

# Chapter 22 7-day diagnostic radiology

Emergency and acute medical care in over 16s: service delivery and organisation

*NICE guideline 94*

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Chapter 22 7-day diagnostic radiology

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## 22 7-day diagnostic radiology

### 22.1 Introduction

Diagnostic radiology plays a crucial role in the clinical assessment of patients with acute medical emergencies (AME); for example, a chest x-ray (CXR) can provide information in patients presenting with chest pain or shortness of breath that influences diagnosis and immediate management. More sophisticated radiological investigations such as computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound (US) and ventilation perfusion (V/Q) scans can also provide important information in patients with AME across a spectrum of presenting complaints. There are certain specific conditions (for example, pulmonary embolism, acute stroke, subarachnoid haemorrhage, cauda equina syndrome or thoracic dissection) that require urgent radiology (for example, CT or MRI) to determine the need for certain critical interventions (for example, thrombolysis, blood pressure control or surgery).

While it would seem inconceivable that access to basic radiology (for example, CXR) could be anything other than universal in a hospital setting, it remains unclear whether such access to all diagnostic radiological services is clinically or cost effective. There is a strategic drive in the United Kingdom NHS to provide a seven day service with the aspiration of equality of access to high quality medical care throughout the week. The provision of a 7-day diagnostic service has been identified by NHS England as being crucial to all elements of patient care<sup>22</sup> and the Royal College of Radiologists has produced standards for providing a 7-day service.<sup>30</sup> There is also existing NICE guidance on specific conditions that would require a 7-day diagnostic service to be present (for example, diagnosis of stroke, head injury and deep vein thrombosis).

Currently there is variable access to diagnostic radiology both in terms of time of the day, day of the week and geographical location, with larger centres tending to provide better access. Whilst plain radiology (for example, a CXR) is, as stated above, universally available in all EDs at all times of the day and days of the week, access to more sophisticated radiology (for example, CT, MRI, US) varies enormously by time of day, day of week and even geographical location. Specifically, for example, some EDs will have access to CT scanning during the day but not at night, or to US scanning during the week but not at weekend; geographical networks may be in place to allow access to certain investigations in certain places which are not available at others.

Given this lack of consistency in access to diagnostic radiology, the guideline committee aimed to address the question “does the provision of seven day diagnostic radiology in hospital improve patient outcomes?” in order to help inform the configuration of seven day services in the NHS.

### 22.2 Review question: Does the provision of 7 day diagnostic radiology in hospital improve patient outcomes?

For full details see review protocol in Appendix A.

**Table 1: PICO characteristics of review question**

<b>Population</b>	Adults and young people (16 years and over) with a suspected or confirmed AME in any part of hospital.
<b>Intervention</b>	24 hour access to diagnostic radiology. Strata: <ul style="list-style-type: none"> <li>• CT</li> <li>• MRI</li> <li>• Ultrasound</li> </ul>

	<ul style="list-style-type: none"> <li>• Nuclear medicine.</li> </ul>
<b>Comparisons</b>	<p>Reduced access to diagnostic radiology as defined by:</p> <ul style="list-style-type: none"> <li>• 7-day working (9am – 5pm)</li> <li>• 7-day extended working</li> <li>• 5-day working</li> <li>• 6-day working.</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Mortality (CRITICAL)</li> <li>• Avoidable adverse events (CRITICAL)</li> <li>• Quality of life (CRITICAL)</li> <li>• Patient and/or carer satisfaction (CRITICAL)</li> <li>• Length of stay (CRITICAL)</li> <li>• Time to definitive diagnosis (IMPORTANT)</li> <li>• Diagnostic turn around for result to healthcare professional (how long before get result) (IMPORTANT)</li> <li>• Staff satisfaction (IMPORTANT)</li> <li>• Representation (IMPORTANT)</li> </ul>
<b>Exclusion</b>	<ul style="list-style-type: none"> <li>• Not evaluating technology – service only</li> <li>• Interventional Radiology</li> <li>• Major Trauma Centres</li> </ul>
<b>Study design</b>	<p>Systematic reviews (SRs) of RCTs, RCTs, observational studies only to be included if no relevant SRs or RCTs are identified.</p>

## 22.3 Clinical evidence

No relevant clinical studies comparing 24 hour access to diagnostic radiology with reduced access to diagnostic radiology were identified.

## 22.4 Economic evidence

### Published literature

No relevant health economic studies were identified.

The economic article selection protocol and flow chart for the whole guideline can found in the guideline’s Appendix 41A and Appendix 41B.

In the absence of health economic evidence, unit costs were presented to the committee – see Chapter 41 Appendix I.

## 22.5 Evidence statements

### Clinical

- No relevant clinical studies were identified.

### Economic

- No relevant economic evaluations were identified.

## 22.6 Recommendations and link to evidence

<b>Recommendations</b>	-
<b>Research recommendations</b>	<b>RR12. What is the optimal configuration in terms of clinical and cost effectiveness of hospital diagnostic radiology services to support 7-day care of people presenting with medical emergencies?</b>
Relative values of different outcomes	<p>Mortality, quality of life, length of stay, avoidable adverse events and patient and/or carer satisfaction were considered by the committee to be critical outcomes.</p> <p>Interval between request and receipt of result or report by the requesting healthcare professional, time to definitive diagnosis, staff satisfaction and representation were considered to be important outcomes.</p>
Trade-off between benefits and harms	<p>The committee prioritised access to 7 day diagnostic CT, MRI, ultrasound and nuclear medicine. The committee identified plain film x-ray as an area where a 7-day service was routinely offered, and therefore they did not include this intervention within the evidence review as it would not change current practice. The provision of these services included 24/7, 7-day extended working, 7-day working (9am-5pm), 6-day working, and 5-day working. No evidence was identified for any combination of these.</p> <p>The committee considered the benefits of access to diagnostic radiology 7 days a week to be critical for many acute medical emergencies to ensure accurate diagnosis and timely and effective treatment. For example, immediate access to CT scans is essential for the investigation of suspected pulmonary embolism, intracranial haemorrhage and thoracic dissection. There are no anticipated harms in providing 7-day diagnostic radiology, if fully resourced. However, if shortages in radiology and radiography staff persist then there is potential for harm through spreading staff more thinly across the week or diverting them from other activities..</p> <p>The committee discussed the lack of evidence identified and opted to develop a research recommendation.</p>
Trade-off between net effects and costs	<p>No economic evidence was identified. Unit costs were presented to the committee (Chapter 41 Appendix I).</p> <p>No economic analysis could be conducted due to a lack of evidence on the benefits and harms. Increasing the provision and access to diagnostic radiology might require an increase in “up front” resources and therefore cost. This would include additional staff time and investment in radiology equipment and machinery where there is currently little provision. The current shortage of trained radiology and radiography staff means that the opportunity cost of expanding services is likely to be higher than that suggested by salary levels, since there is a need to recruit or train additional staff.</p> <p>Although the committee felt that it was likely to have a benefit and could potentially cause a decrease in length of stay, there was no evidence to show the cost impact or magnitude of benefit needed for the provision of a 7 day diagnostic service to be a cost-effective use of NHS resources.</p> <p>The committee decided that a recommendation could not be made due to a lack of evidence and therefore opted to form a research recommendation.</p>
Quality of evidence	No evidence was identified.
Other considerations	<p>Currently there are varying levels of access to different types of radiology. The most common radiological investigations used for AME are plain film chest x-rays and CT scans. All hospitals should have 24/7 access to the former and most will have 24/7 access to the latter, both of which are critical for many AME scenarios.</p> <p>Access to more sophisticated types of radiology (for example, MRI scans or nuclear</p>



<b>Recommendations</b>	-
<b>Research recommendations</b>	<b>RR12. What is the optimal configuration in terms of clinical and cost effectiveness of hospital diagnostic radiology services to support 7-day care of people presenting with medical emergencies?</b>
	<p>medicine) is currently much more limited, with larger centres more likely to provide these as a 7-day service.</p> <p>The committee noted that the provision of a 7-day diagnostic service has been identified by NHS England<sup>22</sup> as being crucial to all elements of patient care and that the Royal College of Radiologists has produced standards for providing a 7-day service.<sup>30</sup> Furthermore, there is existing NICE guidance on acute medical emergencies within specific medical conditions that would require a 7-day diagnostic service to be present. This includes guidance on:</p> <ul style="list-style-type: none"> <li>• The diagnosis of stroke, which recommends the use of brain imaging within the next available 'slot' and definitely within 1 hour, whichever is sooner.<sup>19</sup></li> <li>• The diagnosis of head injury in adults, which recommends a CT head scan within 1 hour of a high risk factor being identified.<sup>18</sup></li> <li>• The diagnosis of deep vein thrombosis, which recommends a proximal leg vein ultrasound within 1 hour in patients with a likely 2-level DVT Wells score, or within 24 hours coupled with interim 24 hour dose of a parenteral anticoagulant if ultrasound is unavailable.<sup>17</sup></li> </ul> <p>The committee considered that immediate access to CT is also needed for other acute medical emergencies, such as thoracic dissection or pulmonary embolus. Rather than recommend research into the effectiveness of 7 day diagnostic radiology compared to no such provision the committee wished to target the research recommendation towards examining what a service supporting 7 day care would be comprised of.</p> <p>NHS radiology services have already made significant moves towards a 7 day service in recent times particularly in terms of diagnostic radiology provision. The committee noted that access to 7-day radiology encompassed access to the equipment as well as access to a person specialised in interpreting the result. They noted that there were some diagnostic radiological investigations for which consultants in non-radiological specialities were sufficiently skilled to provide an interpretation, for example, plain film chest x-rays, whilst MRI and CT would require special expertise.</p> <p>Remote (tele-interpretation) reporting would be possible and could be cost-effective, for example, interpretation from overseas during the night. There are case studies on the NHS England 7 day services website of centres providing 7 day imaging services for CT, MRI and ultrasound including some elective outpatient work at weekends. However, there would be occasions where direct interaction between clinician and radiologist would be needed and could provide added value.</p> <p>There is growing interest in computer-aided detection and diagnosis from radiological images. Were this approach to demonstrate an accuracy comparable to that of an expert radiologist, the potential impact on service delivery should also be evaluated.</p> <p>Interventional radiology is a more complex service to provide. The Royal College of Radiology (RCR)<sup>30</sup> has provided guidance in the document produced by the Academy of Medical Royal Colleges on acute interventional radiology services. It is not possible, practical or affordable to offer such high-level services on all hospital sites. Networks or hub-and-spoke solutions may provide the services that are needed. Both require the movement of potentially acutely unwell patients. The interventional radiologist workforce would need to grow to provide this service throughout England.</p> <p>The Royal College of Radiology has already issued standards and guidance for</p>

<b>Recommendations</b>	-
<b>Research recommendations</b>	<b>RR12. What is the optimal configuration in terms of clinical and cost effectiveness of hospital diagnostic radiology services to support 7-day care of people presenting with medical emergencies?</b>
	<p>delivering services:</p> <ul style="list-style-type: none"> <li>• Standards for providing a 24 hour diagnostic radiology service.<sup>29</sup></li> <li>• Standards for providing a 24 hour interventional radiology service.<sup>28</sup></li> <li>• Seven-day consultant present care implementation considerations.<sup>1</sup></li> </ul> <p>The committee were aware that the provision of a 7-day radiological service may have a substantial cost implication. Therefore, they considered it to be important that any research into the components listed above be conducted with an analysis of cost-effectiveness.</p> <p>The committee were aware of reports from the National Imaging Clinical Advisory Group<sup>20</sup> and Scottish Clinical Imaging Network<sup>27</sup> on 7 day working in imaging that are available.</p>

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## Appendices

### Appendix A: Review protocol

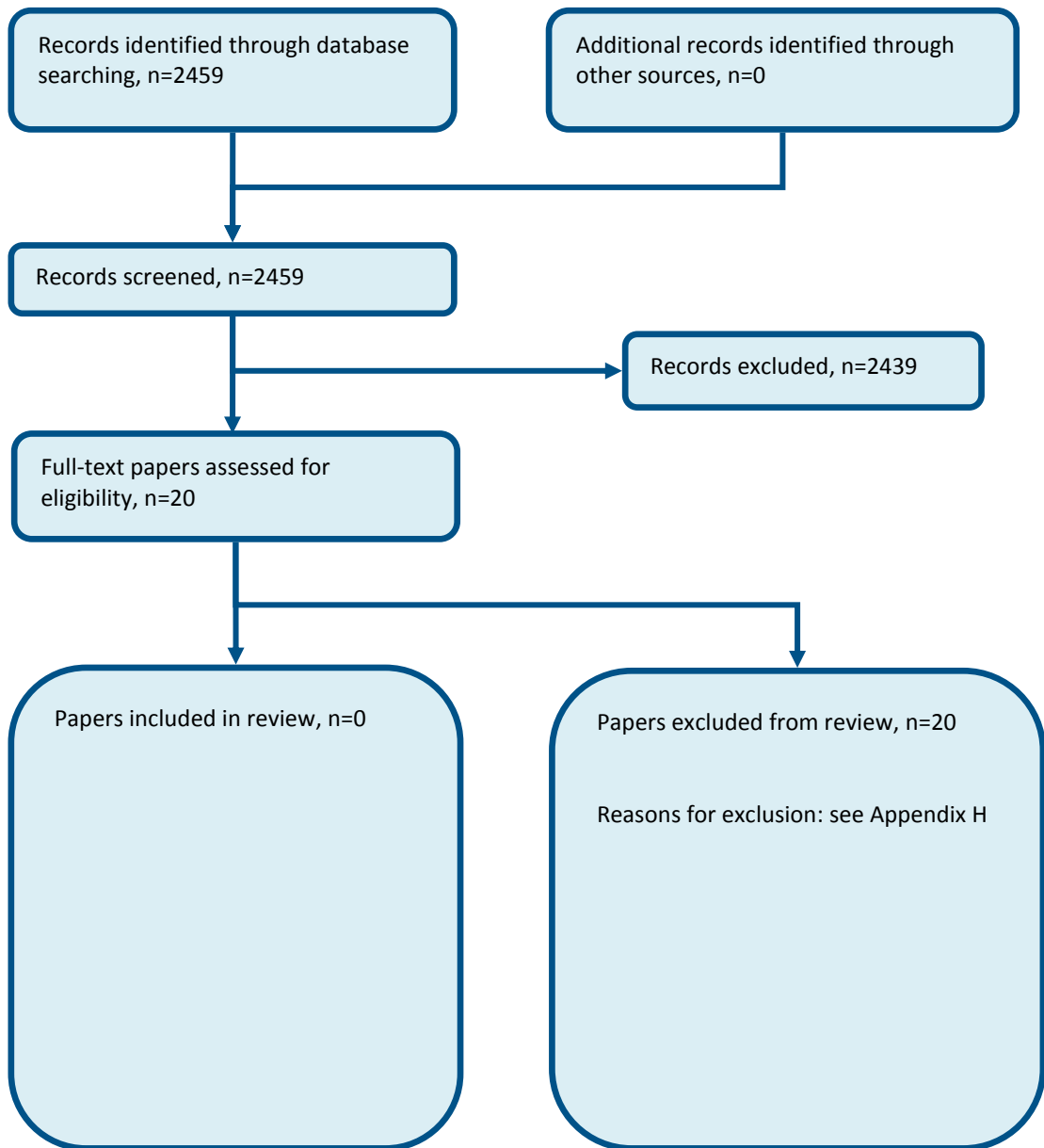
**Table 2: Review protocol: Does the provision of 7 day diagnostic radiology in hospital improve patient outcomes?**

Review question	7 day diagnostic radiology
Guideline condition and its definition	AME. Definition: people with suspected or confirmed acute medical emergencies.
Objectives	To determine if the increase access to investigations, diagnostics and interventions in ED & AMU improves outcomes.
Review population	Adults and young people (16 years and over) admitted to hospital with a suspected or confirmed AME.
	Line of therapy not an inclusion criterion.
Interventions and comparators: generic/class; specific/drug  (All interventions will be compared with each other, unless otherwise stated)	24 hour access to diagnostic radiology. Reduced access to diagnostic radiology; 7-day extended working. Reduced access to diagnostic radiology; 7-day working (9am – 5pm). Reduced access to diagnostic radiology; 6-day working. Reduced access to diagnostic radiology; 5-day working.
Outcomes	<ul style="list-style-type: none"> <li>- Mortality during the study period (Dichotomous) CRITICAL</li> <li>- Avoidable adverse events during the study period (Dichotomous) CRITICAL</li> <li>- Quality of life during the study period (Continuous) CRITICAL</li> <li>- Patient satisfaction during the study period (Dichotomous) CRITICAL</li> <li>- Length of hospital stay during the study period (Continuous) CRITICAL</li> <li>- Time to definitive diagnosis during the study period (Continuous) IMPORTANT</li> <li>- Diagnostic turn around for result to healthcare professional during the study period (Continuous) IMPORTANT</li> <li>- Staff satisfaction during the study period (Dichotomous) IMPORTANT</li> <li>- Representation up to 30 days during the study period (Dichotomous) IMPORTANT</li> </ul>
Study design	Systematic Review RCT Quasi-RCT Non-randomised comparative study Prospective cohort study Retrospective cohort study Case control study Controlled before and after study Before and after study Non randomised study
Unit of randomisation	Patient. Ward. Hospital.
Crossover study	Permitted.
Minimum duration of study	Not defined.
Other exclusions	Studies from non-OECD countries.

Review question	7 day diagnostic radiology
	Technological evaluation. Interventional radiology. Major trauma centres.
Population stratification	CT. MRI. Ultrasound. Nuclear medicine.
Reasons for stratification	It is known that the stratified diagnostic radiology services have different utilisation and associated costs which will impact on the effectiveness of providing a 24-hour service.
Subgroup analyses if there is heterogeneity	<ul style="list-style-type: none"> <li>- Frail elderly (frail elderly; overall); different population.</li> <li>- Clinical condition (Stroke; Pulmonary emboli; Intracranial bleeds; Head Injury; Spinal cord compression or cauda-equina; GI bleeds); Different populations</li> <li>- Reporting physician (Results reported by radiographer/radiologist; Results reported by clinician); Variation in practice.</li> </ul>
Search criteria	Databases: Medline, Embase, the Cochrane Library. Date limits for search: after 1990. Language: English only.

## Appendix B: Clinical study selection

Figure 1: Flow chart of clinical study selection for the review of 7 day diagnostic radiology





## **Appendix C: Forest plots**

No evidence to be included.

## **Appendix D: Clinical evidence tables**

No evidence to be included.

## **Appendix E: Health economic evidence tables**

No relevant health economic studies were identified.

## **Appendix F: GRADE tables**

No evidence to be included.

## Appendix G: Excluded clinical studies

**Table 3: Studies excluded from the clinical review**

Study	Exclusion reason
Al wattar 2014 <sup>2</sup>	Inappropriate comparison. No comparator
Arnaoutakis 2010 <sup>3</sup>	No outcomes of interest
Berner 2003 <sup>4</sup>	Incorrect interventions. Presence of an 'opinion leader'
Burton 2016 <sup>5</sup>	No relevant outcomes
Campbell 2014 <sup>6</sup>	Incorrect interventions. Multivariate analysis with no analysis on radiology access
Carlos 2009 <sup>7</sup>	Editorial
Chana 2016 <sup>8</sup>	Systematic review
Cubeddu 2013 <sup>9</sup>	Incorrect interventions. On-hours versus off-hours
Ebinger 2012 <sup>10</sup>	Incorrect interventions. Access to mobile ambulance-based CT scanner
Hardy 2013 <sup>11</sup>	Incorrect interventions. Immediate versus delayed reporting of radiology results
Jamal 2014 <sup>12</sup>	Study design: diagnostic accuracy
Khoo 2007 <sup>13</sup>	Study design: diagnostic accuracy
Langan 2002 <sup>14</sup>	Inappropriate comparison. Comparison group had 24 hour radiology access
Miller 2012 <sup>15</sup>	Technological evaluation
Moss 1992 <sup>16</sup>	Study design: survey
Ng 2002 <sup>21</sup>	Incorrect interventions. Early versus late CT scan
Notghi 1997 <sup>23</sup>	Incorrect interventions. Retrospective theoretical intervention
Power 2007 <sup>24</sup>	Incorrect interventions. Service reorganisation did not include change in radiology access
Raja 2012 <sup>25</sup>	Inappropriate comparison. Comparison had 24 hour radiology access

Redd 2015<sup>26</sup>

Inappropriate comparison. Comparison had 24 hour radiology access

## **Appendix H: Excluded health economic studies**

No health economic studies were excluded.