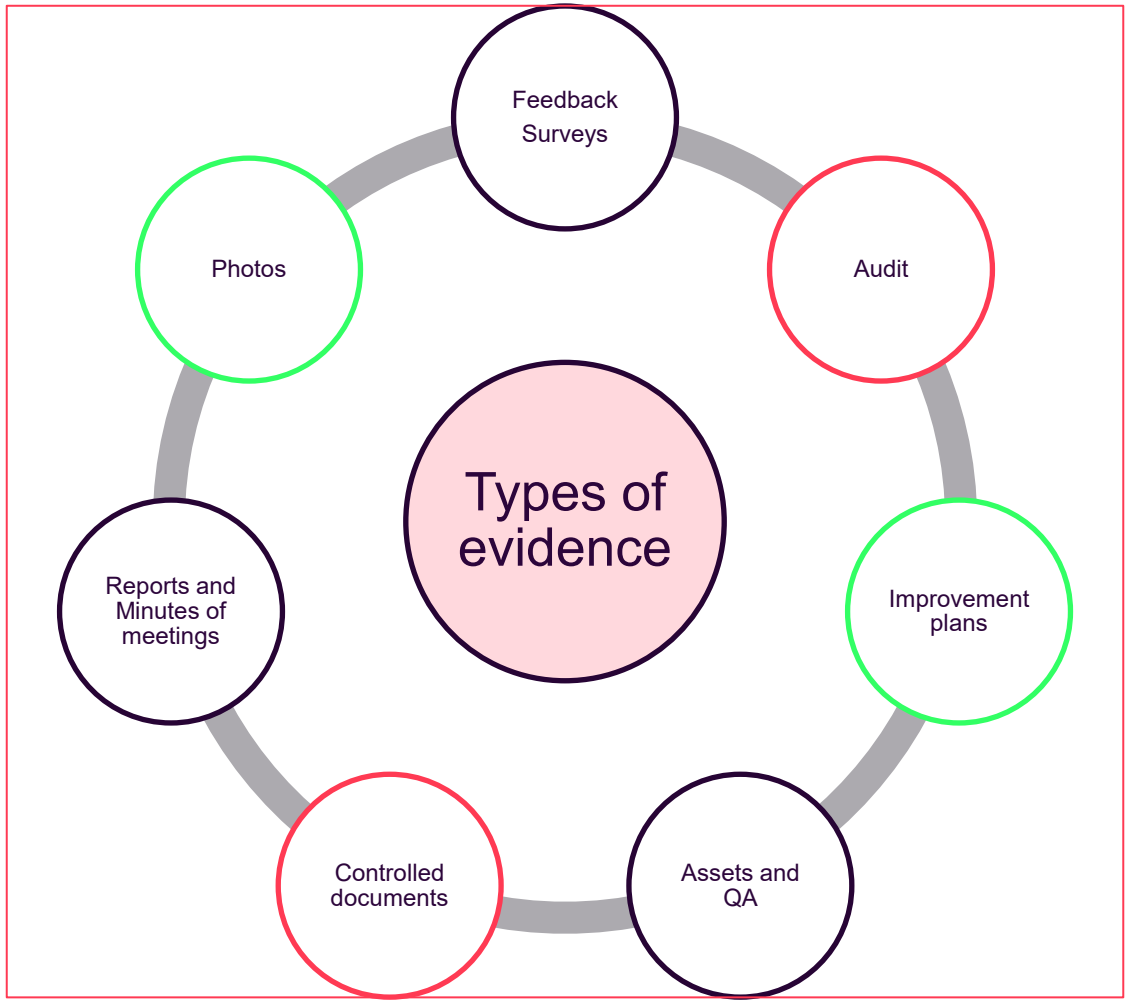
Quality Standard for Imaging

XR-1	XR-2	XR-3	XR-4	XR-5	XR-6	XR-7	8-Modality
• Ensures patients and carers receive sufficient information about imaging services, procedures, and aftercare. • Emphasises respect, privacy, dignity, and security for patients	• Focuses on staffing levels, skill mix, training, and support for staff wellbeing • Includes guidelines for the induction and competence of staff.	• Covers equipment management, quality control, and access to scientific and technical support	• Ensures facilities and equipment meet the needs of patients and comply with relevant standards	• Establishes protocols for referral management, consent, image optimisation, and safety in imaging procedures	• Defines operational policies, risk management, and service improvement plans	• Emphasises the importance of a quality management system, data collection, audit, and learning from feedback	• CT • MRI • Nuclear Medicine • Ultrasound • Interventional Radiology • Addresses unique aspects like safety, training, and clinical protocols.

Ref	Standard
XR-208	**Supporting Staff and Staff Wellbeing** **Quality statement** People employed by the service are supported in their work by the organisation and their colleagues. **Outcome measure** Staff employed within the service feel that they are supported at work. **Indicative inputs** • The service should have a range of measures in place, including (but not limited to): a. Pastoral care initiatives b. Ensuring staff are able to take regular rest/refreshment breaks with suitable facilities such as staff rooms c. A range of staff support programmes d. Access to work-based mental and physical health services e. Support systems in place following incidents and accidents f. A mentor system for new staff g. Support for homeworking and remote working h. Ensure inclusivity and reasonable adjustments considerations are in place. • There should be a programme of support for staff who report bullying or significant peer pressure. • There should be a staff development programme. • There should be regular one-to-one meetings, personal development plans and appraisals. • There should be regular feedback, including: a. Regular departmental surveys b. Organisational surveys c. A clear mechanism for staff to raise concerns (such as a freedom to speak up guardian). • There should be support for learning and professional development. • There should be regular team communications, including team meetings, interdisciplinary and other forms of communication eg staff newsletter, posters etc. • The service should monitor sickness levels and provide support for staff returning to work. • A review of the staff response to the outcome measure should be considered by the service management team. • There should be a policy on homeworking detailing where and when this is possible (see also XR-401).

Quality Standard for Imaging

Achieving the Quality Mark



Evidence

What exists (documents, processes, facilities)

Assurance

How you know it works (monitoring, feedback, actions, audits)

XR-208 Staff Wellbeing-page 26

Quality statement

- People employed by the service are supported in their work by the organisation and their colleagues

Outcome measure

- Staff employed within the service feel that they are supported at work
- Requires the service to think about pastoral care, rest breaks, mental and physical health access, and mentorship for new staff.
- Staff feedback channels, regular appraisals, one-to-one meetings, and staff development plans ensure continuous growth.
- Wellbeing is threaded throughout QSI- examples such as on-call rota and staffing numbers, identifying risks, working from home policies and health and safety.

1. Group Task 1- Evidence and Assurance

A:
List at least 3 indicators that staff feel supported in your service or workplace

What **EVIDENCE** does your service have that supports Staff wellbeing?

B:
What **ASSURANCES** are in place?

What is available now?
Think what peer reviewers would see if they came to your service
What evidence and assurances are missing?

Prompts

- Staffing Skills & training
- Psychological safety
- Fatigue management
- Communication Access to support
- Leadership behaviours
- Safety culture

Group Task 2- Improvement:

A:
Identify one area where your service is not fully meeting XR-208
What are the root causes of this gap?

B:
What could you try immediately?
What might work longer term?
What evidence would track your progress?
What would “excellent” look like in this area?

What quick wins could be implemented in 30–90 days?

What longer-term improvements would strengthen wellbeing?

- Identify the improvement
- Aim
- Who benefits
- What evidence this supports (linked to XR-208)
- How success will be measured- assurances tracked

Group Share Back/Discussion

TASK 1

- What evidence and assurances have you gathered against XR-208
- What gaps have you identified

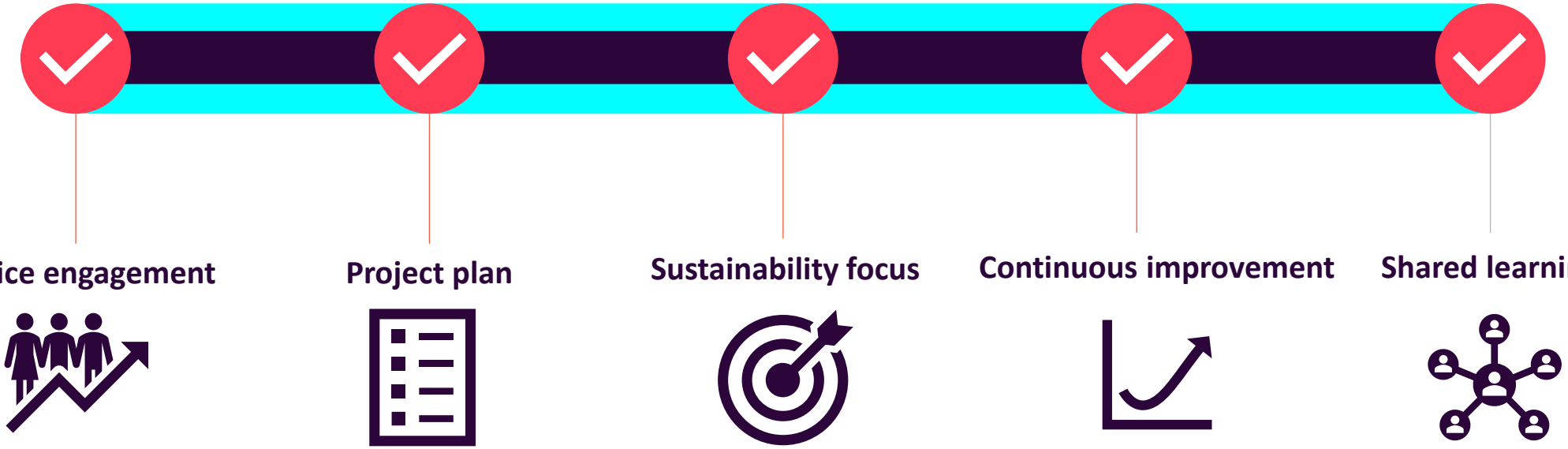
TASK 2

- Your proposed improvement ideas

Pursue excellence but not perfectionism

Key takeaways

Quality Standard for Imaging



Contacts & Joining Information

QSI support

QSI@rcr.ac.uk

https://youtu.be/ri-3iWZEtvI?si=4EPt_DTRAgX2VkYB

Radiology excellence: Navigating the Quality Standards for Imaging

Evidence

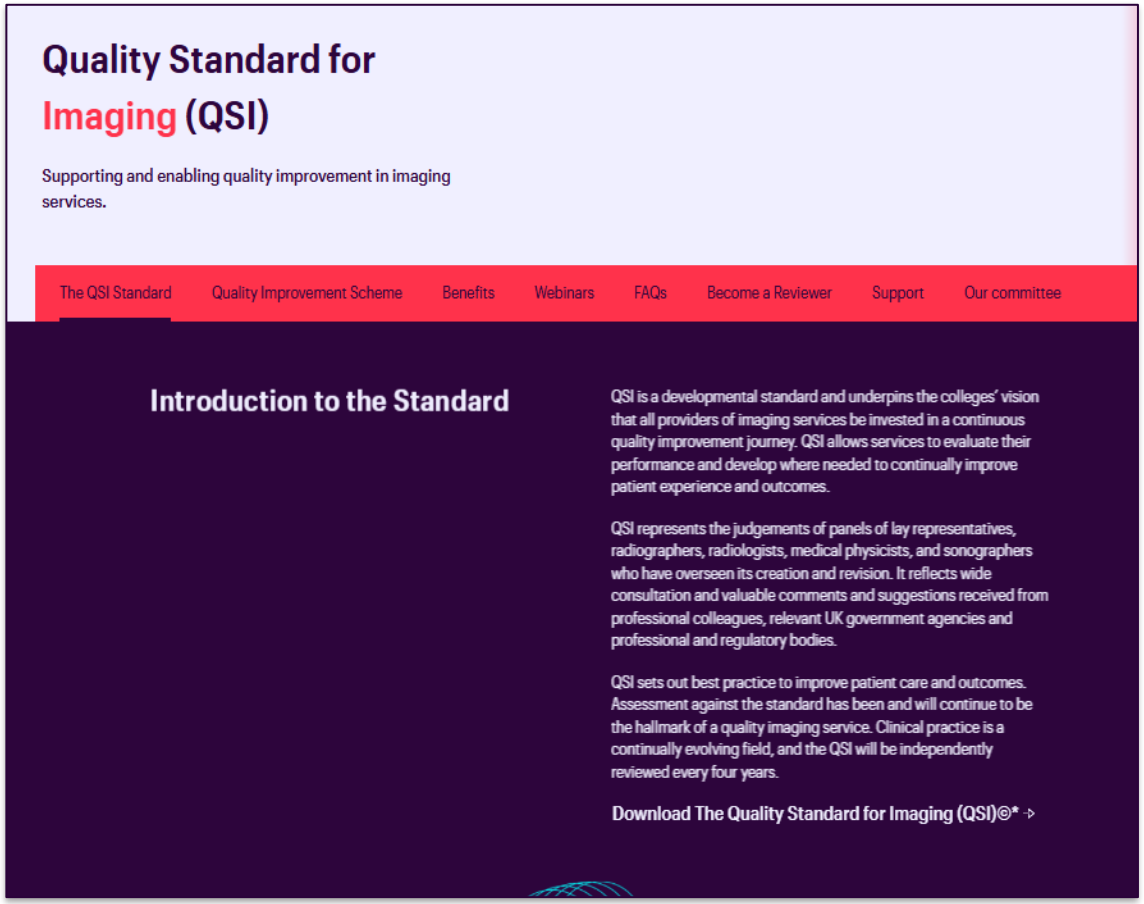
- Agile working policies across services
- Flexible working policies
- Stress management policies
- Appraisal process and effectiveness
- Wellbeing staff communications-minutes of meetings
- Feedback processes
- Pastoral contacts
- Rest facilities (on-site)

Assurances

- Minutes of meeting where staff wellbeing are discussed
- Checking training for V&A and escalating concerns
- Access to occupational health services- staff knowledge
- Staff surveys, feedback mechanisms, appraisal processes
- Freedom to speak up champions-contact posters
- Improvements because of staff feedback*, You Said…We Did*
- Audit of availability of well-being support

Download the Standards:

Quality Standard for Imaging



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Food, Drinks & Networking