Rapid Diagnostic Centres

Vision and 2019/20 Implementation Specification

NHS England and NHS Improvement

Rapid Diagnostic Centres Vision and 2019/20 Implementation Specification

Publishing approval number: 000614

Version number: 1

First published:25 July 2019

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by the NHS Cancer Programme, NHS England and Improvement.

Information Governance Statement

Organisations need to be mindful of the need to comply with the General Data Protection Regulation (GDPR), Data Protection Act 2018, the Common Law Duty of Confidence and Human Rights Act 1998 (Article 8 – right to family life and privacy).

Equalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

1. Introduction

1.1. The commitment to roll out Rapid Diagnostic Centres (RDCs) forms an important part of our broader strategy to deliver faster and earlier diagnosis and improved patient experience. The number of people diagnosed with cancer has been rising in recent years, with a 29% increase in the number cancer diagnoses expected between 2016-2028. To ensure we maintain standards, whilst providing a diagnosis to more people, we will need to transform the way we deliver diagnostic services, including diagnostics for cancer. RDCs will support the new Faster Diagnosis Standard (FDS), which will be introduced from April 2020. RDCs will also complement work to improve screening programmes, augment the potential of artificial intelligence (AI) and genomic testing, and utilise Primary Care Networks to improve early diagnosis in their localities.

1.2. The purpose of this document is to (1) outline the draft vision and approach for how RDCs will develop and support the transformation of cancer diagnosis services over time and (2) provide an implementation specification for Cancer Alliances to begin setting up RDCs in 2019/20. This specification is to ensure the phased implementation of RDCs across England is aligned to and achieves the end vision. We will work with Cancer Alliances and local providers to iterate and standardise the RDC service model as we learn from implementing them in practice. Further guidance on the approach for 2020/21 onwards will be provided in the Autumn.

1.3. In 2019/20, all Cancer Alliances are expected to set up at least one RDC for patients with non-specific symptoms which could indicate cancer; as well as for a cohort of patients with site-specific symptoms who are currently served by an underperforming two week wait or 62 day pathway.

1.4. The RDC service model has evolved from the Multidisciplinary Diagnostic Centre (MDC) service model. MDCs tested service models for non-specific symptoms and were piloted over two years as part of the Accelerate Coordinate Evaluate (ACE) programme, a partnership between Cancer Research UK, Macmillan Cancer Support and NHS England. More detail on the ACE programme and its findings can be found here.

2. Draft Vision for RDCs

2.1. We are setting an ambitious vision for RDCs. In time, RDCs will offer:

- 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.

2.2. By implementing RDCs, we aim to contribute to the following objectives:

- To support **earlier and faster cancer diagnosis** by assessing patients' symptoms holistically and providing a tailored pathway of clinically relevant diagnostic tests as quickly as possible, targeting and reducing any health inequalities that may currently exist;
- To create increased capacity through **more efficient** diagnostic pathways by reducing unnecessary appointments and tests;
- To deliver a **better, personalised diagnostic experience** for patients by providing a series of coordinated tests and a single point of contact.
- To **reduce unwarranted variation** in referral for, access to and in the reliability of relevant diagnostic tests by setting standards for RDCs nationally, mandating consistent data collection to enable benchmarking and providing regional support to roll out RDCs;
- To **improve the offer to staff** with new roles which offer development opportunities, greater flexibility and a chance to work in innovative ways.

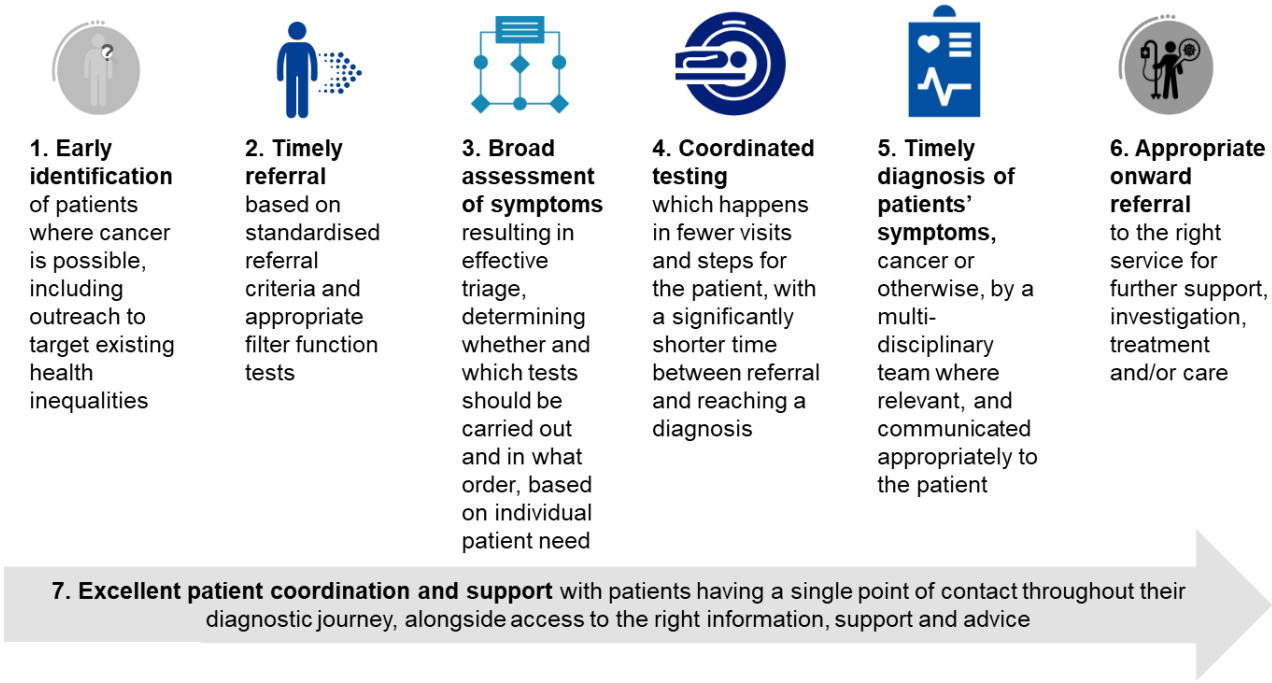
2.3. The implementation of RDCs will be supported by the roll-out of pathology and imaging networks; investment in new equipment, subject to capital availability; and workforce reforms in line with the People Plan[1]. RDCs should work to make best use of capacity and diagnostic staff resources.

2.4. Whilst RDCs will be established for patients with symptoms that could indicate cancer, most patients seen by an RDC will not have cancer. A key wider benefit of RDCs will therefore be diagnosing serious non-cancer conditions more efficiently. In sites which have piloted a similar diagnostic service model to RDCs, more than a third of cases were diagnosed with a non-cancer condition (on top of 8% who were diagnosed with cancer). The non-cancer conditions were commonly associated with diseases of the digestive system (39% of cases); 12% were classified as 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified', which included lung nodules; and 9% related to diseases of the respiratory system[2].

[1] NHS England & NHS Improvement (2019) NHS People Plan. Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/-NHS-People-Plan_June2019.pdf
[2] Cancer Research UK (2019) Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC). Available from: https://www.cancerresearchuk.org/sites/default/files/ace_mdc_report_may_2019_1.1.pdf

3. The RDC Service Model

3.1. We are proposing that RDCs will have the following key components:



3.2. Each of the seven components and the overarching objectives of an RDC should apply to all cohorts of patients eligible to use an RDC. The key components may be carried out in the community, primary or secondary care.

3.3. Patients should have similar diagnostic experiences, regardless of where in the country they go to an RDC. The expectations for a patient's experience are outlined below:

RDC component	Expected experience for patients
Early identification	I or a caregiver will recognise that something isn't right and will know to go to my GP to discuss my symptoms with them. I may be prompted to go to the GP by other local services with whom I feel comfortable discussing my symptoms.
Timely referral	My GP will assess my symptoms and will quickly refer me to an RDC for tests to find out what is wrong. In parallel, I will have some initial tests such as blood tests to provide more information to the RDC about me.
Broad assessment of symptoms	Once I am referred to an RDC, a range of information about me will be considered and discussed with me to determine which diagnostic tests I should have and in what order. The choice about which tests to have will be a shared decision between me and the clinician I speak to.

Co-ordinated testing	I will know which tests I will have, what to expect during each test, how to prepare, and when and where I will have the tests.
Timely diagnosis	My diagnosis will be explained to me by a clinical expert as soon as possible. I will have the opportunity to ask questions and discuss what will happen next based on my personal preferences.
Appropriate onward referral	If I receive a serious diagnosis, whether it is cancer or not, I will have an onward referral to the right specialist team for further investigation and/or treatment. I will not need to repeat tests or to provide the same information again. If I receive a non-serious diagnosis I will be supported to understand what the diagnosis means for me and how I should change my lifestyle and who/ where I can go to if I need further support.
Excellent patient co-ordination and support	Whilst under the care of the RDC I will have a single point of contact who can: (1) help me obtain further information from experts (2) provide clear and supportive conversations about the diagnosis process and (3) know about peer-support or other organisations that I can go to for more information and support. Wherever possible I will be supported in shared decision-making and supported self-management.

4. Approach to implementation

4.1. The RDC vision will be achieved by taking a phased approach to implementation. In the initial years, RDCs will develop services for cohorts of patients with non-specific symptoms and for patients with site-specific symptoms where current two week wait or 62 day pathways have been identified as underperforming. Cancer Alliances can use their 2019/20 funding allocation to cover set-up for both non-specific and site-specific cohorts (see 6.4 for detail on how funding can be used).

4.2. Over time, the national specification will continue to evolve in line with local evidence – including aspects of the RDC service model (e.g. workforce model, capital requirements and patient volumes), which will be standardised at a national level and additional patient cohorts. In Autumn 2019, the national cancer programme will set out a more detailed plan for the rollout of RDCs beyond 2019/20, including guidance on how targeted funding will be used.

4.3. Alliances may use their funding to set up more than one RDC in their locality from the outset, if this will reduce variation in access to diagnostic services in their geography.

4.4. Future additions to the RDC service model will be agreed collaboratively, in order that the most successful developments can be evaluated and standardised where appropriate. These may include testing the model for additional cohorts of patients by opening access to referrers other than primary care, such as Emergency Departments or self-referral.

Why include patients with non-specific symptoms from 2019-20?

4.5. Currently there is a cohort of patients who are considered to have non-specific symptoms, of which up to 8%[3] are likely to be diagnosed with some form of cancer. This rate is likely to decrease as the cohort expands.

4.6. Non-specific symptoms include unexplained: weight loss, fatigue, abdominal pain or nausea; and a GP 'gut feeling' about cancer. There is currently no dedicated urgent diagnostic pathway for this cohort of patients. Existing suspected cancer referral pathways focus on suspicion of tumour-specific disease rather than diagnosing symptoms. Additionally, this cohort of 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)[4];

[3] This equated to 239 cases in the ACE evaluation. Source: Cancer Research UK (2019) Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC). Available from: https://www.cancerresearchuk.org/sites/default/files/ace_mdc_report_may_2019_1.1.pdf

[4] Quality Health (2017) National Cancer Patient Experience Survey 2017 National Results Summary. Available from: http://www.ncpes.co.uk/reports/2017-reports/national-reports-2

- present more often in an emergency setting (e.g. stomach cancer diagnosed at an emergency presentation over 32% of the time and pancreatic cancer 46% of the time compared to 21% overall)[5];

- present with late stage cancer (analysis of the National Cancer Diagnosis Audit shows 67% of people with non-specific symptoms are diagnosed at a late stage in comparison to 45% for people with site-specific symptoms)[6]; and

- are referred on multiple urgent pathways with resulting inefficiencies in healthcare provision.

4.7. Learning from the MDC pilot sites has provided enough proof-of-concept evidence for this type of service model to be rolled out for patients with non-specific symptoms. The ACE evaluation[7] so far shows:

- of the cancers diagnosed by this service model, a high proportion are rare or difficult to detect cancers (56%), which is the category of 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[8];

- this service model provides a fast route to cancer diagnosis with the median time from GP referral to a clinical diagnosis being 19 days;

- this service model supports timely diagnosis of non-cancer conditions with over a third of cases diagnosed with a non-cancer condition (most commonly diseases of the digestive system e.g. diverticular disease or gastritis); and

- 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.

Improving diagnosis for other patient cohorts

4.8. In addition to providing an RDC for patients with non-specific symptoms, Cancer Alliances should use the RDC model to improve rapid diagnosis for a cohort of patients with site-specific symptoms; starting with services where a current two week wait or 62 day pathway has been identified as underperforming. This is to ensure the RDC programme aligns with work underway to improve time to diagnosis for patient referred on suspicion of

[5] Public Health England (2017) Routes to Diagnosis 2006-2016 workbook: Version b. Available from: http://www.ncin.org.uk/publications/routes_to_diagnosis
[6] Cancer Research UK (2018) Multidisciplinary Diagnostic Centre (MDC) based pathways for patients with non-specific but concerning symptoms: Report. [Accessed March 2019].
[7] Cancer Research UK (2019) Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC). Available from: https://www.cancerresearchuk.org/sites/default/files/ace_mdc_report_may_2019_1.1.pdf
[8] Cancer Research UK (2019) Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC). Available from: https://www.cancerresearchuk.org/sites/default/files/ace_mdc_report_may_2019_1.1.pdf

cancer and begins to develop the evidence base for an evolved RDC service model in the future.

4.9. When selecting a cohort of patients with site-specific symptoms, Alliances should prioritise patient cohorts where there is the greatest quantifiable impact to be made locally which will improve:

- Earlier diagnosis;
- Faster diagnosis;
- Excess demand or capacity shortages; and
- Reduce health inequalities in variation.

4.10. Some examples of cohorts of patients that could benefit from an RDC model are:

- Patients with suspected lower or upper GI cancer, where two week wait performance has been below 93% and 62 day performance below 73% nationally;[9]
- Patients with suspected lung or pancreatic cancer, where rates of early diagnosis are below 30% and 1 year survival rates are low.

[9] NHS England (2018) Waiting Times for Suspected and Diagnosed Cancer Patients: 2017/18 Annual Report. Available from: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/06/Cancer-Waiting-Times-Annual-Report-201718.pdf

5. 2019-20 implementation specification for non-specific symptoms

5.1. The next section outlines the core specification RDCs serving people with non-specific symptoms should follow. We expect all RDCs to offer consistent outcomes for patients through delivering each of the seven key components of the RDC model.

5.2. **Component 1: Early identification** of patients where cancer is possible, including outreach to target existing health inequalities.

	Key specification	**Further detail**
5.2.1	Measures must be in place that increase referrals by encouraging the early identification of any patient who has a high likelihood of meeting the referral criteria for patients with non-specific symptoms (listed in Appendix 1) or any underperforming pathway redirected into the RDC.	RDCs should work with emerging primary care networks to raise public and primary care awareness and understanding of non-specific symptoms. RDCs should work with Imaging and Pathology Networks to ensure appropriate and effective testing strategies are developed and continuously reviewed. RDCs should identify and implement measures that support early detection and outreach for specific population groups who have a high risk of cancer or experience high levels of health inequalities (e.g. through voluntary and community sector organisations). Patients and their carers should have relevant information about RDCs from the outset.

5.3. **Component 2: Timely referral** based on standardised referral criteria and filter function tests.

	Key specification	Further detail
5.3.1	RDC services are available to patients meeting the referral criteria.	Mechanisms are in place to ensure referrals are made according to the criteria set out in Appendix 1. RDCs should provide advice and guidance to GPs to support effective and accurate referral, including providing feedback on referrals already made. It is likely this communication will also spread awareness of a new service being set up and encourage referrals to the correct pathway earlier. Patients should be given easy to understand information in English (and other languages as needed), so they know what to expect before being referred to an RDC.
5.3.2	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 all relevant filter function tests (outlined in Appendix 1) are completed as part of the referral process. In most cases, the results of these tests should be received before the referral is made, as they may alter the referral decision. There may be patients for whom waiting for the test results is not appropriate (e.g. in cases of clinical urgency), and the reasons for this should be clearly highlighted as part of the referral. This implementation specification has been developed with reference to the NICE NG12 guidance; *Suspected cancer: recognition*

		and referral[10]. Where the NG12 guidance recommends a site-specific diagnostic test for a non-specific symptom (e.g. direct access chest x-ray for unexplained weight loss), these tests can be carried out as a filter function test for an RDC. The information from these tests will help inform the most appropriate referral route for the patient, but a negative diagnostic test for one type of cancer should not rule out a referral to an RDC if the patient has the relevant concerning symptoms.
5.3.3	All referrals must 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 3) as far as possible including information from the filter function tests. Referrals must be made electronically using an electronic referral system (eRS) and should be sent to the same destination to provide a single point of access. Staff in RDCs should be given access to a patient's Shared Care Record during the referral process.

[10] NICE (2015) Suspected cancer: recognition and referral. Available from: https://www.nice.org.uk/guidance/ng12

5.4. **Component 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.

	Key specification	Further detail
5.4.1	All referrals are reviewed so only appropriate patients are seen in an RDC.	Referrals must be reviewed to ensure all the necessary referral information is present and the RDC is the most appropriate pathway for the patient. After review, patients should be booked into an assessment or booked onto the correct specialist pathway (e.g. if the patient is felt to have a clear indicator of a specific cancer). If patients are re-directed elsewhere, the referrer should be informed of the change. If there are gaps, further information requests will need to be sought from the referrer.
5.4.2	Each patient must be supported in a way that provides a single point of contact throughout their RDC experience.	RDCs must provide a single point of contact and continuity of care for patients. This role can be a carried out by a dedicated individual (e.g. a dedicated patient navigator) or as part of a wider role(s). Specific functions include: • Provide a single point of contact for patients; • Ensure clinicians use shared decision-making techniques with patients as much as possible (ensure they are trained to do this according to best practice); • Co-ordinate appointments (e.g. assessment, testing, or communication of results); • Support patients to access additional services during and immediately after their diagnosis (including support, information and advisory services); • Provides tailored information and guidance about each part of the RDC process and the overall timeline to patients and their carers. Patient navigator roles may, additionally, support the RDC service by ensuring shared and consistent information about the patient's

		journey is available to all those involved in the process, by: • Provide an initial point of contact for GPs to telephone if they have questions about the RDC referral criteria; • Support checking of referrals to the RDC, to ensure referral criteria are met and all required information is present (e.g. completed filter function tests); • Work with GPs to re-direct patients to site-specific suspected cancer pathways, if the RDC is the not the most appropriate diagnostic service for the patient; • Track patients referred to the RDC to ensure they are meeting the Faster Diagnostic Standards; • Coordinate RDC multi-disciplinary team (MDT) meetings to ensure all necessary patients are discussed, and agreed actions are followed up.
5.4.3	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 clinicians working within the local RDC model. 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 consultant, depending on local capability and capacity. 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. Based on clinical best practice, a shared decision with the patients

		should be made to agree the tests, sequence, timing and location of the diagnostic testing. RDCs should ensure they have identified referral pathways to psychological support services where appropriate.
5.4.4	RDCs should ensure they have appropriate escalation protocols in place for patients who deteriorate or require urgent escalation to emergency/ specialist services, at any point during the diagnostic process.	Usual escalation protocols should be adhered to and these should cover what action a non-clinical patient navigator should take if clinical concerns are raised by a patient or carer.

5.5. **Component 4: Co-ordinated testing,** which happens in as few visits for the patient as possible

	Key specification	**Further detail**
5.5.1	The RDC should provide rapid access to all necessary diagnostic tests.	The RDC service should minimise the number of locations and appointments a patient must attend. Wherever possible, assessment and same-day testing should be offered to patients. 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 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.

5.6. **Component 5:** Timely diagnosis, cancer or otherwise, by a multi-disciplinary team, and communicated appropriately to the patient.

	Key specification	**Further detail**
5.6.1	All diagnoses should be confirmed or reviewed through an RDC MDT or other relevant multi-disciplinary meeting.	Regular RDC (MDT) meetings should be held with representation from relevant core specialties (see section 6.2 for RDC workforce requirements). To make, confirm or review an effective diagnosis, MDT meetings should ensure all relevant information is available. Where a clear and urgent diagnosis has been made from a diagnostic test (e.g. cancer confirmed on a CT scan), the relevant referral and communication should not be delayed by waiting for an MDT meeting.
5.6.2	To support diagnoses, RDC clinicians must have access to consultants and/or clinicians from other relevant specialities, where they are not represented at the MDT meeting.	RDCs should ensure the presence of clinicians 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.
5.6.3	The RDC service model should comply with the Faster Diagnosis Standard.	In line with the Faster Diagnosis Standard (FDS), any cancer diagnosis or exclusion should be communicated to the patient within 28 days of referral. It is expected RDCs will set up their services to be compliant with the FDS immediately and will record patients in the Cancer Waiting Times (CWT) dataset when functionality is available from 2020. Cancer staging may occur after referral to an onward service, though staging data should be captured by the RDC.
5.6.4	The approach to communicating a diagnosis should be in line with best practice (NICE CG138) and compliant with Faster Diagnosis Standard rules (CWT Guidance v10).	Communication of any serious diagnosis should be made to the patient in person. Discussions to explain the diagnosis and what will happen next should occur as soon as possible after an MDT meeting (or before an MDT meeting if diagnosis is sufficiently clear and urgent). 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) they are welcome to 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. As part of a supportive conversation, patients should be signposted to local peer support or other services that provide assistance with the emotional and practical experience of living with their diagnosis (cancer or otherwise).
5.6.5	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 or family member. This should happen as soon as practical but should not delay any urgent onward referral for the patient. The diagnosis report and test results should be shared with the GP and relevant specialist services who are continuing to care for the patient.

5.7. **Component 6: Onward referral,** to the right service for further support, investigation, treatment and/or care.

	Key specification	Further detail
5.7.1	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.
5.7.2	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 for specialist care may still need additional diagnostic tests or imaging, even if they have received a diagnosis: • 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.
5.7.3	RDCs should follow the Making Every Contact Count (MECC) approach to support patients who may benefit from direction that encourage them to make positive lifestyle changes.	RDC staff should follow the MECC approach so 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, weight management, nutritional advice, and physical activity. RDCs should apply the principles of Universal Personalised Care[11].

[11] See https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/ for more information on Universal Personalised Care.

6. Enablers

6.1. The next section outlines cross-cutting enablers for RDCs that need to be set-up locally, supporting both the cohorts covered by the 2019-20 specification and any additional patient cohorts the RDC is serving.

6.2. **Workforce**

The following outlines the main workforce considerations for RDCs:

	Key specification	**Further detail**
6.2.1	The RDC service should be staffed in line with core workforce requirements.	The core workforce requirements of an RDC are: • Senior doctor/s with general medical background or primary care training, who will be ultimately responsible for the patient's clinical care; • Clinical Nurse Specialist / Advanced Practitioner; • Patient Navigator (or a role/s carrying out the functions identified in 5.4.2); • Administrative Support; • Primary Care Lead / Champion. RDC roles and responsibilities should be added to relevant job descriptions and job plans for staff e.g. for 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. All clinical staff should have access to appropriate supervision.
6.2.2	RDCs must have regular access to other key clinical specialists to ensure a diagnosis can be made.	Key specialisms, who may be core members of the MDT, or may 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 consultant with generalist medical skills 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 (which can be face-to-face or virtual) to discuss all patients. 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. 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.

6.3. **Delivery considerations**

The following outlines the main delivery considerations for managing RDCs:

	Key specification	**Further detail**
6.3.1	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 for RDCs should specify the point at which clinical responsibility for the patient transfers from one service to another.
6.3.2	RDCs should be accountable to a named director.	A lead director should have overall management accountability for an RDC, including accountability for delivery of the service in line with the specification set out in this document. There should also be an accountable clinical lead for an RDC, ensuring the safety and quality of care of patients seen by an RDC.
6.3.3	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.
6.3.4	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 list of relevant stakeholders is outlined in Appendix 2.

		The leadership of the RDC should ensure 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.
6.3.5	All required data metrics should be collected and reported to ensure service performance can be monitored and evaluated.	Each site must collect data about each patient against this dataset on a regular basis. This should be submitted to the national evaluator when they are in place, as detailed in Section 7. Cancer Alliances should ensure appropriate analytical capacity is protected to prepare and submit this data. This data should also be transformed into suitable management information to inform ongoing service delivery and improvement (see Section 7 for further information).

6.4. **Commissioning and funding arrangements**

	Key specification	**Further detail**
6.4.1	Commissioning and funding arrangements for RDCs should ensure only the appropriate costs are covered by national programme funding.	During 2019/20 Cancer Alliances are encouraged to continue to fund existing MDCs, to support their transition into an RDC by the end of 2019/20. 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); and

		• outreach, training and communications to instigate referrals. Funding should not be used for the provision of diagnostic tests, as this will be funded through existing contracts already, and cannot be used for capital expenditure e.g. investment in major pieces of diagnostic equipment or IT infrastructure.
6.4.2	Minimum expectations from an RDC in 2019/20 should be included in service contracts.	Cancer Alliances will likely need to identify a lead CCG who will be able to provide the necessary commissioning and contracting capabilities and expertise. A locally defined commissioning arrangement should be established 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 as far as possible. It should also put in place appropriate expectations so serious incidents are suitably reported, reviewed and learned from.
6.4.3	Cancer Alliances should ensure adequate population coverage across RDCs.	High-level modelling on the potential population coverage for each RDC within a Cancer Alliance indicates approximately 22% of people currently diagnosed with cancer by any route are diagnosed based on non-specific symptoms. The ACE programme achieved a conversion rate of 8% cancer diagnoses amongst those presenting with non-specific symptoms. We expect this to fall with greater volumes in RDCs but if this conversion rate is assumed then: • Based on these assumptions to diagnose 1 person with cancer 12.5 people need to be seen • Based on these assumptions, an average sized Cancer Alliance would typically make 1,329 cancer diagnoses per month of which 289 would have non-specific symptoms • With a conversion rate of 8%, the number of referrals with non-specific symptoms

		across the whole patch would be 3,607 per month • Cancer Alliances should ensure their RDC(s) provide sufficient capacity so, by the end of the first year, 20% of cancer patients with non-specific symptoms in their area are diagnosed via an RDC and 50% of GPs are actively referring into RDCs. This would mean 361 people per month are seen each month by an RDC(s) in an average sized Cancer Alliance, potentially leading to 29 cancer diagnoses • Cancer Alliances should undertake training and outreach via primary care networks to meet or exceed this % level of uptake • The specific volumes that correspond to these % targets for each Cancer Alliance will be provided separately to Cancer Alliances

6.5. **Digital capabilities, information sharing and information governance**

	Key specification	Further detail
6.5.1	RDCs should be able to share patient data from primary care, within the RDC and to onward referral destinations.	Each RDC should map its data sharing requirements and establish suitable processes and procedures for enabling this. Each RDC should have a data controller to oversee data sharing arrangements.
6.5.2	RDCs should work with their local Caldicott Guardian to ensure suitable information governance 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 all data collected, shared and transferred meets the minimum compliance standards in all operations.
6.5.3	RDC should make use of digital and AI tools wherever they may enhance the RDC 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 into the local Pathology and Imaging networks. Any digital and AI tools should operate in line with NHS Digital work on clinical and data standards and interoperability.

6.6. **Local capacity mapping**

	Key specification	Further detail
6.6.1	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. 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.

7. National monitoring and support

Monitoring and Evaluation

7.1. 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.

7.2. 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.

7.3. Over summer 2019, 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.

7.4. Over summer 2019, 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 (see Appendix 3). 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.

7.5. 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 (as in Appendix 3); broader capture of cost data will be the subject of a collaborative review.

7.6. Recognising local experience will inform how the minimum patient dataset needs to evolve, the National Cancer Team will engage with Cancer Alliances during 2019/20 on the design of the evaluation methodology and the contents of the final minimum dataset – to ensure ease of collection in the longer term. This dataset review will examine the extent to which RDC activity can be tracked through existing national datasets and how the reporting method can maximise the amount of data automatically exported from existing hospital systems. It will also consider how estimates of pathway cost and activity can be captured and aggregated across RDC sites. Cancer Alliances should consider these longer-term objectives as they set up their data collection processes and be prepared to engage with the national team during 2019/20.

7.7. A rapid cycle evaluation and improvement methodology will be used. This will include pseudonymised datasets containing the minimum dataset. RDCs will be required to submit this data to the national team (who will share it with the national evaluation partner) on a quarterly basis. The submission method will be communicated to local RDCs by January 2020.

National support

7.8. The NHS England and NHS Improvement National Cancer Programme team and NHS England and NHS Improvement Regional teams will work with Cancer Alliances to provide support on the implementation of the RDC vision in 2019/20 and beyond.

7.9. The national team will work closely with Cancer Alliances to ensure 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;
- Evaluation;
- Research, innovation, and digital;
- Wider diagnostics transformation;
- Communication and engagement.

7.10. The minimum timeline for Cancer Alliances to work to for 2019/20 is set out below. We expect many cancer alliances will work to a faster timetable:

Timeline	National Programme Milestone
August 2019	Cancer Alliances draft outline plans for implementation of RDCs in line with guidance and submit these to NHS England and NHS Improvement Regional Cancer Leads at the end of the month. A series of webinar sessions will be scheduled to support this process. These plans should primarily cover intended delivery in 2019/20 but include a proposal for how Alliances see RDCs developing in your geography in future years to 2023/24, in line with the vision set out in this document.
September 2019	NHS England and NHS Improvement Regional Cancer Leads provide feedback on 2019/20 plans.
October 2019	2019/20 RDC plans are signed off by the national team, Regional Cancer Leads, and Cancer Alliances.
Autumn 2019	The national cancer programme will set out more detailed expectations for the rollout of RDCs beyond 2019/20, including guidance on how targeted funding will be used. This will be informed by the aspirations Alliances have set out in their initial proposals.
December 2019	Final plans for RDCs 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 they can start accepting patients no later than January 2020.

Appendix 1: Referral criteria and core tests

To support earlier and faster diagnosis, RDCs should use the following minimum referral criteria for the non-specific symptoms' cohort:

Core referral criteria for non-specific symptoms

- 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 vague 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;
- GP 'gut feeling' of cancer diagnosis - reasons to be clearly described at referral.

Exclusion criteria for non-specific symptoms

- 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 to amend to meet local needs

- New and unexplained breathlessness for more than three 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 alongside other symptoms);

- 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. if attending A&E with symptoms that meet the referral criteria.

Filter function tests should be used prior to referral to:

- Support GPs to refer patients via the most appropriate route (i.e. non-specific symptoms 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 the following filter function tests are carried out in primary care, where relevant for patients, to make a successful referral into an RDC:

Core tests for patients with non-specific symptoms:

- CXR;
- Urine;
- FIT;
- 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.

Appendix 2: Key local stakeholders

Engagement with the following local stakeholders is recommended to ensure successful implementation and delivery:

Stakeholder	Purpose of involvement
Key diagnostic and medical specialities such as endoscopy, radiology, pathology, respiratory, oncology, geriatrics and gastroenterology	Provide relevant clinical expertise essential for the development and delivery of the local RDC service model.
Local commissioners	Supports the development, commissioning and expansion of RDCs. Pay for diagnostic testing (e.g. CT scans) within existing commissioning arrangements with providers.
Integrated Care Systems (ICSs)/ System Transformation Partnerships (STPs)	Supports the development and expansion of RDCs to support engagement with the range of provider organisations.
Primary care networks	Working with primary care is essential to identify suitable RDC referrals. Primary Care Networks will help RDCs build capacity and capability across primary care. Pilot sites have also reported a range of benefits when working closely with primary care on RDCs; improved communication between primary and secondary care, awareness of potential cancer symptoms amongst GPs, and more confidence in managing some patients in primary care settings.
Primary care	Engagement with primary care is essential to generate the correct referrals. GP knowledge (generally through education and advice or guidance services) is key to achieving referral quality. Effort should be made to ensure rates of suitable referrals are consistent across all GP practices (e.g. ensuring consistent levels of referrals between GP practices of different sizes). RDCs should provide feedback to GPs

	to improve the quality and quantity of suitable referrals.
Local pathology and imaging networks, and endoscopy networks/ providers, genomic laboratory hubs	Provide capacity for diagnostic testing that enables faster and more responsive reporting. Provide advice to appropriate testing strategies and diagnostics approaches.
Local patient groups and patients who have used the RDC	Understand local patient needs and consult on the model. Capture and act on patient feedback about their experience (e.g. through Patient Experience Surveys).
Public health, Mental Health and Social Care	Create links with relevant services who can provide additional support/ information for patients (e.g. smoking cessation and social care) and who can support outreach for hard to reach groups.

Appendix 3: Minimum Data Set to be collected for each person served by an RDC

As far as possible, each site should collect and submit the data against this dataset on a quarterly basis. As detailed in section 7, the scope and method of collection of this dataset will be reviewed during 2019 in collaboration with Cancer Alliances.

Stage of patient journey	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.
	Person family name	*Free text:* COSD definition CR0050: PERSON's name.
	Person given name	*Free text:* COSD definition CR0060: PERSON's forename(s).
	Person birth date	*CCYY-MM-DD;* COSD definition CR0100:
	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.
	Ethnic category code	*Dropdown;* COSD definition CR0150: Ethnicity of a PERSON as specified by the PERSON.
	Person stated gender code	*Dropdown;* COSD definition CR3170: Person's gender as self-declared
	Postcode of usual address	*Free Text.*
	Index of multiple deprivation level	*Free text; derived from the person's home postcode*
	Co-morbidities	*Free Text; List all co-morbidities using* ICD-10 codes.
	Adult co-morbidity evaluation – 27 score at referral to the RDC	*Dropdown*; COSD definition CR2060: Overall comorbidity score
	Performance status for adults at referral to the RDC	*Dropdown;* COSD definition CR0510: World Health Organisation classification
	Smoking status	*Dropdown;* Current, former, never
	Number of years smoked	*Number;* Active smoking years, exclude non-smoking years

	Cigarettes per day	*Number;* Average number cigarettes smoked per day during active smoking years
	History of alcohol consumption	*Dropdown; COSD definition CR6760*
	Major life events	*Free text;* Includes death of loved ones, loss of employment, moving house, childbirth.
	Pregnancy status	*Y/N/Z (not stated)*
	GAD-7 / PHQ-9 scores	*Number;* Include if available.
	Historical cancer diagnosis	*Free text;* COSD ICD-10 code where relevant
	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: Non-specific symptoms, site-specific symptoms
	Lifestyle changes	*Free text;* Any changes to the 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, Other (please specify)
	Diagnostic referral route (CWT041)	*02 – Rapid diagnostic centre*
	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	*CCYY-MM-DD*
	Date of review of referral by RDC	*CCYY-MM-DD*
	Result of referral	*Dropdown;* accepted, returned to GP, referred to other pathway
	Alternative referral pathway	*Free text;* if applicable
Clinical triage	Date of triage	*CCYY-MM-DD*
	Type of triage	*Dropdown;* Face-to-face appointment, Telephone appointment, Virtual (no appointment)
	Date of DNA	*CCYY-MM-DD;* If relevant. Should be recorded for each occurrence.
	Date of patient rebooked appointment	*CCYY-MM-DD;* 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 three months of receipt of referral to RDC	*Dropdown;* New cancer, Cancer recurrence, Non-cancer serious condition, Non-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

	Multidisciplinary team discussion date	*CCYY-MM-DD*
	Date of primary cancer diagnosis (clinically-agreed)	*CCYY-MM-DD; COSD definition CR2030: DATE OF DIAGNOSIS (CLINICALLY AGREED)*
	Date of communication of cancer or not cancer	*CCYY-MM-DD; CWT103.* In line with guidance for the Faster Diagnosis Standard.
	Date of communication of non-cancer diagnosis	*CCYY-MM-DD;* If communication is by letter, date letter is sent
Onward referral	Date of onward referral or discharge	*CCYY-MM-DD*
	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)	*CCYY-MM-DD; COSD definition CR3120*
	TNM stage grouping (integrated)	*Dropdown;* COSD definition CR0610
	Date of TNM stage grouping (integrated)	*CCYY-MM-DD;* 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	*CCYY-MM-DD;* COSD definition GY7440
	Final Haematological staging	*Free text; C*OSD definition: Ann Arbor: A8280+HA8290+8300+8310+8680 or Binet: HA8240 or ISS: HA8560

	Final Haematological staging date	*CCYY-MM-DD; COSD definition: Ann Harbor: HA8720 or Binet: HA8700 or ISS: HA8710*
	Treatment start date	*CCYY-MM-DD; COSD definition CR1370*
	First treatment category	*Dropdown;* COSD definition CR0470: Planned cancer treatment type
	Patient outcome Six 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	*CCYY-MM-DD;* If relevant. COSD definition CR1270. *To be retained by RDC site*.
	Additional information related to the pathway	*Free text*

Appendix 4: Glossary of Terms

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 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.

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.

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.

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

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.

Rapid Diagnostic Centre 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

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

Faster Diagnosis Standard 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.