NHS Cancer Programme: Faster Diagnosis Framework

28 November 2022

Information governance statement

Organisations 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 and NHS Improvement'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.

- 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.   This document sets out the NHS Cancer Programme's strategic approach to delivering faster diagnosis of cancer. It outlines specific and measurable objectives and key requirements for Cancer Alliances until the end of 2023/24, bringing together previously separate objectives relating to rapid diagnostic centres (RDCs) and Faster Diagnosis Standard (FDS) best practice timed pathways (BPTPs). It also seeks to align this work with related programmes such as the community diagnostic centres (CDC) programme.

1.2.   This document supersedes the RDC vision and 2019/20 implementation specification published in 2019.

1.3.   It is intended to be active for several years. It, therefore, sits alongside annual documents such as the priorities and operational planning guidance for systems and the Cancer Alliances planning pack, both of which set out clear plans and expectations for cancer diagnosis ahead of each financial year based on objectives drawn from this document.

National context

1.4.   The NHS Long Term Plan sets the ambition that, from 2028, an extra 55,000 people each year will survive for five years or more following their cancer diagnosis, and three in four cancers (75%) will be diagnosed at an early stage.

1.5.   Faster and more efficient cancer pathways will not achieve these ambitions on their own. However, they have a crucial contribution to make. By getting patients from referral to diagnosis more quickly we increase their chance of an early-stage diagnosis. Pathway improvements can also indirectly support earlier diagnoses by widening access, providing a platform for piloting and adoption of innovations such as self-referral routes, and reducing barriers between primary and secondary care.

1.6.   Urgent referrals for suspected cancer almost doubled between 2012 and 2019, resulting in more cancers being detected and fewer emergency presentations, but placing a significant operational burden on cancer services. We know that many of our operational performance challenges lie at the diagnostic end of the

pathway. Around 13% of patients on urgent referral pathways were diagnosed with a different cancer than initially suspected.

1.7. It is clear that the number of people investigated for suspected cancer will continue to rise, as a result of both demographic change and actions to target the early diagnosis ambition. Efficient, patient-centred pathways that allow clinicians to focus on the rapid investigation of the highest priority patients will become ever more important.

1.8. In 2021, the 28-day Faster Diagnosis Standard (FDS) was introduced to eventually remove the two-week wait (2WW) standard as recommended by the Independent Cancer Taskforce. The FDS sets a maximum 28-day wait for communication of a cancer diagnosis or ruling out of cancer for patients referred urgently for investigation of cancer (including those with breast symptoms) and from NHS cancer screening. Enabling systems to meet this standard through this document's aligned strategic approach to faster diagnosis is a priority for the NHS Cancer Programme and will support patient care and service capacity.

Faster diagnosis activities to date

1.9. The Faster Diagnosis Programme and this framework build on the significant progress made so far, and the culture of innovation we have seen develop in Cancer Alliances and providers.

1.10. Since 2019, Cancer Alliances have been developing new pathways for patients with non-specific symptoms (NSS) that can indicate cancer. They have also been applying what were termed RDC principles to tumour-specific cancer pathways so that every cancer patient gets the right tests at the right time in as few visits as possible. By November 2021, 80 new NSS pathways had been established and 93 existing cancer pathways have been reported as in line with the principles, including pathways for lung, pancreatic, head and neck, upper and lower GI suspected cancers. These changes show huge promise. However, feedback indicates there are several barriers to full implementation including:

- confusion over nomenclature
- lack of alignment to programmes such as CDCs
- lack of clarity over pathway 'compliance' with the seven RDC principles
- the subjectivity of success measures.

1.11. Since 2018, expert clinical 'task and finish' groups have developed best practice timed pathways (BPTPs) to meet the FDS. These BPTPs identify specific clinical events and tests for patients referred with defined NICE NG12 symptoms. Delivery of the timed pathways will support the highest quality of patient care and reduce variation among patients accessing diagnostics, improving treatment options and outcomes. However, there are still gaps in their implementation across England, and people have also been unsure how these pathways relate to the broader RDC programme.

1.12. In developing this document, the NHS Cancer Programme has engaged with Cancer Alliances and other key stakeholders, charities, and patients, to understand the challenges in implementing the programme and where elements could be improved with further development or clarification. Based on this feedback, this document:

- consolidates and simplifies the ambitions previously set out in the RDC vision and 2019/20 implementation specification, and the FDS BPTPs documents

- sets out an approach to implementation focused on more measurable objectives, supported by metrics that are more specific to the programme's impact

- clearly links the different elements of the programme itself and enablers such as the CDC programme.

1.13. Throughout, the framework recognises that while we provide more specific direction on a core set of deliverables, no service can be delivered entirely to a centrally set blueprint. Flexibility and adaptability to local circumstances remain crucial to the success of the programme. In particular, this framework aims to give Cancer Alliances and their partners dedicated space and budget to pursue local innovations and pathway changes, preserving and building on the excellent work already seen.

2. Nomenclature

2.1. From feedback, it is clear the term 'rapid diagnostic centres' has caused engagement challenges. In the rest of this framework and in national programme

documentation going forward, we will refer to the programme as a whole as the Faster Diagnosis Programme. The following terms will be used to describe the work under this programme:

1. developing non-specific symptoms (NSS) pathways

2. improving existing cancer pathways in line with the faster diagnosis principles and best practice timed pathways (BPTPs).

2.2. We will use the umbrella term faster diagnostic pathways to describe all cancer pathways following an urgent suspected cancer referral.

2.3. Nomenclature should not be a barrier to implementing improvements in cancer care. Although we will use the above terms nationally to communicate programme asks, alternative terms can be used locally to describe these activities, depending on what is clearest for patients and existing services in an area.

3. Faster Diagnosis Programme strategic approach

3.1. This document sets out the overall strategic approach and objectives of the Faster Diagnosis Programme. More detailed deliverables and goals will be set each year in the priorities and operational planning guidance and Cancer Alliance planning packs.

3.2. For patients with suspected cancer, the Faster Diagnosis Programme aims to deliver:

- an earlier and faster diagnosis to patients whether or not that is a diagnosis of cancer
- excellent patient experience, a holistic assessment of patient needs and streamlined support across community, primary and secondary care
- increased capacity in the system, through more efficient diagnostic pathways
- support systems to reach the FDS.

3.3.   The RDC vision and 2019/20 implementation specification introduced seven core principles to transform cancer diagnostic services and better support patients through their diagnostic journey.

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

2. Timely referral based on standardised referral criteria and appropriate filter function tests

3. Broad assessment of symptoms resulting in effective triage, determining whether and which tests should be carried out and in what order, based on individual patient need

4. Coordinated testing which happens in fewer visits and steps for the patient, with a significantly shorter time between referral and reaching a diagnosis

5. Timely diagnosis of patients' symptoms, cancer or otherwise, by a multi-disciplinary team where relevant, and communicated appropriately to the patient

6. Appropriate onward referral to the right service for further support, investigation, treatment and/or care

7. Excellent patient co-ordination and support with patients having a single point of contact throughout their diagnostic journey, alongside access to the right information in accessible formats, support and advice tailored to their needs

3.4.   These principles remain the core underpinning of this framework as the faster diagnosis principles, with the BPTPs documents providing the clinical detail for the co-ordination of tests and timely diagnosis for patients with defined symptom criteria.

3.5.   However, our approach to implementing these principles has changed. Rather than qualitative audits or stocktakes of compliance with these principles, which have proved difficult to apply consistently, we identify in this document a set of specific deliverables based on these principles.

3.6.   These deliverables will also be more measurable in quantitative as well as qualitative terms. We will continue to set clear national standards for consistent data collection to enable benchmarking and better tracking and evaluation of delivery and impact.

3.7.   In line with these principles, excellent experience of care is an important part of delivering high-quality healthcare and key to supporting optimal outcomes such

as quality of life. In 2020, staff, patients and carers co-produced 30 quality markers for cancer diagnostic pathways (Annex 3), based on what matters to them. A collaborative approach across primary, secondary and third sector organisations is required for the successful delivery of the quality markers. Cancer Alliances, in partnership with people that provide and use services, should work towards the implementation and monitoring of these markers.
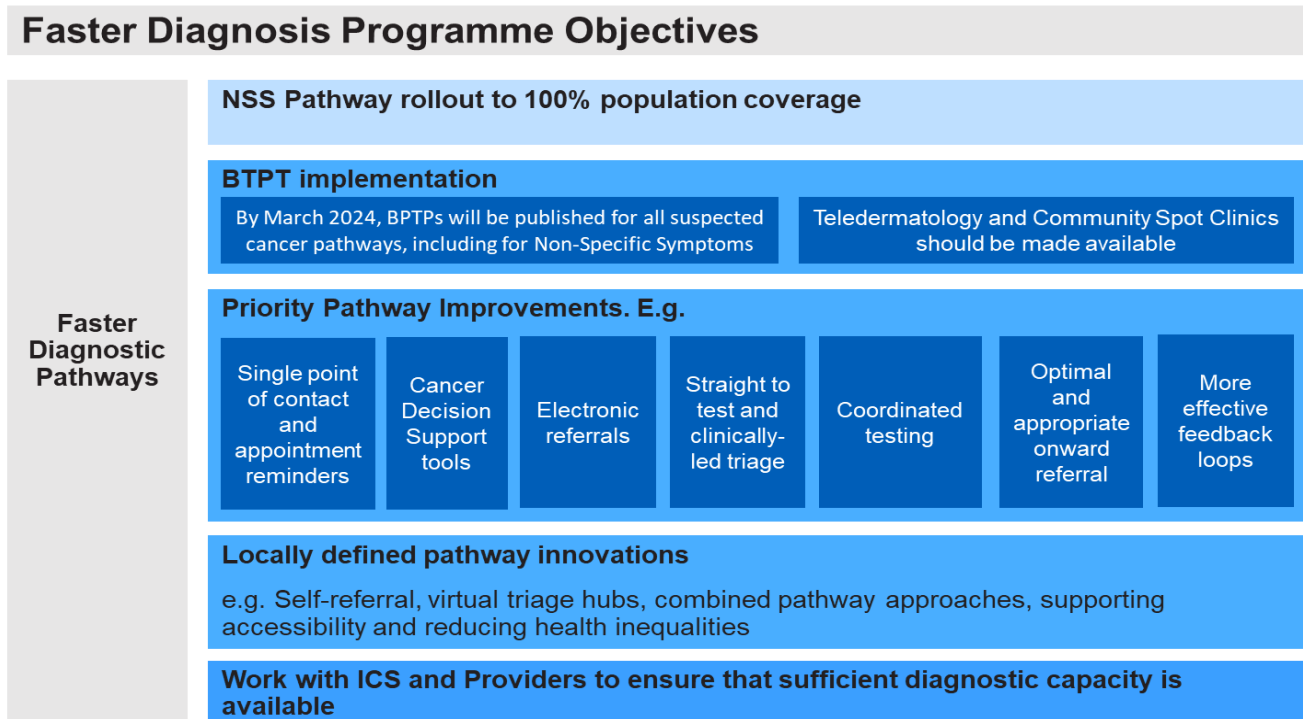
3.8.   Staff working in cancer pathways should follow the making every contact count approach: in everyday interactions they support patients to make positive changes to their physical and mental health and wellbeing. Where appropriate, staff should refer patients to services that support lifestyle changes, eg smoking cessation, weight management and nutritional advice, or appropriate psychosocial support services, including peer support networks and third sector services. Where possible, Cancer Alliances should also engage with primary care to ensure information on local community services is available at the point of referral or following a diagnosis.

3.9.   The NHS Cancer Programme has produced resources to support Cancer Alliances, integrated care systems (ICSs) and their partners to improve psychosocial support services for people affected by cancer. The NHS Long Term Plan set an ambition that every person diagnosed with cancer should have access to health and wellbeing information and support (HWBIS) that meets their needs, from diagnosis onwards. The HWBIS checklist is a practical tool that Cancer Alliances can use to help identify whether HWBIS across cancer pathways requires improvement.

4. Programme objectives

4.1.   Since 2019, objectives relating to faster diagnosis have existed across separate programmes (eg RDCs, BPTPs and Elective Recovery Funding (ERF)). This document brings all our work relating to faster diagnosis into a single programme, with consolidated national meetings, communications and events. From 2022/23 onwards, there will be a single planning process with a single overall budget for this work.

4.2.   Cancer Alliances should achieve the following five key objectives:

1. Complete the rollout of non-specific symptom pathways to achieve 100% population coverage by March 2024.

2. Implement the sequencing of pathways and achieve the maximum timeframes of all published FDS best practice timed pathways.

3. Implement a set of core improvements across all cancer pathways, regardless of tumour type, including:

   - a single point of contact navigates patients through their pathway, including by sending SMS/email appointment reminders
   - cancer decision support (CDS) tools are available and accessible to all GPs
   - all urgent suspected cancer referrals are made electronically
   - straight to test and clinically-led triage models are in place to streamline the start of cancer pathways
   - testing is co-ordinated to minimise the number of locations and appointments a patient must attend
   - processes ensure appropriate onward referral/discharge, whether a patient is diagnosed with cancer or cancer is ruled out
   - guidance to GPs and more effective feedback loops support effective and accurate referrals, with all referrals accompanied by effective minimum datasets.

4. Define and deliver a locally agreed set of pathway innovations and improvements. The focus should be locally challenged pathways (in terms of FDS performance) and measures that support early detection, such as outreach for specific population groups who have a high risk of cancer or experience high levels of health inequality.

5. Work with ICSs and providers to ensure that diagnostic capacity is sufficient for cancer pathways to deliver on our ambitions, in particular by working with the CDC programme at a regional level.

5. Objective 1: Complete the rollout of non-specific symptom pathways to achieve

Faster Diagnosis Programme Objectives

Faster Diagnostic Pathways	NSS Pathway rollout to 100% population coverage						
	BTPT implementation						
	By March 2024, BPTPs will be published for all suspected cancer pathways, including for Non-Specific Symptoms			Teledermatology and Community Spot Clinics should be made available			
	Priority Pathway Improvements. E.g.						
	Single point of contact and appointment reminders	Cancer Decision Support tools	Electronic referrals	Straight to test and clinically-led triage	Coordinated testing	Optimal and appropriate onward referral	More effective feedback loops
	Locally defined pathway innovations						
	e.g. Self-referral, virtual triage hubs, combined pathway approaches, supporting accessibility and reducing health inequalities						
	Work with ICS and Providers to ensure that sufficient diagnostic capacity is available						

100% population coverage by March 2024

5.1. NSS pathways are intended to cover the cohort of patients who do not fit clearly into a single 'urgent cancer' referral pathway, as defined by NG12, but who are nonetheless at risk of being diagnosed with cancer. Symptoms considered 'non-specific' include **unexplained weight loss**, **fatigue, abdominal pain or nausea; and/or a GP 'gut feeling' about cancer**. Historically, this cohort of patients often:

- saw their GP multiple times before referral[1]
- presented more often in an emergency setting[2]

---

[1] Quality Health (2017) National Cancer Patient Experience Survey 2017 National results summary.
[2] Public Health England (2017) Routes to diagnosis 2006-2016 workbook: Version b.

- presented with late-stage cancer[3]
- were referred onto multiple urgent pathways with resulting inefficiencies in healthcare provision.

5.2. Since 2019, new services have been rolled out across England to provide a dedicated urgent diagnostic pathway for this cohort of patients. The development of new NSS pathways and the optimisation of those already established since 2019 remains a key priority. **Cancer Alliances should continue working towards 100% population coverage for patients with NSS of cancer by March 2024.**

5.3. Measurable deliverables for NSS pathways will be specified for each year in the annual priorities and operational planning guidance and Cancer Alliance planning packs.

Referral criteria

5.4. **Core referral criteria** for NSS pathways are outlined in Annex 1. Cancer Alliances should note that there is no maximum age cut-off for patients to be referred onto NSS pathways. Any adult referred onto a NSS pathway should be triaged, investigated and safety netted, regardless of their age. NSS pathways specifically aimed at children or young adults can be developed if considered locally appropriate. These should be delivered in line with their respective service specifications.

5.5. Some areas have developed lumps and bumps clinics, eg for sarcoma, breast or neck lumps. For the purposes of reporting the NSS Evaluation Minimum Dataset and NSS management information, '**lumps and bumps clinics**' should be considered as NSS pathways. Where these are established, however, Cancer Alliances should also ensure that services are in place to support patients with the core NSS symptoms outlined in Annex 1 (eg unexplained weight loss, prolonged fatigue). Patients meeting NG12 criteria for tumour-specific suspected cancers should continue to be referred onto those pathways.

5.6. Core **filter function tests** for NSS pathways are outlined in Annex 1. Cancer Alliances should work with primary care to ensure that filter function tests are

---

[3] Cancer Research UK (2018) Multidisciplinary diagnostic centre (MDC) based pathways for patients with non-specific but concerning symptoms: Report.

consistently performed and that **referral forms** include all the relevant information on patient symptoms and test results for NSS pathways.

5.7. Cancer waiting times (CWT) guidance states that if a consultant thinks the urgent suspected cancer referral is inappropriate this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral. This includes where it is considered that insufficient information has been provided. This also applies to NSS pathways. Patients can be discharged back to their GP following clinical triage and after they have been seen for the first time by a consultant (or member of their team) or at a diagnostic clinic, or go 'straight to test' in a consultant-led service (unless that test is a blood test), if cancer is ruled out at that point.

5.8. Feedback loops with primary care should be established to improve the quality of referrals. Implementing GP clinical decision support tools in primary care will facilitate improvements in referral quality, as can implementing an integrated clinical environment (ICE) button to automatically request all mandatory first-line tests for a NSS pathway.[4]

Routes into NSS pathways

5.9. From 2021/22 planning trajectories and management information from Cancer Alliances that have already achieved 100% population coverage for these services, we estimate that patients with core NSS symptoms account for approximately 2–5% of total urgent cancer referrals. An NSS modelling tool has been updated to reflect this information and support Cancer Alliances to plan services up to the end of 2023/24. Clear definitions of population coverage and other assumptions in this model are included in this tool and user guide. Cancer Alliances can use their own local modelling to support service planning if they prefer.

5.10. Cancer Alliances should continue to engage with primary care to identify patients with NSS and refer them onto these new pathways. Although the emphasis should always be on ensuring the patient is referred to the correct pathway from the start, where patients with NSS (such as unexplained weight loss or anaemia) are referred onto another pathway, they should normally be triaged onto an NSS pathway, as this is likely to provide the fastest and most effective route to a diagnosis. Similarly, if a patient presents to the NSS service and during triage is

---

[4] Humber Coast and Vale Cancer Alliance evaluation case study 2021

found to meet NG12 symptom criteria for a tumour-specific pathway, they should be directed to that pathway for their diagnostic testing.
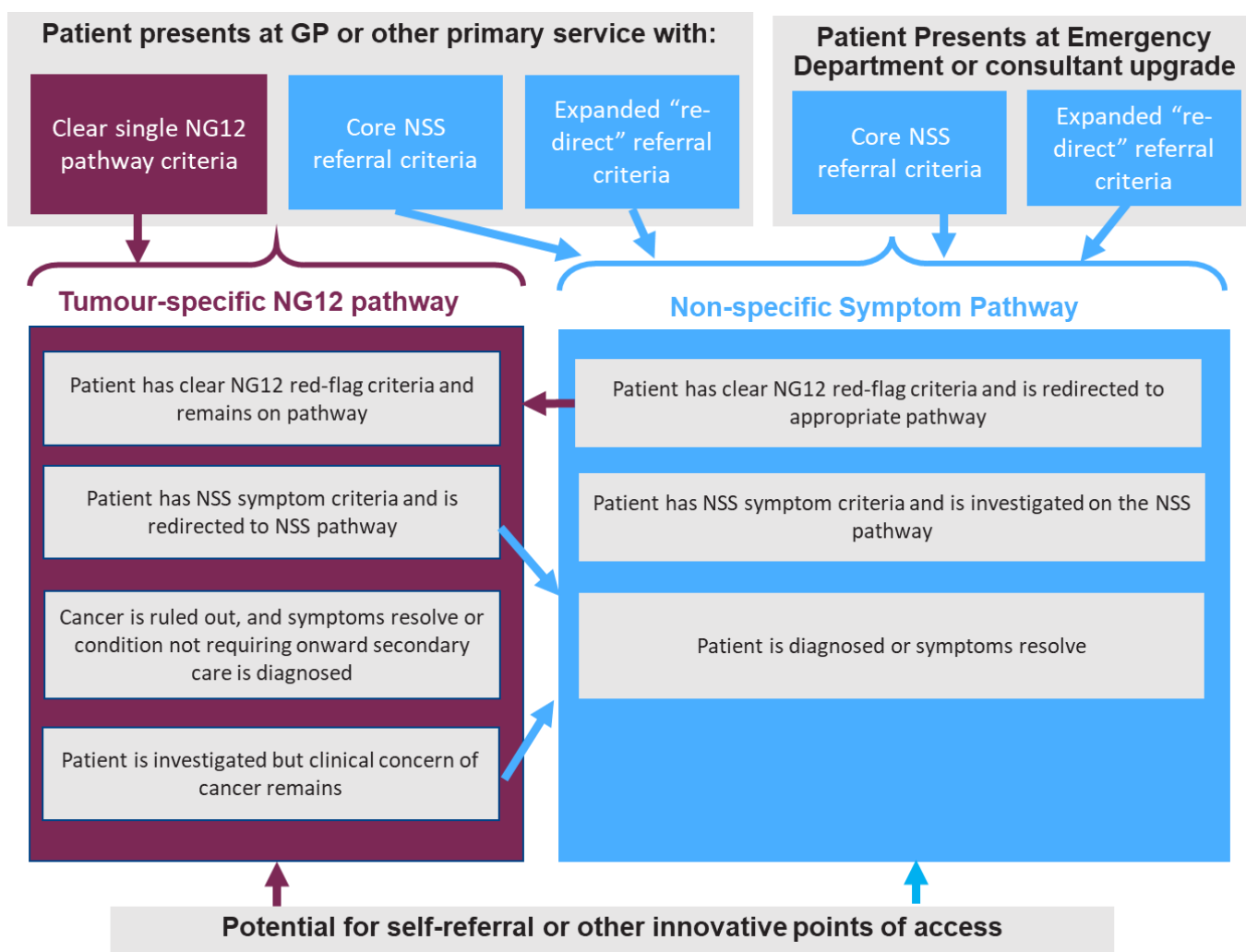
5.11. The exception to this is where clinical judgement is that a change of pathway would unacceptably delay the initial investigations. Where patients are redirected onto an NSS pathway, or indeed any other cancer pathway, the CWT start date remains the same for the purpose of performance monitoring.

5.12. Where patients are referred onto other pathways, the referring specialty should ensure both the patient and their GP are aware of the next steps, outcomes and any changes in point of contact. Where protocols for accepting patients with expanded symptom criteria have been developed, GPs can also refer patients with defined 'redirect' symptom criteria or NG12 criteria for multiple different pathways (that is, where there is no clear single referral route) onto NSS pathways.

5.13. Where a patient has already completed an urgent cancer pathway and that cancer type has been ruled out but clinical concern for suspected cancer remains, the patient should be redirected onto the most appropriate suspected cancer pathway for further investigation, which could be an NSS pathway. This will help ensure patients are supported until a diagnosis is reached and, as far as possible, prevent them from requiring multiple referrals for the same symptoms. The national team will analyse the number of patients nationally receiving multiple referrals within three months of each other to help forecast likely demand via this route. Local evaluation of this is also encouraged.

5.14. Wherever patients are redirected to other appropriate services, providers should ensure clear protocols are in place to support their referral. This includes the sharing of available patient information and test results. Redirect symptom criteria should be agreed with clinical teams, alongside corresponding governance structures.

5.15. An example set of 'redirect' symptom criteria developed and used by the Greater Manchester Cancer Alliance is given in Annex 2.[5]

5.16. Transformation funding for NSS pathways can be used to help streamline access from referrers other than primary care, such as emergency departments,

---

[5] Greater Manchester case study share and learn

consultant upgrades or self-referral. Demand from these sources should be determined, with sufficient capacity provided on the NSS pathway to accommodate this.

5.17. Where 'redirect' criteria are implemented, these should be locally evaluated/ tracked to assess their impact on diagnostic capacity and service demand.

Patient presents at GP or other primary service with:

| Clear single NG12 pathway criteria | Core NSS referral criteria | Expanded "re-direct" referral criteria |

Patient Presents at Emergency Department or consultant upgrade

| Core NSS referral criteria | Expanded "re-direct" referral criteria |

Tumour-specific NG12 pathway

- Patient has clear NG12 red-flag criteria and remains on pathway
- Patient has NSS symptom criteria and is redirected to NSS pathway
- Cancer is ruled out, and symptoms resolve or condition not requiring onward secondary care is diagnosed
- Patient is investigated but clinical concern of cancer remains

Non-specific Symptom Pathway

- Patient has clear NG12 red-flag criteria and is redirected to appropriate pathway
- Patient has NSS symptom criteria and is investigated on the NSS pathway
- Patient is diagnosed or symptoms resolve

Potential for self-referral or other innovative points of access

Non-cancer conditions and continuity of care

5.18. NSS pathways are for patients with symptoms that could indicate cancer, but most will not ultimately be diagnosed with cancer. A key wider benefit of NSS pathways will be diagnosing serious non-cancer conditions more efficiently. In local evaluations of NSS pathways, more than a third of patients 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.[6]

5.19. An NSS pathway should support patients until they are diagnosed and referred onward or their symptoms resolve. Some non-cancer conditions will require referral to specialist services in line with disease-specific NICE guidance (specialist non-cancer conditions), while others can be self-managed or managed within primary care (non-specialist, non-cancer conditions). The patient and their designated GP should be informed of any diagnosis made through NSS pathways. Providers of NSS pathways should ensure patient administration systems can capture and report the NSS referral and any subsequent diagnosis.

5.20. Patients referred for specialist care may still need additional diagnostic tests or imaging, even if they have been diagnosed. Similarly, 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.

Commissioning NSS pathways beyond 2024

5.21. Learning from national, local and Accelerate, Coordinate, Evaluate (ACE) Programme evaluations is building a strong case for the value of NSS pathways. Cancer Alliances should work with their ICSs to consider sustainable commissioning for NSS services in the long term.

5.22. The National Cancer Programme has established a commissioning working group. Following the publication of this framework, the national team will work with this group to develop support materials and share successful approaches to commissioning. A bank of evidence for NSS pathways is being developed to support Cancer Alliances to develop business cases for their services.

5.23. The following evidence of benefits from this service model as shown in the ACE Programme evaluations[7] can be used to support business case development:

---

[6] RDC - evaluation case studies 2021
[7] Cancer Research UK (2019) Key messages from the evaluation of multidisciplinary diagnostic centres (MDC).

- of the cancers diagnosed by this service model, a high proportion are rare or difficult to detect (56%), the category of cancers often diagnosed at a late stage, eg pancreatic or stomach cancer

- around 8% of patients are likely to be diagnosed with some form of cancer

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

- this service model supports the timely diagnosis of non-cancer conditions; over a third of cases are diagnosed with a non-cancer condition, most commonly diseases of the digestive system, eg diverticular disease or gastritis

- most patients have a positive experience; 85% are very satisfied or extremely satisfied with the level of care they have received.

6. Objective 2: Implement the sequencing of pathways and achieve the maximum timeframes of all published FDS BPTPs

6.1.   FDS BPTPs provide clinical detail on the optimal structure, sequencing and timing of pathways for urgent suspected cancer referrals where symptoms meet NG12 referral criteria. Delivery of the pathways will support us to provide the highest quality care to our patients and reduce variation in patient access to diagnostic and treatment options. All BPTPs have been drawn up by clinical task and finish groups, bringing together clinical leaders to provide evidence-based advice on the optimal diagnostic approaches to each cancer.

6.2.   To support the delivery of the FDS, BPTPs were published in 2018/19 for the following suspected cancers:

- prostate
- lung
- colorectal
- oesophago-gastric.

6.3.   By end of 2022, BPTPs will be published for:

- head and neck

- gynaecological
- skin.

6.4. Teledermatology services and community spot clinics should be available to support the skin cancer pathway to speed up diagnosis, manage high volumes of referrals and reduce face-to-face appointments in dermatology clinics that are not clinically necessary.

6.5. By March 2024, BPTPs will be published for all suspected cancer pathways, including NSS pathways.

6.6. Cancer Alliances, ICSs and providers should work together to ensure that FDS BPTPs are fully implemented; that is:

- all patients have access to all events as defined and sequenced by each of the FDS BPTP documents
- there is sufficient capacity in place for the maximum timeframes set out in the documents to be met.

6.7. Pathways should be reviewed against the key events and maximum timeframes set out in each BPTP, and where constraints are identified, the demand for each pathway should be compared to capacity and planned activity. Any shortfalls should be addressed within specific improvement plans, and delivery of maximum timeframes continually monitored, including through time-series data on the proportion of patients meeting each milestone.

6.8. Priority actions for BPTPs will be specified for each year in the annual priorities and operational planning guidance and Cancer Alliance planning packs. Performance against the FDS will remain the overarching headline success measure for delivery of BPTPs.

6.9. Clarification of the 'clock stop' and 'clock start' rules for the FDS is provided in the National Cancer Waiting Times Monitoring Dataset Guidance Version 11.

7. Objective 3: Implement core improvements to all pathways (regardless of tumour type), to be updated annually in planning guidance

7.1.   Based on evaluation and stakeholder engagement, the cross-cutting cancer diagnostic pathway interventions that have been highlighted as having the greatest impact include:

- **Pathway navigation.** Patients should be supported through their pathway with (as far as possible) a single point of contact sending SMS/email appointment reminders. This may be delivered by pathway navigator roles or existing members of the care team, with the approach tailored to suit the pathway. The role may include co-ordination of appointments and providing information/ guidance about each part of the diagnostic process, as well as an overall timeline to patients and carers. They help ensure there is a robust handover of patients to onward care services and support them to access additional services during and immediately after their diagnosis. The pathway navigator role links people with community support and third sector services, including psychosocial resources, and ensures that patients accessibility needs are considered throughout their care. A pathway navigator library is available to support the delivery of this function.

  An effective SMS/email reminder mechanism improves patient appointment attendance and medical compliance. Patient co-ordination tools, such as patient portals, can extend this approach to keep patients informed and engaged in their care, reducing the volume of enquiries to clinical and administrative teams. Providers should continue to consider the needs of patients without access to technology (ie elderly populations, those living in areas of high deprivation, transient populations, etc) and how these can be recorded/flagged on systems and alternative processes provided for them.

- **Straight to test and clinically-led triage models** to streamline the start of the pathway. These enhance the interface with primary care, maximising use of diagnostics and supporting the implementation of the timed pathways.

Administrative teams can also use protocol-based triage developed by clinicians.

- **Co-ordinated testing** to minimise the number of locations and appointments a patient must attend. Where recommended by BPTPs, providers should offer patients assessment and same-day testing, including the hot-reporting of results. Services should have fast and reliable access to diagnostic testing and reporting infrastructure, linking with existing provider patient record systems. Primary care should carry out pre-referral tests, such as eGFR, where indicated to facilitate co-ordinated testing.

- **Processes to ensure optimal and appropriate referral.** Services should refer all patients, regardless of the specific diagnosis, to the most appropriate specialty for onward support, investigation and/or care. Responsibility for the patient remains with the service until the patient receives:

  – a cancer diagnosis and is referred onto a specialist cancer pathway, with primary care informed

     or

  – a non-cancer diagnosis requiring secondary care management and is referred onto the appropriate specialty, with primary care informed

     or

  – a diagnosis not requiring onward specialist care or their symptoms resolve and the patient is discharged, in consultation with primary care

     or

  – a referral onto a NSS pathway because there is a continued suspicion of cancer.

  Safety netting processes should be implemented, eg in patients requiring interval scanning. Where patients have been safety netted, this should be discussed with and explained to the patient.

- **Primary care cancer decision support (CDS) tools**, designed to support healthcare professionals to recognise potential cancer signs and symptoms and manage patients appropriately, should be widely available.

  CDS tools do not replace clinical judgement. Instead, they supplement it with guidance to inform patient management decisions. Some tools also have the

potential to support optimal risk stratification of patients in primary care. This may be to refer, to request filter function tests, to safety net or to decide which pathway is most appropriate. Where these are implemented, engagement and training needs within primary care should be considered to support their effective use. The National Faster Diagnostic Team do not currently support one CDS tool provider over another but can share learning from where tools have been implemented.

- **Electronic referrals.** All cancer referrals should be made electronically, incorporating the technical tools with the clinical and business processes to ensure that all patients are offered clinically appropriate choices. The NHS e-Referral Service has benefits throughout the referral process for patients and the NHS: greater certainty of appointments improves patient experience, and a more efficient referral system eliminates much of the paperwork and time lag associated with non-electronic referrals.

- **Improving feedback and support to GPs.** Services should provide advice and guidance to GPs to support effective and accurate referrals, including feedback on referrals already made. This communication should improve referral practice and spread awareness of new services such as the NSS pathways being established.

7.2.   The minimum data required to accompany referrals and facilitate straight to clinic and diagnostic testing, including where appropriate filter function tests, should be agreed locally with GPs based on the guidance in BPTPs where published. Mechanisms should be in place to ensure referrals are made according to the referral criteria outlined in the BPTP guidance. There should be clear guidance on how and when to refer – information may include patient symptoms in line with NG12, patient demographics, WHO performance status, co-morbidity, risk factors, prescribed medication, need for an interpreter and mental capacity to consent. A limited set of measurable priority objectives based on these core improvements will be specified in the annual priorities and operational planning guidance and Cancer Alliance planning packs. As evidence emerges, other initiatives may be included in planning guidance for future years.

7.3.   Pathways that have been improved in line with these activities do not need to be 'badged' or called something different in local communications.

8. Objective 4: Define and deliver a locally agreed set of pathway innovations and improvements

8.1.   A number of well-evidenced, high-impact interventions should be implemented at across the country. However, it is important that Cancer Alliances have the flexibility to consider local priorities and actions that might be of particular benefit to their services or communities. This is especially important in developing targeted actions to address local health inequalities.

8.2.   Although targets for these activities will not be outlined in the annual priorities and operational planning guidance and Cancer Alliance planning packs, Cancer Alliances should clearly state which innovations they wish to adopt. They should specify the key measurable benefits that their innovations will deliver under but not limited to these headings:

- improved FDS performance
- improved patient experience
- doing these in a way that reduces health inequalities.

8.3.   All locally determined innovations should be evaluated to establish their impact on local services.

8.4.   Examples of these wider transformational change objectives include:

- **Self-referral**, including cancer hotlines to establish a service for people who are concerned they have symptoms of cancer or other serious health conditions. Self-referral should be supported by an appropriate assessment of symptoms and advice and guidance for patients who do not require further testing. Pilot self-referral criteria should be co-designed between primary and secondary care, in consultation with patient representatives and third sector organisations.

- **Triage hubs**, enabling a networked, centralised triage so that referrals are screened by a healthcare professional and directed to the most appropriate pathway and diagnostic tests, including for NSS referrals.

- **Combined pathway approaches.** Some Cancer Alliances have piloted approaches that use a 'single front door' to manage patients with NG12 symptoms for several different cancers. These can provide a combined service for several suspected tumour sites using a single referral form and combined workforce.

- Where FDS BPTPs have not yet been published, **reviews of pathway events** and dependencies to deliver diagnosis or ruling out of cancer within 28 days of referral.

- Going further than BPTP by **adopting 14-day FDS pathways in prostate cancer** where possible to support faster diagnosis and enable an efficient pathway for treatment.

- Over the past three years, Cancer Alliances have piloted outreach initiatives to **support access** to urgent cancer diagnostic pathways and **reduce health inequalities**. Examples include **frailty pathways**, streamlined mental health assessments and linkage to community services.

8.5. National funding is being set aside in 2022/23 to support these initiatives and will be additional to core Strategic Development Funding (SDF). Cancer Alliances will be invited to bid for this extra funding as part of the 2022/23 planning process.

9. Objective 5: Work with ICSs and providers to ensure that diagnostic capacity is sufficient for cancer pathways to deliver on our ambitions

9.1. Delivery of our faster diagnosis ambitions depends on the availability of sufficient diagnostic capacity across primary care, imaging, pathology, endoscopy and surgical/medical modalities.

9.2. The Independent Review of Diagnostic Services for NHS England – Diagnostics: recovery and renewal (October 2020) recommended that CDCs be established to "deliver additional, digitally connected, diagnostic capacity in England, providing patients with a coordinated set of diagnostic tests in the community, in as few

visits as possible, enabling an accurate and fast diagnosis on a range of clinical pathways".

9.3. CDCs are new facilities for carrying out diagnostics, and not just for cancer. CDCs can provide additional capacity for faster diagnosis pathways, including NSS pathways. A pathway may be wholly or partly provided through a CDC setting. CDCs can also benefit faster diagnosis pathways by freeing up capacity in acute hospital diagnostic sites to facilitate transformation activities such as co-ordinated testing or one-stop diagnostic clinics.

9.4. Cancer Alliances, ICSs and providers should determine how CDC capacity should be best used alongside existing capacity.

9.5. Cancer Alliances should identify and quantify diagnostic capacity requirements for each pathway using the approach described in Section 10. As revenue-based transformation funding cannot be used for these (that is, solutions that require capital funding), Cancer Alliances should engage with ICSs to ensure they are included in system-level plans for CDCs, ICS capital plans or other locally-led plans. This should include assessments of future increases in demand, to ensure the delivery of faster diagnosis improvements is sustainable.

9.6. The Cancer Alliance will ensure its work is integrated into the CDC programme of work. CDC proposals will need to be reviewed by Cancer Alliance managing directors to ensure they align with faster diagnosis plans and that capacity requirements for cancer services are included.

9.7. Faster diagnosis leads should be represented on regional diagnostic programme boards, and imaging, pathology and endoscopy networks, as well as in CDC governance structures.

9.8. Cancer Alliances should seek to ensure strategic and operational alignment between relevant programmes, for coherence, transparency, clarity of purpose and appropriate pace.

10. Supporting activities and programme alignment**Pathways-based approach**

10.1. Cancer Alliances, in collaboration with their ICSs and providers, should review their pathways under the objectives set out in Sections 5 to 9. Improvement activities should be managed as co-ordinated programmes to use clinical leadership and project management resources efficiently.

10.2. Faster diagnosis plans should include actions being undertaken as part of operational performance improvements, where these are aimed at the diagnostic phase of the cancer pathway. This should also be the case where they are part of a locally agreed remedial action plan between provider and commissioner or as part of a transformation plan between Cancer Alliances and the NHS Cancer Programme.

10.3. Wherever possible, services, materials and evaluations should be co-designed with patients.

Funding

10.4. Transformation funding will be made available through Cancer Alliances to support activities that deliver faster diagnosis objectives as set out in Sections 5 to 9. Cancer Alliances will be allocated a faster diagnosis budget line and will have the flexibility to determine how this funding is used, as detailed in a clear plan and rationale.

10.5. In 2022/23, £70.85 million is available to Cancer Alliances to fund the service changes required to achieve the objectives outlined in this framework. The [Cancer Alliances planning pack](#) gives more details on funding arrangements for 2022/23. It highlights that budget for the Faster Diagnosis Programme, which was previously allocated separately to RDCs, is now included in the 'Faster Diagnosis and Operational Improvement' place-based allocation.

10.6. Examples of areas where this funding can be deployed are:

- additional diagnostic capacity not funded through existing commissioning routes, including independent sector provision
- additional workforce capacity to improve the optimal clinical management for cancer pathways (eg pathology/radiography capacity)

- fixed-term clinical, admin and patient navigator posts, or sessions that are not funded through existing commissioning routes
- leadership (clinical, nursing and project management)
- enabling costs, eg IT
- communication materials, for patients, the public and primary care
- patient engagement expenses and communication materials
- resources to support the gathering of evidence and development of business cases for sustainable commissioning of faster diagnosis services (at ICS and provider level).

Annual Cancer Alliance plans should include a phased plan detailing the breakdown of funding of activities to support the five objectives of this framework.

10.7. Cancer Alliances should begin work with their ICSs to include faster diagnosis services, eg established NSS pathways, within sustainable commissioning arrangements through building the evidence base and business case for their continuation.

10.8. Cancer Alliances should identify ICS leads who can provide contracting capability and expertise on the commissioning of NSS services. The NHS Cancer Programme has established a working group to develop support materials and enable the sharing of successful commissioning approaches. These will be disseminated through the FutureNHS workspace and delivery groups.

10.9. In assuring Cancer Alliance-level plans, regions should be satisfied that transformation funding spend trajectories are clearly linked to activity or specific interventions and improvements.

11. Monitoring, reporting and evaluation

Monitoring

11.1. Feedback from Cancer Alliances makes it clear that measuring compliance against the seven faster diagnosis principles is a significant challenge for providers. Although the principles provide a useful framework for transformational change, they are not specific enough to be implemented in a standardised way

locally. It is, therefore, challenging for Cancer Alliances to self-audit against these in a comparable way and track progress against them.

11.2. A smaller, more measurable set of implementation metrics for faster diagnosis pathways, including NSS pathways – one that does not require an exhaustive checklist-type approach – will significantly decrease the burden of completing subjective self-assessments of compliance.

11.3. By moving towards a model that allows closer monitoring of outcomes, systems can more effectively evidence improvements in FDS performance and patient outcomes, and reduced variation. More detailed tracking of diagnostic events will also help identify and overcome any bottlenecks/barriers to diagnosing patients faster.

11.4. A set of metrics and data items will be developed to track the delivery of improvements through the BPTPs and the adoption of the wider pathway innovations identified in Sections 6 and 7. Specific delivery targets for each year and key metrics for assessing these will be detailed in the priorities and operational planning guidance and Cancer Alliance planning packs.

Reporting

1.14. 11.5. The data collection for this information will be through the Faster Diagnosis Monthly Management Information returns. A compliance calculator has been developed to support this collection. The monthly management information will include the collection of data for the best practice timed pathway milestones for lung, prostate, oesophago-gastric, colorectal, gynaecology and head and neck cancers.

11.6 For NSS pathways, Cancer Alliances should also continue to collect and submit the for NSS pathways to NCRAS. NCRAS now falls under the remit of NHS Digital, which maintains the mandate to collect identifiable patient data directly from providers. Information governance is in place to support this process, without additional requirements for Cancer Alliances/regions/providers. NSS data is now flowing into the new NHS Digital Trusted Research Environment (TRE), where it is linked to other national datasets to give a full view of the patient pathway. Analysts from the evaluation partners have been granted licences to access the TRE and export results to an interactive dashboard that will be shared with Cancer Alliances, regions and providers.

11.7. NSS referrals will be included in the next version of the CWT guidance, which is expected to be introduced in July 2022. The national team will consult stakeholders on this, and appropriate timelines will be communicated to Cancer Alliances and providers. Providers should already be using the NSS referral type code in the CWT dataset for these patients (TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE – 17 (Suspected – non-specific symptoms)) where patients have been referred to new NSS services. This data is currently being shadow monitored by the national team.

11.8. The Cancer Programme will develop a dashboard showing data at Cancer Alliance, ICS and provider level to allow decisions makers within the system at all levels to review progress against plans and facilitate joint solutions to any barriers to delivery, eg diagnostic capacity. In line with this, the role of the external programme evaluation in assessing improvements against existing pathways and the requirements for any monthly management information will be reviewed.

11.9. As part of the annual planning process and economic evaluation, Cancer Alliances will be expected to identify the costs of delivering the outlined objectives. This will make it transparent where funding has been allocated to ensure improvement plans focus on the requirements asked of the system. This information will support the development of business cases for sustainable commissioning of faster diagnosis services.

Evaluation

11.10. Ipsos Mori in collaboration with the Lancashire and Midlands Commissioning Strategy Unit (CSU) and York Health Economics Consortium (YHEC) have been commissioned to evaluate the Faster Diagnosis Programme until the end of 2023/24. This will include quantitative and qualitative investigation of the following six themes:

- approaches to implementation
- symptoms and diagnoses
- capacity, demand, resource utilisation and cost-effectiveness
- variation
- patient and carer experience
- potential harms.

11.11. An evaluation strategy was developed for the RDC programme in 2020 and was reviewed in February 2022 in line with the Faster Diagnosis Framework. Cancer Alliances should engage with the evaluation partners and support them to identify relevant members of staff to participate in different elements of the evaluation. Evaluation activities may include:

- annual interviews with Cancer Alliances
- a set of case studies each year based on in-depth interviews with service providers
- an experience of care survey
- qualitative interviews with patients
- an impact evaluation and monthly reporting using the TRE data
- economic evaluation activities co-ordinated by YHEC. Gathered information on costs will be linked to the patient-level data in the TRE, to support cost–benefit analyses.

11.12. Results of the evaluation will be shared with Cancer Alliances and local providers to help improve services as the programme develops. The CSU will flow evaluation data into an interactive data dashboard which will include the minimum dataset, linked to other national data sources. We hope this will provide detailed insight for developing excellent patient care and support.

11.13. The impact of the faster diagnosis objectives on reducing health inequalities will be considered throughout all elements of the evaluation, including qualitative interviews with patients and staff, and analyses of the minimum dataset.

Annex 1: NSS referral criteria and core tests

To support earlier and faster diagnosis, the following minimum referral criteria for the non-specific symptoms' cohort should be used.

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
- abnormal radiology suggesting cancer; not needing admission and not suitable for existing urgent cancer referral or cancer of unknown primary pathway.

Exclusion criteria for non-specific symptoms:

- patient has specific alarm symptoms warranting referral onto a single site-specific pathway (in line with NG12)
- patient is too unwell or unable to attend as an outpatient or needs acute admission
- patient is more 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 Cancer Alliances to consider as part of expanded cohorts or to amend to meet local needs:

These should be considered where patients also have other concerning signs of cancer:

- 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 (eg significantly raised CRP and infection excluded, ALP >x2, raised calcium, platelet >400 men, or >450 women alongside other symptoms)
- those who cannot wait for an urgent cancer referral pathway (if local RDC provision supports this), eg 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 (that is, 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 (eg kidney function) has been completed, removing potential delays further along the pathway.

It is recommended that the following filter function tests are carried out in primary care, where relevant for patients, to make a successful referral into an faster diagnosis pathway:

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)
- B12/ferritin/folate and iron studies (if anaemic).

Optional additional tests (where relevant to symptoms):

- ultrasound
- TTG AB (if anaemic)
- GGT
- Prot EP
- LDH

- clotting (for lymphadenopathy referrals, this should be considered a core test)
- HIV
- hepatitis C
- glucose.

Annex 2: NSS redirect example symptom criteria

These redirect symptom criteria were developed by and are currently used in practice by Greater Manchester Cancer Alliance NSS pathways. They were developed in collaboration with clinical and operational experts from the identified tumour group/pathways. Where this process has been implemented, Cancer Alliances have identified cancers that may not have been detected otherwise. For example, in Greater Manchester, the newly established Northern Care Alliance NSS pathway worked with the traditional LGI pathway to accept appropriate redirects, resulting in diagnoses of lung cancer. A share and learn presentation on Greater Manchester's redirect process is available on the Faster Diagnosis Workspace.

Tumour group/ pathway	Symptom criteria for redirecting patients onto NSS pathways	NG12 'red-flag' symptom criteria for patients to remain on tumour-specific pathways
Lower gastrointestinal	Weight loss, decreased appetite, nausea, bloating, abdo pain – non-specific, iron deficient anaemia, dyspepsia	Rectal bleeding, altered bowel habit, positive FIT
Upper gastrointestinal	Weight loss, decreased appetite, nausea, bloating, abdo pain – non-specific, iron deficient anaemia	Melaena, haematemesis, dysphagia, reflux
Haematology	Night sweats, weight loss, inguinal lymphadenopathy	High suspicion of lymphoma or other haematological malignancy
Gynaecological – ovarian	>45 years old with: abdo pain, bloating, weight loss, fatigue, raised/normal CA125	All <45 years old, definite mass, all other specific gynaecological NG12 symptoms
A&E	Patients with non-specific symptoms, or MUO, well enough to be discharged and investigated as an outpatient, where underlying cancer is the main suspicion	All acutely unwell patients requiring inpatient investigation. Patients requiring investigations for other causes of symptoms as a priority

Annex 3: Quality markers for personalised care and experience of care

In 2020, 30 quality markers were co-produced with staff, patients and carers to promote a positive experience of care for people accessing cancer diagnostic pathways. Cancer Alliances, in partnership with people that provide and use services, should assess their own services against these quality markers using them as a framework for measurement.

Ten of these markers were identified as a priority for delivering a good experience of care following co-design sessions with patients and other stakeholders during the first wave of the COVID-19 pandemic:

- Patients are aware that the pathway is to rule in or rule out cancer and the time in which a diagnosis should be communicated (in line with the Faster Diagnosis Standard).

- A patient's ability to attend appointments is considered in the design of services.

- Patients will be navigated through their pathway via a single point of contact.

- Actions are in place to reduce anxiety for patients and carers about initial appointments.

- Patients and carers are told about the VCSE (voluntary, community and social enterprise) sector services that will best meet their support needs at every stage of the pathway.

- All communication with patients and carers is presented in a way that they will understand, taking account of language, cultural, sensory, learning or other needs.

- At the point of discharge or onward referral, the patient is aware of what the next steps are.

- Services measure patient and carer experience and work with people who use those services to make co-produced improvements as a result.

- Services acknowledge and support the emotional, psychological and mental health needs of patients and carers on this pathway.

- Services ensure patients and carers are involved as much as they would like to be during the diagnostic process.

Theme	Number	Quality marker
Personalised care	1.*	How does the service ensure that patients are aware that the pathway is to rule in or rule out cancer and the time in which a diagnosis should be communicated (in line with the Faster Diagnosis Standard)?*
	2.	How does the service ensure that GPs are aware of the criteria for referral?
	3.	How does the service ensure that GPs ensure that all information with regards to onward referral is easy to understand?
	4.*	How does the service ensure that a patient's ability to attend appointments is considered in the design of services? *
	5.*	How does the service ensure that patients and carers feel involved as much as they would like to be during the diagnostic process? *
	6.*	How does the service ensure that the patient will be navigated through their pathway via a single point of contact? *
	7.	How does the service ensure that where the patient may have more than one point of contact a process is in place to ensure continuity of care?
	8.*	What actions are services taking to reduce anxiety for patients and carers with regards to initial appointments? *
	9.	How does the service ensure that a patient only has to tell their story once?
	10.	How does the service ensure that patients are advised that they should bring someone with them to appointments on the pathway – as is possible and appropriate?
	11.	How does the service ensure that patients and carers are given the correct information with regards to how long they will have to wait at appointments?
	12.*	How does the service make sure that patients and carers are told about the VCSE (voluntary, community and social enterprise) sector services that will best meet their support needs at every stage of the pathway?*

Theme	Number	Quality marker
	13.	How does the service ensure that the environment in which the patient and carer is seen is positive and welcoming?
	14.	How does the service support staff to be positive and welcoming?
	15.	What actions does the service take to ensure staff feel supported in their role?
	16.	How does the service ensure that any one-to-one sessions with healthcare providers and patients and carers are held in a private space?
	17.	How does the service ensure that patients and carers understand the information shared with them – especially with regards to diagnosis?
	18.	How are patients (as appropriate) offered access to their full medical/diagnostic/treatment record? Does the service ensure that all letters sent to primary care have the patient included?
	19.*	How does the service ensure that all communication with patients and carers is presented in a way that they will understand, taking account of language, cultural, sensory, learning or other needs? *
	20.	How does the service ensure that spouses, family and carers get the support they need as well?
	21.	How does the service ensure that patients and carers have written information to take away on the day with regards to diagnosis and next steps?
	22.	How does the pathway support the discharge of patients from the service and how is the GP kept informed of the next steps?
	23.*	How does the service ensure that at the point of discharge or onward referral the patient is aware of what the next steps are? *
	24.*	How does the service measure patient and carer experience and work with people who use those services to make co-produced improvements as a result?*
	25.	If the patient has a cancer diagnosis how does the service ensure that the information gathered from the patient in the pathway is passed onto the patient's cancer team?

Theme	Number	Quality marker
A whole-person approach	26.	How does the service ensure that contact with the patient is used as an opportunity for health information and advice?
	27.	How does the service ensure that a patient's physical and psychological symptoms are addressed as appropriate?
	28.	How does the service ensure that staff in the service are aware of the support available to patients and carers in the community including spiritual support?
	29.*	How does the service acknowledge and support the emotional, psychological and mental health needs of patients and carers on this pathway? *
Accessibility and user involvement	30.	How does the service ensure that everyone can access the physical aspects of the service and that reasonable adjustments are made as appropriate?

* An identified priority for delivering a good experience of care.

These quality markers remain specifically relevant to the cancer diagnostic pathway and align with wider work completed by National Voices in 2020, which developed a set of 'I' statements expressing how patients hope to be treated across all health and care settings, which you can find here.

The NHS Cancer Programme has produced resources to improve psychosocial support services for people affected by cancer, which may also support the implementation of the quality markers.