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Rapid Diagnosis Clinic

Programme evaluation

Wales Cancer Network

Final report

December 2023

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Project details and acknowledgements

Title	All-Wales Rapid Diagnosis Clinic Programme evaluation
Client	Wales Cancer Network
Project number	23002
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M.E.L Research would like to thank the national programme team for all their help in delivering this evaluation. Additional thanks go to all the Health Boards, delivery staff and service users that provided feedback on their experiences.

This project has been delivered to ISO 9001:2015, 20252:2019 and 27001:2013 standards.

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Glossary

Abbreviations	Definition
ACE Programme	Accelerate, Coordinate, Evaluate Programme
ANP	Advanced Nurse Practitioner
AOS	Acute Oncology Service
CDH / CDC	Community Diagnostic Hub or Centre
CNB	Cancer Network Board
CNS	Clinical Nurse Specialist
CPD	Continuing Professional Development
CRUK	Cancer Research UK
CSG	Cancer Site Group
CT scan	Computerised Tomography scan
DHCW	Digital Health and Care Wales
FIT	Faecal Immunochemical Test
HEIW	Health Education and Improvement Wales
HCSW	Healthcare Support Worker
LMC	Local medical committee
MDC	Multi-disciplinary Diagnostic Clinic
MDT	Multi-disciplinary Team meeting
MUO	Malignancy of Unknown Origin
NDR	National Data Resource
NICE	National Institute for Health and Care Excellence
NOP	National Optimal Pathway
PPV	Positive Predictive Value
PREM / PROM	Patient Reported Experience Measure / Patient Reported Outcome Measure
RDC	Rapid Diagnosis Clinic
SMT	Senior Management Team
SPM	Senior Project Manager
UHB/ HB	University Health Board / Health Board
USC	Urgent Suspected Cancer
WCN	Wales Cancer Network
WG	Welsh Government

Executive summary

RAPID DIAGNOSIS CLINICS

EVALUATION FINDINGS AT A GLANCE 2020-2023

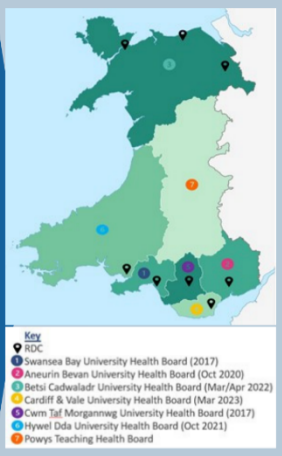
GIG CYMRU NHS WALES | Rhwydwaith Canser Cancer Network

OVERVIEW

A large proportion of people have vague symptoms that don't immediately suggest cancer in a particular tumour site, so often have several referrals from GPs for tests and investigations, sometimes going down inappropriate cancer pathways.

Rapid Diagnosis Clinics (RDCs) offer a single point of access to a diagnostic pathway for all patients with serious vague symptoms that could represent cancer. The RDCs aim to offer a holistic, personalised, accurate and rapid diagnosis of patients' symptoms.

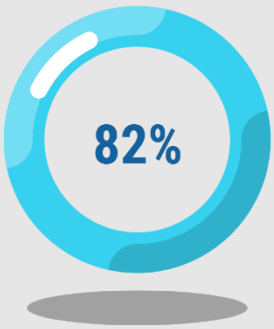
The all-Wales national RDC programme started in December 2020. It was funded and overseen by the Wales Cancer Network (WCN) in collaboration with all Welsh Health Boards and other national bodies including Digital Health and Care Wales, Improvement Cymru etc.



In 2023, RDCs in partnership with the Wales Cancer Network won an NHS Wales Award for providing services in partnership across NHS Wales.

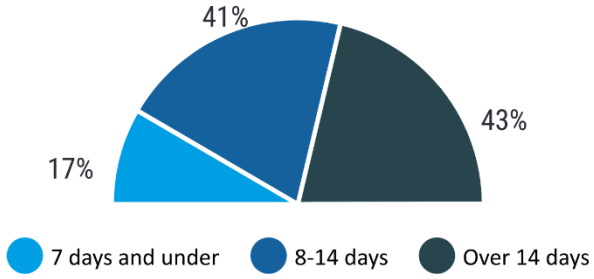
KEY FINDINGS

referrals in 2022/23



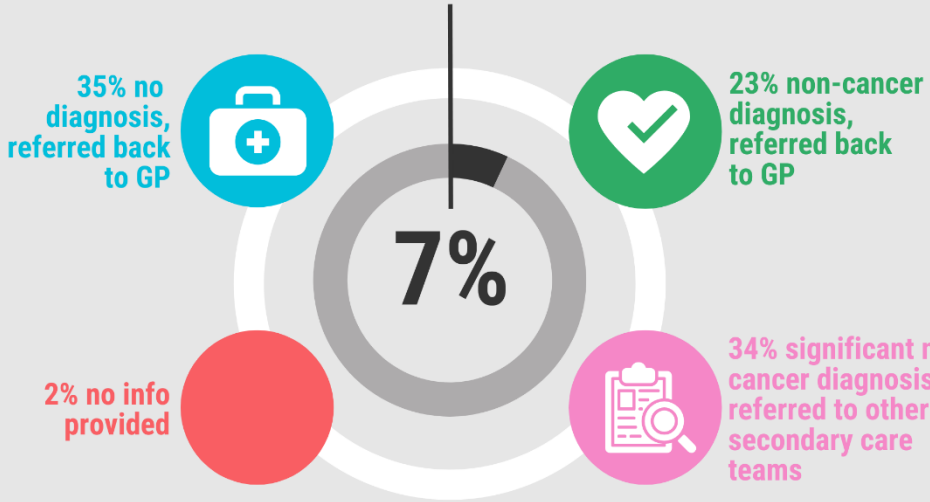
accepted by RDCs

PERCENTAGE OF PATIENTS SEEN WITHIN



Period: 22/23 Q1 – 23/24 Q1. Figures add up to more than 100% due to rounding issue.

Cancer conversion rate



Period: 22/23 Q1 – 23/24 Q1. Figures add up to more than 100% due to rounding issue.

PROPORTION (OF ACCEPTED REFERRALS) OF PATIENTS WHO WERE UNABLE TO ATTEND AT ANY POINT

RDCs	All Wales
4.1%	7.7%

Period: 22/23 Q1 – 23/24 Q1, compared to the 2018/19 DNA (did not attend) rate in outpatient services across Wales

"The process and care was fantastic and the speed of diagnosis took away all stress and fear that is associated when you are concerned that cancer is going to be diagnosed." - Patient

KEY SUCCESSES

Six Health Boards have implemented an RDC service for their local population. Agreements are in place for patients from Powys to be referred to RDCs operated by neighbouring Health Boards.

A high level of job satisfaction reported by RDC staff

Improved communication and understanding between primary and secondary care

Increased awareness of RDC and improved working relationship between the RDC team and other secondary care teams

Improved collaboration and networking between Health Boards and between the RDC teams

Proved that the nationally directed but locally delivered model can work effectively to implement an all-Wales programme

"RDC has demonstrated that patient care and services can be standardised to a certain extent between the Health Boards. It's an example of how collaboration can work when people are open to it." - GP Clinical Lead

KEY CHALLENGES

Inconsistent quality of referrals which require continuous communication and education for GPs

Serving an increasing patient cohort with existing limited resource which can impact on achieving the national 7-day target

Uncertainty over or difficulty in securing funding to expand current service

Inconsistent data inputs from Health Boards to feed into the national dashboard to help assess the equity of RDC service across Wales

FUTURE CONSIDERATIONS

Considering mainstreaming the service or opportunities to develop Community Diagnostic Hubs incorporating RDCs to improve the sustainability of the service

More publicity and educational events with GPs about RDCs, especially face-to-face engagement, to improve quality of referrals

Reviewing the objectives and key audience of the national dashboard to suit future evaluation needs.

Collecting socio-demographic info of patients across systems to help monitor and maintain equity and quality of the service.

WCN to continue to facilitate forums and meetings to enable cross-pollination and networking amongst RDC staff

Evaluated and produced by m·e·l research

About the Rapid Diagnosis Clinic Programme

Background and purpose of national programme

It is estimated that in the UK, 50% of patients with cancer do not present with the red flags required for referral to a site-specific suspected cancer pathway.[1] They would often have several referrals from GPs for tests and investigations, sometimes going down multiple cancer pathways. This can take time, feel disjointed and can be an extremely anxious time for patients.

To address this, Rapid Diagnosis Clinics (RDCs) offer a single point of access to a diagnostic pathway for all patients with serious vague symptoms that could represent cancer. By integrating existing diagnostic provision and using networked clinical expertise and information locally, the RDCs offer a holistic, personalised, accurate and rapid diagnosis of patients' symptoms.[2]

Following a learning visit to see the Danish model, the RDC pilots were set up in Swansea Bay and Cwm Tâf Morgannwg University Health Boards (UHBs) from 2017.[3] These demonstrated that RDCs are a cost-effective solution for improving outcomes for patients presenting with vague, non-specific, but concerning symptoms.[4] The evaluation by Swansea University demonstrated that the RDCs align with the Single Cancer Pathway ambitions by providing a single point of access to diagnostics and drastically reduced the time from referral to diagnosis - from a mean of 84 days in comparator group to 6 days in the RDC. The evaluation also found that the RDC is more cost effective compared to standard patient pathway if at least 4 patients are seen per half-day clinic. Furthermore, the RDCs support the ambition of a *Healthier Wales* by ensuring that the vague symptoms pathway is designed to identify the cause of the patients' symptoms, whether cancer related or otherwise. Overall, the RDCs were deemed a worthwhile public health investment for the population of Wales.

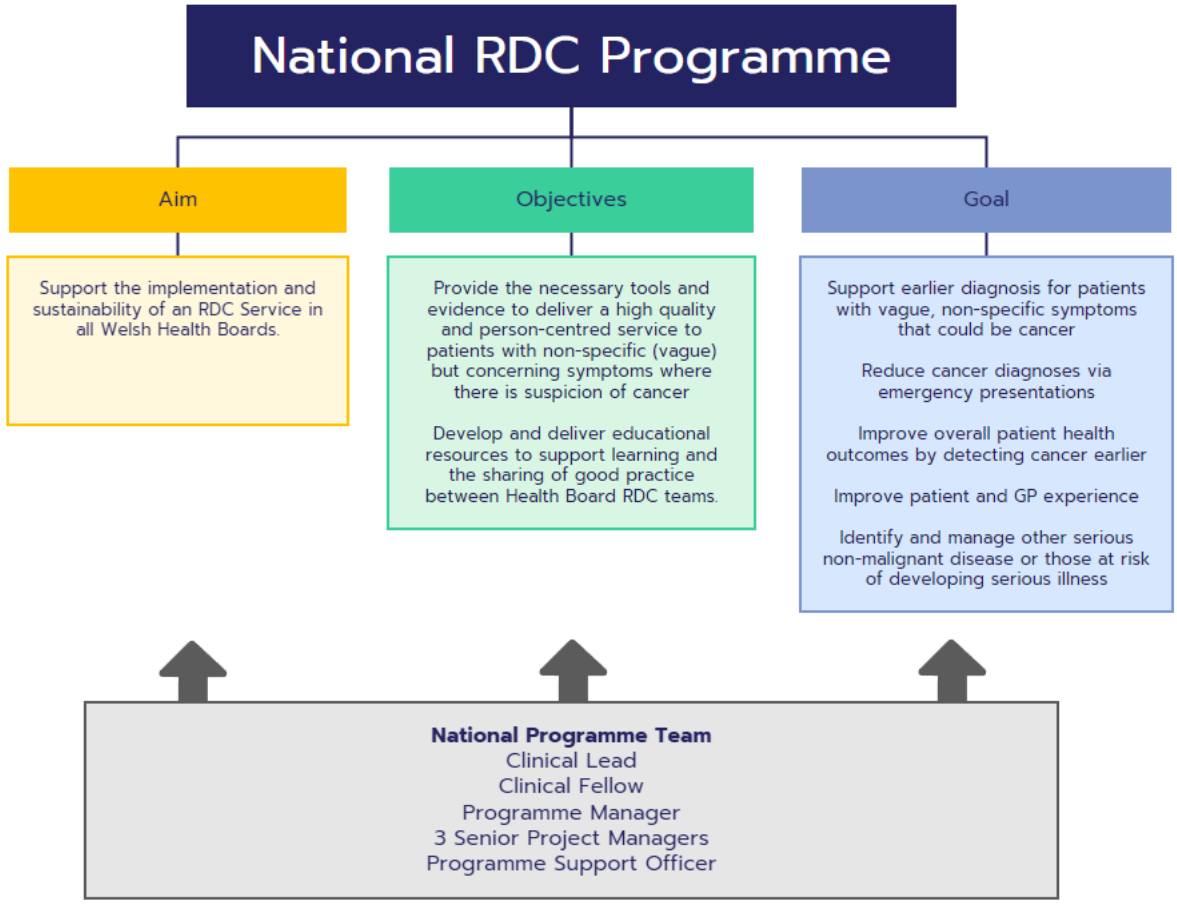
A national RDC programme was therefore created to set the national standards and specifications for service delivery but tailoring the approach by taking account of the local context of each of the seven health boards. The Vague Symptoms National Optimal Pathway[5] gives GPs direct rapid access to their

1 Neal RD, Din NU, Hamilton W, et al. Comparison of cancer diagnostic intervals before and after implementation of NICE guidelines: analysis of data from the UK General Practice Research Database. Br J Cancer. 2014;110(3):584–592.
2 Wales Cancer Network (September 2022). Rapid Diagnosis Clinics: A National Programme for Wales. Available at https://collaborative.nhs.wales/networks/wales-cancer-network/workstreams/rapid-diagnosis-clinics-programme/
3 Vedsted, P. and Olesen, F., 2015. A differentiated approach to referrals from general practice to support early cancer diagnosis–the Danish three-legged strategy. British journal of cancer, 112(1), pp.S65-S69
4 Sewell, B., Jones, M., Gray, H., Wilkes, H., Lloyd-Bennett, C., Beddow, K., Bevan, M. and Fitzsimmons, D., 2020. Rapid cancer diagnosis for patients with vague symptoms: a cost-effectiveness study. British Journal of General Practice, 70(692), pp.e186-e192
5 Welsh Government. (2022). Welsh Health Circular 021: National Optimal Pathways for Cancer (2022 update). Available at: Microsoft Word - Welsh Health Circular - National Pathways 2022 (gov.wales)

local RDC if they suspect a patient might have cancer but does not present with red flag signs and symptoms that fit the National Institute for Health and Care Excellence (NICE) criteria for urgent referral.[6] This national programme, started in December 2020, was funded and overseen by the Wales Cancer Network (WCN) in collaboration with all Welsh Health Boards and other national bodies including Digital Health and Care Wales, Improvement Cymru etc. Figure 1 below lays out the aims and objectives of the national programme and the roles required within the national programme team.[7]

The national programme logic model can be found in Appendix A.

Figure 1. National RDC Programme aim, objectives and goals

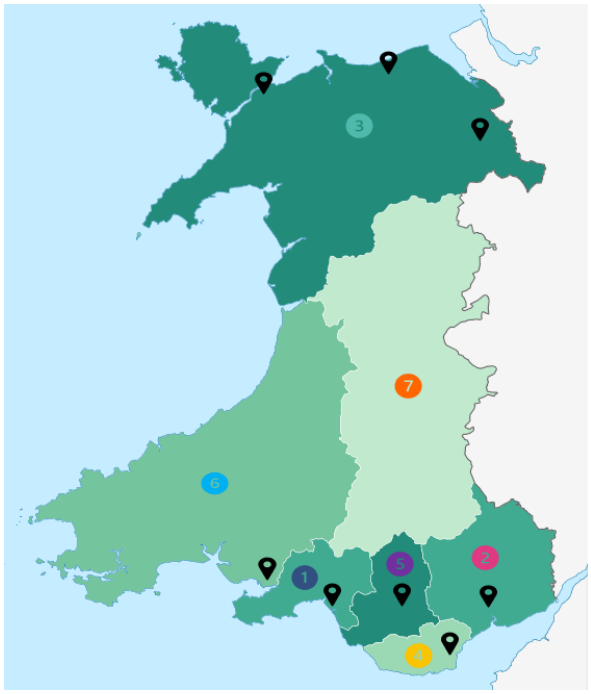


6 National Institute for Health and Care Excellence (2021) Suspected Cancer: Recognition and Referral. https://www.nice.org.uk/guidance/ng12

7 The national programme team consisted of 1 Clinical Lead (0.2 WTE), 1 Clinical Fellow (1 WTE x 12 months), 1 Programme Manager (0.8 WTE increased to 1 WTE), 3 Senior Project Managers (0.6 WTE x 18 months) and 1 Programme Support Officer (0.8 WTE x 10 months then decreased to 0.2 WTE)

An overview of the RDCs

Currently six Health Boards have implemented an RDC service for their local population. Table 1 overleaf gives a quick overview of the Health Boards and the RDC model they are operating on.



Source: Wales Cancer Network

Table 1. Overview of the RDCs

Health Board	Population[8]	GP practices	Start date	RDC Model	RDC core workforce
Aneurin Bevan UHB	588,000	90	Oct 2020 Service paused between June and November 2022	• Location: Grange University Hospital • 2-stop model • 1 clinic per week (morning and afternoon) • # Clinic Slots - 20	• GP / Consultant Physician • Radiologist • Clinical Nurse Specialist (CNS) • Radiology nurse • Clinic Co-ordinator • Clinical Lead
Betsi Cadwaladr UHB	687,000	119	• Mar 2022 - Glan Clwyd and Wrexham • Apr 2022 - Bangor	• Location: Gwynedd Hospital, Glan Clwyd Hospital and Wrexham Maelor Hospital[9] • 1-stop model • 3 clinics per week • # Clinic Slots – 5 in each site, 15 total	• GP / Consultant Physician • Radiologist • CNS x3 • Clinic Co-ordinator x3 • Healthcare support worker (HCSW) x3 • Clinical Lead (x1 who covers all three sites)
Cardiff and Vale UHB	492,000	55	April 2023	• Location: University Hospital of Wales • 2-stop model • 2 clinics per week • # Clinic Slots - 10	• GP / Consultant Physician • Radiologist • CNS • Clinic Co-ordinator • HCSW • Clinical Lead
Cwm Tâf Morgannwg UHB	442,000	67	Sep 2017 (Patients in Bridgend are currently referred to RDC in Swansea Bay UHB)	• Location: Rhondda Valley Hospital[10] (CT scans at Royal Glamorgan Hospital) • Hybrid model • 2 clinics per week • # Clinic Slots – 30	• Consultant Physician • Radiologist • Advanced Nurse Practitioner (ANP) • Clinic Co-ordinator x 2 • HCSW • Clinical Lead

8 Source: StatsWales mid-year population estimates by Health Boards
9 Wrexham Maelor Hospital also accepts referrals from North and mid-Powys.
10 Current RDC referral pathway for Bridgend patients is to the RDC in Swansea Bay UHB.

Health Board	Population	GP practices	Start date	RDC Model	RDC core workforce
Hywel Dda UHB	383,000	55	Oct 2021	• Location: Prince Philip Hospital • 1-stop model • 1 clinic a week • # Clinic Slots - 5	• GP / Consultant Physician • Radiologist • CNS • Clinic Co-ordinator • HCSW • Clinical Lead
Swansea Bay UHB	380,000	58	Jul 2017	• Location: Neath Port Talbot Hospital • 1-stop model • 2 clinics per week (have been adding two additional monthly clinics to meet demand) • # Clinic Slots – 5-6 (12 total)	• GP / Consultant Physician • Radiologist • CNS / ANP • Clinic Co-ordinator • HCSW • Clinical Lead

Powys Teaching Health Board	134,000	16	• March 2021 - South Powys (excluding Ystradgynlais)
			• March 2022 – North Powys
			• April 2022 - Ystradgynlais cluster (South Powys)
				• Powys GPs can refer patients to RDC in surrounding UHBs:
				  ○ North Powys -> Betsi Cadwaladr UHB
				  ○ Mid-Powys -> agreement being put in place to refer patients to Betsi Cadwaladr UHB
				  ○ South Powys (excluding Ystradgynlais) -> Aneurin Bevan UHB
				  ○ Ystradgynlais cluster -> Swansea Bay UHB
				• Cancer Research Wales funding to explore rural RDC model	

Evaluation approach

Evaluation purpose and objectives

To support the WCN in assessing the implementation and impact of the national RDC programme, M·E·L Research were commissioned to carry out an independent evaluation. The evaluation looked to explore the following:

- **understanding the impact** of the RDC programme on patients, primary care staff, secondary care staff and wider Health Board services
- assessing whether the RDC programme represents added value for NHS Wales
- **learning and improving** from experience, therefore, to share learning and best practice

To address the evaluation aims, a set of research questions were developed:

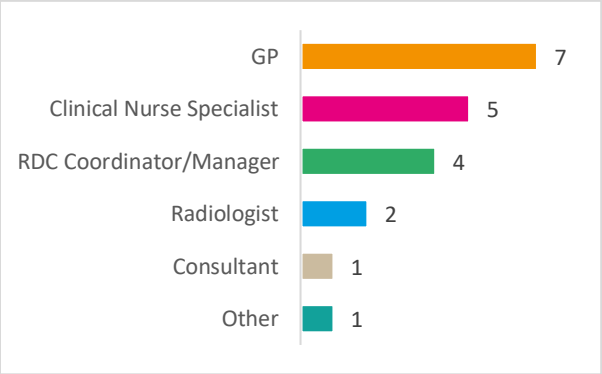
Evaluation aim	Research Questions
What was the impact of the RDC programme on patients, primary care staff, secondary care staff and wider Health Board services?	1. *Were short- and medium-term outcomes met? If not, why and what can we learn from that?* 2. *How does the achievement of outcomes compare across the key stakeholder groups: patients, primary care staff, secondary care staff and health boards?* 3. *Were there any unintended outcomes, positive or negative? Why?* 4. *What was the value of a nationally directed but locally delivered model?* 5. *Was there any demographical and geographical variation in inputs, outputs and outcomes? What could be learned from these?*
Did the RDC programme represent added value for NHS Wales?	6. *What efficiencies do RDCs offer compared to the alternatives?* 7. *What was the added value of the programme?*
What was the wider learning of the programme?	8. *How well did the programme work? What could have been done better?* 9. *How has this collaborative approach facilitated change?* 10. *What does the future look like for RDCs?*

Evaluation activities

RDC staff feedback form:

An online feedback form was designed to gather stakeholders' views on RDC progress to date, key challenges and learning of the RDC implementation, and their feedback on the national programme. The form was anonymous in nature unless the respondents consented to provide their contact details for a follow-up interview.

Figure 2: Feedback form returned by job role



The form was circulated by the WCN RDC programme team to 46 stakeholders who have been involved in the implementation and/or delivery of their local RDC. It was also promoted in the RDC meetings, RDC Nurse Forum, RDC Coordinators Forum and the Vague Symptoms Cancer Site Group (CSG) meetings, plus email reminders sent by the WCN RDC programme team.

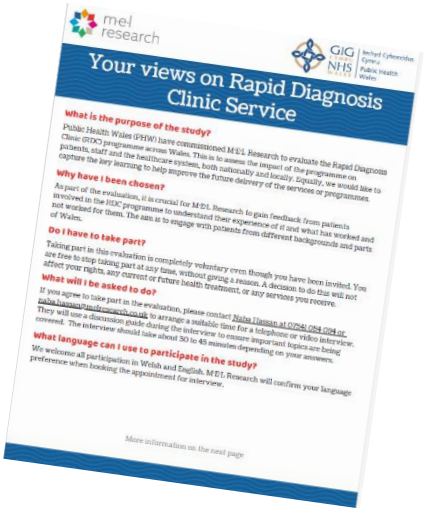
20 people in total replied, resulting in an overall response rate of 43%. 8 out of those also agreed to be interviewed.

RDC staff in-depth interviews

Staff who are/were involved in the implementation and/or delivery of their local RDC were also invited to take part in an interview to explore further the outcomes, impact, added value and wider lessons of the national RDC programme. A discussion guide was used to ensure all key topics were covered during the interview. In total, 22 staff members took part in this activity.

Patient in-depth interviews

Patients attending the clinic were provided with an information sheet setting out details of the evaluation, what it would involve, how they could provide feedback, the importance of the research and how personal data would be processed and managed. A Welsh version was also made available. Patients who wished to provide feedback on their experiences could contact M·E·L Research directly to arrange an interview session. The approach aimed to minimise the


Your views on Rapid Diagnosis Clinic Service

What is the purpose of the study?

Public Health Wales (PHW) have commissioned M·E·L Research to evaluate the Rapid Diagnosis Clinic (RDC) programme across Wales. This is to assess the impact of the programme on patients, staff and the healthcare system, both nationally and locally. Equally, we would like to capture the key learning to help improve the future delivery of the services or programmes.

Why have I been chosen?

As part of the evaluation, it is crucial for M·E·L Research to gain feedback from patients involved in the RDC programme to understand their experience of it and what has worked and not worked for them. The aim is to engage with patients from different backgrounds and parts of Wales.

Do I have to take part?

Taking part in this evaluation is completely voluntary even though you have been invited. You are free to stop taking part at any time, without giving a reason. A decision to do this will not affect your rights, any current or future health treatment, or any services you receive.

What will I be asked to do?

If you agree to take part in the evaluation, please contact Naila Hassan at 02920 054 024 or naila.hassan@mel-research.co.uk to arrange a suitable time for a telephone or video interview. They will use a discussion guide during the interview to ensure important topics are being covered. The interview should take about 30 to 45 minutes depending on your answers.

What language can I use to participate in the study?

We welcome all participation in Welsh and English. M·E·L Research will confirm your language preference when booking the appointment for interview.

More information on the next page

need to exchange personal information between the RDC teams and the evaluation team at M·E·L. The evaluation team would only collect and process patients' personal information with clear and direct consent.

A discussion guide was used to help explore patients' experience of the RDC, the impact of the RDC and where improvements could be made. The uptake of this approach was low and only six patients approached M·E·L to give their feedback. As part of the evaluation, 6 customer journey maps were created, based on the patient interviews, to visually present their experience of the RDC and the outcomes and impact (see Appendix B).

All patient interviews were carried out over the phone as it was the preferred method. All staff interviews were conducted via MS Teams. With consent, the interviews were recorded digitally, then entered into a transcript analysis grid for further exploration.

Table 2 presents a summary of the evaluation activities and the number of participants involved from each Health Board.

Table 2. Evaluation data collection activities delivered

Health Board	Staff feedback form	Staff interview	Patient interview
Aneurin Bevan	1	3	
Betsi Cadwaladr	7	5	2
Cardiff and Vale	3	3	
Cwm Tâf Morgannwg	3	3	
Hywel Dda	2	3	1
Swansea Bay	4	5	3
Wales	20	22	6

Limitations

The evaluation team planned to complete around 10 interviews per Health Board RDC, engaging with c.6 staff members and c.4 patients. The interviewing activity was carried out between July and early October 2023 with several attempts made by the national programme team to encourage engagement with the evaluation. During this period the RDC teams also faced several challenges e.g. service pressures due to increased demand, limited staff availability and competing priorities which hindered their ability to participate in the evaluation activities.

As demonstrated in Table 2 above, the engagement levels are lower in some Health Boards which limited our ability to present views from different job roles within their RDC, particularly from GPs / consultant physicians and radiologists.

The approach adopted by the evaluation team to engage with patients also did not yield the level of interest as anticipated. If an evaluation is to be conducted again for the RDC service, it might work better to recruit patient participants via the existing RDC patient experience survey.

It is also worth noting that the evaluation has not engaged with commissioners and local authority public health etc. from each Health Board area to gain their views on the RDC service and on their future commissioning priorities.

Evaluation findings

This section presents the findings under each aim of the evaluation.

What was the impact of the RDC programme on patients, primary care staff, secondary care staff and wider Health Board services?

Intended programme outcomes

For **patients** with vague, non-specific symptoms that could be due to cancer, the RDC has, in the main, improved the speed of diagnosis from the point of GP referral which would lead to improved overall patient health outcomes and reduce cancer diagnoses via emergency presentations, amongst other long-term outcomes defined in the national programme logic model (Appendix A). According to the programme monitoring data[11], 58% of RDC patients were seen within 14 days from the point of referral since April 2022 (17% within 7 days[12]). Impact of COVID, limited manpower within the RDC teams, NHS strike action and public holidays should be taken into consideration while examining this figure.

Six out of the seven Health Boards in Wales have implemented an RDC, and agreements are in place for patients from Powys to be referred to RDCs operated by neighbouring Health Boards.[13] Reviews were also carried out to see how a rural RDC could be set up for Powys. It is worth exploring the possibilities of providing extra clinics at different times or locations to improve the equity of access to the service, especially amongst the Health Boards which predominantly cover rural geographical areas. *"I think being a rural Health Board and the restriction on space to hold our clinic, we do find that patients coming from afar have a long journey to clinic."- RDC Coordinator*

Another long-term objective of the national programme was to Improve the identification and management of other serious non-malignant disease or those at risk of developing serious illness. This has certainly been achieved via the RDC with 34% of patients found with significant non-cancer diagnoses across Wales according to the programme monitoring data. Those patients were then referred to other specialists or secondary care teams. The RDC provides a *"Rapid assessment of often very worrying symptoms for patients without significant delays in diagnostics or clinic appointments. Patients are visibly reassured when they leave the clinic knowing that they have had a full assessment,*

11 Source: National RDC outcome reporting tool and dashboard
12 Target set in the National Optimal Cancer Pathway for Patients with Vague (Non-Specific) Symptoms, available at https://executive.nhs.wales/networks-and-planning/cancer/wcn-documents/clinician-hub/csg-pathways-and-associated-documents/vague-symptoms-national-optimal-pathway/
13 Patients from South Powys and North Powys are currently being referred to RDCs. An agreement is in place for Mid-Powys but at present, referrals are not being made.

and nothing has been found. In contrast those with a serious (cancer or non-cancer) diagnosis are grateful for the rapid assessment and treatment or onward referral plan." – GP Specialist

The RDC Patient Experience survey data collected in 2022/23 reflects the positive outcomes and experience of RDC patients.[14]

Source: Rapid Diagnosis Clinics Patient Experience Data 2022-2023 Report (n=627, covering RDC patients of Betsi Cadwaladr UHB, Hywel Dda UHB and Swansea Bay UHB)

14 The survey was developed by the WCN in collaboration with Health Board RDC Teams. Each Health Board adopted their own way to share the survey with patients.

For the **Health Board RDC Teams**, most have been operating for at least 12 months with the exception of Cardiff & Vale UHB, and have developed a working model that is suitable for their own local setting, while still following the agreed Vague Symptoms National Optimal Pathway (NOP) and service specification.[15] It is also evident that the national programme has successfully facilitated cross learning and collaboration between the RDCs through a dedicated programme team at the WCN with regular forums for CNSs and RDC Coordinators and the quarterly CSG meetings for vague symptoms. *"RDC has demonstrated that patient care and services can be standardised to a certain extent between the Health Boards. It's an example of how collaboration can work when people are open to it." - GP Clinical Lead*

What also came across strongly during the evaluation was high level of job satisfaction expressed by RDC staff, a very positive outcome. *"That's what gives me that fire in my belly to make a difference to patients' lives and the clinic in general is making a difference. And also for me, job satisfaction is through the roof." – RDC ANP; "The fact that the service offers a quick pathway from GP referral to clinic appointment thus avoiding delays for potential cancer diagnosis. Being involved in the patient's journey from booking appointment to attendance at clinic and having the results. It has been an honour bringing this service to the local community." – RDC Coordinator/Manager*

For **primary care**, although the awareness of RDC and quality of referrals is generally improving, the feedback from most RDC staff engaged in the evaluation was that more work can be done to further improve these and face-to-face engagement and educational events would work best. The national programme team attempted to seek feedback from GPs via an RDC GP survey.[16] Although only 16 surveys were completed between April and June 2023, the majority found the process of referring patients to the RDC convenient, and the service has helped alleviate their stress/frustration for having no clear pathway to follow for patients with vague cancer symptoms and the need to make multiple referrals to different specialisms with patients "bouncing around".

For **secondary care**, there is reported increase of awareness of RDC and improved working relationship between the team and other secondary care teams (cancer and non-cancer), through proactive engagement and communication from the Health Board RDC teams and the multi-disciplinary team meetings (MDT).

For the **wider system**, as highlighted above, the national programme has helped create a collaborative environment for the RDC teams, and RDC staff also felt that the communications between them and

15 https://executive.nhs.wales/networks-and-planning/cancer/workstreams/rapid-diagnosis-clinics-programme/rdc-documents/rapid-diagnosis-clinics-a-national-programme-for-wales/

16 The online survey was disseminated by email to all GP Practices in Wales. It was also promoted through the WCN Newsletter, WCN Twitter account and the Macmillan Primary Care Cancer Framework GP Leads/ Facilitators, etc.

primary care have improved as a result. *"The GPs are getting bounced from one place to the other and the whole purpose of this pathway was to try and give the GPs somewhere to send the patients that they are worried about." – Radiologist; "I think it's broken down the barrier between primary and secondary care, which I think is has been a really positive thing...We've been able to support local GP meetings and tell them about the clinic, and tell them our results, and what we've done and that's a really positive thing as well." - Consultant Radiologist*

Unintended outcomes

The **quality of referrals** was a common issue raised by RDC staff and relevant stakeholders across all Health Boards, mostly around the required Set 'A' tests which include various blood tests and FIT (Faecal Immunochemical Test) not completed when referrals were made. The effort required to educate GPs on a case-by-case basis was perhaps not anticipated by the RDC teams initially and higher rates of declined referrals could be observed from the programme monitoring data in early 2022/23. It was also reported that not all GPs are aware of the RDC (including not knowing or not advising patients that it's a cancer service for vague symptoms), some RDC teams are only getting referrals from a few GPs, and some GPs are using RDC as a gateway to get their patients seen more quickly regardless of the symptoms.

Effort has been made and plans are being put in place to further engage and educate GPs to improve their awareness of the service and understanding of the referral criteria. For example, Betsi Cadwaladr UHB has an intranet page with all the information for RDC referrers, which has been advertised widely in communications with primary care. Aneurin Bevan UHB also launched their intranet page in Summer 2023 which enables GPs to check what the criteria for RDC referrals are and tests needed to help improve the quality of referrals.

With the **increased awareness** of the service, the RDC Teams are faced with **increased referrals** whilst being uncertain if extra funding to expand the workforce within the team or to introduce additional clinics could be obtained. This could lead to delays in the pathway and compromise the ethos of the service being 'rapid' for patients. *"We get most of the sessions filled, I suppose the unintended consequences were a victim of our own success and the referral rate has gone up hugely. When we were able to get patients always seen within a week now it sometimes slipped to 10 days, two weeks which we don't like at all, that makes us feel quite jumpy." - Consultant Radiologist*

Values of the nationally directed but locally delivered model

Most stakeholders felt that it was a necessary approach to enable the service to be rolled out across all of Wales. The national programme team worked with and supported Health Boards to deliver the RDC service which aligned with the NOP and Service Specification but allowed for adaptions to meet the needs of their local population. It helped overcome potential barriers and hurdles together, instead of each Health Board introducing the service themselves in isolation. The locally delivered model was also appreciated as *"I think that whatever you do nationally has to allow flexibility for what you've got available locally, you know and that be in terms of scanning resource, in terms of clinical resource, in terms of a simple thing like rooms." - RDC Clinical Lead; "Oversight from a national team with expertise ensures the service is designed to deliver the right care for all patients. Locally delivered ensures each RDC is implemented with its local demographic in mind and works to improve local services and resources alongside the RDC pathway." – RDC Clinical Lead*

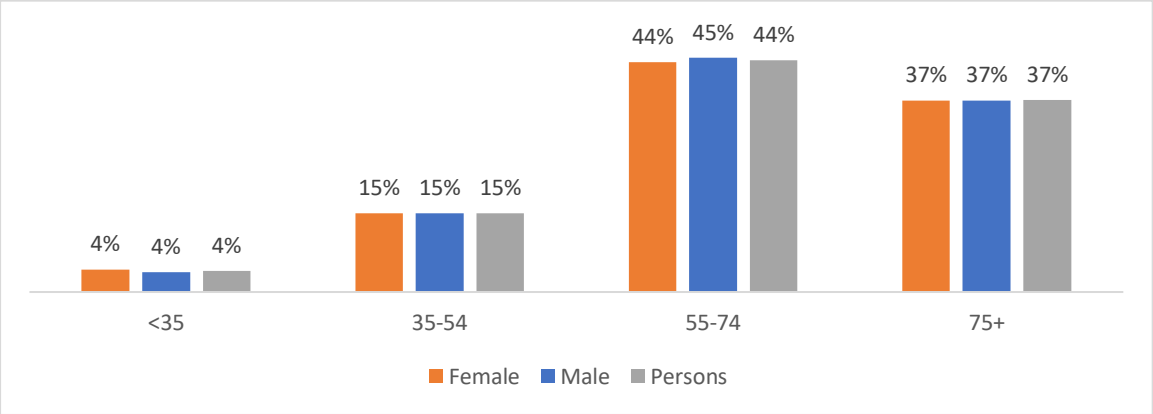
19 out of the 20 staff who filled in the feedback form agreed that the nationally driven but locally delivered approach worked. *"I think it is unlikely it would have happened if there had not been a nationally driven programme as it allowed many of the barriers to be broken down. Locally there was some dissent at us following the approach from the national programme." – RDC Clinical Lead; "By gathering all the national information, it was then communicated back to us and we were then able to discuss and chat about what worked well and what we wanted to take forward. It also helped if we needed to change practice, other ideas or ways that had been used Nationally for us to try." – RDC CNS; "Nationally driven but locally delivered works well as it provides a set of agreed standards but each health board will have their own challenges in delivering the service so it allows some flexibility in the model." – RDC Clinical Lead*

Any demographical or geographical variation in inputs, outputs and outcomes

From the national RDC dashboard output data, the evaluation team was able to review the number of accepted referrals, average number of days between referral and RDC appointment, and cancer conversion rate by age group and by gender (Figure 3-5). The results show very small variations between the different sub-group of patients which is positive.

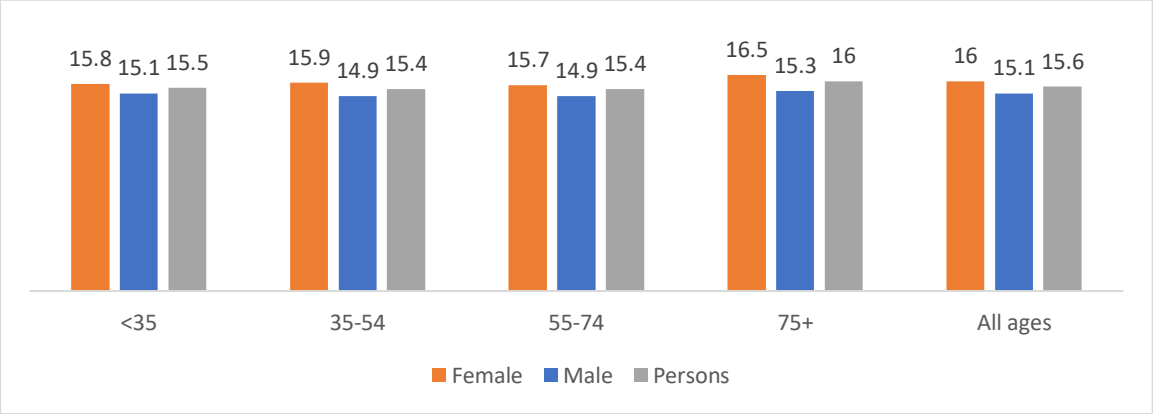
The evaluation team was not able to analyse the RDC patient experience survey data by demographics due to the information not being collected currently - something to consider for the WCN and Health Boards to help monitor and maintain the equity and quality of the service.

Figure 3. Number of accepted RDC referrals by age group and gender



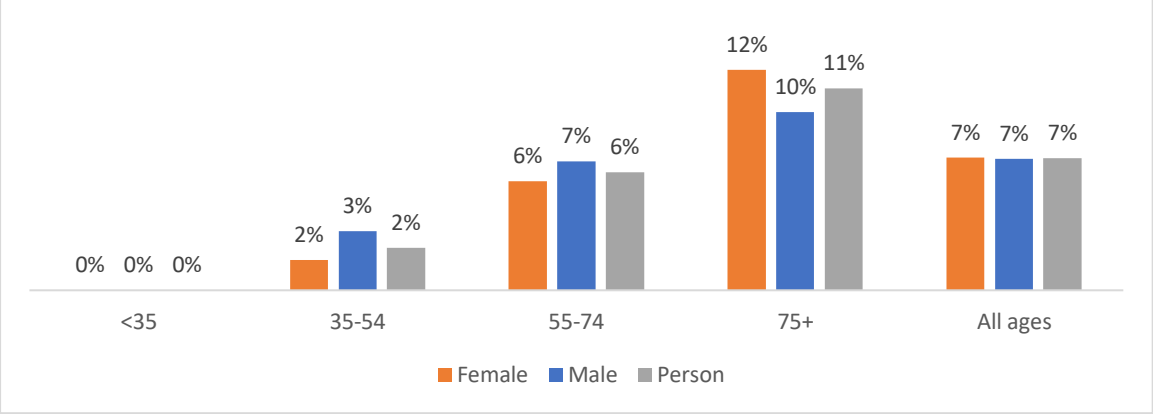
Sources: National RDC Dashboard output covering 2022/23-23/24 Q1

Figure 4. Average number of days between referral and RDC appointment by age group and gender



Sources: National RDC Dashboard output covering 2022/23-23/24 Q1

Figure 5. Cancer conversion rate by age group and gender



Sources: National RDC Dashboard output covering 2022/23-23/24 Q1

As part of the evaluation, six in-depth case studies have been created to highlight the outcomes and key findings for each of the Health Boards operating an RDC. They can be found in Appendix C. Table 3 provides a brief summary of each RDC and their key challenges.

Table 3. A brief summary of the RDCs

Health Board	RDC summary	Key challenges
Aneurin Bevan UHB	▪ Covering mainly urban areas ▪ Received the 3rd highest number of referrals in 2022/23 despite service being paused in Q2 ▪ Receiving referrals from South Powys (excluding Ystradgynlais) ▪ Cancer conversion rate above the Wales average ▪ Non-cancer diagnosis not considered a clinical outcome of the RDC ▪ After the service pause, the RDC was moved to being under the clinical delivery division which has helped improve the operation of the service	▪ Consultant physicians are mainly locum GPs and can only sign off patient letters when in clinic - causing delay ▪ RDC CNS on long-term sick leave
Betsi Cadwaladr UHB	▪ Largest Health Board in Wales, covering both urban and rural areas (approx. 50/50) ▪ Only RDC operating at more than one hospital ▪ Received the 2nd highest number of referrals in 2022/23 ▪ Receiving referrals from North Powys ▪ Cancer conversion rate below the average across all RDCs ▪ Reported the highest percentage of patients seen within 7 days from referral	▪ Coping with increasing service demand with existing resource ▪ Securing funding and resource to expand the service
Cardiff & Vale UHB	▪ Covering mainly urban areas ▪ Newest RDC to be operating in Wales (started in April 2023) so at very early stage of implementation ▪ Knowledge sharing sessions facilitated by WCN helped eliminate potential barriers ▪ Looking to move from 2-stop to 1-stop ▪ Reported the highest cancer conversion rate in 2023/24 Q1 ▪ Reported a higher rate of patients not attending appointments than the average across all RDCs	▪ Educating and communicating with GPs to help improve the quality of referrals ▪ Improving service resilience
Cwm Tâf Morgannwg UHB	▪ Covering mainly urban areas ▪ One of the pilot sites for RDC in 2017 ▪ Only RDC operating a hybrid model; CT scans and physical assessments conducted at different hospitals ▪ Patients in Bridgend currently referred to Swansea Bay UHB ▪ Received the 2nd highest number of referrals in 2022/23 Q1+Q2 (Q3&Q4 data not available for evaluation) ▪ Cancer conversion rate on par with the average across all RDCs ▪ Reported the lowest percentage of patients seen within 7 days and 8-14 days from referral (based on 2022/23 Q1+Q2 data)	▪ Coping with increasing service demand with existing resource ▪ Improving service resilience

Hywel Dda UHB	▪ Covering largely rural areas ▪ Received the lowest number of referrals ▪ Cancer conversion rate above the average across all RDCs ▪ Reported the 2nd lowest percentage of patients seen within 7 days and 8-14 days from referral ▪ Reported the lowest rate of patients not attending appointments	▪ Engaging with and educating GPs who have not referred ▪ Improving the equity of access to an RDC in the Health Board
Swansea Bay UHB	▪ Covering mainly urban areas ▪ One of the pilot sites for RDC in 2017 ▪ Received the highest number of referrals ▪ Receiving referrals from Ystradgynlais cluster in South Powys ▪ Have been running additional clinics to deal with demand ▪ Cancer conversion rate on par with the average across all RDCs ▪ Reported the 2nd highest percentage of patients seen within 7 days from referral	▪ Securing resource for endoscopy sessions to expand diagnostic ability within the RDC ▪ Securing extra funding and resource to deal with increasing demand

Did the RDC programme represents added value for NHS Wales?

14/20

agreed that RDC has led to more efficient use of resources within their Health Board

2 disagreed and 4 didn't know

source: staff feedback survey

The aim of the evaluation was not to examine the cost effectiveness of the RDC as the pilot conducted in Swansea Bay UHB and Cwm Tâf Morgannwg UHB demonstrated that RDCs are a cost-effective solution for improving outcomes for patients presenting with vague, non-specific, but concerning symptoms if the capacity utilisation of the clinic is above 80%.[17] Instead, the evaluation focused on understanding the added benefits and values of the service, compared to the conventional pathways before the RDC was introduced.

It is estimated that in the UK, 50% of patients with cancer do not present with the red flags required for referral to a site-specific suspected cancer pathway.[18] Even when a patient is referred on to an urgent suspected cancer (USC) pathway with specific red-flag symptoms, there can still be different routes within the pathway that they need to go down. The RDC provides a single point of access to a diagnostic pathway and can normally see a patient within 7 to 14 calendar days from the point of GP referral. Those RDCs that operate the 1-stop model can normally give patients their diagnosis on the

17 Sewell, B., Jones, M., Gray, H., Wilkes, H., Lloyd-Bennett, C., Beddow, K., Bevan, M. and Fitzsimmons, D., 2020. Rapid cancer diagnosis for patients with vague symptoms: a cost-effectiveness study. British Journal of General Practice, 70(692), pp.e186-e192

18 Neal RD, Din NU, Hamilton W, et al. Comparison of cancer diagnostic intervals before and after implementation of NICE guidelines: analysis of data from the UK General Practice Research Database. Br J Cancer. 2014;110(3):584–592.

same day. *"The patients referred to us would have sat on waiting lists for a long time as 'Routine' or 'Urgent' as their symptoms do not meet the criteria for USC pathway. Patients that are seen on the Vague Symptom Pathway in the RDC are more likely to have a cancer found at a stage that is treatable. Previously patients would likely arrive in A&E with a higher-grade cancer, very poorly and with a poor prognosis. In short, patients have a better prognosis, receive treatment that can be curative/life prolonging and less strain on hospital waiting lists." – RDC Coordinator/Manager; "It is saving patients being referred via an incorrect pathway and causing them to have inappropriate investigations and then investigations repeated. I also think it will save some emergency admissions." – RDC Clinical Lead*

The RDC has substantially sped up the diagnostic pathway as it provides a one-stop shop for patients with direct access to CT scans, holistic assessment, clinical expertise and MDT. Patients with a cancer diagnosis are normally referred directly to the relevant specialties straightaway which further reduces their waiting time for treatment. Those who receive a non-cancer diagnosis but with chronic or complex health conditions have also been referred to appropriate service for treatment.

The fast turnaround time also helps reduce patients' anxiety and stress levels as *"for the patient it can be stressful because their GP says to them, well I think we could do a CT scan but I'm going to have to ask to see if I can get you one and then I'll let you know if we have…..So it just cuts out all of that anxiety and waiting on things as well." – RDC Clinical Lead; "The ethos of RDC is just remarkable. Patients are just seen so quickly and the support they receive is phenomenal." – Cancer Service Manager*

In terms of cancer diagnosis, 203 were diagnosed across all RDCs between 2022/23 Q1 and 2023/24 Q1, representing a 6.9% diagnosis rate. The figure is an indication and may not reflect the true conversion rate of the RDCs in Wales due to missing data from one Health Board in 2022/23 Q4 and the RDC in Cardiff & Vale UHB only started operating in 2023/24 Q1.

When reviewing the non-attendance rate of RDC appointments, a statistical report produced by The Welsh Government on outpatient activity highlights that across Wales in 2018-19, the percentage of appointments where outpatient did not attend was 7.7%.[19] In comparison, the rates of RDC appointments are 4.1% on average, a very positive outcome of the service.

Another added value which comes across strongly in the evaluation is high job satisfaction amongst RDC staff. *"It's very satisfying working in the clinic. I have time to talk to patients, understand their personal circumstances, explain to them the test results and the next steps." – RDC Clinical Lead; "It's really rewarding to be part of the pilots that show that things can be done to make things better across the board. I've been really, really proud to be part of it actually." – Consultant Radiologist*

19 Source: https://www.gov.wales/outpatient-activity

Finally, other cancer specialties within Swansea Bay UHB are using funding from Moondance Cancer Initiative to trial the RDC model within their specific pathways, i.e., neck lump cancer, colorectal cancer.[20] This is something other Health Boards are very interested in also.

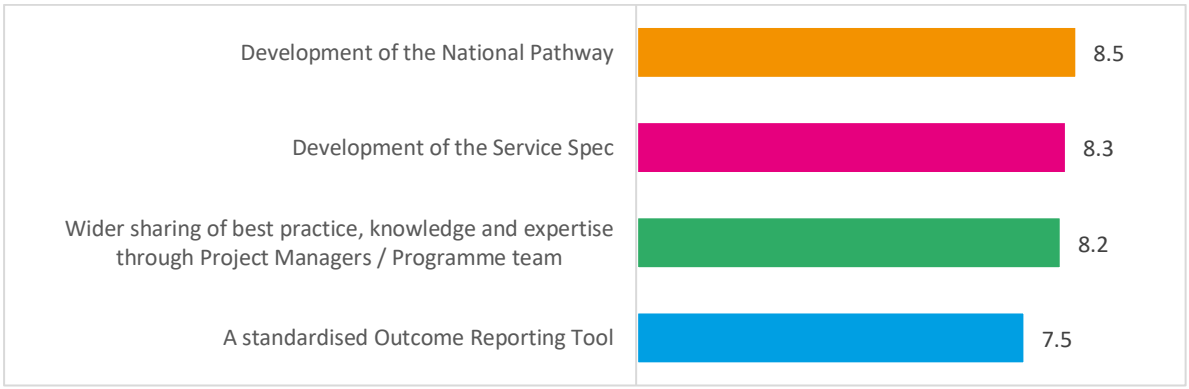
What was the wider learning from the programme?

How well did the programme work? What could have been done better?

Overall, the programme was perceived to work well although some teething issues still needed to be reviewed and addressed, particularly around the quality of referrals and resilience of the service / RDC team. Key enablers of the success have been:

- Support and endorsement from radiology
- The development of the NOP and service spec
- A dedicated National Programme Team to facilitate change and collaboration
- Endorsement from senior management within the Health Boards
- Buy-in across primary and secondary care
- A strong belief of the ethos and what the RDC is trying to achieve within the RDC teams and secondary care teams.

Figure 6: From a scale of 1 to 10, how well the following were achieved by the programme



Source: staff feedback form (n=20)

20 https://moondance-cancer.wales/projects/supporting-the-rapid-diagnosis-centre-model-in-wales/supporting-the-rdc-model-in-wales

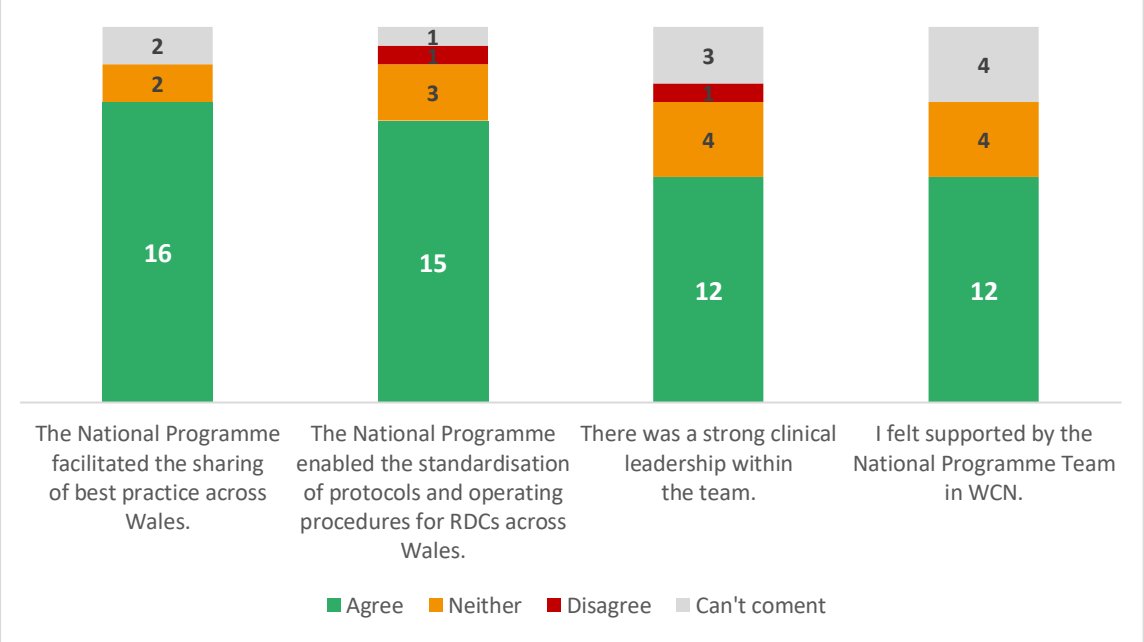
The feedback on the National Programme Team was positive overall. Almost all who took part in the staff feedback survey agreed that the team worked well with their Health Board to deliver an RDC in their local area. *"I personally have received a lot of support from the Wales Cancer Network in setting up the RDC. Their input has been invaluable in getting the service off the ground." – RDC Clinical Lead; "I think The Wales Cancer Network has been an important key to the Health Board. Through them sharing of ideas and opportunity to talk with other Health Board areas has been implemented." - RDC Coordinator / Manager; "They [the National Programme Team] have been so supportive throughout. When I first started the job, I was anxious but excited about the brand new role; they were always available to chat and answer questions. They encouraged us to grow in our roles and question if we thought there was a better way to run our clinics. Throughout they arranged regular meetings to update us and allow time to discuss changes and our thoughts and feelings on our RDC. They have been a great support and a wealth of information." – RDC CNS*

19/20

agreed that the national RDC Programme Team worked well with their Health Board to deliver an RDC in the local area.

source: staff feedback survey

Figure 7. Feedback on the national RDC programme team



Source: staff feedback form (n=20)

Ideas for WCN to improve support and engagement for RDC moving forward include:

- continuing with the regular updates for all RDC staff members
- continuing with the CNS / ANP / Co-ordinator forum meetings for exchanging ideas and networking

- providing more advice on data collection and data analysis to assess the efficacy of the service including identifying and addressing any inequality.

The programme implementation was not without challenges; some key ones highlighted by stakeholders were:

- A lack of awareness and understanding of the RDC within primary care
- A lack of buy-in from secondary care staff at the beginning and push back from other specialties when making onward referrals
- Having a suitable 'home' for the clinic, including its physical location and which directorate it sits under
- Limited workforce which impacts on the resilience of the service
- A lack of readily available funding to expand current capacity to deal with increasing demand
- Wider factors such as COVID 19 and financial situation with NHS Wales

Some argued that RDC would not be needed if GPs can have direct access to CT scans and can have direct dialogue with radiologists. Many counterargued that the RDC does not just provide CT scans but a one-stop holistic assessment of the patient to determine the cause of their symptoms, regardless of whether it is cancer or something else, combined with clinical expertise from the consultants / physicians and specialist GPs who are experienced with cancer or other chronic diseases. Moreover, the RDC has direct access to MDT which *"has very open lines of communication which greatly speeds up the process. They [RDC] can achieve much more in the time that they have with the patient." – RDC Co-ordinator*

Some felt that it would have been more helpful for them to set up the local RDC if they had had the opportunity to visit the pilot sites in Cwm Tâf Morgannwg UHB and Swansea Bay UHB to see how it worked in practice. This could not have been achieved as most RDCs were set up during COVID which made face-to-face engagement difficult. It's a useful learning for future, nonetheless.

How has this collaborative approach facilitated change?

The national programme enabled all the Health Boards to collaborate on a service that each one is operating slightly differently, but with the same aim. The forums and meetings facilitated by the national programme team has offered RDC staff the opportunity to learn from each other – enabling cross-pollination between Health Board RDC teams. *"We had where people were sharing their experiences which was very useful because I think we are all experiencing similar issues." – Radiologist; "RDC has demonstrated that patient care and services can be standardised to a certain extent between*

the HBs. It's an example of how collaboration can work when people are open to it." – RDC Clinical Lead

What does the future look like for RDCs?

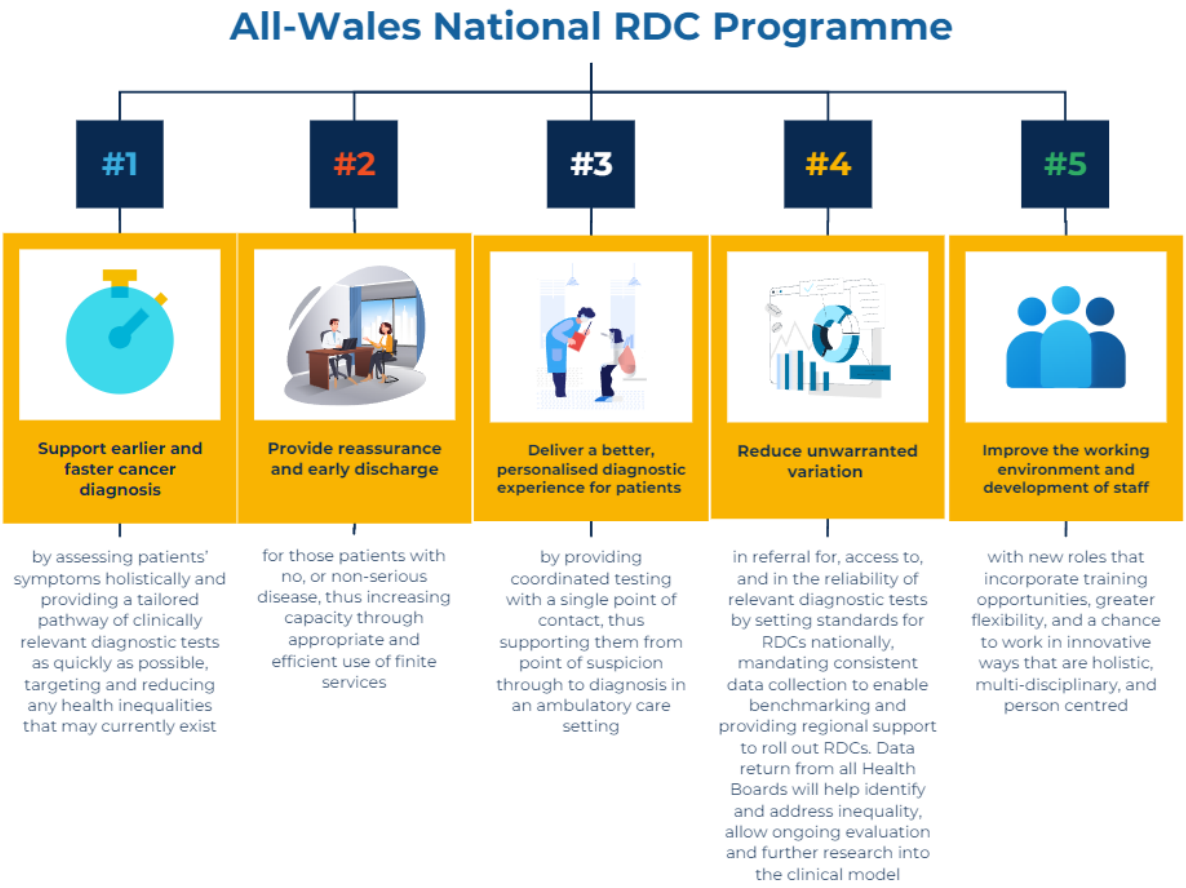
The national RDC programme has proved the concept and that RDCs work well in practice. There is a strong consensus amongst staff that the service should be continued and can be adopted by some other specialties, e.g., neck lump cancer, colorectal cancer. However, many felt that the RDCs would struggle with capacity to deal with the increasing demand if extra funding cannot be secured from their Health Board or other sources to recruit more staff and provide extra clinics. *"We are trying to build a more robust and resilient service to minimise the delays in access and appointments. Part of this is negotiating the financial and workforce demands of the service in the context of the wider Health Board spend. Education and communication between RDC and primary care needs to constantly evolve so that the right patients attend the right service first time. This is an ongoing challenge."- RDC Clinical Lead*

The idea of situating the RDC within a community diagnostic hub (CDH)/centre (CDC), out of the secondary care setting was mentioned. The CDCs have been operating in England for a few years, following Professor Sir Mike Richards' Review of NHS diagnostics capacity.[21] They allow patients to access planned diagnostic care nearer to home without the need to attend acute hospital sites. Similar to the concept of the RDC, the CDCs aim to provide a single point of access for patients, enabling access to a range of diagnostic tests to achieve early diagnosis and streamline healthcare services. Having the RDC within a CDH/CDC could help improve the equity and access of the service for patients with vague cancer symptoms across Wales, particularly for those who live in more rural areas. Key considerations would be how the RDCs within a CDH/CDC could be staffed and how the CDC pathways could be integrated with existing systems within primary and secondary care. *"Ideally the RDC should be within a community diagnostic hub where patients can have rapid access to all test mediums, and not just CT scans. Around 30% patients could avoid complete body radiation and might just need an endoscopy and an ultrasound for example. It's not possible to do so in the secondary care setting." – RDC Clinical Lead*

21 Richards, M., 2020. Diagnostics: Recovery And Renewal: Report of the Independent Review of Diagnostic Services for NHS England. Available at https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf

Key learnings

All in all, the national RDC programme has achieved the objectives as set out in the implementation specification document:



Six out of the seven Health Boards in Wales have implemented an RDC, and agreements are in place for patients from Powys to be referred to RDCs operated by neighbouring Health Boards. 17% of patients were seen within 7 days from the point of referral since April 2022, and a further 41% were seen within 8-14 although these ratios may decrease as the RDCs continue to deal with the increasing demand of the service. To support the Welsh Government's vision of a healthier Wales, around a third of RDC patients were diagnosed with non-cancer but serious or concerning health conditions and were referred for further investigation.

A high level of job satisfaction is apparent amongst RDC staff. Many felt they were making a difference and felt proud to be involved in a service as such. Several also highlighted the different standards of service NHS patients receive beyond the RDC pathway and how the ethos of RDC should be the ethos of all public health care services.

The **nationally directed but locally delivered model** worked well. Many considered it an essential approach to enable the collaboration and roll-out of the RDCs across Wales. It is worth noting that the same concept of service model is being explored in other cancer specialities in Swansea Bay UHB, supported by funding from Moondance Cancer Initiative.[22]

Although the national programme was successful in its delivery, some key challenges remain to be addressed. To improve the **quality of referrals** will require a continuous effort of RDC staff to communicate and educate their local GPs. Face-to-face engagement is considered to be much more effective than digital and paper communications, however it is more labour intensive.

The data fed into the **national dashboard** were not of consistent quality across the Health Board RDC teams. Some missing information and inconsistent numbers can be found and therefore relevant figures presented in this report and case studies are for indication only.

The **resilience of the RDC service** in each Health Board is also a key concern highlighted by RDC staff. It is the evaluator's understanding that most, if not all, of the RDC staff are on a permanent contract, either full-time or part-time. This signifies the Health Boards' commitment and the sustainability of the service although it does not eliminate the challenge of the RDCs needing to serve an increasing patient cohort with the same limited resource, while trying to achieve the 7-day target. How to future proof the service will be an important consideration for each Health Board RDC team moving forward.

Recommendations for future delivery

1	RDC teams to consider engaging with GPs through e.g., newsletters, CPD (continuing professional development) events, or individual visits (labour intensive) to increase service awareness and improve quality of referrals.
2	As a standalone service, it would be challenging to ringfence the funding for RDC on a longer-term basis due to financial pressures faced by the NHS and future changes in service priorities. To help improve the sustainability and resilience of the service, Health Boards to consider: ▪ mainstreaming RDC by incorporating it into existing funding, this could also help with recruitment of new staff (e.g. offering a full-time instead of 0.2 WTE role); ▪ reviewing staff structure and the appropriateness of the staff renumeration in relation to the job roles required in an RDC; ▪ opportunities to develop Community Diagnostic Hubs incorporating a RDC.

22 https://moondance-cancer.wales/projects/supporting-the-rapid-diagnosis-centre-model-in-wales/supporting-the-rdc-model-in-wales

3	WCN to review the purpose of the national dashboard, who the key audience are and what the future monitoring and evaluation needs might be. This would help define the key performance indicators and the Health Boards to see the benefits of providing the data. Other indicators which could be included to support continuous service improvement are: ▪ Percentage of cancers (out of total) diagnosed through RDC, ▪ Number of GP practices use/not use the service, ▪ Clinic capacity utilisation. Other information to help assess the equity of the service could include demographics (beyond age and gender), the Welsh Index of Multiple Deprivation, etc. It is also worth reviewing whether all indicators should be reported on a quarterly basis; some could be done annually.
4	WCN and Health Boards to consider including demographic questions in the existing RDC patient experience survey to help monitor and maintain equity and equality of the service. The survey could also be utilised as a means to recruit research participants for future service evaluation needs.
5	WCN to continue to facilitate forums and meetings to enable cross-pollination and networking amongst RDC staff.

Appendix A: The national programme logic model

RDC Logic Model – National RDC Programme						
Situational context	**Inputs**	**Outputs**		**Outcomes/ Impact**		
Context *What external factors interact with and influence the programme?*	**Resources** *What resources will be required to achieve the desired outcomes?*	**Activities** *What activities need to be performed to cause the necessary outcomes?*	**Participants** *Who will we reach?*	**Short Term (ST)** (12 months) *What knowledge or skills do people need for the MT outcomes occur?*	**Medium Term (MT)** (1-3 years) *What behaviours need to change for LT outcomes to be achieved?*	**Long Term (LT)** (3-5 years) *What will the situation look like when we achieve the desired situation or outcome?*
WELSH CONTEXT • No pathway for patients with vague symptoms • NICE Guideline 12 – Suspected Cancer • Vague symptoms poor/ PPV for cancer • Poor cancer outcomes and experience for patients presenting with vague symptoms • Danish Three-Legged Strategy • CRUK ACE MDC Programme • RDC Pilot Evaluation • Diagnostic and workforce pressures **POLITICAL SITUATION** • Welsh Govt commitment & priority • HB commitment to maintain funding for RDCs beyond WCN contribution	**PEOPLE** <u>WCN Programme Team:</u> • Clinical Lead • Clinical Fellow • Programme Manager • Regional Project Managers (x3) • Programme Support Officer <u>Stakeholders:</u> • HB RDC teams • WCN programmes • NHS Collaborative programmes • Health Board executives • Health Board Cancer Teams	• Provide leadership, project management and an enhanced level of support to Health Board RDC teams • Clinical Leadership/ Support and Advice through National Clinical Lead role • Develop a Vague Symptoms National Optimal Pathway • Develop and implement the RDC Service Specification • Deliver RDC Learning Events (x2) • Develop and implement a National RDC Dashboard • Develop and implement an	**PRIMARY CARE** • Clusters and LMCs • GPs • ANPs • Non-clinical staff **SECONDARY CARE** • Cancer-specific pathways/ MDTs • AOS/ MUO Pathways • Non-cancer specialists • Radiology • Diagnostic Services • AHP/ Pre-habilitation Teams	**HB RDC TEAMS** • Increased knowledge amongst HB RDC teams so that they have the confidence to implement an RDC service • Enhanced information available for HB RDC teams to support planning, development, and implementation processes • RDC service models designed to support COVID-19 guidance • Enhanced information sharing and networking between HB RDC teams • Patient experience collected by all RDC teams (PREMs/ PROMs)	**HB RDC TEAMS** • Joined up implementation of RDCs across Wales • Reduced 'silo' working • Use of a nationally agreed and clinically endorsed pathway and service spec to support implementation and ongoing service development **PRIMARY CARE** • Increase in appropriate GP referrals to the RDC/ reduced referral back to GP from RDC triage **WIDER SYSTEM** • Increased access to data pertaining to an RDC service and the Vague Symptoms Pathway to drive service	• Population of Wales has access to an RDC service • Support earlier diagnosis for patients with vague, non-specific symptoms that could be cancer • Reduce cancer diagnoses via emergency presentations • Improve overall patient health outcomes by detecting cancer earlier • Improve patient and GP experience • Improve the identification and management of other serious non-malignant disease or those at risk of developing serious illness

GEOGRAPHICAL SITUATION Urban and rural geography within and between HBs **POPULATION** Considerable variation across and within HBs in age structure, ethnicity, mobility, health education, patient performance status and multiple chronic diseases **ECONOMIC SITUATION** • Significant financial pressure within the NHS • Covid-19 recovery pressures	• Health Board teams (other specialisms) • Improvement Cymru • HEIW • DHCW/ NDR • Cancer Research UK • Cancer Research Wales • NHS Scotland • Department of Health (NI) • Wales Cancer Alliance • Macmillan Cancer Support • Swansea Bay RDC leadership team **FINANCIAL** ~£800,000 WCN funding **TIME** • To build and maintain relationships with stakeholders • Time and flexibility to attend meetings	evaluation and reporting framework • Develop RDC educational sessions (with HEIW) • Establish and support RDC Nursing and Coordinator forums • Promote the Welsh RDC model locally, nationally, and internationally • Facilitate the sharing of knowledge and learning across HBs	**COMMUNITY CARE** • Dietician • Social prescribers • Occupational Health **HEALTH BOARD** • RDC teams • Senior management • Cancer performance managers • Decision makers/policy makers • Health Board Executive Teams • Business Intelligence teams • Patients, Families and Carers	**PRIMARY CARE** • Increased awareness of Vague Symptoms pathway and referral process • GP experience collected by all RDC teams **SECONDARY CARE** • Increased awareness of the aims, value and impact of an RDC across secondary care teams (cancer and non-cancer) **WIDER SYSTEM** • Increased awareness locally and nationally of RDCs and the national programme • Improved Primary/ Secondary Care interface and enhanced communication	improvement and innovation	• Decreased mortality and morbidity (from earlier specialist care) • Reduced demand in outpatient clinics/ secondary care • Reduced variation and improvement in cancer outcomes within and between Health Boards • Increase in clinically appropriate care • Achievement of WG/CNB Earlier Diagnosis vision

Assumptions:

- Key stakeholder groups in Health Boards are interested in the RDC model (buy-in)
- Health Boards have the resources to plan, implement, maintain, and continuously improve their RDC service
- Health Boards are willing to work with and share information with the WCN RDC programme and each other
- Key stakeholder groups will be interested in attending learning events, webinars, and forums
- Programme activities will be effective in changing behaviours and increasing knowledge/ awareness

Issues/ Challenges:

- Data collection and monitoring system
  - Delayed submissions and issues with data quality due, in part, to the manual entry that is required
- Nationally driven but locally delivered model
  - SPMs limited in terms of 'doing the doing'
- Engagement and relationship with Health Board teams
  - Project heavily reliant on the acceptance (or not) of the SPM
- Personnel changes within the National Programme team
  - Clinical Fellow, SPMs, Programme Manager – slowed processes and progress due to loss of continuity and working knowledge of the programme and projects

Enablers:

- Swansea Bay Leadership team
  - Clinical expertise and knowledge which ensured that teams would not 'reinvent the wheel'
- Nationally driven but locally delivered model
  - Facilitated the sharing of information and enabled teams to overcome challenges at pace
- Mixture of skill sets within national team
  - Data, evaluation and working knowledge of the programme
- Communication
  - Diverse range of engagement activities (e.g., learning events, webinars) provided multiple platforms to engage with stakeholders
- Commitment from WCN SMT
  - The funding, enthusiasm, and support from the WCN supported the rapid planning and implementation of RDCs across Wales

Appendix B: Patient journey maps

DAVID'S JOURNEY

ABOUT DAVID:

David is an 86 year old, white British male in Swansea. He is a widower and lives alone. David lives close to the beach, listens to radio and was active before his illness.

REASONS FOR REFERRAL:

David had been having pain in his back for about 3 months starting in March. He went back and forth to his GP who initially thought it was muscular pain. His GP sent him for a CT scan in May but the pain got progressively worse so he went to the GP for an emergency appointment. He had lost weight and was dehydrated because he didn't feel like eating or drinking because of the pain. His GP requested an urgent blood test and when the results came back he was referred to the RDC because they felt there was something underlying.

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Early June

David was **referred to the RDC in late May**, but couldn't be seen until June due to staff holidays and strikes.

Same day

David attended the RDC in June for a **blood test**, which was done **within 10 minutes.**

Few hours later

David had a **CT scan within a few hours** and was administered morphine for the pain. He was then sent for a **MRI scan.**

Same day

David was **diagnosed with an abscess** on his spine.

Same day

David was **referred straight to the acute medical unit** and was admitted.

OUTCOME FOR DAVID:

David was diagnosed with an abscess on his spine and admitted to hospital immediately. If the abscess hadn't been picked up in time he was told he could have lost his spinal cord. He was admitted to the hospital immediately without any waiting because the RDC had already completed the tests.

"You know, they were fantastic. I've got nothing bad to say about them."

"I was referred straight into the admissions unit, which is where we needed to be."

ANN'S JOURNEY

ABOUT ANN:

Ann is a 74 year old, white British female in Betsi Cadwaladr. She is retired and lives alone. She lives in a small village and loves gardening and walking.

REASONS FOR REFERRAL:

Ann was being treated for polymyalgia by her GP. She had blood tests but when they came back her ESL numbers weren't coming down (which they should have been with medication). Her GP was concerned she was missing something and decided to refer Ann to the RDC to see if anything else was going on. Ann was referred on a Thursday and had an appointment the following Thursday.

Arrived at RDC — Ann arrived at the RDC at **9am**

Same day — **Within minutes** she was taken to the waiting room

Few hours later — Ann **had a CT scan** and was told she could go and get something to eat and drink

Same day — Ann returned to the waiting room and the **scan result was ready**

Same day — Ann was **given the all clear for cancer** - she was given advice regarding her medication

OUTCOME FOR ANN:

Ann was pleased to hear that she did not have cancer and that there was nothing wrong (other than polymyalgia). Ann was given advice regarding managing her condition and advised to reduce her medication slowly.

"I think it's very good for the family because they, your family, tend to worry if you think there's something going on, don't they? And you have to wait a long time for tests. It's very worrying period, but because it was a very quick appointment and because they gave you the results on the day, it took a lot of stress out of it for me and for the family."

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SIMON'S JOURNEY

ABOUT SIMON:

Simon is a 41 year old, white British male in Swansea. He is married with a one year old child and works in communications.

REASONS FOR REFERRAL:

Simon went to his GP with symptoms and was sent for blood tests. When the blood tests were returned, his GP referred him to the RDC. Simon received a phone call from the RDC to explain what was going to happen and why.

Attends RDC

Simon was seen approximately **two weeks after being referred by his GP.**

Same day

Simon had a **CT scan on the day he attended the RDC.**

Few hours later

Simon received the results of his scan **a few hours later**

A week later

Unable to give a firm diagnosis, Simon is asked to **attend a week later for further blood tests.**

OUTCOME FOR SIMON:

Simon was invited back to the RDC for follow-up blood tests to confirm the cause of his symptoms.

> *They were approachable and genuine. Put me at ease with everything. Walked me through everything.*

> *The speed of the referral and the appointment was really impressive.*

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ANDREW'S JOURNEY

ABOUT ANDREW:

Andrew is a 42 year old, white British male in Swansea. He is married with two children, works full-time and enjoys socialising with friends and family.

REASONS FOR REFERRAL:

Andrew had been experiencing shaking in his hands and a few other symptoms that weren't quite normal so he went to his GP for blood tests. After receiving the blood test results, his GP wasn't sure what was wrong so he decided to refer Andrew to the RDC. Andrew's appointment was for the following Friday but the clinic called to say they had an earlier appointment available and so Andrew was seen within 8 days of being referred.

Arrived at RDC

Andrew arrived at the RDC **at 1pm.**

Within minutes

Andrew was taken to a room to be **weighed and have observations taken.**

Few hours later

Andrew had a full body **CT scan and within a few hours** had the results.

Same day

Andrew was **diagnosed with a kidney tumor which had spread to his brain.**

Same day

Andrew was **sent straight to another hospital that day to start receiving treatment.**

OUTCOME FOR ANDREW:

Andrew was diagnosed with a tumor on his Kidney which had spread to his brain, causing the symptoms he was experiencing. The RDC arranged for him to attend a different hospital that evening so he could start treatment immediately.

"I don't actually quite know what we would have done if the GP hadn't sent us to the Diagnostic centre to be honest with you, without that clinic we probably would have been waiting months."

"You know, the fact that he's got something (cancer) it could have been too late to do anything about it."

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MARY'S JOURNEY

ABOUT MARY:

Mary is a 71 year old, white British female in Hywel Dda. She is a retired nurse and enjoys walking.

REASONS FOR REFERRAL:

Mary had been experiencing severe weakness and tiredness. She had visited her GP who had sent her for blood tests but he was confused by the results and decided to refer her to the RDC. The RDC then phoned Mary and explained what would happen and that if she needed a CT scan she would have one that day. Mary had seen her GP in early September but he then contracted Covid-19 so her referral was delayed. Mary was seen at the RDC at the end of September.

Late September — Mary arrived at the RDC.

Same day — Within minutes she was taken to have **tests and observations.**

Few hours later — Mary had a **CT scan** to try and determine the cause of her symptoms.

Same day — Mary was **called that day with the results.**

Same day — Mary was given the **all clear for cancer** but they **discovered a problem with her lung.**

OUTCOME FOR MARY:

Mary was told that she did not have cancer but she did have a problem with her lung. She was referred to a pulmonary specialist straight away.

"Excellent experience in the clinic. Excellent. Outstanding Care. The nurses were brilliant. The doctors were lovely, and I couldn't say a bad word, but they were wonderful."

"I suppose we can't have one in every area, you know it would be nice if we did."

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MATTHEW'S JOURNEY

ABOUT MATTHEW:

Matthew is a 71 year old, white British male in Betsi Cadwaladr. He is retired, lives in a village and loves gardening.

REASONS FOR REFERRAL:

Matthew had been losing weight and was experiencing muscle loss and night sweats. He had been visiting his GP for quite a while about it and was undergoing blood tests. His GP wasn't sure what the issue was and was going to send him for an ultrasound on his liver. Matthew's son had heard about the RDC and contacted his fathers GP to ask if Matthew could be referred there. His GP agreed and referred Matthew at the end of March.

Mid-April

Matthew was **referred to the RDC in late March,** but couldn't be seen until **mid April.**

Same day

Matthew attended the RDC and had **CT scan straight away.**

Few hours later

Matthew was **diagnosed with lymphoma.**

A month later

Matthew was **referred for a biopsy which he had a month later and then started chemotherapy.**

OUTCOME FOR MATTHEW:

Matthew was diagnosed with lymphoma which he was told was treatable and responsive to treatment. If he had only had the ultrasound scan (recommended by his GP) it would not have detected the lymphoma and would've delayed treatment.

"I don't think it could have been better. They were really understanding the way that they spoke to me. You know, it put you at ease, you know, you knew what was happening."

"Because I went to the rapid diagnostic clinic they caught it early."

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Appendix C.1: Case study for Aneurin Bevan RDC

RAPID DIAGNOSIS CLINICS CASE STUDY

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Aneurin Bevan University Health Board

Overview

Population: 588,000

GP practices: 90

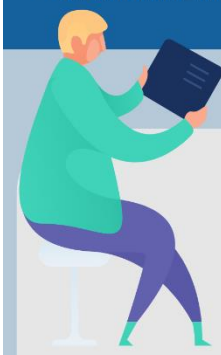
RDC start date: October 2020*

Workforce: GP / Consultant Physician - Radiologist - CNS - Radiology Nurse - Clinic Co-ordinator - Clinical Lead

RDC model: 2-stop ** & 1 clinic per week (5 slots total)

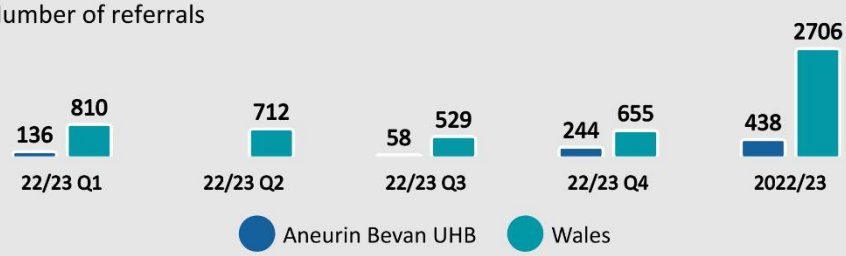
RDC clinic location: Grange University Hospital

*Service paused between Jun and Oct 2022
**CT + consultation with physical assessment on different days



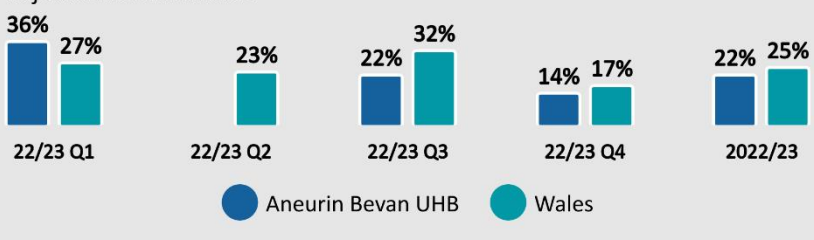
RDC OUTPUTS

Number of referrals



(No data in 22/23 Q2 for ABUHB due to service being paused)

Rejected referral rates

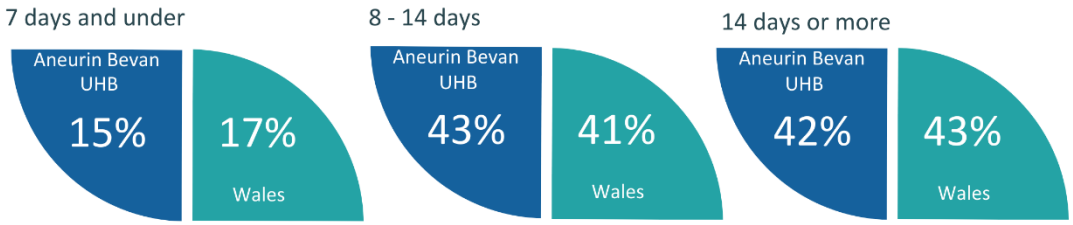


(No data in 22/23 Q2 for ABUHB due to service being paused)

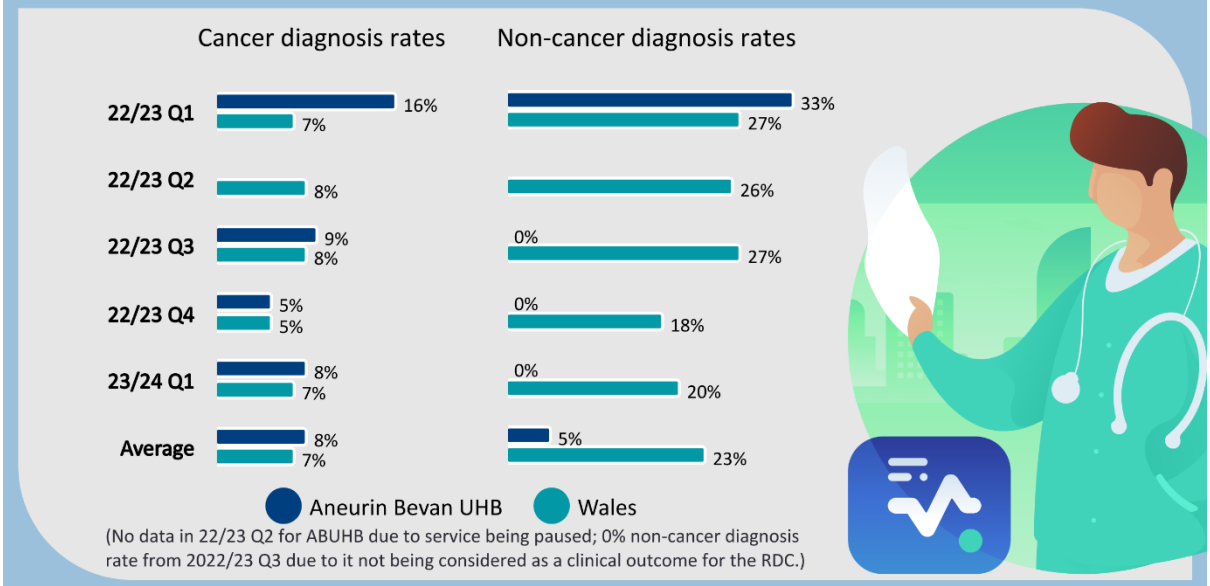
Average number of days between referral and RDC appointment

	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Average
Aneurin Bevan UHB	21	No data	12	15	9	14
Wales	17	16	14	13	16	15

PERCENTAGE OF PATIENTS SEEN WITHIN



Period: 22/23 Q1 – 23/24 Q1. Figures may add up to more than 100% due to rounding issue.



(No data in 22/23 Q2 for ABUHB due to service being paused; 0% non-cancer diagnosis rate from 2022/23 Q3 due to it not being considered as a clinical outcome for the RDC.)

PROPORTION (OF ACCEPTED REFERRALS) OF PATIENTS WHO WERE UNABLE TO ATTEND AT ANY POINT

Period: 22/23 Q1 – 23/24 Q1

Aneurin Bevan UHB	Wales
4.2%	4.1%

PATIENT EXPERIENCE

RDC patient experience survey was sent out via DrDoctor to 129 patients who attended the RDC clinic between 1st April and 31st August 2021. 34 of them took part, resulting in a response rate of 26%. The survey results suggest that, overall, patients had a very positive experience of the clinic, and that it was not an issue for them to attend the clinic twice (first time for the CT scan and second time for the consultation and physical assessment).

Information and communication prior to RDC attendance

the RDC information leaflet was easy to understand — 100%

GPs fully explained the referral — 59%

GPs provided patients with a RDC information leaflet — 38%

"An exceptional service from beginning to end."

RDC clinic experience

91% — Very/quite easy to attend the clinic twice

88% — Had not difficulties travelling to the RDC

82% — Results were completely explained by the RDC team

"The kindness of staff and speed of treatment was so much better than the regular referral route. I'm very grateful to all the RDC staff and hope this programme can be extended."

79% — Given clear information about what would happen next

71% — The pre-clinic call was very/somewhat useful

Amazing service. Everybody that I was in contact with could not do enough for me."

STAFF FEEDBACK

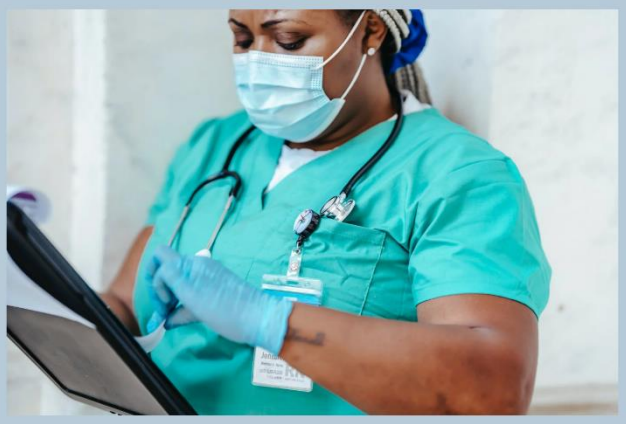
Impact of the RDC

The RDC massively sped up patients' pathway compared with how they were before.

It has helped improve the relationship between radiologists and GPs – better collaboration between primary and secondary care.

Strong clinical leadership and ownership, including being under the clinical delivery division, has helped improve how the RDC is operated in Aneurin Bevan UHB.

A primary care cancer referral intranet page was launched recently which enables GPs to check what the criteria for RDC referrals are and tests needed to help improve the quality of referrals.



"It [the RDC] massively sped up patients' pathway compared with how they were before. The programme takes weeks out of their individual pathway."

"It's beneficial when you think about patients having one appointment with another to another to another and you know the longer term delay of actual diagnosis.....how many times they would have to be seen and then how much that would cost being seen by different services, the administrative support, the time etcetera."

Future considerations

- Adapt current protocols/systems so that GPs can sign off patient letters at their own surgery rather than wait until they are in the RDC next which could lead to delays in the pathway. (The consultant physicians of the clinic are mainly locum GPs and some only cover the clinic once a fortnight.)
- How to future proof the nursing role and capacity within RDC
- Continue to engage and educate GPs about RDC, e.g. its purpose and the referral criteria

Evaluated and produced by m·e·l research

Appendix C.2: Case study for Betsi Cadwaladr RDC

RAPID DIAGNOSIS CLINICS CASE STUDY

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Health Board

Overview

Population: 687,000

GP practices: 119

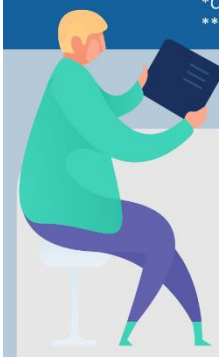
RDC start date: March-April 2022

Workforce: GP / Consultant Physician - Radiologist - CNS - Clinic Co-ordinator - HCSW - Clinical Lead (x1 who covers all three sites)

RDC model: 1-stop* & 3 clinics per week (15 slots total)

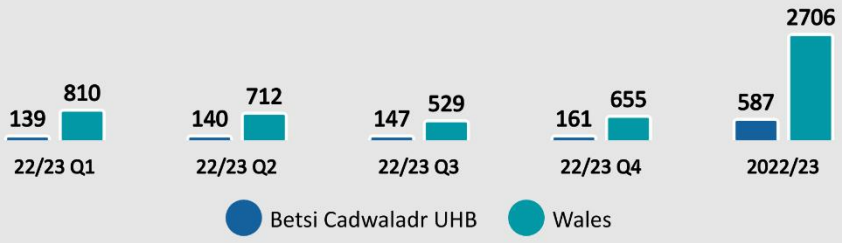
RDC clinic location: Gwynedd Hospital, Glan Clwyd Hospital and Wrexham Maelor Hospital**

*CT + consultation with physical assessment on the same day
**Wrexham Maelor Hospital also accepts referrals from North and Mid-Powys.

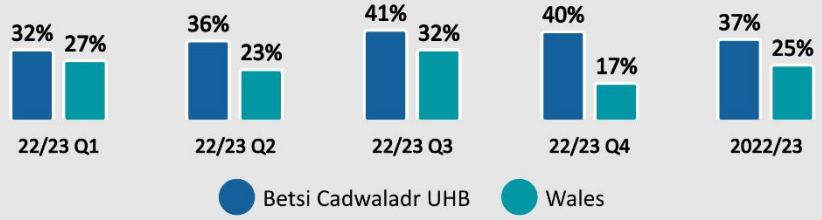


RDC OUTPUTS

Number of referrals



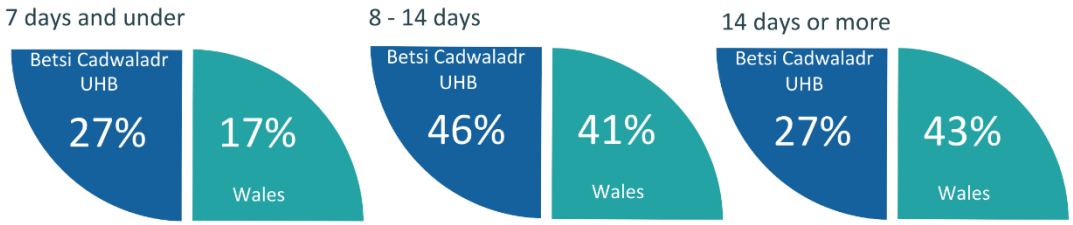
Rejected referral rates



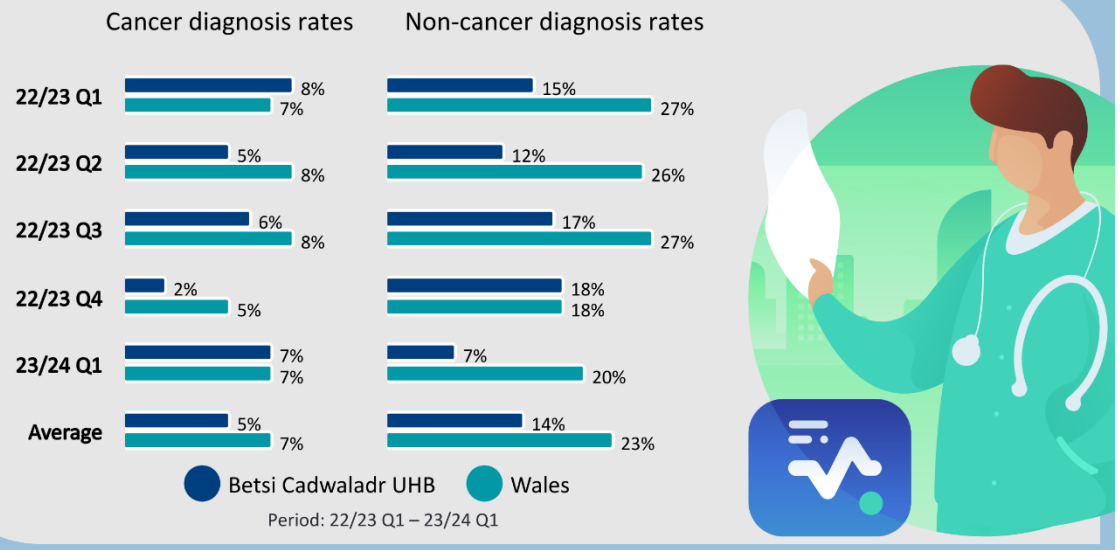
Average number of days between referral and RDC appointment

	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Average
Betsi Cadwaladr UHB	9	13	14	12	13	12
Wales	17	16	14	13	16	15

PERCENTAGE OF PATIENTS SEEN WITHIN



Period: 22/23 Q1 – 23/24 Q1. Figures may add up to more than 100% due to rounding issue.



Period: 22/23 Q1 – 23/24 Q1

PROPORTION (OF ACCEPTED REFERRALS) OF PATIENTS WHO WERE UNABLE TO ATTEND AT ANY POINT

Period: 22/23 Q1 – 23/24 Q1

Betsi Cadwaladr UHB	Wales
6.0%	4.1%

PATIENT EXPERIENCE

In financial year 2022/23, 367 RDC patients in Betsi Cadwaladr UHB were invited to give their feedback via the RDC Patient Experience Survey. 232 of them took part, resulting in a response rate of 63%. The survey results suggest that, overall, patients were highly satisfied with the RDC service, and that they felt well-informed and supported throughout the process.

Information and communication prior to RDC attendance

- GPs fully explained the referral 72%
- Had time to discuss the RDC information leaflet 39%
- GPs provided patients with a RDC information leaflet 45%

"All the information I've had from the hospital has been very, very clear and all the staff have really sat down and fully explained."

RDC clinic experience

- 99% Felt that they were treated with dignity and compassion by the RDC team
- 99% Given clear information about what would happen next
- 99% Staff clearly explained what was going to happen during the appointment

"It's a very worrying period, but because it was a very quick appointment and because they gave you the results on the day, it took a lot of stress out of it for me and for the family."

- 97% Results were completely explained by the RDC team
- 95% Had the opportunity to discuss any concerns during the pre-clinic call
- 91% Had no difficulties travelling to the RDC

"It's enabled me to understand why this rapid weight loss and why I was getting the night sweats. The doctor had tried it, did all different types of blood tests. I would have had the liver ultrasound and that would have come back negative because the CT scans showed that the liver was OK..... So they would have just done the ultrasound of the liver and I would have not had the results [lymphoma cancer]."

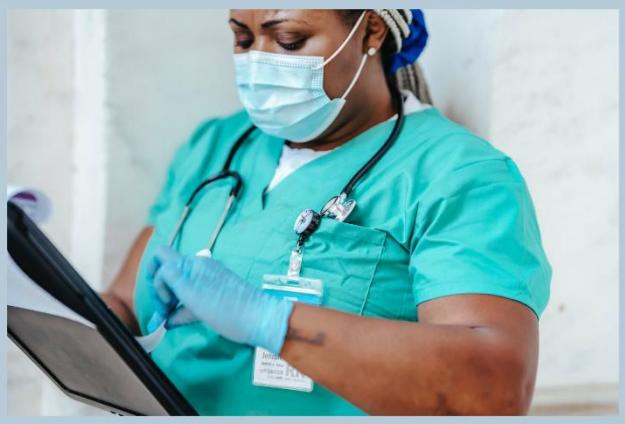
STAFF FEEDBACK

Impact of the RDC

The patients who are diagnosed with malignancy of unknown origin are usually diagnosed on an emergency admission, because they often present with very vague symptoms. Patients are being seen and diagnosed a lot quicker because of RDC.

The RDC provides primary care a referral pathway for patients with vague symptoms of cancer which benefits the primary care clinicians and the patients.

The nurses, the admin and the physicians, radiologists and doctors work well together to make for a smooth-running experience for patients.



"For the patient it can be stressful because their GP says to them, well I think we could do a CT scan but I'm going to have to ask to see if I can get you one and then I'll let you know if we have.....So it just cuts out all of that anxiety and waiting on things"

"Vague symptoms are a big, big problem for GPs, so I think having somewhere to send them to in secondary care is useful."

"It [RDC] saves the primary care an awful lot of time and it saves them an awful lot of problems from thinking about what's happening with this [CT scan] report."

Future considerations

Additional clinics may be required as the service becomes better known and the number of referrals continues to grow

More publicity and educational events with GPs about RDCs, especially face-to-face engagement, to improve quality of referrals

Evaluated and produced by m·e·l research

Appendix C.3: Case study for Cardiff & Vale RDC

RAPID DIAGNOSIS CLINICS CASE STUDY

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff & Vale University Health Board

Overview

Population: 492,000

GP practices: 55

RDC start date: April 2023

Workforce: GP / Consultant Physician - Radiologist - CNS - Clinic Co-ordinator - HCSW - Clinical Lead

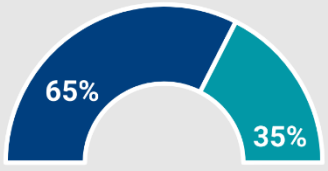
RDC model: 2-stop * & 2 clinics per week (10 slots total)

RDC clinic location: University Hospital of Wales

*CT + consultation with physical assessment on different days

RDC OUTPUTS

127 referrals in 2023/24 Q1

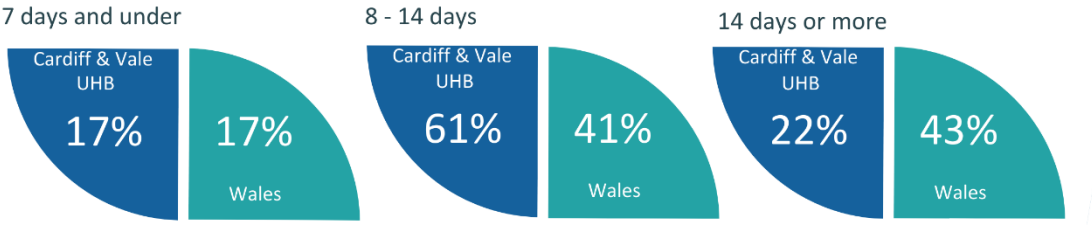


Accepted referrals Rejected referrals

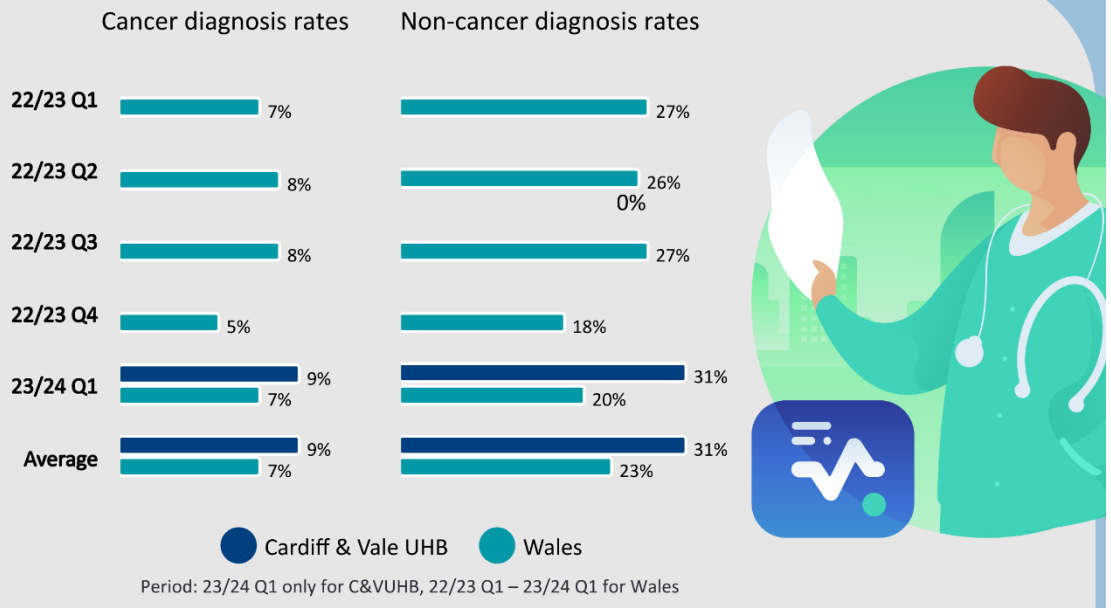
Average number of days between referral and RDC appointment

	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Average
Cardiff & Vale UHB	No data	No data	No data	No data	12	12
Wales	17	16	14	13	16	15

PERCENTAGE OF PATIENTS SEEN WITHIN



Period: 23/24 Q1 only for C&VUHB, 22/23 Q1 – 23/24 Q1 for Wales. Figures may add up to more than 100% due to rounding issue.



Period: 23/24 Q1 only for C&VUHB, 22/23 Q1 – 23/24 Q1 for Wales

PROPORTION (OF ACCEPTED REFERRALS) OF PATIENTS WHO WERE UNABLE TO ATTEND AT ANY POINT

Cardiff & Vale UHB	Wales
7.2%	4.1%

Period: 23/24 Q1 only for C&VUHB, 22/23 Q1 – 23/24 Q1 for Wales

STAFF FEEDBACK

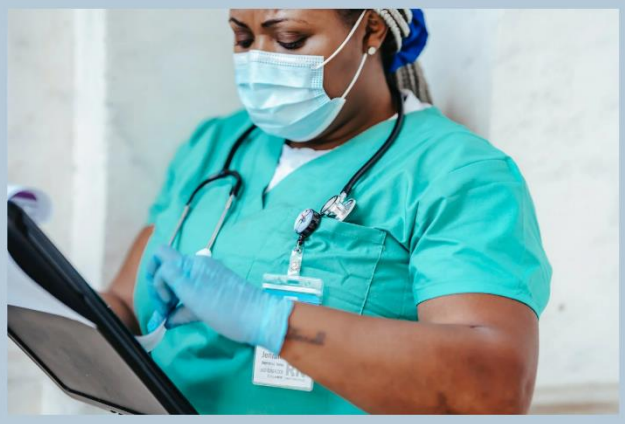
Impact of the RDC

Improved staff job satisfaction and team working

Validating patients' worries and concerns, allowing prompt investigation and follow-up treatments if required

Providing rapid access to diagnostic test to investigate vague but worrying symptoms that do not fit standard USC pathway criteria.

"I enjoy the undifferentiated nature of the patient problems we see and the opportunity and time to assess and manage patients holistically."



"That's what gives me that fire in my belly to make a difference to patients' lives and the clinic in general is making a difference. And also for me, job satisfaction is through the roof."

"A single referral probably takes about 5 to 10 minutes to do, but if you're doing that for several patients a week, across every GP practice, that's a lot of time that you're saving from bounced referrals."

Future considerations

- Organising GP engagement and education events to raise awareness, clarify the purpose of RDC and its referral criteria
- Considering the impact of attending evening CT scan appointments in the winter months, especially for older patients

Evaluated and produced by m·e·l research

Appendix C.4: Case study for Cwm Tâf Morgannwg RDC

RAPID DIAGNOSIS CLINICS CASE STUDY

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Cwm Tâf Morgannwg University Health Board

Overview

Population: 442,000

GP practices: 67

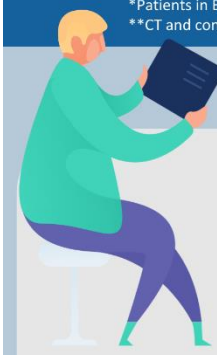
RDC start date: September 2017

Workforce: Consultant Physician - Radiologist - ANP - Clinic Co-ordinator x2 - HSW - Clinical Lead

RDC model: Hybrid model**, 2 clinics per week (30 slots total)

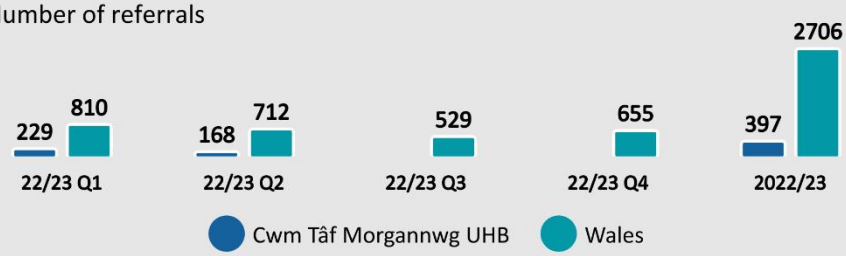
RDC clinic location: Rhondda Valley Hospital* (CT scans at Royal Glamorgan Hospital)

*Patients in Bridgend are currently referred to RDC in Swansea By UHB
**CT and consultation with physical assessment on the same day (1-stop) or on different days (2-stop)



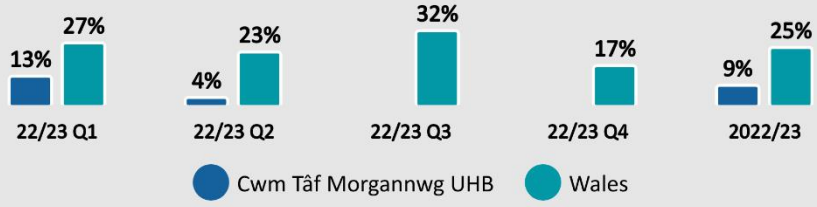
RDC OUTPUTS

Number of referrals



(Missing data for CTMUHB in 22/23 Q3 & Q4)

Rejected referral rates

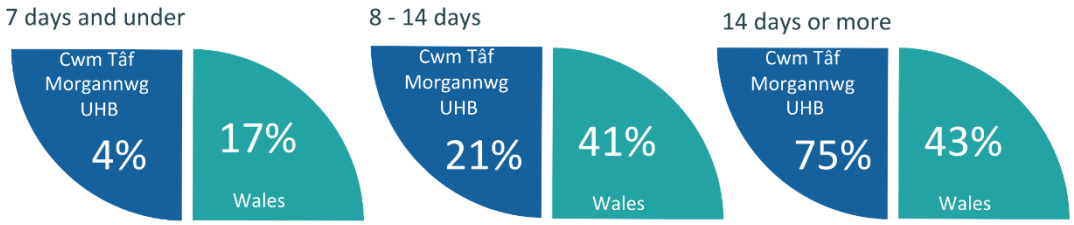


(Missing data for CTMUHB in 22/23 Q3 & Q4)

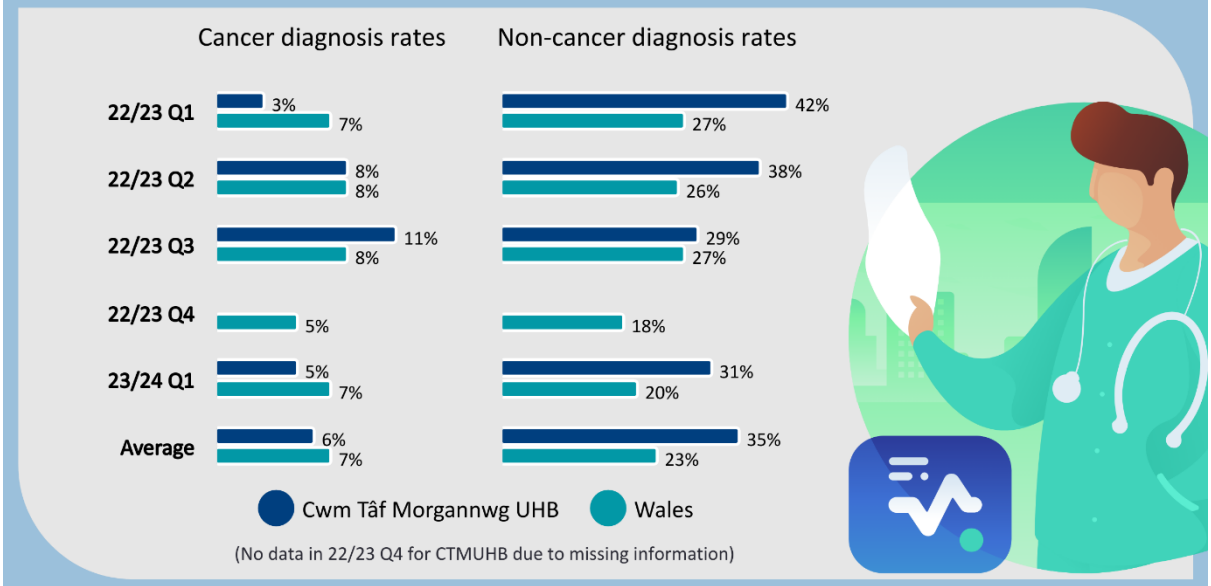
Average number of days between referral and RDC appointment

	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Average
Cwm Tâf Morgannwg UHB	26	27	No data	No data	21	25
Wales	17	16	14	13	16	15

PERCENTAGE OF PATIENTS SEEN WITHIN



Period: 22/23 Q1 – 23/24 Q1. Figures may add up to more than 100% due to rounding issue.



(No data in 22/23 Q4 for CTMUHB due to missing information)

PROPORTION (OF ACCEPTED REFERRALS) OF PATIENTS WHO WERE UNABLE TO ATTEND AT ANY POINT

Period: 22/23 Q1 – 23/24 Q1

Cwm Tâf Morgannwg UHB	Wales
4.4%	4.1%

PATIENT EXPERIENCE

"If only such clinic existed when my husband went through his illness. It took him many months to go through the diagnostic process and perhaps he would have been alive now had this clinic existed back then."

"It is great for us the patients, and it is great for the NHS as it meant I was put on the right medication as soon as possible"

"The process and care was fantastic and the speed of diagnosis took away all stress and fear that is associated when you are concerned that cancer is going to be diagnosed."

STAFF FEEDBACK

Impact of the RDC

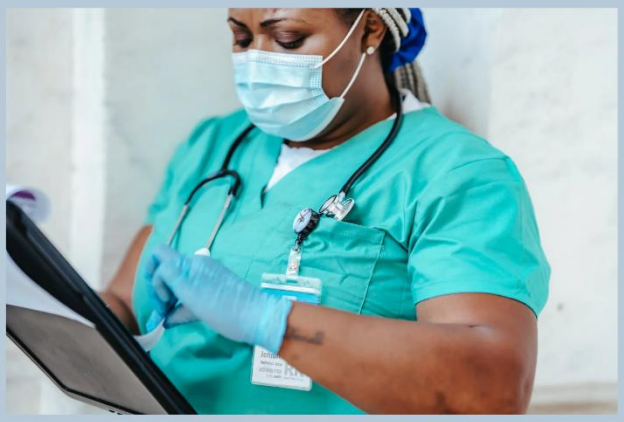
Providing holistic and speedy care for patients and somewhere for GPs to refer patients with vague symptoms

Improved communication with GPs which helps improve the quality of referrals

RDC related meetings have encouraged shared learning and collaboration with others

Well established and embedded within Cwm Tâf Morgannwg UHB

STAFF FEEDBACK



"The impact on patients is huge, having a quick and efficient pathway to offer reassurance or a diagnosis of a clinical condition in a relatively short period of time is game changing."

"I think it's more beneficial for the patient because obviously everything's done, and they sort of know the results on the day which I think was the aim from the beginning."

"It has a lot to do with validation of how patients are feeling and then just knowing that there's nothing wrong, which obviously is a massive impact on them."

Future considerations

- Looking into ways to improve the resilience of the RDC team to provide a consistent service to patients and a robust working model for staff
- Additional clinics and staffing might be required to deal with increased referrals
- Securing resource/support for teams in the Health Board to collect data needed to feed into the national dashboard on a quarterly basis

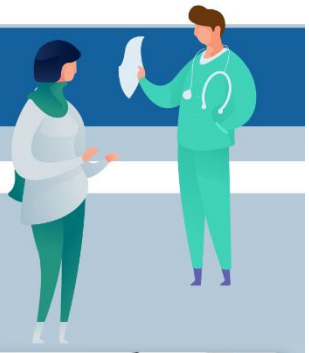
Evaluated and produced by m·e·l research

Appendix C.5: Case study for Hywel Dda RDC

RAPID DIAGNOSIS CLINICS CASE STUDY

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hywel Dda University Health Board



Overview

Population: 383,000

GP practices: 55

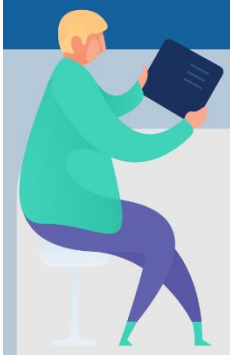
RDC start date: October 2021

Workforce: GP / Consultant Physician - Radiologist - CNS - Clinic Co-ordinator - HCSW - Clinical Lead

RDC model: 1-stop * & 1 clinic per week (5 slots total)

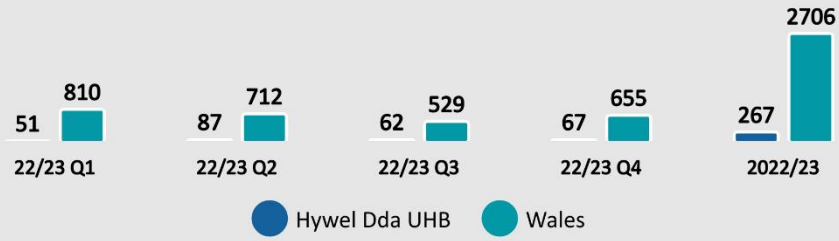
RDC clinic location: Prince Philip Hospital

*CT + consultation with physical assessment on the same day

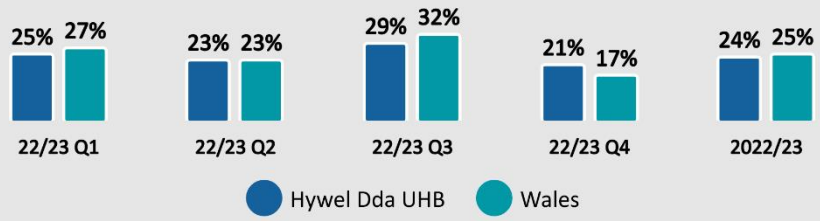


RDC OUTPUTS

Number of referrals



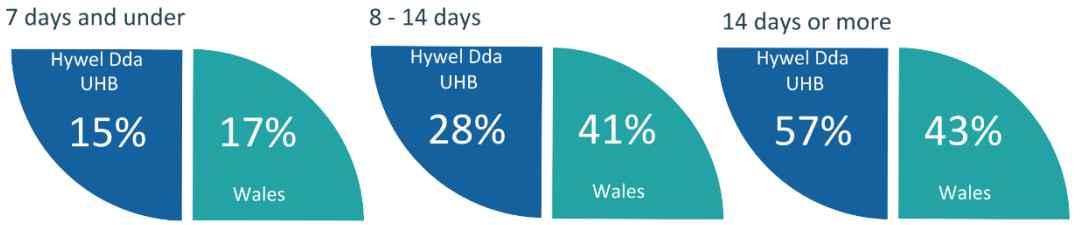
Rejected referral rates



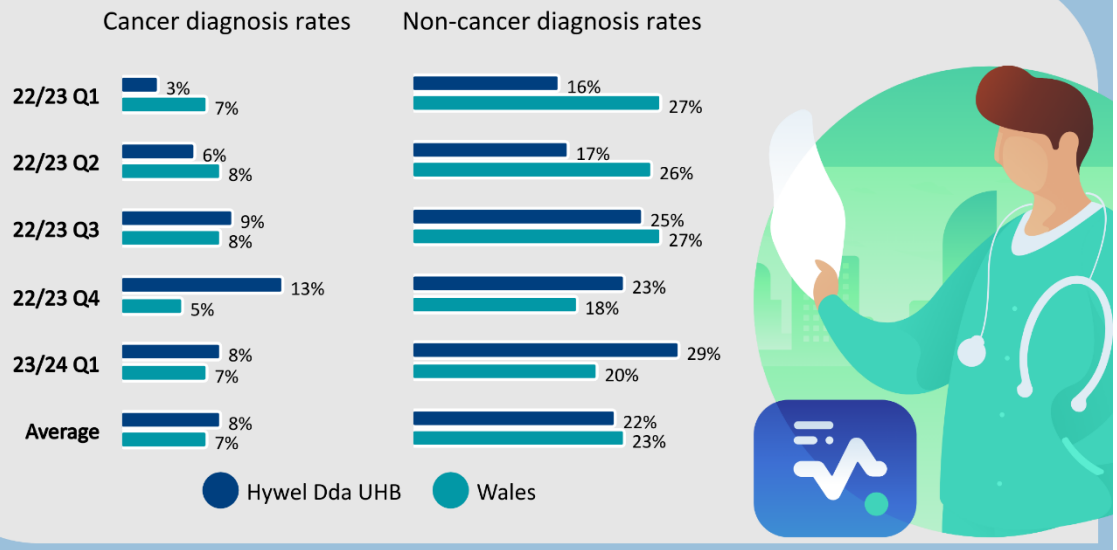
Average number of days between referral and RDC appointment

	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Average
Hywel Dda UHB	13	14	21	16	20	17
Wales	17	16	14	13	16	15

PERCENTAGE OF PATIENTS SEEN WITHIN



Period: 22/23 Q1 – 23/24 Q1. Figures may add up to more than 100% due to rounding issue.



PROPORTION (OF ACCEPTED REFERRALS) OF PATIENTS WHO WERE UNABLE TO ATTEND AT ANY POINT

Period: 22/23 Q1 – 23/24 Q1

Hywel Dda UHB	Wales
1.5%	4.1%

PATIENT EXPERIENCE

In financial year 2022/23, 770 RDC patients in Swansea Bay UHB were invited to give their feedback via the RDC Patient Experience Survey. 319 of them took part, resulting in a response rate of 41%. The survey results suggest that, overall, patients were highly satisfied with the RDC service, and that they felt well-informed and supported throughout the process.

Information and communication prior to RDC attendance

- GPs fully explained the referral — 67%
- Had time to discuss the RDC information leaflet — 47%
- GPs provided patients with a RDC information leaflet — 44%

"I can't speak highly enough of the clinic. The staff were fantastic."

RDC clinic experience

- 99% — Felt that they were treated with dignity and compassion by the RDC team
- 97% — Given clear information about what would happen next
- 95% — Staff clearly explained what was going to happen during the appointment

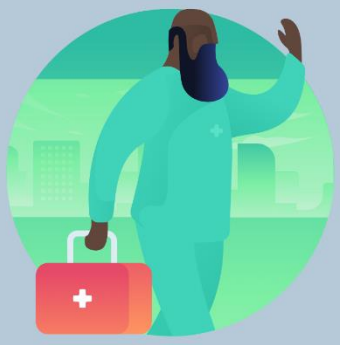
"He [the GP] advised us he was sending us to the Rapid diagnostic centre, which we never used before, we didn't know it existed. The appointment was for the following Friday... my husband was diagnosed with cancer of the kidney from that CT."

- 94% — Results were completely explained by the RDC team
- 93% — Had no difficulties travelling to the RDC
- 93% — Had the opportunity to discuss any concerns during the pre-clinic call

"So as soon as we got in there within the 1st 10 minutes, bloods were taken and then my dad was seen and then referred for a CT scan and then the outcome and then an MRI scan from 8:45 till about 2:00 o'clock."

STAFF FEEDBACK

Impact of the RDC

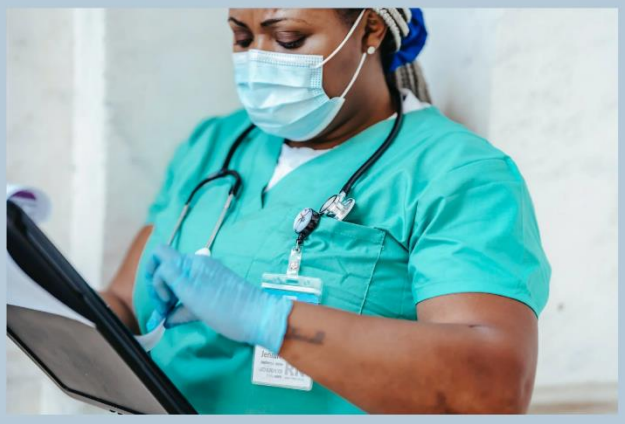


Picking up a lot of non-cancer diagnoses and making onward referrals

Starting up a new service working with dietitians to support patients with weight loss but non-cancer diagnosis

Excellent for vague symptoms and as a one-stop service, much quicker for the patient between being referred and diagnose, especially for catching advanced cancers

Providing a more joined up service and enabling the CNS to be the single point of contact for the patient as they go through the diagnostic journey



"It was a very rewarding role being able to do things properly. There was a definite unmet need. The whole service, the whole concept of the RDC was filling a previous, you know, huge gap for people."

"The benefits have been a fast reliable service that delivers within the cancer targets. Patients, family and friends are prevented from long delays receiving their results and avoids undue stress."

Future considerations

Explore opportunities to improve equity of access to an RDC in Hywel Dda UHB (the Health Board covers a large geographical area and is predominantly rural in the southwest of Wales)

Educate and engage with GPs who have not referred patients to RDC

Evaluated and produced by m·e·l research

Appendix C.6: Case study for Swansea Bay RDC

RAPID DIAGNOSIS CLINICS CASE STUDY

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Swansea Bay University Health Board

Overview

Population: 380,000

GP practices: 58

RDC start date: July 2017

Workforce: GP / Consultant Physician - Radiologist - CNS - Clinic Co-ordinator - HCSW - Clinical Lead

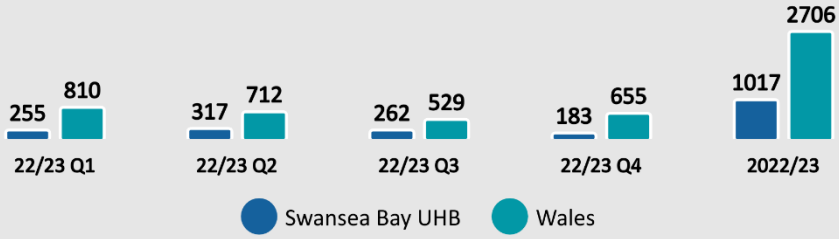
RDC model: 1-stop * & 2 clinics per week , plus 2 x monthly clinics to meet demand

RDC clinic location: Neath Port Talbot Hospital

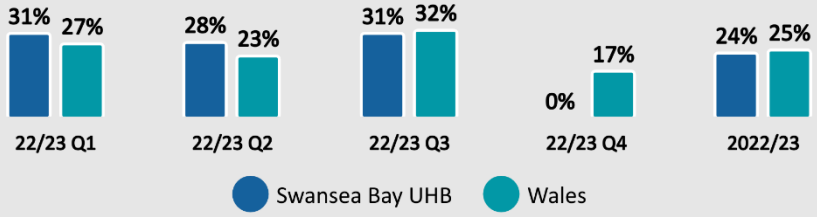
*CT + consultation with physical assessment on the same day

RDC OUTPUTS

Number of referrals



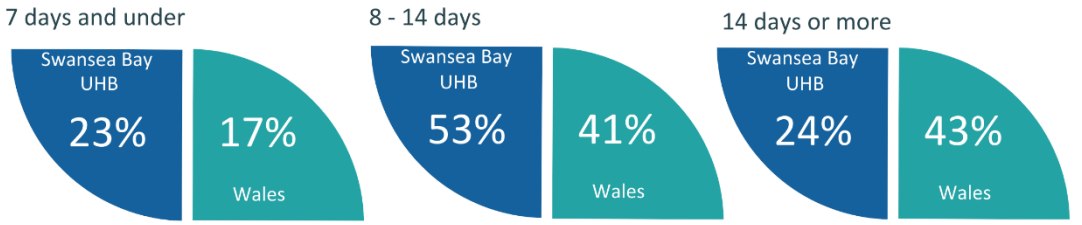
Rejected referral rates



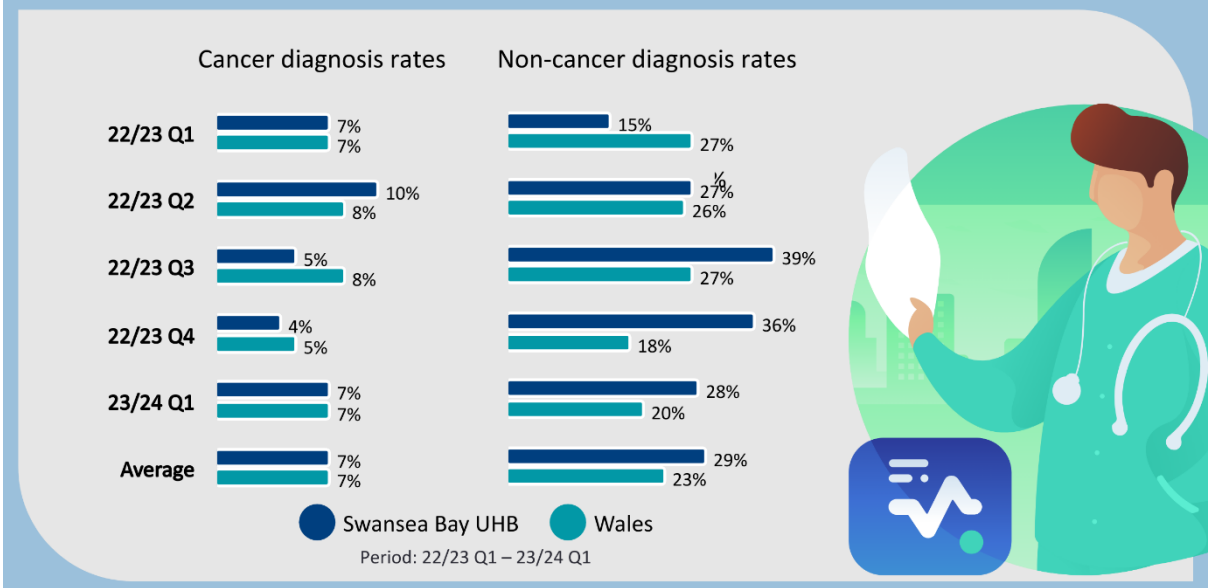
Average number of days between referral and RDC appointment

	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	Average
Swansea Bay UHB	11	11	13	9	13	11
Wales	17	16	14	13	16	15

PERCENTAGE OF PATIENTS SEEN WITHIN



Period: 22/23 Q1 – 23/24 Q1. Figures may add up to more than 100% due to rounding issue.



Period: 22/23 Q1 – 23/24 Q1

PROPORTION (OF ACCEPTED REFERRALS) OF PATIENTS WHO WERE UNABLE TO ATTEND AT ANY POINT

Period: 22/23 Q1 – 23/24 Q1

Swansea Bay UHB	Wales
3.4%	4.1%

PATIENT EXPERIENCE

In financial year 2022/23, 770 RDC patients in Swansea Bay UHB were invited to give their feedback via the RDC Patient Experience Survey. 319 of them took part, resulting in a response rate of 41%. The survey results suggest that, overall, patients were highly satisfied with the RDC service, and that they felt well-informed and supported throughout the process.

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"So as soon as we got in there within the 1st 10 minutes, bloods were taken and then my dad was seen and then referred for a CT scan and then the outcome and then an MRI scan from 8:45 till about 2:00 o'clock."

STAFF FEEDBACK

Impact of the RDC

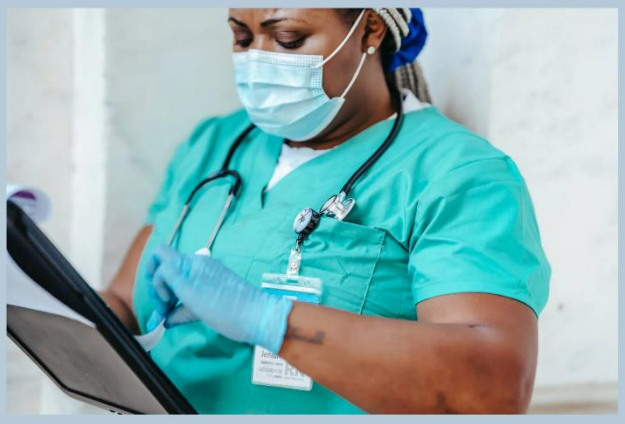
Patients are not 'bounced around the system' and are being seen quite quickly

Number and quality of referrals are improving due to GP engagement and education

Other life-threatening and life-changing conditions (non-cancer) have been identified

Other cancer specialties are using external funding to trial the RDC model within specific pathways

Overall a positive experience for both patients and staff



"It's really rewarding to be part of the pilots that show that things can be done to make things better across the board. I've been really, really proud to be part of it actually."

"The ethos of RDC is just remarkable. Patients are just seen so quickly and the support they receive is phenomenal."

Future considerations

- Secure resource for endoscopy sessions to expand diagnostic ability within the RDC
- Additional clinics and staffing would be required to deal with increased referrals
- Continue with GP education to improve the quality of referrals

Evaluated and produced by m·e·l research

m·e·l research