



**Rapid Diagnosis Clinics:
A National Programme for Wales**

**Implementation specification for health
boards across Wales**

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Statement

This document has been developed to set out the core specifications for Rapid Diagnosis Clinics in Wales that should be adopted by each individual health board.

In creating this document, the NHS Wales Cancer Network has reviewed the requirements and standards of care that are expected to deliver this service.

Disclaimer

Wales Cancer Network assumes that within each Health Board healthcare professionals will use their clinical judgment, knowledge and expertise when deciding when it is appropriate to apply this document.

This document does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Wales Cancer Network disclaims any responsibility for damages arising out of the use or non-use of this document.

Equality impact and assessment

The Equality Impact Assessment (EQIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable Health Boards to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re-assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity, and language (Welsh).

This policy has been subjected to an Equality Impact Assessment.

The Assessment demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

1. Introduction

The purpose of this document is to:

(1) Outline the vision and approach for how rapid diagnosis clinics will develop and support the transformation of cancer diagnosis services over time.

(2) Provide an implementation specification for Health Boards to begin setting up their local Rapid Diagnosis Clinics. This specification is to ensure that the phased implementation across Wales is aligned to and achieves the end vision.

(3) Outline how Wales Cancer Network proposes to work with Health Boards and local providers to iterate and standardise the Rapid Diagnosis Clinic service model as we learn from implementing them in practice beyond the pilot centres.

1.1 Background

Data from the latest Welsh Cancer Intelligence and Surveillance Unit (WCISU) show that whilst overall cancer survival rates in Wales continue to increase, the degree of improvement is slowing down¹. Wales has the highest European age-standardised rate (EASR) per 100,000 population for new diagnosis of cancer (all cancers except non melanoma skin cancer (NMSC)). In addition, Wales has the lowest overall one year and five-year all-cancer survival and highest cancer mortality rates in certain cancer types as published by the International Cancer Benchmarking Programme (ICBP)².

Health inequalities remain apparent, with five-year survival in the most deprived areas being only 75% of that in the least deprived areas, and the gap widens further for specific cancer groups such as breast and lung. Furthermore, international cancer survival comparative studies have ranked Wales in the lower half of 32 selected countries for twelve types of cancer³.

¹ Welsh Cancer Intelligence and Surveillance Unit (2019) Cancer survival in Wales, 1995 – 2016: official and statutory statistics; Available at <https://phw.nhs.wales/services-and-teams/welsh-cancer-intelligence-and-surveillance-unit-wcisu/cancer-survival-in-wales-1995-2016/>

² International Cancer Benchmarking Partnership. Available at https://www.cancerresearchuk.org/health-professional/data-andstatistics/international-cancer-benchmarking-partnership-icbp/publications#Publications_ICBP1

³ De Angelis R.; Sant M.; Coleman M.P. *et al.* Cancer survival in Europe 1999-2007 by country and age: results of EUROCARE-5-a population-based study. *Lancet Oncology* 2014; **15:23**-34.

The Cancer Delivery Plan (2016-20)⁴ described a shared vision for the people of Wales where risk is minimised and cancer incidence, mortality, and survival rates are improved and comparable with the best. The next phase of cancer service development must take advantage of the widespread consensus that has emerged on priority areas. Namely, that cases of cancer are detected at an earlier, more treatable stage, diagnostics are streamlined and made more accessible, and complex treatment pathways are optimised. Throughout this process it remains vitally important that patients' holistic needs are properly supported and they are empowered to co-produce their own care.

A key step towards improving patient experience and outcomes from cancer is the implementation of the Suspected Cancer Pathway (SCP) in Wales. Welsh Health Boards and NHS Trusts are now in the process of developing plans to ensure that all patients, from the point at which cancer is first suspected, will receive diagnostic tests and start their first definitive treatment within 62 days.

Prior to the introduction of the SCP, patients diagnosed via non-urgent pathways may have had to wait up to 8 weeks for a radiological investigation or 18 weeks for a clinic appointment which can have a detrimental effect on clinical outcomes. The SCP will more accurately reflect patient experience from the first point of suspicion of cancer through a unified waiting time measure. For those patients who do not have cancer, this will ensure prompt reassurance, and reduce unnecessary stress and anxiety.

The ethos of Rapid Diagnosis Clinics (RDC) therefore fits well with that of the SCP. Over half of all patients who are eventually diagnosed with cancer do not present with the red flag signs and symptoms that fit the National Institute for Health and Care Excellence (NICE) criteria for urgent referral (NG12)⁵.

A significant proportion of this group will have non-specific, vague and persisting symptoms, such as weight loss or new pain, which causes a great deal of distress and a steady decline in overall health and wellbeing. In the absence of a holistic diagnostic service for these patients, GPs with their 'gut feeling' that there is malignant pathology often struggle to access timely diagnostics and end up making consecutive referrals until a diagnosis is eventually made. Yet more delays are introduced when patients with these vague symptoms are deemed not to meet current site-specific referral criteria, both objectively and through interpretation of the referral,

⁴ Wales Cancer Delivery Plan 2016-2020. Available at <https://gov.wales/cancer-delivery-plan-2016-2020>

⁵ National Institute for Health and Care Excellence (2021) Suspected Cancer: Recognition and Referral. Available at Wales Cancer Delivery Plan 2016-2020. Available at <https://gov.wales/cancer-delivery-plan-2016-2020>

leading to the downgrading of referrals in secondary care without discussion with the referring physician. This situation clearly has consequences in terms of outcomes and demonstrates the unmet need that exists for both this patient group and primary care.

The RDC programme will address these difficulties by improving efficiency through the patient journey. By reducing variation, improving the transition between primary and secondary care, and providing direct access to diagnostic services, the RDC, alongside the SCP will work to improve both patient experience and cancer outcomes.

1.2 The RDC Programme in Wales

Wales Cancer Network supported a multi-disciplinary team visit to Denmark in 2016 to learn from colleagues who were tackling similarly poor cancer survival outcomes. The focus was on supporting earlier diagnosis by developing a three-legged strategy⁶:

- I. Fast track pathways for patients with red flag symptoms pointing to specific tumour sites.
- II. GP direct rapid access to key diagnostic tests such as colonoscopy or low dose CT, for patients with common symptoms where a specific cancer was a distinct possibility. These are known as 'YES/NO' clinics.
- III. Multi-disciplinary diagnostic centres for GPs to directly refer patients with vague but concerning symptoms in whom cancer was a significant differential diagnosis, but who had no site-specific features.

Wales Cancer Network set about testing the Danish model with two RDC pilots set up in Cwm Taf Morgannwg and Swansea Bay University Health Boards with funding from the Cancer Pathway Innovation Fund. The aim was to evaluate if direct GP access to these diagnosis clinics led to faster diagnosis, onward referral, and initiation of cancer treatment in patients with vague symptoms. A second ambition was to drive an increase in the number of earlier stage cancers diagnosed, enabling more patients to receive treatment, leading to an improved experience and outcome, with overall fewer delays than we know this cohort currently experiences in the system.

The RDC addressed a clearly unmet need for patients with vague symptoms who did not meet the 'red flag' urgent referral criteria for cancer. Evaluation of the pilot projects was overwhelmingly positive with good engagement and feedback from patients and GP clusters. The pilots demonstrated a

⁶ Vedsted, P., Olesen, F (2015). A differentiated approach to referrals from general practice to support earlier cancer diagnosis – the Danish three legged strategy. **Br J Cancer** 112(Suppl 1): S65–S69

significant reduction in time to diagnosis through the RDC pathway and furthermore, a cost effectiveness study undertaken by the Swansea Centre for Health Economics (Swansea University), found significant financial savings per cancer diagnosis made. Conversion rate to cancer for all referrals was 6% in Cwm Taf and 11% in Swansea Bay, well above the 3% threshold for investigation recommended by current NICE guidance (NG12).

Learning has also been shared from the experiences and evaluations to date of the Multidisciplinary Diagnostic Centre (MDC) service models developed as part of the Accelerate, Coordinate Evaluate (ACE) Programme in England. Cancer Research UK's ACE Programme piloted MDCs across five English sites. All pilots were symptom based and multidisciplinary, using a rapid general diagnostic pathway that was patient focused. They demonstrated comparable conversion rates for cancer diagnosis (8%) across a broad range of tumour sites⁷. Importantly, the results further validated GP 'gut feeling' of cancer in patients with persistent vague symptoms as a statistically significant independent predictor.

The ACE programme does differ significantly in that some centres have tailored pathways to investigate specific tumour site symptoms, as a way of tackling underperformance of current urgent suspected cancer pathways. The Welsh RDC programme offers GPs a clear point of access to multi-disciplinary assessment and diagnosis based on their clinical intuition and knowledge of the patient. This holistic approach ensures a true vague symptoms pathway that is designed to identify the cause of the patients' symptoms, whether cancer related or otherwise.

A number of National Optimal Pathways (NOPs) have already been developed which clearly map out expected timelines for the investigation and treatment of cancer regardless of the route of entry into the system. The Vague Symptoms pathway was developed with input from key stakeholder groups to ensure this cohort of patients have access to the same services and support from the point of referral. On the 21st June 2022 the Vague Symptoms pathway was approved by the NHS Collaborative Executive Group and mandated by Welsh Government as a Welsh Health Circular on the 28th July 2022.

Rapid Diagnosis Clinics were announced as part of the NHS Long Term Plan (2019)⁸ in England which also recognised the need for radical investment and reform of diagnostic services. Capacity was already stretched due to steadily rising demand, which was having knock on effects on diagnostic waiting times, cancer and elective care, even prior to the COVID-19 pandemic. In light of these findings, a key recommendation from the

⁷ Chapman, D., Poirier, V., Vulkan, D. et al. (2020) First results from five multi-disciplinary diagnostic centre (MDC) projects for non-specific but concerning symptoms, possibly indicative of cancer. *Br J Cancer* **123**, 722–729.

⁸ NHS Long Term Plan 2019. Available at <https://www.longtermplan.nhs.uk/online-version/>

Richards Report⁹ is the establishment of community diagnostic hubs. These have been defined as highly productive elective diagnostic centres for a range of specialty conditions. It was recognised that in the case of cancer, community diagnostic hubs should be aligned with the delivery of RDCs and incorporated into that service model.

1.3 RDC Aims and Objectives

RDCs will aim to deliver on an important unmet need for cancer patients in Wales by offering:

- A single point of access to a diagnostic pathway for all patients with vague symptoms that could indicate cancer.
- Personalised, accurate, and rapid diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally.

Through implementation RDCs will strive to achieve the following objectives:

- Support **earlier and faster cancer diagnosis** by assessing patients' symptoms holistically and providing a tailored pathway of clinically relevant diagnostic tests as quickly as possible, targeting and reducing any health inequalities that may currently exist;
- Provide **reassurance and early discharge** for those patients with no, or non-serious disease, thus increasing capacity through appropriate and efficient use of finite services;
- Deliver a **better, personalised diagnostic experience for patients** by providing coordinated testing with a single point of contact, thus supporting them from point of suspicion through to diagnosis in an ambulatory care setting;
- **Reduce unwarranted variation** in referral for, access to, and in the reliability of relevant diagnostic tests by setting standards for RDCs nationally, mandating consistent data collection to enable benchmarking and providing regional support to roll out RDCs. Data return from all health boards will allow ongoing evaluation and further research into the clinical model;

⁹ Richards, M (2020). Diagnostic Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England. Available at <https://www.england.nhs.uk/publication/diagnostics-recovery-and-renewal-report-of-the-independent-review-of-diagnostic-services-for-nhs-england/>

- **Improve the working environment and development of staff** with new roles that incorporate training opportunities, greater flexibility, and a chance to work in innovative ways that are holistic, multi-disciplinary, and person centred.

Integral to the implementation of RDCs will be the support of the national endoscopy, pathology and imaging networks to ensure the best available use of existing capacity. Provision for regular rapid access testing, scanning, and live reporting will require flexibility and workforce planning, particularly on acute care sites until diagnostic hubs can be established.

2.0 The Road to Implementation

Phase 1:

Wales Cancer Network Visit to Aarhus and launch of the Welsh pilots

The Wales Cancer Network arranged for a multi-professional team from across Wales to visit Aarhus University and the Silkeborg Regional Hospital in Denmark to explore how they had radically transformed and improved their overall cancer survival. Their underlying principle of the 'three legged' strategy is that the organisation of healthcare systems should reflect the reality that early-stage cancer presents very differently in general practice, and unilateral focus on 'red flag' symptoms was not sufficient.

The introduction of RDCs provides a dedicated pathway for patients where primary care professionals have a 'gut feeling' that there may well be a malignancy, but symptoms do not point to a site-specific cancer. Following on from this visit, Cwm Taf Morgannwg and Swansea Bay University Health Boards piloted a vague symptoms pathway for patients with serious, non-specific symptoms that could be suspicious of cancer which cause the GP clinical concern.

Phase 2:

Cancer Implementation Group Evaluation of the pilot sites

In August 2020, the final Cancer Implementation Group (CIG) (now known as the Wales Cancer Network Board) evaluation of the pilot sites was completed, building on the findings reported in November 2019.

Summary of the findings (see *appendix 1* for the full report):

- The pilots successfully demonstrated a **reduction in the number of days from referral to diagnosis from 84.22 days** in the comparator arm **to 6.29 days** for patients diagnosed and discharged from the RDC. The comparator arm was defined as patients who were downgraded from their GP USC (Urgent Suspected Cancer) referral

and then subsequently found to have a cancer diagnosis as the cause of their symptoms.

- Swansea Bay and Cwm Taf Morgannwg **achieved a conversion rate of 11.1% and 6.4% respectively**, which is comparable to the 8% conversion reported by CRUK's ACE programme and significantly higher than the 3% conversion rate promoted by NICE.
- **35% received a significant non-cancer diagnosis** leading to timely onward referral and treatment for a range of chronic and complex health conditions (e.g. cardiac, respiratory, diabetes, and mental health).
- The service has been rated highly for providing a patient centred approach, whilst being accessible for primary care.
- Swansea Bay UHB data shows that **half of the patients (51.8%) diagnosed with cancer were at stage three and four**.
- The cost effectiveness study from Swansea Bay UHB ¹⁰ highlighted a **saving of £1,745 per cancer diagnosis made, and further reductions in cost per RDC patient from £651.54 to £485.25 if the clinic was increased from four to six patients**, compared to the costs of a down-graded patient from a USC pathway. With four or more patients the RDC outperforms standard clinical practice even whilst overestimating implementation costs.

Overall, patients presenting to the RDCs often have complex health needs, but typically present with advanced cancer, where urgent diagnosis and treatment have the potential to make a significant difference to patient outcomes and experience through timely access to diagnostics and treatment.

Phase 3: Scoping exercise with Health Boards across Wales

Following the successful outcomes of the pilot evaluation, the WCN conducted a scoping exercise with Health Boards (HBs) across Wales. Letters were addressed from the Clinical Lead and Interim Manager and disseminated out to each Health Board in July 2020, to establish their appetite, plans, and any support they would need to set up and implement a local RDC.

¹⁰ Sewell, B., Jones, M., Gray, H. *et.al.* (2020) Rapid cancer diagnosis for patients with vague symptoms: a cost-effectiveness study. *British Journal of General Practice*; **70** (692): e186-e192

There was a positive response to the results from the Welsh pilots and ACE Programme and colleagues acknowledged the benefits of a cost-effective, rapid access vague symptoms pathway. Furthermore, all the returned applications were keen to learn from the successful RDC approach taken in Swansea Bay and adapt this model to local service needs moving forward.

Project management was identified as a key resource to help assist with the scoping and planning phase, in particular to help develop business cases. Financial support was an additional need to help cover the cost of running the clinics and recruit additional members of staff, such as advanced nurse practitioners and administrative managers.

Swansea Bay UHB remain committed to taking on a leadership role within the national programme, expanding their regional diagnostic service, and providing an enhanced level of support, training and education to other sites.

Phase 4:
Chief Executive Approval for a National Programme

Following the scoping exercise, the WCN presented the pilot evaluation paper at the Collaborative Executive Group (CEG) meeting in September 2020, seeking approval to move forward with a national programme and consider the financial support requested by each of the Health Boards.

The CEG approved the development of a Wales Cancer Network-led national programme approach to the implementation of RDCs across Wales. It was noted that there was a need to define and aim for the best and most sustainable model for Wales, which embeds best practice from a workforce perspective, and to be clear about the overall impact on the cancer pathway.

In December 2020, the WCN held their inaugural meeting of the RDC Stakeholder Group chaired by the newly appointed clinical lead. This group was essential in creating opportunities for shared learning across Health Boards and other organisations in the third sector, government, and NHS England.

In 2022, all Health Boards have established or are in the process of establishing an RDC in their area. The RDC programme designed a data set to support service development and evaluation and this is currently being used by the Health Boards offering an RDC service.

2.1 RDC Access Criteria

For RDCs to remain efficient and effective a once weekly clinic model has been endorsed as the **minimum** set standard for all RDC clinics in Wales. Services operating more regionally may need to increase this frequency to accommodate demand. Further learning to help put this into practice will be shared by Swansea Bay who have successfully run twice weekly clinics.

Criteria for inclusion have been established to encourage appropriate primary care referrals from the outset. Similarly, exclusion criteria are in place to ensure patients do not enter the vague symptoms pathway when they are unsuitable or meet the criteria for other dedicated urgent referrals.

Inclusion Criteria:

The clinic is suitable for any patient aged 18 years and over who may present with vague symptoms such as:

- Unexplained weight loss
- Severe unexplained fatigue
- Persistent nausea and/or appetite loss
- New atypical pain e.g. abdominal or bone pain
- Unexplained abnormal blood tests e.g. anaemia, hypercalcaemia, thrombocytosis
- GP has a 'gut feeling' that there is serious underlying disease that is likely to be due to occult malignancy
- Patient is well enough, willing, and able to go through the process and attend the clinic day
- GP has requested 'Set A' bloods at the time of referral
- Patient is not suitable for any site-specific urgent pathway

Exclusion Criteria:

- Patient meets the criteria for a site-specific pathway or is already on the SCP
- Patient is under 18 years of age
- Symptoms are most likely due to a recurrence of known cancer
- Patient is too unwell to attend or clearly needs acute admission
- Patient is unwilling or unable to attend at short notice, or for a whole day if necessary
- A serious non-cancer diagnosis is **HIGHLY** likely

It is accepted that there may be some patients who are seen in the RDC and discharged back to the GP with no diagnosis being made, but in whom symptoms persist. GPs who remain concerned about these patients

are encouraged to discuss individual cases directly with the RDC before making a second referral.

3.0 The Vague Symptoms Pathway

The Vague Symptoms Pathway aims to establish a standardised process for all patients with vague symptoms **potentially due to cancer** from the point of referral through to diagnosis and onward treatment. The pathway accurately reflects current procedure at the RDC in Swansea Bay UHB which has continued to deliver a 'one-stop shop' approach for patients through the pandemic.

3.1 COVID-19 Considerations

We acknowledge that as the situation with the pandemic is evolving, the pathway represents a gold standard, which may be difficult to achieve due to changes in regulations and restrictions. Furthermore, health boards may need to devote more time and resources to different parts of the pathway according to their local resources, demand and capacity for radiology and pathology services, and workforce pressures.

The vision is to achieve an efficient pathway for patients with a single point of entry from their GP. In efforts to reduce footfall and time spent on acute sites some Health Boards are planning or currently operating a 'two-stop' approach. This means patients attending for imaging are not required to wait on site for reporting and results, instead attending a separate clinician appointment. Whilst this may be deemed necessary in the short term, WCN anticipates all RDC teams actively working towards achieving a 'one stop shop' approach in line with best practice.

It may also be necessary to incorporate virtual elements into the pathway. The multi-disciplinary team (MDT) meetings may need to be held virtually to minimise contact and travelling between sites. However, the face-to-face collaborative approach is a proven vital component of the cultural change RDCs enable. Evidence shows the model improves both staff and patient experience and virtual working may temporarily delay the development of shared working, team building, and a holistic consensus approach to the MDTs. Virtual working should therefore be reviewed regularly in line with official national guidance.

RDC administrators/managers should also confirm that the necessary expertise is present at every meeting to ensure a comprehensive and informed approach to the investigation and diagnosis of each patient. As a minimum every MDT should include a senior clinician, a radiologist, and the CNS/ANP key worker who can advocate for the patient. Virtual technology should be optimised to avoid unnecessary delays in decision making which will negatively impact on patient experience and delay initiation of treatment.

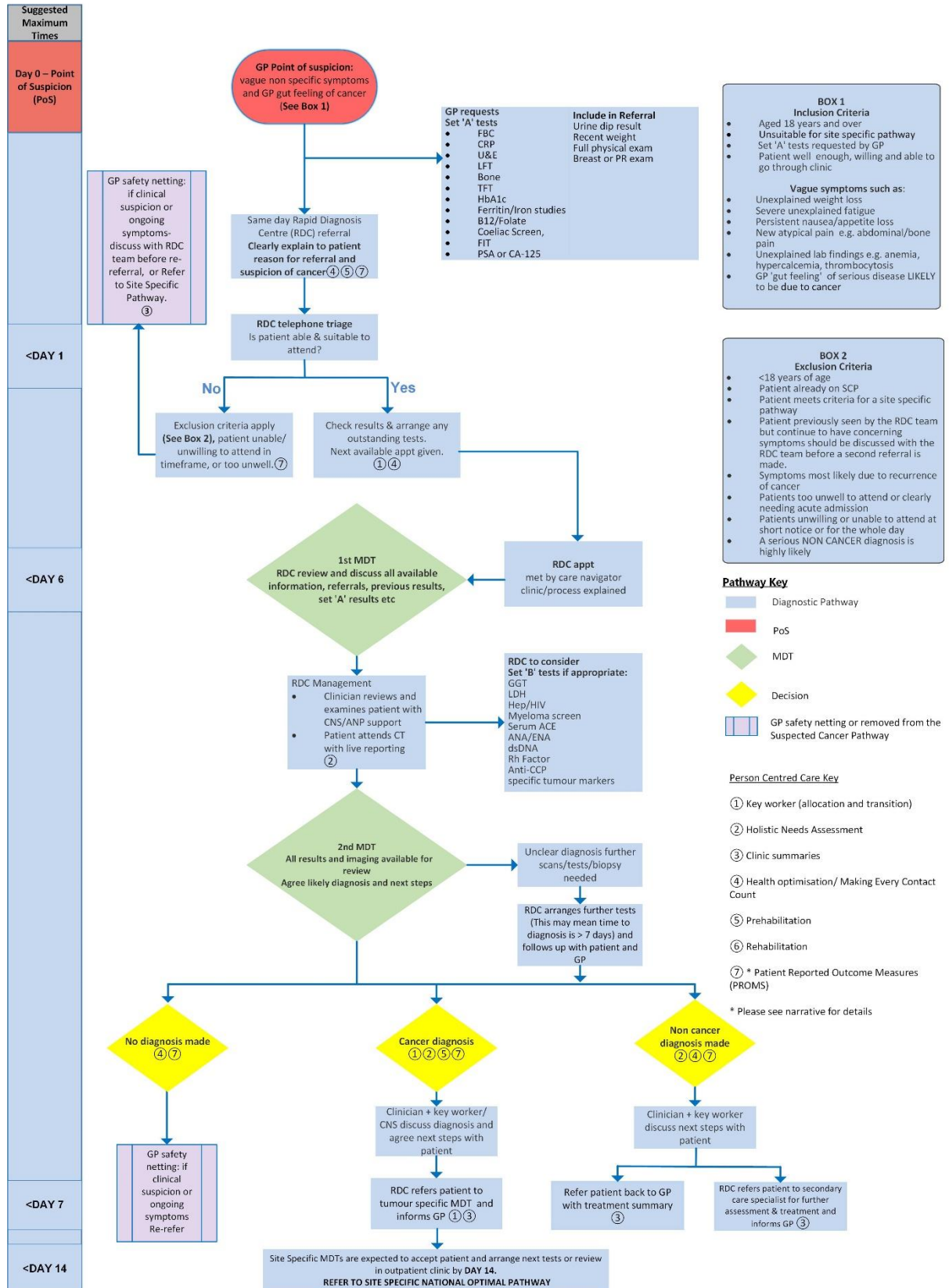
Most importantly, the pathway is designed to be a benchmark of what each RDC in Wales will ultimately strive to achieve. This should guarantee a uniform high standard of patient experience regardless of which RDC they attend in the country and regardless of the healthcare setting.

3.2 RDC: Vague Symptoms Pathway



Rhwydwaith
Cancer Cymru
Wales Cancer
Network

National Optimal Cancer Pathway for Patients with Vague (Non Specific) Symptoms: for patients aged 18 years and over



3.3 Person Centred Care

In line with existing NOPs the person centred care key has been applied to this pathway to highlight where patients should receive information, advice, and assessments tailored to meet their needs. All Health Boards should provide a key worker to patients at the time of diagnosis.

3.3.1 General health risk assessment and optimisation

The general health status of a patient at presentation and diagnostic stage will affect their ability to undergo potentially curative treatment, adhere to treatments, while also affecting quality of life and survival.

Failure to address any health issues identified has the potential to negatively impact on the efficacy of treatment. All patients should have a general health screen as per existing NOPs (Making Every Contact Count recommend that this includes anaemia, smoking and alcohol habits, review of comorbidity and screening for other morbidities)¹¹.

3.3.2 Holistic Needs Assessment

Each patient should be offered a holistic needs assessment (HNA) at identified intervals during their cancer pathway, beginning at the time of diagnosis in the RDC. Although not mandatory, subsequent assessments should continue to be offered as the patient progresses through their cancer journey to address any change in needs and priorities.

HNAs should be used to inform and develop a formal care plan which is produced and shared with the patient and their care providers across care sectors. The key worker should ensure the results of patients' HNA are considered in MDT decision making.

3.3.3 Prehabilitation

Prehabilitation is a holistic multidisciplinary approach which aims to improve physical condition, nutritional status and emotional fitness prior to treatment. By assessing all risk factors such as smoking, alcohol, nutritional deficit, and mental wellbeing early on in the cancer pathway teams can do their best to ensure the patient is as fit as possible for the treatment ahead.

Engaging with the multi-disciplinary team from the outset ensures referrals are tailored to the patients' individual needs and priorities. Addressing these needs prior to treatment has shown to not only improve mood and

¹¹ Making Every Contact Count (MECC). Public Health Network Cymru. More information available at <https://mecc.publichealthnetwork.cymru/en/about/>

adherence to treatments, but also improves resilience and the ability to cope with the rigours of treatment¹².

3.3.4 Rehabilitation

Each patient should have their multi-professional rehabilitation needs considered before, during, and after any treatment. Referral to local Allied Health Professionals (AHP) services should be made in a timely manner in order to meet these needs in accordance with the National Rehabilitation Standards for Wales¹³ and the network agreed rehabilitation pathway¹⁴.

3.3.5 Patient Reported Outcomes

Increasingly, patients are being asked to provide their views on their health and healthcare experiences using patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). These are important feedback tools that can be used to help assess and meet patient needs and understand their experience of the care being provided. The data can also identify areas of good and poor practice and provide an evidence base from which to drive service improvement.

Value in Health is a national programme of work striving towards achieving a Value-Based Health Care (VBHC) approach across NHS Wales in support of Prudent Healthcare principles¹⁵. The national action plan is working to embed patient relevant outcome measures into the system in a manner that facilitates direct delivery of care and shared decision making. Some specific cancer pathways such as lung and prostate are already available on the national PROMs platform. The RDC programme team have begun initial consultations with the VBHC team to work towards incorporating PROMs and PREMs into the RDC process. As work progresses there may be changes to how these person centred care elements are represented on the vague symptoms pathway and addressed in the clinic setting. A National RDC Patient Experience Questionnaire was co-produced by the RDC programme team, patient experience specialists and people affected by cancer (PABC). This will give a uniform set of questions to support the evaluation of patient experience across all Welsh RDCs.

¹² Prehabilitation and Optimisation Programme (POP) May 2018. Aneurin Bevan University Health Board. Available at <https://www.wales.nhs.uk/news/48312>

¹³ National Standards for Rehabilitation of Adult Cancer Patients, 2010, Welsh Assembly Government

¹⁴ Macmillan rehabilitation pathway available at: <https://www.macmillan.org.uk/assets/macmillan-cancer-rehabilitation-pathways.pdf>

¹⁵ Value in Health. (2020). What is value based healthcare? Available at: <https://vbhc.nhs.wales/>.

4.0 Core Implementation Specification for RDCs

The RDC service model should have the following key components:

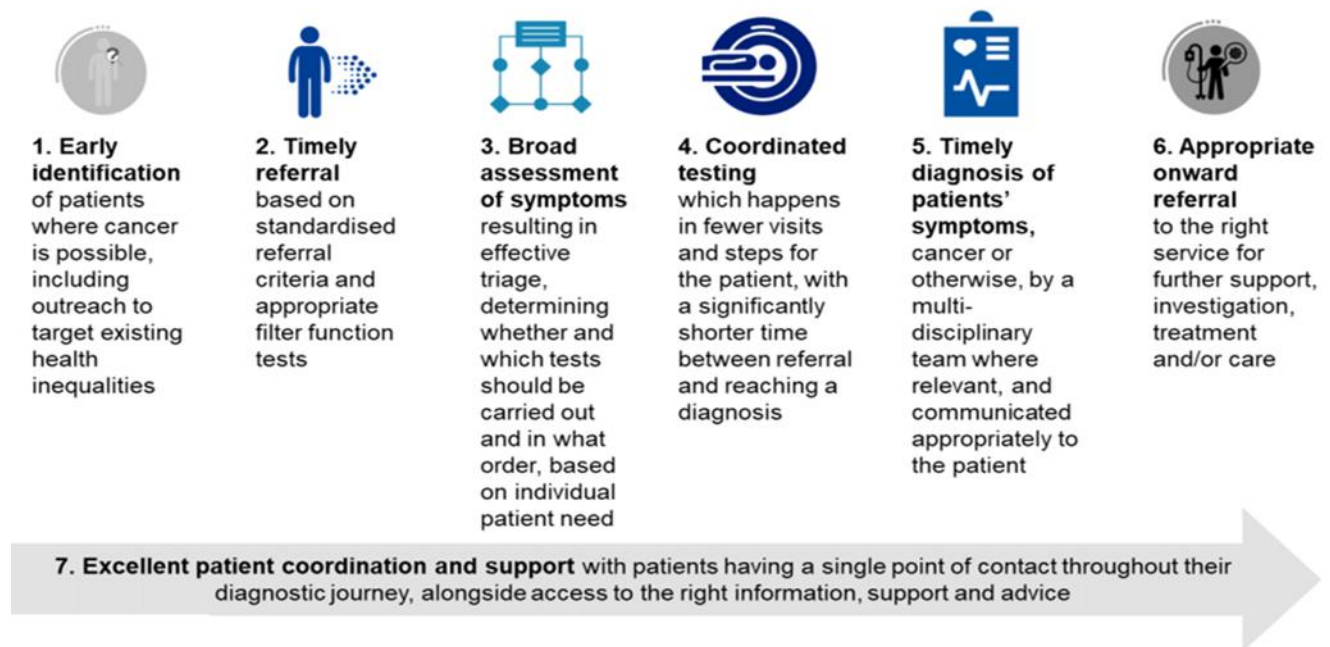


Fig.1: RDC Service Model (*taken from Rapid Diagnostic Centres: Vision and 2019/20 Implementation Specification*)¹⁶

This section describes the **core specification** RDCs should follow in providing their service to patients with vague non-specific symptoms. The expectation is for all RDCs to offer consistent outcomes for patients through delivery of each of the seven key components of the service model, regardless of locality. The key components may be carried out in the community, primary or secondary care setting.

4.1 Early identification of vague symptoms

- RDCs should work with primary care clusters and complement public health campaigns that aim to raise awareness of vague symptoms, targeting populations where health inequalities are apparent.
- RDCs need to form professional links with the Swansea Bay RDC Team, who are providing a national leadership and training role within the programme. This learning needs to be implemented and rolled

¹⁶ NHS England and NHS Improvement (2019). Rapid Diagnostic Centres: Vision and 2019/20 Implementation Specification. Available at <https://www.england.nhs.uk/wp-content/uploads/2019/07/rdc-vision-and-1920-implementation-specification.pdf>

out to primary care clusters at the earliest opportunity to ensure GPs understand the role of the RDC and refer appropriately from the outset.

RDCs should make available relevant service information for patients and carers which is offered at the point of referral from the GP. Any patient leaflets should be accessible in patients' native languages and avoid unnecessary jargon.

4.2 Timely referral based on standard criteria

- RDCs should provide education and advice to GPs to enable them to make timely appropriate referrals, providing feedback on any unsuitable referrals to the service to support continuous learning, and enabling the service to improve and grow.
- Health Boards need to work with RDC teams to ensure GPs have appropriate access to all point of referral filter tests required by the RDC.
- Where NICE (NG12) guidance recommends a site-specific diagnostic test for a non-specific symptom (e.g. faecal immunochemical tests for unexplained weight loss without rectal bleeding), these tests can be carried out as a filter function test for an RDC. The information from these tests will help inform the most appropriate referral route for the patient, but a negative diagnostic test for one type of cancer should not rule out RDC referral if other relevant symptoms are present. Additionally we emphasise that GPs should refer on suspicion and are not required to wait for any Set A results.
- All referrals to the RDC should be made via a set electronic format to a single point of access. Referrals need to capture relevant patient information in line with the minimum agreed standardised data set as far as possible (see *appendix 2*).
- All RDCs should appoint an administrative manager who can act as a first point of contact for GPs who may have questions about the referral process or criteria. The manager should also be responsible for processing referrals ready for the triage team on a daily basis, ensuring patient tracking information is accurate and up to date at each stage of the process.

4.3 Broad assessment of symptoms and effective triage

- Referrals to the RDC should be reviewed daily to ensure the necessary information and filter tests have been requested by the GP. This should be followed by telephone triage to confirm details

with the patient and ensure they are able to attend before booking into the next available clinic appointment.

- RDCs should endeavour to avoid delays in booking the patients' first appointment where further information is needed from the GP or filter tests have not been done, unless there is a clear indication that the patient would be more appropriate for an alternative pathway.
- RDCs should feedback to the referring GP/team in the event that a patient is triaged and redirected to an alternative pathway.
- RDCs should provide a key worker to act as a single point of contact for patients. The key workers role will be to co-ordinate appointments and tests for patients once they enter the RDC pathway. They will keep the patient informed about the RDC process and timeline, and support the patient in accessing relevant support and advisory services following a diagnosis. Key workers will be the patients' advocate where needed and ensure clinicians engage with patients and adopt co-productive, shared decision-making strategies.
- All patients should be offered a face-to-face assessment to review the history and timeline of symptoms, with a comprehensive clinical examination to support the diagnostic process. The assessment can be delivered by any suitably qualified clinician e.g., consultant, GP, Clinical Nurse Specialist (CNS) or Advanced Nurse Practitioner (ANP).
- A clear escalation protocol needs to be in place for every RDC for patients who require emergency treatment or admission at any point in the process, with clear guidance for non-clinical staff working in the RDC for the procedure that is to be followed.

4.4 Co-ordinated testing in as few visits as possible

- The vision for every RDC should be to provide same day clinical assessment and diagnostic testing to all patients. Any service model that deviates from this standard needs to be able to justify its reasoning and should be proactive in minimising the length of time for any variation.
- RDC key workers or administrative managers should ensure that all patients booked into clinic have had their Set 'A' filter tests requested by the GP. Any outstanding tests should be arranged, wherever possible, on non-acute sites (e.g., community hospitals or primary care phlebotomy services). Referrals should **not** be declined on the

basis of outstanding blood tests and equally, patients should not experience a delay in their first appointment as a result.

- RDCs should have clearly defined links with their local imaging network to ensure rapid access to testing and live reporting of scans. Participation of radiology at the MDT is an **essential and invaluable** part of the diagnostic process which should be agreed from the outset and incorporated into job plans.
- Where possible RDCs need to utilise existing local testing and imaging network capabilities and regularly review demand and capacity. Any changes to the RDC process need to be communicated and agreed with these networks from the outset to avoid diagnostic delays being introduced into the RDC pathway.
- After the initial sequence of diagnostic tests have been completed via the vague symptoms pathway, results should be reviewed in an MDT setting before discussion with the patient. Any further tests should be based on best practice; and should be discussed with the patient. A shared decision should be agreed with the patient, ensuring they understand and agree to the sequence, timing, and (wherever possible) location of the further tests.

4.5 Timely diagnosis by an MDT

- Every patient attending the RDC should be discussed in an MDT which must include the clinician who has assessed the patient, the radiologist reporting the imaging, and the patients' key worker.
- RDCs need to ensure links with other specialties who will not be represented at the MDT so that communication and advice can be sought, rapidly, via telephone or email to help support the management of patients.
- Communication of a diagnosis (cancer or otherwise) should be communicated to patients, in person wherever possible, as soon as possible after the MDT. Where there is a need to communicate this information via video or telephone consultation, this should be discussed and agreed with the patient during the face-to-face assessment.
- Diagnosis should be given by the clinician assessing the patient, with the support of the patients' key worker. The patient should be given

the opportunity to bring a friend or relative with them for support for this part of the process.

- Clinical teams need to ensure written and verbal communication is delivered in language that is clearly understood by the patient. Where required professional translation services should be planned for and utilised. Every effort should be made to avoid using relatives or friends who have attended to support the patient as translators.
- Following the diagnosis key workers should signpost patients to relevant peer and community support organisations. A holistic needs assessment should also be offered at this stage.
- After the diagnosis has been explained to the patient relevant test results and outcomes should be communicated promptly to the GP and relevant specialist services who will be taking over the patient's care.

4.6 Onward referral to the right service

- In accordance with the Vague Symptoms NOP, the RDC will retain responsibility for all patients until any onward referrals have been accepted. Following communication with the patient, about their diagnosis and next steps, the RDC team will make an onward referral to either a site-specific cancer MDT or relevant speciality.
- In the case of no diagnosis being found the patient will be reassured and the RDC will discharge the patient to the referring GP communicating their test results and any discussions that have been had. The long-term outcomes for the group of patients discharged from the RDC with no diagnosis remains an area of interest for further research and investigation. These patients should be reviewed to understand what proportion, if any, go on to be diagnosed with cancer, or other serious disease. Moving forward this follow up may occur at a national level using data from the National Data Repository.
- Patients receiving a cancer diagnosis at RDC may require additional tests or imaging such as biopsies, endoscopy, or further staging scans. RDCs may wish to work with local site-specific MDTs to develop protocols to request these additional tests on their behalf whilst the patient awaits MDT discussion or outpatient review. This may help to further minimise any potential diagnostic delays.

- All RDC patient facing staff should be familiar with the Making Every Contact Count (MECC) approach and endeavour to empower patients to make positive changes to their physical, psychological, and emotional health and wellbeing throughout the process. Key principles of person-centred care should be incorporated into every step of the process e.g., pre-habilitation at the point of triage and first contact, holistic needs assessment at the point of first face to face assessment and when communicating a diagnosis.

5.0 Key Service Requirements

5.1 Workforce

RDC roles and responsibilities should be added to relevant job descriptions and incorporated into job plans for colleagues providing sessional commitments, to ensure dedicated time is given to RDC clinics, MDTs, and any associated tasks.

RDCs must be aligned within an assigned directorate to ensure appropriate clinical governance, clinical responsibility, and sustainability of the programme. It is vital to recognise and minimise single points of failure within the system. The RDC must be led by a **team** of dedicated staff who understand its ethos and can ensure continuity of the service.

RDCs should endeavour to recruit from a sustainable staff pool with provisions for supervision, training, and development that will ensure a resilient service. The holistic MDT approach provides an ideal environment for the development of innovative new roles e.g. senior non-medical practitioners that seek to prioritise patient need and move away from traditional silo working.

Swansea Bay RDC Team will develop their leadership role for the RDC programme to address these requirements and will provide an enhanced level of support, education and training to all RDCs and their staff.

The core workforce requirements of an RDC are:

- RDC Clinical Lead – a senior clinician at consultant level, with a general medical or primary care training background to oversee the service and to support the Health Board RDC team.
- RDC clinician
- RDC Radiologist
- RDC Clinical Nurse Specialist or Advanced Nurse Practitioner

- A Key Worker - who will act as co-ordinator and first point of contact for the patient (which may be the RDC CNS/ANP).
- A Cancer Navigator role who will offer holistic support to patients during their clinic appointment and assist them throughout the day. This may be any suitably trained staff member, such as a registered nurse or healthcare support worker.
- RDC manager to provide administrative support and ensure smooth running of the MDTs and clinic appointments.

RDCs need to implement key links with other clinical specialists to ensure timely access to advice and support for patients where diagnosis and management needs additional input. This is not an exhaustive list but should include:

- General and acute medicine
- Oncology
- Gastroenterology
- Respiratory medicine
- Endocrinology
- Elderly Care
- Haematology
- Radiology
- Pathology
- Endoscopy
- Rheumatology
- Mental Health services
- Palliative Care
- Dietetics

The outcome of any discussion between a generalist clinician and a specialist should be documented if it takes place outside of an RDC MDT meeting, and any decisions made should be included in any onward referrals and correspondence to the GP.

Furthermore, RDC teams need to ensure they have access to Allied Health Professionals (occupational therapy, physiotherapy, dietician, social worker) who will accept patient referrals and provide support to address any needs identified from undertaking a HNA with the patient.

5.2 Endoscopy Provision

Data from both the Welsh pilot sites and the ACE Programme in England have demonstrated that a significant proportion of patients referred to the RDC require further gastrointestinal investigation, either colonoscopy or oesophago-gastro-duodenoscopy (OGD). Furthermore, the majority of non-cancer diagnoses made have fallen under gastrointestinal disease.

WCN acknowledges the pressures faced by endoscopy services in Wales and the recovery plan being put in place by the National Endoscopy Programme. RDC oversight groups in individual health boards should work collaboratively with endoscopy leads and where additional regional capacity is being developed, seek to negotiate how best the RDC refers patients for timely procedures. It is envisaged that vague symptoms will eventually sit alongside the other National Optimal Pathways and as implementation is standardised data collection and analysis will contribute to further demand and capacity modelling as the recovery plan progresses¹⁷.

Additional diagnostics may also be required such as:

- MRI
- Radiologically guided biopsies
- Specialist ultrasound

The decision to undertake these additional tests will generally be guided by the site-specific optimal pathways and the local specialist MDT. Local policy and protocols around provision and access to these referrals will likely emerge as the relationship between RDC and site-specific teams continually develop.

5.3 Improved interface between primary and secondary care

Key to the success and efficiency of the RDC will be timely and appropriate referrals from general practice that contain all the relevant information. Active engagement with local GP practices and clusters is vital, not only to promote the service but to educate about its purpose and discuss any potential concerns. Experience from the pilots has proven that pro-active engagement and collaboration with primary care from the beginning improves the quality of referrals being made and avoids overwhelming the system.

Written information should be made available to all GPs to assist in their consultations with patients when discussing a referral. RDCs should produce and distribute GP referral guidance and patient information leaflets which clearly explain the RDC process and emphasise the importance of patients attending both the appointment and associated tests. Following the appointment a clinic report should be completed which summarises the investigations and diagnosis/decisions made. This should be sent to the GP within one working day.

¹⁷ Welsh Government. National Endoscopy Programme: Action Plan 2019-2023 (Revised October 2020)
Available at <https://gov.wales/national-endoscopy-programme-action-plan-2019-2023>

CNS/ANP can act as liaisons between primary and secondary care to ensure comprehensive handover of key clinical information. Learning from the Swansea Bay team has led to a system whereby any cancer diagnosis is relayed by telephone by the CNS/ANP to the GP practice to ensure prompt communication. Outcomes of HNAs and any ongoing social and psychological needs the patient may have disclosed can also be discussed at the time. This initial contact is then followed up the next working day with a letter.

5.4 Data Standards

All RDCs will be required to collect and submit data aligned to the agreed minimum national data set that covers both Suspected Cancer Pathway and RDC specific data items, shown in summary below (see full descriptions in *appendix 2*).

RDC01	Number of patients referred to the service
RDC02	Age of the patient at date of GP referral
RDC03	Gender of the patient
RDC04	Number of patients referred to the service by GP practice code
RDC05	Patient's symptoms upon referral
RDC06a	Number of days from date of GP referral to date of first diagnostic test
RDC06b	Number of days from date of test to date of RDC Clinic visit
RDC07	Number of patients with a: <ul style="list-style-type: none"> • Cancer diagnosis • Non cancer diagnosis • No diagnosis
RDC08	Number and stage at diagnosis
RDC09	Type of cancer and ICD 10 code and description
RDC10	Number of patient alive at 1 year from a cancer diagnosis via RDC
RDC11	Review GP records of patients with no diagnosis found at 1 year
RDC12	Number and where in the RDC pathway did patients fail to attend
RDC13	WHO Performance Status at presentation to RDC

Table 1: Agreed RDC Data Set

It is essential that the WCN and Health Boards operating an RDC are able to continually monitor and evaluate data to support the service to develop and improve over time, and in response to nationally agreed work streams. This will enable the appropriate national cancer reporting as well as assisting with cancer clinical audits, cancer waiting times/suspected cancer pathway and quality outcome indicators for Wales.

The evaluation framework has been developed and agreed with the RDC stakeholder group (March 2021). This will serve as a structure to promote development of new RDCs whilst allowing improvement to the one-stop RDC clinic model (post COVID-19) for more established RDCs.

The quarterly analysis of the data, with support and feedback from the national RDC team, will hopefully accelerate learning and optimise patient experience. Data sharing across Wales, and beyond, can only enhance the process. The WCN, in collaboration with Digital Health and Care Wales (DHCW) and NHS Collaborative Health & Intelligence team, are working towards a National RDC Dashboard with automatic feeds.

RDCs need to have appropriate resources in place to ensure pathways are seamless and have the infrastructure to accurately track patients from referral to treatment. Administrators/managers appointed to the role should be proactive in entering referral data and checking that patients are tracked when they enter and leave the RDC pathway. Currently there is no provision for electronic alerts that flag patients that are stagnant on the pathway therefore these administrative checks are essential to the cancer navigator role and will avoid further delays to patients being seen and treated promptly. As work with DHCW progresses, adaptive changes may be made to these systems and the guidance will be updated accordingly.

6.0 RDC Governance

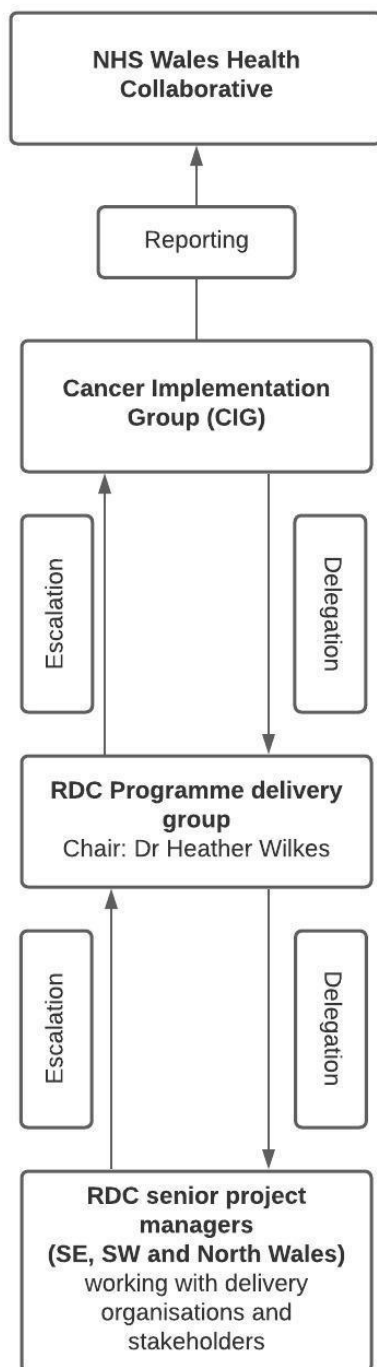


Fig 2. RDC governance structure

As previously described and illustrated in figure 2, each delivery organisation will be supported by a regional senior project manager who is employed directly by the Wales Cancer Network. These senior project managers will collaborate and be supported by the National RDC Programme delivery group which is chaired by Dr Wilkes from Swansea Bay

RDC as part of their commitment to leading the national programme forward. In turn the programme delivery group will report to the Cancer Implementation Group (now known as Wales Cancer Network Board) for approval and monitoring at each stage of the roll out.

6.1 Date of review

This document is scheduled for review in July 2023 and will be updated at that time with any new evidence or amendments.

If an update is carried out the policy will remain extant until the revised policy is published.

Appendices

Appendix 1

RDC pilot evaluation full report



RDC Evaluation
Report_v1a.docx

Appendix 2

RDC national data standards



RDC Data Sets v 1.4
updated 202108.xlsx