Wessex Cancer Alliance

Service Specification

Rapid Diagnostic Service

Published: September 2019
Wessex Cancer Alliance

Contents

1. Introduction page 3
2. Drivers for Change page 3
3. Opportunities and Constraints page 4
4. About this Document page 4
5. Service Model page 5
6. Patient Experience page 5
7. Overarching Principles and Commitments page 5
8. Stakeholders and Partners page 6
9. Non Specific Symptoms (NSS) Explained page 7
10. Rapid Diagnostic Service (RDS) Specification page 8
11. Enablers page 8
12. Wessex RDS Model – Visual page 9
13. Wessex RDS Model – Narrative page 10
14. Wessex RDS Model – Risks and Benefits page 11
15. Digital Enablement page 11
16. Implementation Options to Consider page 13

Appendices

A. National Guidelines: NSS RDC* Specification Details page 14
B. National Guidelines: NSS RDC* Enablers page 19
C. National Guidelines: Referral Criteria and Core Tests page 26
D. National Guidelines: Minimum Data Set for RDC* Patients page 28
E. Glossary page 33

*National documentation refers to a Rapid Diagnostic Centre, or RDC. This term has been left in this document where a National Document has been referenced.

1. Introduction

Establishing a Rapid Diagnostic Service (RDS) for Wessex will deliver faster and earlier diagnosis, and an improved experience for cancer patients. The NHS Long Term Plan sets ambitions for establishment of Rapid Diagnostic Centres as follows.

'3.59. The new faster diagnosis standard will be underpinned by a radical overhaul of the way diagnostic services are delivered for patients with suspected cancer. From 2019, we will start the roll-out of new Rapid Diagnostic Centres (RDCs) across the country to upgrade and bring together the latest diagnostic equipment and expertise, building on ten models piloted with Cancer Research UK, which have focused on diagnosing cancers where patients often present with non-specific symptoms and may go to their GP many times before being sent for tests, such as blood and stomach cancers. In time, RDCs will play a role in the diagnosis of all patients with suspected cancer, including self-referral for people with red-flag symptoms. For patients with cancer, this will mean they can get quicker access to an accurate diagnosis and begin their treatment. The majority of patients who do not have cancer, but may have other conditions, will be referred on quickly to get the right support.' (NHS Long Term Plan, January 2019)

RDCs will support the new Faster Diagnosis Standard (FDS), introduced from April 2020.

Wessex Cancer Alliance will establish its own Rapid Diagnostic Service (RDS) for Non Specific Symptoms by January 2020.

2. Drivers for Change

The primary driver for change is to improve patients' experience during one of the most stressful times in their lives. Currently patients can visit their GP several times with non specific symptoms (NSS) before being referred, and can then wait some time for a diagnosis. This not only delays cancer treatment commencing, but also delays further diagnostics of serious conditions when cancer is ruled out.

Other secondary drivers include:

- Delivering the Long Term Plan ambition to diagnose 75% of patients at an early stage
- Meeting the national 28 day diagnosis target and wider cancer waiting times standards
- Creating increased capacity through more efficient diagnostic pathways by reducing unnecessary appointments and tests
- Delivering the Long Term Plan aim to create diagnostic imaging networks to share clinical images amongst specialists
- Delivering a better experience for patients by providing a series of coordinated tests and a single point of contact
- Reducing unwarranted variation in referral for, access to and in the reliability of relevant diagnostic tests by setting standards regionally, mandating consistent data collection to enable benchmarking
- Improving the offer to staff as new roles will be created which offer development opportunities, greater flexibility and a chance to work in innovative ways
- Addressing perceived and real inequalities of access, and the reality that some patients are not served by existing pathways

The implementation of the RDS will be supported by the roll-out of pathology and imaging networks and an investment in new equipment, subject to capital availability, and workforce reforms.

3. Opportunities and Constraints

3.1 Opportunities

Wessex has a reputation for leading the way in cancer, and therefore has ambitious goals for its RDS model, as follows:

- A single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer, regardless of the route of referral
- An initial assessment service not constrained by geographical locations, so access is equitable for rural and island inhabitants as well as those located in cities and highly populated urban areas.
- A personalised, accurate and timely diagnosis of patients' symptoms by integrating existing diagnostic provision, utilising networked clinical expertise and information, and introducing new ways of working where appropriate
- Diagnosing serious non-cancer conditions more efficiently

3.2 Constraints

- Access to diagnostics and treatment for island and rural patients will remain a challenge beyond referral stage
- RDS funding does not allow for capital investment or increasing diagnostic capacity so the solution cannot depend on this
- There are workforce limitations to any 'new' service, as recruitment remains challenging

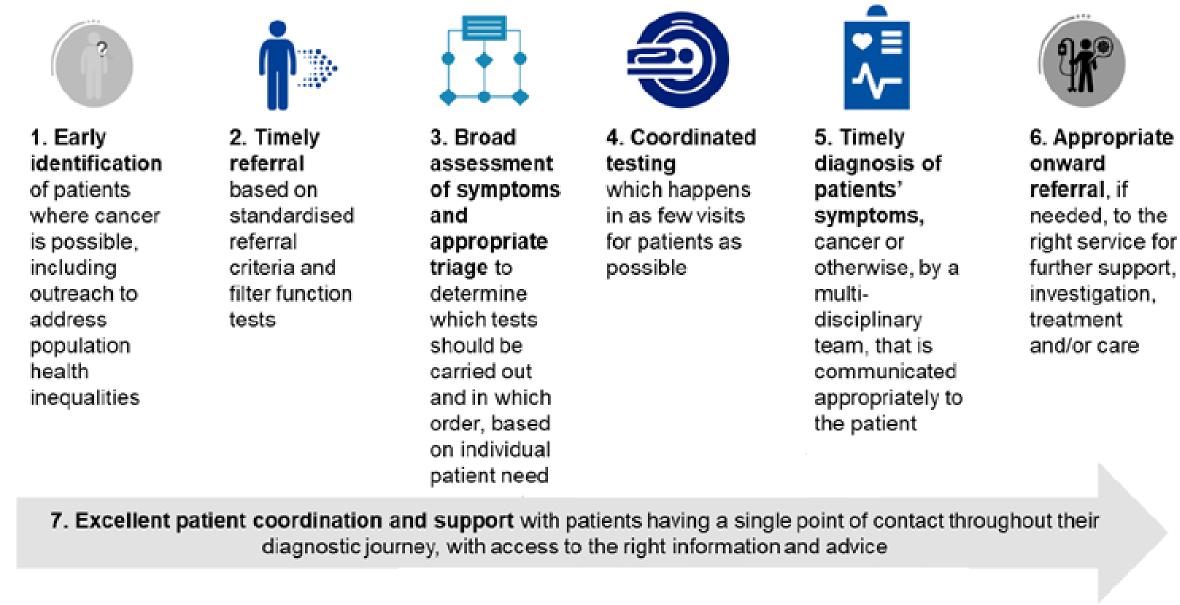
4. About this Document

This specification outlines the essential requirements of the service, as described in the national guidelines, and the model that Wessex Cancer Alliance partners will use to deliver this goal. It describes the current optimum pathway for cancer diagnostics, with the recognition that this will evolve and improve over time particularly with the development of digital advances.

The aim of the service reconfiguration is to develop a fully-integrated, patient-focused pathway. It is about driving improvements along the entire pathway and across the whole system.

The goal of the Wessex RDS is to create a more ambitious model than previous Multi-Disciplinary Models and Vague Symptoms Clinics.

5. Nationally Specified Service Model



1. Early identification of patients where cancer is possible, including outreach to address population health inequalities

2. Timely referral based on standardised referral criteria and filter function tests

3. Broad assessment of symptoms and appropriate triage to determine which tests should be carried out and in which order, based on individual patient need

4. Coordinated testing which happens in as few visits for patients as possible

5. Timely diagnosis of patients' symptoms, cancer or otherwise, by a multi-disciplinary team, that is communicated appropriately to the patient

6. Appropriate onward referral, if needed, to the right service for further support, investigation, treatment and/or care

7. Excellent patient coordination and support with patients having a single point of contact throughout their diagnostic journey, with access to the right information and advice

6. Patient Experience

The patient's experience in previous programmes, such as the ACE model[5] is largely positive. Expected patient benefits of the RDS include:

- Faster diagnosis – less worry waiting for news
- Earlier diagnosis – better outcomes for earlier staging
- Shorter pathway - less appointments, less 'ping-ponging' back and forth to GP
- Consistent people helping navigate, named contacts
- Integrated approach more holistic
- Ideally if not cancer, patients are referred on within hospital, not back to GP, therefore reaching diagnosis of other conditions more quickly
- Potential to access RDS via multiple pathways, not just GP

7. Overarching Principles and Commitments

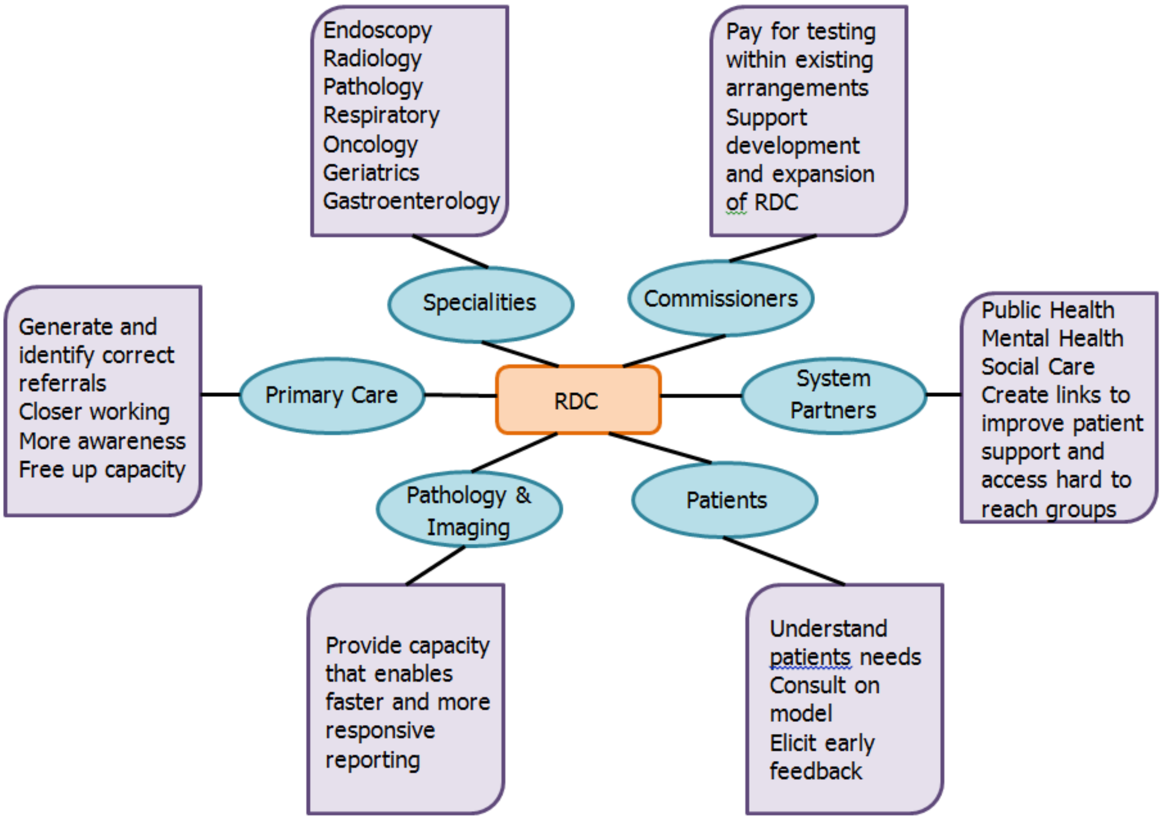
These are the over-arching features of a high quality, integrated, patient-focused pathway to which all providers within Wessex Cancer Alliance currently aspire.

- Leadership – a named leader takes responsibility for each part of the pathway and ensures system-wide collaboration
- Partnership Working - work together as part of an integrated team to deliver the best outcomes and experiences for patients
- Data Collection - collect data on clinical outcomes and patient experience (and other relevant metrics), and submit to regional and national bodies
- Patient Feedback - demonstrate a commitment to elicit feedback from patients on a regular basis and use this to inform service improvement
- Aim for 'teachable moments' for patients who do not have cancer (Making Every Contact Count - MECC)
- Research and Innovation - participate fully in clinical trials and research.

- Education and Training - facilitate access to high quality training and development opportunities for staff and services — with providers working in partnership and undertaking joint training where appropriate in order to deliver education in efficient, joined-up way.

8. Stakeholders and Partners

Working in partnership with key stakeholders will be essential to the success of the RDS development, implementation, and ongoing delivery. Note below RDS is referred to as RDC by the National team (Rapid Diagnostic Centre)



9. Non specific symptoms (NSS) Explained

Around 8% of patients with NSS will have cancer[1]. These symptoms include:

- Unexplained weight loss
- Fatigue
- Abdominal pain and/or nausea
- GP 'gut feeling'

Although this percentage may seem quite low, these patients are less likely to survive, as they present later, often as emergencies. This is because there is not urgent diagnostic pathway as there is for site specific tumour diseases. Due to the apparently mild symptoms, patients often:

- see their GP multiple times before referral (33% of sarcoma patients had to see their GP three or more times before referral in comparison to 10% for skin cancer patients)[2]
- present more often in an emergency setting (e.g. stomach cancer diagnosed at an emergency presentation over 35% of the time and pancreatic cancer 47% of the time compared to 19% overall)[3]
- present with late stage cancer (analysis of the National Cancer Diagnosis Audit shows that 67% of people with NSS are diagnosed at a late stage in comparison to 45% for people without NSS[4]
- are referred on multiple urgent pathways with resulting inefficiencies in healthcare provision

Using an RDS service model to diagnose patients with NSS builds on the evidence gathered on pilot Multidisciplinary Diagnostic Centres (MDCs) over two years, as part of the Accelerate-Coordinate-Evaluate (ACE) programme.

The ACE evaluation[5] so far shows that:

- of the cancers diagnosed by this model, a high proportion (56%) are rare or difficult to detect cancers, often diagnosed at a late stage e.g. pancreatic or stomach cancer
- around 8% of patients are likely to be diagnosed with some form of cancer[6]
- this model provides a fast route to cancer diagnosis with the median time from GP referral to a clinical diagnosis being 19 days
- this model supports timely diagnosis of non-cancer conditions with over a third of cases diagnosed with a non-cancer condition
- the majority of patients have a positive experience, with 85% of patients being very satisfied or extremely satisfied with the level of care they have received

---

[1] Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC), Cancer Research UK, April 2019. Available at: [https://www.cancerresearchuk.org/sites/default/files/ace_mdc_report_may_2019_1.1.pdf]

[2] Quality Health, *Cancer Patient Experience Survey: CPES 2017 National Results*. Available at: http://www.ncpes.co.uk/reports/2017-reports/national-reports-2.

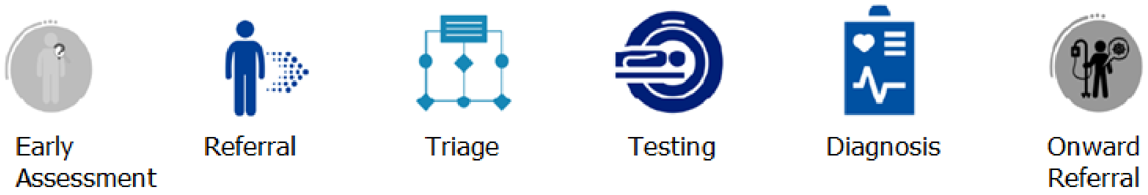
[3] Public Health England, *Routes to Diagnosis 2006-2015 workbook: Version 2.0a, December 2017*. Available at http://www.ncin.org.uk/home.

[4] ACE Programme, *Multidisciplinary Diagnostic Centre (MDC) based pathways for patients with non-specific but concerning symptoms: Interim Report.* Available at: https://www.cancerresearchuk.org/health-professional/diagnosis/accelerate-coordinate-evaluate-ace-programme/multidisciplinary-diagnostic-centres-mdcs

[5] ACE Programme (Wave 2): Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC). Available at https://www.cancerresearchuk.org/health-professional/diagnosis/accelerate-coordinate-evaluate-ace-programme/multidisciplinary-diagnostic-centres-mdcs.

[6] Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC), Cancer Research UK, April 2019. Available at: [https://www.cancerresearchuk.org/sites/default/files/ace_mdc_report_may_2019_1.1.pdf]

10. National RDS Specification



The national guidelines describe best practice at each stage of the process and can be found in Appendix A.

11. Enablers

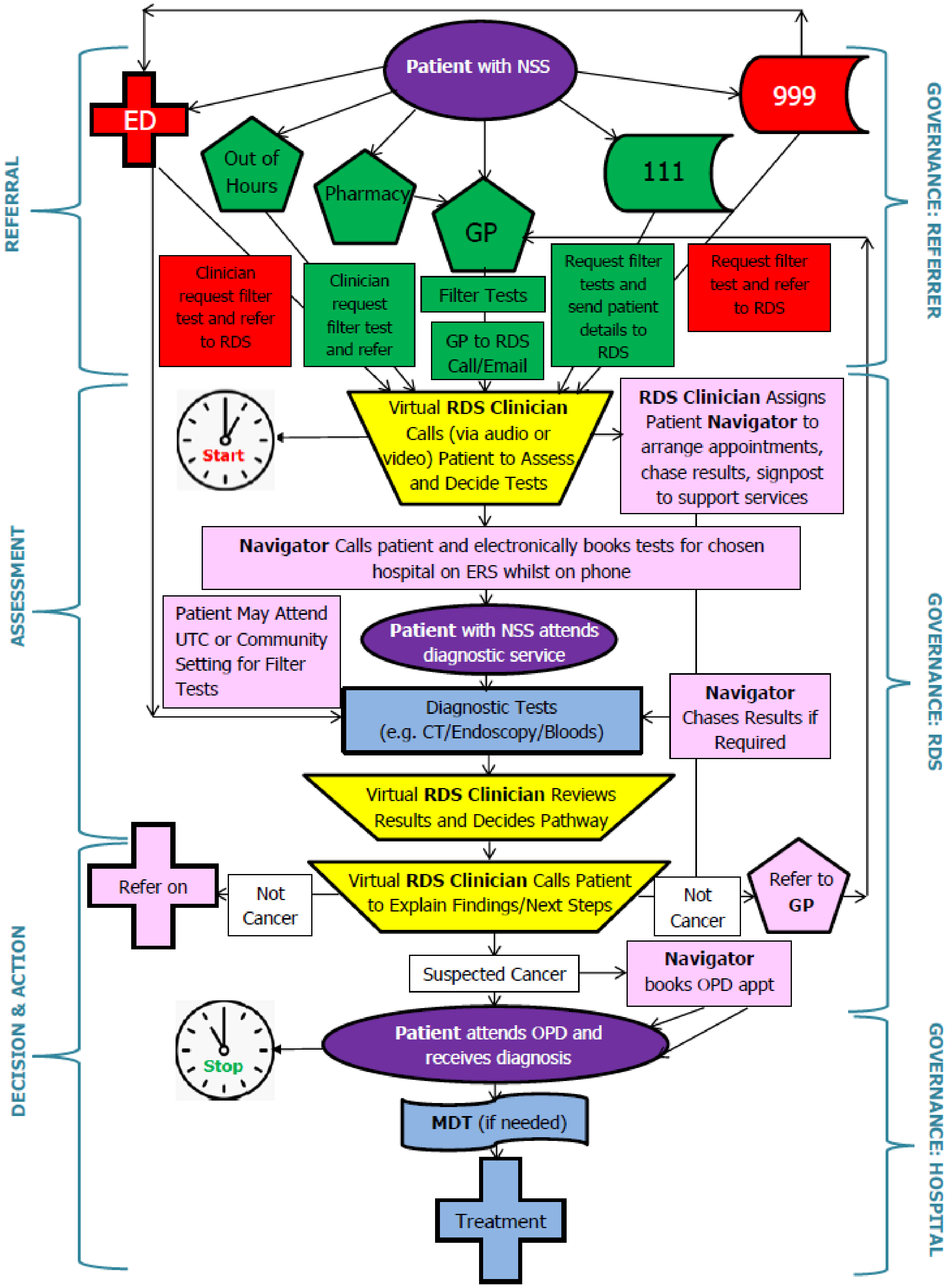
The success of any model relies on a number of factors to allow the RDS to work and thrive. These include:

- Workforce development to ensure the right roles and skills are in the right places
- Delivery considerations to ensure governance, accountability and leadership
- Commissioning and funding to ensure a smooth transition from national programme funding to local service contracts
- Digital capability and information handling to maximise the use of technology and ensure the absolute security of patient data when sharing between partners
- Capacity mapping to ensure that population demand can be met through planning the development of existing resources
- Measurement of success to include local monitoring and national reporting
- Utilising national resources and accessing shared best practice
- Meeting the ambitious national timeline whilst not compromising on quality

Full details are provided within the national guidelines in Appendix B.

12. Wessex RDS Model - Visual

The Wessex Model is visualised below.


REFERRAL
ASSESSMENT
DECISION & ACTION
GOVERNANCE: REFERRER
GOVERNANCE: RDS
GOVERNANCE: HOSPITAL
Patient with NSS
ED
999
Out of Hours
Pharmacy
GP
111
Clinician request filter test and refer to RDS
Clinician request filter test and refer
Filter Tests
GP to RDS Call/Email
Request filter tests and send patient details to RDS
Request filter test and refer to RDS
Start
Virtual **RDS Clinician** Calls (via audio or video) Patient to Assess and Decide Tests
RDS Clinician Assigns Patient **Navigator** to arrange appointments, chase results, signpost to support services
Navigator Calls patient and electronically books tests for chosen hospital on ERS whilst on phone
Patient May Attend UTC or Community Setting for Filter Tests
Patient with NSS attends diagnostic service
Diagnostic Tests (e.g. CT/Endoscopy/Bloods)
Navigator Chases Results if Required
Virtual **RDS Clinician** Reviews Results and Decides Pathway
Refer on
Not Cancer
Virtual **RDS Clinician** Calls Patient to Explain Findings/Next Steps
Not Cancer
Refer to GP
Suspected Cancer
Navigator books OPD appt
Stop
Patient attends OPD and receives diagnosis
MDT (if needed)
Treatment

13. Wessex RDS Model - Narrative

Referral

Regardless of the route of patient access, the patient would be diverted to a single centralised virtual RDS. This may be through GP visit or online consultation, a visit to ED, or via a call to 999 or 111. All referrals should be same day, by either telephone or electronically.

The 28 day clock will start on receipt of referral at the RDS. The RDS will assign a patient navigator to follow the pathway and ensure the patient is kept informed throughout, and to chase through appointments and results in order to meet target times. The Navigator will also signpost the patient to support and wellbeing services.

Triage

A central RDS Team of clinicians with an understanding of cancer will speak to the patient via audio or video and assess the symptoms and inform them of the tests required, and what the process will be. Anyone in the RDS referring for CT scans will need to be trained to be compliant in ionising radiation medical exposure regulations (IRMER). The patient navigator will be informed of the tests required.

Testing

The patient navigator will call the patient and book the tests in the chosen diagnostic service location through the Electronic Referral System in the RDS. Where possible tests will take place all on one day. If not already completed prior to referral, this will include core blood tests either on the day at the chosen setting, especially if the patient has not come via GP, as well as scans and other hospital-based investigations. The patient will attend the tests and results will be reported quickly, chased through by the patient navigator. The results will be accessible electronically.

Diagnosis

The RDS Clinician will be notified electronically of the results and be able to look at results and scans online. The RDS will make an assessment and telephone the patient and advise on next steps. If cancer is suspected, the patient will be asked to attend an outpatient (OPD) appointment, following MDT discussion as required, to discuss their results. The RDS Clinician will ask the Navigator to book the appropriate MDT discussion if required with subsequent OPD appointment. The Navigator will contact the patient with an appointment date taking place as soon as possible.

Treatment

When the patient attends their OPD appointment, they will be notified of their diagnosis. At this point the 28 day clock will stop. The patient's results will have been taken to the relevant MDT for discussion (if there is not an obvious treatment pathway) to allow the patient to discuss treatment options. The patient will also be offered recruitment into clinical trials if appropriate. Once the patient has selected treatment, they will go onto the standard site specific treatment pathway.

Onward Referral

If it is not a cancer diagnosis, the patient navigator will coordinate a referral to the relevant department in the hospital for further investigation, based on the recommendation of the RDS clinician. If this is not appropriate, then the navigator will refer the patient back to their GP.

14. Wessex RDS Model - Risks and Benefits

NB: There is an element of subjectivity based on author's influence and stakeholder feedback.

Strengths/Benefits	**Weaknesses/Risks**
Virtual single hub for all of Wessex, making geography irrelevant	Relies on shared access to ERS and care records
Similar infrastructure already in place and working well in dentistry, ambulance and OOH services	Cultural shift away from family GP dependency for referral and filter tests
Service doesn't rely solely on GP referral, so more patients likely to be diagnosed at an early stage. Likely to pick up patients, who may previously get signposted and lost	Filter tests would need to take place before scanning for patients not coming via GP, meaning a potential additional step
Doesn't have to be hospital-based	Flexible workforce required to staff virtual RDS
Dedicated standalone service without conflicting priorities	Relies on greater patient awareness to increase self-referral
Patient has an informed and supportive contact (navigator) throughout the diagnostic journey	Potentially more difficult to book diagnostics if relying on allocated electronic slots rather than being on site
Allows patient to choose hospital and/or allows booker to pick hospital with most capacity	Temporary capacity pressure in diagnostics in the short term
Access via any pathway, allows patients to self-refer	Additional training may be required for RDS clinicians, to ensure compliance with IRMER when booking scans
Frees up primary care capacity	
Frees up secondary care capacity	

15. Digital Enablement

Hosting

A platform to host the RDS is required, and due to the short time frame, this needs to be an existing IT platform that can be utilised or suitably adapted. An existing open Personal Health Record (PHR) may be suitable for this, depending on availability and rollout timescales across Wessex.

Some further exploratory work would need to be explored to enable this:

- A workshop to determine whether the PHR can be adapted
- Where would patient consent need to be captured (111/999/GP)
- What would be the costs for developing a view for the RDS clinicians
- What would be the timeframe for giving access to GP information via GP Connect to the PHR (dependent on NHS Digital team).

The RDS provider will need to map the IT landscape across the region to ensure relevant connections are made and are secure.

Referral

This referral pathway should be achievable through the Electronic Referral System (ERS).
An additional link between the RDS and GP Connect would be highly beneficial as it would allow RDS assessing clinicians to see the patient's history.

Access could be given to enable RDS clinicians to both make referrals via ERS and track progress providing the RDS clinicians can sit under an CCG ODS code that is recognised to make referrals. RDS clinicians would need to be registered for smartcards so an organisation with Registration Authority would also be required. Organisations accepting the referrals would need to add these to ERS.

Many of the decision-making trees already exist in ED triage and in 111 Pathways, but the algorithm currently sends patients back to their GP. So development and/or education would be required locally to ensure flow through to the RDS instead. It is hoped that in time national adaptations could be made to the Pathways, subject to the success of this model.

An extensive GP awareness programme would be required to ensure GPs are aware of the new pathway and know how to access it. This will also apply to Practice Nurses who are seeing patients with NSS. There is a significant opportunity in influencing in reverse, through the use of GP coding, which allows Pattern Recognition and can flag up patients with concerning symptoms to the GP for proactive identification.

Awareness raising and education would also be required in Emergency Departments, Pharmacies and Out of Hours teams to highlight access routes.

Across all routes, education of referral criteria is key. For all referral routes into the RDSs, the range of filter tests should also form an essential part of training, as these will reduce the flow of patients through to the RDS.

Booking Tests and Accessing Results

Patients must have core filter tests to ensure they access the right pathway as early as possible. The results would be fed back to GP systems to keep the GP informed of progress, then accessed by the RDS clinicians via the Personal Health Record. The RDS process relies on booking pathways from the ERS into diagnostics. However, filter tests should not be allowed to hold up the pathway. If time before CT/Endoscopy investigations, does not allow time for filter tests, they should be delivered on the same day as scanning.

Support
The success of the model relies on efficient digital connections that work well between the RDS and ERS. It is therefore suggested that some IT Support capacity is built into the RDS workforce to facilitate the implementation and ongoing development.

Future
The speed of development of Artificial Intelligence in assessment, testing and diagnosis offers opportunities to automate much of the pathway within the next few years. The RDS Lead and IT support must remain abreast of emerging tools to ensure that the patient and workforce can access the quickest and most accurate diagnosis available.

16. Implementation Options to Consider

Delivering the entire specification across the whole of Wessex immediately is likely to be overly ambitious and does not offer the opportunity to try, fail, succeed, learn and adjust. It is therefore suggested to the RDS Provider that they consider a staged implementation.

- Geographical or site specificity: Using the central RDS to channel patients from specific populations or into specific hospitals.
- Technological marriage: Starting with providers who have IT systems already in place that link easily into the central RDS.
- Focused routes of referral: Education and awareness-raising with one or two of the many referral routes, to enable a gradual build of patients. E.g. GPs only (advantage of having patients who have already received filter tests), or 111 and ED only (advantage of having patients who have been filtered through consistent and standardised criteria).

Appendix A: National Guidelines: NSS RDC Specification Details

A1. Early Identification

Key Specification	Further Detail
Increase referrals by encouraging the early identification of any patient meeting the referral criteria (listed in Appendix C).	RDCs work with emerging primary care networks to raise public and primary care awareness/understanding of NSS. RDCs identify and implement early detection and outreach for specific population groups who have a high risk of cancer or experience high levels of health inequalities. RDCs work with imaging and pathology networks to ensure testing strategies are developed and reviewed. Patients and carers will have relevant information about RDCs.

A2. Timely Referral

Key Specification	Further Detail
RDC services are available to patients meeting the referral criteria.	Ensure that referrals are made according to the criteria set out in Appendix C. RDCs provide advice and guidance to GPs or other access routes to support effective referral, and feedback on referrals made. Patients should be given easy to understand information, so they know what to expect when referred to an RDC.
Patients referred from primary care must have the relevant filter function tests carried out prior to referral to the RDC.	Mechanisms must be in place to ensure that all filter function tests (outlined in Appendix C) are completed as part of the referral process from primary care. Consideration for filter tests needs to be given to patients who access the RDC through other routes, e.g. ED, 111. When filter tests have not taken place, this needs to be highlighted on the referral. Negative filter tests should not rule out a referral if a patient meets many of the symptoms criteria.
All referrals should be made electronically, from the earliest possible point, and must contain all the relevant information.	Referrals must capture relevant information about the patient, in line with the minimum data set (see Appendix D) including information from the filter function tests. Patients coming through ED, 111 and other routes outside the GP may be an exception, and in these cases as much data as possible should be provided in the absence of filter tests. Referrals must be made electronically using an electronic referral system (eRS). Staff in RDCs should be given access to a patient's Shared Care Record during the referral process.

A3. Assessment of Symptoms and Triage

Key Specification	**Further Detail**
All referrals are reviewed so that only appropriate patients are seen in an RDC.	Referrals must be reviewed to ensure all the necessary referral information is present and that the RDC is the most appropriate pathway for the patient. After review, patients should be booked into an assessment or re-directed to the correct pathway. If patients are re-directed, the referrer should be informed of the change. If there are gaps, further information requests may need to be sought from the referrer.
Each patient must be supported by a single point of contact to provide continuity of care throughout their RDC experience.	In the Wessex model, this will be a Patient Navigator. Patient Navigators are non-clinical roles that provide a single point of contact for patients. The role can be a carried out by a dedicated individual or as part of a wider role. They can fulfil some or all functions listed below: • Provide a single point of contact for patients • Ensure clinicians use shared decision-making techniques with patients as much as possible • Co-ordinate appointments (e.g. assessment, testing, or communication of results) • Track patients referred to the RDC to ensure they are meeting the Faster Diagnostic Standards • Coordinate with RDC multi-disciplinary team (MDT) meetings to ensure all necessary patients are discussed, and agreed actions are followed up • Support patients to access additional services during and immediately after their diagnosis (including support, information and advisory services) • Provide information and guidance about the RDC process to patients and their carers • Ensure that patients with a non cancer diagnosis are referred on, or back to their GP.
All patients must be offered the most appropriate initial assessment based on their symptoms, initial test results and history.	Virtual, telephone or face-to-face assessments should be offered depending on what is deemed most appropriate for the patient by RDC clinicians or nurses. The type of assessment must respond to the complexity and severity of a patient’s symptoms. Assessments can be delivered by a Clinical Nurse Specialist (CNS), Advanced Nurse Practitioner (ANP) or a GP, depending on skillset. Following the assessment, staff with sufficient seniority and breadth of clinical expertise must be available to effectively assess the information about the patient and determine the most appropriate list and sequence of diagnostic investigations that should be offered, drawing on additional MDT members as needed.

	After the proposed sequence of diagnostic tests is established, this must be discussed with the patient. A shared decision should be made to agree the tests, sequence, timing and location of the diagnostic testing. RDCs should identify referral pathways to psychological support services where appropriate.

A4. Co-Ordinated Testing

Key Specification	Further Detail
The RDC should provide rapid access to all necessary diagnostic tests.	The number of locations and appointments must be minimised. Wherever possible, same day testing should be offered. RDCs should have fast access to diagnostic testing and reporting infrastructure, linking with existing provider patient record systems. Standard first line tests will often include upper and lower GI endoscopy, phlebotomy and associated blood testing, and imaging (CT, MRI, and/or ultrasound). Other diagnostic tests should be offered to patients as and when required. When building a testing infrastructure, RDCs should identify and utilise any local imaging and pathology network capabilities. Records should be stored electronically as part of a patient’s existing record.

A5. Diagnosis

Key Specification	Further Detail
All suspected diagnoses should be confirmed through a multi-disciplinary meeting.	Regular RDC MDT meetings may be held, either virtually or in person. This may not be appropriate if a site specific pathway is identified by the RDC, in which case the case will go to the relevant MDT. To make an effective diagnosis and treatment plan, MDT meetings should ensure all relevant information is available, particularly access to a single health record and clinical images. These could take place before the patient’s OPD appointment so treatment options are offered at the same time as the diagnosis is communicated, or after the appointment to allow time for the patient to process the diagnosis. Patient feedback from early implementers can guide this.
To support diagnoses, RDC clinicians must have access to consultants and/or clinicians from other relevant specialities, where	RDCs should ensure the presence of clinicians (in person or by phone/digital means) from relevant disciplines at MDTs or ensure they can be contacted via e-mail or telephone communications outside of MDTs to support the management of relevant patients. Full access to the imaging

they are not represented at the MDT meeting.	network and personal health record will be important in facilitating the best treatment recommendations.
The RDC service model must comply with the 28 Day Faster Diagnosis Standard.	In line with the Faster Diagnosis Standard, any cancer diagnosis or exclusion should be communicated to the patient within 28 days of referral. It is expected that RDCs will be compliant with FDS immediately and record patients in the Cancer Waiting Times (CWT) dataset from 2020. Cancer staging may occur after referral to an onward service, though staging data should be captured by the RDC.
The approach to communicating a diagnosis should be in line with best practice (NICE CG138) and FDS rules (CWT Guidance V10).	Communication of any serious diagnosis should be made to the patient in person. Clinic appointments to explain the diagnosis and what will happen next should occur as soon as possible after an MDT meeting. The patient should be given the diagnosis by a consultant or appropriately trained team member in the presence of a Clinical Nurse Specialist (where relevant). The patient should be informed (e.g. by the patient navigator) that they can bring someone to support them at the clinic appointment. A cancer diagnosis should be communicated in a language the patient can clearly understand and translation services or other adjustments should be provided if needed. Ideally, a family member should not be used for translation when a diagnosis of cancer is given. Patients should be signposted to support services.
Each patient should have a diagnosis report before they are discharged or referred on.	This diagnosis report should be shared with and explained to the patient and, where relevant, their carer. This should be asap, but should not delay onward referral. The diagnosis report and test results should be shared with the GP and relevant specialist services who are continuing to care for the patient.

A6. Onward Referral

Key Specification	**Further Detail**
The RDC will hold responsibility for the patient until a successful onward referral has been made.	Responsibility for the patient remains with the RDC until the patient receives: • a cancer diagnosis and is referred onto a specialist cancer pathway, with primary care informed; or • a serious, non-cancer diagnosis and is referred on to the appropriate specialty, with primary care informed; or • a non-serious diagnosis, or a resolution of symptoms is made, and the patient is discharged in consultation with primary care.

RDCs should refer all patients, regardless of the specific diagnosis, to the most appropriate services for onward support, investigation and/or care.	Patients referred on may need additional diagnostic tests or imaging, even if they have received a diagnosis, e.g.: • Patients with a cancer diagnosis may need further radiology, histology or molecular diagnostic testing to guide their treatment • Responsibility for such diagnostic tests will sit with the specialist team to which the patient is referred.
RDCs should follow the Making Every Contact Count (MECC) agenda to support patients who may benefit from direction that encourage them to make positive lifestyle changes.	RDC staff should follow the MECC agenda so that everyday interactions with patients can support them to make positive changes to their physical and mental health and wellbeing. Where suitable staff should refer patients on to other services that may support any lifestyle changes e.g. smoking cessation, nutritional advice, physical activity, or weight management services. RDCs should apply the principles of Universal Personalised Care.

Appendix B: National Guidelines: NSS RDC Enablers

The next section outlines cross-cutting enablers for RDCs that need to be set-up locally, supporting both the vague symptoms specification and any additional patient cohorts that the RDC is serving.

B1. Workforce

Key Specification	Further Detail
The RDC service should be staffed in line with the core workforce requirements.	The core workforce requirements of the Wessex RDC are: • RDC Clinical Lead – overall accountability • RDC GPs/Clinical Nurse Specialists / Advanced Practitioners (skillset dependent) – to assess and diagnose • Patient Navigator – to be patient's contact, make appointments, track timescales and targets • RDC Manager – to manage operations, rotas, recording and reporting information • *Access to* Education/Awareness/Communications Function - to promote RDC and liaise with referrers (could be RDC Manager as above) • *Access to* IT support – to ensure systems and connections work • *Access to* Diagnostics Specialists for advice and/or clarification RDCs should be recognised in the job plans of all staff e.g. consultants and core MDT members. This will ensure RDCs have the capacity to safely ensure equality of access for patients, staff time needed to run clinics, check referrals, attend MDTs and complete related administration.
RDCs must have regular access to other key clinical specialists to ensure a diagnosis can be made	Key specialisms, who will be core members of the MDT, or be available for advice, and work closely with the core RDC team include: • general and acute medicine • oncology • gastroenterology • respiratory medicine • elderly medicine • haematology • radiology • pathology (e.g. histopathology, haematology, microbiology and virology) • endoscopy • clinical biochemistry • rheumatology • infectious diseases • mental health services

	Access to sufficient breadth of expertise can be achieved through one of two models. The choice of model should be determined based on local capability and capacity: • **Generalist-led**: A team of appropriate senior clinicians will provide initial medical opinion and retain overall responsibility. The consultant will seek advice from consultants in other specialties as needed via e-mail, telephone, and by presence at RDC or specialty-based MDTs. • **Multi-disciplinary**: Clinicians from a range of specialities will attend regular MDT meetings to discuss all patients (either in person or digitally). To enable participation, smaller specialties could offer support to certain parts of the MDT, as with current MDTs, where particular types of cases are clustered where a given specialist cannot be present for the entirety of the meeting. Expert collaboration enables extremely informed assessment but may be resource-intensive. Imaging and diagnostic reports will be available. The outcome of any discussion between a generalist clinician and a specialist clinician should be documented if it takes place outside of an RDC MDT meeting.

B2. Delivery Considerations

Key Specification	Further Detail
RDCs should operate under clearly defined governance arrangements, with a clinical lead identified for the service.	Clearly defined lines of accountability need to be developed and followed in order to ensure there is effective oversight of RDCs within host provider organisations. This should include recording, monitoring and learning from incidents relevant to the RDC (e.g. missed diagnosis). These should be able to be extracted and shared with national colleagues if required. Governance arrangements should specify the point of transfer from one service to another. This should include all patient data and contact, as well as the sharing of clinical images and diagnostic reports.
RDCs should be accountable to a named director.	A lead clinician should have overall accountability for the safety and quality of care of patients served by an RDC, including accountability for delivery of the service in line with the specification set out in this document.
When setting up an RDC, there should be a suitable forum to provide clinical and operational leadership.	There should be a suitable existing or new (e.g. a steering group) forum that provides leadership to an RDC. The forum should play a defined role within local RDC governance arrangements to discuss the RDC service on a regular basis. Relevant local stakeholders (see Appendix 2) should be engaged or involved in forums as needed.

RDCs should work closely with wider services and have strong relationships with other relevant clinical specialities.	The patients referred to an RDC will have a wide range of symptoms and potential diagnoses, and consequently there will need to be a high degree of co-ordination between different specialties (offering access to specialist clinicians and procedures) and wider stakeholders to achieve a timely and accurate diagnosis. The leadership of the RDC should ensure that adequate access to specialists and tests in different specialities are maintained. A networked multi-site approach to delivering RDC services should be considered, particularly where it allows for sharing of expertise and resources to deliver a more efficient service. These should be developed in partnership with local imaging and pathology networks. Suitable local governance arrangements (e.g. Service Level Agreements) should be in place to ensure effective working across organisations
All required data metrics should be collected and reported to ensure that service performance can be monitored and evaluated.	Each site must collect and submit data about each patient against the RDC minimum dataset on a regular basis (see Appendix D for further information). Alliances should have analytical capacity to prepare and submit this data.

B3. Commissioning and Funding

Key Specification	**Further Detail**
Commissioning and funding arrangements for RDCs should ensure that only the appropriate costs are covered by national programme funding.	During 2019/20 Cancer Alliances can continue to fund MDCs, to support any transition into an RDC. National programme funding can be used for: • setting up a dedicated strategic programme team for a Cancer Alliance; • funding a dedicated operational programme team to implement the first RDC • additional staffing required to run an RDC • additional one-off costs to set up an RDC e.g. costs of meetings and to facilitate virtual working (excludes capital expenditure); IT setup. • outreach, training and communications to instigate referrals Funding should not be used for capital expenditure e.g. investment in major pieces of diagnostic equipment or IT infrastructure. Funding must not be used for provision of diagnostic tests, as these should be through existing contracts.
Minimum expectations from an RDC in 2019/20 should be included in service contracts.	You are likely to need to identify a lead CCG commissioner. A suitable commissioning agreement should be entered into that sets clear expectations of the scale and scope of RDC pathway. This should be consistent with the details outlined

	in this specification and allow for future revision to include additional cohorts. The scope should cover the service provided as well as required reporting (for evaluation, monitoring purposes) in line with the minimum dataset provided. It should also put in place appropriate expectations so that serious incidents are suitably reported, reviewed and learned from.
Cancer Alliances should ensure adequate population coverage across RDCs.	c22% of people with cancer are diagnosed based on NSS The ACE programme achieved a conversion rate of 8%. This is expected to fall with greater volumes in RDCs, but assuming this rate: • To diagnose 1 person with cancer, 12.5 people need to be seen • An average alliance would make 1,329 diagnoses per month, of which 289 would have NSS • With conversion of 8%, the number of referrals with NSS would be 3,607 per month. • Alliances should ensure their RDCs have capacity that by end of the first year, 20% of patients with NSS are diagnosed through an RDC and 50% of GPs are referring to RDCs. This would mean a patient flow of 361 per month in an average size alliance, potentially leading to 29 cancer diagnoses. • Alliances should carry out training and outreach to referrers to meet or exceed this. • Specific volumes will need to be calculated for Wessex, but these figures are a guide in the meantime.

B4. Digital and Information Factors

Key Specification	**Further Detail**
RDCs should be able to share patient data, imaging and diagnostic reports from the referrer and to onward destinations	The RDC should map its data sharing requirements and establish ways of doing this. There should be a data controller to oversee this.
RDCs should work with their local Caldicott Guardian to ensure suitable arrangements are in place for data collection and storage.	Each RDC will need to work with the Caldicott Guardian in their respective provider organisation(s) to ensure that all data and diagnostic information collected, shared and transferred meets the minimum compliance standards in all operations.
RDC should make use of digital and AI tools wherever they may enhance the service.	Digital and AI tools e.g. those providing decision support for clinical triage or supporting business intelligence of diagnostic services and patient scheduling have the potential to increase efficiency of RDCs. RDCs should consider partnerships with technology providers to incorporate such advances into their Centres. These should be linked to any local Pathology and Imaging networks in line with the

	Imaging National Strategy. Any digital and AI tools should operate in line with NHS Digital Work on clinical and data standards and interoperability.

B5. Capacity Mapping

Key Specification	**Further Detail**
During 2019/20, Cancer Alliances will carry out future demand and capacity mapping using a template provided by the national team.	RDCs will alter the demand flows and use of capacity within each Cancer Alliance. It is important the impact of RDCs on demand and capacity is well understood and can be modelled based on estimated volumes. If not already available, Cancer Alliances should develop a baseline mapping of capacity in their area and how this is utilised by current patient volumes. The impact of introducing RDCs should then be modelled onto this - assuming the target volumes outlined in this specification for the first year of operation. Some patients will be new patients, others may be patients who would previously have been referred on a routine referral or a cancer-specific two week wait pathway. Alliances, in collaboration with regional offices, should regularly monitor the impact of the RDC on these other referral routes. This modelling should be expandable to estimate future demand and capacity as the coverage of the RDC expands and additional types of cohorts are included in their scope - towards the eventual goal of covering all referrals of patients with cancer-related symptoms. A template will be provided by the Cancer Alliance Data, Evaluation, and Analysis Service (CADEAS) in August 2019 to support Cancer Alliances to complete this activity. This exercise should be undertaken with input from local imaging and pathology networks. This mapping and modelling should be used to ensure sufficient capacity is commissioned to meet local demand for RDC services. It should inform any future business cases for capital investment in diagnostic capacity and workforce. Capacity and demand models are already in place for imaging, to monitor the diagnostic service. In modelling the populations RDCs should serve, due consideration should also be given to local information about population health (e.g. areas with high deprivation, local health inequalities) and existing service performance.

B6. Monitoring and Evaluation

There will be a process of monitoring and evaluation of RDCs with the objective of understanding which RDC service models contribute to the aims of:

- Supporting earlier and faster cancer diagnosis
- Creating increased capacity through more efficient diagnostic pathways
- Delivering a better diagnostic experience for patients
- Reducing unwarranted variation in referral for and access to relevant diagnostic tests
- Improving the offer to staff with new roles

Management information should be submitted to the national team to track the growth of, and impact from, RDCs. This will support ongoing national conversations around further investment into workforce and capital.

The NHSE/I National Cancer Programme and the Cancer Alliance Data, Evaluation, and Analysis Service (CADEAS) will procure an independent national evaluation partner who will be responsible for confirming the precise methodological approach to evaluation of RDCs. CADEAS will work with Cancer Alliances to establish a minimum dataset for RDCs – with reference to an adapted form of the dataset used for the ACE programme. Once the national evaluation partner is procured, the minimum data set may need some amendments. The minimum data set will include metrics that capture patient information at each stage of the journey through an RDC. This data will be used to drive forward evidence-based improvements including through the identification of health inequalities. As far as possible, each site should collect this data in anticipation of a similar dataset being finalised with the appointed evaluator.

Given the size of the dataset, Cancer Alliances should ensure appropriate analytical capacity is protected to prepare as much of this data as possible. This should be submitted to the national evaluator when they are appointed. RDCs should also work with their finance teams to track detailed management and operational costs of the RDC (including details of activity per patient and corresponding workforce requirements) in order to estimate a patient level pathway cost. The reporting of cost data is only required for tests undertaken; broader capture of cost data will be the subject of a collaborative review.

B7. National Support

The NHSE/I National Cancer Programme team and NHSE/I Regional teams will work with Cancer Alliances to provide support on the implementation of the RDC vision in 2019/20 and beyond. The national team will work closely with Cancer Alliances to ensure that these nationally delivered support activities meet their needs. They are likely to cover:

- Training for specific RDC posts, development, and shared learning
- RDC implementation, governance and quality assurance
- Collaborative alignment with national imaging and pathology programme ambitions
- Evaluation
- Research, innovation, and digital
- Wider diagnostics transformation
- Communication and engagement

B8. National Timetable

Timeline	National Programme Milestone
August 2019	Cancer Alliances draft outline plans for implementation of RDCs in line with guidance and submit these to NHSE/I Regional Cancer Leads at the end of the month.
September 2019	NHSE/I Regional Cancer Leads provide feedback on outline plans
October 2019	Plans are signed off by the national team, regional cancer leads and cancer alliances.
December 2019	Final plans will be set out as part of the publication of the national implementation programme for the Long Term Plan.
January 2020	Local agreements and governance is set up for at least one RDC site per Cancer Alliance so that they can start accepting patients no later than January 2020.

Appendix C: National Guidelines: Referral criteria and core tests

To support earlier and faster diagnosis, RDCs should use the following referral criteria for the NSS cohort:

Core referral criteria for NSS

- New unexplained and unintentional weight loss (either documented >5% in three months or with strong clinical suspicion)
- New unexplained constitutional symptoms of four weeks or more (less if very significant concern). Symptoms include loss of appetite, fatigue, nausea, malaise, bloating
- New unexplained abdominal pain of four weeks or more (less if very significant concern)
- New unexplained, unexpected or progressive pain, including bone pain, of four weeks or more
- Referrer 'gut feeling' of cancer diagnosis- reasons to be clearly described at referral

Exclusion criteria for NSS

- Patient has specific alarm symptoms warranting referral onto site-specific two week wait pathway (in line with NG12)
- Patient is too unwell or unable to attend as an outpatient or needs acute admission
- Patient is likely to have a non-cancer diagnosis suitable for another specialist pathway
- Patient is currently being investigated for the same problem by another specialist team

Optional referral criteria – for Alliances to consider as part of expanded cohorts or local need

- New and unexplained breathlessness for over 3 weeks (not requiring admission and not due to heart failure, VTE, IHD, COPD or Chest infection)
- Unexplained thromboembolism (depending on local alternative pathways)
- Abnormal laboratory findings not explained by established or self-limiting disease and not needing admission (e.g. Significantly raised CRP and infection excluded, ALP >x2, raised calcium, platelets >400 men, or >450 women)
- Abnormal radiology suggesting cancer; not needing admission and not suitable for existing urgent cancer referral or cancer of unknown primary pathway
- Those who cannot wait for an urgent cancer referral pathway (if local RDC provision supports this), e.g. attending ED with symptoms

Where possible, filter function tests should be used prior to referral to:

- Support GPs to refer patients via the most appropriate route (i.e. NSS or site-specific), leading to a higher referral quality
- Reduce the risk of test duplication later in a patient's pathway
- Ensure all necessary pre-investigation testing (e.g. kidney function) has been completed, removing potential delays further along the pathway

It is recommended that the following filter functions tests are usually carried out in primary care or a community based setting in order to make a successful referral into an RDC:

Mandatory tests for patients with NSS prior to referral to RDS:

- CXR
- Urine dip stick
- FIT (where available)
- FBC
- ESR and/or CRP
- U&E with eGFR
- LFTS (including globulins)
- TFTS
- HBA1c
- Bone
- CA-125 (Women)
- PSA (Men)

Optional additional tests (where relevant to symptoms):

- Ultrasound
- B12/Ferritin/Folate (if anaemic)
- TTG AB (if anaemic)
- GGT
- Prot EP
- HIV
- Clotting
- Glucose
- LDH

Ideally these tests will be organised by the RDC if a patient comes via another route other than GP, and may or may not happen prior to further investigation. It is recognised that for the patient’s convenience, they may happen at the same time as other tests, such as on the same day as the scan appointment. RDCs need to be mindful of this, as they may want to liaise with community settings to carry out blood tests, if time allows prior to scanning. To clarify: For the sake of the patient and efficiency of the pathway, scans should not be delayed in order to wait for these test results, they should only be carried out in advance if there is time before the scan.

Appendix D: National Guidelines: Minimum Data Set for RDC Patients

Stage of Pathway	**Metrics**	**Data Format; Definition**
Presentation	NHS number	*Free text;* COSD definition: CR0010: Primary identifier of a PERSON. Or non-NHS Number patient identifier if NHS Number not available. *To be retained by the RDC site.*
	Person family name	*Free text:* COSD definition CR0050: PERSON's name. *To be retained by RDC site.*
	Person given name	*Free text:* COSD definition CR0060: PERSON's forename(s). *To be retained by RDC site.*
	Date of birth	*dd/mm/yyyy;* COSD definition CR0100: *To be retained by RDC site.*
	Age at referral	*Derived from Date of Birth and Date of Referral to RDC site.*
	Patient anonymised identifier	*Free text.* To replace data not to be shared with the National Cancer Programme by the RDC site in order to pseudonymise the data.
	Ethnicity	*Dropdown;* COSD definition CR0150: Ethnicity of a PERSON as specified by the PERSON
	Gender	*Dropdown;* COSD CR3170: Person's gender as self-declared
	Home postcode	*Free Text.* To be retained by the RDC site.
	Index of multiple deprivation level	*Derived from the person's home postcode*
	Co-morbidities	*Free Text; List all co-morbidities using* ICD10 codes.
	Co-morbidities score 27 (adult) at referral to the RDC	*Dropdown*, COSD definition CR2060: Overall comorbidity score
	Performance status (adult) at referral to the RDC	*Dropdown;* COSD definition CR0510: World Health Organisation classification
	Smoking status	*Dropdown;* Current, former, never
	Number years smoked	*Number;* Active smoking years, exclude non-smoking years
	Cigarettes smoked per day	*Number;* Average number cigarettes smoked per day during active smoking years
	Alcohol consumption	*Number;* Average units per week
	Major life events	*Free text;* Includes death of loved ones, loss of employment. Moving house, childbirth.
	Pregnant?	*Y/N*

Stage of Pathway	**Metrics**	**Data Format; Definition**
Presentation	GAD-7 / PHQ-9 scores	*Number.* Include if available.
	Historical cancer diagnosis	*Y/N*
	Historical cancer diagnosis detail	*Free text;* If (Y) above, PRIMARY DIAGNOSES for the standardised definition of primary diagnosis using ICD 10 code
	Previous presentation at RDC	*Y/N*
	Symptoms at presentation	*Grid with linked fields – Symptoms, Symptoms detail e.g. amount of weight lost, Duration of symptoms in weeks;* Symptom options: Weight loss, loss of appetite, fatigue, nausea, malaise, bloating, abdominal pain, other new or progressive pain, GP 'gut feel'
	Date symptoms first started presenting	*CCYY-MM-DD*
	Additional symptoms at presentation	*Free text;* Detail on any additional symptoms not covered in the above.
	Cohort type	*Dropdown;* Options: NSS, SSS
	Lifestyle changes	*Free text;* Any changes to patient's lifestyle within the past year e.g. sleep, exercise, or diet that could be linked to the symptoms or that were implemented by the patient to try to relieve the symptoms
	Number of attendances with related symptoms to primary care	*Number;* Within the past year
Filter Function Tests	Filter function tests	*Grid with linked fields – Test performed, Result (Normal/ Abnormal), Cost of test;* Test options: Chest X-ray, Urine dipstick, FIT, FBC, Other blood tests, Other (please specify)
Referral to RDC	Route of referral	*Dropdown;* GP referral; Secondary care referral, Emergency care referral or attendance (include A&E consultant referral), Self-referral, Pharmacy referral, National Screening programme referral, 7 Other (e.g. 111) (please specify)
	Diagnostic referral route (CWT041)	*02 – Rapid Diagnostic Centre*
Stage of Pathway	**Metrics**	**Data Format; Definition**

Referral to RDC	Name of GP	*Free text;* GP with which patient is registered
	Name of GP practice	*Free text;* GP with which patient is registered
	GP practice code	*Free text;* GP with which patient is registered
	Date of referral to RDC	*Dd/mm/yyyy*
	Date of review of referral by RDC	*Dd/mm/yyyy*
	Result of referral	*Dropdown;* accepted, returned to GP, referred to other pathway
	Alternative referral pathway	*Free text;* If appicable
Clinical Triage	Date of Triage	*Dd/mm/yyyy*
	Type of Triage	*Dropdown;* Face to Face, telephone, virtual
	Date of DNA	*Dd/mm/yyyy;* If relevant. Should be recorded for each occurrence.
	Date of patient rebooked appointment	*Dd/mm/yyyy;* If relevant. Should be recorded for each occurrence.
Diagnostic Testing	Tests ordered and conducted at the RDC	*Grid with linked fields – Test Ordered, Test Appointment Date, Location of Test Appointment, Attended? (Y/N), Test Result (Abnormal / Normal), Cost of Test;* Test options: Chest X-ray, Urine dipstick, FIT, FBC, Other blood tests, CT scan (chest), CT scan (abdomen), CT scan (pelvis), CT scan (full body), CT Colon, PET-CT, Ultrasound, MRI scan, Endoscopy, Colonoscopy, Biopsy, Other imaging tests (please specify), Other tests (please specify)
Diagnosis	Diagnosis status within 3 months of receipt of referral to RDC	*Dropdown;* New cancer, Cancer recurrence, Non-cancer serious condition, Non-cancer serious condition, Symptoms resolved, Investigations ongoing
	Primary diagnosis (ICD)	*Free text;* PRIMARY DIAGNOSES for the standardised definition of primary diagnosis using ICD 10 code
	Other diagnoses	*Free text;* PRIMARY DIAGNOSES for the standardised definition of primary diagnosis using ICD 10 code
	MDT discussion date	*Dd/mm/yyyy*
	Date of primary (clinically-agreed) diagnosis	*Dd/mm/yyyy; COSD definition CR2030: DATE OF DIAGNOSIS (CLINICALLY AGREED)*
Stage of Pathway	**Metrics**	**Data Format; Definition**

Diagnosis	Date of communication of cancer/not cancer	*Dd/mm/yyyy.* CWT103. In line with guidance for the Faster Diagnosis Standard.
	Date of communication of non-cancer diagnosis	*Dd/mm/yyyy;* If communication is by letter, date letter is sent
Onward Referral	Date of onward referral discharge	*Dd/mm/yyyy*
	Specialty patient is referred on to	*Dropdown;* Specialty patient is referred to or if patient is discharged back to their GP. MAIN SPECIALTY CODE: ttps://www.datadictionary.nhs.uk/data_dictionary/attributes/m/main_specialty_code_de.asp
	Onward referral to site-specific pathway	*Dropdown:* COSD definition CR3190: Multidisciplinary Team meeting type
	Additional referral to complementary support	*Free text:* e.g. referral to support group, mental health services
Cancer Follow Up	TNM stage grouping (final pre-treatment)	*Dropdown;* COSD definition CR0580
	Date of TNM stage grouping (final pre-treatment)	*Dd/mm/yyyy; COSD definition CR3120:*
	TNM stage grouping (integrated)	*Dropdown;* COSD definition CR0610:
	Date of TNM stage grouping (integrated)	*Dd/mm/yyyy;* COSD definition CR3130.
	TNM edition number	*Dropdown;* COSD definition CR2070: UICC edition number used
	Final FIGO staging	*Dropdown;* COSD definition GY7010
	Final FIGO staging date	*Dd/mm/yyyy;* COSD definition GY7440:
	Final Haematological staging	*Free text;* COSD definition: Ann Harbor: A8280+HA8290+8300+8310+8680 or Binet: HA8240 or ISS: HA8560
Stage of Pathway	**Metrics**	**Data Format; Definition**

Cancer Follow Up	Final Haematological staging date	*Dd/mm/yyyy; COSD definition: Ann Harbor: HA8720 or Binet: HA8700 or ISS:* *HA8710*
	First treatment start date	*Dd/mm/yyyy; COSD definition CR1370:*
	First treatment category	*Dropdown;* COSD definition CR0470: Planned cancer treatment type
	Patient outcome 6 months after first treatment start date for cancer	*Dropdown;* Complete response, partial response, cancer progression, death
	Primary procedure (OPCS)	*Free text;* COSD definition CR0720: OPCS code
All condition follow up (within 12 months from date of referral to RDC)	Person death date	*Dd/mm/yyyy;* If relevant. COSD definition CR1270
	Additional information related to the pathway	*Free text.*

Appendix E: Glossary

Accelerate, Coordinate, Evaluate (ACE) Programme was jointly funded by Cancer Research UK, Macmillan Cancer Support and NHS England. The pilot developed centres for patients referred by their GP because of non-specific but concerning symptoms that could indicate cancer.

Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Clinical nurse specialist (CNS) is an advanced practice nurse who can provide expert advice related to specific conditions or treatment pathways.

CT scan a computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body.

Electronic Referral System (ERS) is a booking system for referring patients into further investigations, usually from primary to secondary care.

Emergency Department (ED) is a hospital based service, also known as 'Accident and Emergency (A&E)' and previously 'Casualty'.

Endoscopy is a procedure where the inside of a patient's body is examined using an instrument called an endoscope. An endoscope is a long, thin, flexible tube that has a light source and camera at one end. Images of the inside of your body are relayed to a television screen.

Faster Diagnosis Standard (FDS) is a new cancer diagnosis standard, designed to ensure patients find out within 28 days whether they have cancer. This new standard will be introduced in 2020.

Ionising radiation medical exposure regulations (IRMER) provide safeguards for individuals exposed to ionising radiation from medical equipment for imaging, treatment or research purposes.

Making Every Contact Count (MECC) is an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing.

Multidisciplinary Diagnostic Centre (MDC) These centres were part of the national Accelerate, Coordinate, Evaluate (ACE) Programme jointly funded by Cancer Research UK, Macmillan Cancer Support and NHS England. The centres were for patients referred by their GP because of non-specific but concerning symptoms that could indicate cancer.

MDT (multidisciplinary team) is a team of health professionals with a variety of roles and specialisms, who work together to provide treatment and care.

MRI (magnetic resonance imaging)is a type of scan using radio waves and a magnetic field to create images of the body.

Non-specific symptoms (NSS) are self-reported symptoms that do not indicate a specific cancer or involve an isolated body system.

Outpatient Department (OPD) is where patients go for hospital appointments that do not require overnight stay.

Patient navigator is an individual who helps to facilitate a patient's journey through different pathways. Navigators work by providing patients with a single point of contact to the service and provide relevant information and to help them move through the service. Navigators can provide co-ordination of testing and treatments and tracking of patients.

Personal Care Record or Personal Health Record (PCR or PHR) is a record of a patient's medical history, personal details and ongoing tests and results. Also known as 'Patient Notes'.

Rapid Diagnostic Centre (RDC) is a service model that provides:
1. a single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer
2. a personalised, accurate and timely diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked expertise and information locally

Rapid Diagnostic Service (RDS) is Wessex's virtual implementation of the Rapid Diagnostic Centre concept.

Site-specific symptoms (SSS) are self-reported symptoms that indicate a specific cancer as outlined by NICE Guidelines (NG12).

Urgent Treatment Centre (UTC) is GP-led, open at least 12 hours a day, every day, offering appointments that can be booked through 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people that cause people to attend Emergency Departments.