Rapid Diagnostic Service Plan

2020-2024

Purpose

This paper has been developed to inform TVCA stakeholders of the scope and progress to date in establishing the RDS programme for TVCA including the high-level deliverables for both the lung and colorectal RDS pathways. The pathway requirements and schematics documented in this paper have been reviewed and approved as a minimum set of requirements by the respective TVCA CAG (Clinical Advisory Groups) as well as the TVCA RDS Working group.

2020 proved to be a challenging year, the NHS rose to the challenge of managing the covid-19 pandemic. As we look to recover, we must embed the learnings around developing green covid-lite pathways that deliver improved patient experience and faster streamlined diagnosis.

We are asking colleagues to review the paper below and join the trust socialisations sessions on March 9th and 10th to further inform the high-level plan below. Accompanying this paper is the baseline assessment against the pathway minimum requirements conducted in November which we will look to refresh with trusts to support agreement to work together to deliver the pathways for lung and colorectal as a system and build towards the Long term plan ambition for cancer – **3.59 The new faster diagnostic standard will be underpinned by the radical overhaul of the way diagnostic services are delivered for patients with suspected cancer.**

Background and rationale

In 2016 TVCA participated in the national ACE 2 (Accelerate, coordinate and evaluate) programme to develop MDC (multidisciplinary centre) pathway models for patients with vague or nonspecific symptoms which could represent cancer.

This multi-year programme has since been well adopted by TVCA with data from the Oxford pilot being used to inform the national roll out of the RDC (rapid diagnostic centre) implementation specification 2019/20 https://www.england.nhs.uk/wp-content/uploads/2019/07/rdc-vision-and-1920-implementation-specification.pdf. In summary the ACE evaluation identified that pilot sites found around 8% of patients who went through the pathway were likely to be diagnosed with some form of cancer.

The ACE programme then formed part of the broader RDC programme within LTP (Long term plan) strategy https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ with the ambition to deliver faster and earlier diagnosis of cancer and improved patient experience. This programme will directly support the 28 day faster diagnostic standard (FDS) which was due to be fully operational from April 2020 but due to the impact of the covid-19 pandemic is now due to be fully operational from April 2021. Funding for this programme has been outlined through to 2024.

The LTP describes a 10-year goal that by 2028 there will be an increase from 50 to 75% of cancers diagnosed at stage 1&2.

In May 2020 TVCA reviewed the outline approach defined in the **TVCA Executive board RDC Options Paper** and considered the initial learnings from the Covid-19 response for cancer. The live data from the TVCA PTL returns indicated a prolonged recovery from the pandemic and therefore the approach has been to refine this year's approach to target 2 poorly performing pathways. A working group was established to deliver the RDC principles of uniform pathway adoption across TVCA underpinned by live data with several key enablers along the pathway to ensure optimal patient experience and a faster diagnostic process.

In September 2020 an expanded plan was presented and agreed at the TVCA Executive board to describe the **pathway visions for lung and colorectal** including the scope for the supporting enablers and a phased plan for roll out on the pathways.

At the October 2020 meeting of the RDS working group there was agreement that this plan (approved by both the SE region and National cancer programme) along with the **baselining of both pathways, including a 12-month diagnostic demand review** and the outline scope for the enablers on both pathways should be shared more widely for greater input from across TVCA. This would further increase the momentum and support delivery according to the approved TVCA workplan for 2021/22.

Understanding the patient experience is crucial, and whilst the approach to capturing this on a real time basis as the programme progresses is developed, the TVCA RDS Primary care lead worked closely with the TVCA RDS patient representative to develop and then conduct semi structured interviews with patients who had recently been diagnosed with cancer. It has highlighted that there are some very simple ways in which we can **improve the experience for patients** in the short term and we will prioritise these during the initial roll out of RDS pathways.

In January, there have also been subsequent developments around the **Community Diagnostic Hub (CDH)** project which is currently gathering momentum. The RDS work is being considered a separate project to this which will continue without delay for the planned proposals around CDH's to crystallise, however the Alliance is working with local ICS's to take CDH proposals forwards and the intention would be to consider integration of the RDS into CDH's once they are functioning.

The RDS working group plan was to **socialise this paper via MS Teams** recorded sessions in early December 2020 with trust, CCG and primary care colleagues for further expert input into the plan. However, due to a subsequent peak of COVID, this was delayed and the sessions are now being added back into diaries for late February, early March 2021. In order to deliver the visions for rapid diagnostic services for the population of TVCA we will need not only the Executive board approval which is in place but most importantly all partners aligned and committed to delivering the programme.

The learnings from implementing the lung and colorectal RDS pathways and further data collected from the MDC's across TVCA will be used to inform wider more progressive RDS models for TVCA from 2021 onwards. The TVCA ambition for 2024 is **all cancer pathways will be incorporated into a single rapid diagnostic service model for TVCA**.

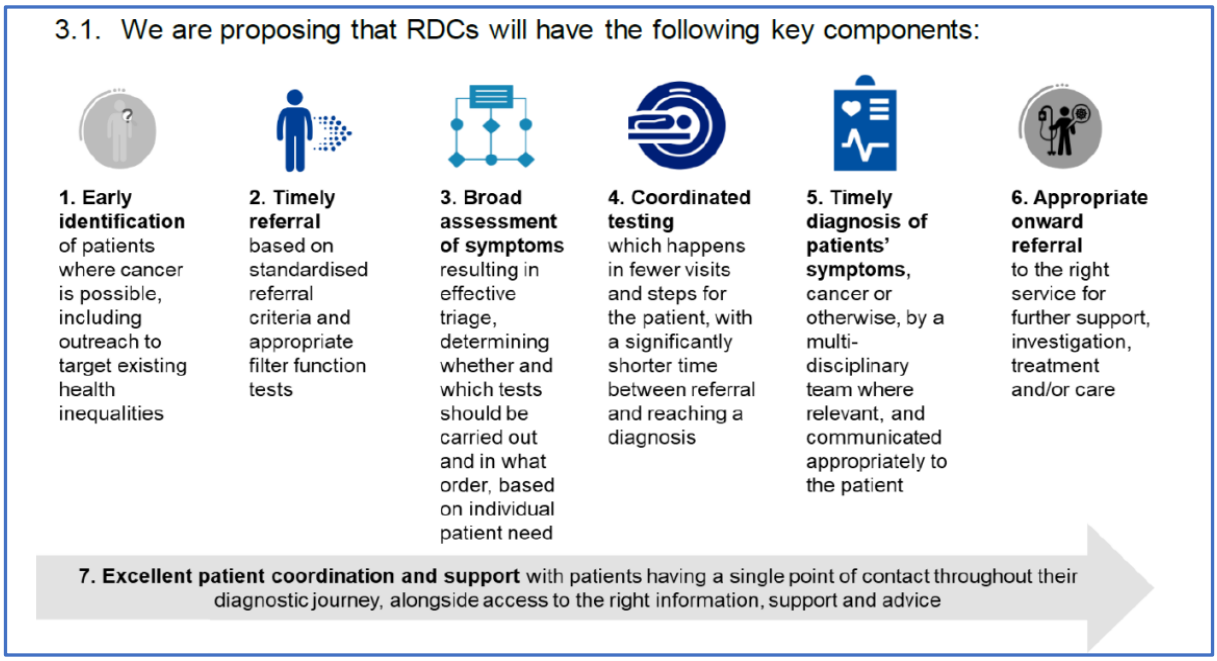
Please join us, influence the plan and ensure that we can deliver the best possible experience for our population and our systems by 2024.

National RDC principles

An ambitious national vision for RDC's focuses on:

- A single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer;

- A personalised, accurate and rapid diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally



It is important to note that despite the models being referred to as centres there is no funding available to developed dedicated sites for diagnostics at present. As mentioned above, in due course they may be integrated into CDH's however, the flow diagram above refers to the key service components that once in place will streamline pathways for patients and improve experience. TVCA will therefore adopt the acronym of **RDS (rapid diagnostic service)** terminology to describe plans for 2020-2022.

Pathway Vision – Lung and colorectal

What is set out below is the **minimal requirements** that would be needed to run the service. Individual Trusts may exhibit variations in how they exactly do things in order to fit with their current processes, but the standards below would be the requisite for a successful RDS.

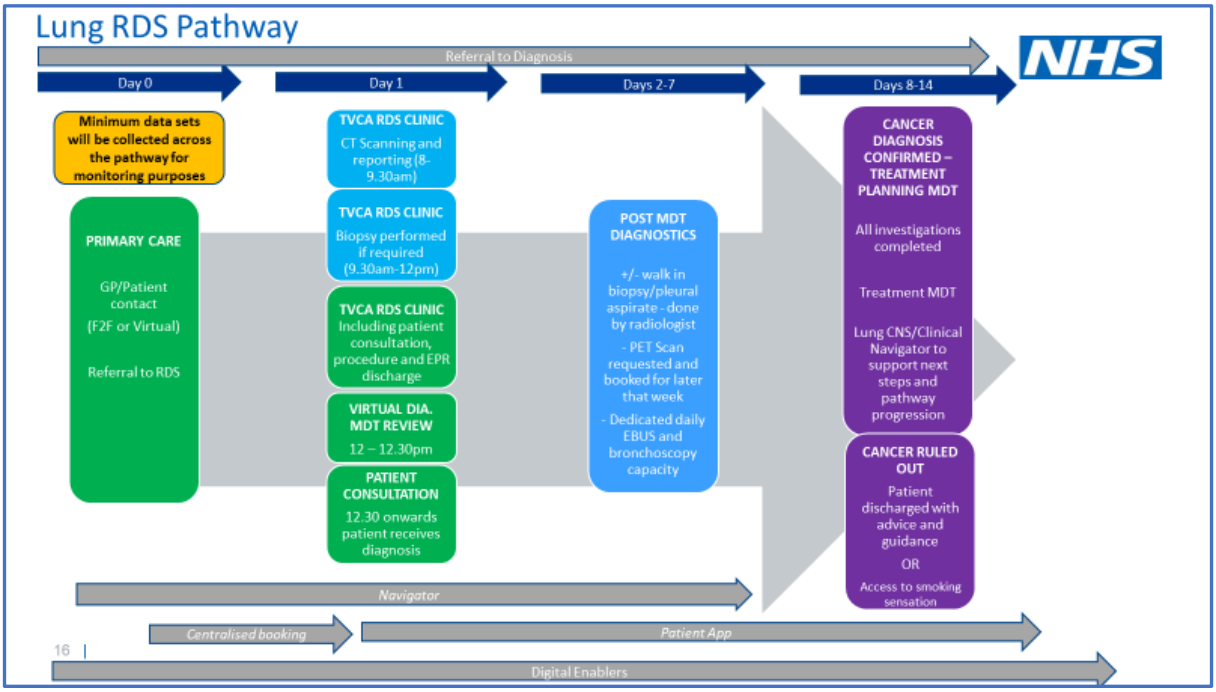
Lung

Aim

Lung RAPID pathway (rapid access to pulmonary investigation days)

The pathway schematic is to be expanded following a further clinical review with the Lung CAG lead, TVCA clinical Director and NIHR colleagues to further develop and ensure aligned equitable access for all patients across TVCA. Elements to be expanded are potential access to x-ray and later, screening

within primary care as well as clearly identifying where each step within the pathway can occur within TVCA, including maximal use of specialist diagnostics across the alliance geography.
The aim of the RAPID pathway is to ensure all patients have a clear diagnosis, whether or not that is lung cancer, within seven days of referral. The referral can come through GP 2WW, lung cancer screening programmes or internally from other hospital departments.



Lung pathway minimum requirements:

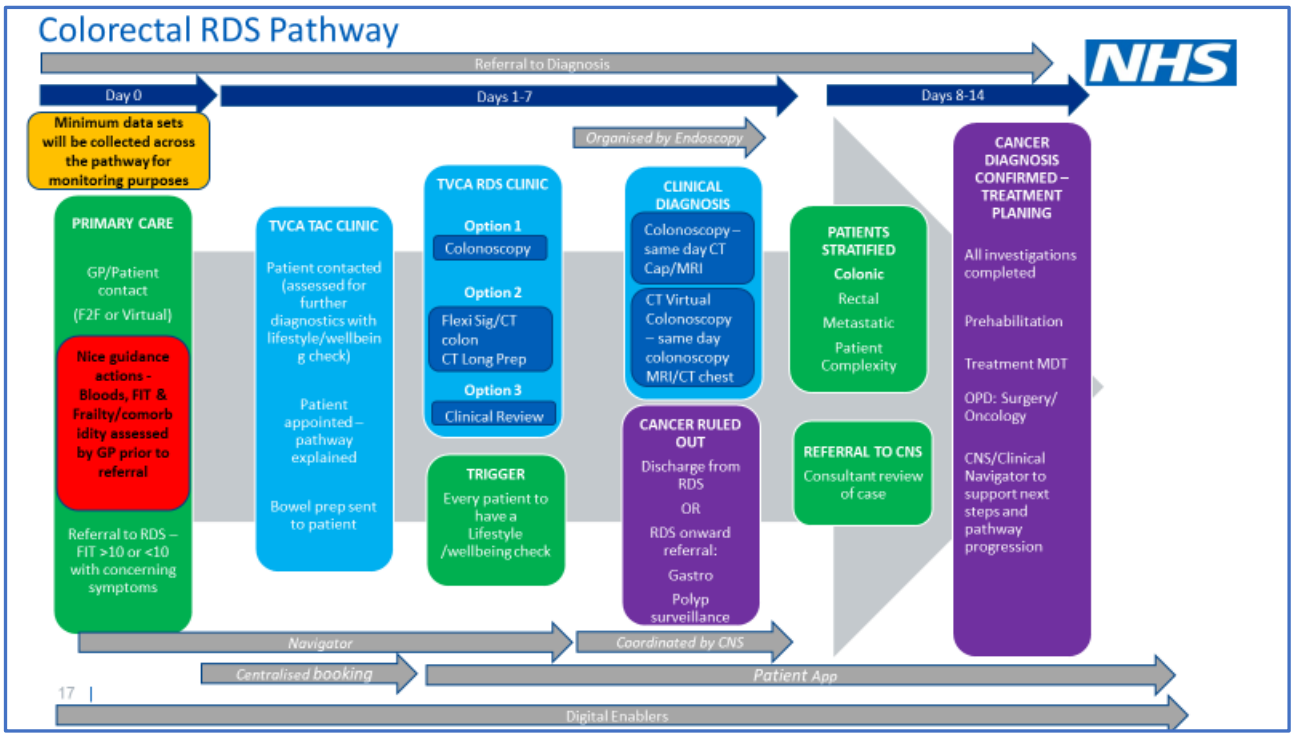
1) Patient books to see GP with symptoms
2) Patient is seen by GP and is examined and has any necessary tests requested – **Day 0**
    a. Bloods
    b. CXR
    c. Frailty and comorbidity scores
3) Referral made to the RDS
4) **Day 1-7**
    a. CT scan done and reported
    b. Biopsy arranged and completed
    c. Diagnostic MDT type review of results
    d. Patient seen and informed of diagnosis and next steps (discharged if not cancer, transferred to alternative pathway)
    e. Any further tests completed e.g. PET scan/EBUS
    f. The aim is to complete as many steps in a one stop clinic as possible
5) **Day 8-14**
    a. All results collated
    b. Patient discharged if not cancer / transferred to alternative pathway
    c. Sent onwards to MDT with all results and scans if cancer confirmed

Colorectal

Aim

Building on the work across TVCA during Covid -19 to introduce FIT testing in primary care (Appendix 1).

To provide a streamlined system for the early diagnosis/exclusion of colorectal malignancy. In those patients in whom cancer is confirmed, their journey through the subsequent staging investigations should be efficient, easy to navigate and personalised to their particular needs, ensuring that initial diagnosis dovetails in with ensuing treatment pathways.
The service needs to be tailored to the individual patient and offer a platform for them to interact with their own journey through initial diagnosis into treatment and follow up.



Colorectal pathway minimum requirements:

1) Patient books to see GP with symptoms
2) Patient is seen by GP and is examined and has any necessary tests requested – **Day 0**
    a. Bloods
    b. FIT test
    c. Frailty and co-morbidity scores
3) Referral made to the RDS if FIT >10 or <10 with concerning symptoms
4) **Day 1-7**
    a. Virtual consultation to determine which pathway the patient needs to follow – incorporating lifestyle and wellness check
    b. Any bowel prep sent to patient
    c. Sent for appropriate test:

i. Colonoscopy
ii. Flexi sig/CT colon CT long prep
iii. Clinical review

d. Dependant on results will proceed to have colonoscopy/CT/MRI CT virtual colonoscopy
e. If no cancer detected, patient discharged back to GP / transferred to alternative pathway

5) **Day 8-14**
   a. If cancer detected, stratified onto the correct pathway and referred to the CNS and the MDT
   b. Clinical appointment to discuss results
   c. MDT to plan treatment

Enabling Functions

In line with the principles for developing RDS models both pathways share a number of supporting enablers to deliver optimal patient experience and time to diagnosis. The enablers are essential to deliver both the timed expectations for both pathways and to ensure optimal patient experience. Where indicated subgroups have been developed to ensure we are able to take forward the work at pace. At TVCA we have been well supported by both the AHSN and NIHR who have been able to support working with commercial partners to deliver the ambitions of the programme.

The working group has agreed that optimal delivery of the RDS for TVCA will require the following enablers to be developed. Some are to be delivered in-year others will be delivered in 2021.

1) Booking of patients

There has been considerable discussion around whether there will be a central point where referrals are received or whether referrals should just be received in the closest Trust. The advantages of central referral are that patients could potentially be directed to other centres with more capacity and it also allows for sharing of workforce, but an advantage of it being Trust based would be the ability for the team to work closely with the clinical teams to drive the service. There was agreement that regardless of the final decision, there should be standardisation of the process across the Alliance as well as clear governance recommendations on the pathway that the TVCA would help drive and monitor. Wessex Cancer Alliance have successfully piloted a central RDS booking system where the staff have access into individual Trust booking systems in order to book tests in the most appropriate place and this should be further explored.

2) Patient Tracking Portal

The vague symptom pathways now in place across most of TVCA (and some of the rest of England) have captured the very positive experience patients have had with a named navigator for them to link in with during their diagnostic journey. However, we are also aware that much more could be done to streamline the diagnostic process and keep the not just patient best informed but the wider system – GP, CNS, lead clinician and RDS team. Whilst the value of the navigator is recognised, as RDS pathways become common place a person cannot and should not be the single point for all information for a

patient. Digital solutions can be delivered that would provide timely information to patients to support their journey and enable our navigator workforce to focus on the supportive human contact and optimal patient experience.

The key components of this system include:

- App based push-pull system
- Partnered with LCHR (local health and care record) therefore could be become part of a larger portal
- Patient would be sent a login once referral received at central booking hub
- Information available about the cancer pathway they have been referred on (what should be expected/what tests they might have/information about what this means/ location of RDS appointment)
- Patient receives notification of their appointment(s) on the system (either they can book it, or the RDS books it, but ultimately, patient can see the appointment and change it if not convenient)
- GP can see everything as soon as patient logs onto the system
- As tests are done, results are stored on the patients record in the system
- Can contain information about key workers and contacts
- Would have the ability for the patient to interact with it and ask questions which are answered in a timely fashion by the RDS navigator in the first instance
- Ultimately, if the patient is given a cancer diagnosis, the app will give patient further information about what to expect next
- All investigations and info would be packaged up and sent to the treating Trust for action, therefore reducing repeat tests and patients having to repeat their journey thus far

The ambition for this portal is that in time it would provide a continuous record of the cancer pathway and could also act as the remote system by which patients manage their own supported self-management post treatment.

3) Consolidated diagnostics

Understanding of the current diagnostic capacity is key to the delivery of this programme. As such, an initial understanding of key metrics within the agreed Lung and Colorectal pathways in relation to turn around times (TATs) was required. In November 2020, we undertook a **baselining scoping exercise** by asking Trusts to provide information of their TATs for the key diagnostic steps within each pathway. For Lung, all Trusts were asked to undertake the return of the five key diagnostic points and for Colorectal, BHT and OUH undertook returns relation to six key diagnostic steps.

Following receipt of the data from Trusts, these were consolidated at Alliance level to provide an overview of where each metric is currently being met or not. This overview will support discussions with Trusts around the required actions to support compliance of the pathways to facilitate the aim of the RDS pathways of diagnosing patients faster.

Review of the data received and analysed, provided clarity on the key areas of the diagnostic pathway of the two pilot pathways.

For Lung, key findings included the following:

1. Variance in trusts who held dedicated cancer slots for the cancer pathway
2. Average turnaround times (TAT's) across the alliance for key tests within the Lung pathway were all greater than 7 days, with greater variance at trust level

For colorectal:

1. Both trusts, except for one specific diagnostic procedure (flexi sig) have dedicated cancer slots for the colorectal diagnostic pathway
2. Despite dedicated slots, the average TAT's were beyond the expected pathway design

It is recognised that the submission of the data was challenging. In some instances, the data covered periods of the COVID-19 pandemic, which is likely to have impacted the 'true' position of the data. In addition, the 12-month period reviewed also varied from trust to trust, therefore, not a complete correlation, however, provided and supported in the understanding of the current diagnostic challenges within the system.

As part of the implementation of the RDS pathway, we will be working closely with the trust cancer operational teams to support the tracking of the patients within this pathway. Within the **TVCA data hub,** we will implement an **RDS Pathway Analytics Portal** which will provide oversight of each step of a patient's pathway from referral to diagnosis as well as next steps (confirmed cancer, onward referral for non-cancer condition and referral back to GP where appropriate). Part of this key next step will involve additional data from trusts will be required to inform this overview. We hope that the additional data will be managed via the current data automation agreements in place, however, where there is new data required, we will work with key colleagues to agree an update to those agreements already in place.

4) RDS teams – describing the optimal workforce

Defining the optimal workforce to successfully deliver new pathways is an essential component of this programme. Whilst we are committed to positioning key roles within RDS pathway's we recognise that this will require a degree of local variation. We are therefore proposing a set of RDS minimum requirements for the key roles of RDS Navigators.

We look forward to working with trusts to further define the optimal RDS clinic workforce as a key next step in operationalising pathways across TVCA.

Evaluation of the SCAN and nonspecific pathways within and outside of TVCA has highlighted the significant role the navigator assumes within RDS pathways. The benefits include improved patient experience, improved administration of the pathway and better utilization of clinical resource to deliver clinical care. This has recently been endorsed as a recommendation from the cancer adapt and adopt recovery programme following the first peak of Covid-19.

TVCA RDS Navigator

We have completed a full navigator baseline across TVCA to understand where this type role is already in place, how the role functions across the patch and where we have gaps. The full baselining is available within the RDS meeting pack.

In summary the outputs of the navigator baseline and TVCA nurse lead review indicated the following:

- Variation in navigator coverage for lung and colorectal across TVCA trusts
- Variation in types of navigator role
- Lack of consistency in reaching out to primary care
- A balance needs to be struck with describing the RDS navigator role to ensure it fits with wider trust clinical and administrative teams
- Alignment and commitment across TVCA to introduce the RDS navigator for both pathways working to a minimum set of requirements that would allow flex in exactly how the role would working wider teams
- The budget for RDS will enable allocation of sufficient funding for posts to be recruited to for a fixed 2-year term, with ongoing evaluation of the role to develop roles as we progress and ensure we can evidence the benefits for sustainable retention of roles. We will review current and projected requirements for navigators with individual trust and CCG meetings to agree financial allocation and commitment to recruit to these roles

Both pathways will also be built around an RDS clinical team who will receive the patient on day 1 of the diagnostic pathway and manage their initial schedule of tests, patient consultation, ongoing diagnostic pathway requirements, onward referral to specialist MDT, transfer onto a non-cancer pathway or discharge with health and wellbeing advice. Work remains to clearly identify and agree the blend of roles required to support this for colorectal and lung pathways across TVCA. We would look to take this forward on the same basis of agreement of the minimum RDS workforce requirements to establish a complaint RDS pathways.

Shaping the RDS with patient and staff experience

Engagement with patients and the public is essential to ensure services are responsive to the needs of people affected by cancer throughout their cancer journey. Our communities – and the voluntary community and social enterprise (VCSE) organisations that support them – are key to understanding what works locally. It is essential that the RDS programme can work in partnership with patients and the public to transform cancer services across Thames Valley.

It is widely accepted that patient experience is a crucial quality outcome in health care, better staff experience is just as important and should be central to the conversation about healthcare design so that the right changes are made changes that benefit both staff and patients.

The involvement of both service users and staff in the development of the RDS is vital given the clear and strong associations between staff experience and patient experience:

- The involvement of service users is crucial given they are the ultimate beneficiaries of the services;
- Staff factors associated with patient satisfaction include; work pressure felt by staff, and the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver.

In December the TVCA Primary care lead worked closely with the TVCA RDS patient representative to develop and then conduct semi structured interviews with patients who had recently been diagnosed with cancer. 16 interviews were conducted with patients who had recently been diagnosed with cancer. In summary the key findings indicated:

- Patients would like more information when they go to their GP and are referred on a 2WW pathway
- Written down information is more helpful
- Patients would like more personal contact to ask questions
- Some patients were not clear why certain tests were being conducted
- Some patients reported duplication within the system (history taking and tests)
- Nurse specialists were endorsed throughout as providing kindness

Recommendations on how to embed these learnings will be shared in due course, there was agreement at the RDS working group that establishing the minimum patient experience requirements for the pathway would be a sensible approach for review and approval across TVCA.

Engagement will take multiple forms building on the baseline of the current experience of patients and then staff across both lung and colorectal cancer pathways. This will continue to be developed with semi-structured interviews. We would like to work with existing feedback mechanisms with trusts to ensure we can capture experience on pathways as close to real time as possible.

Methods of engagement and involvement:

- Patient and staff participation within RDS working group
- Qualitative research using a semi-structured one-to-one interview between patients and staff by an independent clinical lead;
- Virtual patient reference group;
- Virtual engagement events

How will we get there – indicative roll out of RDS pathways

The planned RDS Pilot Sites for 2021

Trust	Vague Symptoms Pathway Status	Go live Date	Activity (to Nov 2020)	New RDS Lung	New RDS Lower GI (proposed)
OUH	Live	Apr-17	2217	Wave 1 – July 21	Wave 1 – July 2021
FHFT	Live	Nov-19	47	Surrey Sussex Cancer Alliance	Surrey Sussex Cancer Alliance
BHT	Live	Dec-19	75	Wave 1 – July 21	Wave 1 – July 2021
RBFT	Live	Sep-20		Wave 1 - July-21	Wave 2 - Sep 2021
GWH	To go live in 2020/21			Wave 1 - July-21	Wave 2 - Sep 2021
MKUH	Local pathway	N/A		Wave 1- July -21	Local pathway in development

LTP deliverables September 2021

1) **A nonspecific symptom pathway within the alliance geography covering 20% of the alliance population**

This has been achieved via the vague symptom pathways across TVCA which are now operational except for RBFT (Sept 2020) and GWH (March 2021)

2) **A site-specific pathway adopted within the alliance geography covering 20% of the alliance population**

This will be achieved through the scheduling described below.

Lung pathway rationale for whole pan alliance approach:

The majority of patients diagnosed with lung cancer are transferred to a tertiary centre to complete the diagnostic pathway. The RDS working group would therefore like to adopt this pathway across the alliance in wave 1. This is to ensure that all centres have the capacity and capability to adopt the rapid access to pulmonary investigation days at the front end of the pathway, this would then ensure timely onward referral to specialist diagnostic locations for biopsy and PET CT to drive pathway completion within 14 days.

Colorectal pathway rationale for staged introduction across TVCA:

Given the very large pathway volumes (**15974** – 2ww GP referrals seen; **569** 62-day patients treated/Apr 19 – Mar 20), the significant challenge following covid-19 and the lung pathway already being adopted across TVCA in year, the RDS working group would like to propose 2 pilot sites in wave 1. The proposed sites (BHT and OUH) already have an active vague symptom pathway and would therefore be best placed to utilize the learning within the lower GI pathway. We would like to discuss this option with the TVCA Exec board for agreement of sites.

Measurement

The TVCA working group will continue to monitor progress against the defined project plan to ensure the project is delivered on time by end of March 2021.

Interim outcomes July 2021:
RDS Lung RAPID pathway: Operational pan TVCA
RDS Lower GI pathway – Operational within 2 trusts within TVCA

How can you help?

It is important that we hear from as many people as possible at this early stage of development. Please do feedback your thoughts or comments to england.tvcaadmin@nhs.net