

Classification: Official

Publication approval reference: PAR1130



Faster diagnostic pathways

# Implementing a timed head and neck cancer diagnostic pathway

Guidance for local health and care  
systems

20 March 2023

# Contents

Best practice timed diagnostic pathways .....	2
The Faster Diagnosis Standard .....	3
The case for change .....	3
Actions for cancer alliances .....	5
Benefits of pathway change.....	6
28-day best practice timed pathway .....	8
Additional information .....	13

# Best practice timed diagnostic pathways

Best practice timed pathways support the ongoing improvement effort to shorten diagnosis pathways, reduce variation, improve patient experience of care, and meet the Faster Diagnosis Standard (FDS). The guidance will support cancer alliances and constituent organisations to adopt consistent, system-wide approaches to managing this diagnosis pathway.

This guidance sets out how diagnosis within 28 days can be achieved for the suspected head and neck cancer pathway. This guidance covers upper aerodigestive tract squamous cell carcinomas. Alongside the pathway itself, resources are highlighted to support implementation of the pathways.

This head and neck pathway is part of a [series](#), published since April 2018. From previous pathways implemented by cancer alliances, [implementation guidance](#) was shared in June 2021, identifying areas that are key to success, such as setting up with clinical and operational engagement, auditing pathways, allocating project management resources, ensuring leadership, analysing data, and sharing successes. This guidance complements existing resources such as NICE guidelines (including NG12) and should therefore be read alongside such guidance.

While the guidance stipulates recommended clinical actions and timings to support pathway design, we recognise that responsibility for clinical decision making remains with local clinical teams with the knowledge and expertise to make appropriate decisions and policies.

The pathway in this document was developed by a multi-disciplinary consensus group with clinical leaders from local and specialist services across England, and expert advice from cancer alliances. For any questions about this document please email [england.CancerPolicy@nhs.net](mailto:england.CancerPolicy@nhs.net).

**Dame Cally Palmer**

National Cancer Director  
NHS England

**Professor Peter Johnson**

National Clinical Director for  
Cancer  
NHS England

**Jennifer Graystone**

Chair of the Head and Neck  
Task and Finish Group  
NHS Cancer Programme

# The Faster Diagnosis Standard

We committed in the [NHS Long Term Plan](#) to provide a faster diagnosis for patients through the introduction of the [faster diagnosis standard](#) (FDS). This standard will ensure patients are told they have cancer, or that cancer is excluded, within a maximum of 28 days from referral. The new standard is intended to:

- reduce the time between referral and diagnosis of cancer
- reduce anxiety for the cohort of patients who will be diagnosed with cancer or receive an ‘all clear’
- reduce unwarranted variation in England by understanding how long it is taking patients to receive a diagnosis or ‘all clear’ for cancer
- represent a significant improvement on the current two-week wait to first appointment target, and a more patient-centred performance standard.

FDS performance data, including a breakdown by suspected cancer pathway, has been published since June 2021, and faster, more streamlined pathways will be a priority.

As the key system-wide organisations for cancer services, cancer alliances will need to work across the local system to ensure that implementation is prioritised by senior stakeholders, clinical leaders, and operational colleagues, and that capacity is prioritised to enable the standard to be delivered.

The FDS has been formally performance managed since October 2021 activity, in line with cancer services recovery, with an initial threshold of 75%. Cancer alliances will need to ensure that they have plans to meet the threshold, which will need to be increased in subsequent years if we are to contribute to achieving the early diagnosis ambitions in the NHS Long Term Plan.

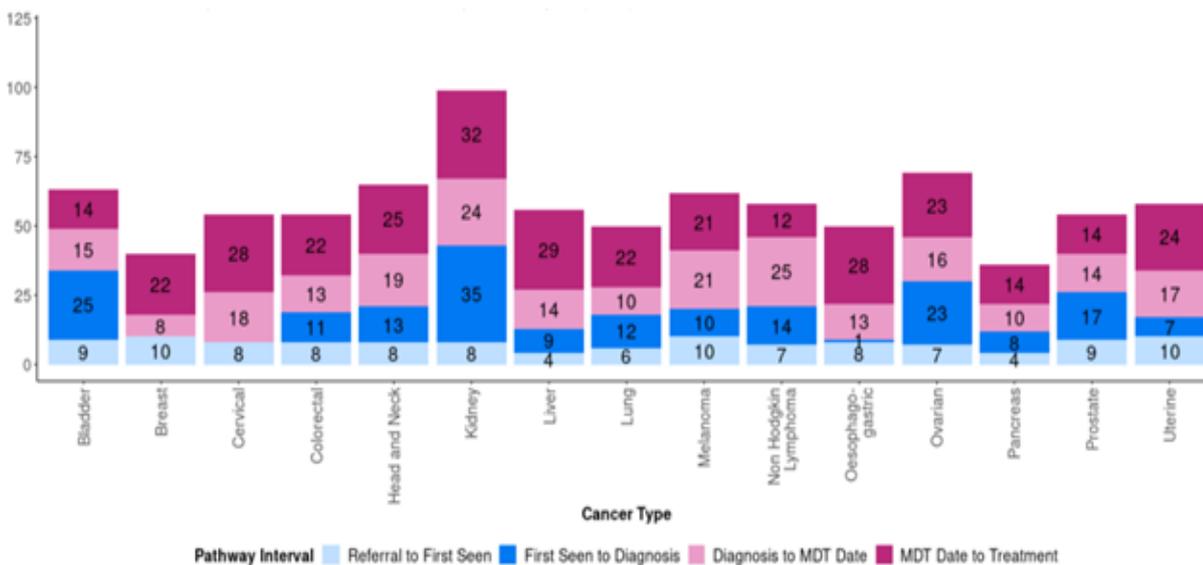
## The case for change

- Head and neck cancer is the **eighth most common cause of cancer** in England affecting more than 11,000 people each year.
- Suspicion of head and neck cancer is the **fourth most common suspected urgent referral type** in England, representing 9% of all urgent suspected referrals in 2020.

- In 2018, patients with head and neck cancer had some of the **longest intervals between referral and commencement of treatment** among all cancers in England.
  - This varied by cancer alliance with a range of 54 to 75 median days.
- Between 2018 and 2020, only 61% of patients diagnosed with head and neck cancer commenced treatment within 62 days of referral.
  - This varied by cancer alliance with a range of 47% to 80%; and in 2020/21, varied by integrated care system (ICS) with a range of 24% to 82%.
- For cancer patients in England diagnosed between 2015 and 2019, **five-year age-standardised net survival was only 62% for larynx cancer.**
- In 2018, **only 13% of oropharynx, base of tongue, tonsil, soft palate and uvula cancers were diagnosed at an early stage (1 and 2).**
  - This varied by cancer alliance with a range of 7% to 19%.

A streamlined and more efficient pathway will reduce overall waiting times, avoidable delays and the variation currently seen across the country. Alongside adoption of the best practice timed pathway, cancer alliances must ensure the appropriate resources and capacity are in place to deliver high-quality services to more patients.

**Figure 1: Median days from referral to treatment by cancer type, England (2018)**



# Actions for cancer alliances

In 2023/24, **all systems** are asked to develop plans to:

- Implement and maintain priority pathway changes.
- Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity, particularly via community diagnostic centres (CDCs), is prioritised for urgent suspected cancer.
- Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs.
- Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput.
- Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24.

**NHS England** provide support, funding and guidance to help cancer alliances improve outcomes and reduce variation. The following support is available:

- Funding and programme management to support delivery to achieve the Faster Diagnosis Standard and best practice timed pathway milestones.
- Implementation Guidance for achieving pathways.
- Collaboration and networking events to share best practice.

“The patient pathway from referral to decision to treat for head and neck cancer is one of the most complex cancer pathways. The patients are a heterogenous group with often extensive co-morbidities and each tumour subtype has its own set of investigations and diagnostics which are challenging to schedule in a timely fashion.

“The key features of this pathway are to improve the triaging of patients so they can access the right tests, first time, and the streamlining of the transfer between local unit and specialist centre with defined responsibility for the respective steps.

This should be integrated with timely booking and reporting of the diagnostic and staging investigations. It is expected that once a decision is made at the local unit to refer to the specialist centre, if a PET is indicated, a booking should be made so it is available for the specialist [multidisciplinary team (MDT)] meeting.

“The proposed changes are simple but do require better administration of existing pathways. Their implementation is anticipated to reduce waiting times for critical investigations and decision making and enable prompt starts for treatment for those diagnosed with cancer.”

**Jennifer Graystone**, on behalf of the Head and Neck Task and Finish Group,  
NHS Cancer Programme

## Benefits of pathway change

### For patients and unpaid carers

- Reduced anxiety and uncertainty of a possible cancer diagnosis, with less time between referral and receiving the outcome of diagnostic tests.
- Improved patient experience from fewer visits to the hospital, particularly to specialist centres if possible, and avoiding emergency admission.
- Potential for earlier recognition and initiation of pre-optimisation for treatment that could reduce complications and adverse outcomes.

### For systems

- Reduced demand in outpatient clinics with increased straight to test provision and use of pathway navigators.
- Allow resources to be targeted at patients with cancer by removing non-cancer patients earlier in the 62-day pathway.
- Improved quality, safety, and effectiveness of care with reduced variation and improvement in outcomes.

### Experience of care

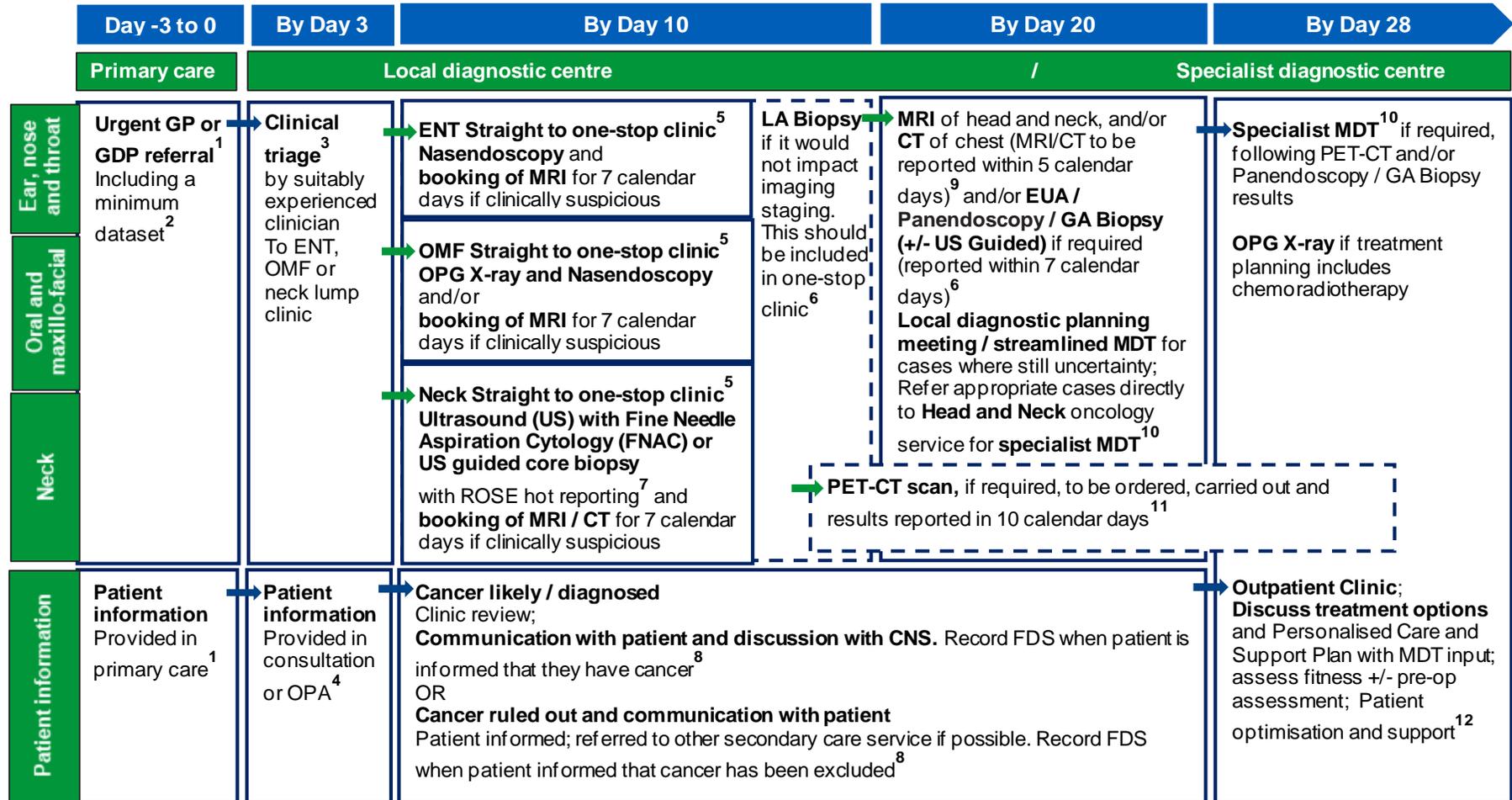
- Patients and carers know they are urgently referred for investigation of suspected cancer and should expect diagnosis within 28-days.

- Ensure that patients and carers' ability to attend appointments is taken into account and additional support is offered, where necessary.
- Patients are communicated with clearly, understand the information provided, and are given additional support, such as access to a clinical nurse specialist (CNS) or navigator, psychological support, buddy system, where necessary.

### **For clinicians**

- Using a nationally agreed and clinically endorsed pathway to support quality improvement and reconfiguration of head and neck cancer diagnostic services.
- The use of predetermined diagnostic algorithms and standards of care to streamline clinical decision-making and reduce delays for MDT discussion.
- Improved ability to meet increasing demand and ensure best utilisation of the highly skilled workforce.

# 28-day best practice timed pathway



See detailed information on pages 10 to 13

## Detailed information

**1. Urgent GP or general dental practitioner (GDP) referral pathway** should be used for patients who meet NG12 criteria for suspected cancer pathway referrals. The National Cancer Waiting Times Monitoring Dataset Guidance v11.1 sets out consultant upgrade rules, including from non-GP scenarios such as A&E and acute settings. cancer alliances may agree local arrangements to facilitate patient self-referral, community diagnostic centres and other referral routes, including non-GDP members of the dental team, to access this pathway. It is noted with the implementation of community diagnostic centres that referral pathways may be subject to change.

**Primary care should inform the patient** that they are being referred for an urgent suspected cancer pathway, although stating that vast majority of referrals result in non-cancer diagnoses. Primary care should also make the patient aware of their responsibilities to make themselves available for the first four weeks for full diagnostic testing.

**2. A minimum dataset should be agreed locally with GPs**, to accompany the referral and facilitate straight to clinic and diagnostic testing, which includes:

- patient symptoms in line with NG12
- patient demographics
- anticoagulant status
- WHO performance status
- co-morbidity
- smoking status and alcohol intake
- prescribed medication (when auto-populated, if possible, in practice IT system)
- need for interpreter
- mental capacity to consent
- (where IT systems support) to also include pictures of visible index lesion as part of surface anatomy.

Referrals from dental teams may not include all the minimum dataset as they will not have access to test results. Capacity will need to be considered for

completing missing dataset tests in the first outpatient appointment (OPA) or one-stop clinic, following referral from primary care.

**For suspected neck lumps the minimum dataset should also include** sizing and shape of neck lump, duration of lump, and B symptoms where possible.

- 3. Clinical triage** can be done by a suitably experienced clinician, including a Clinical Nurse Specialist. Patients should be triaged based on NICE NG12 symptoms, with persistent unexplained hoarseness going to ENT clinic, unexplained ulceration in the oral cavity lasting for more than three weeks, a lump on lip or oral cavity, or red or red and white patch in oral cavity going to OMF clinic, and unexplained lump in the neck going to the neck lump clinic.

**If a patient is medically unfit for straight to one stop clinic**, patient should be reviewed in clinic. If deemed medically fit, the appropriate first line investigations should be performed and reported within seven days of triage so that this cohort can progress on the pathway in the same timeframes. Patients should have same day investigations to reduce repeat visits and improve patient experience. Telephone or video consultation could be used to determine suitability for straight to one-stop clinic and pre-assessment. Preparation for any tests can be communicated to patients at this stage.

- 4. Patients and care-givers should be asked** what information they require about the pathway, provided with standard leaflets about investigations when sending confirmation of appointment, confirmation of next step(s) and any patient needs required to prepare for the day (for example, can they eat and drink before), and whether they have any disabilities or language barriers.

Preferences for amount of information and when it is provided will vary, and therefore it will help to provide caseworker/navigator telephone contact details to provide support throughout the pathway and outside of clinic times, provide signposting to charities and support services, provide information about care-givers attending appointments, and offer follow-up if patients do not receive confirmation of appointment in expected timescale.

**Where possible, continuity of caseworker/navigator should be provided** to enable familiar contact and to build trust. Patients should also be informed that it is likely they will receive one or more procedures and/or diagnostic tests on the same day, at the first face-to-face appointment.

5. **One stop clinic for neck lumps** should have a radiologist present to provide immediate support and decision making to interpret ultrasound and undertake biopsy. There should be facility for patients to be booked in for examination under anaesthesia (EUA) within seven calendar days of the one stop clinic, where the clinician deems it necessary to make robust therapeutic decisions. While this Guidance does not formally cover suspected thyroid cancer, the [British Thyroid Association Guidelines for the Management of Thyroid Cancer](#) sets out investigative tests, which could align to the test and timings outlined in this pathway.
6. **Biopsy** should be undertaken for all patients with remaining clinical suspicion of cancer, unless sufficient tissue sampling is already obtained through fine needle aspiration cytology (FNAC). As biopsy can result in post-biopsy changes which prevent accurate staging, local anaesthetic (LA) biopsy should only be undertaken if it would not impact the staging performed on imaging. LA biopsy is normally appropriate if the tumour is large or exophytic in the upper airway or clinically evident in the oral cavity.

**Histopathology reports for tissue sampling** should usually be available in 7 calendar days. This may be longer if ancillary tests are required to establish a diagnosis or if the pathway for a sample reaching the reporting laboratory is delayed. All histopathology should have a designated point of receipt, sign-off and management responsibility to ensure that reporting is not lost between different clinicians. Perioperative care of older people undergoing surgery (POPS) assessment to be carried out by day 10, at or immediately following one stop clinic to assess suitability for GA biopsy for further investigations.

7. **Ultrasound with FNAC** to be carried out, if required in one-stop clinic, by a head and neck radiologist or clinical specialist ultrasound practitioner in head and neck. FNAC to be hot reported on the day using rapid on-site specimen evaluation (ROSE). Alternatively, if US guided biopsy is considered appropriate locally, this should be arranged as early as possible, and carried out no later than by day 15, to allow for full reporting and any further investigations to be carried out.
8. **Patients should be informed** about cancer being ruled out, or diagnosed at the earliest face-to-face opportunity, unless the patient has expressed an alternative method of communication in order to speed up communication. In this timed pathway, this can be done at a one-stop clinic, a follow-up testing or results

outpatient appointment. Early consideration of patient's fitness for radical therapy and requirements for pre-habilitation should be addressed as soon as possible in the pathway to minimise delays in expediting treatment.

All patients diagnosed with cancer should have a referral to relevant allied health professionals (AHPs), including a specialist dietitian and speech and language therapist within seven calendar days of diagnosis, and where required, will also be involved during treatment planning. Local protocols and initiatives should be developed in collaboration with perioperative medicine, elderly care and specialist dietitians.

**Where cancer is ruled out**, in some cases it would be appropriate to provide a MRI or CT before onward referral to a non-cancer routine pathway. Where cancer is excluded or confirmed, the FDS 'clock stop' can be completed at this point of communication with the patient. **Cancer waiting time rules** (including 'clock start', 'adjustments' and 'clock stop') are set out in the National Cancer Waiting Times Monitoring Dataset Guidance v11.1.

**9. Standard imaging protocols should be applied for all CT, MRI, ultrasound and PET-CT** and these should comply with Royal College of Radiologists' recommendations or equivalent. **Systemic imaging (thoracic CT) should be available** for all patients with cancer of the upper aerodigestive tract. Further information is available in [BAHNO Standards 2020](#). Ring-fenced general cancer MRI slots should be considered to ensure that MRI capacity is available to deliver expected MRIs within seven calendar days of biopsies.

**10. The core roles at the full MDT** (to be carried out following cancer diagnosis) are lead clinician, radiologist, pathologist, oncologist, CNS and relevant AHP, to review investigation results with a pathway navigator. An oncologist with an interest in head and neck cancer and a radiologist with an established head and neck interest should be present at the full MDT. The capacity required to deliver these core roles should be reflected in job plans. [National guidance on how to maximise effectiveness of MDT meetings](#) is available. Locally agreed, clear criteria for referral to sMDT can also support with efficient pathway management.

It is unlikely that all necessary management decisions will be made at a single MDT. Some cancer patients require more than one MDT discussion before final diagnosis and treatment options are reached. This can consist of a diagnostic

planning meeting or mini-MDT between radiologist, oncologist and referring surgeon and pathologist at days 10 to 16. Some small cancers may only require one discussion. MDTs could consider direct referral from pathologists and radiologists, ensuring that a robust process is implemented to ensure the patient's diagnosis is communicated before receiving any subsequent appointments.

11. [PET-CT service specifications](#) set out the standards of care expected from organisations funded by NHS England to provide specialised care, including the expected timings for the provider to “appoint an examination date, perform the examination, complete the diagnostic report and return the diagnostic report and images to the referring clinician within seven business days or as specified by the contract”.

PET-CT is indicated for diagnosis of occult primary tumour with metastatic squamous cell carcinoma neck nodes, T4 cancer of the hypopharynx or nasopharynx, or N3 cancer of the upper aerodigestive tract (<https://www.nice.org.uk/guidance/ng36>). PET-CT should be carried out and reported within 10 calendar days, and by day 25, to allow preparation for pre-arranged outpatient clinic and treatment planning discussion by day 28.

12. **Personalised care and support planning** should be based upon the patient and clinician(s) completing a holistic needs assessment (HNA), usually soon after diagnosis. The HNA ensures conversations focus on what matters to the patient, considering wider health, wellbeing, practical issues and support in addition to clinical needs and fitness. This enables shared decision-making regarding treatment and care options.

## Additional information

### Audit tool

Can be used to undertake a baseline audit of services being delivered and whether sufficient capacity is in place to routinely deliver, identify areas for improvement, select measurements for improvement, and conduct re-audits as part of continuous improvement.

Day	Pathway step	Service in place?	Capacity in place?
-3 to 0	GP and GDP referral and locally agreed minimum dataset		
	Patient information resources, co-developed with patients		
By day 3	Clinically led triage and local protocols need to be in place to reduce delays		
By day 10	Straight to one-stop clinic provision for all eligible patients		
By day 20	Histopathology results taken during procedures should be reported within 7 calendar days		
	CT / MRI dedicated all tumour cancer slots from clinical triage, and/or follow-up from one-stop clinic investigations		
	PET-CT scan, if required, should be carried out (to nationally agreed service specifications) and reported within 9 calendar days of request		
By day 28	MDT for review and planning of potential treatment options, with alternative treatment options pre-agreed based on potential outcome of further tests		
	Treatment options discussed at multi-disciplinary outpatient clinic		

## Cancer alliance workspace

Cancer alliances access this workspace for national guidance, resources, and to share learning. Please use [this space](#) to upload materials you have developed locally and that you think would be useful for colleagues implementing this pathway across the country.

## Acknowledgements

This guidance was developed by the NHS Cancer Programme and builds on experience and expertise provided by the Head and Neck Task and Finish Group membership, including clinical representatives: Jennifer Graystone, Cyrus Kerawala, Brian Bisase, Rahul Jayaram, Ajay Wilson, Lydia Fresco, Emma King,

Mehmet Sen, Keith Hunter, Jagrit Shah, Gitta Madani, Shanmugasundaram Ramkumar, Priyamal Silva, Steven Noble, Lakshmi Rasaratnam, Anthony Cunliffe, Pepe Shirlaw; operational representatives: James Heasman, Stephen Scott; patient and charity representatives: Chris Elkington and Paul Vose; and the Cancer Programme: Cally Palmer, Peter Johnson, David Fitzgerald, Dan Cariad, Matthew Keeling, Sehrish Hussain, Peter Hawkins, Ayesha Dave, Tarana Akther, Maite Bikenge.

NHS England  
Skipton House  
80 London Road  
London  
SE1 6LH

Contact: [enquiries@england.nhs.uk](mailto:enquiries@england.nhs.uk)

This publication can be made available in a number of alternative formats on request.