The Wessex Rapid Investigation Service – FAQ's

Background

Launched in 2018, the NHSEI's Long Term Plan has cancer as one of its focuses. It set an ambition to enable an extra 55,000 people per year survive their cancer diagnosis for 5 years or more. As part of this it determined to create new Rapid Diagnostic Services across the country. Different areas have implemented different services: in Wessex, a remote service was rolled out in stages across the area from June 2020, with full access to all Wessex practices from January 2021.

> Cancer accounts for more premature deaths (under the age of 75) in the UK, than cardiovascular, respiratory, and hepatic conditions combined.

Frequently asked questions:

1. Why does the practice have to do such a comprehensive work up?

   With the service covering such a large geographical area (Lyme Regis to Emsworth, and Ventnor to Tadley), and the need to keep it a "rapid" service, all patients must have a complete work-up, including physical examination and a minimum dataset of investigation results. (FBC, ESR, CRP, renal, liver, bone function, HbA1c, PSA/CA125, urinalysis, and FIT test). With no physical clinic, the service is not able to see patients face to face and has no facility to undertake blood, urine, and FIT tests, and logistically it is simpler and quicker, if there are outstanding tests needed, for these to be arranged and undertaken local to the patient. This cohort of tests have been specifically selected to efficiently identify if the patient might be more appropriately referred into secondary care via a different NG12 pathway rather on to the non-specific symptoms' pathway.

2. Additional Patient information

   It is valuable for our service to have narrative included within the referral that is informative and up to date. It allows our team of clinicians to fully assess the referral ensuring the patient is appropriate for the service.
   Due to the nature of being a virtual service it is of paramount importance that any patient referred to the RIS has the capacity to consent and to accurately respond to the numerous questions they will be asked from our clinicians.

3. How do I make a referral?

   There is a 2 week wait proforma to complete, to (hopefully) support a smooth referral. The proforma should be fully completed including an informative narrative. The referral must be added to the Electronic Referral System (E-rS). The RIS will not be able to see that a referral has

been made until the proforma has been added and a "dummy" appointment booked. The patient should not be informed of this "dummy" appointment as this can lead to unnecessary anxiety for the patient if the RIS team do not call at the time of this slot.

4. Who is on the team?

   The team is led by Dr Kathryn Nash (UHS Hepatologist), supported by Mr Paul Nichols (UHS Colorectal Surgeon) and Mr James Douglas (UHS Urologist). They are supported by 2 GPs (Dr Laura Watson and Dr Richard Roope) and 4 Nurse Practitioners (Charlotte Smith (Lead NP), Celin Thomas, Elizabeth Buse and Dhanya Varun). The clinicians, in turn, are supported by a manager and admin team.

5. Once I have made the referral, what then happens?

   Each referral is clinically screened to ensure the referral is appropriate (i.e., there is not an existing pathway better suited for the patient), and all required test results are available. Once accepted the RIS admin team call the patient to fix an appointment, with the option of video- or telephone-call. The vast majority choose the latter. This will usually be within 2 working days of the receipt and acceptance of the referral. If the clinical screen highlight that a more suitable pathway should be considered, or the referral is missing vital results this will be communicated with the referring practice via e-RS and the designated NHS.net email address for the surgery. One of the frontline GPs or Nurse Practitioners will then have a detailed remote consultation with the patient, exploring the full medical history in detail. If further investigation is deemed appropriate, any required investigations will be requested at the patient's nearest/choice of hospital. If no further investigation is recommended, the patient will be appropriately safety netted and discharged back to the GP with a summary.

6. Which tests can you arrange?

   Our most common first-line test is a CT Chest / Abdo / Pelvis with contrast. Please note that if you are referring for urgent endoscopic tests, then the referral should be directed to Upper or Lower GI.

7. How soon will the patient have their investigations?

   These are normally undertaken within 2 weeks of the clinical consultation.

8. When does the patient hear the results?

   Once we have the investigation report, it is discussed at the next MDT meeting (Mondays and Thursdays). A management plan is made and is communicated to the patient by telephone.

9. Will the referrer need to make further referrals if a cancer is diagnosed?

   No, the RIS team will make any onward referrals to the appropriate 2 week wait referral pathway, with a copy of the referral sent to the GP. The RIS will continue to support the patient until they are safely under the care of the appropriate specialist team with a CNS contact and an onward management plan.

   The only exception to this is:

   In the unfortunate event that a referral to a community based palliative care team is required, the RIS would anticipate the GP would refer to the correct team. This will be fully communicated to the GP directly by phone and within patients Discharge Summary.

10. What will happen if a significant non-cancer diagnosis is made?

    Again, the RIS team will make the appropriate onward referral if required and the patient supported until the successful transfer of care is complete.

11. What will happen if no cause is found for the symptoms and findings that led to the RIS referral?

    The patient would be discharged back to their GP team with advice re symptom control, monitoring and safety netting advice given to the patient.

12. What communication can I expect to receive?

    We sometimes call GP surgeries to discuss referrals. We are aware that this is time consuming and are very grateful for our GP colleagues' co-operation. We find this communication can be a really valuable part of the process. The GP team will receive a letter when the patient has been clerked, detailing any investigations requested. We will also send copies of any onward referrals. Where the patient is discharged from the RIS with safety netting advice, the GP Team will receive a copy of the letter sent to the patient, with specific "advice to GP Team". At the time of the patient's discharge from our team, the discharge letter is sent to both the patient and the GP surgery.

13. Over the first full year what has been the cancer conversion rate, and non-cancer significant diagnosis conversion rate?

    Around 4.7% of referrals have had a cancer diagnosed and were referred onwards. A further 31% were referred onwards with a non-cancer finding. The remaining patients were reassured that there was nothing serious found to explain their symptoms and then discharged to their GP Teams for ongoing care.

Cancer diagnosis rate: 4.7%*
Other significant diagnosis: 31%*

14. What is the difference between the RIS and CUP referral pathways?

    The RIS is a Non-Site Specific (NSS) pathway for patients in whom there is clinical concern there may be a cancer somewhere, but the symptoms are systemic (e.g., weight loss, fatigue, generalised abdominal pain, persistent or rising thrombocytosis). The Cancer of Unknown Primary (CUP) pathway is for those with newly diagnosed secondary cancer, e.g., liver metastases on ultrasound, where the primary is as yet unknown.

15. How has the service been received by patients?

    Patients are given the opportunity to feedback. This has been almost universally favourable, although our set-up as a remote service does present some challenges.

16. Does the RIS have capacity for more referrals?

    Yes, there is clinical, diagnostic, and administrative capacity for more referrals.