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Clinically-led review of NHS cancer standards

Models of care and measurement

9th March 2022

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Foreword

In June 2018 the Prime Minister asked for a clinically-led review of NHS access standards to ensure they measure what matters most, both in optimising clinical outcomes and to patients.

This report sets out an approach to modernising and streamlining cancer waiting times standards, refocusing performance measures on the critical NHS Long Term Plan objective of earlier and faster diagnosis, while continuing to incentivise the best clinical care.

Cancer services and approaches to diagnosis, treatment and care have changed beyond recognition in the 20 years since the introduction of the first cancer waiting times standards. From a situation in which there were no standardised measures at all, we now have nine standards, with a further standard, the new faster diagnosis standard, in the process of being fully implemented. At the same time, the number of cancer referrals has increased hugely – more than doubling between 2010 and 2021 – a welcome trend that has seen more cancers diagnosed and emergency presentation rates fall, but one that has put substantial pressure on cancer services to manage an increasingly complex workload.

Most crucially, as we have learnt more and more about how to successfully diagnose and treat cancer, and as medical technology has advanced to provide more accurate imaging and new less invasive tests, the guidance and rules governing the cancer waiting times standards need to keep pace. To support clinicians to deliver new, innovative approaches to care and maximise opportunities for patients to benefit from these, the rules and standards need to adapt to ensure appropriate treatment and clinical management of patients remains the priority.

The approach set out in this document aligns with the recommendations in the 2015 Independent Cancer Taskforce report, and builds on the NHS Long Term Plan

ambitions and commitments, to ensure that the cancer waiting times standards support our long-term goals, delivering the best possible clinical care and experience for patients.

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Summary

This report sets out the final recommendations relating to cancer waiting times standards from the Clinically-led review of NHS access standards (CRS), and we are inviting patients, clinicians and the public to respond to them in this consultation (see Section 4 for details of how to respond and the questions we would particularly welcome feedback on).

The proposed measures align with the recommendations of the 2015 Independent Cancer Taskforce report, build on our NHS Long Term Plan ambitions and commitments, and draw on the learning from experience through COVID-19.

The NHS Long Term Plan set an ambition that by 2028, 75% of people with cancer will be diagnosed at an early stage. The CRS proposes changes to cancer waiting times standards based on the principles of simplification, modernisation and a shift in focus towards speed of diagnosis. The review has been led by Professor Steve Powis, National Medical Director of NHS England, with support from a Clinical Oversight Group, consisting of clinicians and patient group representatives, in addition the cancer work has been supported by the Clinical Advisory Group for Cancer as well as a specific CRS taskforce established to support the programme, which included a wide range of clinical professionals from a number of specialties.

In 2015 the Independent Cancer Taskforce recommended that the current two-week wait (2WW) standard be replaced with a 28-day faster diagnosis standard (FDS), which 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. This was recommended because at the time no pathway measure captured the whole time elapsed from GP referral for a test to the patient receiving a definitive diagnosis or cancer exclusion. The taskforce proposed that focusing on this time would encourage commissioners and providers to consider how best to streamline and optimise diagnostic pathways for the vast majority of patients.

The 2WW standard only requires hospitals to provide an appointment within two weeks and does not consider how long a patient waits to get a diagnosis or ruling out

of cancer. As clinical models and technology have evolved and improved over more than 20 years, it has in some cases become a barrier to best practice.

For example, for breast cancer the recommended model of care is the triple assessment – for which patients attend one appointment to receive an assessment, mammogram and biopsy. However, a recent Getting It Right First Time survey showed that 30% of trusts were providing separate appointments for these tests, as the first appointment stops the 2WW clock and allows them to meet the target. Shifting the focus from the provision of an appointment to the giving of a definitive diagnosis helps ensure all patients receive appropriate and ideal models of care.

The proposals set out in the Interim report on the Clinically-led Review of NHS Access Standards were field tested in 11 trusts from August 2019 to ensure they could be safely implemented and were not detrimental to patients or overall operational performance. We found no adverse events as a result of ceasing the publication of the 2WW; maintained performance against the 28-day and 62-day standards relative to non-test trusts; and no significant increase in time to first appointment. The test sites increased the proportion of patients first seen within seven days compared to the control group and five increased their FDS performance relative to the baseline during the field-testing period of September to December 2019. In post-testing phases the test group have outperformed the control group against both the FDS and 62-day standards. Patients, staff and test sites have told us that the new approach more closely relates to patient priorities and efforts to improve outcomes, and provides greater flexibility in how care is organised so that new technologies and ways of working can be adopted more readily.

The CRS 2019 interim report additionally recommended simplifying the existing treatment standards into two standards, focused on ensuring that patients are treated (i) within 31 days of a decision to treat and (ii) within 62 days of starting on a cancer pathway. This would reduce the nine performance standards (which the CRS concluded were “complex and difficult to understand for both patients and NHS staff”) to a more meaningful and focused three.

Further clinical updates to the rules governing the cancer standards were introduced in 2020 to ensure they do not disincentivise modern clinical practice, including a revision of the list of permissible ‘enabling treatments’ and adjustments to waiting times standards where a patient requires urgent treatment of another medical condition

before starting their cancer treatment. The key changes are described in Annex A but as these have already been implemented, they do not form part of this consultation.

1. Introduction

Cancer is a priority for the NHS – more people are surviving cancer than ever before, but even more lives can be saved by diagnosing cancer earlier and starting treatment as quickly as possible.

The NHS Long Term Plan ambition is to save thousands more lives each year by dramatically improving how cancer is diagnosed and treated –by 2028, an extra 55,000 people each year surviving for five years or more after being diagnosed with cancer and 75% of people with cancer diagnosed at an early stage (Stage I and II). Faster diagnosis is a key enabler to achieving earlier diagnosis and the reason the 2015 Independent Cancer Taskforce report recommended that the current two-week wait (2WW) standard be replaced with a faster diagnosis standard (FDS). This recommendation was adopted as one of the five key NHS Long Term Plan commitments for cancer.

In June 2018 the Prime Minister asked the National Medical Director of NHS England and NHS Improvement to review the core NHS access standards, including those for cancer, in the context of the model of service described in the NHS Long Term Plan, to ensure that they measure what matters most clinically and to patients, and to recommend any required updates and improvements to ensure that NHS standards:

- promote safety and outcomes
- drive improvements in patients' experience
- are clinically meaningful, accurate and practically achievable
- ensure the sickest and most urgent patients are given priority
- ensure patients get the right service in the right place
- are simple and easy to understand for patients and the public
- do not worsen inequalities.

The Clinical Review of Standards has been undertaken in three phases:

1. **Considering what is already known about how current targets operate and influence behaviour** – during earlier engagement on the NHS Long Term Plan, assessment of the available academic, clinical and operational

evidence for the current standards' effectiveness in driving improvement in quality, safety and outcomes for patients.

2. **Mapping the current standards against the NHS Long Term Plan** – as the planned improvements in care took shape, assessment of whether the current standards would help transform and deliver better care and treatment.
3. **Testing and evaluating proposals** – where new or updated standards were proposed, real-world testing of these to ensure that they deliver the expected change in behaviour and experience for patients, before making any final recommendations for wider implementation.

A Clinical Oversight Group was established to provide advice and insight as we developed the recommendations and approach to testing, and as we began to learn from test sites. The group includes representatives from the Academy of Medical Royal Colleges, the Royal Colleges of Surgeons, Physicians, Nursing, Psychiatrists and Emergency Medicine; as well as patient representative bodies including Healthwatch, the Patients Association and cancer and mental health charities. Their expertise has been invaluable in developing the recommendations and proposals set out in this consultation.

The Cancer CRS is recommending changes to ensure cancer waiting times standards better reflect current clinical and operational models of care. This report sets out how we hope to use a new set of cancer waiting times standards to drive improvements in access, waiting times, including outcomes for users of services and seeks views from members of the public and wider NHS organisations.

2. Proposal for measuring cancer waiting times

Context

Nine access standards currently cover a range of treatment and referral routes for cancer. This is more than for all other elective care. These standards can be complex and difficult to understand for both patients and NHS staff.

One of the standards, the ‘two-week wait (2WW)’ is detailed under Part 9 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, and sets out the:

> “Duty to make arrangements to provide an appointment with a specialist for those patients urgently referred for treatment for suspected cancer… within the period of 2 weeks beginning with the start date in not less than 93% of cases where that treatment is provided in that data collection period”, where treatment is defined as “assessment by a specialist in order to progress towards a diagnosis”.

The other eight current cancer waiting times standards, detailed in the Handbook to the NHS Constitution, are:

- a maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers
- a maximum 31-day wait for subsequent treatment where the treatment is surgery
- a maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy
- a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen
- a maximum two-month (62-day) wait from urgent referral for suspected cancer to first treatment for all cancers
- a maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer
- a maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers)
- a maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected.

The goal of the Cancer CRS has been to develop a new, simplified set of patient-centred standards appropriate to modern cancer care that are understandable both clinically and to help the public. The standards constitute a commitment from the NHS to people with a suspected or diagnosed cancer, and therefore must be easily understood both by patients and the clinical teams caring for them.

We have also proposed updates to the rules and guidance around the standards so that as far as possible they always promote, and avoid disincentivising, the appropriate clinical management of patients. For example, they ensure that the ideal model of care for suspected breast cancer – the triple assessment for which patients attend one appointment to receive an assessment, mammogram and biopsy – is not disincentivised (as it currently is according to many of our stakeholders).

Consolidating and modernising treatment standards

The CRS interim report, published in 2019, stated that the current nine access standards for cancer with different reporting thresholds added "unnecessary complexity" for management and interpretation by both the NHS and patients. It proposed replacing the three standards related to treatment starting within 62 days for urgent referrals, consultant upgrades and screening with one standard; and replacing the four standards related to first and subsequent treatments within 31 days from diagnosis with one 31-day treatment standard for all patients. All patients covered by the current standards are captured by the scope of the new standards, but for the first time people with breast symptoms and those not initially referred on a 62-day pathway but given a consultant upgrade are also brought within the scope. Broadening the scope of the 62-day standard will better and more fairly reflect the delivery of cancer services at provider level, by including pathways that contribute up to 50% of cancer diagnoses and treatments but are not currently counted. Combining the standards in this way is unlikely to have a substantial impact on headline performance.

Alongside the review of the standards themselves, NHS England and NHS Improvement convened a clinical and operational panel, chaired by Professor Peter Johnson, to review the rules governing the cancer waiting times standards. In particular, this aimed to minimise the potential for cancer waiting times rules to penalise or disincentivise appropriate clinical management of patients. The panel recommended allowing for the treatment of another clinically urgent condition before starting cancer treatment and allowing treatment of a metastatic site to count as first definitive treatment. The panel also reviewed the list of permitted 'enabling treatments' that can count as starting first definitive treatment for cancer, which had become significantly out of date.

At the same time, it is proposed to remove the reference within the Cancer Waiting Times guidance to the 31-day referral to treatment period for Urgent GP (GMP, GDP or Optometrist) referrals for acute leukaemia, testicular cancer, and children's cancers.

No separate performance standard currently exists for these patients and reporting of these patients within the numerator and denominator of the 62-day all cancer National Statistics published by NHS England will continue.

Although most of these changes to the guidance will affect only a relatively small number of patients, resolving these issues will help maintain clinical confidence in the standards and the rules governing them. Looking beyond this standalone review of the standards, the National Clinical Director for Cancer with the Clinical Advisory Group for Cancer will review the cancer waiting times guidance on a regular basis to ensure it remains in line with best clinical practice.

The changes made in the updated cancer waiting times guidance reflecting these changes (version 11) published in 2020 are summarised at Annex A. Subject to acceptance of the recommended changes to the treatment standards and the 2WW standard in this document, a version 12 will be published to explain how these changes will come into effect; a draft of this is published alongside this document for comment.

Focusing on diagnosis

The 2WW standard was introduced 20 years ago as one of the first of the new wave of NHS targets. The standard only requires hospitals to provide an appointment to 'stop the clock' – regardless of whether that appointment is of value for the patient.

This made sense when this standard was proposed in 2000. However, time, technology and clinical practice have moved on and the 2WW requirement can now hamper clinical management and patient experience, unnecessarily taking up patient and clinician time, reducing the benefits to be gained from the more modern, innovative pathways available and presenting a barrier to modernisation and greater efficiency in clinical processes.

Many pathways can now go 'straight to test', without the need for an outpatient appointment. Yet several clinicians told us that some patients who should be on a straight-to-test pathway for a diagnostic such as a colonoscopy are instead being brought in for an outpatient appointment solely to 'stop the clock', adding very little value to their overall clinical pathway.

Technology now allows remote consultation in some cases, or even remote review of images of skin lesions. Yet those who could have their skin lesion reviewed remotely

without ever needing to come into hospital for an appointment continue to be brought in unnecessarily – to meet the 2WW requirement.

Similarly, the 2WW has hampered the introduction of the simple, non-invasive faecal immunochemical test (FIT) that can reduce the number of people requiring a colonoscopy and direct them towards more appropriate tests such as new capsule endoscopy. The difficulty of booking the test and turning results around all within 14 days has led many trusts to reject this improvement and continue to offer outpatient appointments to ensure they hit the target. In some trusts, 2WW performance can be over 99% on the lower GI pathway, with fewer than 20% of the same patients ultimately receiving a diagnosis within 28 days.

Breast cancer is another example of this effect. Whereas the ideal model of care is the efficient triple assessment, a recent Getting It Right First Time survey showed that 30% of trusts continue to provide separate appointments for these tests, as the first appointment stops the 2WW clock and allows the target to be met.

The 2015 Independent Cancer Taskforce report recognised that the current 2WW standard does not measure the most meaningful metric to the patient: the time they wait to receive a diagnosis or have cancer ruled out. They recommended replacing the 2WW standard with a patient-centred faster diagnosis standard that ensures the time from referral to diagnosis of cancer is no more than 28 days. The Cancer CRS endorsed this proposal in its interim report, and in this final report we propose the 2WW standard is removed, starting in 2022, to shift the focus completely to maximising the speed with which we diagnose or rule out cancer.

Recommended new standards

The recommended new standards to support the new models of care and innovations that benefit patient outcomes are as follows:

Measure	Clinical rationale and implications for patient care
Faster diagnosis standard (FDS): Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	Brings together existing urgent referral routes into one simple standard. More explicit focus on measuring and incentivising faster diagnosis. Urgent cases include those referred: • by their GP with urgent cancer symptoms • by their GP with breast symptoms; • by cancer screening services. It is important that people are diagnosed quickly after referral so they can start treatment as soon as possible. Patients will need to have their first appointment with a consultant well before the 28-day point to ensure communication of diagnosis within that timeframe. The FDS was included in the Standard Contract for 2021/22 published in March 2021, with an initial performance threshold of 75%.
Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms), consultant upgrade and NHS cancer screening	Brings together three existing urgent referral routes into one simplified standard. Includes urgent cases as above. Having a single headline measure and ensuring the clinical guidance governing inclusion within it reflects modern clinical practice, adds clarity and greater focus on what really matters to patients.
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients	Brings together four existing treatment standards into one simplified standard. All cancer patients need to begin treatment quickly after the decision to treat is made. Maintains guarantee of swift start to treatment for all cancer patients.

3. Patient and public engagement and proposal testing

Before testing the proposals, we engaged with stakeholders in June 2019, and received responses from 46 organisations, including hospitals, Cancer Alliances and charities across the country.

Responses overall supported the core proposals in the interim report, including the simplification and modernisation of standards. Support for the immediate removal of the 2WW standard was more mixed, with some asking whether the time taken to first appointment should be lengthened or whether there may be knock-on impacts on 62-day performance. This area was therefore chosen for focus during field testing.

The NHS Cancer Programme also engaged extensively with its Patient and Public Voice Forum on the proposal to replace the 2WW standard with the FDS standard; this received a positive response. Concerns raised centred on how the change will be communicated to patients, to ensure the FDS is well understood and realistic expectations of care are set for all patients.

The Cancer Programme continues to engage regularly with a wide range of stakeholders, including through its well-established charity forum, the National Cancer Board and Task and Finish groups including a range of clinicians and cancer charities who have contributed to this work.

Testing

The CRS interim report in March 2019 set out our intention to test the proposals before making final recommendations, including the replacement of the 2WW standard with the FDS. The test sites were carefully selected to give a mix of rural and urban communities, geographical spread across the country, and higher and lower performers and to ensure they had the necessary data quality and IT infrastructure in place to enable robust recording and reporting during the test period.

The performance of the test sites in this period has been compared with that of a control group of 16 hospital trusts across the country with a similar case mix and set of circumstances. All sites had their 2WW, 62-day and FDS performance baselined for the period April to July 2019. FDS data completeness and activity were also included in the baseline assessment.

Testing began in September 2019 in two phases: the first from September to December 2019 focusing on whether the standard could be rolled out safely and the second in three periods from April 2020 to July 2021 on improving performance against the FDS.

With the onset of the COVID-19 pandemic in March 2020, the Cancer CRS process was suspended, but changes to data publications and removal of accountability for delivering the 2WW remained in place. Data continued to be collected after the end of the testing period, with robust analysis possible from October 2020 following a series of trust mergers and the immediate impact of the first wave of the pandemic which resulted in extremely volatile performance across the country.

What has been learnt

Both qualitative and quantitative analysis from field test sites was undertaken, making use of existing data sources publicly (cancer waiting times data) and internally (weekly Patient Tracking List submissions to NHS England and NHS Improvement) available. Qualitative information was sourced directly from test sites and through the independent CRS evaluation carried out by SQW.

Below we have summarised findings under three broad headings:

- impact on patient care
- impact on design of services
- how best to implement new standards.

Impact on patient care

No significant issues or concerns were raised by either the clinical or patient groups involved in the test sites, and we observed promising improvements in some areas against a continuing backdrop of significant year-on-year increases in the number of people receiving an urgent cancer referral.

Data from the test sites demonstrated that patients are not waiting significantly longer for first appointment than previously, reducing concerns that moving from the 2WW to the 28-day FDS could result in slower appointments for patients. For example, since October 2020 waiting times for suspected breast cancer in the test and control groups have been comparable.

Performance against the 62-day standard during the first testing phase (September to December 2019) was also comparable between the test and control groups (77.9% vs 77.1%). However, in the total post-testing dataset performance for the test group was significantly higher (April to July 2021 data: 74.9% vs 71.7%).

During the testing phase there was also no observable difference between the control group and test group for FDS performance (77.7% vs 77.2%), and again in all post-testing phases the test group outperformed the control group (April to July 2021 data: 78.7% vs 71.9%). The test group's FDS performance has also returned to pre-testing baseline levels whereas the control group is 4.80% below this. This suggests that test sites may have been able to recover faster from negative impact of COVID-19 on performance.

Following questions from patient groups, we carried out a more detailed analysis to look at performance for people referred by their GP with suspected breast cancer. Since October 2020, performance against the FDS (the proportion of people with suspected breast cancer receiving a diagnosis or cancer being ruled out) has been marginally better in the test group than in the control group (92.9% vs 91.0%). In June and July 2021 performance was 4% better in the test group than the control group. In each of the three months up to and including July 2021, the percentage of patients meeting the FDS within two weeks has been better in the test group than the control group (65.9% vs 56.0% in July 2021).

Early analysis of the testing period data also showed an emerging positive relationship between FDS performance and 62-day performance when applying a one-month lag (e.g. how April's FDS performance affects May's 62-day performance).

Impact on design of services

Feedback from test sites indicates that services can quickly flex their models to provide a diagnosis or rule out cancer more quickly. Several test sites have focused on increasing the proportion of 'one stop' clinics offered to patients on particular

pathways, making the most of new technology and optimal pathways, and modifying the skill mix of their workforce, e.g. by using new patient navigator roles.

Further gains can be anticipated from the flexibility afforded by removing the 2WW standard. For example, for people with suspected skin cancer, new teledermatology models could rule out cancer without the need for a face-to-face appointment; breast services will be able to focus on providing triple assessment clinics for all patients even during spikes in demand; and services will not be disincentivised from introducing diagnostic innovations such as FIT.

How best to implement new standards

Staff feedback supported the introduction of the new cancer access standards; they were perceived to be more patient-focused. This feedback did identify key potential challenges for their implementation by trusts related to administration, due to increased tracking of patients who have cancer ruled out, and capacity, where front-loading of tests to meet the standard may put extra pressure on diagnostic services. It was also noted that for some cancers with more complex pathways achieving the 28-day FDS will be more difficult. The NHS cancer programme has already produced optimal timed pathways for some of these cancers and will consider adding to these for pathways where there may be particular challenges.

Potential unintended consequences raised included added pressure to shift diagnostic tests from secondary to primary care, given concerns about capacity. This should be monitored closely, and any GP with a suspicion of cancer should always retain the option to immediately make an urgent referral for cancer. Given recent unprecedented growth of over 10% per year in cancer referrals, we consider the risk of a significant shift in this pattern to be small.

Consulted staff said they did not expect any patient safety or clinical issues as a result of the new FDS standard. However, we have been told from the NHS England and NHS Improvement online engagement with stakeholders and NHS Cancer Programme's Patient and Public Voice Forum that greater clarity on the meaning of 'communication of diagnosis' to the patient would help distinguish 'reaching a diagnosis' from 'finalising a treatment plan', which is not required within 28 days.

Staff told us that although we have not been monitoring performance against the 2WW standard during testing, they have and will continue to monitor time to first seen locally as this is one of their operational milestones in the cancer pathway.

4. Your views

We are seeking responses to the following questions. Individual responders are welcome to respond to all or some of the questions. The engagement questions represent a consultation on the proposals set out in this paper and should be taken as also applying to any changes that might be required to the NHS Standard Contract to implement these changes if approved.

Recommended standards for cancer
Faster diagnosis standard: Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening.
Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms), consultant upgrade and NHS cancer screening.
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Current standards

1. Are you aware of the current cancer standards?

2. What do you understand the two-week wait first seen standard to mean?

3. What do you understand the 31-day first treatment standard to mean?

4. What do you understand the 62-day referral to treatment standard to mean?

5. To what extent do you agree or disagree with the proposal to replace the expectation of an appointment within two weeks with people receiving a definitive diagnosis or ruling out of cancer within 28 days of referral?
   (1 strongly disagree to 5 strongly agree)

   Please explain your reasoning.

6. To what extent do you agree or disagree with the proposal to simplify the existing referral to treatment standards by combining them into one 62-day standard?
   (1 strongly disagree to 5 strongly agree)

Please explain your reasoning.

7. To what extent do you agree or disagree with the proposal to simplify the existing decision to treat to treatment standards by combined them into one 31-day standard?
(1 strongly disagree to 5 strongly agree)

   Please explain your reasoning.

How to respond

This consultation runs from **9th March 2022 to 6th April 2022.**

Responses can be submitted through the consultation form on the NHS England and NHS Improvement website or by email to England.reviewofstandards@nhs.net
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Annex A: Summary of changes to cancer waiting times guidance, version 11

Version 11 of the cancer waiting times (CWT) guidance was published in August 2020 and applies to activity that ended on or beyond 1 July 2020.

Subject to acceptance of the recommended changes to the standards, version 11 will be updated to allow their implementation and at the same time widen the CWT scope to include non-specific symptom referrals reporting and pTa bladder cancer and low-grade brain tumours. Version 12 of the CWT guidance has been published for comment alongside the consultation on the Cancer CRS recommendations.

Summary of changes between Versions 10 and 11

First seen standard specifics
The number of healthcare professionals who can make urgent suspected cancer referrals is expanded beyond General Medical Practitioner, General Dental Practitioner and optometrist where this is agreed locally.
Clarification on national requirements in management of urgent suspected cancer and breast symptomatic referrals: • If a consultant thinks the two-week wait referral is inappropriate, this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral. • The date of receipt of initial referral or the conversion of the unique booking reference number (UBRN) into a booking should always count as the start of the pathway and be recorded as CANCER REFFERAL TO TREATMENT PERIOD START DATE. This includes scenarios where additional information is requested from the referrer and where a patient is unavailable for a period of time. • A patient should not be discharged because they are unavailable within a specified timeframe, and processes should be in place to ensure patients have the choice to book outside the two-week wait timeframe.
Clarification on how to record ‘clock start’ for patients who are progressing along a national best practice timed pathway following a direct access diagnostic test, now covering all suspected cancer types.

New guidance on the recording of non-specific symptom referrals supported by the updates to the cancer waiting times dataset and national system.
28-day FDS specifics
Guidance on how to record scenarios where a communication of diagnosis of cancer or ruling out of cancer is made to a patient's carer or parent.
Updated methodology on reporting of the faster diagnosis standard where a decision to treat is made prior to diagnosis: • Reporting now fully driven by communication of diagnosis date to the patient. • Where a decision to treat date precedes this date, it will then be used for calculating the waiting time for this standard.
Treatment standard specifics
Revised list of permitted 'enabling treatments' that would allow a 'clock stop': • Additions: – dental extractions prior to radiotherapy – percutaneous gastrostomy line insertions – vaccinations prior to removal of spleen – transpositions of ovaries (for preserving fertility/reducing side effects) – drugs which form part of chemotherapy regimens which commence prior to chemotherapy drugs (eg B12 vitamin). • Removals – iron infusion – cystodiathermy
New guidance around recording active monitoring for low and low–intermediate risk prostate cancer. For this cohort, patients are by default recorded as starting active monitoring on communication of diagnosis to ensure they have time to consider their options.
New guidance for CAR-T therapy. Where a patient is receiving CAR-T therapy the point at which cells are extracted can be classed as the start of first definitive treatment.
Updated guidance around recording of TURBT as first definitive treatment. Now can only be recorded as first definitive treatment if tumour is effectively removed.
Changes to the guidance around treatment of a metastatic site tumour where the primary is known. This can now count as a first definitive treatment.
Patient choice treatment adjustment can now be applied to both admitted and non-admitted pathways.

New treatment adjustment introduced for clinically urgent treatment of another condition.
New treatment adjustment introduced for egg harvesting.

Annex B: Modelling performance against combined 62-day and 31-day standards

Performance against the combined 62-day and 31-day standards has been modelled using existing cancer wait time (CWT) data, which can be compared against performance under the previous separate standards.

Performance against the combined 31-day decision to treat to treatment standard

Table 1 shows the published totals and performance against the existing 31-day decision to treat to treatment standards for April to July 2021. Applying the reporting logic of the combined 31-day standard demonstrates that performance against the existing 31-day first treatment standard is slightly improved in all four months from the addition of the subsequent treatment standards. The totals for the numerator and denominator of the combined standard are higher than the totals for the individual standards due to the addition of some subsequent treatments not currently in scope of the 31-day standards (eg HIFU/RFA).

Table 1: 31-day standard performance, April to July 2021

		31 Day First Treatment (96%)	31 Day Subs Surgery (94%)	31 Day Subs Anti-Cancer Drugs (98%)	31 Day Subs Radiotherapy (94%)	31 Day Combined (96%)
Apr-21	Numerator	23511	3787	7618	7030	42277
	Denominator	24963	4478	7698	7309	44811
	Performance	94.2%	84.6%	99.0%	96.2%	94.3%
May-21	Numerator	23605	4086	7700	7112	42858
	Denominator	24810	4617	7768	7322	44915
	Performance	95.1%	88.5%	99.1%	97.1%	95.4%
Jun-21	Numerator	25826	4194	8123	8054	46581
	Denominator	27293	4826	8181	8259	48978
	Performance	94.6%	86.9%	99.3%	97.5%	95.1%
Jul-21	Numerator	25633	4094	7852	7825	45760
	Denominator	27072	4694	7915	8032	48096
	Performance	94.7%	87.2%	99.2%	97.4%	95.1%

Source: National Cancer Waiting Times Monitoring dataset, NHS England, and NHS Improvement

Performance against the combined 62-day referral to treatment standard

Table 2 shows the published totals and performance against the existing 62-day referral to treatment standards for April to July 2021. The estimated additional upgrade pathways have been included to model the impact of implementing Version 12 of the CWT guidance. This would mandate a requirement to upgrade all patients for whom cancer is suspected but who are not already monitored on a 62-day pathway no later than the point of referral to a cancer multidisciplinary team (MDT) meeting. Some exceptions will be permitted for reasons of practicality, e.g. patients first presenting in emergency settings and who receive treatment in the same episode before an upgrade can take place.

The estimate has been calculated by comparing consultant upgrade 62-day totals as a proportion of all first treatments for all providers, taking the provider at the 75th percentile and applying its proportion of upgraded pathways to all providers below it. The combined standard also includes breast symptomatic referral to treatment patients who are not currently in scope or data on them published.

Table 2: 62-day standard performance, April to July 2021

		62 Day GP (85%)	62 Day Screening (90%)	62 Day Upgrade (n/a)	Breast Sympt RTT (not published)	Estimated Additional Upgrades	62 Day Combined (85%)
Apr-21	Numerator	9903	1352	3241	113	2611	17220
	Denominator	13139	1820	3894	137	3264	22254
	Performance	75.4%	74.3%	83.2%	82.5%	80.0%	77.4%
May-21	Numerator	9485	1378	3371	113	2678	17025
	Denominator	12999	1849	4030	147	3464	22489
	Performance	73.0%	74.5%	83.6%	76.9%	77.3%	75.7%
Jun-21	Numerator	10417	1576	3641	127	2785	18546
	Denominator	14218	2154	4426	172	3672	24642
	Performance	73.3%	73.2%	82.3%	73.8%	75.8%	75.3%
Jul-21	Numerator	10371	1569	3551	137	2836	18464
	Denominator	14386	2066	4345	173	3790	24760
	Performance	72.1%	75.9%	81.7%	79.2%	74.8%	74.6%

Source: National Cancer Waiting Times Monitoring dataset, NHS England and NHS Improvement

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