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To:
- NHS trust and foundation trust:
  - chief executives
  - chairs
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors
- ICB chief executives
- Cancer Alliances

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1 February 2023

Dear colleagues,

Maximising 62 day backlog reductions

Firstly, we would like to thank you for all your efforts to reduce the 62 day backlog, while continuing to see significant numbers of new patients. Following the letter on 12 January 2023 about *Elective actions for the 78 week cohort,* which outlined the key areas of immediate focus, we wanted to also set out the equivalent priorities for the cancer 62 day backlog.

There has been significant progress over the Autumn where we have consistently seen backlog reductions nationally which are far higher than in previous years. It is clear that the vast majority of services are now tackling the capacity increases that need to take place in order to fully meet demand, particularly in the diagnostic stage of the pathway, where we know that focus can make the most improvement in backlog reduction. This is especially the case for trusts within the Tiering process who have been able to radically reduce their backlogs – from Birmingham, to Bristol, to Cumbria.

Prioritising Community Diagnostic Centre Capacity

NHS England has asked all CDCs in geographies with high cancer backlogs to prioritise capacity within imaging and endoscopy to accelerate diagnosis for people currently awaiting diagnostic treatment within the 62 day backlog. Remaining CDC revenue funding is being prioritised for this purpose, and we would ask trusts to speak to their nearest CDC to confirm what capacity could be made available over the coming 10 weeks. NHS England is also linking trusts with high cancer backlogs in with those who have succeeded in reducing backlogs through optimising their imaging and endoscopy services so that they implement those tried and tested arrangements locally.

Implementing FIT triage for 2WW patients on endoscopy waiting lists

We are already seeing very strong progress on the rollout of FIT, with the proportion of Lower GI referrals accompanied by a FIT more than doubling in the last five months. Whilst we know many trusts are now actively triaging *new referrals* on the basis of FIT, it is clear that there are still many 2ww patients on endoscopy waiting lists who have not yet been FIT tested. We are asking trusts to ensure FIT is also applied retrospectively to that cohort, where clinically appropriate, so those patients with a FIT negative result and no ongoing clinical concerns indicating colorectal cancer, can be stepped down onto alternative pathways or discharged in line with British Society of Gastroenterology & Association of Coloproctology of Great Britain & Ireland guidance, and colonoscopy capacity can be prioritised for higher risk patients.

Making maximum use of wider local capacity

We know that many of you are now maximising diagnostic capacity in the Independent Sector, including through additional funding made available through Cancer Alliances, and intend to increase volumes over the course of the next 8 weeks. This will be a critical contributor to backlog reduction given we remain in a period of high UEC pressures. NHS England is currently working with the Independent Healthcare Providers Network to identify areas of surplus colonoscopy capacity in particular and we would encourage all trusts unable to secure sufficient IS capacity to contact their Regional IS Lead, including consideration for using local tariff agreements to increase volumes up to the end of March.

Continued focus on data validation and accuracy

Finally, in common with elective recovery, it is important that active validation in line with published guidance is in place to ensure an accurate understanding of patient progress along the pathway and specifically recorded clock stops where patients receive a definitive diagnosis or treatment. Particular areas where there is potential to make progress before March include:

- Skin data, where appropriate validation work is essential for a clear understanding of the current PTL position.
- Robust administrative processes to ensure patients are removed from the PTL as soon as cancer is excluded (with endoscopy a particular area of opportunity) with communication of this decision to patients as soon as possible.

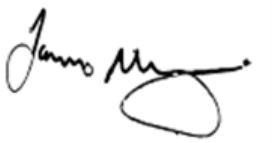
- Patients should only be counted once on the Cancer PTL, so where a patient is transferred to another provider only the provider who is currently responsible for the patient's ongoing care should report the patient.

Trusts should work on validation so that the position reported at the end of March is as accurate as possible to use as the basis for future planning.

Thank you again for your significant efforts to date to support cancer patients, where the early diagnosis data shows us that clinical outcomes are likely now to be significantly improved compared to 2021/22. With your further support over the next ten weeks we are confident this progress can continue and provide us a strong foundation for our ambitions to further improve outcomes for patients over the coming year.

Yours sincerely,

Dame Cally Palmer
National Cancer Director
NHS England



Sir James Mackey
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Prof Peter Johnson
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