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

2021

# RAPID DIAGNOSIS CENTRE

# STANDARD OPERATING PROCEDURES

# POLICY

Version 01

# Contents

# 1.0 Aims of the Rapid Diagnosis Centre @ NPTH

- To provide a diagnosis for suspected cancer patients with vague symptoms
- To reduce the time to diagnosis in patients with nonspecific symptoms but with the potential to have a serious underlying problem.
- To improve patient experience by means of timely and prompt investigations along with pathways of communication.
- To improve the outcomes for patients diagnosed with cancer via a vague symptom pathway.

# 2.0 Purpose

The purpose of this Standard Operating Procedure is as follows, (please refer to Appendix 1):

- To outline and standardise the RDC pathway
- To provide a rapid diagnosis for patients who present to GP surgeries in Neath Port Talbot, Swansea and Bridgend with vague but worrying symptoms raising the suspicion of underlying cancer.
- To ensure that staff responsible for, or participating in the delivery of the Rapid Diagnosis Centre (RDC) understand their defined roles, responsibilities and accountabilities.
- To ensure effective and timely processes are in place, without any unnecessary steps and delays so that the patient is investigated and seen by the RDC Team in the allocated RDC clinic sessions.
- The key team will initially comprise of a Consultant Radiologist, Consultant Physician, Clinical Nurse Specialist (CNS), Health Care Support Worker (HCSW), GP Project Lead, Senior Service Manager and a RDC Co-ordination Manager.
- To incorporate a robust tracking process to make sure that patients are not delayed or missed in line with Single Cancer Pathway (SCP).
- To develop robust onward referral pathways for a number of specialities.

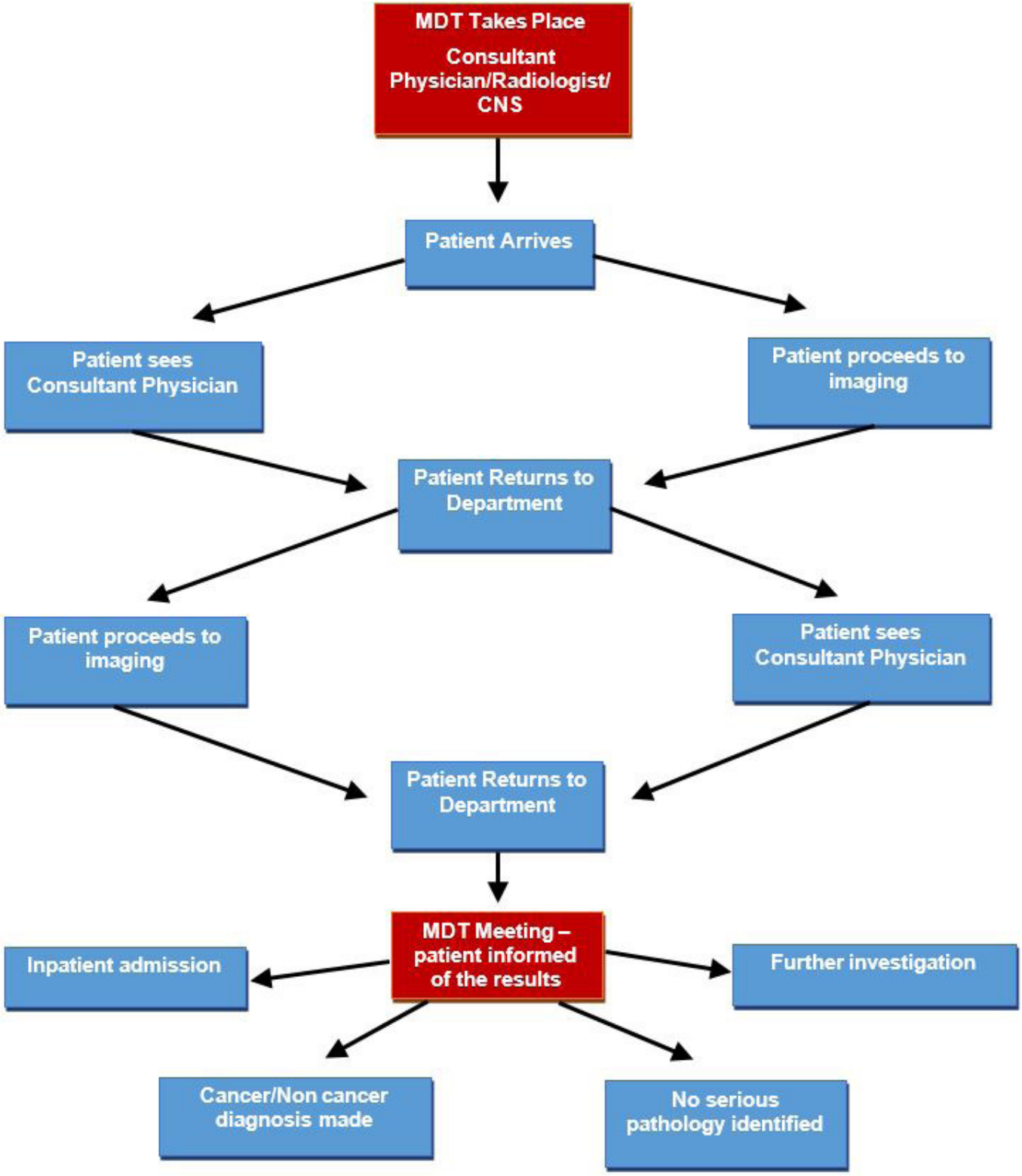
# 3.0 Capacity Required

The current capacity requirements to run 2 clinics a week:

- Consultant Physician – 2 sessions per week
- Consultant Radiologist – 2 sessions per week
- HCSW – 2 sessions per week
- Radiology Department – 2 sessions per week
- Support from CNS, Coordination Manager, Senior Service Manager, GP Project Lead

## 4.0 Clinic pathway

Referrals will be electronically received for example via Welsh Clinical Communications Gateway (WCCG).



# 5.0 Rapid Diagnostic Pathway

Patient attendance at GP Surgery (refer to Appendix 2)

1. Patient presents to primary care with non-specific symptoms e.g fatigue, weight loss.
2. GP undertakes clinical examination.
3. GP suspects possibility of underlying malignancy, but not indicative of tumour site and does not fit with existing cancer referral pathway.
4. GP informs patient they may have a serious underlying problem and that a referral will be made to the Rapid Diagnosis Centre.
5. GP provides patient with information leaflet containing information on what happens next.
6. GP completes blood test request form and arranges for patient to have bloods taken. Set A investigations on referral:
    - Bloods - FBC, U&E/EGFR, LFT, Coeliac Screen, CRP, Ferritin, Bone profile, Glucose, HbA1C, Males – PSA, Females – CA125
    - Urine Dip
    - Weight
    - Clinical examination findings including PR/Breast exam

7. GP completes and submits a cancer referral via the WCCG portal. The referral form should be marked/identified for the Rapid Diagnosis Centre. The referral must include reason for referral, why cancer is suspected and clinical examination findings detailed above.

# 6.0 Referral Information

**6.1 Patient Inclusion Criteria**

Essential – All patients must fulfil ALL of these:

- > 18 years of age
- GP is within catchment area
- The patient is well enough to go through the process
- The patient understands the reason for referral, the process and is able to attend the RDC, possibly for a few hours at a time at short notice
- "Set A" investigations have been requested
- There is no other urgent referral pathway suitable for this clinical scenario

**Qualifying Clinical Criteria**

Essential – All patients must have at least one of these:

- Unexplained weight loss
- Unexplained laboratory test findings (eg. anaemia, thrombocytosis, hypercalcaemia)
- GP Clinical Suspicion of a serious disease that could be due to cancer / GP "gut feeling"
- Severe unexplained fatigue
- Persistent nausea or appetite loss
- New atypical pain (eg. diffuse abdominal pain or bone pain).
- Unexplained shortness of breath
- Unexplained night sweats

**6.2 Patient Exclusion Criteria**

Essential – All patients must have none of these:

- Those patients already on a designated cancer pathway
- Those patients who are suitable for a site specific cancer pathway
- Referral via secondary care including ED or GP outside pilot area.
- Patients <18 years of age
- Symptoms related to a previous cancer diagnosis and most likely to be due to a recurrence.
- Seen in RDC within last 3 months with no new symptoms
- Patent too unwell to attend
- Patient obviously needs acute admission
- Patient unable/unwilling to attend at short notice
- A serious NON CANCER diagnosis is highly likely

# 7.0 SOP for RDC Team – once referral received

Please refer to appendix 3

1. WCCG referral received by the Registration Team and is registered on WPAS by assigning to Mixed Clinician and 812001 Rapid Diagnosis Centre (Service Code). The referral is transferred to the RDC Welsh Clinical Portal (WCP) worklist which is available to RDC team.
2. Referral is viewed and triaged electronically by RDC clinical staff (ensuring inclusion criteria has been met and sufficient detail included).
3. WCP is updated. Referral is either accepted or returned to the GP with detailed reasoning and additional advice.
4. On accepting of referral, an electronic 'data profile' and checklist is completed by CNS or Coordination Manager (CM).
5. Either CNS or CM rings patient with appointment date details and books into the next available clinic, for a mutually agreeable appointment time where possible. If clinic attendance is more than 5 days, an appointment letter with leaflet will be sent to patient.
6. CNS/key worker contact details provided to patient.
7. WPAS is update to reflect appointment details. Casenotes are requested.
8. CM transfers information from patient 'data profiles' to clinical summary sheet and sends via email to Consultant Physician, Consultant Radiologist, CNS and radiology representative.
9. CM preps for clinic the afternoon before the clinic. This includes:
    - Patient packs – GP referral, set A bloods, clinic sheet, pathology labels, patient checklist.
    - Patient case notes
    - Observation sheet
    - Create MDT list on Synapse
10. Any surplus designated CT slots will be released back to Radiology by 2.30pm the day before clinic.
11. In line with Health Board OPD guidance:
    - If a patient does not attend (DNA) a confirmed appointment, they are to be discharged from the RDC and their GP informed.
    - If a patient notifies the coordinator on the day of their confirmed appointment that they cannot attend (CNA), they will be offered one more appointment.

# 8.0 SOP for RDC Team – during clinic session

Please refer to Appendix 4 & 5

1. Patients are discussed at the 1st MDT which includes Consultant Physician, Consultant Radiologist, CNS (if CNS not available CM will attend). Initial investigation results along with patient notes are available. The usual MDT format will be adopted.
2. Patient attends clinic in the morning, is met by the HCSW and informed of MDT plan. This may include assessment by the Consultant Physician or attending Radiology department for diagnostic imaging, first.
3. HCSW records patient's weight, blood pressure, heart rate, oxygen saturations and temperature.
4. All patients needing diagnostic imaging, are escorted to the Radiology Department by the HCSW.
5. All requested scans will be reported live by the Consultant Radiologist.
6. 2nd MDT is commenced when all radiological and clinical investigations are completed.
7. Results and management plan are discussed with patient on the same day by CNS and/or Physician.
8. CM to obtain a copy of referral forms for onward investigation and is responsible for distributing these to the relevant department in a timely manner.
9. Patients are assigned an outcome on WPAS with the following key:

| Outcome | Local Reason |
|---|---|
| **Discharged** | **No serious pathology** |
| **Discharged** | **Differential diagnosis made/suspected – GP to manage** |
| **Further investigation** | |
| **Further investigation** | **Referral to another consultant** |
| **Referral to another consultant** | **USC** |
| **Referral to another consultant** | **Blank (Urgent)** |
| **Referral to another consultant** | **No diagnosis made** |
| **Inpatient admission** | |

10. CNS to update GP on day of clinic with any significant diagnoses.
11. Clinic letters are created and approved on DMS preferably within 24hrs. GP letters are automatically sent electronically. Onward referrals are emailed to the relevant speciality.
12. CM records the outcomes from the clinic on WPAS and Cancer Tracker.

# 9.0 Roles and Responsibilities of Key Staff

**9.1 Role of the RDC CNS**

- The CNS is the main point of contact for patients and GPs from the point of referral, throughout the clinic appointment and following diagnosis until care is taken over by appropriate site-specific team.
- Duties include:
  - Vetting referrals in a timely manner
  - Gathering relevant clinical information including past medical history and test results on each patient referred
  - Attend RDC MDT with Radiologist and Consultant Physician
  - Support and supervise RDC HCSW
  - Provide counselling and support for patients diagnosed with cancer or other serious illness
  - Discuss and action referrals for support services e.g. Specialist Palliative Care, welfare benefits advice, District Nursing, OT, Physio, Dietetics and prehabilitation
  - Provide written information on disease site and key worker contact details
  - Complete Holistic Needs Assessment
  - Will update GP's on day of clinic with any significant diagnoses.
  - Liaise with cancer MDTs and speciality leads, ensuring documentation completed and submitted in line with MDT deadlines
  - Monitor and act upon test results

**9.2 Role of the RDC Coordination Manager**

- Provide secretarial and administrative support to the team
- The coordinator will be the person responsible for ensuring all information is accurately recorded. This includes cancer tracking.
- Act as a point of contact for RDC queries, redirecting clinical queries to the appropriate members of staff

Duties would include:

- Book patients and complete clinic prep
- Liaise with Physicians and Radiologist to determine clinic cover
- Update clinical systems to reflect current circumstances
- Update data sets on a regular basis
- Support clinic as and when required
- In collaboration with the service manager, complete data requests when needed
- Type clinic letters and send on any onward referrals
- Scan request forms for further investigations and confirm receipt
- Arrange RDC meetings with internal and external bodies

**9.3 Role of the Consultant Physician**

Duties would include:

- Review of referrals prior to clinic
- Attend RDC MDT
- Carry out clinical assessment of patient
- Document and dictate clinical/radiological findings and management plan
- Develop and instigate management plan

**9.4 Role of the Consultant Radiologist**

Duties would include:

- Act as a representative for the RDC team at local and external meetings.
- To ensure radiology cover is always available for planned and unplanned leave
- Review and advise on the appropriateness of referrals if recent imaging has been performed
- Using clinic expertise suggest and discuss further tests using prudent and appropriate resources
- Ensure clear lines of communication

**9.5 Role of the RDC Health Care Support Worker**

Duties would include:

- Meet and greet patients making sure they are aware of the clinic proceedings
- Ensure patients have received adequate hydration in preparation for possible CT scan with contrast
- Undertake patient observations
- Escorting and chaperoning patients when needed for investigation
- Undertake blood tests as and when required in clinic
- 1st point of contact for supporting and facilitating a positive patient experience
- Undertake administrative duties within the remit of the role.

**9.6 Role of the GP Lead**

Duties would include:

- Represent and support the RDC at a local and national level
- Support the CNS with review and triage of referrals
- Clinical Lead for RDC
    - ◊ Chair meetings as and when required
    - ◊ Provide clinical feedback to GP referrers
    - ◊ Liaise with executive colleagues with regards to the strategic direction of the RDC

# 10.0 Key Data measurements:

To ensure that the clinic is effective and efficient, the following key data parameters were developed and agreed to be measured by the RDC.

# 11.0 Standard Operating responsibilities

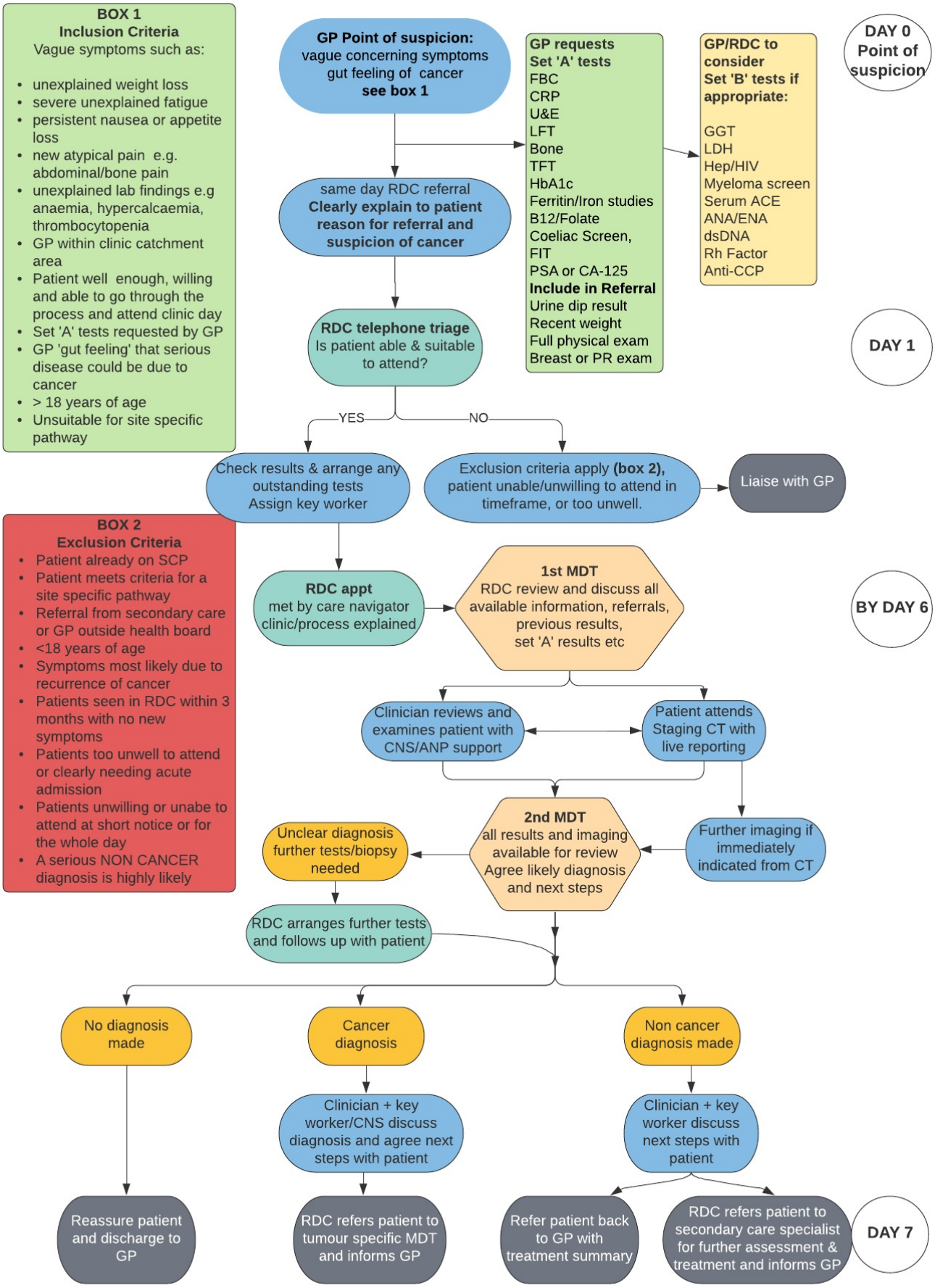
The responsibility for the procedures described in this SOP applies to:

- RDC GP Lead
- RDC Physician
- RDC Consultant Radiologist
- RDC CNS
- RDC HCSW
- RDC Coordination Manager
- RDC Senior Service Manager

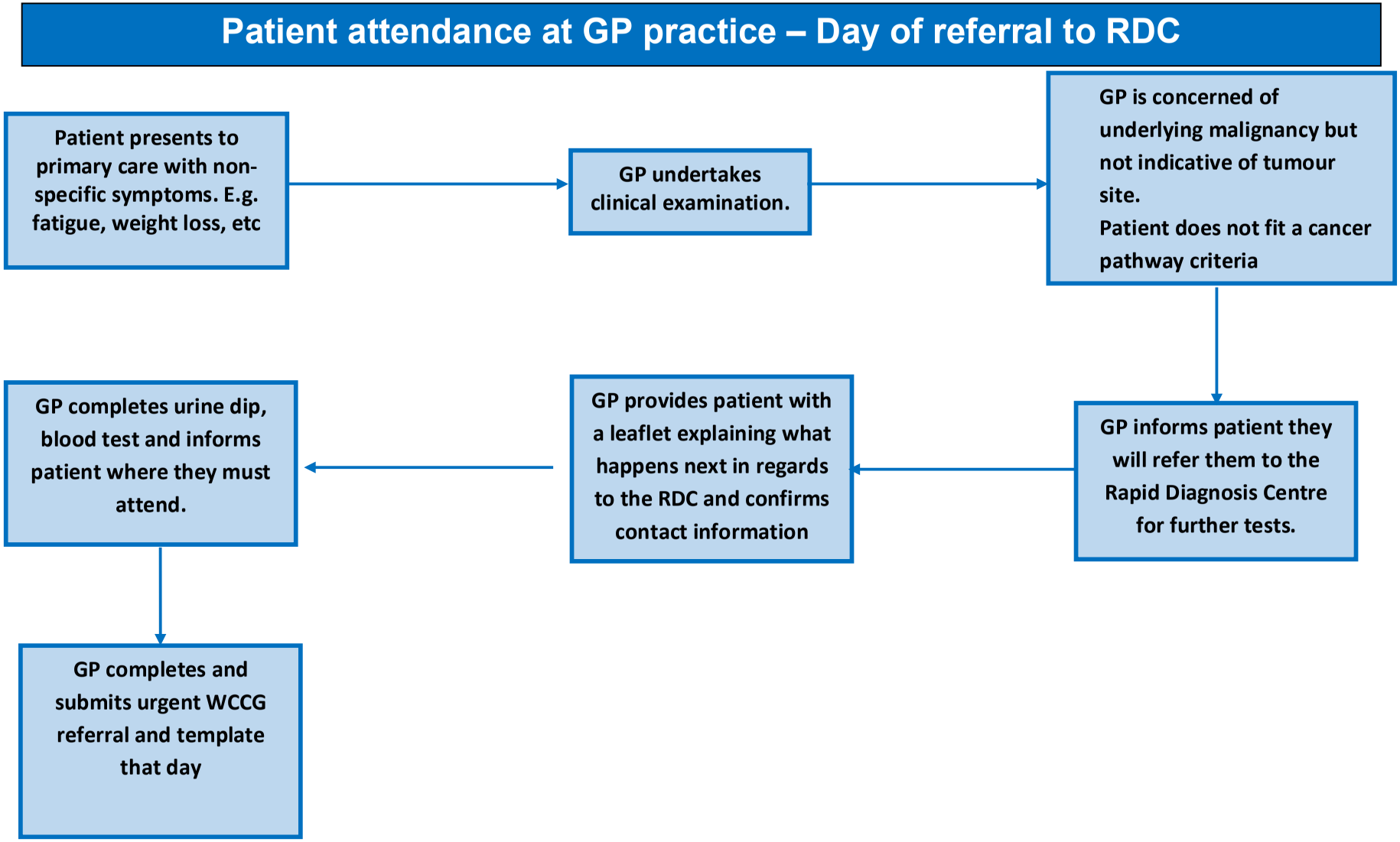
# 12.0 Change History

SOP no. 01 - May 2021

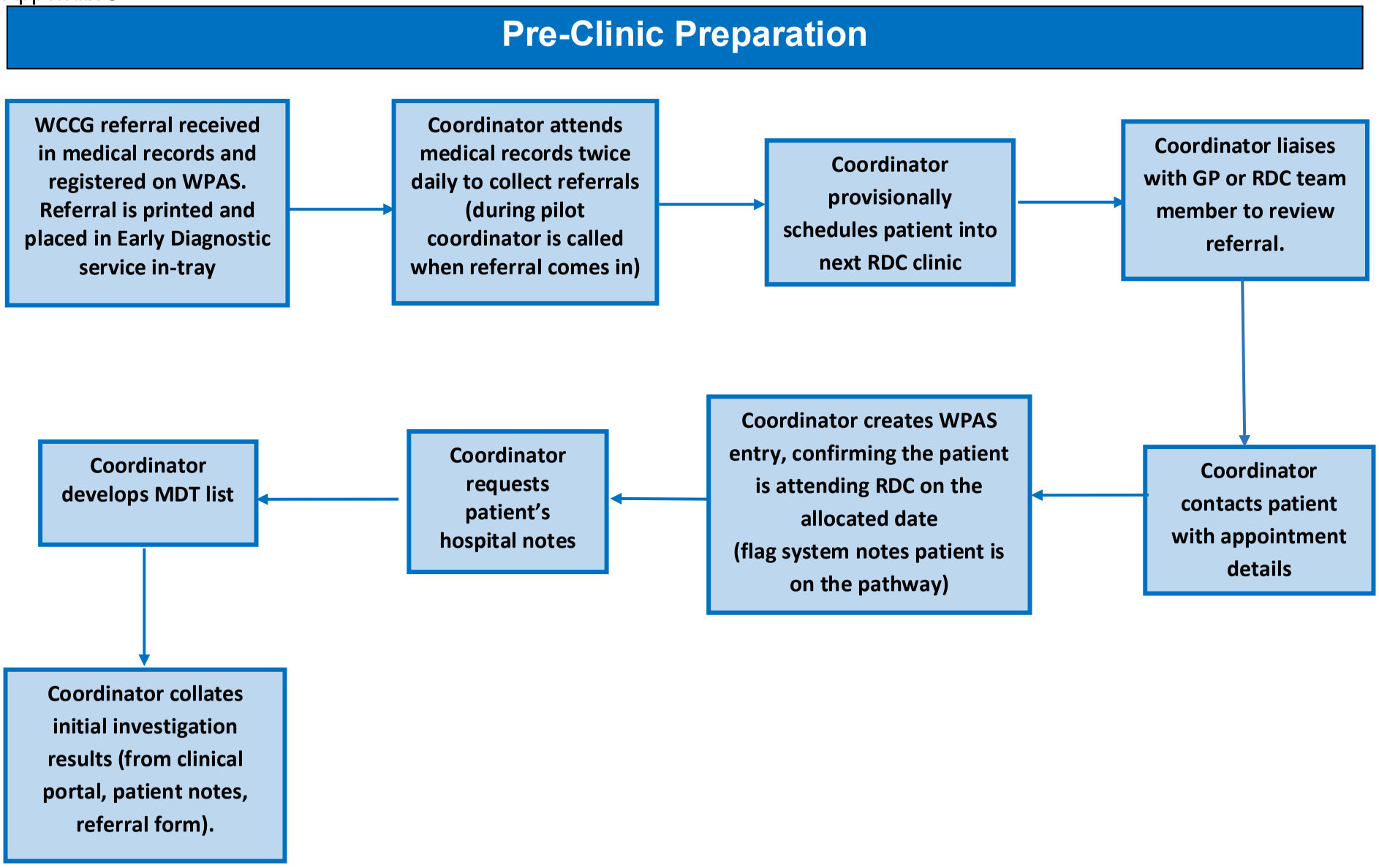
Appendix 1


BOX 1
Inclusion Criteria
Vague symptoms such as:
unexplained weight loss
severe unexplained fatigue
persistent nausea or appetite loss
new atypical pain e.g. abdominal/bone pain
unexplained lab findings e.g anaemia, hypercalcaemia, thrombocytopenia
GP within clinic catchment area
Patient well enough, willing and able to go through the process and attend clinic day
Set 'A' tests requested by GP
GP 'gut feeling' that serious disease could be due to cancer
> 18 years of age
Unsuitable for site specific pathway
BOX 2
Exclusion Criteria
Patient already on SCP
Patient meets criteria for a site specific pathway
Referral from secondary care or GP outside health board
<18 years of age
Symptoms most likely due to recurrence of cancer
Patients seen in RDC within 3 months with no new symptoms
Patients too unwell to attend or clearly needing acute admission
Patients unwilling or unabe to attend at short notice or for the whole day
A serious NON CANCER diagnosis is highly likely
GP Point of suspicion:
vague concerning symptoms
gut feeling of cancer
see box 1
same day RDC referral
Clearly explain to patient reason for referral and suspicion of cancer
GP requests
Set 'A' tests
FBC
CRP
U&E
LFT
Bone
TFT
HbA1c
Ferritin/Iron studies
B12/Folate
Coeliac Screen,
FIT
PSA or CA-125
Include in Referral
Urine dip result
Recent weight
Full physical exam
Breast or PR exam
GP/RDC to consider
Set 'B' tests if appropriate:
GGT
LDH
Hep/HIV
Myeloma screen
Serum ACE
ANA/ENA
dsDNA
Rh Factor
Anti-CCP
DAY 0
Point of suspicion
RDC telephone triage
Is patient able & suitable to attend?
DAY 1
YES
NO
Check results & arrange any outstanding tests
Assign key worker
Exclusion criteria apply (box 2), patient unable/unwilling to attend in timeframe, or too unwell.
Liaise with GP
RDC appt
met by care navigator
clinic/process explained
1st MDT
RDC review and discuss all available information, referrals, previous results, set 'A' results etc
BY DAY 6
Clinician reviews and examines patient with CNS/ANP support
Patient attends Staging CT with live reporting
2nd MDT
all results and imaging available for review
Agree likely diagnosis and next steps
Unclear diagnosis further tests/biopsy needed
Further imaging if immediately indicated from CT
RDC arranges further tests and follows up with patient
No diagnosis made
Cancer diagnosis
Non cancer diagnosis made
Clinician + key worker/CNS discuss diagnosis and agree next steps with patient
Clinician + key worker discuss next steps with patient
Reassure patient and discharge to GP
RDC refers patient to tumour specific MDT and informs GP
Refer patient back to GP with treatment summary
RDC refers patient to secondary care specialist for further assessment & treatment and informs GP
DAY 7

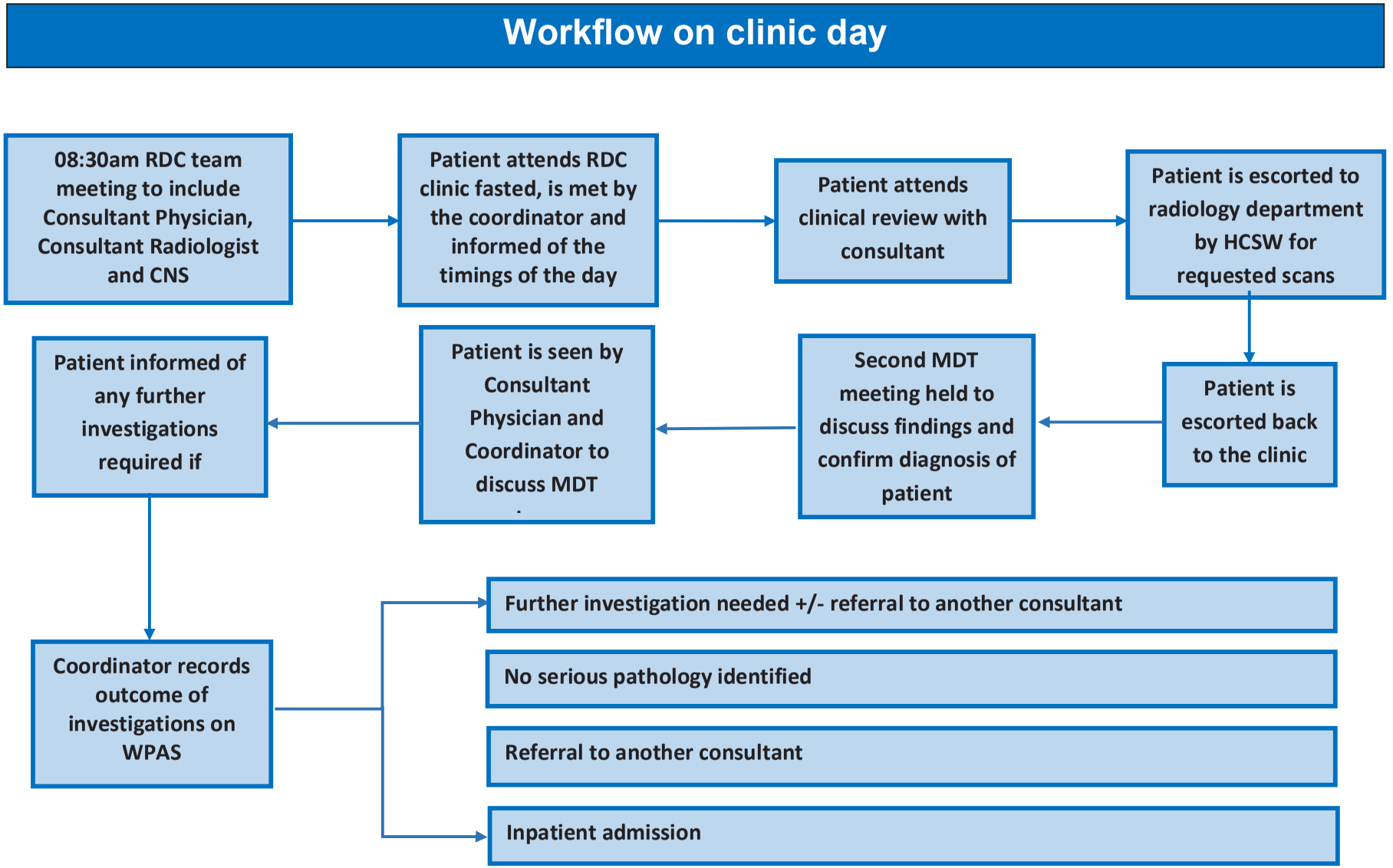
Appendix 2


Patient attendance at GP practice – Day of referral to RDC
Patient presents to primary care with non-specific symptoms. E.g. fatigue, weight loss, etc
GP undertakes clinical examination.
GP is concerned of underlying malignancy but not indicative of tumour site.
Patient does not fit a cancer pathway criteria
GP informs patient they will refer them to the Rapid Diagnosis Centre for further tests.
GP provides patient with a leaflet explaining what happens next in regards to the RDC and confirms contact information
GP completes urine dip, blood test and informs patient where they must attend.
GP completes and submits urgent WCCG referral and template that day

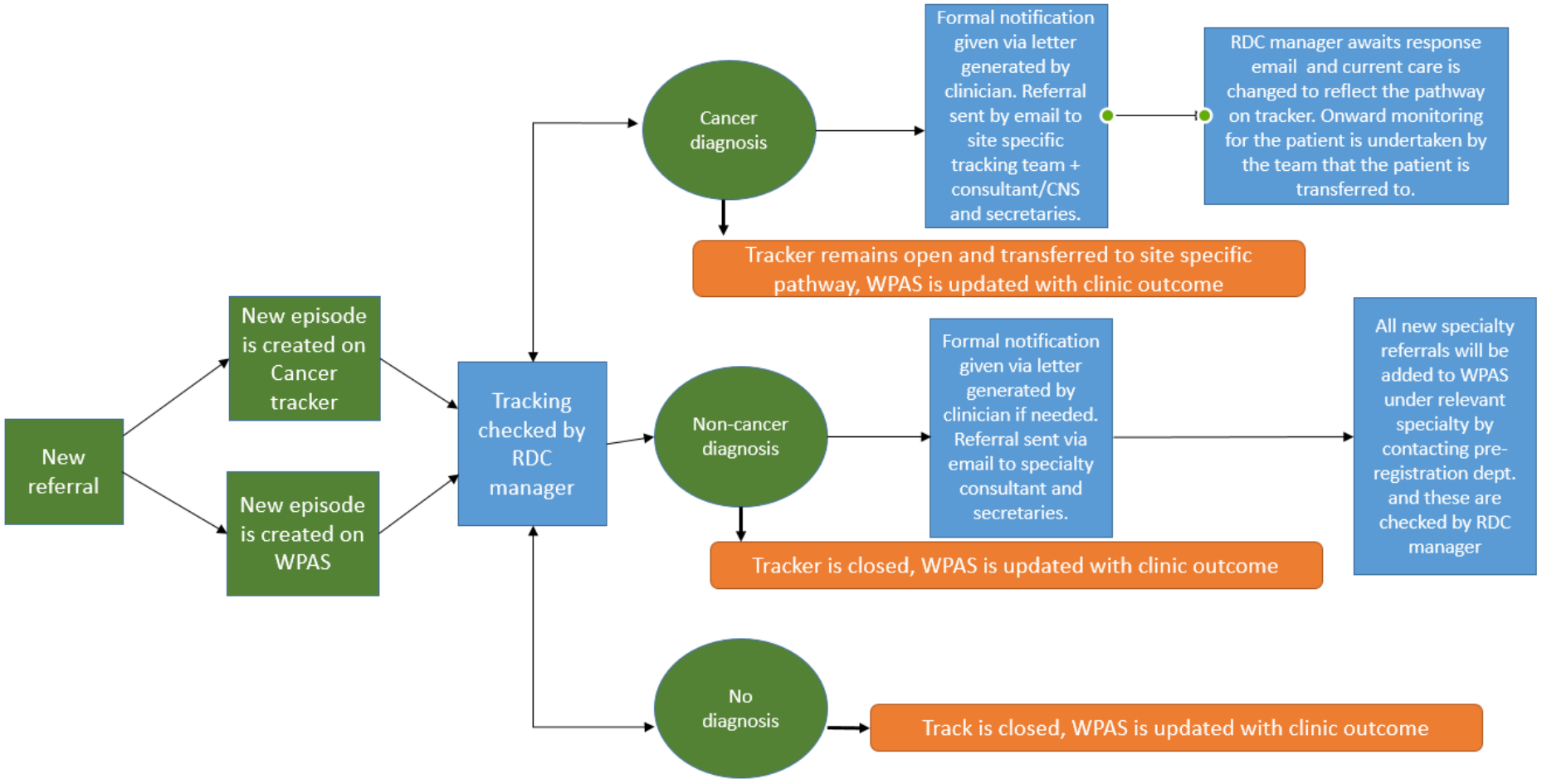
Appendix 3


Pre-Clinic Preparation
WCCG referral received in medical records and registered on WPAS. Referral is printed and placed in Early Diagnostic service in-tray
Coordinator attends medical records twice daily to collect referrals (during pilot coordinator is called when referral comes in)
Coordinator provisionally schedules patient into next RDC clinic
Coordinator liaises with GP or RDC team member to review referral.
Coordinator contacts patient with appointment details
Coordinator creates WPAS entry, confirming the patient is attending RDC on the allocated date (flag system notes patient is on the pathway)
Coordinator requests patient's hospital notes
Coordinator develops MDT list
Coordinator collates initial investigation results (from clinical portal, patient notes, referral form).

Appendix 4


Workflow on clinic day
08:30am RDC team meeting to include Consultant Physician, Consultant Radiologist and CNS
Patient attends RDC clinic fasted, is met by the coordinator and informed of the timings of the day
Patient attends clinical review with consultant
Patient is escorted to radiology department by HCSW for requested scans
Patient is escorted back to the clinic
Second MDT meeting held to discuss findings and confirm diagnosis of patient
Patient is seen by Consultant Physician and Coordinator to discuss MDT
Patient informed of any further investigations required if
Coordinator records outcome of investigations on WPAS
Further investigation needed +/- referral to another consultant
No serious pathology identified
Referral to another consultant
Inpatient admission

## Appendix 5


New referral
New episode is created on Cancer tracker
New episode is created on WPAS
Tracking checked by RDC manager
Cancer diagnosis
Formal notification given via letter generated by clinician. Referral sent by email to site specific tracking team + consultant/CNS and secretaries.
RDC manager awaits response email and current care is changed to reflect the pathway on tracker. Onward monitoring for the patient is undertaken by the team that the patient is transferred to.
Tracker remains open and transferred to site specific pathway, WPAS is updated with clinic outcome
Non-cancer diagnosis
Formal notification given via letter generated by clinician if needed. Referral sent via email to specialty consultant and secretaries.
All new specialty referrals will be added to WPAS under relevant specialty by contacting pre-registration dept. and these are checked by RDC manager
Tracker is closed, WPAS is updated with clinic outcome
No diagnosis
Track is closed, WPAS is updated with clinic outcome
As all patients are listed on WPAS, they will be present on 'referral to treatment times' reports showing their current activity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