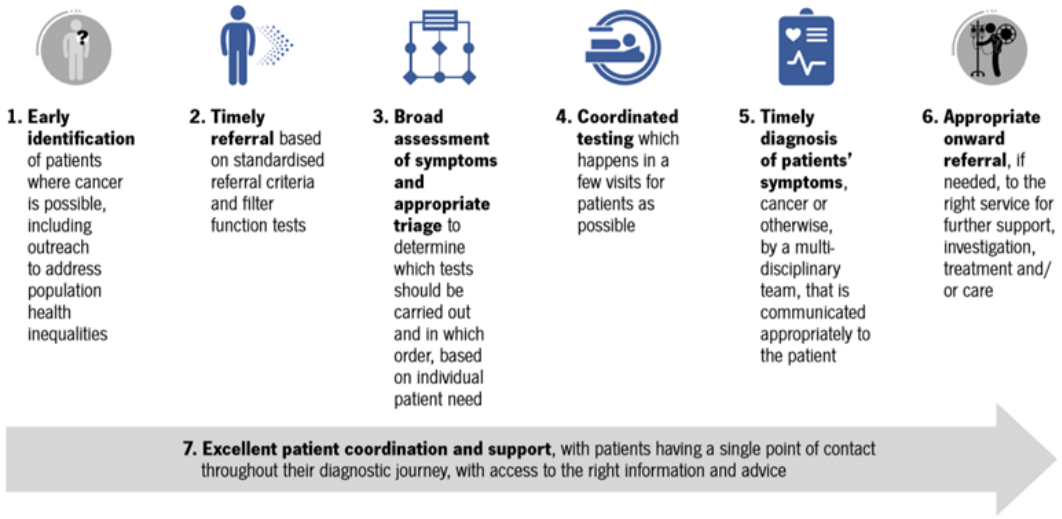
	Name **Position** **Date**	**FOR APPROVAL**
1.	**Title/Subject -** Wessex Rapid Diagnostic Service (RDS) Next Steps	
2.	**Background/Context** In September 2019 the Wessex Cancer Alliance Board approved and supported the Wessex Cancer Alliance Rapid Diagnostic Service (RDS) Specification for Wessex. The goal of the Wessex RDS is to create a more ambitious model than previous Multi-Disciplinary Models and Vague Symptoms Clinics, including going further than the learning from the ACE pilot project. The Wessex Cancer Alliance has been allocated £13,564,653 transformational funding for the 5-year planning period 2019 -2024 as part of the national RDC delivery planning and implementation programme, this is to apply the 7 RDC principles to pathways:  In June 2020 the WCA RDS service was launched, initially with a single PCN in Poole, with a phased rollout plan agreed to deliver the nationally submitted trajectory for the RDS programme. This in addition to the focus on Non-Specific Symptom (NSS) referrals requires the application of the seven National Rapid Diagnostic Centre (RDC) principles (above) to site specific referrals by 2023/24. *The requirement to….'embed Rapid Diagnostic Centre Principles in patient pathways'* has been reiterated in the July 2020, Covid 19: cancer services recovery plan template for Alliances and ICSs/ STPs for the period September to March 2021. Specifically, to: • Continue to drive forward the development of Rapid Diagnostic Centres (RDC), in line with the RDC Specification, to provide faster diagnosis for suspected cancer referrals and embed pathway changes. • Accelerate the adoption of RDC principles within diagnostic facilities for people with suspected cancer, including the use of centralised clinical triage and patient prioritisation for diagnostics (based on clinical need).	

	Initial pathways selected for 2020/21 were Upper GI, to reflect the pancreatic pathway redesign, skin and lung with a phased trajectory to deliver 100% for all planned pathways by 2023/24. Wessex has ambitious goals for its RDS model, as follows: • A single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer, regardless of the route of referral • An initial assessment service not constrained by geographical locations, so access is equitable for rural and island inhabitants as well as those located in cities and highly populated urban areas. • A personalised, accurate and timely diagnosis of patients' symptoms by integrating existing diagnostic provision, utilising networked clinical expertise and information, and introducing new ways of working where appropriate • Diagnosing serious non-cancer conditions more efficiently The aim of the service reconfigurations driven by the RDS is to develop a fully integrated, patient-focused pathway and to drive improvements along the entire pathway and across the whole system. The launch of the WCA RDS hub and planning for next steps including a focus on unplanned, emergency, presentations and self-referral pathways was delayed due to the Covid 19 pandemic. The impact of Covid 19 has presented opportunities which may offer the opportunity to accelerate the implementation of the wider WCA RDS model. By mirroring the aim to implement the national RDC principles across all pathways in a system the WCA RDS will equally aim to ensure: • Patients receive support and accurate advice on how to safely access services, particularly given concerns about travel and infection prevention and control; • Resources are used in the most productive way to see patients more quickly (faster diagnosis) and reduce backlogs in cancer diagnostic services; • Diagnostic services in a system are accessed based on clinical need, within the constraints experienced due to Covid19; • Workforce is used flexibly to adapt to service capacity and patient needs; • Innovations are adopted and embedded in cancer diagnostic services, both to 'lock in' beneficial changes we have implemented through the Covid19 response and to help overcome any additional Covid19 related issues; and • That actions are taken to ensure the optimal patient and carer personalised experience along the pathway.
3.	**Rapid Diagnostic Centres and the Long-Term Plan (LTP)** The LTP specifically states that: *From 2019, we will start the roll-out of new Rapid Diagnostic Centres (RDCs) across the country to upgrade and bring together the latest diagnostic equipment and expertise, building*

	on ten models piloted with Cancer Research UK, which have focused on diagnosing cancers where patients often present with non-specific symptoms and may go to their GP many times before being sent for tests, such as blood and stomach cancers. *In time, RDCs will play a role in the diagnosis of all patients with suspected cancer, including self-referral for people with red-flag symptoms.* *For patients with cancer, this will mean they can get quicker access to an accurate diagnosis and begin their treatment.* *The majority of patients who do not have cancer, but may have other conditions, will be referred on quickly to get the right support.*

4.	**The Wessex Cancer Alliance Cancer Plan and Rapid Diagnostic Service (RDS)**
	
	Building on learning from the 10 Cancer Research UK pilot sites the Wessex RDS initially focuses on diagnosing cancers where patients often present with non-specific symptoms (NSS) and may go to their GP many times before being sent for tests (such as blood and stomach cancers). The Wessex RDS will ensure that patients suspected to have a cancer presenting with non-specific symptoms will get quicker access to an accurate diagnosis and commence treatment.
	
	The majority of patients who do not have cancer, but who have other conditions, will also benefit from a swift on-ward referral to access the right support in secondary or primary care.
	
	Alliance ambitions for year 1 align with those outlined by the National Rapid Diagnostic Centre (RDC) which are to provide sufficient capacity so that 20% of cancer patients with non-specific symptoms are diagnosed via an RDC and that 50% of GPs are actively referring into RDCs
	
	With a focus in developing a virtual RDS for Wessex, plans include:
	
	• Reviewing the resilience of IT systems, diagnostic capacity and impact on clinical pathways and
	• Evaluating benefits in terms of outcomes and patient experience.
	• Expanded access to rapid diagnostic services for pancreatic cancer, building on learning from pilot sites
	• Delivering a better experience for patients by providing a series of coordinated tests and a single point of contact.
	
	Key deliverables include:
	• A reduction in unwarranted variation in referral,
	• Access to and improved reliability of relevant diagnostic tests by setting regional standards
	• Mandating consistent data collection to enable benchmarking;
	• Improving the offer to staff as new roles will be created which offer:
	  ○ Development opportunities,
	  ○ Greater flexibility and a chance to work in innovative ways;

- Addressing perceived and real inequalities of access, and the reality that some patients are not well served by existing pathways.

5. **RDS roll out to date**

The PCN roll out plan has been based on a three phased approach building on the learning from the experience of the phase 1 early adopter PCNs. These 5 PCNs were identified via an expressions of interest process and included 3 Dorset and 2 Hampshire PCNs.
The initial go-live scheduled for April 2020 was paused due to the Covid pandemic with a decision to further breakdown phase 1 to allow for further testing of the digital and clinical processes.

A 2-week pause was added whilst issues with ICE access for the RDS clinical team were resolved. Whilst manual processes were available the time constraint of these impacted on the ability to rapidly scale up the roll out.

PHASE	LOCATION/PCNS	TRUST GOING LIVE	DATES
1a	1 Dorset PCN	Poole	22nd June – 19th July
1 b & c	2 Dorset PCNs		20th July – 16th August
1 d & e	2 Hampshire PCNS	Bournemouth Southampton Portsmouth	17th August – 11th October
2	All of IOW Rest of Dorset	St Marys Dorset County	12th October – 29th November
3	Rest of Hampshire	Hampshire Hospitals	30th November through to January

Despite the delayed launch and subsequent pause to the revised timetable WCA will deliver faster than the 5-year planning trajectory submission, referenced in the section on WCA funding and commitment.

Effectively 100% of GPs / PCNs will be able to refer clinically appropriate patients to the WCA RDS in year 2 of the funded programme instead of the 10% population coverage planned in year and 100% commitment by year 5 in 2023/24.

6. **Alignment of the Wessex Cancer Alliance Rapid Diagnostic Service Model with National and Local Long-Term Planning Ambitions.**

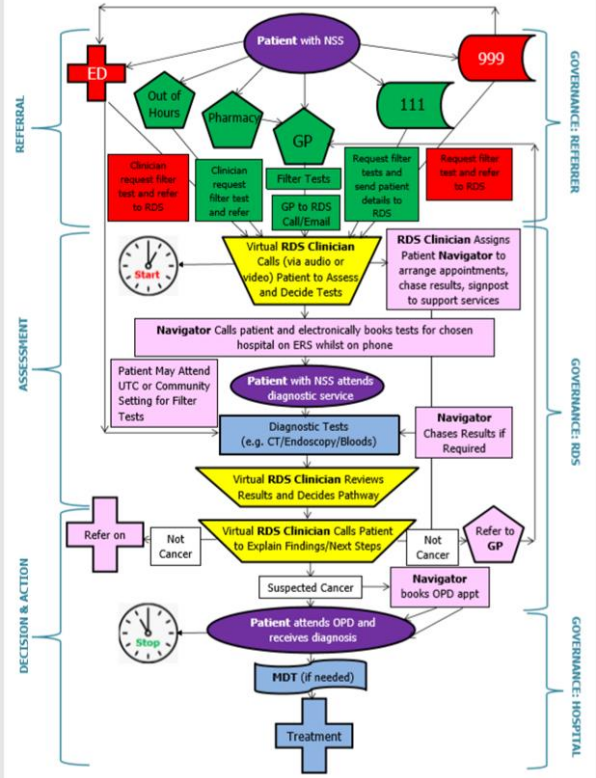
Development and implementation of the Wessex Rapid Diagnostic Service (RDS) has focused on the exploration of and maximising of digital opportunities which is a focus of the LTP.

In particular there has been a focus on the utilisation of digital solutions and referral redesign to deliver a pan Wessex 'virtual' RDS which will reduce outpatient attendances.

	As part of RDS planning the Alliance approach will strengthen the path from cutting edge innovation to business-as-usual, spreading proven new techniques and technologies and reducing variation. NHS digital services resources and leadership and the coordination of key digital stakeholders, and suppliers, via the digital task and finish group, has been critical to the successful design and implementation of digital solutions to enable the clinical launch of the Wessex RDS. The implementation of the RDS in Wessex has demonstrated the ability to accelerate the path from innovation to business as usual. Additionally, the RDS model aims to reduce multiple attendances by defining and streamlining the clinical pathway with a centralised co-ordination of diagnostics by the RDS clinical team. As part of its delivery of the NHS Long Term Plan Wessex will aim to create diagnostic imaging networks to include the ability to share clinical images amongst specialists. Investment in Dorset to enable county wide image sharing has been funded from year 1 RDS funding. This is underpinned by the RDS digital workstream strategy to enable Wessex wide image sharing. By building on the strength and alignment with its partners Wessex Cancer Alliance the development of the RDS service specification has focused on ensuring th at health inequalities including those particular to Wessex are addressed. Patient engagement has been at the heart of and influenced the design and implementation of the Wessex RDS. An NHS/I Equality and Health Inequalities Analysis (EHIA) has been completed, reviewed by the South East regional and National RDC team and submitted for the GP Referral NSS pathway which went live on 22nd June 2020. This EHIA recognises the importance of and impact on hard to reach groups including those with a learning or physical disability such as autism and hearing or visual impairment. Consultation and patient engagement tested access to existing telephone triage services and tested the 'virtual' model concept. The RDS aligns with the local response to the LTP by supporting the implementation of the Faster Diagnosis standard from 2020. A timed GP referral pathway has been defined for patients presenting with NSS, including those with suspected pancreatic cancer, so that the RDS, which has been registered as a stand-alone organisation, will deliver against the 28-day standard.
7.	**National Rapid Diagnostic Centres (RDC) Vision and Implementation** [1] The national vison for Rapid Diagnostic Centres and Implementation issued in July 2019 sets out the commitment to roll out RDCs as part of a broader strategy to deliver faster and earlier diagnosis and an improved patient experience.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/07/rdc-vision-and-1920-implementation-specification.pdf

	The key driver for change is the anticipated 29% increase in the number of cancer diagnoses expected between 2016 and 2028 with a recognition that a transformational change in the delivery of diagnostic services will be required in order to maintain standards whilst providing a diagnosis to more people. The ambition is that RDCs will support compliance with the 28-day Faster Diagnosis standard whilst complementing LTP aspirations to improved screening programmes, augment the potential of artificial intelligence and genomic testing and utilise Primary Care Networks to improve early diagnosis in their localities. The shared vision for RDCs is ambitious and in time RDCs will offer a: • Single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer; • Personalised, accurate and rapid diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally. Implementation of RDCs will contribute towards: • Supporting earlier and faster cancer diagnosis by holistically assessing patient symptoms and providing a tailored pathway of clinically relevant and timely diagnostics • Targeting and reducing any health inequalities • Creating increased capacity through more efficient diagnostic pathways and by reducing unnecessary appointments and tests • Delivering a better, personalised diagnostic experience by providing a series of coordinated tests and a single point of contact • Reducing unwarranted variation in referral, access to and reliability of diagnostics tests by setting RDC standards and via a nationally mandated data collection to enable benchmarking and regional support to roll out RDCs • Improving the offer to staff with new roles offering development opportunities, greater flexibility and a chance to work in innovative ways.
8.	**The Wessex RDS model and alignment to with the RDC components** The Wessex RDS model has been designed based on the service specification which was presented to and approved by the Wessex Cancer Alliance Board September 2019 and is based on the following:



The approach to implementation has been executed via a resourced RDS programme structure which has been underpinned by a co-ordinated task and finish group approach supported by project management support and expertise. See Appendix 1 for further details.

Developed in conjunction with key stakeholders the service specification and service has been developed for and designed by patients who will continue to shape future service delivery as the RDS programme continues to be rolled out.

The early identification of patients where cancer is possible including outreach to target existing health inequalities is being delivered with insight provided from the patient engagement strategy developed and executed in partnership with Wessex Voices who will continue to support service evaluation activities.

The RDS GP role will provide in reach support at a practice level to support early identification of and support to hard to reach groups in a primary care setting. This in turn will provide support to and tie in with initiatives to deliver against the Early Cancer Diagnosis DES (Directed Enhanced Service) good practice guidance.

Timely referral based on standardised referral criteria and filter function tests has been the subject of clinical discussion and development including via the, clinically led, referral and triage task and finish group and stakeholder engagement activities and events. The form has been developed to reflect the additional focus on suspected pancreatic cancer referrals as the targeted site-specific priority pathway with the RDS clinical hub team responsible for the identification and onward referral for diagnostics based on an agreed pancreatic cancer

	diagnostic pathway. A clinical reference group has been established to maintain oversight including compliance against and modifications required to the referral pro-forma to ensure compliance against the clinically agreed timed pathway and the identification of shared learning which can be addressed in partnership with referrers and key stakeholders. The RDS hub clinical team has been established to deliver a timely diagnosis, cancer or otherwise, by a multidisciplinary team, appropriate to the patient. Activities will include the required broad assessment of symptoms and appropriate triage to determine tests based on individual patient needs. Access to local diagnostic testing for the patient and the retained clinical responsibility for patients referred to the RDS will enable a coordinated approach to testing, with attendances kept to a minimum not least because of the 'virtual' nature of the RDS clinical model. The principle of onward referral to the right service for further support, investigation, treatment and / or care is established as part of the RDS GP referral timed pathway. Any identified contractual and commissioning implications will be addressed via the Commissioning and Finance Task and Finish group who are working to the principle that: *The RDS service is designed to move patients who are already in the healthcare system but not on a recognised pathway, into a pathway which will improve patient experience, be effective and efficient. Such patients are likely to already be utilising diagnostic and clinical expertise, but as the service is currently not set to meet their needs, may attend for multiple and uncoordinated primary and secondary care attendances including diagnostics.* *Therefore, the RDS will in effect be a pump priming service to allow the existing services to realign. At the end of the four-year period all Wessex patients who are appropriate should be accessing this pathway and we should have good evaluation and learning from the project.* *The challenge is to extract resources from the existing services to ensure they support RDS as business as usual once pump priming resource ceases.* The process of identifying partners to support the health economics modelling to enable the cost of current pathways to be determined and unbundled has commenced.
9.	**Reflection on impact of Covid** There is a need for RDS to reflect on the impact of covid on its workstreams and those developments and opportunities which have arisen as a direct result of the move towards virtual triage and assessment and the minimising of non-essential clinical face to face contact. Covid has shown us that the NHS and the WCA RDS has the capability of maximising on the aspirational vision of a wholesale virtual RDS model. Benefits have been realised which also offers further opportunities including: 1. Move towards digital contact in primary and secondary care stages of the pathway. 2. Redesign of administrative and clinical triage and assessment of 2 week wait referrals.

	3. Review of contracts of employment for RDS staff – with a move towards sessional and remote working opportunities. 4. Recruitment and retention by optimising candidate pool by moving away from a fixed geographic base. 5. Equality and compliance both in terms of recruitment and flexible working opportunities. 6. Cost benefit with the reduction in travel times between locations, meetings and clinics along with potential reduction in facilities cost. 7. Parity with the planned approach taken in other organisations such as SCAS in moving towards home based clinical staffing models. 8. Service sustainability as a result of easier recruitment due to flexible working opportunities. 9. Achieves the pan Wessex ambition to ensure opportunities to support, be involved and work within the RDS hub are truly equitable across the Wessex Cancer Alliance footprint.
10.	**National RDC 2020/21Delivery in light of Covid** The National RDC team in consultation with the RDC task and finish group have considered the impact of Covid on the ability for Alliances to deliver against the 2020/21 aspirations. Whilst recognised that the immediate impact of Covid 19 was to constrain opportunities for transformational change RDCs are now considered as being critical to the recovery of cancer performance. Increasingly national guidance, including the recovery of Cancer Diagnostic Services During Covid 19, include references to the importance of and opportunities associated with the application of the RDC principles. Whilst concerns about funding have been identified in a number of Alliances the decision has been taken to maintain the 2020/21 RDC deliverables to: *To build on 19/20 activities to create a new referral pathway for at least 20% of people with NSS and one challenged site-specific pathway with at least 50% of GPs actively referring*. *By 2024 all alliances should achieve full population coverage for NSS pathways and every pathway should be applying RDC principles* Wessex Cancer Alliance will be ahead of this and its five-year planning trajectory for NSS referrals with the phased roll out delivering 100% PCN and GP coverage by the end of this financial year instead of 2023/24 as anticipated. The national RDC task and finish group decision to not modify the 2020/21 ambition has been based on the belief that: • RDCs are recognised as a key part of cancer recovery • NSS pathways are even more important to ensure the right patients are referred down appropriate 2WW pathway • A number of site-specific pathways will need to have been redesigned in light of Covid and the expectation that RDC principles will be applied including in part to address diagnostic backlogs Increasingly Wessex is being approached by other Alliances to share its approach which is

	viewed as being both innovative and aligned to the current NHS landscape where digital and virtual models are rapidly being considered as part of the national response to cancer recovery.
11.	**WCA commitment and funding** WCA has been awarded a total of £13,564,653 transformational RDC funding for the 5 year planning period 2019 -2024. This is broken down as £1,171,000 for year 1 of the RDS programme with a subsequent £12,393,653 for years 2-5 which commenced in April 2021[2]. For this year, 2020/2021 the RDS budget is £2,102,408 with the annual breakdown for remaining years as: • £3,084,000 for year 3 2021/2022 • £3,217,000 for year 4 2022/2023 • £3,987,000 for year 5 2023/2024 This scale of funding presents a unique and significant opportunity to deliver transformational step change across a range of cancer site specific pathways whilst enabling patients to access these pathways via an increased range of 'entry points' including emergency, out of hours, pharmacy and self-referral. This may benefit the traditionally hard to reach groups who are reluctant to access their GP and / or are not registered with a GP practice such as travellers and the homeless population. In addition to the development and launch of an RDS to provide faster diagnosis for patients referred with a suspicion of cancer with either NSS or a suspected pancreatic cancer, Alliances are tasked with ensuring and demonstrating that RDC principles are applied to all tumour sites by 2024. As part of its 5-year planning trajectory submission the WCA has committed to implementing an RDS which provides a single point of access for the Wessex geography, co-ordinated via a central virtual hub. This is in addition to the phased roll out of the application of RDC principles underpinned by a commitment to deliver transformational change to site specific pathways where indicated.

[2] National RDC 5-year planning trajectory submission template 2020

Cancer type	Planned population coverage across the Cancer Alliance			
	Y2 (2020/21)	Y3 (2022/22)	Y4 (2022/23)	Y5 (2023/24)
Brain / Central Nervous System	0	30%	60%	100%
Breast	0	0	0	100%
Gynaecological	0	0	60%	100%
Haematological (excl. acute leukaemia)	0	30%	60%	100%
Head and Neck	0	30%	60%	100%
Lower Gastrointestinal	0	0	0	100%
Lung	10%	10%	50%	100%
Sarcoma	0	30%	60%	100%
Skin	30%	60%	100%	100%
Upper Gastrointestinal	40%	50%	100%	100%
Urological (excl. Testicular)	0	0	0	100%
Non-specific symptoms	10%	30%	60%	100%

Whilst nationally it has been acknowledged that the impact of Covid 19 may result in a reprioritisation of trajectory plans for Wessex work in year 2 continues to include a focus on the:

- **Upper GI pathway** with the inclusion of the suspected pancreatic cancer pathway as part of the RDS launch and referral process
- **Skin** to explore the possibility of rolling out the RDS principle to Dermatology. This work will build on and complement the work underway across the STP/ICS on different dermatology projects.

12. **WCA RDS Unscheduled Care Pathway**

The RDS hub partnership which includes South Central Ambulance Services (SCAS) affords the WCA RDS programme a unique opportunity to deliver the unscheduled care pathways as identified in its broader specification.

In particular by focusing and aligning with the benefits of and direction of travel of the 111 service it is anticipated that the RDS could expand to enable patients to access the RDS via additional entry points. It is recognised that 111 services are increasingly being used by patients as a default to access care.

This increased 'ease of use 'and acceptance by the public and health care population may prove beneficial to the RDS timescales for expanded access.

For 111 services next step options cover a spectrum from emergency to home management interventions including sending an ambulance or booking directly into an 'appointment'. All of which is based on the need for the 'right flags' to be identified to ensure patient safety balanced with timely onward management.

Both the RDS and 111 services include elements of remote assessment and aim to ensure that patients are booked into the correct pathway first time with the need to minimise multiple handovers leading to delays for the patient. SCAS also offers support to health professionals which mirrors RDS aspirations of an enhanced role involving the RDS clinical team and as part of the RDS GP role.

Opportunity exists for the RDS programme team, supported by SCAS functionality and expertise, to move away from the scope and focus on the NSS pathway towards being able to offer a steer for 'obvious' symptoms pathways by exploring the concept through symptomatic

	pathways. Scoping for next steps is considering whether to: • Consider site specific pathways such as breast lumps, post-menopausal bleeding and testicular lumps and / or symptomatic red flags such as rectal bleeding or an unexplained persistent cough greater than 3 weeks. Covid and respiratory symptoms suspicious of an underlying lung cancer are recognised as a key area for consideration by SCAS. In particular the need to ensure that red flag symptoms are identified and that safety netting processes exist to enable patients to be fast tracked and not lost in the system. Work has commenced on the identification of disposition and symptom groups which might indicate a direct referral to a GP, which could potentially be managed within the scope of the RDS underpinned by existing 111 technical ability. SCAS are currently able to onward refer by messaging although this is currently largely limited to dentists and primary care the algorithm logic exists for this principle to equally be applied to secondary care referrals which would be a requirement for the RDS. On a practical level whilst the nationally defined baseline questions cannot be adapted without national oversight there is potential to add supplementary questions to enable targeted onward management. A precedence has potentially been set with SCAS currently exploring a children's pathway with commissioners which will include video conferencing and additional time requirements. This approach has similarities to a potential RDS clinical model which will also include additional time requirements and digital access for patients. Funding implications will need to be factored into the future commissioning arrangements for an RDS unscheduled care pathway. The aim of this new unscheduled care RDS pathway would be to assess urgency with a default to a potential GP referral, potentially hosted by the RDS and for the development of RDS bespoke next steps from existing pathways. The key benefits are that this provides an opportunity to consider a service for the population who are currently unwilling to access GP's whether due to age, gender or language barriers where remote access contact / technology may be of benefit. Whilst it is recognised that the scope of the RDS engagement strategy will need to be extended to cover this model and the Equality and Health Inequalities Analysis refreshed opportunities to provide access for these hard to reach groups has been identified as a key challenge which requires addressing.
13.	**Next Steps** Continue to explore opportunities for self-referral pathways for breast and testicular lumps and post-menopausal bleeding with the opportunity to dock in with SCAS 111 functionality along the lines of similar services such dental and mental emergencies. Review the RDC 5-year trajectory submission in conjunction with the WCA Faster Diagnosis

	delivery plan for site specific pathways to identify and implement transformational changes as part of the WCA response to delivering the Long-Term Planning objectives. Continue to optimise and identify changes made to existing suspected cancer referral pathways where the application of the national RDC principles have delivered a benefit. As part of these pathway reviews understand the current impact and opportunities to redesign pathways where patients are currently presenting with suspected cancer symptoms and diagnosis via emergency departments. The aspiration is for the RDS to be the benchmark for enabling pathway improvements.
14.	**Recommendation** For the Wessex Cancer Alliance Board to: 1. Confirm that the vision and RDS specification remains unchanged and reaffirm commitment to ensure delivery. 2. Approve and support the continued rollout of the Rapid Diagnostic Service for Wessex, ensuring that the national target that every site specific pathway should be applying RDC principles by 2024 is achieved.

Appendix 1 Work Programme updates

RDS programme

Below is an update of activities during and since the start of the Covid 19 pandemic for each of the RDS programme task and finish groups:

Digital Group – despite the conflicting priorities for IT colleagues to support the massive shift towards home working and remote access this group continued to meet virtually.

To date they have delivered on the tactical solution to enable the RDS to go-live with a soft launch on 22nd June 2020.

Work has included progression of 'big ticket' digital solutions including**:**

- Negotiating challenges around setting up the RDS as a distinct organisation where no precedence exists.
- Similarly, eRS has been implemented despite initial expectations that this wouldn't be possible to enable referrals to mirror existing 2 WW referral processes.
- The procurement and configuration of a community version of Systm One TPP, providing PAS (Patient Administration Systems) functionality for the RDS, and an RDS incidence of Somerset Cancer Record (SCR) to enable activity reporting including 28**-**day Faster Diagnosis (FDS) and against the wider Cancer Waiting Times standards.
- The development of system templates to support clinical processes.
- Enabling access to ICE systems (Integrated Clinical Environment) for requesting and reporting. Phase 1 has been delivered in line with the PCN roll out plan initially with Poole hospital and progressing to Southampton, Portsmouth and Bournemouth hospitals Whilst work has commenced aligned with Phase 2 of the PCN rollout to enable access on the Isle of Wight and the remainder of Dorset.
- Linked to the above scoping expansion of ICE function to cover endoscopy and pathology, with workarounds whilst this is being developed.

Referral criteria and triage – the significant progress made by this work stream, as anticipated, has become embedded in the newly formed RDS Clinical Reference Group (CRG) which brings together primary and secondary care clinicians.

Paul Nicholls has been providing secondary care consultant clinical leadership with the CRG consisting of Jane McLeod and Sarnia Ward as a continuum of the referral criteria and triage workstream. Jane Winter has been providing nursing / AHP input with Zaed Hamady as the chair of the pancreatic cancer task and finish group.

Work completed includes:

- The development of a clinical and operational protocol document required for the RDS. This is a live document and will continue to evolve as the RDS processes develop.
- Review of the suspected pancreatic referral form and pathway which resulted in a decision to create a single RDS referral form and clinical pathway for ease of access for primary care colleagues. We will audit the service every 6 months in the first instance. During the audit process we will be able to identify the impact of non-specific symptoms on pancreatic cancer diagnosis rates.
- Support for the development and refinement of the clinical roles required to deliver the interim and substantive recruitment into RDS roles. This has included reviewing options for honorary contract appointments to increase the relative attractiveness of the RDS consultant role.
- Ongoing clinical governance and oversight for decisions pertaining to the clinical function of the RDS hub.
- Applying a timed pathway to the GP referral pathway to ensure a step change in diagnostic timescales.

In addition to which the CRG acts as a clinical moderator having reviewed each of the RDS referrals received and providing supportive advice and feedback to referrers and making changes to the RDS referral proforma to improve clarity for referrers.

CRG members have also supported communication and engagement activities including as part of the continued programme rollout but also externally to RDC peers including Surrey Heartlands CCG.

Diagnostic Demand and Capacity – this workstream has been closed in light of the ongoing surgical and diagnostic capacity demand and capacity programmes driven by Covid 19.

The National Rapid Diagnostic Centre (RDC) team have been contributing to cancer performance recovery and renewal guidance which includes the draft Cancer Diagnostic Services During Covid 19 document. This includes a section on the role of RDCs and RDSs in improving the resilience and responsiveness of cancer services. Ensuring rapid diagnosis of patients will help to manage increased diagnostic waiting lists and increase capacity to respond to any influx of patients.

The opportunity to review this stream of work in the light of the need to establish imaging networks remains the focus and, again this document recommends that, building on the RDC Specification, all local systems should accelerate the delivery of the existing diagnostic networks for imaging and pathology.

Commissioning and Finance – this work stream has been reinstated with:

- A revised and focussed brief and a review of the group membership. Members will be primarily Commissioners with responsibility for ICS/STP level cancer services, Specialist Commissioning, and are able to commit to and make commissioning decisions and or refer them to appropriate Board level in their organisations.
- Discussions have taken place with NHSE and CSU colleagues to commence the process of health economics modelling to:
    - ensure that at the end of the four-year period all Wessex patients who are appropriate for referral to the RDS should be accessing this pathway.
    - evaluation and learning from the project is ensured.
    - enable resources to be extracted from existing services to ensure they support RDS as business as usual once pump priming resource ceases.

Pancreatic cancer – work continued in terms of developing the pathway, with the decision taken to 'separate' referrals at the point of triage within the hub to progress along a suspected pancreatic cancer diagnostic pathway. Referrals from PCNs therefore, will be via the same as with all other RDS referrals.

The proposed pancreatic diagnostic pathway has been reviewed by members of the CRG before being implemented.

The correlation between late onset diabetes and risk of early pancreatic cancer was robustly reviewed with a balance between overwhelming the RDS with low risk patients, who would be unnecessarily concerned, and the early diagnosis of pancreatic cancers. This agreement will be kept under review underpinned by a clinical audit supported by the newly appointed RDS Data Analyst.

The Hub Implementation Group - has continued to meet virtually and initially increased the frequency of meetings to match the relaunch of the RDS planning.

Frequency has now been stepped back to fortnightly and the group continues to review the progress of

the project and the availability of clinical staffing, digital solution preparedness and making recommendations as to the RDS go live and the PCN and Trust phased roll out timetable.

Whilst the service went live on 22nd June difficulties with user access to the Poole ICE requesting and a low number of patients meant that it was not possible to 'live' test the digital and clinical processes before switching on eRS to allow referrals into the RDS from the additional 2 Poole PCNs. The decision was therefore taken to pause the plan by 2 weeks to allow for a fuller testing of the resilience of new clinical and digital processes.

Phase 1, covering 3 Poole and 2 Hampshire PCNs and RDS requesting enabled in 4 NHS Trusts, has been completed with planning and engagement on target for Phase 2 in October 2020.

We will also be asking PCN's coming on board, to ensure they have access to all the filter tests required, prior to their go live dates and that all patients are going to be available and contactable.

Programme management planning and engagement – in line with the roll out planning engagement activities have commenced which includes identification and engagement with key staff groups including admin staff in radiology, cancer services teams and endoscopy.

Go live task and finish groups are being introduced including in:

- Poole – weekly meetings are in place
- IOW – communication and engagement and implementation meetings are underway
- PHT – implementation meetings continue to monitor processes after go-live 17th August RBH – have advised a preference for no further meetings after go-live 17th August. Any identified concerns or issues to be managed on a case by case basis.
- HHFT and DCH – aligned with phase 3 but initial contact via cancer managers has been undertaken,

Additional work streams have been relaunched or commenced including:

Patient engagement and communication – supported by Wessex Voices and Copia productions the RDS service has:

- Developed an evaluation and feedback strategy including the development and testing of a telephone questionnaire to enable live feedback.
- Developed patient and staff information leaflets in different formats, including as a printable template for GPs at the point of referral.
- Supported the development of the Cancer Matters Wessex website and as work develops this will host an on-line user feedback questionnaire and include Frequently Asked Questions as learning evolves.
- An approach to signposting including ensuring the Making Every Contact Count (MECC) principles are embedded in the contact with the patient and RDS Hub team.
- An Equality and Health Inequalities Analysis (EHIA) has been undertaken which has been reviewed by both the regional team and National RDC team to ensure that due diligence has been undertaken and that the principle of parity of access across Wessex has been achieved when developing the RDS. This will improve patient experience and potentially clinical outcomes whilst mitigating risks of legal challenge.

Financial Governance and accountability – Jennifer Terry has been appointed to provide financial support to the RDS, in a shared post with the pathology network.

Work is progressing to develop a detailed budget and reporting process which encompasses financial governance and best practice. This has in turn supported the development of the, currently draft Memorandum of Understanding (MoU). This is in final draft stage and will be reviewed in discussion with UHS and SCAS as the 'partnership' responsible for hosting the RDS hub.

Allocation of funding to support RDS next steps both in the current year, year 2 2020/21, and for year 3 has commenced,

Details of spend and updates on returns of investments, such as the image sharing solution funded in Dorset, will form part of the regular reporting to the RDS steering group.

Programme and project management documentation continues to be both developed and updated and saved on both the NHS Futures Collaborative platform and the WCA shared drive, examples include:

1. Updated project plan which includes:
    a. Hub implementation group actions
    b. Actions by area
    c. Decisions and Approvals
    d. Risks and Issues
    e. Escalations
2. Project initiation document
3. RDS Programme Governance
4. Digital Task & Finish Group Action Log
5. Clinical documents including
    a. Clinical and Operational Policy
    b. Optimal Timed Clinical Pathway for GP referrals
    c. Referral Form
    d. Discharge summary requirements
6. Communication Strategy